DDN

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OPPORTUNITY KNOCKS

LET'S NOT WASTE THIS CHANCE TO END ROUGH SLEEPING

DDN

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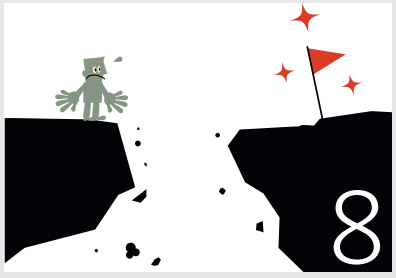

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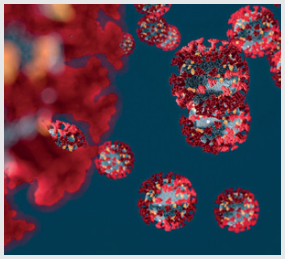

Find the resources to stay ahead of coronavirus from the DDN partners and community at **www.drinkanddrugsnews.com**

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.

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'Will we make the most of this opportunity?'

'IT'S ABOUT GIVING PEOPLE MUCH MORE POWER over the choices they make.' Service providers are telling us that six months into lockdown, there are opportunities in the 'new normal' (p12). One of the most exciting prospects is the government's pledge to 'end rough sleeping for good' (p6). Will we get the next steps right to make the most of what Dame Louise Casey calls an 'extraordinary opportunity'?

Hearing from peer networks (p15) highlights the resources we have for informing treatment – what could be more effective than learning from the experts? Overdose Awareness Day should teach us that harm reduction is not an optional extra, but a matter of life over death. Stigma at home and abroad is standing in the way of essential progress and we must be receptive to wherever we can bring this expertise to the heart of the treatment system.

The new Staywell centre in Derby (page 20) is an enterprise that's using lived experience to great effect, working alongside over-stretched treatment services to offer many dimensions to recovery and wellbeing – what Recovery Month is all about.

And alongside all the ideas, here's a thought: do we consider the fact that taking drugs can feel rather nice? I'll leave you with Nick Goldstein's article on p10.

Claire Brown, editor
Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

Government scraps Public Health England

The government is abolishing Public Health England (PHE), it has announced. A new organisation, The National Institute for Health Protection (NIHP), will instead bring together PHE and NHS Test and Trace and focus on a 'rigorous science-led approach to public health protection'.

Although the new body is starting work immediately it will not be formalised until next spring in order to 'minimise disruption', the government says. While NIHP's responsibilities will cover the COVID-19 testing programme, emergency response and preparedness and surveillance of infectious diseases, it remains unclear what arrangements will be made for PHE's other functions, including the Alcohol, Drugs & Tobacco part of its Health and Wellbeing Directorate.

In a speech to the Policy Exchange health secretary Matt Hancock said that PHE's prevention and health improvement agenda would be 'embedded right across government', with a consultation to follow. 'I'll be saying more on this over the coming weeks,' he stated. DHSC will be organising an external stakeholder advisory group to support this and 'provide expert advice from leading thinkers in public health, health care and local government', the government says. Interim executive chair of the new organisation will be Baroness Dido Harding, while the interim chief executive officer of PHE will be Michael Brodie, currently CEO of NHS Business Services Authority.

More than 80 health organisations including the Alcohol Health Alliance, Alcohol Change UK, Humankind and Turning Point have issued a statement in the *BMJ* outlining their fears over PHE's abolition. 'As organisations committed to improving health and reducing inequalities, we are deeply concerned that the government's plans for the reorganisation of health protection in the UK pay insufficient attention to the vital health improvement and other wider functions of Public Health England,' it states. While the establishment of the stakeholder advisory group was a 'welcome step', reorganisation of PHE's health protection functions risked fragmentation, it warns, and calls on the government to reverse public health budget cuts. 'Organisational change is difficult and can be damaging at the best of times – and these are not the best of times.' *Full statement at https://smokefreeaction.org.uk/phehealthimprov/*

Interim executive chair of the new organisation will be Baroness Dido Harding.

Northern Ireland to consult on minimum pricing

NORTHERN IRELAND is to launch a 'full consultation' on MUP, health minister Robin Swann has announced. The decision follows a review of its alcohol and drug strategy carried out last year. Northern Ireland's new substance use strategy, *Making life better – preventing harm and empowering recovery* will be issued for consultation this autumn, with the MUP consultation to follow within a year. Although the proportion of adults in Northern Ireland drinking above the recommended guidelines fell from 26 per cent to 20 per cent between 2010-11 and 2017-18, alcohol-related deaths have continued to rise while hospital admissions increased from just over 9,500 in 2008-09 to more than 11,500 in 2016-17. MUP has already been introduced in Scotland and Wales.

'The impact of alcohol misuse is being felt by too many families and communities across Northern Ireland on a daily basis,' said Mr Swann. 'We need to consider fully every option available to us to reduce this blight on our society. I have been closely following the Scottish Government introduction of minimum unit pricing on alcohol since 2018 and have been noting with interest the early positive evaluation reports.' The announcement was a 'positive step forward', said chair of the Alcohol Health Alliance, Professor Sir Ian Gilmore.

"The impact of alcohol misuse is being felt by too many families and communities."

ROBIN SWANN

Calorie labels for alcohol?

THE GOVERNMENT will launch a consultation on plans to provide calorie labelling for alcohol, it has announced. The consultation forms part of the government's obesity strategy designed to 'beat coronavirus and protect the NHS'. Around 80 per cent of people are unaware of the calorie content of alcoholic drinks, the government says, with alcohol consumption estimated to account for almost 10 per cent of calorie intake for those who drink. Around 3.4m people are consuming an additional day's worth of calories per week, it adds.

'When the calorie equivalent of a large glass of white wine is the same as a slice of pizza or a cocktail is the equivalent of a cheeseburger, it is clear why alcohol products should be included in the government's plans to tackle the obesity crisis,' said chair of the Alcohol Health Alliance, Professor Sir Ian Gilmore. 'Alcohol is a factor in more than 200 health conditions and is the leading risk factor of death among 15-49 year olds in England. Labelling on all alcohol products with prominent health warnings, low risk drinking guidelines and information on ingredients, nutrition and calories would help equip the public with the knowledge they need to make healthier decisions about what and how much they drink.'

Home secretary 'minded to' explicitly exempt poppers from Psychoactive Substances Act

The home secretary, Priti Patel, has written to the ACMD seeking its advice on formally exempting alkyl nitrates – or 'poppers' – from the 2016 Psychoactive Substances Act. There has long been confusion about the exact legal status of the substances, and as the lawfulness of their supply remains uncertain, the home secretary is "minded to remove this uncertainty by explicitly exempting" the substances from the act, she states.

Although an initial proposed amendment to exempt alkyl nitrates from the Psychoactive Substances Bill was defeated, the ACMD later advised then drugs minister Karen Bradley that in their view the substances would still fall outside of the scope of the act as they did not have a direct effect on the central nervous system (*DDN*, April 2016, page 4). A 2018 Court of Appeal ruling, however, stated that substances that only have an indirect psychoactive effect could still be covered by the legislation.

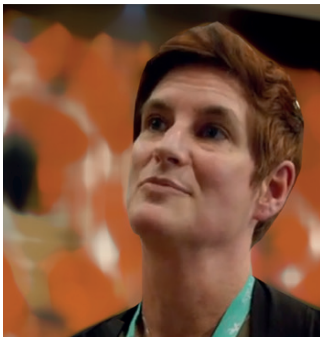
The home secretary's letter also seeks the ACMD's advice on the drivers of increasing powder cocaine use among young people and drug sales on the 'dark net'.

> The ACMD later advised... the substances would still fall outside of the scope of the act as they did not have a direct effect on the central nervous system.

Family focus

THE THEME OF THIS YEAR'S #STOPTHEDEATHS initiative is the role families can play in saving the lives of people at risk of overdose. The campaign, which was launched three years ago (*DDN*, September 2018, page 5), encourages people across Scotland to understand their role in helping to prevent overdose deaths. Although the figures are yet to be released, there are fears that 2019's drug death toll for Scotland could once again be the highest ever. 'The focus on families for this year's Stop the Deaths initiative is welcome and timely,' said CEO of Scottish Families Affected by Alcohol and Drugs (SFAD), Justina Murray. 'We know families play a vital role in preserving and saving the lives of those at high risk of overdose and death, but this is often overlooked. This includes everything from meeting their basic needs for food and shelter, to supporting them to engage with treatment and recovery, and continuing to offer them enduring love, hope and connection.'

'Every fatal overdose can be prevented,' added Scottish Drugs Forum CEO David Liddell. 'With training and support, families can learn how best to support people when they are most at risk.' *www.stopthedeaths.com*



'We know families play a vital role in preserving and saving... lives.'
JUSTINA MURRAY

Hep C world first

NHS TAYSIDE has become the world's first region to effectively eliminate hepatitis C, with 90 per cent of patients diagnosed and 80 per cent of infected cases treated by the end of last year. NHS Tayside has diagnosed almost 2,000 people since testing began, and treated more than 1,800 – more than 90 per cent of the estimated prevalence of hep C, meeting the WHO's elimination target 11 years early. The NHS Tayside project, which was developed in partnership with the University of Dundee, began in a single needle exchange and eventually led to a redesign of services with a focus on testing people who use drugs before they enter treatment.

'If you can offer treatment at a very early stage, while people who are infected are still actively injecting – when they have contact with other people who inject and share equipment with other people – their chances of transmission disappear because they're not infected any more,' said consultant hepatologist Professor John Dillon. 'It's the idea of treatment as prevention.' Getting such a high proportion of people treated was a 'huge achievement,' added Hepatitis C Trust chief executive Rachel Halford. 'People who inject drugs often struggle to access treatment due to barriers like stigma around the virus and drug use. NHS Tayside has shown that it doesn't have to be this way and that everyone can be treated for this virus. If services adapt to patients, everyone can clear the virus and we can make sure we leave no one behind.'

Local News

Powerful pop-ups
A series of pop-up performance videos have been created to mark International Overdose Awareness Day by BDP, Outside Edge, small performance adventures and Theatre Royal Plymouth's 'Our Space' project. 'Overdose has touched many lives,' said Theatre Royal's Sara Rhodes. *smallperformance adventures.com/work-projects/international-overdose-awareness-day*

Joining up
Phoenix Futures has launched a research partnership with Liverpool John Moores University. The aim is to 'facilitate a more symbiotic relationship between research and practice' and integrate emerging evidence into service delivery, says Phoenix.

London calling
Outside Edge Theatre Company is starting a free weekly drama group in Southwark for anyone affected by addiction issues. 'You don't need to have any experience of drama, you just need to be abstinent on the day of the workshop,' say the organisers. *http://edgetc.org/drop-in-drama/*

Opening the do

The efforts to get homeless people into emergency accommodation must not be wasted, as **DDN** reports

Homelessness has been long been regarded as complex, difficult, inevitable – and easy to ignore. The substance misuse sector has struggled to maintain outreach services in the face of disappearing funding and has tried to create care pathways with varying levels of success.

A conference on homelessness and addiction last year (*DDN* February 2019, page 16), raised many questions – why don't we take notice of the evidence to stop 'thoroughly preventable' drug poisoning deaths with simple and cost-effective harm reduction measures such as naloxone? Why are we still discharging from hospital onto the street? Why are care pathways so fragmented? Why aren't we creating routes out of dependent drinking? Why is there no help for smokers?

While COVID-19 has thrown everyone's life into disarray, there is one group of people who might actually benefit as a result. Things couldn't have seemed much worse for the street homeless population when housing minister Robert Jenrick announced £105m to provide interim housing to take thousands of rough sleepers off the street during the pandemic, including £16m for people in emergency accommodation to access specialist help for substance misuse. The money is also aimed at helping rough sleepers to secure their own tenancies, as part of the government's commitment to 'end rough sleeping for good'.

Dame Louise Casey, chair of the COVID-19 Rough Sleeping Taskforce called the 'Everyone in' initiative an 'extraordinary effort' and an 'extraordinary opportunity' to turn lives around if we get the next steps right. 'I am clear that there can now be no going back to the streets as people begin to move on from the emergency accommodation that has been put in place,' she said.

In London the initiative has taken shape through the Homeless Drug and Alcohol Service (HDAS), commissioned by Public Health England and the Greater London Authority. The 'pan-London system' involves the South London and Maudsley (SLAM) and Central North West London (CNWL) NHS Trusts, working with Change Grow Live and Turning Point (who coordinate logistics), We Are With You and Phoenix Futures. A 24-hour phone line is manned by recovery workers from the pool of organisations involved.

Dr Emmert Roberts is clinical lead for HDAS and told *DDN* how the service was commissioned for three months in March, extended for another three, and is looking likely to carry on for longer. A 'hodge podge of a system' at the beginning, it has had to come a long way in a short time, he says. 'It was chaos – getting people off the streets as quickly as you can. Once they were off the street, we could do more stuff.'

The first challenge was to secure rooms in hotels, and this involved splitting the intake into three distinct cohorts. People with symptoms or who tested positive for COVID-19 needed to be isolated in 'COVID care' rooms. The next category was 'COVID protect' for those who tested negative but who had medical vulnerabilities. Everybody else was assigned a 'COVID prevent' room.

Once this was achieved – which Roberts admits involved 'abject

'I am clear that there can now be no going back to the streets as people begin to move on from the emergency accommodation...'

DAME LOUISE CASEY

HOMELESSNESS DURING LOCKDOWN.
Far left: Leicester, August 2020 – a man begs outside a Marks and Spencer store. Credit, Darren Staples/Alamy.
Centre left: Tottenham Court Road, London, April 2020 – tents set up by homeless people outside Habitat. Credit, Monica Wells/Alamy.
Left: Southbank, London – volunteers serving hot meals for homeless people in Riverside Walk arches. Credit, Alla Bogdanovic/iStock.

oors

chaos' at first, because of the speed everything had to be put in place – there was a chance to tackle 'the whole suite of drug and alcohol issues'. Anyone could call anytime from the hotels to ask for advice, and many of the calls related to alcohol withdrawals and prescribing issues.

Harm reduction was a high priority, so naloxone was introduced and people were given a workbook of psychosocial interventions to complete in their hotel rooms as a way of bridging the gap left by lack of face-to-face contact. One of the big initiatives has been the opportunity to tackle smoking, with 2,000 e-cigarettes distributed alongside other nicotine replacements – a window to reduce tobacco harm as well as enabling people to stay in their rooms to avoid transmitting the virus.

'Harm reduction initiatives can really work well with this population, as well as preventing COVID spread,' says Roberts. 'It showed that there is willingness among people to reduce their tobacco consumption.' He hopes that funding being made available for a pan-London coordinator for tobacco harm reduction will improve access for people who are rough sleepers and help them to reduce their tobacco use long term.

As Roberts stresses, each part of the initiative has been a learning curve, so supporting the hotels to house their guests safely has been paramount. 'We've been working with local hotels to provide education and training to minimise risks relating to alcohol withdrawal, naloxone training and how to use e-cigarettes,' he says.

The other part of the project that needed to be bedded in fast was the strategic working between the partners. Where there were normally 'turf wars' between services there had to be a change in approach, so that people could stay with their original treatment providers when they moved location to prevent them from dropping out. The proactive partnership culture was also helpful for feeding into health alliances – the GPs and nurses working in the hotels, as well as the homeless charities steered by St Mungos.

Much of the time and energy has been taken up through facilitating new referrals into treatment, says Roberts, and 'a lot were people who have never been in the treatment services before or are generally hard to reach. We facilitate their involvement with local services and prevent any bad practice happening in the hotels, including dodgy detoxes and people not understanding about substance misuse.'

While 'lots of things have gone well', the team is bracing itself for an 'uptick in homelessness'. 'I don't know what the future holds and we're not out of the crisis yet so it's very difficult to know what we're going to return to or what the new normal is going to be,' says Roberts. 'I would hope that we've learned some lessons about how we treat homeless people within our services – but given that we don't know what the lie of the land will be over the next few months, it's hard to know if this will have any lasting impact.'

'We've been working with local hotels to provide education and training to minimise risks relating to alcohol withdrawal, naloxone training and how to use e-cigarettes.'

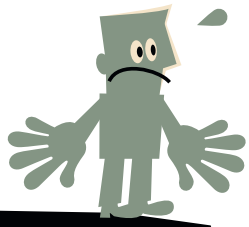
DR EMMERT ROBERTS

Getting people off the streets and into a safe place had to be done very quickly and in an emergency situation, so he is frank about it being 'chaos' at the beginning. But through bringing the health teams, homeless charities and substance misuse teams and hotel staff together, they have been able to help with all kinds of issues, including immigration and benefits. Each of the hotels in London has a resident homelessness sector organisation – mainly St Mungos – running the day-to-day life, with HDAS being the central coordinator for the substance misuse sector.

'It's been challenging and chaotic, but the fact we've been able to come together and have city-wide input has been very useful,' says Roberts. 'The government has agreed to try to end homelessness by the end of parliament in 2024 and the work we've done will hopefully help that.'

He is painfully aware that 'the state of funding in the entire sector is quite dire at the moment, with over £250m of disinvestment over the past five years', and that 'this isn't going to rectify that'. The abolition of PHE feels like another hammer blow. But there's no denying that being plunged into this emergency situation has already had some amazing results for individuals who were invisible before COVID turned our world upside down.

'This isn't going to be a substitute for the overall disinvestment,' says Roberts. 'But it might go some way towards improving access for this particular population.' And if you're one of the 5,000 people in London or 15,000 people nationally who have entered a housing support scheme for the first time, that could feel like a wide-open door. **DDN**



Blocking the path

What proportion of England's problem drinkers are actually in treatment? And are increasing rates of unmet need the result of austerity-driven funding cuts? **Mike Ashton** investigates

How well is England doing at getting people who need help into treatment for their drinking problems? It matters, because the more of the in-need population we treat, the smaller the alcohol-dependent population and the less the related harm. *Drug and Alcohol Findings* conducted an examination for England in 2014 when the figures were most reliable (*see https://findings.org.uk/PHP/dl.php?f=tr_pop_uk.hot&s=dd for the full story and references*).

Then, about 112,000 drinkers were in specialist treatment. We found rationales for this representing just 7.5 per cent of harmful or at least mildly dependent drinkers, and up to 43 per cent of those who score in surveys as at least 'moderately' dependent. In between was a 19 per cent estimate based on a formula constructed for the Department of Health. This aimed to exclude drinkers who, despite a high risk to health, scored as non-dependent in surveys, but to include lower-risk drinkers dependent enough not to remit, even after an extended brief intervention.

The population in need of treatment becomes constricted further if we take into account whether prospective patients actually want or intend to take a treatment route to curbing their drinking, and/or are making what to them seems a rational choice to continue to drink to excess.

COULD DO BETTER

Though the question of what proportion of the in-need population is in treatment has several answers, what seems sure is that England could be doing better – not least because Scotland seems to be treating proportionately three times as many of its problem drinkers. An estimate for Leeds is that raising treatment access to that level would cut the alcohol-dependent population by nearly a fifth over five years, and save a further 65 lives.

Since 2014, however, things seem to have got worse (*Fig 1*). Initiated in 2010, the government's austerity policies are prime targets for the underlying reason why alcohol treatment numbers have been falling despite sustained levels of need – the chart shows numbers falling consistently since 2013-14. The highest line is the number of patients whose presenting substance use problems included alcohol, the lowest those with alcohol as their sole presenting substance use problem. In between are actual or estimated numbers of patients treated primarily for their drinking problems, the basis for the calculations above.

These figures must be married with trends in estimated treatment need to assess whether need is increasingly failing to be met. The methodology which yielded the 19 per cent estimate for 2014 has been used to estimate the alcohol-dependent population in England from 2010-11 to 2017-18. In 2017-18 the estimate was just 1.6 per cent lower than in 2013-14, yet over the same period the patient caseload fell by about 17 per cent – from equivalent to just over 19 per cent of the in-need population to 16 per cent (see chart). The drop was within margins of uncertainty, but was consistent each year from 2013-14. With a presumed substantial pool of unmet need, even if there had been no fall in the proportion of the in-need population being treated, a diminishing caseload would still have been of concern.

HOSPITAL ADMISSIONS

Another statistic used to indicate need for treatment is hospital

> 'Austerity might increase unmet need by obstructing the main routes for converting need into demand for and entry into treatment.'

admissions of patients diagnosed with mental or behavioural disorders due to drinking (*Fig 2*).

As with the alcohol-dependent population, the treatment caseload as a proportion of admissions has fallen each year since 2013-14, from about 32 per cent to 22 per cent in 2018-19, suggesting that treatment has been capturing smaller and smaller proportions of the in-need population since austerity took hold.

So concerned were Public Health England (PHE) at the 'fall ... in the context of high levels of unmet need' that in 2018 they mounted an inquiry. It spotlighted 'financial pressures and service reconfiguration', but also made it clear that the prime service-reconfiguration suspect – integration of alcohol with drug services – was itself mainly driven by 'reduced local substance misuse budgets'. This change is said to have led to a defocus on alcohol and a less specialist response to problem drinking, as well as possibly deterring drinkers from services which looked and felt like they were for drug users.

OBVIOUS ANSWERS

For one well-informed commentator, the time for PHE's cautious pointing to austerity was past: 'Some in the field may feel the answer is obvious – continued cuts to treatment budgets (put at 26 per cent for adult and 41 per cent for youth services) have inevitably led to less resources and a changing landscape with very few alcohol-only services remaining, described as a "crisis" in alcohol treatment.'

These views and that of PHE's inquiry were reinforced by an Alcohol Change UK survey of alcohol services and allied professionals in England in 2017. Key findings were that most respondents could not say there was sufficient local access to these services, and that the main reason was the funding squeeze. The same year a survey of substance use services in England warned that 'the capacity of the sector to respond to further cuts has been seriously eroded'. Instead of targeting the 'comprehensive and high quality services' needed to actualise the government's recovery agenda, providers were now concerned about being able to maintain the basics of safety and quality.

NEED AND DEMAND

Austerity might increase unmet need by obstructing the main routes for converting need into demand for and entry into treatment (*Fig 3*). That this has been at least partly the case was suggested by a report on alcohol treatment in England in 2011-12 from what was the National Treatment Agency for Substance Misuse (NTA). It was concerned at how few people had successfully been referred to specialist treatment by GPs or A&E departments, despite the fact that around one in five people seeing a GP is drinking at risky levels and about a third of emergency attendances are alcohol-related. If there was cause for concern then, there was even more later: from a peak of 15,900 in 2009-10, by 2013-14 these two sources accounted for 15,132 treatment starts of people primarily treated for their drinking; as a proportion of all treatment starts, the trend was consistently down from 23 per cent in 2008-09 to 19 per cent in 2013-14 (see chart).

Since 2014-15 reports instead record patients with alcohol problems unaccompanied by problems with use of illegal drugs – the 'alcohol-only' caseload. However, the trends described above continued. The concurrence between the raw numbers (black lines) and the percentage these represented of all new referrals (orange lines) shows that GPs and A&E departments were not just referring fewer and fewer patients in absolute terms, but also relative to other referral sources. By 2018-19 these accounted for just 12 per cent of all new alcohol-only referrals compared to 23 per cent of patients with a primary alcohol problem in 2008-09.

In the end, PHE's grounds for concern seem a stronger foundation for policy responses than attempts to assess the met-need versus total-need fraction. For numbers in treatment to be falling when there is some hard-to-pin-down, but perhaps substantial, degree of unmet need suggests something is increasingly going wrong in access to treatment for problem drinking in England.

Mike Ashton is co-editor of Drug and Alcohol Findings, www.findings.org.uk

Figure 1. Alcohol-involved patients in treatment for substance use problems in England from 2005/2006

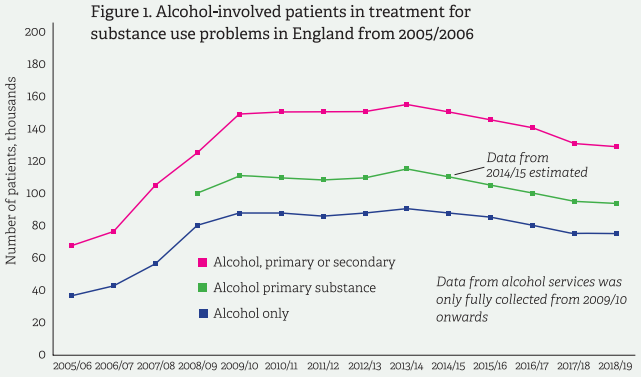


Figure 2. Patients in treatment in England primarily for alcohol problems from 2010/11 as proportions of indicators of need for treatment

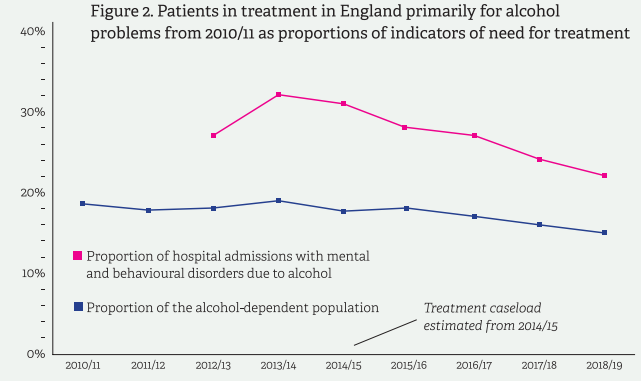
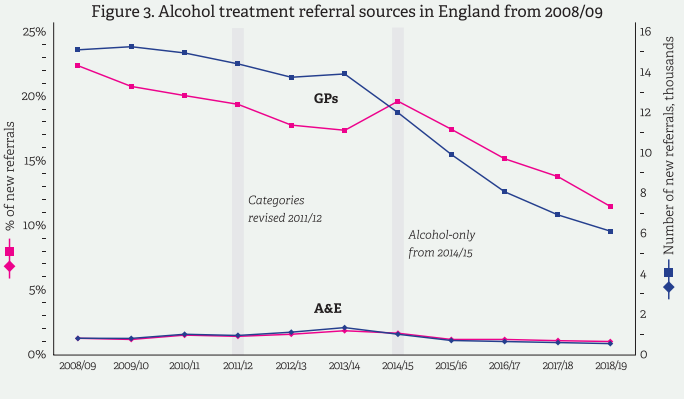


Figure 3. Alcohol treatment referral sources in England from 2008/09



WE NEED TO TALK ABOUT PLEASURE

Our refusal to acknowledge that drugs can be a happy experience is hampering our attempts at treatment, says **Nick Goldstein**

We've all heard enough about coronavirus to last a lifetime. But one of the more positive aspects of the lockdown is that it has given us time and space to sit down and think about the difficult issues that we kick into the long grass. One of the subjects I find repeatedly cropping up is pleasure – our perception of pleasure and our attitude towards it.

The dictionary definition of the noun 'pleasure' is a feeling of happiness and enjoyment – a feeling we all know. Pleasure is usually perceived to be harmless – a fringe benefit of existence even – BUT if that pleasure is derived from something society perceives as a negative, all hell breaks loose. And there are few things society regards as negatively as drug use.

Consequently, drug use has become deeply stigmatised and the root of that is 'intoxophobia' and faulty misperceptions of pleasure. Intoxophobia, the fear of intoxication, has been around for a long time and exists as a result of ignorance of different, altered states of consciousness. Any behaviour different to our norms creates fear, and no one likes to be scared – in fact fear makes people angry.

The misperception of drug use as purely pleasurable is also the result of ignorance – an ignorance that also ends in anger, but this anger is caused by resentment rather than fear. Think of it as a version of Max Weber's protestant work ethic – a concept that implies that pleasure must be worked for, striven for, and not bought by the ten bag. So, some poor schmuck wandering around high as a kite doesn't go down well because of all those misconceptions, misperceptions and outright intolerance relating to pleasure.

Sadly, those misconceptions and misperceptions surrounding drug use and pleasure exist in the substance misuse field too. From key workers to consultants in every treatment agency and treatment provider, it's lurking. It can be seen in the drugs prescribed (both major drugs prescribed in treatment, methadone and buprenorphine, are perceived to offer little pleasure) and in the limited amounts prescribed, which are subsequently sub-optimal.

Have you ever heard a prescriber say to a struggling client, 'Oh dear! Your sample is positive. You're obviously struggling with this dosage/prescribed drug. So let's increase your dose/change the drug for something you might prefer – something you might actually want to take because you enjoy it.' No, me neither. The response is much more likely to involve decreasing dosage and increasing restrictions for the client.

Rather than concentrate on Freud's pleasure principle, it would be far better for us all if more emphasis was paid to a much earlier commentator, Epicurus. Epicurus, who was a noted Greek philosopher, suggested that primarily pleasure was found in relieving pain. At least 50 per cent of substance misuse clients experience dual diagnosis and suffering. The very fact they

'Pleasure is usually perceived to be harmless – a fringe benefit of existence even – BUT if that pleasure is derived from something society perceives as a negative, all hell breaks loose. And there are few things society regards as negatively as drug use.'

Media Trading/iStock

use drugs and fall into the sphere of substance misuse services is a grim indictment of modern psychiatry, because no one goes into substance misuse treatment if they have another option. Gabor Maté's ideas around trauma and addiction would suggest an even higher percentage of service users are suffering.

Put simply, people don't go into treatment to keep the party going, for free dope. Considering the modern treatment service, it can easily be construed that you have to be desperate to sign up. So it would be great if the drugs that enable clients to function and provide much needed stability were not seen as a vice or pleasure, but rather seen as just medication.

I'll probably be burned at the stake for mentioning it, but demonisation of drugs and the pleasure they can impart is seen far too often in recovery settings. I appreciate the seriousness of recovery, but if your schtick involves demonising drugs and pleasure to maintain one's own recovery it might be time to find another narrative.

Our negative attitude to pleasure can even be seen to limit the effectiveness of what little harm reduction we practise. The work of Magdalena Harris, associate professor at the London School of Hygiene and Tropical medicine and a leading researcher, suggests that the most effective forms of harm reduction tend to fall around ways to extend pleasurable drug use rather than the much more common and more ineffective 'wages of sin are death/do this or die' approach.

A more civilised attitude to pleasure would change things, and our only chance of this is a full and frank discussion around pleasure and our attitude to it. An inability to accept pleasure is the elephant in the room. It leads to stigma, poor drug treatment and poor relationships between services and service users. This, sadly, won't change until there's been a debate – and considering the subject, it will be a painful debate.

My contribution to this debate is this. Since mankind came down from the trees we've wandered around, and when hungry we ate some of the plentiful plants. Some plants nourished us, so we kept eating them. Some plants poisoned us, so we stopped eating those. And some plants – special plants – made us feel good... *really* good. We definitely kept eating them!

You have to accept pleasure is a very human problem, because only mankind would make pleasure a problem. Most animals, wisely, just enjoy it.

Nick Goldstein is a service user

They said what..?

Spotlight on the national media

THE DECISION to scrap Public Health England in the middle of a pandemic that has claimed 65,000 British lives is cynical and wrong... it is not a failing institution and its weaknesses reflect years of Conservative cuts.
Guardian editorial, 18 August

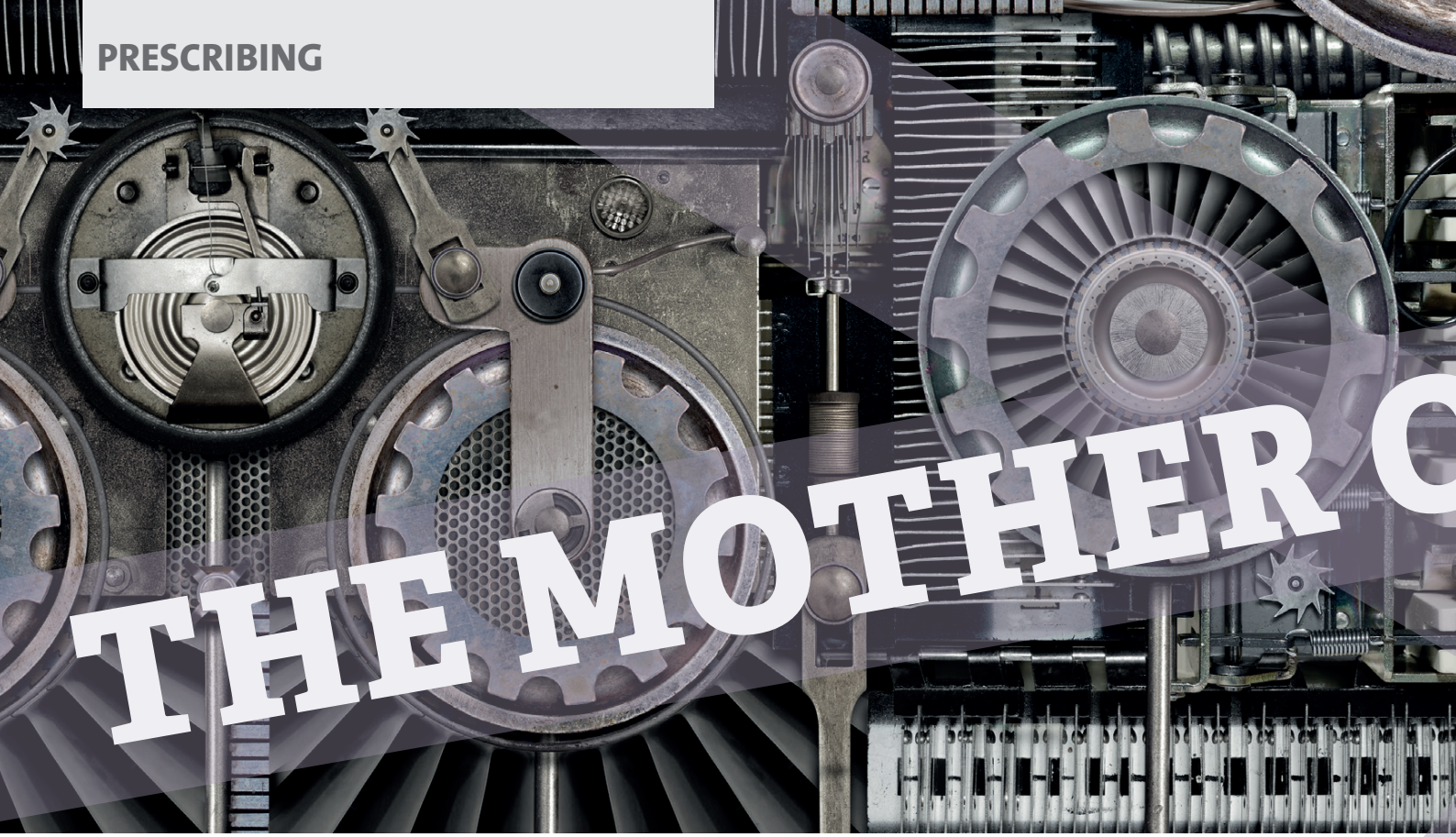
THIS BUNCH OF NANNYING NO-MARKS enjoy an annual budget of £300m and legions of bosses enjoy six-figure salaries, but ask yourself this: for all that cash, apart from eating an extra apple, how has your life been improved?
Nick Ferrari, Express, 23 August

THE PRIME MINISTER AND HIS MERRY BAND OF FELLOWS seem to care about alcohol in so far as the effects it has on people's waistlines – last week they announced plans for calorie labelling on booze... – but there appears to be precious little concern for the effects it has on people's brains and lives. It could even be argued that the folks in charge actively encourage the drinking of alcohol, not just in their desperation to reopen pubs over and above almost everything else, but also in their trashing of alcohol and drug services.
Bryony Gordon, Telegraph, 8 August

PEOPLE WHO USE DRUGS are perceived to have self-inflicted the psychological and physical pain they experience. We see them as deviant. This lazy and widely held attitude is not discreet, and the shame and stigma do little to promote recovery from addiction. We don't need to look far to see where our national empathy really lies – the suffering of cats and dogs always triggers a better response than one for those trapped by addiction.
Ian Hamilton, Independent, 14 July

The decision to scrap Public Health England in the middle of a pandemic that has claimed 65,000 British lives is cynical and wrong... it is not a failing institution and its weaknesses reflect years of Conservative cuts.

IN A WAY, I'M GLAD we don't legalise drugs in this country. Because – and you'll have to excuse me for making one of history's tiredest arguments – look what we did with that incredibly dangerous substance alcohol: we had a choice between strict regulation and building a towering culture entirely around it, and chose the latter. Could you imagine just how unbearable drugs culture would be in this country if it was legalised? Second-wedding hen-do mums with 'Live, Laugh, Love' etched across a TK Maxx bong; hard lads in pub gardens arcing bottles of poppers in the air every time Harry Kane scores a penalty; entire counties ready to fight each other – the way Devon and Cornwall argue about the order the jam is supposed to go on a scone – over whether a bump of cocaine is better than a line. This is why we can't legalise drugs in this country. It's nothing to do with moral panic, and everything to do with cultural decline.
Joel Golby, Guardian, 22 July



THE MOTHER O

It's now almost six months since lockdown revolutionised the way services operate. But could this have actually led to an increase in service user choice? **DDN** reports

'I don't like the phrase "new normal", but I think what that will be is a blended mix', Andrew Horne, executive director of We Are With You, Scotland, tells *DDN*. 'It's about giving people much more power over the choices they make. Rather than saying, "Here's your worker, here's your one-to-one session, and you travelled 40 miles across the Scottish borders or Cornwall irrespective of what the transport system is like" – now it's "video me".'

COVID-19 has had a huge impact on service users' experience of treatment, not least the all-pervading sense of insecurity in the early days of the pandemic. But, as numerous *DDN* articles have illustrated over recent months, services were quick to adapt and ensure continuity of provision for their clients in exceptionally difficult circumstances. Initiatives adopted have ranged from preparing food for service users to providing them with smartphones, and one of the most significant changes – as with most other sectors – has been the large-scale shift from face-to-face to online activity.

SCRIPTS AND PICK-UPS

Inevitably, a key area to be affected has been provision of substitute medication, with many pharmacies – particularly in the early days of lockdown – either closing or operating significantly reduced hours. This meant service users being moved from daily to weekly or fortnightly pick-ups, often with little or no notice.

'There was a lot of uncertainty in the first couple of weeks, and real concern about continuation of scripts,' says national service user representative for Change Grow Live, Tony Lee. 'What my service was able to do was move everybody to a 14-day pick-up, and in the first couple of weeks that did create some anxiety. People were thinking, "Oh my God, will I manage?" But by the time it came to the second pick-up two weeks later that seemed to have gone away.'

Feedback has shown that the move away from daily pick-ups has actually improved some people's relationships with partners and children, he says, and has been particularly welcome for anyone looking after an elderly parent. 'Now they don't have to go to a chemist every day with the risk of bringing COVID back into the house. A lot of people have been really, really complimentary about the service taking that chance of giving them a 14-day prescription. It improves choice, it improves flexibility. We're not getting anything negative on that front at all. I'm a national rep – I speak to people all over the UK – and it's the same feedback every time.'

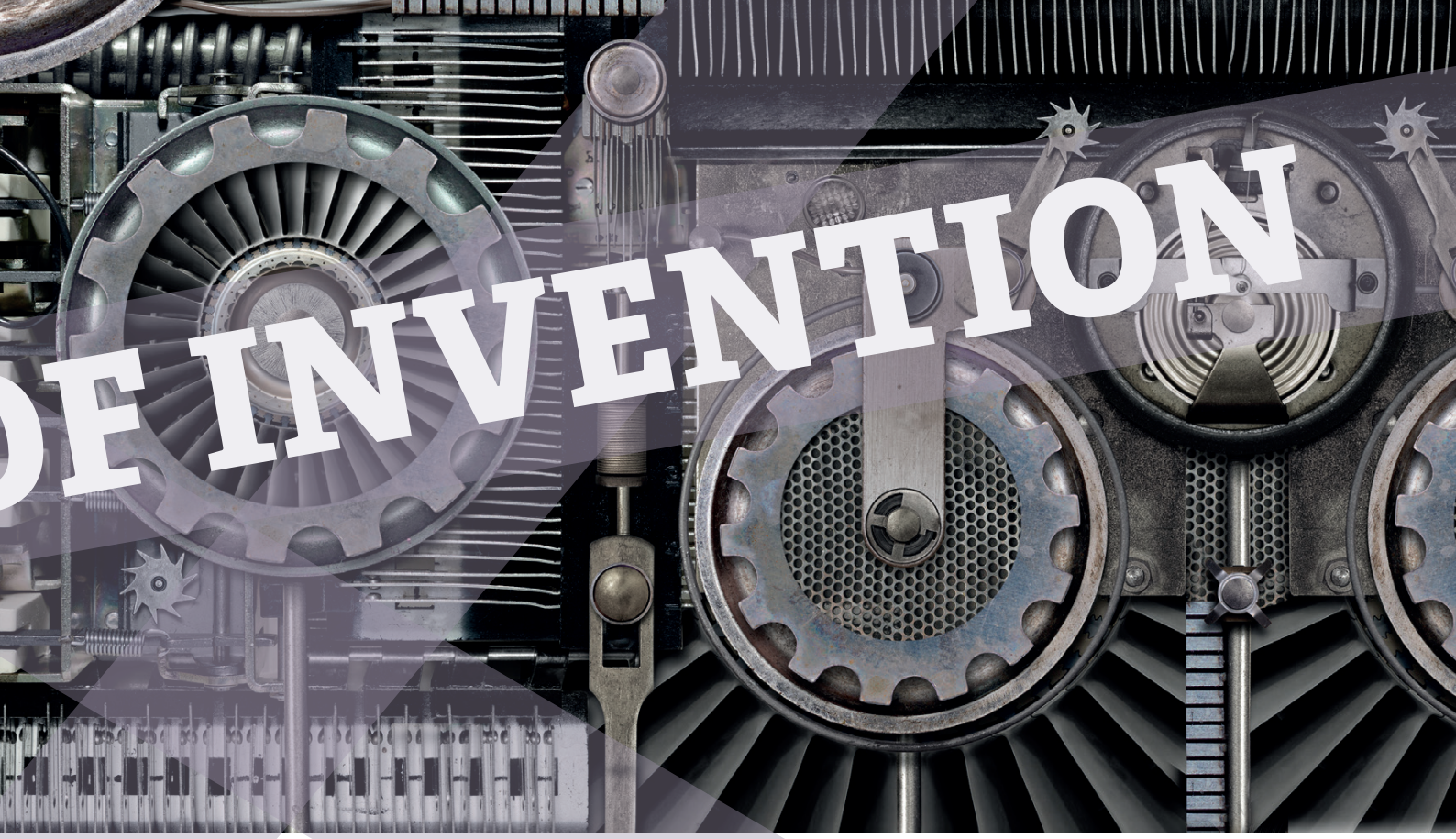
His service user council has now taken steps to ensure that no one is moved back to daily supervised consumption without good reason, he states. 'We demanded some safeguarding measures be put in place, so the person has to go through two processes to be put back on supervised consumption. That's really helpful because it reassures the client and brings them into that decision, so nothing's decided without their input. And we've created an appeals system where we can respond rapidly to anyone complaining that they've been put back on supervised consumption needlessly.'

IN CONTROL

We Are With You has found much the same, adds Horne. 'We moved as many people as we could across to fortnightly pick-up, and the feedback has been very interesting.

'When we did our service user survey, 70 per cent said they didn't want to go back to daily pick-up.'

ANDREW HORNE



DE INVENTION

When we did our service user survey, 70 per cent said they didn't want to go back to daily pick-up. Two or three people said it was the biggest trigger point for relapse, because they were constantly in contact with people who were carrying illicit Valium or whatever. People also felt much more in control of their lives and how they dealt with dosage – instead of having to go to a chemist and drink 120ml of methadone they could spread that over the day.'

His organisation changed all its prescribing options, with a lot more use of buprenorphine, for example. 'We just gave people options as to what they were more comfortable with. In Scotland we turned all our services into needle exchanges, because we knew people were going to struggle with chemists, we created click-and-collect for needle exchange, and did a lot of video prescribing as well.'

TAILORED TO NEED

Not every organisation made the shift to fortnightly pick-ups, however, and instead worked to make sure people were getting a service tailored to their needs. 'We never went to fortnightly,' says medical director at WDP, Dr Arun Dhandayudham.

'Even before the lockdown we were already risk-assessing each patient individually, looking at all their health risks and pick-up regimes. We were already well advanced in our planning, and the maximum anybody got was one week – we were also working very closely with the pharmacies to establish what kind of resilience they had in terms of cover. So we individualised each service user's pick-up – some went from daily supervised to daily unsupervised, or from once or twice a week to a maximum of weekly.'

Closer working with pharmacies also provided a chance to stay informed about clients who weren't coming into services, says his colleague, operations manager Vanessa Duke. 'We've been in pharmacies very regularly dropping off prescriptions and talking about clients that they might be seeing but maybe we haven't seen. We've also taken in naloxone, safe storage boxes and leaflets around public health campaigns like World Hepatitis Day.'

ONLINE SUPPORT

One of the most significant changes across the sector has been the move to online support, which is not something that everyone thought would necessarily work. 'A really interesting stat among our service users is that 56 per cent were able to use online groups from a standing start, which is huge,' says Horne. 'Everybody said, "It'll never work – they just won't do it." But a huge amount of people have asked if we'll continue with the online groups after lockdown, because they like the blend of both.'

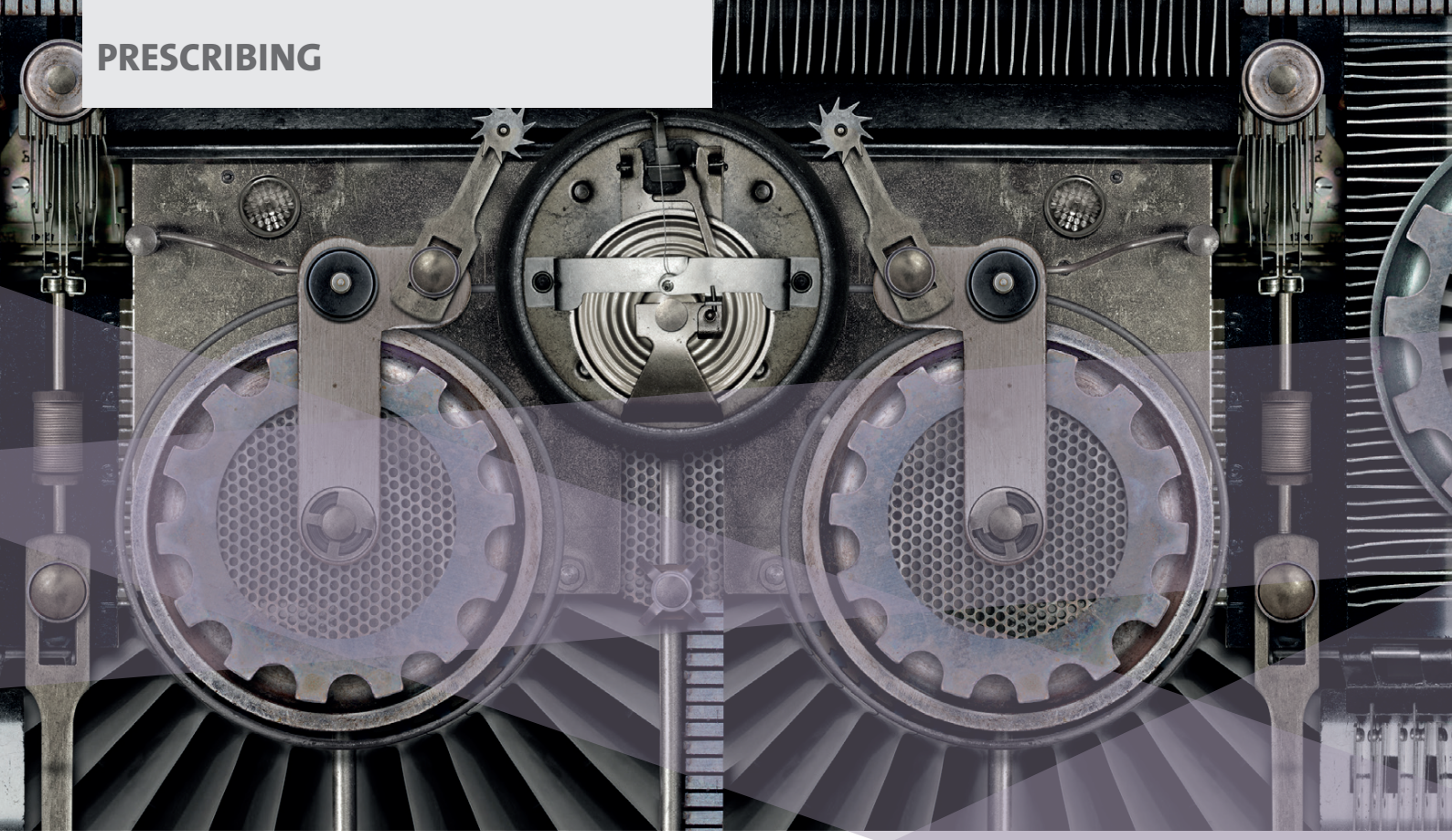
'We're getting feedback from workers as well who are saying they've never had so much contact with clients'

TONY LEE

'My service has been a skeleton workforce, but it depends on what you want to put in – that's what you get out of it,' Barry, a service user based in Essex, tells *DDN*. 'You'll hear people complain, but it all depends on the individual and if you're determined to get help. My script's always there, I can always message my key worker to answer my questions or sort out any problems, and there's online support if you need it. It's down to your own determination.'

The overwhelming majority of clients understand completely why these changes had to be made, stresses Duke. 'And many of them have enjoyed the opportunity to work in a different way. That's had some really positive outcomes, but some have struggled with the more limited one-to-one contact. And of course for some clients it's been a reduction in face-to-face contact across multiple services. Where that's been the case we've worked with them and identified if it's ok to bring them in to service – where they've got complex needs or are significantly socially isolated, or if there are particular risks in the home environment.'

While many clients have enjoyed the opportunities offered by online support, it's been 'a mixed picture', agrees Tony Lee. 'We have a lot of clients who don't have access to the internet – one of the things we've been trying is giving out phones so at least we can contact them and have a conversation. We can have a conference call and bring them



into the meeting, and we've taken it further than a therapeutic approach, with social evenings, quizzes and talent nights. So we've definitely been able to broaden the scope of what's on offer – people are really happy with that extra choice of having a phone call or going on Zoom.'

IMPROVED ENGAGEMENT

One of the recurrent themes of an ongoing Change Grow Live survey has been the choice aspect, he points out, and not just from service users. 'We're getting feedback from workers as well who are saying they've never had so much contact with clients, especially the hard-to-reach people who would never come into a service. They'll pick up a phone, so the engagement side with these clients has been so much better.'

In some cases, the new ways of working have sped up the implementation of initiatives that organisations were already thinking about. 'I think the big thing is that there's an appetite for change and a different way of working,' says Horne. 'For example, we're very conscious of the importance of the first four weeks in people's recovery journey. Traditionally you'd call somebody in for an assessment and then try to get them into treatment. But an appointment in a week's time is very little use – people want an appointment tomorrow and the next day and the next. We really increased contact, so we'll still have physical meetings but interspersed with maybe three or four 15-minute chats – by phone or video or maybe just WhatsApp, "How are you doing, what's your plan for today, how did you get on yesterday?" We lose a lot of people in the first four weeks across the sector, and we really need to engage – this has allowed us to do that. So a lot of what happened during lockdown has allowed us to unlock what we were thinking anyway.'

The charity has also been able to reach out to people who wouldn't normally access services, he adds. 'Attending appointments online or via the phone can take away anxiety and logistical challenges, and we've completely revamped our web pages to give much more clarity of advice. We would often have people come on a web chat to say, "I think I need to do an alcohol detox but I'm a primary school teacher – I'm not going to a drug and alcohol service." We know there's this massive proportion of people out there who are struggling but never come near services, so we're really trying to open up.'

'If local lockdowns come into place we're fully prepared – we can be very flexible in what we do.'

DR ARUN DHANDAYUDHAM

FLEXIBLE APPROACHES

So with the new ways of working now bedded in, how are people feeling about the long-term options? 'At the beginning there was a lot of insecurity, a lot of uncertainty, but it's now a way of life,' says Dhandayudham. 'Early on we were very focused on the complex patients, the risky patients, the ones who had needs around safeguarding, but as time's gone on we're trying to bring back a lot of our normal interventions – the BBVs, the alcohol detoxes, and face-to-face work even for non-complex patients. But it's very much a flexible approach, so if local lockdowns come into place we're fully prepared – we can be very flexible in what we do.'

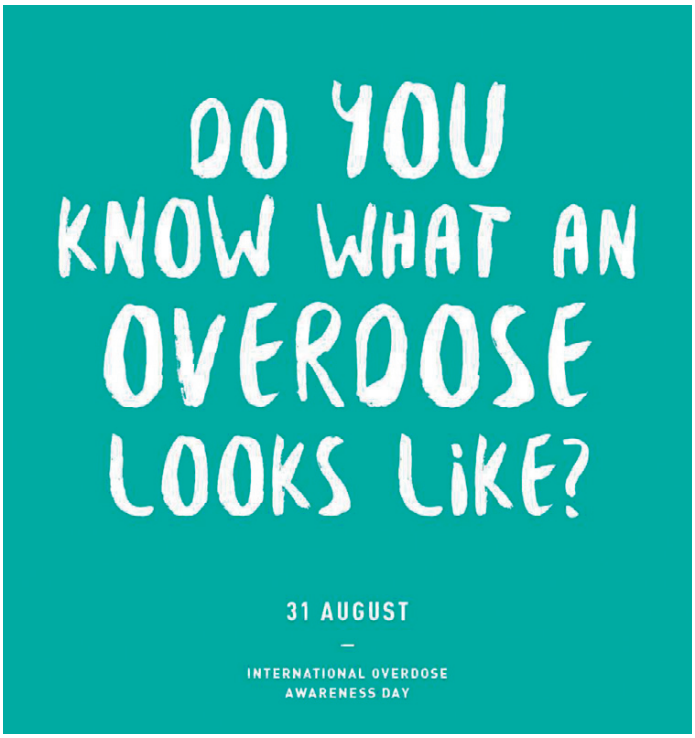
'I'm fairly optimistic,' says Tony Lee. 'I'm a client myself, I still access services, and I like my options now, I really do. Some days it's not always possible to go into a service so to be able to say, "Can I have that by Zoom or a phone call?" is tremendously helpful. It takes the pressure off me, and off the service.'

'I've got COPD so I have to be careful,' says Barry. 'Where it used to be going to see your key worker fortnightly it's now monthly, and you're sitting two or three metres away. But I've not found it to be a problem, and if there is any issue I call or text and things get sorted. If you go in daily you're drug tested and alcohol tested, whereas if you're having a conference call there's nothing to stop you drinking or using drugs after – but the only person you're lying to is yourself. I get all the help in the world, and it's because I want that help.' **DDN**

This article has been produced with support from an educational grant provided by Camurus, which has not influenced the content in any way.

BE ACTIVE!

A webinar to mark International Overdose Awareness day heard ideas from peer networks in the Netherlands, Ukraine and Norway. **DDN** reports



International Overdose Awareness Day is a global event held on 31 August each year that aims to raise people's awareness around overdose and reduce the stigma of drug-related death.

'Eighteen months ago we identified that we don't hear the voice of active drug users. So we set up a group for injecting drug users in Glasgow City Centre.' Jason Wallace, senior development officer at the Scottish Drugs Forum (SDF) explained how the groups, at each end of the city centre, were working well. 'We have our voices heard, for better drug treatment and better health.'

Chairing the SDF webinar, he then asked Theo Van Dam, 'founding father of drug using movements in the Netherlands', to talk about how he organised the groups effectively. 'With the first group, my interest was health promotion,' said Van Dam. 'We got money for this. We wanted eight field workers. This was a serious job so it needed to pay serious money.'

The government made the point that the workers might buy drugs with this money. 'But my response was, "So what? I don't know what you're doing with your money."' Undeterred, he got groups together and paid travel costs immediately. They talked about what was going on in each city, the methadone programmes and the 'ridiculous' fact that people had to attend every day at the same time. They spoke to social workers and policymakers and politicians.

> Olga Belyaeva from Ukraine described how 30 years of propaganda had 'legalised discrimination against people who use drugs'.

Having structure was an important part of successful progress, says Van Dam, and to be 'a serious partner to whoever you're talking to'. The groups looked at how things were being done, right down to house rules in the day centre – 'We said it's too much, too many.' They ended up with one rule: to 'behave normal'.

There have been serious setbacks – including the closure of the day centre by police. But there have also been successes, such as getting police and social workers along to see drug users taking drugs – a huge step forward in understanding and empathy.

Olga Belyaeva from Ukraine described how 30 years of propaganda had 'legalised discrimination against people who use drugs'. As coordinator for the Eurasian Network of People who Use Drugs, she had been fortunate to meet like-minded activists and hear about naloxone – much needed in a country that ignored harm reduction. 'To come into OST you have to be HIV positive, so some people tried to be infected,' she said. Mental health issues were prevalent within her community and it was difficult to get a job. There was great need to create social enterprises.

Arild Knutsen of the Association for Humane Drug User Policy shared experience in Norway. The country's first drug consumption room in 2005, alongside harm reduction and calls for legalisation, had come against opposition from the Drug Abusers Association, an organisation from the temperance movement. 'So we realised we needed representation – more substitution treatment and more access to treatment,' he said.

With 'big political pressure' against drug consumption rooms and 'more police actions against open drug societies', the association organised a rally and protested against drug policy. 'We were invited into parliament,' he says, 'and this became drug users' day. We go in every year to discuss policy.'

The dialogue needed to extend to talking to people all the time, including reaching out to media. 'We did this in a respectful way, so we can live in harmony,' he says, but the message was firm: 'Many people are dying of overdoses.' As a field worker Knutsen was in a position to make an immediate difference, handing out naloxone. The association had a 'switch' campaign, encouraging people to smoke heroin instead of injecting it.

Since then there have been important milestones, including involving politicians in a decriminalisation campaign and improvements in substitution programmes. Oslo and Bergen have developed heroin-assisted treatment (HAT) programmes, 'so drug policy is changing now,' he says.

In a Q&A session chaired by Kirsten Horsburgh of SDF, speakers were asked for the key difference people who use drugs could make when changing drug policy.

'You have to be an organiser' and 'you have to cooperate', said Van Dam. 'If people can count on you, you can make steps.' Knutsen agreed that it was important not to be seen as 'the enemy – just drug users, drug abusers' but as people who can run democratic organisations. 'We are important resources,' he said. **DDN**

In tune with nat

From the heart of the Cornish countryside Bosence Farm Community has been developing ecotherapy, as **Tom Packer** explains

'One of the main things I wanted was to come somewhere where I could get away from things. At Bosence I feel completely removed from temptation and can focus on my treatment and concentrate on getting well.'

Coming down from London to 22 acres of beautiful Cornish gardens and woodland, Nick found a tranquil environment away from all distractions. Alongside the detoxification, stabilisation and round-the-clock nursing support – including a highly specialised service for young people – Bosence has recently introduced an ecotherapy programme.

Nick can now take part in four individual weekly sessions:

Propagation, providing clients with the necessary skills to learn how to plant seeds and care for plants.

Herbal tea making, which aims to promote wellness and relieve stress by helping participants to achieve a more relaxed state of mind. Those taking part are introduced to a range of herbs and gain an understanding of how they nourish the nervous system and strengthen the immune system.

Nature observation, designed to promote care, respect and understanding of the natural world. Clients learn how to identify different species of wildlife and observe and interpret the environment around them.

Forest bathing and mindfulness, which teaches the basic principles of forest bathing, mindfulness, improving sensory awareness and breathing techniques.

'In the mornings I'll often take a walk around the grounds, just to admire the scenery and breathe in the country air,' says Nick. 'I've really enjoyed the guided nature walks around the nature trail, where I have been able to take part in wildlife surveys, to identify a range of species. I've been given responsibility to look after the greenhouses, which I really appreciate as it's my way of giving back and contributing to the day-to-day running of Bosence. I've learnt so much.'

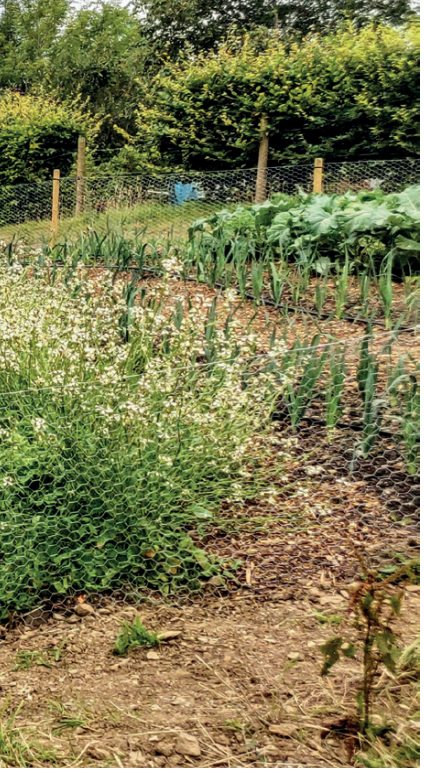
In an age of technology there is mounting evidence to suggest that by pushing away from nature, we have begun to lose contact with a necessary tool for optimal mental health.

Pioneering research carried out by R S Ulrich in the late 1970s examined the psychological influence of scenes of nature on the stress experienced by individuals and medical recovery rates. Ulrich was able to demonstrate that observing 'natural' scenes increased feelings of friendliness, affection, joy and playfulness, boosting the production of serotonin without the use of antidepressant medication.

In more recent years there has been a growing recognition of ecotherapy and the vital role it plays in optimising positive mental health, with a clear application in supporting individuals to overcome addiction and maintain long term recovery. Ecotherapy can also give people a sense of achievement and purpose, providing structure and routine to people who might not have these in their lives.

A recent article published in *New Scientist* explores the importance of outdoor space and nature in recovery and mental health. It describes how in the Shetland Islands, people with a physical or mental ill health are being recommended to 'take in the sights and sounds of seabird colonies, build woodland dens or simply appreciate the shapes of clouds'.

A New Zealand initiative found that two-thirds of patients were 'more active and felt healthier' six to eight months after this 'green prescription', it adds, and almost half had lost weight. 'Meanwhile, ecotherapy, which involves participating in outdoor activities



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'Ecotherapy can also give people a sense of achievement and purpose, providing structure and routine to people who might not have these in their lives.'

such as gardening or conservation, is emerging as a promising treatment for mild to moderate depression.'

These findings are also supported by a study from the University of Essex that found that a walk in the country reduces depression in 71 per cent of participants. The researchers found that as little as five minutes in a natural setting, whether walking in a park or gardening in the backyard, improves mood, self-esteem, and motivation. A reduction in stress has been proven to lower levels of the stress hormone cortisol, reduce pulse rate and lower blood pressure.

The sessions at Bosence are all facilitated by horticulturalist and land manager, Noah Hall, who ensures the grounds are maintained to the highest standard, enabling clients to fully benefit from the incredible natural environment. Over the last few years he has created a woodland nature trail and sensory garden, and is also responsible for an ever increasing harvest of fresh organic produce, grown in several on-site polytunnels and allotments.

To complement the ecotherapy sessions, Noah also provides a weekly cookery session to those enrolled on the residential treatment programme, with much of the produce sourced on site. Alongside the structured sessions, residential clients have the option to help with seed sowing, potting on, planting veg and flowers, weeding, watering, strawberry picking, or whatever needs doing, and also have the opportunity to conduct wildlife surveys.

Feedback from the sessions has been overwhelmingly positive, with participants commenting that they have found them to be both informative and inspiring, while helping them to feel calm and relaxed.

Holly, a local client from Cornwall, says that the ecotherapy project has provided her with a number of new experiences and opportunities. 'In the last few weeks I've acquired the skills to identify a variety of the different types of herbs and through education sessions I've gained knowledge on how to combine, prepare and cook different types of tea,' she says.

'Since the start of my treatment, I've regularly been involved with the planting and harvesting of fruit and vegetables. In particular, I've enjoyed taking part in "Vegan Friday", where I have learnt new recipes and prepared several dishes using only the produce grown on site. When I complete treatment, I will definitely continue to cook these recipes as regularly as I can.

'I'm looking forward to taking part in mindfulness sessions in the next couple of weeks,' she adds. 'I feel so relaxed in such a tranquil and peaceful environment.'

The coming weeks will see the introduction of a formal measurement tool to gauge and monitor client feedback, similar to those we use to evaluate the effectiveness of the various interventions that comprise our treatment programmes. In the longer term, we plan to offer a formal structured 12-week ecotherapy programme that will include sessions such as creative writing and drawing outdoors.

We're lucky that our spacious and diverse site has afforded us with the perfect environment to incorporate such a varied range of ecotherapy techniques into our programmes.

Tom Packer is business development manager at Bosence Farm Community, a member of the Choices Treatment Consortium

SHIFTING SANDS

In the third part of 'Doctor Wars', **Bill Nelles** looks at the advent of the NTA – and what came after

The increasing numbers of GPs caring for opioid users through the '90s and providing oral methadone – and later buprenorphine – had the effect of encouraging NHS specialist clinics to either further entrench their personal view of treatment, or to embrace the opportunity to work with GPs. And, increasingly, specialist support was being provided by consultants and their teams. I could cite examples of entrenched non-prescribing clinics by name, but it's not my intention to recriminate about things done in years gone by. I don't, however, extend that same tolerance to today's treatment policy in England, because we clearly have yet to learn the lesson that all valid treatments must be available.

As we moved towards 2000, these shafts of progressive light coincided with the interest in patient advocacy being shown by Whitehall. Ostensibly a patient advice liaison service (PALS) was to be set up in hospitals and other NHS services to help patients negotiate the system, and even make complaints. The initiative started with John Major but was made more powerful by the incoming Labour government under Tony Blair. Some of us couldn't see how such PALS services could assist drug users, but we were also fortunate to have Mike Trace as deputy drug tsar – he would advance the goal of patient support and advocacy for 'service users', as we came to be called.

Many doctors and consultants were particularly helpful to us. Dr Clare Gerada was the medical lead for drug treatment in the late '90s at the Department of Health. She was instrumental in the birth of the Methadone Alliance, authorising our first grant of £9,000 to start our helpline. Professor John Strang also listened to our case and supported us, and Dr Chris Ford, one of the first 'GPwSIs' (a GP with a special interest in treating drug users) joined our board because we took being an alliance between people in treatment and their treatment providers very seriously.

The next big change was the advent of the National Treatment Agency for Substance Misuse (NTA), with a feisty and pragmatic chief executive, Paul Hayes. Mike Trace, Annette Dale-Perera, and Dr Emily Finch also joined the NTA – not everything was perfect but they ensured that the care being provided increasingly followed what was now being called 'evidence-based medicine'.

There was criticism of the NTA for its crime prevention approach and I wasn't enthused to begin with, but I preferred people getting treatment rather than prison. But the NTA negotiated and invested large funding increases that improved treatment services – by 2008 they had doubled the number of people receiving treatment services to 2m.

For the first time there were clear quality standards, more flexible clinical guidelines and good practice protocols for the treatment field. The NTA was not just about methadone and prescribing approaches – it spent much time and energy encouraging and highlighting residential services as well as focusing on family support and abstinence groups for people moving off medication.

cocoparisienne/pixabay

In case you feel that I only bang on about medical treatments, let me say that I am particularly supportive of high-quality residential treatment, especially when one's life is in a real mess, as mine was in 1981. Phoenix House in South London provided me with enormous help, support, and housing. But therapy on its own wasn't enough for me, and I described in my last article the reason why I returned to methadone and found my own pathway to stability and self-worth.

But entry must be governed by patient choice, and a safety net must exist to provide a swift return to prescribing approaches so that people do not return to using the poison increasingly dominating our streets. Ensuring close communication between such services would certainly deserve 'payment by results'. We all know there is no magic treatment that works for everyone, and that all the evidence-based treatments should be quickly available in every locality.

NTA CHAMPIONS, from the left: Mike Trace, Dr Clare Gerada, Professor John Strang, Dr Chris Ford, Paul Hayes, Annette Dale-Perera, Dr Emily Finch

'The NTA negotiated and invested large funding increases that improved treatment services – by 2008 they had doubled the number of people receiving treatment services to 2m.'

The first five years of the Alliance saw our team effectively intervene in three hundred or so requests for help, collaborate with the Royal College of General Practitioners in training our advocates alongside GPs for the same qualification, and organise the annual national drug treatment conferences in partnership with Exchange Supplies. When I left for Canada in 2004 I felt we had made our point and I didn't expect that anyone could or would want to change the treatment system back to the extremes of strict abstinence warring with harm reduction initiatives. I certainly didn't expect being likened to a car stuck in a parking lot.

How wrong can one be? By 2007 The Royal Society for the Arts (RSA) (not exactly an authority on drug treatment) had a go, and the BBC (ditto) also weighed in on the issue, reporting – with no clear evidence – that only 3 per cent of drug users entering treatment had completed it and emerged 'drug free'. I don't believe these figures. I don't believe that even the direst treatment provider has such a low success rate, especially in this case with the bar set at the highest level – becoming drug free (not usually an immediate goal for long-term opiate users). But the damage was done – methadone and approaches like it were again labelled 'problems' instead of 'effective ways to reduce injecting poisonous street drugs'.

Then came the coalition government, the Conservatives and the Centre for Social Justice, and the campaigns to denigrate methadone started back up. Well known authorities such as Professor John Strang and other advocates have continually beaten back attempts to end the provision of opiate maintenance and they need your continued support to do so.

By the end of June 2012 an expert group convened to bring 'stakeholders' together produced their final report. It concluded that opioid substitution treatment would remain as 'a key tool within a recovery orientated system... underpinned by a full range of treatment interventions'. Talk about slippery wording.

It's depressing to see England mess things up so badly. Reductions in funding and the hiring of those opposed to prescribing approaches have already made themselves felt. A former colleague and friend, now in his mid-60s, wrote to me last week saying that he is finding it hard to obtain a maintenance script for 25mg of oral methadone a day!

Anyone wishing for a more comprehensive history should read *Substitution treatment in the era of 'recovery': An analysis of stakeholder roles and policy windows in Britain* by Karen Duke, Rachel Herring, Anthony Thickett and Betsy Thom, a well written commentary on these changes.

There have been times when doctors based their actions not on clinical evidence gathered together, but on subjective viewpoints. But I hope I've also shown that, particularly in times of medical crisis for users, caring means providing all the interventions that we know reduce harm. This is not the time to allow politicians undue influence to limit clinical judgements.

Making the case that providing opioids to people doesn't do anything to move them forward just isn't true, especially when people also get active support and services. I am still alive and heathy after nearly 40 years on MMT. Without it I would be as dead as all the people I left behind in Canada in 1977.

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

OVERDOSE AWARENESS

Commemorating Overdose Awareness Day, **James Parker** looks at how Forward Trust are supporting those most at risk

Both our prison and community substance misuse teams are doing fantastic work to support people who are at risk of an overdose. Here are just two examples of recent initiatives:

IN PRISON: HMP ELMLEY

Prisoners are at particular risk of overdosing because illicit substances were in limited supply throughout lockdown. While this is positive, our concern was that as restrictions eased there would be a sudden influx of substances – dangerous for people whose tolerance levels have dropped dramatically.

'Now restrictions are starting to ease, a member of the team is prioritising residents who are most at risk or who appear to have used recently, offering brief interventions and reviews,' Nichola Bennett, Forward team leader at Elmley, told us. 'Whilst we're limited in some of the things we'd normally do because of social distancing, our team has created a COVID-specific harm minimisation leaflet about the dangers of using after lockdown, which has been rolled out to all our prisons.'

As soon as the team can deliver harm minimisation workshops again, they'll be the priority, alongside recruiting more peer workers to increase their presence on wings and availability to residents.

IN THE COMMUNITY: ASHFORD, KENT

All frontline staff are trained in the use of naloxone to mitigate the life-threatening effects of an overdose. Staff at Forward's Ashford hub put their naloxone training into practice last month when one of our clients came to use their needle exchange service.

'A client came in and told us he'd overdosed,' explains Tarnya Hurcombe, team leader at the Ashford hub. 'We called an ambulance, but before it arrived he got agitated and tried to leave. Then he collapsed outside the building. We donned full PPE and brought naloxone kits to where he was lying. Routine first aid was performed but the client remained unresponsive. We knew that naloxone was the next step.'

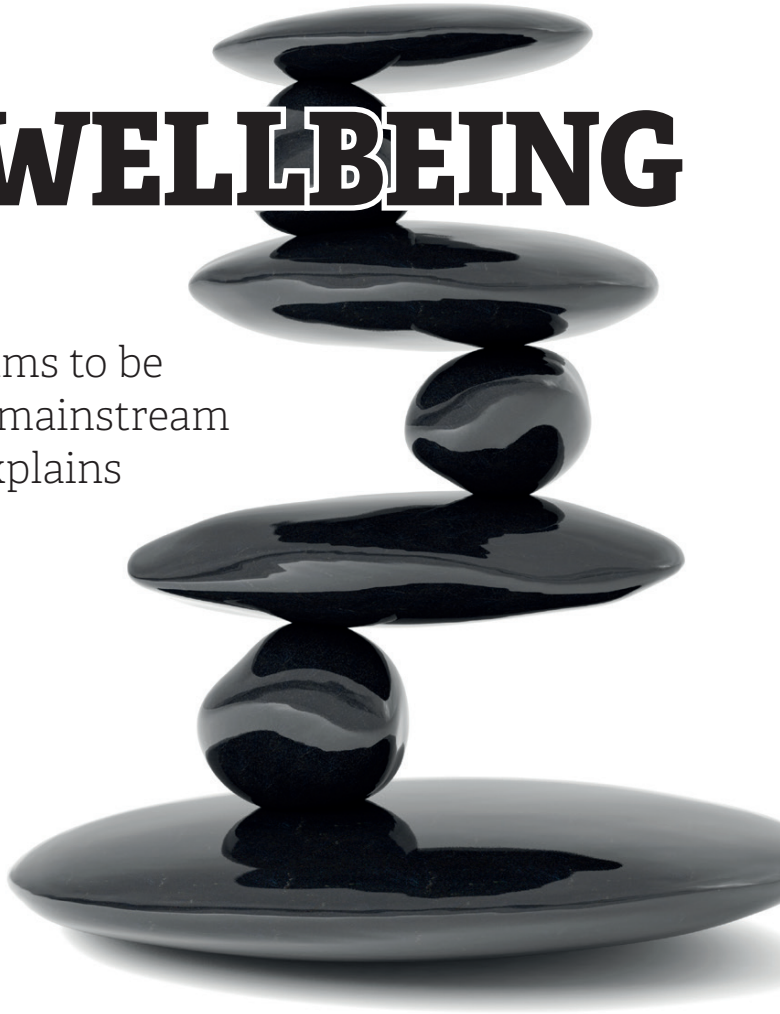
Abbie, one of our drug and alcohol practitioners, administered the naloxone and the client came to moments later, just as the ambulance arrived.

'Abbie and the whole team were amazing,' says Tarnya, adding: 'It just goes to show the importance of naloxone training.' We offer naloxone and training to every opiate client that attends one of our hubs, as well as to service users' loved ones.

James Parker is head of services at Forward Trust

CENTRE OF WELLBEING

A new recovery enterprise aims to be more than just a 'bolt-on' to mainstream services, as **Jamie Gratton** explains



In 2020, the time of global crisis, we expect to hear news of companies closing down rather than starting up. However, Staywell Derby CIC is bucking that trend with a vibrant new community-focused social enterprise, set up by a passionate team whose members all have lived experience of mental health, addiction, homelessness and trauma.

From Derby city centre, Staywell brings together a wide variety of people and businesses who all have the same goal – to create a safe space for people to heal, grow and develop.

The idea started around ten years ago, based on the notion of a recovery community organisation (RCO), which uses lived experience of those who are in recovery from addiction to help those who are still struggling. We extended this to a wider wellbeing ethos and decided that a proactive approach to wellbeing was vital, especially during these difficult days.

Everything we want to achieve is based on the seven pillars of wellness: physical, emotional, intellectual, social, spiritual, environmental, and occupational. This allows us to grow and be a small part in not only an individual's wellbeing journey, but also to help improve the wider community's wellbeing.

The lived experience approach means we can incorporate experience from our past to empathise and understand what people are experiencing better. As David Gilbert says in *The Patient Revolution*, 'The magic comes when the wisdom gained during suffering meets the wisdom gained when one got lost in the first place... to create something deeper – an enriched expertise.'

We're passionate about recovery and wanted to use our lived experience to compliment the work that services do around the area – a proactive approach to get people looking after their own wellbeing. We know we can't catch everyone, but we can help the over-stretched services in Derby.

We've already got a great partnership with CHIME to Thrive, a user-led organisation which shares the same ethos on patient leadership and community approaches to wellbeing. Here, lived experience practitioners support individuals struggling with their mental health, addiction and trauma, while the social enterprise provides consultancy and training to organisations around co-production, peer support, trauma, and compassion-led approaches to mental health.

We have already received amazing support from organisations like Community Action Derby, and Praxis Probiotics CIC are helping us to develop the café, with their focus on nurturing both health and change and their like-minded passion about community.

Our building will be community focused and led, with a 'safe space' coffee shop and community kitchen and Staywell Derby ambassadors on hand. These lived experience volunteers will have training in everything from wellbeing support to referrals, and will be able to help people tell their story in a positive way.

With the vibrant café and wellbeing 'get away' space downstairs, the first floor will house a wellbeing academy with all kinds of different courses to build creativity, learning skills and confidence.

> A wider wellbeing ethos and... proactive approach to wellbeing is vital, especially during these difficult days

The academy will help people to set up support groups and there will also be a live feed to access our courses for people who are housebound or can't get to the Staywell Derby wellbeing hub.

At the top of the building a community hub will have space for small grassroots projects to hire out or hot desk, with everyone sharing the same ethos. The project's directors, including Lauren Jones, Pippa Nayer, Rosa Beue Parry and Kelly Carson, are all passionate about bringing their lived experience to the table to help others.

I've had my own battle with addiction and homelessness, and have been in recovery for 20 years, so I'm passionate about challenging stigma. Working in the community, and also within the public sector and services and as a social prescriber in the NHS, has further fuelled this.

Even without COVID-19 there's always been a need for a proactive approach. There's great work being done throughout the city but we want to make sure lived experience is not just an add on – we can give a whole new dimension to support and help. Lockdown has increased people's emotional and wellbeing issues and we can help people who wouldn't normally go into services get back on track.

Jamie Gratton is Staywell Derby's founder and operations director. The group is inviting involvement from other social enterprises and grassroots projects, and is looking for volunteers – visit https://staywellderby.org.uk/

SUSTAINING THE FUTURE

Phoenix Futures chief executive **Karen Biggs** sets out the thinking behind the charity's new strategy

PHOENIX FUTURES

The work we do at Phoenix leads to change. Our services span a wide spectrum and meet the unique individual needs of people – whatever their hopes and ambitions for themselves or their family's future. In 2014 we worked with staff, external stakeholders and people who use our services to create a set of values and beliefs. We thought carefully about these as we wanted them to be our compass, guiding our day-to-day work and our decision making: we are passionate about recovery, we value our history, and we believe in being the best.

These values have served us well in the last six years – they set out what we expect of ourselves and each other – and this year we are launching our new strategy, *Sustainable recovery.* It has three broad areas of focus which build on the work of the last strategy, *Confident about recovery* – we will continue to deliver and develop services that sustain recovery, we will ensure we have the skills and resources to sustain delivery, and we commit to making a sustainable difference in the world.

Our psychosocial expertise has been vital through the COVID pandemic, and in the coming year we will be continuing to develop our expertise in a wider range of multiple and complex needs including trauma and mental health. There will be specific projects on diversity and inclusion and health and wellbeing. We will also be looking at how we maintain our values and culture in the new remote world.

That new world has to be a sustainable world, and we are committed to making a difference. Last year I posed a question – could we be carbon neutral? The very bright and energetic minds in Phoenix said yes, so we started to put a plan together to achieve it. Last year we reduced our carbon emissions by 27 per cent, and we will be able to declare carbon neutral status in November 2020.

The thinking that created the sustainable recovery strategy came before the pandemic, but now seems more relevant than ever. People's lives will continue to change and we will start to create a new Phoenix normal. It will be a challenge but our guiding principles and our energy and commitment will help to create truly sustainable recovery.

ERRATUM: In Jody Leach's article (*DDN*, July/Aug, p17) we explained the acronym OCAN incorrectly. It should have read Offenders with Complex and Additional Needs and we apologise to the author for our error.

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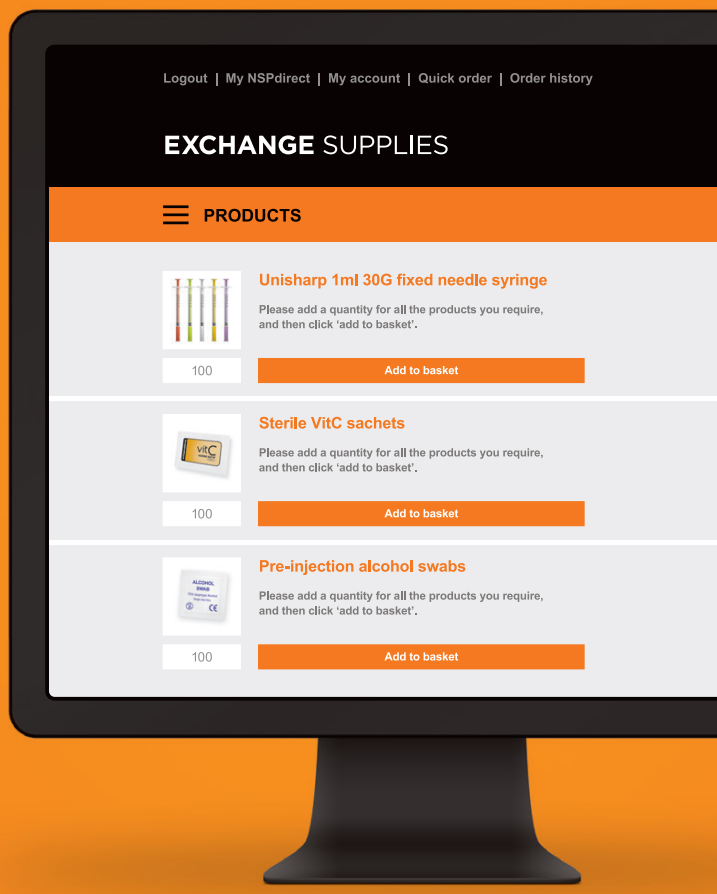

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