DDN

Drink and Drugs News
July/August 2020
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THE HEAT IS ON
Doctor wars: the tumultuous days of the 1980s

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Drink and Drugs News is published by **CJ Wellings Ltd**, Romney House, School Road, Ashford, Kent TN27 0LT
t: 0845 299 3429

Editor: Claire Brown
e: claire@cjwellings.com

Advertising manager: Ian Ralph
e: ian@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

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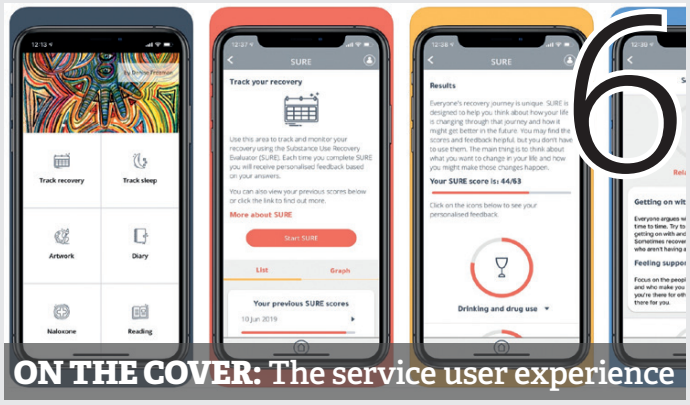

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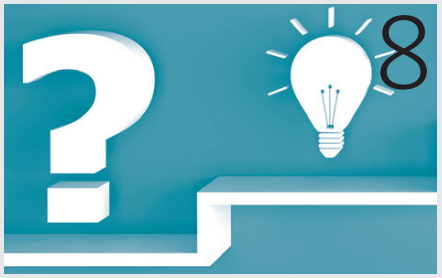

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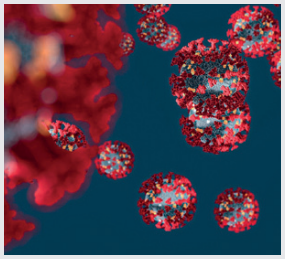


Find the resources to stay ahead of coronavirus from the DDN partners and community at **www.drinkanddrugsnews.com**

We are especially grateful to our network of partners at this difficult time and thank each and every one of them for their loyal support.

DDN is a self-funded independent publication. Our bespoke partnership packages provide an opportunity to work closely with the magazine. Please get in touch to find out more.

'Service users are central to everything'

CONVERSATIONS AT THE MOMENT often come back to feelings of anxiety and isolation, so we're pleased to be able to keep sharing the ways you're responding positively to the COVID situation. Forward Trust are among those looking for creative ways to engage their service user community (p10), while Open Road and Humankind are also redoubling their efforts to connect with service users and make sure no one is isolated (p16 and p22).

With lockdown likely to have a disproportionate effect on women (June issue, p9), we have an insight into domestic abuse support (p12), while Kevin Flemen looks out for young people in the summer party season with some targeted harm reduction advice (p9).

As Bill Nelles (p14) would be the first to remind us, harm reduction must stay top of the agenda so we're pleased to see the cross-sector mobilisation to make injecting facilities a reality (p18) and to support the call for redoubled efforts on eliminating hepatitis C (p11) as World Hepatitis Day approaches on 28 July.

As one of our letter-writers points out (p20) service user involvement should be central to everything we do, so we hope you get involved with the two initiatives from the research team (p6) and PHE (p8) to bring lived experience to the heart of informing treatment.

Claire Brown, editor

Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

Gambling oversight 'complacent' and 'weak', says Commons committee

The bodies overseeing gambling are failing to protect people who are vulnerable to gambling harms, says a report from the House of Commons Public Accounts Committee. The Department for Digital, Culture, Media & Sport (DCMS) and the Gambling Commission – which it oversees – have an 'unacceptably weak understanding' of the impact of gambling harms and lack measurable targets to reduce them, says the document, which was published less than two weeks after a report from the All Party Parliamentary Group (APPG) for Gambling Related Harm called for a complete overhaul of the UK's system of gambling regulation alongside a ban on all gambling advertising.

The public accounts committee found the pace of change to ensure effective regulation to be 'slow' and the penalties imposed on companies that do too little to address problem gambling 'weak'. 'Where gambling operators fail to act responsibly, consumers do not have the same rights to redress as in other sectors,' it says. As gambling increasingly moves online, DCMS and the Gambling Commission have failed to adequately protect consumers, even when problems such as increased risk of gambling harm during the COVID-19 lockdown have been identified. The committee is calling for a published league table of gambling operators' behaviour towards customers, with 'naming and shaming' of poor performers. It also wants to see DCMS embark on an immediate review of the Gambling Act.

'What has emerged in evidence is a picture of a torpid, toothless regulator that doesn't seem terribly interested in either the harms it exists to reduce or the means it might use to achieve that,' said committee chair Meg Hillier. 'The commission needs a radical overhaul – it must be quicker at responding to problems, update company licence conditions to protect vulnerable consumers and beef up those consumers' rights to redress when it fails. The issue of gambling harm is not high enough up the government's agenda.' The review of the Gambling Act was 'long overdue', she added, and an opportunity to see a 'step change' in the treatment of problem gambling. 'The department must not keep dragging its feet – we need to see urgent moves on the badly needed overhaul of the system.'

Gambling regulation: problem gambling and protecting vulnerable people at www.parliament.uk

'What has emerged in evidence is a picture of a torpid, toothless regulator that doesn't seem terribly interested.'
Meg Hillier MP

More than 120 children slain in Duterte's 'war on drugs'

MORE THAN 120 KILLINGS OF CHILDREN and young people were carried out in the Philippines between 2016 and 2019, according to Geneva-based World Organisation Against Torture (OMCT) and the Philippine Children's Legal Rights and Development Center. Just under 40 per cent of the killings were carried out by the police, with the remainder by 'unknown individuals, often masked or hooded assailants, some of them with direct links to the police'. The report – which is based on interviews with families, witnesses and local authorities, as well as official documents – states that the children's ages ranged from just 20 months up to 17.

The deaths documented were either the result of direct targeting, mistaken identity, 'collateral damage' or 'as proxies when the real targets could not be found'. Almost all of those interviewed asked not to be named, and most did not even file a case for the murder of their children through fear of reprisals.

'Over the past four years we have hardly seen any meaningful reaction to the wanton killing of thousands of people under the pretext of the "war on drugs",' said OMCT secretary general Gerald Staberock. 'It is the total lack of accountability that feeds the cycle of violence, including the war on children we are witnessing.' *How could they do this to my child? at www.omct.org*

Philippines. 12th Apr 2019. Protestors against drug-related killings rallied on the streets of Manila carrying a cross and 'stop the killings' placards. Credit: Sherbien Dacalanio/Alamy

Postal NSP launches

AN ONLINE POSTAL NEEDLE EXCHANGE SERVICE has been launched by harm reduction specialists Exchange Supplies to make sure people can access the equipment they need during the COVID-19 pandemic, which has seen reduced staffing levels at many pharmacies. NSPdirect allows drug services to provide a full online and postal needle exchange service during the pandemic and beyond. Services or partnerships joining the scheme are supplied with a set of secure activation codes, which can then be distributed to service users to set up their own online accounts to order equipment.

As with any NSP, clients have the option to use the service anonymously – all data transfer to and from the site is encrypted, and personal information is securely stored. Clients can log in to review their order history, select favourites and repeat previous orders. *More information at www.exchangesupplies.org*

Government launches second phase of Carol Black review

The second part of Professor Dame Carol Black's independent review into illegal drug use in England has now been launched, the government has announced. While the initial phase looked at drug supply and demand, the second will study treatment provision, recovery services and prevention.

The review will look at how drug treatment interacts with housing, employment, mental health and criminal justice services, with the overarching aim of ensuring that vulnerable people get the right support to 'recover and turn their lives around in the community and in prison'. The final document will contain policy recommendations to government, including around funding, commissioning and how local bodies are held accountable to 'ensure they are effective'. The review's first phase concluded that even if more money were made available for drug treatment, there would still be 'a lot of work to do' to build up capacity and expertise in the sector (*DDN*, March, page 4).

'In my foreword to part one I said that behind the thorough analysis of the market for illicit drugs that we had just completed lay a very tragic human story – about the effect on individuals, their families, youngsters caught up in the trade, and the economy,' said Professor Black. 'We showed a decade-long erosion, under previous governments, in almost every aspect of drug addiction, prevention, treatment and recovery. We now have the opportunity to correct this and build a better world. To do this many stakeholders and government departments must work together as never before.'

'We showed a decade-long erosion, under previous governments, in almost every aspect of drug addiction, prevention, treatment and recovery.'
Prof Dame Carol Black

Address lockdown 'time bomb', urges Adfam

PEOPLE COPING WITH A LOVED ONE'S DRUG USE, drinking or gambling have been hard hit by the COVID-19 lockdown, according to an Adfam survey. Half of respondents to *Families in lockdown* said the situation had had a negative impact on their own mental health, while 28 per cent said they were experiencing more verbal abuse than usual, and 13 per cent admitted to being concerned for their safety.

85 per cent of respondents said lockdown had made a 'bad situation worse'

Around 5m people are thought to be dealing with the negative effects of loved one's alcohol or drug use in the UK, with 85 per cent of respondents to the survey saying the lockdown had made a 'bad situation worse'. Many will need urgent additional support as lockdown conditions ease, warns the charity. 'When you are already isolated, fearful or in poor mental and physical health, lockdown takes an even bigger toll,' said chief executive Vivienne Evans. 'Even when restrictions ease, people will need help and support to recover. Now more than ever, we need a national conversation about how we can help people to cope with the life-long impacts of a loved one's alcohol, drug or gambling problem.'
Survey at adfam.org.uk

A quarter of drinkers consuming more

MORE THAN A QUARTER OF PEOPLE who have ever drunk alcohol think they have been drinking more during lockdown, according to Alcohol Change UK. Almost half said they expected to continue drinking at the same rate as the lockdown eases, while 17 per cent said they anticipated drinking more. The figures are based on a survey of more than 2,000 people, around 1,600 of whom were current or former drinkers.

Just under 20 per cent of this group said they had been drinking to cope with stress or anxiety, with parents of under-18s more likely to cite this as a reason than non-parents or parents of adult children. While 38 per cent of those who typically drank seven or more units a day said they were now drinking more, more than one in three people had been taking 'active steps' to manage their alcohol consumption, including having alcohol-free days or looking for advice online. 'From the very start of lockdown, charities and treatment services have warned of the impact on people's drinking,' said chief executive Richard Piper. 'This research shows that we were right to worry.'

Local News

PRIMARY PROJECT

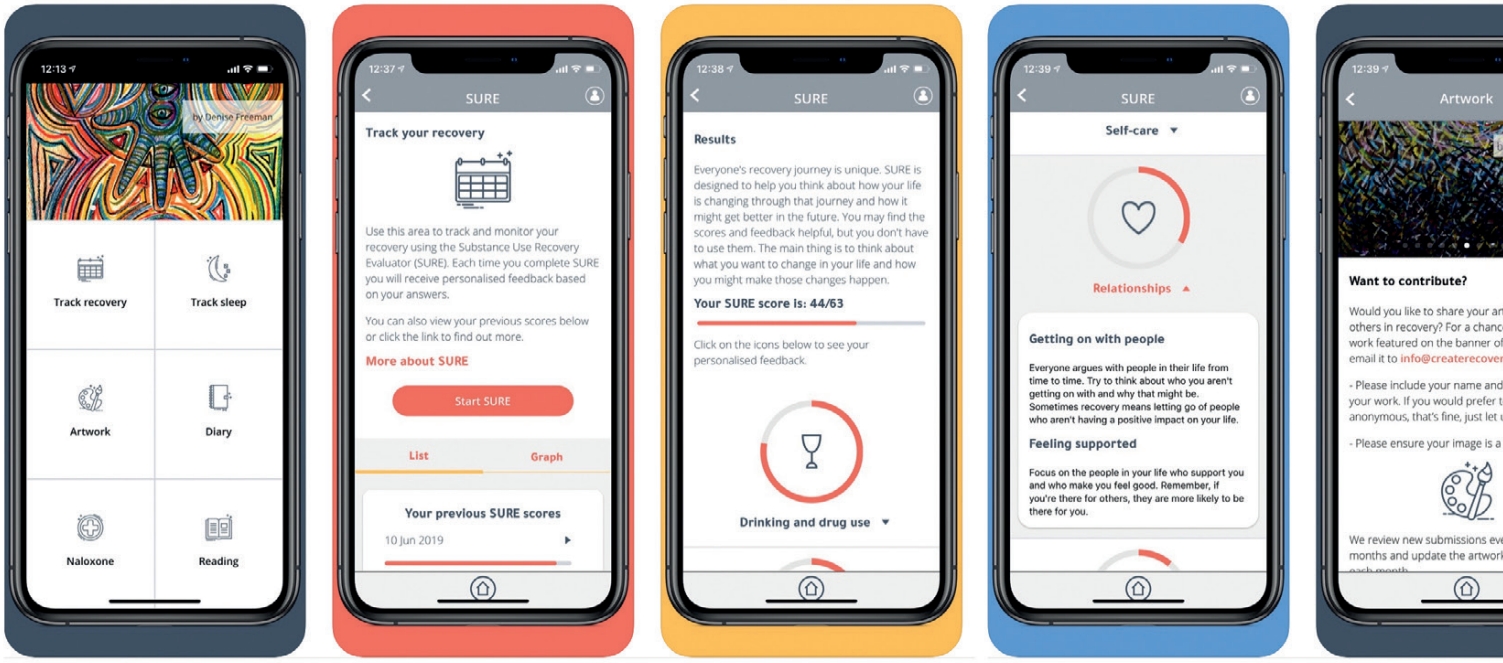
A new London NHS primary care gambling service has been launched by the Hurley Group GP partnership and GambleAware. Many people with issues 'don't necessarily talk about their gambling,' with their GP, said service lead Dr Clare Gerada. 'We will be exploring how to identify them' – and help them get the right treatment. *www.primarycaregamblingservice.co.uk*

STRONG IDENTITY

The University of Brighton is working alongside youth researchers who have experienced mental health issues to understand if activism can boost identity and sense of belonging. 'Research tells us that a strong and positive civic identity offers us direction in life and indicates that we matter in the world,' said principal researcher Angie Hart. *More information at www.ukri.org*

APPROPRIATE SUPPORT

Guidance on setting up specialist alcohol support for people from the Punjabi and other communities been launched by Aquarius, Manchester Metropolitan University and Birmingham University. 'Far more attention is needed to support our diverse communities,' said project lead Sarah Galvani. *www.mmu.ac.uk/rcass/our-expertise/suab*



A SURE start

The new SURE Recovery app is a vital resource powered by the lived experience of its users, say **Ed Day**, **Jo Neale**, **Alice Bowen** and **Paul Lennon**

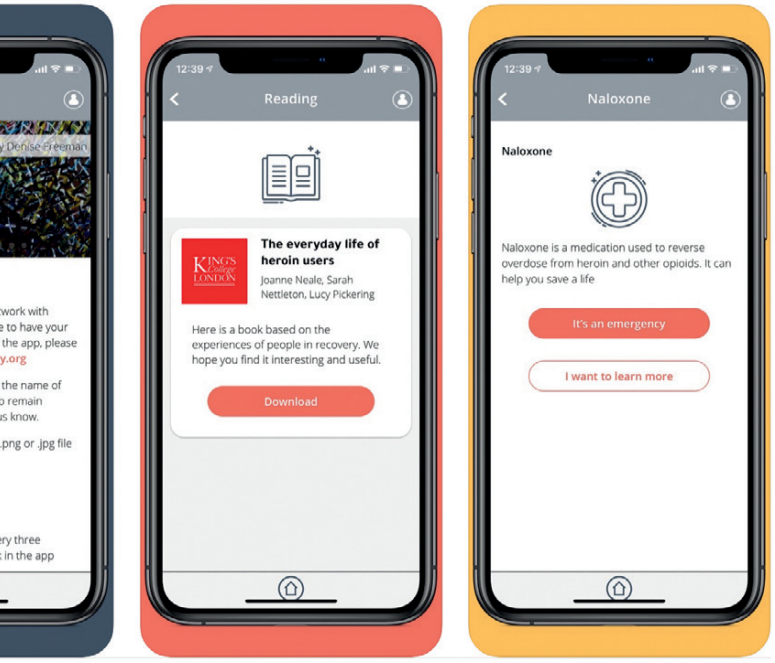
One of the key tasks of the national recovery champion role is to bring people together within the addictions field to tackle a common goal – overcoming the pain and misery that addiction can bring. People with lived experience of addiction have a crucial part to play in recovery-oriented systems of care, and it is important that their voice is heard when policy is being developed. This is particularly so as the country adjusts to the changes imposed by the COVID-19 pandemic, and as the next phase of Dame Carol Black's review of drug treatment services begins (*news, page 5*).

The SURE Recovery app offers a new mechanism for supplying anonymised feedback on important topics relevant to the development of good quality treatment services. Each month users of the app will be invited to respond to a key question that will be developed by the recovery champion working with the app development team, which includes researchers from King's College London and people with lived experience of addiction. Researchers from the app team will analyse the data from those who consent and share the anonymised findings with key policy makers, including Public Health England and NHS England. The sharing of anonymised data is completely optional, and people can use the app without answering any research questions.

SURE Recovery is available to download for free from Google Play and the App Store. The work to produce SURE Recovery was undertaken in collaboration with people using alcohol or other drugs, in treatment and in recovery. It was also supported by an addiction service user research group linked to a London-based peer mentoring service called the Aurora Project.

A wide range of other people were also involved in developing SURE Recovery, including addiction clinicians, Create Recovery (a small arts charity that supports people with experience of addiction issues to develop their creativity) and Mindwave Ventures (an app developer that focuses on user-centred digital design). The work was generously funded from various sources, including Action on Addiction, the Alexander

> Not everyone has a smartphone or tablet computer, but there is evidence that people who use substances increasingly have good access to mobile technology.



Mosley Charitable Trust, the Mackie Foundation, and the NIHR Maudsley Biomedical Research Centre, King's College London.

In developing SURE Recovery, the project team followed a co-design process to make sure that the app would meet the needs and expectations of people experiencing addiction. They conducted interviews and focus groups with people who were using substances, in treatment and in recovery, in order to better understand the process of recovery and how an app might support this. Successive versions of the app were also reviewed and tested by people with lived experience of addiction to make sure that functionality was optimised, the meaning of all text was clear, all graphics and images were appropriate, and there were no bugs or system crashes.

Not everyone has a smartphone or tablet computer, but there is evidence that people who use substances increasingly have good access to mobile technology. Mobile health apps, such as SURE Recovery, tend to be easy to download and cheap to use. They can therefore be an additional valuable resource for people who may not be in contact with services, and for people who may be thinking about, or working on, their recovery. We know that people do not generally use mobile health apps in a sustained way for months and years – instead they tend to be used as and when people feel they meet their current needs. This is how the development team expect that SURE Recovery will be used.

It seems likely that different features of the app will appeal to different populations at different points in time and with different effects. For example, the recovery tracker, with its personalised feedback, may 'nudge' people to reduce their substance use, change their behaviours, or encourage those who are not in treatment to enter treatment. The artwork feature may have a therapeutic effect, enhance self-esteem or appeal to those who find it difficult to express themselves in words. Meanwhile, the naloxone feature may increase engagement with take-home naloxone and improve overdose management competency, so potentially saving lives.

We encourage anyone with lived experience of addiction and an interest in recovery to download the app and give it a try. If you like it, we ask that you tell other people so they know about it too. If you think it can be improved, please let the research team know. People with experience of addiction have a right to good mobile health apps just like any other population, and the aim is to ensure that the SURE Recovery app is a resource that can help as many people as possible.

SURE AIMS AND FEATURES

SURE Recovery is intended for people who are using drugs or alcohol, in recovery, or thinking about recovery. It has five main aims and six key features. The five aims are:

1. **To enable** people to track and monitor their own recovery journeys
2. **To enable** people to recognise when they might need help
3. **To enable** people to identify sources of support
4. **To enable** people to find inspiration from others in recovery
5. **To generate** new data that will help researchers and policy makers better understand substance use and recovery

The six key features are:

1. **A recovery tracker**: this allows people to monitor their own recovery using a co-designed validated outcome measure called the Substance Use Recovery Evaluator (or SURE). Once SURE is completed within the app, personalised feedback and a score are generated. Weekly, monthly and yearly scores can then be viewed in a graph, allowing app users to view and track how their scores change over time.
2. **A sleep tracker**: this works in a similar way to the recovery tracker. App users can complete a co-designed validated scale of sleep problems called the Substance Use Sleep Scale (or SUSS). This will then produce personalised feedback and a score that also allows app users to monitor and review their sleep problems over time.
3. **A diary function**: this provides a private space where people can record their thoughts and feelings.
4. **Artwork**: the app provides a platform for people to share their artwork with the recovery community. App users can submit their artwork for possible display in the banner on the home screen of the app.
5. **A naloxone resource**: this feature provides instruction on the use of naloxone in the event of overdose. There are also informational resources, including a training video and a knowledge tracker which uses the Opioid Overdose Attitudes Scale (OOAS), a validated measure of overdose management competency.
6. **Reading material**: app users have free access to the book The Everyday Lives of Recovering Heroin Users, based on the lived experiences of people in recovery.

If you have an Android device, the SURE Recovery app can be downloaded from Google Play. If you have an iOS device, the SURE Recovery app can be downloaded from the App Store. People can also follow and communicate with the SURE team via Facebook, Twitter (@SURE-Recovery), Instagram (sure-recovery) and YouTube.

- *Ed Day is national drug recovery champion and clinical reader in addiction psychiatry at University of Birmingham.*
- *Jo Neale is professor in addictions qualitative research at King's College.*
- *Alice Bowen is research assistant at King's College.*
- *Paul Lennon is director of the Aurora Project*

MF3d/iStock

THE RIGHT QUESTIONS

Now in its 30th year, the Unlinked Anonymous Monitoring Survey is a vital tool for harm reduction, says **Emily Phipps**

This year the Unlinked Anonymous Monitoring Survey (UAM) of people who inject drugs celebrates its 30th anniversary in England and Wales and 18th anniversary in Northern Ireland, making it the longest running annual survey of this cohort in the world.

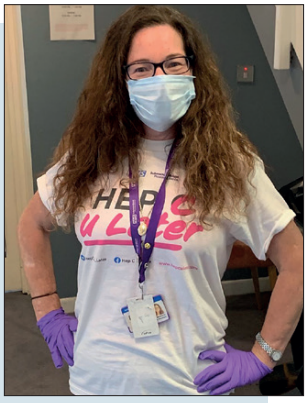
Coordinated by Public Health England (PHE), the survey consists of a self-completed questionnaire and biological sample that is anonymously tested for HIV, hepatitis B and hepatitis C to monitor trends in blood-borne viruses (BBVs) and behaviours that impact transmission, such as needle sharing, testing and treatment uptake. No identifiable information is collected, and the survey or test result cannot be traced back to an individual, making it easier for us to ask questions about risky behaviours that might otherwise go unanswered.

The UAM is a powerful tool for advocacy and service planning, both nationally and locally. Each centre undertaking more than thirty surveys each year is provided with a free, detailed report of their responses to help them understand what the key priorities for their clients are. Nationally, the report feeds in to key annual publications such as *Shooting up* and *Hepatitis C in the UK*. The survey data is also shared internationally with the World Health Organization and European Centre for Disease Control to support global BBV elimination initiatives.

In current times, championing the needs of people who inject drugs and ensuring continued access to services is incredibly important. There are valid concerns that reduced uptake of BBV testing and difficulties in delivering the same level of needle and syringe provision during the pandemic will lead to an increase in infections among this group. The UAM, now more than ever, is an essential tool for understanding the impact of COVID-19 on people who inject drugs, and to keep track of progress as services recover.

The UAM team would like to say a huge thank you to all of our volunteers and participants who have been undertaking the survey during the last few difficult months – the data you have collected is absolutely vital. If you would like to join the UAM survey, or have taken part previously and would like to restart, the UAM team would love to hear from you. Every survey completed is a hugely valuable source of information on this population group who are otherwise often under-represented in policy and statistics. For further information, please contact Claire Edmundson, at claire.edmundson@phe.gov.uk.

Dr Emily Phipps is consultant epidemiologist at the National Infection Service, PHE. She prepared this work with Megan Bardsley, HIV/STI surveillance and prevention scientist, and Claire Edmundson, senior scientist, at PHE



'We have had a phenomenal number of responses to the Unlinked Anonymous Monitoring Survey, which provides us with a wealth of information about our clients – the addition of a finger-prick test for the anonymous blood sample part gives us another opportunity to offer diagnostic testing. Through this testing done alongside the survey, we have picked up 47 cases of hepatitis C that we may not have done otherwise.'

Louise Hansford, regional hepatitis C elimination co-ordinator for the South of England

LONG HOT SUMMER

Summer weather and lack of other entertainment mean that young people are once again turning to outdoor partying on a large scale. Drug services are going to have to get creative about harm reduction, says **Kevin Flemen**

Stephen Arnold

In many post-apocalyptic films there's an unbearably naff sequence where everyone has a party. It's like *The Matrix Reloaded* 'Zion dance party' and usually involves everyone getting into tribal drumming and showing off their tattoos. It turns out that all these scriptwriters were, in fact, absolutely on the money. While the COVID-19 pandemic is nowhere near over and social distancing is still in theory the order of the day, we're at the Zion dance party stage of proceedings.

A few weeks ago I ran a 'young people and drugs' webinar and one of the things I flagged up was the likelihood as we exited lockdown of unlicensed events becoming a bigger issue. One participant highlighted that it was already happening in Bristol – that was a month ago. Since then the prediction has come to pass and there has been a massive upsurge in house parties, block parties, illegal raves and spontaneous open-air events. Some of these have made the national news, but the media attention has so far mostly been on litter and conflict with the police – the issue of drugs and safety has not yet been discussed so widely.

The upsurge in unlicensed music events should come as no surprise. Pubs are only now reopening on a restricted basis, nightclubs won't be reopening for the foreseeable future and organised festivals have been cancelled. A cohort of people who have been furloughed, have lost work or are entering the summer unclear if they are going on to higher education are bored and craving social interaction and entertainment. And the weather's hot. Partying outside is very clearly going to be the order of the day.

The drug harm reduction input at some organised events pre-lockdown has been very successful in making festivals and clubs much safer. Onsite drug testing, festival welfare, trained staff and harm reduction interventions were helping to raise awareness of, and reduce the risks from, high-strength pills and powders and pills containing unknown and possibly dangerous cuts, as well as providing help to those in distress. The best of these were collaborative exercises between promoters, police and welfare services.

This festival harm reduction doesn't translocate to illegal events quite as easily, especially in the current climate. Clandestine events may be organised online with the final location announced at the last minute. Organisers are understandably wary of engaging with any statutory bodies – wariness that is likely to extend to drug services. Even where workers or volunteers could gain access, their own safety needs to be ensured in terms of COVID-19, personal safety and not getting caught up in any enforcement action. There had been concern that scarcity of precursor chemicals could mean a shortage of MDMA and the re-emergence of more dangerous compounds such as PMMA. Conversely there have also been reports of extremely high-potency pills, with peak doses in excess of 350mg being reported.

Without any doubt, as we exit lockdown, the explosion in unlicensed events will be the issue to contend with and drug services need to engage with this fast, creatively and at a grassroots level, if they are to provide much-needed input.

Kevin Flemen runs the drugs education and training initiative KFx www.kfx.org.uk

Given that unlicensed events are going to be one of the issues over the summer months, interventions are essential. And the 'how to' for working with unlicensed events means revisiting earlier harm reduction and being less reliant on permitted access and high-tech onsite testing. It's going to need to be more grassroots, including:

- **production of clear accessible literature**
- **use of testing sites** such as WEDINOS, Pill Reports and The Loop to promote awareness of contaminated pills, high-strength and other dangerous products
- **safety advice** about use of nitrous oxide
- **engaging with promoters** via social media so that they can make events safer – water onsite, access for emergency services, trained volunteers and engaging with drug services to provide outreach if possible
- **peer education** – as, more often than not, drug services won't be on site it's essential to equip those attending events with the resources and tools to manage critical incidents. Making sure attendees know how to spot signs of MDMA overdose and manage it is critical
- **using What3Words** https://what3words.com/ to ensure that emergency services can locate people at outdoor events with pinpoint accuracy
- **general harm reduction** with a view to addressing COVID-19 spread including the sharing of snorting tubes, spliffs, drinks and balloons
- **legal advice** cards such as Release 'Bust Cards' so that people detained during enforcement activity know their rights and can access legal advice
- **personal safety advice**

REACHING OUT

Staying connected has never been more important, says **Jason Moore**

Karen & Summer Kala / Alamy

The COVID-19 pandemic has changed every aspect of how we live and interact with people, and left many feeling anxious and isolated. As an organisation that prides itself on our hands-on, face-to-face approaches, one of the key challenges for Forward has been finding creative ways to engage our service user community. We've also wanted to make sure we can do everything we can to help them feel connected – not just to us, but to their loved ones and wider recovery community.

Right from day one, our staff and volunteers rose to the challenge admirably, finding all sorts of inventive and novel ways to keep in touch. Our family work coordinator Rebecca Mistry (along with a little help from her children Aaria and Ethan!) created packs for prisoners with children, to help them continue to connect with their families when family visits stopped. The packs contained items such as stationery, crayons and jokes to tell little ones to keep them smiling and advice on how to talk to children about COVID – something difficult for every parent, let alone one who isn't able to physically see their child.

We also piloted a live chat service on our website, called Reach Out. Open every weekday from 9am to 3pm, Reach Out provides a friendly voice and a sympathetic ear to anybody struggling or seeking advice, particularly on matters such as drug or alcohol issues, mental health challenges, housing problems or benefit concerns.

In our community projects, we've been exploring the use of video conferencing software to continue the delivery of practitioner-led, structured group programmes in Hull and East Kent, as well as our Recovering Families groups. Our East Kent team now also sends out weekly text messages to clients with updates and advice on how to stay safe. We've identified all OST clients without a contact number and supplied them with their own mobile phone so that they can stay in touch with their key workers. Meanwhile, our dedicated prescription delivery team has been travelling all over East Kent, delivering prescriptions to pharmacies to ensure clients have their medication on time.

'Forward Connect' is our friendly community of current and former clients, graduates and volunteers. They – along with some of our alcohol pathway clients in East Kent – have been using Kaizala, a secure multimedia messaging app to keep in touch with each other as a source of social support.

And last but not least, our recovery support service has been working with prison teams to identify clients who are due to be released from prison and equip them with mobile phones when they get out, to ensure they are still able to access remote assessments and treatment services. We are truly appreciative of some additional funding that has been received from supportive partners to help fund this additional work.

We're incredibly lucky to have such a dedicated and responsive team, as well as access to technology that has made it possible to stay connected with our clients and graduates. Living through a pandemic has brought us all challenges, but it has been amazing to see the creative and positive way our staff and volunteers have risen to the challenge, bringing a much-needed human connection to those we support.

Living through a pandemic has brought us all challenges, but it has been amazing to see the creative and positive way our staff and volunteers have risen to the challenge, bringing a much-needed human connection to those we support.

'Never underestimate the power of a letter or card, particularly at a difficult time like this,' says Rebecca Mistry. 'It's the small things that are really making a difference, and a handwritten letter from someone you love can really put a smile on their face. Aaria wanted to be able to help mummies and daddies who weren't able to see their children to keep in touch with their little ones, and also to give prisoners some good drawing opportunities – because who doesn't love drawing!'

Jason Moore is divisional director of substance misuse at The Forward Trust

DOUBLING DOWN

With World Hepatitis Day on 28 July, now is the time to redouble our efforts towards hepatitis C elimination, says **Rachel Halford**

World Hepatitis Day this year will be unlike any other we have celebrated before. Hepatitis C continues to have a huge impact on people who inject drugs, with the latest statistics showing the rate of new infections among injecting drug users remains worryingly high. The surge of activity we have seen since last summer when NHS England signed an elimination deal with the pharmaceutical industry – not only to provide medication but also to commission case-finding initiatives – has largely come to a halt as a different virus has taken centre stage.

As with almost all other areas of healthcare, the impact of COVID-19 on services providing hepatitis C treatment has been sudden and dramatic: nurses and doctors were re-deployed overnight, clinics were cancelled, most testing ceased and new treatment starts were generally delayed. HCV Action, a network for professionals working in hepatitis C coordinated by The Hepatitis C Trust, found that around one quarter of the 22 hepatitis C treatment networks (operational delivery networks) were only able to treat patients already on their registers or no cases at all at the end of May, even as clinics began to recover.

Understandably, as many doctors and nurses have had their time diverted from clinics to wards in order to provide much needed additional capacity, some areas were under greater strain than others. Despite these difficulties, a number of services have demonstrated phenomenal creativity and determination to continue to help people. Many of The Hepatitis C Trust's peer-to-peer support staff and volunteers have been going into temporary accommodation across the country to test people who had been living on the streets. This brilliant partnership working between NHS trusts, other charities, alcohol and drug services, and the hotels and hostels themselves has allowed many hundreds of people who had been rough sleeping to be tested and referred on to treatment – engaging a population for whom the traditional treatment model is often not accessible.

> 'Even with the persistence of laudable efforts to target those people most at risk of infection, there has been no notable reduction in new transmissions in recent years. '

COVID-19 has laid bare the extent of health inequality in this country. In England, people living in the most deprived areas are around twice as likely to die from COVID-19 compared to those in the least deprived. Hepatitis C likewise impacts disproportionately upon the most vulnerable in our society – almost half of the people with hepatitis C who go to hospital come from the poorest fifth of the population.

As health services begin to recover from the strain of increased admittances to intensive care, it is essential we re-focus efforts to address those disease areas which predominantly affect disadvantaged and marginalised populations, of which hepatitis C is one. With easy-to-take drugs that have a short treatment term and high cure rate there is no excuse for the UK not to meet its commitment to eliminate hepatitis C by 2030 – the World Health Organization's hepatitis elimination goal, which we joined many other countries in signing up to. Progress has been positive on diagnosis and reducing hepatitis C-related deaths, but we have a long way to go before we can viably achieve and sustain elimination.

Even with the persistence of laudable efforts to target those people most at risk of infection, there has been no notable reduction in new transmissions in recent years. Prevention is absolutely vital to achieving elimination and yet currently harm reduction provision does not go far enough, with 36 per cent of people who inject drugs reporting in 2018 that they did not have adequate needle and syringe equipment for their needs, heightening the risk of hepatitis C transmission through sharing injecting equipment. We must ensure people are supported to access needle and syringe exchanges adequate for their needs and so reduce the spread of blood-borne viruses such as hepatitis C.

The majority of hepatitis C cases in the UK remain undiagnosed, resulting in potentially tens of thousands of people experiencing health complications including liver damage and an increased risk of mortality. This World Hepatitis Day we must applaud services for their incredible hard work and dedication so far, and redouble our efforts to prevent new infections and expand testing and treatment until we have achieved elimination.

Rachel Halford is chief executive officer at the Hepatitis C Trust

SAFEGUARDING

The lockdown has forced services providing domestic abuse support to become even more resourceful and innovative, says **Miranda Hawtrey**

Working in a setting supporting those with addiction issues and complex needs is always a delicate balancing act. But when the coronavirus outbreak swept through the UK in March 2020, the team at Jane's Place in Burnley had an extra challenge on their hands.

Jane's Place is a somewhat unique service established in 2017 by SafeNet Domestic Abuse Support Services, who provide domestic abuse support to women, men and children. They are also the lead providers for Lancashire Refuges.

Jane's Place is the only one of its kind in the North West – not only does it help to support women who are fleeing from all forms of domestic abuse, but it also breaks down barriers often posed by traditional refuge. A lack of appropriate accommodation and support for women and families with complex needs who need to escape from domestic abuse often results in outcomes such as women returning or staying with the perpetrator, escalating risk and coping strategies such as increased substance use, a lack of trust in services and sofa surfing, which often results in rough sleeping.

Jane's Place is named in memory of Jane Clough, who was killed by her ex-partner in 2010. Jane's parents, John and Penny Clough (pictured), are now SafeNet patrons.

A MAMMOTH TASK

The challenge of implementing safety measures and managing the extra risk posed by lockdown in this kind of specialist environment has been a mammoth task, and the team knew they had to adapt the service fast to ensure they could keep everyone involved safe and continue to support their residents.

They started by expanding and increasing their safehouse provision to provide safe spaces for those residents who were shielding, showing symptoms and needing to self-isolate. Those with serious drug and alcohol use issues and/or sex working women who found it impossible to adhere to the government guidelines had to be kept safe regardless of whether or not they were able to comply, and the team achieved this by use of separate safehouse facilities with specialist intensive floating support.

Each individual resident had an emergency COVID plan created and tailored to meet their needs. Along with various other measures, such as extra cleaning, PPE and updating residents and checking in to make sure they knew what the guidelines were, the team quickly pivoted the service to offer as much flexibility and support as possible.

> 'Jane's Place is the only one of its kind in the North West – not only does it help to support women who are fleeing from all forms of domestic abuse, but it also breaks down barriers often posed by traditional refuge.'

This hasn't come without its setbacks. The team have faced difficulties accessing help from outside agencies that would usually support residents, and accessing healthcare has been made much more difficult by skeleton staff in other agencies and lack of GP appointments. The residents also voiced that they were missing group work; the need for connection during their journey plays a big part in recovery.

GETTING CREATIVE

Alongside the practical solutions – with staff members collecting methadone for residents daily and assisting with non-molestation orders received via court sessions

SANCTUARY

over the phone with residents – the team got creative. They introduced ways for residents to connect with professionals and loved ones virtually, created online recovery groups and set up online quizzes and games to help boost morale.

With the lockdown also came a devastating rise in domestic abuse incidents, in the UK and beyond. More than ever, this highlighted the need to find other ways to reach victims who were not safe at home. The team introduced a new online chat service via their website to enable victims to safely access advice and support during periods of isolation or when they were confined at home with a perpetrator and unable to use previous routes to safety, manned by trained support workers.

WHAT NEXT?

So what next for Jane's Place? No one knows how long restrictions will be in place or what the 'new normal' will look like, so the team are always thinking ahead and looking at new ways to engage with residents. This includes 'walk 'n' talk' sessions, encouraging communal gardening as a soothing way to pass the time and, most importantly, continuing to listen to what residents want via their 'finding our voice' consultations.

Miranda Hawtrey is a support worker at Jane's Place

CASE STUDIES: SARAH AND KERRY

FLEEING TRAUMA: SARAH, AGED 34

Sarah had begun taking prescription medication and drinking alcohol at 14 years old as a way to numb the trauma of being gang raped. Both Sarah's parents had issues with addiction and she felt unsupported in dealing with this horrific trauma. Growing up, she said she always felt 'unloved'. During her adult life, Sarah was repeatedly subjected to sexual abuse by various males, and her drug use escalated to using heroin and crack daily.

Sarah then was in an abusive relationship and gave birth to two children. The children were subsequently removed by social care due to domestic abuse and substance abuse by both parents. Sarah became street homeless and soon got involved with another abusive male who forced her into sex work to fund substances for them both. Using heroin and crack daily, Sarah's mental health and physical health dramatically deteriorated and she was also regularly shoplifting to fund substances. Things became too much for Sarah and she attempted to take her own life after a serious assault by her partner. She was then referred to SafeNet and accepted at Jane's Place Recovery Refuge.

Sarah's life dramatically changed once admitted to Jane's Place. Her self-esteem and confidence returned as staff supported her to address health issues and receive support with her mental health. Jane's Place referred Sarah to Inspire Wellbeing and she was allocated a key worker to help support her with substance use.

Sarah is now abstinent from all substances and back in contact with her children who live with family. She is no longer shoplifting or sex working and wants to start volunteer work after lockdown. Staff referred Sarah for specialist sexual trauma counselling and she also is supported by attending a trauma recovery group.

Sarah has said her drug use was spiralling out of control but she has dramatically changed her life with the support of staff. Sarah says the support she has received to reconnect with her children has been very important to her recovery and motivation. 'Without Jane's Place I would be dead,' she says. 'You saved my life,'

ESCAPING VIOLENCE: KERRY, AGED 39

Upon referral, Kerry had been in a physically violent relationship for the past seven years. She had been threatened with a knife and her children had been removed for their own safety, as a result of her addiction and domestic abuse in the family home. Kerry referred herself into SafeNet's services after trying several refuges who would not accept her as she was using alcohol and substances daily.

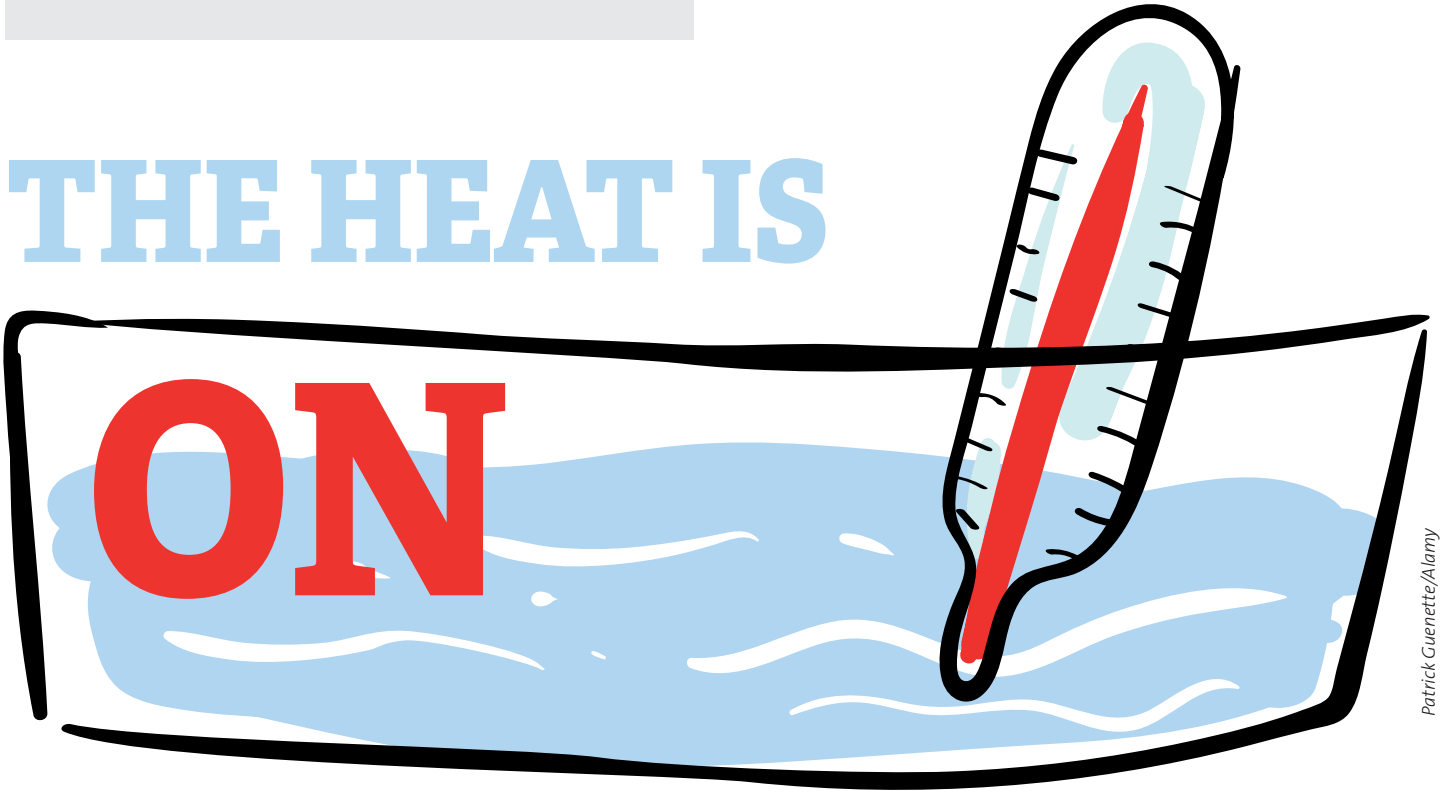
Kerry was drinking heavily, using crack and heroin, was on a methadone script, and was also having physical withdrawal symptoms – such as seizures – when she didn't have alcohol. She was also a prolific shoplifter to fund her addictions, and had spent time in prison as a result.

Kerry was still having regular phone contact with the perpetrator when she arrived, who would often try to manipulate her, use controlling and coercive behaviour, give verbal abuse and threaten self-harm if she didn't return home. SafeNet supported Kerry to stop contact and she attended domestic abuse groups at Jane's Place. Extensive safety planning work was done as part of her support plan and as her mental health improved, Kerry was able to focus on her recovery.

While at Jane's Place, Kerry's anxiety reduced and she was no longer having suicidal ideation. Kerry completed RAMP (reduction and motivation programme) as part of her recovery support plan and, with the support of Jane's Place and Inspire Wellbeing, she reduced her methadone and alcohol intake.

Kerry's physical health greatly improved too – she gained weight, began to take pride in her appearance and was focused on getting fitter and healthier. She also began to rebuild relationships with her family and was then accepted for detox and rehab to complete her journey.

THE HEAT IS ON



Patrick Guenette/Alamy

In the second part of 'Doctor Wars', **Bill Nelles** describes the tumultuous days of the 1980s

By 1983, the cold war among doctors treating drug users was becoming a lot hotter, and there was still no public health response to drug use.

The Home Office consultants still met regularly, and included private doctors as well as NHS consultants. The NHS doctors felt the private doctors prescribed overly generously, didn't demand reductions, left their patients 'still addicted', and even charged them fees. The private doctors felt the NHS doctors were too rigid and their patients poorly treated. *Guidelines on the treatment of drug misuse* ('orange guidelines') were the first national guidance issued by this group in 1984 – they pleased few. For instance, the guidelines considered that medically supervised detoxification was a 'simple and short-term process with spontaneous remission possible', and also stated that maintenance was not acceptable. 'Evidence-based treatments' didn't really exist in addiction medicine at that time.

Ironically, the main use of the orange guidelines was as evidence in 1986 at Dr Anne Dally's General Medical Council (GMC) hearing. She was a feisty senior private doctor on the working group and one of the signatories of the 1984 guidelines. I gave testimony supporting her at her GMC hearing, having become the drug education officer at the Terrence Higgins Trust (THT) a year earlier, but her verdict was guilty of maintenance! While she was able to still be a doctor, she was never allowed to prescribe controlled drugs again. Her practice evaporated almost overnight.

Because of its policy of avoiding methadone and arresting users for the possession of syringes alone, Scotland was one of the first parts of the UK to see the unusual and mostly lethal illnesses associated with AIDS and injecting drug use. Cheap heroin from Iran and the easy availability of Temgesic, (ironically, an early sublingual form of buprenorphine) had vastly increased the number of people injecting opioids, and police pressure had made clean needles impossible to obtain.

But two factors had yet to reveal themselves. The first was, of course, the AIDS epidemic, with the first Scottish drug user dying in Scotland in 1983. The second was the growing involvement of general practitioners in providing services to drug users and their influence on practice. Britain had not made methadone a drug needing a Home Office licence, and thanks largely to the efforts of dear Dr Tom Waller – an ACMD member who batted it back every time it was put forward – it was never adopted as policy.

By 1983, the cold war among doctors treating drug users was becoming a lot hotter, and there was still no public health response to drug use.

These trends intersected in early 1985, when a young GP in Edinburgh published a paper in the BMJ which galvanised me, and many others, into serious action. Dr Roy Robertson, (now the Queen's physician in Scotland and professor of addiction at Edinburgh University), had been seeing drug users for some years, and maintaining some with dihydrocodeine. He was able to obtain HIV test kits in advance of their national availability, and in late '84 had taken blood for HIV antibody assay from around 160 patients. He knew they shared used needles, and the paper showed that 51 per cent had already been infected by HIV.

The effect of this news cannot be exaggerated. Research testing in London was showing rates of under 5 per cent positive, so we realised we had a short window to make a difference if we moved fast. By the summer of 1986, teams in London, Liverpool, Edinburgh and Amsterdam and, of course, the US were working very hard to understand what they were facing, and the UK and Holland had already

implemented needle exchanges to stop sharing and prescribing to reduce injecting.

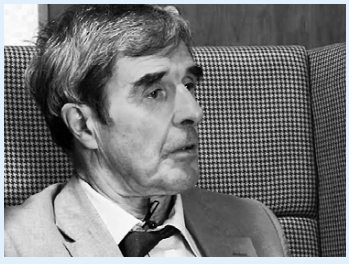
But there were still battles to be fought over clean injecting equipment. I had been seconded to the Standing Conference on Drug Addiction (SCODA) from the THT to write a booklet about AIDS for drug users, but in February '86 I spoke at a large National Haemophiliac Society meeting in Newcastle at which I represented SCODA and called for a serious examination of supplying clean needles.

This was picked up on *Newsnight*, and on Monday I found myself called to the office of the director. In fact the Friday before, after six months of abstinence from opiates, I had engaged a private doctor to look after me so that I didn't resume injecting. He strongly objected that I had supported needle exchanges. I was also told that I 'looked stoned' and under no circumstances could someone work in a drugs agency even on legal methadone. That same day I returned to the THT where we concentrated on reducing the risk for drug users through advocacy with politicians, speaking engagements, and writing leaflets. By 1988, the McClelland report in Scotland and the ACMD special report chaired by Ruth Runciman gave the green light to access to clean needles, setting up 15 pilot schemes in England and Scotland. These were quickly expanded when the pilots reported favourably and both reports called for an immediate re-evaluation of methadone prescribing.

GPs had also become more independent and proactive especially if they had no specialist prescriber. West Berkshire Health Authority under Ailsa Duncan, their drugs coordinator, engaged me in 1988 to train a group of around 15 GPs to prescribe methadone. It was a five-day course with a written handbook. Apart from Ailsa, none of the doctors were aware they were being trained by a methadone patient!

I have great respect for all evidence-based treatment including non-prescribing approaches when it's what the patient seeks. But present policies that deny people such approaches are shameful and should not be tolerated. In the last part of this series, we will look at the golden age of drug services – the first eight years of 2000. And how it all collapsed and we ended up where we are now.

Bill Nelles is an advocate and activist, now in Canada. He founded The (Methadone) Alliance in the UK



'We know that the main method of transmission [of AIDs] among drug takers is the sharing of dirty needles... It was clearly documented in a paper produced by Edinburgh professionals in February 1986. The Scottish Office commissioned a report from a committee chaired by Brian McClelland published in September 1986, which recommended decisively that the government should bite the bullet and provide clean syringes at an exchange centre, where drug injectors would be able to obtain free needles and syringes.

'The government's response to that call has been so inadequate as to be positively irresponsible. They sat on the McClelland report for months. Eventually, they announced 15 pilot schemes, 12 in England and three in Scotland. Of course such projects involve problems – the minister may wish to comment on them – but we must make the projects work.'

Gavin Strang MP (Edinburgh, East), House of Commons debate 31 March 1988

WHERE TIME STANDS STILL

Things need to move faster to support prisoners on release, heard the parliamentary group. **DDN** reports

All probation services would move to the public sector in June 2021 – 'a massive step forward in providing a unified service,' according to Katie Lomas, chair of the National Association of Probation Officers (NAPO). Outsourcing the supervision and rehabilitation of offenders to community rehabilitation companies (CRCs) in 2015 had had some disastrous consequences and resulted in poor outcomes for the people they were meant to serve, she told the Drugs, Alcohol and Justice Cross-Party Parliamentary Group (which met online).

Clients had multiple needs and services had to be flexible and responsive, against a background of tightening resources. Partnerships were being hampered by a lack of information sharing, which was making it too easy for people to 'slip through the cracks'. Everything in probation was about relationships, she said, and we must 'develop and maintain excellent partnerships in prison, resettlement and the community'.

Despite reports by Lord Patel and Lord Bradford outlining problems and recommendations, there had been little analysis and follow-up or evidence that anything had been taken forward, said Professor Alex Stevens, former chair of the ACMD's Custody-Community Transitions Working Group. Prisoners were still routinely released on a Friday afternoon without any support in place, including housing, and just £46 in their pockets. While the proportion of prisoners released with naloxone had increased from 12-17 per cent in England, the pace of change was far too slow.

Amy Levy, Humankind's assistant director for North East prisons reported positive results from partnership working and mutual support during the COVID situation, with a focus on continuity of care and harm reduction. Jaya Karira and Max Griffiths, working in WDP services, also emphasised the value of improving communications between prisons and treatment services, specifically around prisoners' medication needs on release. They also called for mandatory naloxone distribution and diligence around BBV testing and information-sharing with community healthcare teams.

A prison officer for more than 30 years, Jo Simpson spoke of his frustration that despite improvements, the service had 'hardly come on in leaps and bounds'. 'I have seen some good reports but nothing done with them,' he said. Technology in prisons was 'non-existent' when it could have helped significantly during COVID, enabling prisoners to talk to their families and continue their education.

'People tend to blame the prison staff, but we get frustrated that things aren't happening,' he said. 'They keep saying we've got a drug strategy programme – but where is it?' **DDN**

AIMING HIGH

Even in the most difficult circumstances recovery is always possible, says **Jody Leach**

We are a local charity supporting those struggling with addiction across Essex and Kent. Together with our main substance misuse provisions, some of the other projects we also deliver to support vulnerable populations include our work within a specialised women's refuge, the Essex Appropriate Adult service, our targeted housing support service and our 'SOS Bus' services.

Mirroring previous articles on the 'new normal' of delivering substance misuse provision at this time, the pandemic and its restrictions have had an unprecedented impact on all our services and how we have been able to evolve to continue supporting those most vulnerable. While it's hard not to, rather than detail all the amazing work our teams, wider treatment system partners and the local community have undertaken to help continue supporting our service users, I feel it's important to share the voice of some of those service users and examples of positive recovery at this uncertain time.

COPING WITH CHANGE

For the majority of those we support, change is not popular and can be anxiety provoking at the best of times. We have worked tirelessly to help manage the imposed uncertainty that the pandemic has created, by continuing to offer the structure and support that is normally provided as standard. We have been impressed with how our service users have accepted and adapted to the required changes – not only have they worked with us to support our teams, many have told us that elements of our new ways of working are actually preferred to practices we had been doing for some time. COVID-19's impact is tragic, but we are indebted to our service users for their investment in what we do to share these valuable insights. The following examples highlight how the measures we have taken over the last three months have been experienced positively by those using our services.

In response to many refuges excluding those with substance misuse needs, we deliver a specialist service within a refuge to ensure these vulnerable women are supported into potential recovery. One of our service users told us that while being addicted at any time in life was difficult, 'adding COVID-19 to the situation poses a whole new dimension to overcome. Having resided at a women's refuge since January, I have had first-hand knowledge of the detrimental effect COVID-19 has had on others. Lockdown has taught me that I can be patient and content with my own company and it has pushed me to try and learn new things.

'I am very lucky to be working with Open Road and my worker has been nothing short of brilliant,' she continued. 'She has thought of me at every turn and introduced me to meetings all over the county, including many new opportunities. She is fully aware I am not a huge fan of attending meetings, so having Zoom meetings has actually aided my recovery journey and allowed me to meet others all over the county in similar situations as myself. The amount of pressure Open Road have endured in the current pandemic must have been monumental, and without any previous experience to draw on, they have been fantastic.'

APPROPRIATE SERVICES

Our Appropriate Adult (AA) service supports many held in custody with additional substance misuse needs. We are proud to have continued delivering this crucial support throughout the lockdown – despite its challenges – thanks to the passion and commitment of our teams. Essex Police's custody commander said of the service, 'Of a special note is the fact that Open Road have continued to provide support to detainees – something that is almost unique in my experience in the AA world at this present time.'

Given the impact of the lockdown on the night-time economy, our usual SOS Bus services have not been needed. Instead, in collaboration with the


Jankovoy/iStock

local council, our staff used the service's minibuses to transport local homeless residents to temporary accommodation.

PANDEMIC COMPLICATIONS

Our housing support service has been extremely busy supporting service users that are being negatively impacted further by the pandemic. One was referred into the service following the death of his brother whose funeral he was unable to finance. Our worker liaised with the relevant housing association and welfare rights advisor to enable the tenancy to be transferred, and an intensive package of support was made available. Had this work not been undertaken, our service user would have remained isolated and alone during a heartbreaking situation that was made all the more difficult by social movement restrictions. The implications for his ongoing recovery are obvious, but we are happy to report that he is continuing to do well with his reduction in substitute prescribing and abstinence from illicit drug use.

One of our young service users has particularly struggled during lockdown and found it hard to get into the new routine of not seeing friends at school and being at home constantly. He is classified as high risk as he self-harms regularly and feels he can't disclose his self-harm experiences to other professionals. He now looks forward to the increased telephone and video calls from his worker that are helping him to manage his self-harming and drug-using behaviours.

'One of our young service users has particularly struggled during lockdown and found it hard to get into the new routine of not seeing friends... and being at home constantly. He is classified as high risk as he self-harms regularly and feels he can't disclose his self-harm experiences to other professionals. '

This example highlights the recovery-focused passion that our workers continue to share despite the circumstances, and how we are always trying to put the needs of our service users first. One of our workers spent time speaking with a treatment-naïve individual that just happened to be waiting in the street for a friend that was attending an appointment with our service. This person was street-homeless and had been using heroin and crack since the age of 14. Despite the strict guidelines in place to avoid transmission, the worker was able to safely organise an initial assessment, as she felt that if the person was offered a time to return the opportunity may be missed for them to follow through on their apparent desire to access treatment.

He was extremely grateful for this quick thinking and left the service with his first-ever prescription for substitute medication, and was also issued with – and accepted – naloxone. He was supported to register with a GP and referred into OCAN [Offenders with Complex & Additional Needs] provision and the DWP to access benefit assistance.

IT WILL GET BETTER

One of our recovery support service users perfectly sums up how they have experienced our response during the lockdown: 'I miss everyone at Open Road and can see how important the service is even more now through the COVID-19 pandemic. I have always isolated myself and shut myself away, feeling like a burden or a pathetic weak person who cannot even sort themselves out. Open Road helps me to feel like I am able and can try again and not give up.'

To our fellow service providers and service users who may be reading this, things will get better. Until this new normal allows us to fully resume helping even more people struggling with addiction, we will keep trying to showcase to others that recovery continues to be a possibility for anyone that seeks support at this most unusual time.

Jody Leach is quality and treatment manager at Open Road

DOORSTEP CHAL

Strong partnerships could overturn nimbyism and make supervised injecting facilities a reality, **DDN** reports

A supervised injecting facility (SIF, also referred to as a drug consumption room or DCR) is not the only answer to reducing drug-related deaths, but could fit into 'a multi-component strategy' to reduce vulnerability, overdose risk and fatal outcomes from overdose. Introducing an online session, Professor Alex Stevens of the University of Kent wanted to discuss the evidence, the obstacles and a way forward for making SIFs a reality.

'Not only do they save lives, they help people to improve their injecting technique, access treatment and harm reduction services, and address other vulnerabilities in their lives,' he said.

Release's executive director Niamh Eastwood looked at whether a SIF could be legal. With the government ignoring the ACMD's recommendations and continuing to oppose such a facility, three offences relevant to a DCR/SIF stood out in particular – possession, encouraging or assisting a person to commit an offence, and contravening the Anti-Social Behaviour Act.

With legislation unlikely to change anytime soon, she suggested that a way forward would be through multi-agency agreements between the police, local authorities, PHE, health providers and prosecution services. 'Letters of comfort' could be provided by police to allow local services to provide harm reduction equipment such as citric acid and foil. 'The impetus comes from local activity,' she said.

DCI Jason Kew gave thoughts on working with the police to open a SIF. His strong view was that it was a health matter – 'a medical facility, a harm reduction facility' – and it wasn't the police's place to lead on this work. The data on drug misuse deaths showed 'a clear picture of where we need to act sooner,' he said. With 78 legalised DCRs operating in Europe without a single drug-related death, we needed to 'humanise the statistics'. 'Is there really the public interest in prosecuting a healthcare professional trying to safe somebody's life? Absolutely not,' he added.

'DCRs attract a great deal of emotion for or against them,' said Rudi Fortson QC. A local memorandum of understanding was the best way forward, he suggested. 'One has to look at the reality of the situation, which is that despite 14 years of campaigning to even pilot a DCR within the United Kingdom, we haven't got one. Why not? It comes back to those fundamental issues of public acceptability of a DCR on their doorstep.'

Saket Priyadarshi, medical lead at Glasgow Alcohol and Drug Recovery Service, had been closely involved in making the case for a DCR in the city – a move provoked by an outbreak of HIV in people who injected drugs. A formal health needs assessment by public health colleagues had resulted in recommendations for a heroin-assisted treatment service (HAT) and a SIF. Glasgow's health and social care partnership – which included police and people with lived experience of using drugs in public places – had accepted the recommendations and asked for a business plan for a SIF in the city.

'Is there really a public interest in prosecuting a healthcare professional trying to safe somebody's life?'

DCI JASON KEW

The model they proposed was co-located with HAT and a very low threshold service 'to capture as many of our target population as possible', including pregnant drug users. The large fixed-site model 'would manage the clinical governance concerns being expressed' and it included an aftercare area.

The project is currently snagged by 'a constitutional stand-off between Edinburgh and Westminster' but they have made plans around public engagement to manage local concerns and 'have an evaluation and research agenda in place'. A HAT service has already been implemented in the interim, and they anticipate that the SIF will be a 'scaled-up version'.

The West Midlands had also been developing a model, as Megan Jones, head of policy for the Office

SafePoint, a supervised injection facility in Surrey, part of the larger Vancouver area, Canada. Credit: Xinhua/Alamy

LENGE

Health authority staff members work at SafePoint, a supervised injection site in Surrey, Canada. Credit: Xinhua/ Alamy

'We know there are unofficial consumption rooms... but we don't have DCRs that can call themselves that, or that are recognised in law.'

MARTIN BLAKEBROUGH

of the West Midlands Police and Crime Commissioner, explained. The office had begun by looking at the scale of the drug problem in the region, with the cost of heroin and crack cocaine users calculated as £1.4bn and the cost of crime committed by the average heroin or crack user as £26,000.

A drug policy summit had involved the public in looking at a new approach, with the drivers of reducing harm, reducing crime, and reducing cost. The eight recommendations had included DCRs, and an independent report – *Out of Harm's Way*, written by Ernie Hendricks in March 2020 – covered evidence from the UK and across the world. Its two main recommendations were to develop a business case through a multi-agency steering group, and to work with government and the steering group to support a DCR pilot site in the West Midlands.

We had to be led by the evidence, take the public with us and have an 'open mature conversation about drug policy and its failings,' she said. It needed to be done with existing treatment providers and people with lived experience, be linked to the homelessness agenda, and be done through a partnership approach.

Martin Blakebrough had been asked to talk about developing a model for Wales, and as CEO of Kaleidoscope he had experience of an early SIF model. In the '70s and '80s Kaleidoscope ran a club that also had a needle and syringe exchange in it, with a methadone dispensing system and doctors and nurses: 'In many ways it was a drug consumption room, but it wasn't actually publicised as that.'

Looking at other places, such as Cardiff, 'we know there are unofficial consumption rooms there, in hostels,' he said. 'So it's not quite right to say we don't have consumption rooms – but we don't have DCRs that can call themselves that, or that are recognised in law.'

The idea that the facility had to be an expensive option was 'ridiculous', he added. 'In Wales we're saying "it's just a room". The idea that we need to create ridiculously safe spaces that are sterile is also difficult – would you want to be drinking beer in a sterile environment? We have to create services that are hugely attractive to the people we want to serve. And they need to be involved in the design and development of that service.'

Peer mentors were the best people to advise someone on how to inject drugs, and the idea should be around creating a space for service users to help each other – 'and if it's part of a drug service or adjacent to it, I don't really see the public outcry,' he said. 'Let's make this happen by using the skills and passion of our drug using community and champions', giving them the money to run the services, the legal cover, and the clinical assistance they needed to run the place safely.

Mat Southwell, technical consultant specialising in community mobilisation for people who use drugs, agreed on the value of peers' central role and added that it was really important to give drug users choice around a highly medicalised model or a drop-in style community centre approach. 'If you involve people in the design of a project they're going to have more investment,' he said.

It was important to think about their inclusion in staffing too, as part of an 'empathic committed service'. Drug user groups had been 'pivotal' to delivering NSP around the country and different parts of the world and were well placed to carry on managing many DCR environments, as they did already.

'It's not about saying either nurses or peer educators, but saying what's the combination we can put together to maximise the impact of a system,' he commented.

Summing up the session, Alex Stevens said it was really important to build the evidence base, both in the UK and globally, for whether and how SIFs work. Three clear stages of development, piloting and evaluation could be taken from the Medical Research Council's framework and 'all this needs to be done alongside service user involvement from the very early stages'.

We were not starting from scratch, but had research to build on, including a 'logic model' of how these services work from Australia and Canada. A look at costs and benefits could lead to a template that people could plug their local data into.

Joining in the summing up, the senior police representative Jason Kew added: 'This is depoliticising it, about saving people's lives, about keeping people safe – it's as basic as that. People talk about going soft on drugs, but there's nothing soft about preventing deaths. Nothing.' **DDN**

HAVE YOUR SAY
Write to the editor and get it off your chest
claire@cjwellings.com


EDUCATION

THE BENZO TRAP

Improving our understanding of benzodiazepines would save many lives, says **Kevin Flemen**

Initial benzo dependency was largely driven by massive over- and long-term prescribing, something that has been addressed but remains an issue.

Escaping the trap

‘Jake took his own life on 23 August 2015 after a ten-month battle with his mental health and self-medicating with “benzos”. What I saw in our quest to get him help was beyond words.’

INSIDE THE BENZO TRAP

I read with interest ‘The Benzo Trap’ by Kevin Flemen (DDN, June, page 6). I recognised every issue covered, as my son Jake was himself in ‘the benzo trap’ five years ago. It was a world that I knew nothing about then, but sadly now I have some insight and a little knowledge of it.

Jake took his own life on 23 August 2015 after a ten-month battle with his mental health and self-medicating with ‘benzos’. What I saw in our quest to get him help was beyond words. Jake was denied a dual diagnosis, could not get a safe prescription for diazepam, was passed from pillar to post, told to continue to source diazepam from the internet, and suffered a seizure when trying to detox himself. It was just awful.

The coroner issued a Regulation 28 to prevent future deaths and commented that she was ‘baffled by the systems’ which she went on to describe as ‘disjointed’. I spent two years following up the Coroner’s recommendations and am aware of some changes.

I am passionate about change and plan to mark the fifth anniversary of Jake’s death in August by revisiting of all of the recommendations made by the coroner and contacting all of the agencies concerned. Dual diagnosis is of particular interest to me. I want to know what Jake’s experience would be today.

Many thanks for highlighting these issues in DDN.
Mel Anderton, by email

HAVING OUR SAY

It was useful to hear of the new forum for commissioners (DDN, June, page 11) – I expect there are plenty of people, like myself, who are interested in this. I hope that when it gets going it is open to involvement from those who aren’t commissioners but have a vested interest in informed and good quality commissioning practice.

Too often we hear about the activities, decisions, action plans and charters of ‘closed’ groups after a consultation that has involved talking to their own narrow membership, such as the treatment providers.

Please don’t forget the service users in all of this – the people who you are setting out to help in the first place. We have a lot to say and a lot to give.
A Barnes, by email

FIGHTING SPIRIT

Bill Nelles’ series is fascinating, thank you. I came into this field when the Alliance was on the downward. These articles have made me start to look up what user activism used to mean.

Am I the only person to be terrified at the demise of harm reduction? Is there anyone out there from the ‘old days’ who is still passionate about making a difference? Even looking back at the old issues of DDN in your archive makes me feel that we have lost a lot of the old fighting spirit.
Stephen West, by email

PICTURE YOUR STORY

All the best stories have a moment of identification. The reader or viewer may not have directly experienced the events of the story, but in the moment they form a psychological connection with the storyteller. These moments are a bridge whereby the viewer can empathise with the storyteller and share an understanding of their inner life and circumstances.

The film critic Roger Ebert said, ‘the movies are like a machine that generates empathy. It lets you understand a little bit more about different hopes, aspirations, dreams and fears. It helps us to identify with the people who are sharing this journey with us.’

Over the last five years we’ve curated an amazing array of stories through the Recovery Street Film Festival and distributed them far and wide to help create these wonderful moments of empathetic identification. Festival films have been screened everywhere from high streets, to prisons, to the Houses of Commons and Lords. We believe the more we can close the gap between the lived experience of people in addiction and recovery and the those without direct experience, the more likely we are to be able to reduce the stigma of addiction. Stigma misleads us to believe another person is a risk to us, it leads to marginalisation and discrimination. But the moments of identification that run through our festival films tell us the truth – that other person is us, someone who shares our journey.

This year we’ve moved the festival online. We’re open for submissions of your one-minute films until Monday 3 August. So if you have lived experience of addiction please do share your experience with us. This year’s theme is ‘isolation’, something many of us have experienced in different ways recently. But the theme is just a starting point, so be as creative or simplistic as you wish. If you’ve got fancy film making equipment to use then great, if not use your smartphone camera.

Check out the details at www.rsff.co.uk and find us on Facebook, Twitter and YouTube.
James Armstrong, Phoenix Futures

DDN welcomes your letters
Please email the editor, **claire@cjwellings.com**, or post them to DDN, CJ Wellings Ltd, Romney House, School Road, Ashford, Kent TN27 0LT. Letters may be edited for space or clarity.

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Chris Montgomery

IN THE ZOOM ROOM

Musician **Nick Davis** is a member of Humankind's 5 WAYS to Wellbeing: the Recovery Academy in Leeds. Here he tells how Zoom meetings have helped him stay connected

I actually feel more supported during the lockdown. I feel I've got much closer to a lot of people, even though we've not met physically. We're in touch all the time and we've become really good friends – not just people who meet in meetings.

You can often go into normal meetings and turn up, check in, say your thing and leave straight afterwards. Not hang about for a coffee, not talk to anybody else. But now people open up more because they are sitting in their own home. You almost feel like you've been invited into each other's homes, and people talk more personally when they're in that situation.

In normal times, some people find it difficult to get to meetings because of transport issues. Some can't afford the buses, some have anxiety issues getting on buses, some can't get out of bed. But it's great that to attend a meeting now, you can roll out of bed, brush your hair, press a button on your computer and be there. I know a lot that find Zoom far, far easier.

The thing that we always say in recovery is it's great to a have a routine. Clearly during lockdown our routines get thrown out of the window, but these Zoom meetings have given everybody a routine and something to look forward to.

It became apparent that a lot of people are relying very much on these meetings. We know that in recovery, weekends can be really tough as people find they're more isolated. It came to a head when a lady who comes in the Zooms regularly was particularly down and depressed one Saturday. She said – and it nearly broke my heart – how she just wanted to go and sit outside 5 WAYS even though it was closed, because she'd feel better and closer to us all.

And I thought, there's no reason why we can't set up our own Zoom groups among ourselves, because we've all got to know each other pretty well. Now, it's a bit like when you're in rehab and you're with the same people all the time and you get to know them inside out. So we set up our own Zoom chats on a weekend, just for a social chat. It's not endorsed by 5 WAYS or Forward Leeds. It's not an official thing, but I did speak to our workers about it. I'm not a trained counsellor or anything. I'm just in recovery, like anyone else.

We get people together at the weekend, and we talk about all sorts. If people have got particular issues, they can get things off their chest. But we just have a natter as well and it's just like sitting in a coffee bar or the lounge at 5 WAYS where you talk about all sorts of rubbish. So, yeah, with the Zoom meetings, I feel far more connected and very, very lucky.

5 WAYS to Wellbeing: the Recovery Academy is the centre in Leeds for those now in recovery from an alcohol or drug misuse issue.

My typical week

Monday 2pm – a SMART meeting.

Tuesday 11am to 12.30pm – a quiz that two workers host and that's great fun as well.

Tuesday 2pm – another check-in meeting.

Wednesday 11am – a music therapy-type session. Two people pick three particular songs that have helped either through lockdown or their recovery or that mean something to them. They talk about those songs, play them on YouTube on the split screen, and then we discuss what they mean.

Wednesday 2pm – another check-in meeting.

Thursday morning – a recovery workshop, usually two hours.

Thursday 2pm – another check-in and chat for a couple of hours.

Friday 2pm – with the weekend coming up we do a mindfulness session, just to chill out and get us ready for the weekend.

HANGING UP THE CLIPBOARD

Regular DDN contributor **David Finney** reflects on 23 years in the sector

'I am so grateful that my life took the turn it did, bringing me into a field of work where the restoration of broken lives was absolutely the core purpose.'

Working in the drug and alcohol treatment sector is very life affirming. Personally, I am so grateful that my life took the turn it did, bringing me into a field of work where the restoration of broken lives was absolutely the core purpose. So many people said to me those simple words 'this place saved my life', and for each one there was a story of past sadness but equally there was a hope and a future. This was made possible by the people working in this field who showed strong personal commitment, often coming from experience.

So what have I learned over time? Initially as head of inspection in North Somerset and then as national policy lead for the Commission for Social Care Inspection (CSCI), I had some great dialogue with representative bodies such as EATA and the Recovery Foundation. People such as Simon Shepherd, Nick Barton, Chip Somers, Noreen Oliver and Deirdre Boyd put their heads above the parapet and challenged perceptions of the treatment sector within government. Collaboratively we developed some good national standards for residential treatment centres, and the high point for me was in 2008 when I proudly announced at UKESAD that treatment services were way ahead of the national average in terms gaining excellent ratings. So I learned that proactive representative bodies and a listening arm of government led to improved standards of care and treatment.

One of the major improvements I observed over the years has been the focus on the individual. Initially, I found that in residential services there was a tendency to see the programme as the most important thing, sometimes overseen by some larger-than-life charismatic characters. Not to say that this didn't work for many people, but subsequently the personalisation agenda led to better-developed individual care planning which I believe accorded people a higher degree of respect and dignity. It also enabled them to go forward with more self-esteem and better-developed personal resilience for the future.

Another important development was the integration of services before and after residential treatment. Initially I came across shocking examples of discharge, such as a black plastic bin bag on the doorstep and a train ticket home. I am glad to say that many services now offer great aftercare packages, supported living arrangements, employment and training opportunities and proper integration with community services, all of which means that recovery is far more sustainable.

To briefly comment on two important themes – funding and regulation – once the NTA pooled treatment budget was removed local public health bodies became responsible for purchasing services. This meant that competing priorities led to a reduction in statutory funding for treatment, and now that the coronavirus pandemic has struck it seems obvious to say that there will be yet more pressure on these budgets. This means that treatment services will need to be even more persuasive, collaborative and creative in their organisation and bidding if they are to thrive.

I took early retirement in 2009 and began a career as a consultant. This was when CQC came into being and the regulation of treatment services moved from the adult social care to the hospitals directorate, with the intention that the treatment element of services would be better regulated. However, the medical aspects of treatment seem to have become the main focus of inspection, with less regard for the psychosocial elements that are crucial in enabling people to make their life-changing decisions. I note that CQC have recently announced that they are revising their inspection methodology again, and in the light of the pandemic have introduced an 'emergency support framework' which will inevitably lead to a strong focus on infection control. Treatment services will need to prepare themselves well for the challenge that these two changes represent and maintain an open dialogue with CQC.

As I hang up my clipboard and retire, I want to re-emphasise my deep sense of gratitude for the many people who have journeyed with me, those who have both challenged me as a regulator and stood by me as I stepped into the new world of consultancy – special thanks to *DDN* who helpfully published articles and hosted training courses in which I attempted to keep people updated with CQC changes. Finally, I firmly believe that this is a life-changing area of work, which brings transformation and hopefulness to many. Long may it continue!

They said what..?

Spotlight on the national media

DRUG TREATMENT is just as politically and morally charged as drug use – a factor we rarely witness in other areas of health such as cancer or cardiac care.

Drug treatment doesn't enjoy the privilege of being based on evidence – even though we have ample evidence from the government's own scientific advisors – but in political ideology.

This matters not in an abstract theoretical way, but a very real one. It determines who lives, and who doesn't.

The UK already has the highest number of drug-related deaths in Europe and every year we manage to set new records for those dying due to drugs. Rather than treat this problem with the urgency and attention it deserves, the government explains these thousands of premature deaths away by saying they are due to an ageing cohort of drug users.

Remember they are describing people in their forties; you must go back far more than a century to find average life expectancy reaching 40.

Ian Hamilton, Independent, 1 June

IF I EVER FEEL THE NEED to have several nice cold buckets of slime tipped over my head, I point out that most of the supposed terrorist attacks in this country are, in fact, the work of solitary drug-crazed losers. The drug involved is most often marijuana, though steroids are also increasingly implicated, as are some prescription medications.

But it is mainly marijuana, which is just now the subject of a huge billionaire-backed campaign to allow it to be advertised on TV and sold in supermarkets. Yes, that is what legalisation means. Within seconds one choir of morons will be yelling that I am 'an apologist for Islamic terror'. No, I am not. I hate terrorism of all kinds and wish we did not give into it so often. As I turn to deal with them, a second choir of morons will begin to howl that marijuana has no links with mental illness or crime, is a valuable medicine, and how dare I damage its chances of being legalised?

Peter Hitchens, Mail on Sunday, 28 June

EVERYWHERE I GO I see groups of kids drinking and smoking in parks, with no regard for social distancing, the unmistakable smell of marijuana filling the air.

Deprived of the guidance provided by school structures and teachers, how many 16-year-olds will not return in September, and instead embrace the worst of street culture and become lost to the lure of drugs and county lines gangs?

Sarah Vine, Mail, 24 June

THE HEPATITIS C TRUST

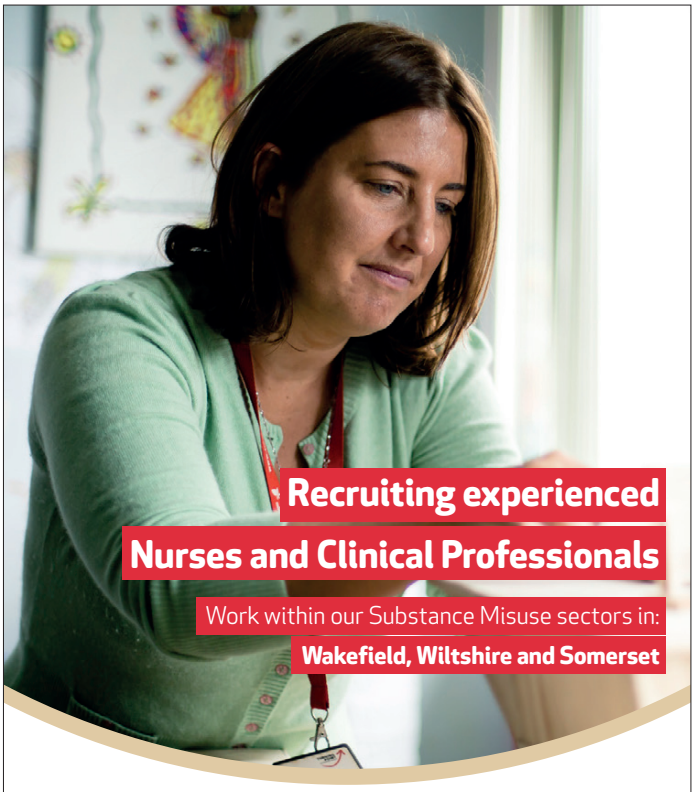
PASSIONATE PEER LEADS WANTED

The Hepatitis C Trust is expanding its network of peer workers across the country and will be looking to recruit up to 20 new staff to join its team before the end of the year. As the UK's charity for hepatitis C patients, and a leading player in national efforts to eliminate the virus, The Hepatitis C Trust has proven the role of peers in engaging those who meet the most challenges in accessing services.

The Hepatitis C Trust will be seeking passionate and skilled peer leads with excellent communication, engagement, and organisational skills to be part of a history making journey to eliminate the virus. Experience of working within drug services and with volunteers, having been affected by hepatitis C or having supported someone who has hepatitis C are all desirable if you feel that you or someone you know may be interested.

DDN will be hosting a series of job adverts with details of how to apply over the coming months so please look out for an opportunity in your area.

www.drinkanddrugsnews.com/jobs



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