DDN

Drink and Drugs News
December 2021 – January 2022
ISSN 1755-6236

SCRIPTED
The history of buprenorphine

FIRM FOUNDATIONS
Why we need quality supported housing

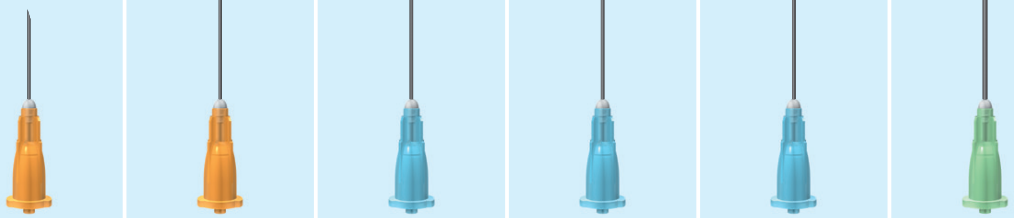
TIME FOR REFLECTION

WHAT REALLY WORKS IN HARM REDUCTION?

NEW!

total dose

Extending our low dead space needle range to include a blue 23G, 38mm (1½ inch), hypodermic needle.



TO16	TO25	TB25	TB30	TB40	TG40
Orange 25G	Orange 25G	Blue 23G	Blue 23G	Blue 23G	Green 21G
16mm	25mm	25mm	32mm	38mm	38mm
[⅝ inch]	[1 inch]	[1 inch]	[1¼ inch]	[1½ inch]	[1½ inch]

For drawing up, intramuscular injection, and deep vein injections.

For maximum reduction in dead space in a detachable needle/syringe combination use a low dead space needle like Total Dose.

EXCHANGE SUPPLIES

MAKING INJECTING SAFER

DDN

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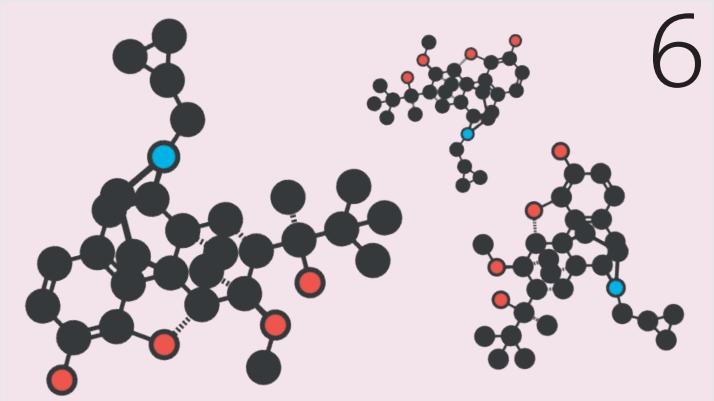

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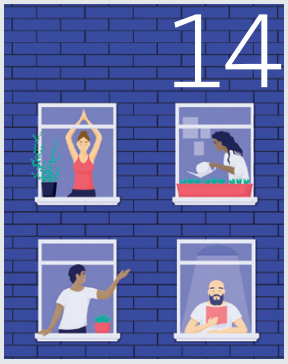

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THANK YOU TO OUR PARTNERS

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.

Let's rise to the challenges ahead

It's been a while since we got together for 'live' debate, so what a treat to be given *DDN* sessions at HRI's online Constellations event. We chose to focus on naloxone action, peer-led initiatives on hepatitis C, and two issues that have fired up our pages for many years – ensuring people are on the dose that suits them, and the all-important dialogue that moves way beyond the 'harm reduction v recovery' days and focuses on our collective assets and interests.

Our reports on pages 10, 12, 16 and 21 give a flavour of the will – and urgent need – to unite on these vital issues. The timing and the need to challenge spending cuts could not be more important, so please send us your thoughts and let's keep up momentum.

Getting – and giving – the right dose means staying informed enough to make these decisions, so we're excited to offer the first in an authoritative and independent three-parter on buprenorphine (page 6). It's part of our role to present the facts while giving you the forum to debate, question and offer vital lived experience to complete the picture. And as we take stock of the year that was (p23), let's be thankful for the will to communicate, which helps our sector rise to the challenges ahead. Have a happy and safe festive season and here's to strong bonds between all of us in 2022.

Claire Brown, editor

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

Deaths in treatment up by almost 30 per cent

Almost 3,800 people died while in contact with drug and alcohol treatment services in 2020-21, according to statistics from the Office for Health Improvement and Disparities (OHID), a 27 per cent increase on last year.

While all substance groups saw a decrease in deaths in treatment last year, this year there were increases of 20 per cent in the opiate group and 36 per cent in the non-opiate only group. The alcohol-only group also saw an increase of 44 per cent, while the non-opiate and alcohol group recorded an increase of 37 per cent.

Much of this will have been the result of the pandemic, says OHID, with fewer people able to access inpatient detox, reductions in treatment for BBVs and liver disease, changes to lifestyle and COVID itself.

There were 275,896 adults in treatment services in 2020-21, a slight increase on the previous year – more than half were in treatment for problems with opiates, and almost 30 per cent for alcohol. Unlike previous years there was a fall in the number of people entering treatment for crack cocaine, used either with or without opiates, with the number at its lowest level since 2016-17.

Drug Group	Female	Male	TOTAL
Opiate	38,904 (28%)	101,959 (72%)	140,863
Non-opiate only	8,915 (32%)	18,690 (68%)	27,605
Non-opiate and alcohol	9,220 (30%)	21,468 (70%)	30,688
Alcohol only	32,486 (42%)	44,254 (58%)	76,740
TOTAL	89,525 (32%)	186,371 (68%)	275,896

Breakdown of people in treatment by sex and substance group – *www.gov.uk*

'People facing drug or alcohol addiction, already a vulnerable and oftentimes isolated group, had to endure a global pandemic that radically altered how they could receive support,' said Collective Voice.

'In the early phase of the pandemic the treatment system had to adapt almost overnight to new agile ways to deliver core interventions. And despite the heroic efforts of workers, managers, commissioners and peers, many services were forced to temporarily close their doors.

The pandemic also prevented those with drug and alcohol problems from accessing the wider array of 'safety-net' services including primary, secondary and acute care.' However, the reasons behind the long-term erosion of the field's capacity to support people in need were 'plain to see in Dame Carol Black's recent review', Collective Voice stated. 'This recent rise in deaths makes only more important the announcement of the cross-government drug strategy in the coming weeks.'

Adult substance misuse treatment statistics 2020 to 2021 at www.gov.uk

People needing residential being failed, says Phoenix

THE SYSTEM that enables access to residential rehab 'isn't working', says a new report from Phoenix Futures. Although residential treatment is now being delivered to a higher standard than ever before – allowing people with complex needs to lead 'happy and healthy lives' – fewer people are able to access it, says *Making rehab work*.

Thousands more people every year need to be able to access residential services, states the document, which challenges preconceptions about residential being poor value for money. The causes of the 'dramatic' decline in access over the last decade are complicated, it says, and while addressing funding and commissioning is vital, commitment is also needed from a range of bodies including providers and central and local government.

The report's findings are based on the input of people who use a range of services and those with lived experience of residential, alongside commissioners and providers. The report 'does not advocate for one treatment approach', says Phoenix, and calls for 'appropriately funded' community-based treatment alongside improved access to residential.

'Residential treatment is a place of safety for some of the most traumatised and socially deprived people in society,' writes chief executive Karen Biggs.

'When people cannot find safety and security where they live, residential treatment offers them that place of safety, structure, and mix of interventions to build a better life away from imminent danger and risk. However, in England it has become increasingly difficult, and even impossible in some regions, to access this specialist life-saving treatment unless you can afford to pay for it privately. With access to residential treatment at a record low, and drug and alcohol harms at a record high, this is an issue we can't ignore.'

Doc at www.phoenix-futures.org.uk

UNODC warns of 'flood' of Afghan heroin

THIS YEAR'S OPIUM HARVEST in Afghanistan is up by eight per cent compared to 2020, to almost 7,000 tons, which could lead to global drug markets being 'flooded with around 320 tons of pure heroin', says UNODC.

Afghanistan accounted for 85 per cent of global opium production last year and now supplies eight out of ten of all opiate users worldwide, says *The drug situation in Afghanistan 2021 – latest findings and emerging threats*. While this year's income from Afghan opiates is estimated to be between US$1.8bn and $2.7bn inside the country, 'much larger' profits are being made through international supply chains.

The uncertain political situation in Afghanistan since the withdrawal of US troops and the Taliban's takeover earlier this year is driving up prices, which almost doubled between May and August. This is the fifth year in row to see production 'at historic highs of more than 6,000 tons' but higher prices could be a strong incentive for farmers to cultivate even more, leading to a far bigger harvest next year.

Methamphetamine production is also 'sharply' increasing in the country, the report adds. 'Afghanistan is in a state of constant crisis, with a precarious economy and wider instability enabling illicit markets', says the document, with up to 97 per cent of the population now at risk of sinking below the poverty line. *Report at www.unodc.org*

‘Constant bombardment’ of alcohol ads threatens people in recovery

EnVogue Photo / Alamy

The ‘constant bombardment’ of alcohol adverts, particularly over Christmas and during major sporting events, makes it difficult for people in recovery ‘to fully participate in everyday life’, says a new report from the Alcohol Health Alliance (AHA). The umbrella group of more than 60 organisations is calling on the government to take urgent action to protect ‘both those in recovery and children from overexposure to alcohol marketing’.

Marketing can act as a ‘trigger’ for relapse among vulnerable groups, says *No escape: how alcohol marketing preys on children and vulnerable people*. Children also demonstrate high levels of brand awareness through their regular exposure to alcohol marketing, it states, with more than 80 per cent reporting seeing it within the last month. ‘Research has consistently shown that alcohol marketing is causally linked to alcohol use among young people, including starting to drink at an earlier age or engaging in riskier consumption,’ AHA states.

Alcohol marketing was a ‘significant contributor’ to alcohol harm in the UK, said AHA chair Professor Sir Ian Gilmore.

‘The glamourisation of a harmful product creates a culture where alcohol is seen as an essential part of everyday life,' he stated. 'With deaths linked to alcohol at record highs, we are in desperate need of a new approach. The Health and Care Bill plans to introduce advertising restrictions such as a 9pm watershed for "less healthy food or drink" advertising on TV and a prohibition of paid-for "less healthy food or drink" advertising online, at the end of 2022. Alarmingly, alcohol is not currently included in these plans and is bizarrely not considered a less healthy drink. This needs to change. The government must now introduce comprehensive marketing restrictions in both real world and digital spaces to ensure that vulnerable adults and children are protected from alcohol advertising and its harm.’

UK world fourth for humane drug policies

THE UK IS THE FOURTH LEADING COUNTRY on ‘humane and health-driven’ drug policies, according to the new Global Drug Policy Index. Norway is in first place, followed by New Zealand, Portugal, the UK and Australia, with Brazil, Uganda, Indonesia, Kenya and Mexico occupying the bottom five places.

The index, which has been developed by the Harm Reduction Consortium, is made up of 75 indicators across five main themes – criminal justice, extreme responses, health and harm reduction, access to internationally controlled medicines, and development. However, even first-ranked Norway only has a score of 74 out of 100, with the UK scoring 69. The median score across all 30 countries ranked is just 48.

Drug law enforcement continues to target non-violent and possession offences, says the index, with only three countries surveyed managing to ‘truly’ divert people away from the criminal justice system.

Just five countries, meanwhile, have allocated ‘adequate’ funding for harm reduction programmes, and the ‘militarised and law enforcement’ approach continues to prevail. The disproportionate impact on people marginalised on the basis of their ethnicity, gender or socio-economic status was reported to some extent across all countries, with the UK marked down for the way its policies impact ‘to a very large extent’ on low-income and some ethnic groups and ‘to a moderate extent’ on women.

‘Forty-eight out of 100 is a drug policy fail in anyone’s book,’ said Ann Fordham, executive director of the International Drug Policy Consortium, lead partner in the Harm Reduction Consortium. ‘None of the countries assessed should feel good about their score on drug policy, because no country has reached a perfect score. Or anywhere near it.’ *globaldrugpolicyindex.net*

Local News

COFFEE TIME

WDP has partnered with SEND Coffee to offer rough sleepers in Camden hot drinks in a local coffee shop in exchange for Capital Card points. The scheme will give service users an ‘opportunity to benefit from companionship which most of us take for granted,’ said WDP chair Yasmin Batliwala *capitalcardrewards.com.*

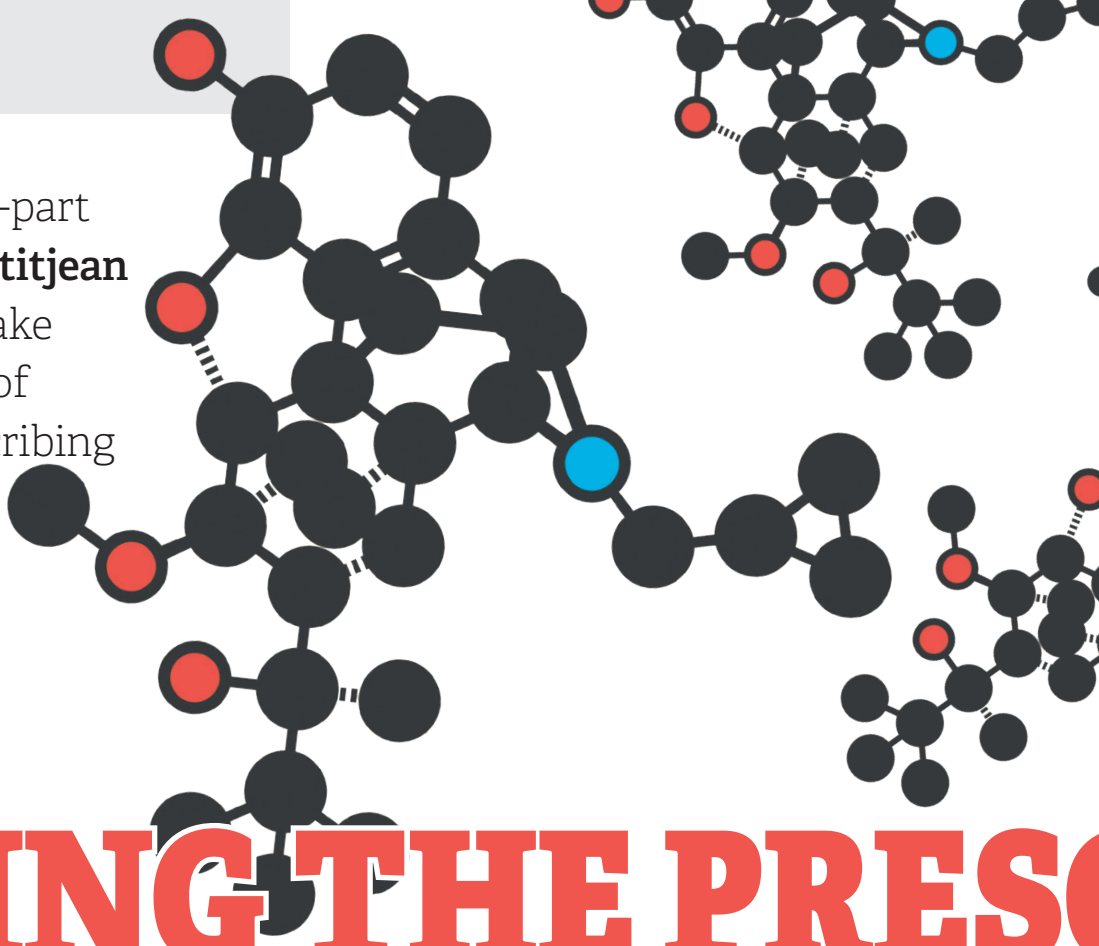
PARTNER CALL

Alcohol Change UK is looking for local partners for its new project to help identify and respond to cognitive impairment in dependent drinkers, building on the success of the Blue Light Project and the Safeguarding Vulnerable Dependent Drinkers Project. *Contact mike.ward@alcoholchange.uk*

PEER PROJECT

LJWG is working with Hackney Council to scope the feasibility of developing a peer-led and delivered NSP, with additional hep C awareness and testing capacity. Based on focus groups with people who use NSP and interviews with specialists from across London, the report will be featured in the next *DDN*.

In the first of a three-part series, **Dr Georges Petitjean** and **Deanne Burch** take a look at the history of buprenorphine prescribing



FILLING THE PRESC

This article is the first in a series examining the past, present and future of buprenorphine in the treatment of opioid dependence. Buprenorphine is a medication used in opioid substitution treatment (OST), and it has also been used extensively for the management of pain. The surge of buprenorphine prescribing during the COVID-19 pandemic triggered a reflection of its journey, and with the recent introduction of long-acting injectable buprenorphine we question what its future is within drug treatment services.

DEVELOPMENT

In the USA, the Committee on Drug Addiction was created in the 1920s where it studied the morphine molecule, searching for medicines which would not cause addiction. It was hoped that they would find a medicine which could be used in the place of opium based medicines.

The search to find a non-addictive analgesic began in the 1920s following increasing concerns that opioid addiction was resulting from iatrogenic prescribing. The opioid agonist methadone was initially developed during World War II and it was prescribed minimally in the 1950s. Due to the lack of agreement on its safety and its inability to produce the desired effect without addiction, the search for opioid antagonists commenced.

The concept of 'substitution treatment' was first developed in response to the opium and morphine addiction epidemic in the USA.

The concept of 'substitution treatment' was first developed in response to the opium and morphine addiction epidemic in the USA.

BUPRENORPHINE CHEMISTRY

Buprenorphine is a partial agonist at the mu opioid receptor and an antagonist at the kappa receptor:

μ-opioid receptor

Buprenorphine has a very high affinity, a low intrinsic activity, and a slow dissociation at the mu receptor.

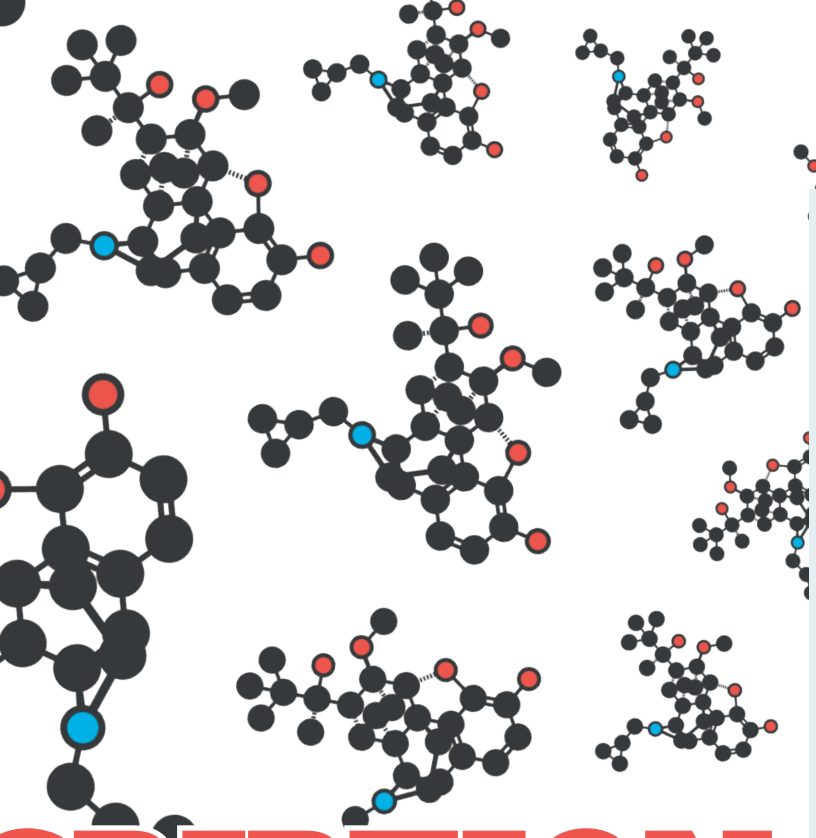
It has unique and clinically desirable pharmacological properties: lower misuse potential, milder withdrawal symptoms on dose reduction than methadone and a ceiling effect at higher doses (meaning that an overdose of buprenorphine is less likely to cause fatal respiratory depression than an overdose of a full mu opioid agonist like methadone).

Buprenorphine produces a dose-related blocking of drug 'high' from 'on-top' use of heroin, making it particularly appealing to well-motivated patients.

However, if taken too soon in opioid-dependent patients, buprenorphine can displace heroin and other opioids from the receptors, yet not provide the equivalent degree of receptor activation, thereby leading to a rapid drop in opioid effect and the onset of opioid withdrawal symptoms ('precipitated withdrawal').

κ-opioid receptor

The high-affinity kappa receptor antagonism of buprenorphine is involved in reducing stress-induced drug-seeking behaviour. Also, kappa antagonism has demonstrated antidepressant properties.



CRIPTION

the USA. It was fully recognised by then that even if a safe and side-effect free alternative was discovered, the addiction problems countries faced would not be resolved in totality due to the complex factors that influence addiction. Therefore, it was suggested that antagonists may assist in managing the problems associated with addiction, rather than completely resolving them. During the 1960s there was a shift from attempting to cure addiction to finding a medicine that alleviated some of the risk.

Naltrexone, an opioid antagonist, was produced in the 1960s but only used as a supplementary treatment from the 1980s.

DISCOVERY

In the mid-1960s buprenorphine was discovered. Longer acting relapse prevention methods such as antagonist depot injections were studied in the 1970s, while researchers also explored whether naloxone could be added to opioid medicines, and it was around this time that the search for a medicine with both antagonist

WHAT DO PATIENTS THINK ABOUT BUPRENORPHINE?

We asked some patients what their experience was of being prescribed buprenorphine and received both positive and negative feedback

POSITIVE EXPERIENCE OF BUPRENORPHINE

'Buprenorphine is far better than methadone – when I came off it [methadone] I had to go through six weeks of hell. I felt like an old man, with aches and pains, hallucinating. I did a 14-day detox. When I came off buprenorphine it was much easier, just a few days of restless legs and that was it If I'd have known what it was like coming off of methadone I'd rather have just stopped off the heroin. Methadone is worse than heroin itself. I went down to 2mg on methadone – three weeks after coming off methadone I felt so bad I took a total of 100mg diazepam, and they didn't even touch the sides.'

'You feel like an old man, the pain is unbelievable – 18 years ago this happened, they kept me on maintenance.'

'I came off buprenorphine a few times, no issues like I said, just restless legs the first night, then the second night a full night's sleep. I was a lot younger back then, the helpful thing is to exercise.'

NEGATIVE EXPERIENCE OF BUPRENORPHINE

'I didn't get on with buprenorphine at all, although most people I know have got on with it. The first time they didn't bring me down to 30 mg of methadone before I switched onto it, I was on 70mg. I left it two to three days to be in withdrawal, took one and then I was ill, I was actually going to a job interview that day – 20 minutes before I went for the job interview it felt like a super cluck. I had to go out and get something.'

'I tried to get onto buprenorphine three times. This was seven or eight years ago.'

'I prefer the methadone. It's something mental I suppose, I've been on it for so long.'

THE FRENCH MODEL

In France in the 1980s, the widespread off-label use of buprenorphine was being used to treat addiction. In 1995, it was the first country to approve the use of buprenorphine for the treatment of opioid dependence.

There was an acknowledgement at the time of increasing levels of overdoses and it was suggested that the majority of people who were opioid dependent were not receiving treatment. GPs were enabled to prescribe buprenorphine and they adopted a low threshold, far-reaching approach.

This approach incorporating GPs had the benefit of normalising addiction treatment into mainstream care. Financial barriers were reduced for GPs and patients. The outcomes were:

- *The number of people treated for opioid dependence with buprenorphine vastly overtook the numbers prescribed methadone.*
- *The majority of buprenorphine treated patients in Europe were in France.*
- *Overdoses reduced enormously.*
- *Pharmacists saw an increase in retention into treatment rates.*
- *HIV infections in people who injected drugs fell dramatically.*
- *However, France saw a higher number of patients injecting their buprenorphine, particularly when lower dosing was used.*

The French model is an example of where reducing the financial, procedural and stigmatising barriers associated with treatment has resulted in positive outcomes for patients.

and agonist properties began to really accelerate. Methadone maintenance was largely looked upon as a solution to treating opioid-dependent veterans and crime in the USA. Despite its support, its limitations were recognised fully.

By the late 1970s it was assumed that buprenorphine could effectively replace methadone as a treatment in opioid dependence because of its low misuse potential – essentially it was thought to have the benefits of both methadone and naltrexone but fewer drawbacks.

TREATMENT

Although sublingual buprenorphine was launched from 1982 for analgesia, it wasn't until 1998 that it was licensed for the treatment of opioid dependence in the UK as an alternative to methadone.

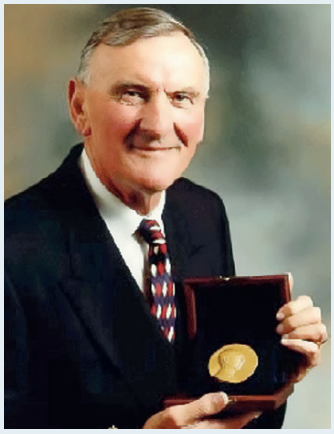
Despite the support buprenorphine gained as having the potential to be the next major medicine for treating opioid dependence, it took three decades to be fully approved and utilised in drug treatment services. The development of buprenorphine met with political and social challenges and as an additional option for opioid substitution treatment it has had mixed responses from patients. The dismantling of the barriers that can exist for opioid substitution treatment, as seen with the widespread use of buprenorphine in France, have led to innovative ways of tackling overdose, treatment and retention rates.

In the next article we will look at the introduction of different buprenorphine preparations, its use during the COVID-19 pandemic, and its safety and cost in comparison to methadone.

Dr Georges Petitjean is the substance misuse medical lead for Inclusion, part of Midlands Partnership NHS Foundation Trust. Deanne Burch is the hepatitis C elimination coordinator for the NHS Addictions Providers Alliance (NHS APA).

BUPRENORPHINE PIONEERS

We owe the ability to use buprenorphine as an opioid substitution treatment today to some scientists with endless determination and perseverance. Among them, William Martin, Kenneth Bentley, Donald Jasinski and John Lewis (pictured).



John Lewis was born in Gloucester in 1932 and studied chemistry at Oxford. He was instrumental in the development of buprenorphine.

Inclusion: www.inclusion.org
The NHS Addictions Provider Alliance: www.nhsapa.org

The authors have not received any financial or other support from pharmaceutical companies and the articles are their own opinion. See the February 2022 issue for part two.

WHAT DID CLINICIANS THINK ABOUT BUPRENORPHINE?

We asked Dr Emily Finch, vice chair of NHS APA, vice chair of the Addictions Faculty at the Royal College of Psychiatrists and clinical director at South London and Maudsley NHS Foundation's Southwark Central Acute and Addictions Directorate.

When buprenorphine first came to the market as an addiction treatment option in the UK, what were the fears and expectations in drug and alcohol services?

Discussions were dominated by cost when it first came in. It was initially much more expensive. So there were many thoughts about who was most suitable for it – essentially we were rationing it. The first person I gave it to [in 2004] went into precipitated withdrawal. It probably made me very cautious. Over time prescribers and service users gradually understood the need to be in withdrawal when given the first dose.

There were concerns about the difficulties supervising it. It took longer. It was a time when methadone maintenance was not very old in England and most methadone was supervised. At that time we also had lofexidine which we were using for detox. Service users did not like it at all initially.

We were sceptical about the evidence from France, where methadone was not an option, and the US literature where it was introduced because they couldn't use methadone in 'office based' settings – effectively primary care. We knew about its reduced overdose potential but we weren't that convinced.

In your opinion, has buprenorphine reached its initial expectations of being a safer and preferred alternative to methadone?

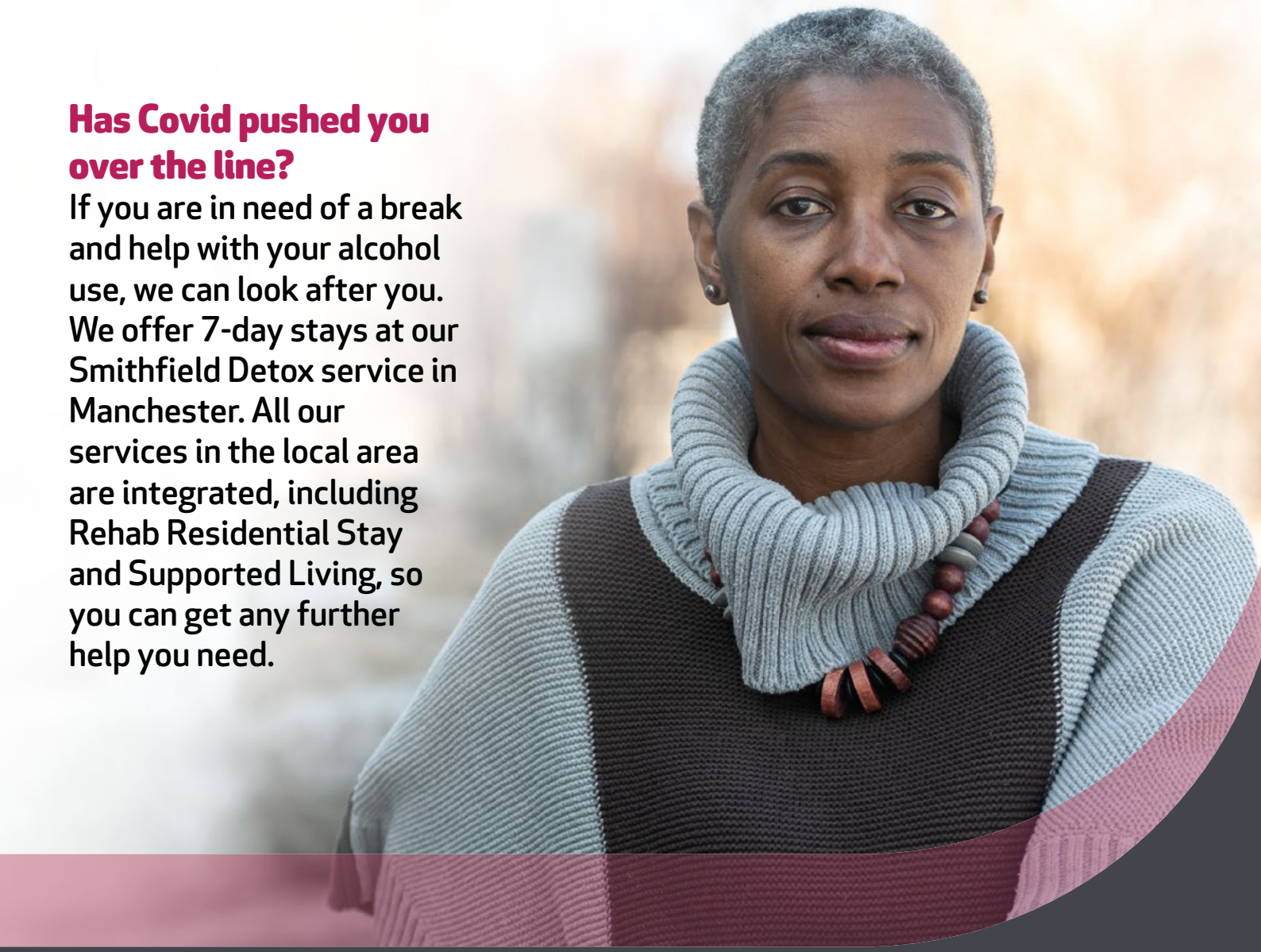
I don't think that was the initial expectation – perhaps by the drug companies, but not by most UK prescribers. It has revolutionised opioid detox and has been successful where drug use may be less chaotic. That is its biggest impact – it is safer but only if the service user will take it. All of my prescribing and the policies I have written have emphasised offering buprenorphine as an option equal to methadone – maximal patient information and influenced by the NICE technology appraisal. Often this means prescribing buprenorphine first, then if that is not successful they're prescribed methadone.

How do you explain that buprenorphine prescribing has not become the 'gold standard' in opioid substitution therapy, as it was originally predicted to be?

I don't think it was predicted to be the 'gold standard'. Perhaps it is because it doesn't make service users intoxicated. So, they stop taking it. The fact that they need to be in withdrawal for induction is a barrier. Other barriers can be the perception that you cannot 'use on top' and the fear of not being able to use.

Additionally there has been diversion of buprenorphine in prisons because of the inability to supervise it and the difficulty in induction for many. This can reduce retention rates. The reality is that many people who use drugs in the UK carry on 'using on top' of their opioid medication. Does that say something about the adequacy of the rest of the treatment system?

Turning Point Smithfield In-Patient Detox



Has Covid pushed you over the line?

If you are in need of a break and help with your alcohol use, we can look after you. We offer 7-day stays at our Smithfield Detox service in Manchester. All our services in the local area are integrated, including Rehab Residential Stay and Supported Living, so you can get any further help you need.

Call us now to discuss options and costs.
7-day stays from **£1855**

Book your stay now on **0161 827 8570** or **smithfield.admissions@turning-point.co.uk**

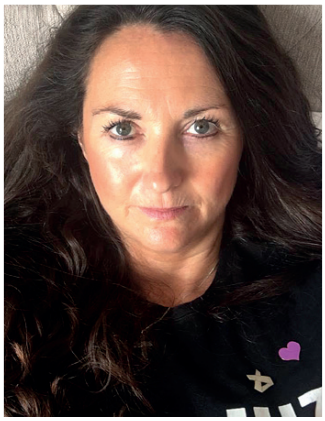
Visit our website at **mytp.me/detox**

TURNING POINT
inspired by possibility

UNITED FRONT

Tightening purse strings mean that the sector needs to be careful to not drift back to the bad old days of the harm reduction vs recovery wars, hears **DDN**

'I'm an unapologetic and passionate harm reductionist, but I also love recovery,' said Vicki Beere, chief executive of Project Six. 'Both are extraordinarily important.' She was addressing *DDN*'s 'More to join us than divide us' session at the HRI online event Constellations. However, she continued, government policy of 'get them in, keep them in, get them out, keep them out' when it came to services – coupled with ever-reducing budgets – was a major challenge in terms of meaningfully bringing the two together. 'We have a really badly damaged ecosystem in drug and alcohol services. We've lost those small, community-rooted, passionate organisations – we've got a system that focuses on hitting the target but missing the point. There is hope, but we need to support each other to get there.'



'Our job... is to make sure that people have access to all the paths that will help them.'
ANNEMARIE WARD

VISIBLE RECOVERY

Visible recovery needed to be a central element of harm reduction services, said Stuart Green, manager of Aspire Drug and Alcohol Service and a member of CLERO – 'harm reduction and recovery is a spectrum.' LEROs could play a vital role as they were strength-based and asset-based and recognised that individuals were the experts about themselves, he said. 'Recovery is a very personalised experience.'

It had been difficult for many in both the harm reduction field and recovery community to separate the recovery movement from the political agenda, said FAVOR UK CEO Annemarie Ward. This 'political ramping up of language', along with shrinking budgets and their effect on commissioning, had helped start a shift back to entrenched positions over the last couple of years, with even the word 'recovery' becoming tainted in many people's eyes through its association in some areas with disinvestment. 'It's very human to become tribal or fixed to one particular philosophy. But the great thing about both harm reduction and recovery is that they have tremendous principles that everybody could align under if they can see the similarities rather than the differences.'

'The analogy for me is that if you break your leg you want a doctor mend it but you want someone who's previously had a broken leg to help you with recovery,' said Green. 'There's a role to play for both,' and the best intervention was always people with lived experience. 'With person-centred services and LEROS there's a different passion there – it's 24/7, they don't stop at the weekend. Meaningful change isn't going to happen once a fortnight in a one-hour key-working session. We might be able to nudge someone, but realistically it's about what happens in between.' The beauty of the LERO space was that it became bigger with every person in recovery, he added.

CHOICES AND OPTIONS

People needed choices and options, said Beere. 'There's absolutely a real need to bring back small and medium-sized organisations – and LEROS are brilliant – that can create that flourishing ecosystem', and commissioners needed to genuinely understand the importance of social value and localism, 'not just a tick-box on a tender where everybody writes the same thing'. It now took genuine bravery for smaller organisations to challenge the hand that feeds, and the system needed to take account of that, she said.

There were some encouraging signs in commissioning however, said Green. 'We're seeing a bit of a paradigm shift. In terms of price versus quality, quality is creeping up more as a percentage of tenders, which is really good news, and we're seeing longer tenders going out.'

Failure to recognise individual differences – and treatment programmes being too generic – was a major problem, said Ward. 'It's not just that there's a lack of evaluation of all the recovery paths, but a lack of monitoring and real-world data around what is it that helps us get and stay well. Our job as professionals is to make sure that people have access to all the paths that will help them, and not to punish people for one particular path not working for them.'

'I'm an unapologetic and passionate harm reductionist, but I also love recovery.'
VICKI BEERE

LIVED EXPERIENCE

'It's really important that we have that lived experience voice, but what we're not very good at in our sector is getting the voice of the people who don't access our services, who don't get through the door,' said Beere. 'They're the ones I really want to hear from. I think we've got a job in our sector to find and listen to that voice, even if it's really hard to hear.'

This was especially the case in Scotland, Ward stated. 'Sixty per cent of the people who should be in treatment are missing – they're not even showing up. It's not because they're "hard to reach". That's usually the rhetoric, but it's because services aren't attractive enough.'

There were people in LEROs who had 'never touched service land', said Green, 'because people do naturally recover.' LEROs were not for everyone, he acknowledged. 'But if you look at why people aren't engaging in services, it's because we're offering the wrong thing.' **DDN**

CLERO

ENOUGH IS ENOUGH!

The sector must unite to challenge stigma, says **Tim Sampey**

In 2010 the United Kingdom Drug Policy Commission published a report on the stigmatisation of drugs users, and finished by stating, 'if society is serious about supporting recovery from drug problems it has to get serious about challenging stigma.' It doesn't feel as if we have got far, does it?

It seems as if there has never been a concerted attempt to challenge the way wider society views people with substance use disorders, and as Mother Teresa predicted, we have become the lepers of the twenty-first century – shunned, excluded and unwanted.

A quick scan back over the past decade offers us hope that a united front built around a worthy moral cause can force a gradual systemic change. At last, individuals with mental health disorders are viewed as more than 'the nutter on the bus'. Black Lives Matter and the Me Too movements have shown us that a mirror can be held up to wider society, demanding that they do better and recognise the essential truth in the adage 'do unto to others as you would have them do unto you'.

Working With Everyone were recently commissioned by the NHS Addictions Provider Alliance (APA) to hold a series of workshops looking at the lived experience of stigma among people who use drugs. Stories of the way in which the participants were treated by the wider health system, including GPs, mental health services and hospitals, were depressingly familiar in their negativity and in several instances genuinely shocking, making a nonsense of the idea of integrated care systems. How can there be an integrated care system in England if a large part of that system regards us either as not their problem or unworthy of support?

It seems as if there has never been a concerted attempt to challenge the way wider society views people with substance use disorders.

It is time the sector united around the persistent and endemic stigmatisation of those who struggle with their substance use and took the battle into society, the press, and the corridors of power. We need to remind them that we are mothers and fathers, sons, and daughters, and that we are as deserving of our place in the sun as they.

LEROs can and must play a central part in this. After all, there is not one of us who has not been on the receiving end of stigmatisation repeatedly. It is time we joined hands with the rest of the sector, and held up the mirror, stating 'enough really is enough'.

Tim Sampey is chief executive of Build on Belief, writing as a member of the College of Lived Experience Recovery Organisations (CLERO)

I took a moment to have a quick look through the *DDN* back issues on the website and found literally hundreds of articles all of which outlined the damage that stigma had caused.

STIGMA SPIRAL

I have been a *DDN* reader for many years and was saddened when I opened the last issue to see the cover story on being trapped by stigma (*DDN*, Nov, p6).

It's not that the article wasn't interesting or challenging, it's just the fact that this is still such a major issue and holds so many people back from getting the help that they need.

I took a moment to have a quick look through the *DDN* back issues on the website and found literally hundreds of articles all of which outlined the damage that stigma had caused.

You would have hoped by now that the message would have gotten through that stigmatising language and behaviour is unacceptable and does not help.

I know that there is a lot of fantastic work going on to challenge stigma and I would like to thank *DDN* for their ongoing work covering this – I just wish that they didn't have to!

Sue Jenkins, by email

HELP GUIDES WANTED

I used to have a cannabis and drink problem in the '80s and '90s but managed to get this under control in the mid-'90s. Could anyone direct me towards a drink safe guide and some facts on cannabis?.

David D, HMP Durham

(Please email suggestions to the editor and we can send on information by post.)

VITAL MOMENT

I was very interested in the idea of 'a treatable moment' (*DDN*, Nov, p16) and I wish this idea would take hold. I am exhausted with trying get help for my son and am petrified that one day it will be too late. I don't want it to be a trip to A&E that makes professionals see him as a priority – I want our GP surgery to understand that he needs help now. I wish Dr Brinksman was our GP.

Mrs S Bell, by email

DDN welcomes all your comments. Please email the editor, **claire@cjwellings.com**, join any of the conversations on our Facebook page, or send letters to DDN, CJ Wellings Ltd, Romney House, School Road, Ashford, Kent TN27 0LT. Longer comments and letters may be edited for space or clarity.

/ddnmagazine @ddnmagazine
www.drinkanddrugsnews.com

PEER POINTS

The Constellations session Staying Alive: Naloxone Action!, chaired by **DDN**, explored the vital – and often unpaid – work peers were doing to get naloxone into the hands of people who need it

'We've created an underclass', said George Charlton, who works across the UK developing peer-to-peer naloxone training and supply programmes. Media headlines about 'junkies' had caused a disconnect between 'some of the most socially excluded and disenfranchised people in our communities' and the general public, he said. 'People who do care for drug users are other users, which is why peer-led projects are so important.'

Drug-related deaths were 'needless and avoidable', he stated, and the most important people he worked with were those with 'lived and living experience of addiction'.

'The best way to get this out into the community is for drug users to go into the community.'
LEE COLLINGHAM

Naloxone provided a 'wonderful opportunity to keep people alive. It's not the whole solution, but it's part of the solution.'

PRIVILEGED ACCESS

One of the key strengths of peer-to-peer naloxone programmes was that people who use drugs have privileged access to drug-using venues, supply systems and markets, he said – 'they have instant trust and credibility.' However it was vital to ensure that all organisations involved in a project were 'fit for purpose', he stressed. 'We won't recruit any peers until we've made sure that we've addressed any of the bureaucracy that could get in the way', with everyone needing to be fully aware that lived experience often meant active drug use. 'These aren't recovery projects, they're harm reduction projects.'

Community mobilisation involved asking people to 'own and be part of' the projects, which often meant building trust as many had been let down in the past. 'As providers, we have the assets, the naloxone, the governance, the frameworks for peers to work within – the rooms, the teas, the coffees, the expenses. Let's give them access to all of that, and let's give them the project. Let's see what the peers are doing with our support, not what "our" project is doing.'

'The best way to get this out into the community is for drug users to go into the community,' agreed Nottingham-based harm reduction activist and longtime *DDN* associate, Lee Collingham. 'Unfortunately, the other side of my work is seeing drug users being exploited and not being paid for the work they do.'

'We firmly believe that we cannot continue with this process of only having peers on a voluntary basis,' stated Kirsten Horsburgh, who leads SDF's work on drug-death prevention and is coordinator of Scotland's national naloxone programme. 'We absolutely need to drive home the importance of paying peers for the work they're doing – it's utterly crucial.' Criminal record checks could be an unnecessary barrier for many of those eligible for doing the work, however, and while services were often able to work around this it still needed to be urgently addressed.

Scotland's drug death situation had been described as a 'public health emergency' for many years without the major action to address that, she continued. 'And then something like COVID comes along and you see how quickly things are put in place when a public health emergency is taken seriously – immediate access to resources, changes to practice, fast-tracked law changes, all the things we really require for addressing the drugs death crisis.'

PROGRESSIVE

The country's naloxone programme had been in place since 2011, however, supplying more than 100,000 take-home kits. 'Scotland has been fairly progressive in a number of areas around distribution,' she said, despite legal restrictions, and with a national awareness campaign in place since August (*DDN*, September, page 4). 'The focus for the campaign we were commissioned by the Scottish Government to deliver is about a wider societal response,' not just targeting people who use drugs or their families – 'every single person can do something.' More than 30,000 people had visited the Stop The Deaths website in ten weeks, with much of the feedback – especially from family members and people who use drugs themselves – emphasising that 'just seeing that on such a public platform, on mainstream TV and across the country, was really powerful – that recognition that these lives matter.'

nigelbrunsdon.com

'People who do care for drug users are other users, which is why peer-led projects are so important.'
GEORGE CHARLTON

In the first year of Nottingham's naloxone programme 'we spent less than £2,000 and over 100 overdoses were reversed', said Collingham. 'That's 100 families that still had loved ones.' As one of the faces of the national naloxone billboard campaign (*DDN*, May, page 12), he was able to choose his own message to go alongside his image. 'As someone who's carried both it was clear to me that carrying naloxone is easier than carrying a mate's coffin. Let's have our loved ones at home, and let's carry naloxone.' **DDN**

www.stopthedeaths.com

We need to prioritise naloxone supply in high-risk settings if we're going to properly tackle drug-related deaths, says **Mohammed Fessal**

BROADENING THE REACH

The continued increase in the rate of drug-related deaths in England, Wales and Scotland is a tragedy, not only for those individuals and families directly affected, but for the UK as a whole. Proactive responses are vital, and naloxone supply must be a crucial priority in efforts to reduce the death rate. At Change Grow Live, a key focus in our harm reduction work over the last five years has been increasing the availability of naloxone to those within structured treatment, as well as their family, friends, and wider network.

Naloxone penetration has accelerated since the onset of the pandemic – between 19 March and 21 July 2020, we reached an additional 7,418 service users, meaning 70 per cent of our opioid caseload was in possession of a naloxone kit and efforts to expand our reach are ongoing. Our priorities for national naloxone supply are set out in our new *Naloxone strategy for 2021*, and a key focus is reaching people who are not in structured treatment and are therefore at most risk.

The strategy identifies the need to prioritise naloxone supply and awareness in hospitals, prisons, homeless hostels/shelters, as well as within ambulance services and across regional police forces. Homeless hostels and pharmacies remain key allies in ensuring naloxone penetration within communities, and pharmacies also play a central role. Since 2015, 19 per cent of the 3,768 kits that Change Grow Live has supplied to pharmacies have been used in an overdose situation, compared with 4 per cent of kits supplied to services and wider settings.

As part of efforts to reach high-risk groups, Change Grow Live has been running the first ever naloxone project within approved premises (APs). Formerly known as bail or probation premises, APs house high-risk individuals who have left prison. There are 101 APs in the UK, providing over 2,000 bed spaces, and more than half of deaths in APs are drug-related.

This project has resulted in the successful distribution of naloxone across over 40 per cent of the national network of APs and gives us confidence that, with the support of the relevant stakeholders, current gaps in provision can be rectified rapidly. Change Grow Live has worked closely with the National Probation Service to develop a comprehensive online training module, and this has now been rolled out across the 42 APs where we provide substance misuse services.

This training module provides clear, evidence-based guidance, empowering staff to know when to use naloxone and to have the confidence to act fast. Feedback from staff shows beyond doubt that effective training, not just supply, is an essential component of successful implementation – staff want to help keep people safe, but the idea of administering a drug in a crisis situation raises multiple questions and concerns.

> 'My hope is that our new naloxone strategy provides a useful guide to where the gaps currently are, but also demonstrates... that naloxone supply is not just possible, but essential.'

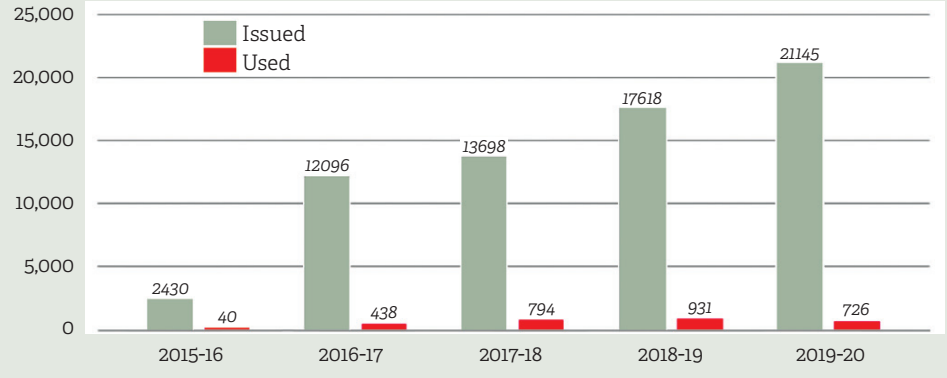
Since the project started naloxone has already been administered to reverse two potentially fatal overdose cases and the National Probation Service is now planning the roll-out of training and naloxone supply to the remainder of the AP estate. We are supporting this roll-out wherever possible, through the sharing of training resources and best practice, and the training module and approach to distribution is also informing ongoing projects with regional police forces in the West Midlands and Cambridgeshire and a planned national roll-out in settings managed by the Salvation Army.

My hope is that our new naloxone strategy provides a useful guide to where the gaps currently are, but also demonstrates to wider stakeholders working in high-risk settings that naloxone supply is not just possible, but essential. Navigating multiple systems and achieving buy-in from the gatekeepers of those systems is essential, but ultimately our strategy is calling for a joined-up approach founded upon a shared commitment to save lives wherever possible. The more that our sector can demonstrate the immediate benefits of naloxone provision in new settings, the quicker we will be able to fill the current gaps in provision.

Change Grow Live's 2021 Naloxone strategy is at www.changegrowlive.org

Mohammed Fessal is chief pharmacist at Change Grow Live

Naloxone kits issued by CGL services each year



SAFE AS HOUSES

The need for quality supported housing is now greater than ever, says **Gill Arukpe**

I have worked in supported housing for a long time, over forty years to be precise. I was a frontline worker in Women's Aid, housing women and children fleeing from violent and controlling relationships – sometimes three or four families sharing a three-bed house in a residential street. Just pause and think how desperate all those women and their children were, and still are today, to uproot courageously and move into overcrowded shared accommodation, often staying for over a year before their housing situation is resolved.

In the '90s, I managed one of the largest hostels in London, Arlington House. It accommodated 400 men who had been homeless and had mental health and substance misuse issues. I share this with you to show how the needs of people in the UK have not changed over decades. Supported housing was and still is needed for the most vulnerable of our society, and we need to continue providing it – and doing so even better.

CHANGING TIMES

Over the past ten to 20 years, the supported housing field has changed hugely. Most supported housing schemes for adults with social care and health issues run in much smaller buildings now, which is positive. In the Social Interest Group (SIG) we provide housing and accommodation services for adults who have had a long-term enduring mental illness and often have comorbidity with addiction or personality disorder. We also work to support people who have been in the criminal justice system and have mental health issues, personality disorders and substance or alcohol misuse.

It is essential to our residents and us that we provide trauma-informed accommodation. It is vital that our residents feel valued, and that the look of the housing and the upkeep of that accommodation is of high specification – this is essential in aiding residents' recovery and rehabilitation or resettlement. In my experience, if you offer poor quality accommodation, no matter how good the support is residents will find it difficult to trust you and engage. Their mood is affected, and the level of aggression in the house can rise quickly.

ESSENTIAL SPACE

Providing spacious rooms with ensuite facilities so residents do not have to share is essential. Many of our residents have had to share facilities for years. They have often experienced trauma and had poor experiences using support in the past. The need to value them as people by the quality of the accommodation is essential. The SIG has a property strategy which we hope to realise over the next three years – to replace all our accommodation that does not provide ensuite as a minimum.

In my experience, if you offer poor quality accommodation, no matter how good the support is residents will find it difficult to trust you and engage.

Very recently National Housing Group approached me and told me about their vision to provide supported housing that was fit for purpose. Refreshingly, they asked for our input while they got the building ready before completion.

Bohdan Skrypnyk / Alamy

I have visited a property they are working on now and they have thought carefully about residents' privacy, mental wellness, and the light in communal areas, while also recognising the need to keep everyone safe and involved. They are not insisting that all rooms are for rental income – they have listened to our need to have space for us to provide education and learning on-site. They have even thought about the environmental impact and the cost of running a supported house.

NEW PARTNERSHIPS

I am looking forward to entering a partnership with the National Housing Group soon – their staff are not only property experts but have employed people who have previously worked in the sector and understand our needs as providers and residents as recipients of support. Look out for our announcement of the opening of our first partnership house.

A version of this article also appeared in Inside Housing magazine.

Gill Arukpe is CEO of the Social Interest Group.

FIRM FOUNDATIONS

National Housing Group share the story of one of their residents

James was helped by our Pathways to Independence service in Kent. He entered our low/medium support Newlyn Court project in July 2018 – he had been referred while homeless and has spent time in custody and on community orders. His most recent offence was for shoplifting in July 2019 – he was given a 12-month suspended sentence.

James has struggled with an addiction to heroin for 14 years. He moved away from his family home at 15 and has been without a settled home since then. He had surrounded himself with associates who held pro-criminal attitudes and who also struggled with addiction. Rough sleeping exacerbated this lifestyle, and he became reliant on services like the local day centre for support, food and social interaction.

James has struggled with an addiction to heroin for 14 years. He moved away from his family home at 15 and has been without a settled home since then.

James had additional support needs – he had no budgeting skills as all his adult life was spent homeless, with poor money management leading to debts and an acknowledged struggle to take responsibility for himself and his actions.

James' health was compromised. After years of drug use, he has contracted hep C and had never prioritised treatment for this because of homelessness and recovery from addition. James has struggled with his mental health and emotional wellbeing during his time with us, and he was diagnosed and medicated for anxiety and depression. During his time, he has experienced suicidal thoughts and overdose attempts. James accepted the support from staff and engaged well with primary healthcare services during times of crisis.

For now, James is doing very well. He has drawn strength from the peer support he finds in Cocaine Anonymous meetings, having a sponsor, studying the 'big book' and talking with others who share his experiences and can offer him support. He has recently completed 90 meetings in 90 days, has spoken publicly and applied to volunteer back at the day centre which once was a trigger point for him. James is on a reduction programme and plans to spend a short time in detox to wean himself off completely.

James is now self-sufficient in most areas of his life. He manages his accommodation well and is now in one of our self-contained units in Tumim House, as a stepping stone to complete independence. He can now budget effectively and has no debt. James has better relationships with family which he cherishes, and he is looking forward to a family wedding this year. He has worked hard and even though he sometimes still has 'drug thoughts' he has learnt from experience not to let his guard down and to renew his commitment to support networks and communicate openly with his support coach, probation and drug workers..

BODY POSITIVE

Peers are a group leading the fight against hep C, hears **DDN**

'I love what I do,' Paul Huggett, peer coordinator for the Hepatitis C Trust, told the *Positive about being positive* session at HRI's Constellations harm reduction festival. 'When I give someone the diagnosis that they're positive but then tell them I've had it, they say, "but you look well". I say, "exactly".'

There had been a significant year-on-year increase in the number of people being treated since 2017, said Hepatitis C Trust regional manager, Danny Morris, but there was still a long way to go when it came to reducing chronic infections, particularly in the wake of COVID-19. Rates of equipment sharing, meanwhile, were still around 25 per cent – 'a big, big concern for us' – and around half of those living with hepatitis C were still unaware of their status. The trust delivered peer projects across the UK, he said, working closely with hepatology teams, drug and alcohol services, homelessness services and prisons, with the majority of staff having lived experience. One vital aspect of their work was modifying and speeding up pathways into treatment, particularly for more marginalised communities.

'I've booked people several appointments and two years later they eventually say they're ready to do it. They'll come round in the end.'

NATHAN MOTHERWELL

INDIVIDUAL NEED

'That's a big part of it,' said Nathan Motherwell, a peer coordinator for the trust. 'For example, they don't write to homeless people at the drug service anymore.' He helped to make sure that treatment was adapted to suit people's individual needs and coordinated and recruited other peers, using his experiences to build rapport with his clients. 'I was a very chaotic drug and alcohol user, but all of the things I experienced – even including prison – have ended up being useful in some way. When I talk to people I say, "I used to do that", and it breaks down some of that shame.'

Elimination was now becoming a reality, partly through treating whole communities of injecting drug users in different locations – 'we've probably significantly reduced the risk of anyone getting hep C in the Medway towns over the last three years.' The key was to 'be persistent and don't take it personally,' he said. 'Sometimes people don't want to engage. I've been sworn at when people are busy trying to score, I've booked people several appointments and two years later they eventually say they're ready to do it. They'll come round in the end.' There was often an intense level of support needed, particularly for clients with dual diagnosis, and this involved working closely with other agencies. 'These are the people with the highest risk of reinfecting themselves or infecting others. But we've got good outreach teams and they know these people.'

People often lied, he said, partly because of the shame. 'But if you break down the practice – who they use with, when, where and how, you can often change one little bit and that might help.' This could be something as simple as getting people to carry their own equipment, spoon or bottle of water. 'Some of the peers are still on methadone scripts so they're a lot closer to where people are at, and have managed to engage people that I couldn't.' Clients were also encouraged to find other people for testing in exchange for vouchers, he said – 'sometimes people will turn up with five others.'

EDUCATION AND PREVENTION

Education and prevention were vital, said Huggett, who was in active addiction for 20 years. 'We all know it's full of fear and stigma, but if you start talking about it, it eases all that stuff.' Having a regular presence at hostels and drop-in centres for testing days was also crucial, he said. 'If they keep seeing us, eventually they'll get tested.' It was about 'being consistent with love, care and compassion – they're going to come round and we're going to get them.'

He coordinated a team of four peers with eight volunteers, and a current project involved target-testing in a pharmacy. 'The more testing you do, like with COVID, the more positives you find.' But it was then vital to make sure the right level of support and care was in place to get them through treatment. 'Gold standard is not knowing they're positive and leaving them out there.

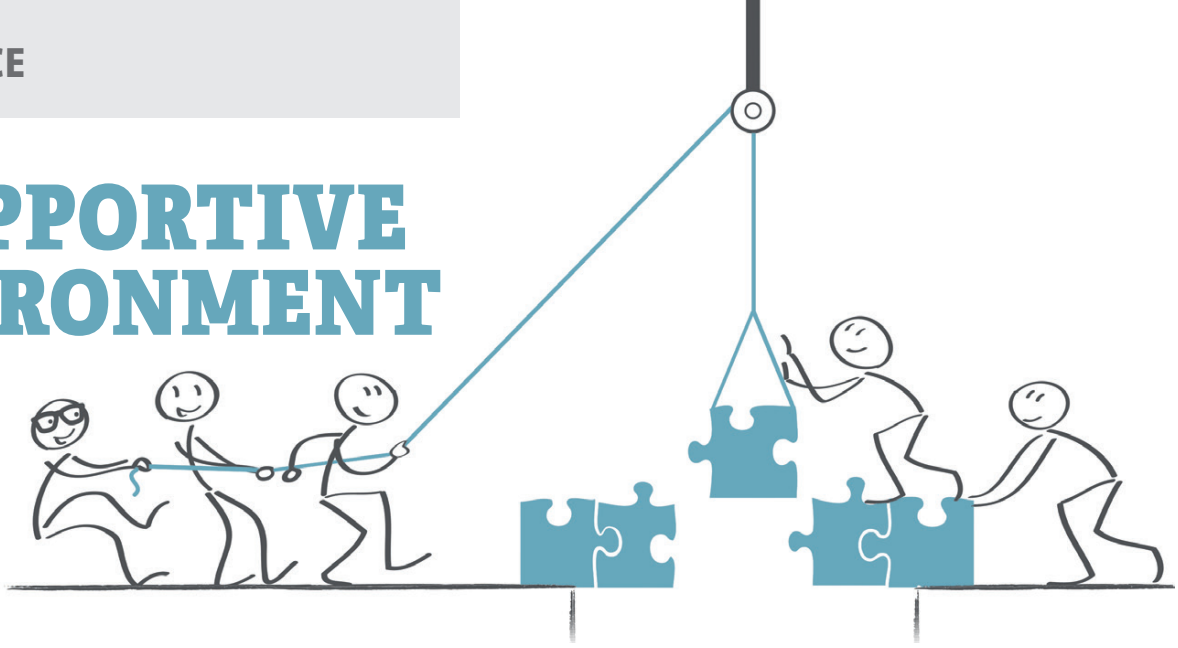
'When I give someone the diagnosis that they're positive but then tell them I've had it, they say, "but you look well". I say, "exactly".'

PAUL HUGGETT

THE BEST JOB

'It's about more than hep C,' he stated. 'Once they told me I'd got the all-clear it made the impossible possible. It made getting stable on a script seem doable, even sobriety seemed achievable. Because I'd just beaten a killer disease. I've got the best job in the world because every week I'm telling people they've got the all-clear from hep C.' **DDN**

A SUPPORTIVE ENVIRONMENT



In the first of a two-part article looking at the impact of menopause on colleagues and service users, **Helen O'Connor** talks about the importance of creating menopause-inclusive workplaces.

Women make up 51 per cent of the UK workforce, with women over the age of 50 being the fastest growing segment. This is also the age at which women will commonly experience menopause transition as oestrogen levels decline, although it can also happen for younger women, transgender, and non-binary people too and the perimenopause and symptoms can begin some years before.

Some women experience the impact of oestrogen diminishment during their menopause as a 'cliff edge' that significantly affects their physical and mental health. About eight in ten women will experience noticeable menopause symptoms, of which 45 per cent will find their symptoms hard to deal with, both in and out of the workplace. It can also affect their relationships and may occur alongside other challenging life events, such as an 'empty nest', divorce, or caring for elderly relatives.

These problems can be exacerbated by a lack of understanding about the menopause and how to support people who are experiencing a difficult menopause transition at work, or when it is treated as something embarrassing, taboo, or a joke.

Results of several different surveys indicate that this has a direct impact on work life and retention of colleagues:

- *10 per cent have considered leaving work because of the menopause*
- *55 per cent said the menopause impacted negatively on their work life and productivity*
- *59 per cent took time off due to menopause symptoms*
- *60 per cent said their workplace offered no menopause support*

> 'Ten per cent of colleagues have considered leaving work because of the menopause.'

Issues can include conflict and tension between colleagues about room temperatures; difficulties attending meetings or running groups and keyworking sessions in confined spaces that exacerbate hot flushes; high sickness absences and the stress of meetings to discuss them; emotional problems at work including anxiety, and changes in performance because of lack of sleep and a loss of focus. Add to this the frustration that can come from trying to get help and appropriate treatment from a GP and how it might also be affecting one's personal life, and this can be an incredibly difficult life event to navigate.

Seeing an opportunity to enhance our workforce health and safety policies to directly address the menopause, I volunteered to lead on shaping WDP's menopause policy and toolkit. Our people and culture team were really enthusiastic and encouraging of this direction and of my involvement, and I value being part of a responsive and supportive organisation that welcomes organisation-wide initiatives and ownership of them to originate from those working within services.

After consulting other organisations' policies and guidelines, and menopause advocates and experts, I drafted our (Peri)menopause at work policy, which was put out for a staff consultation that was open to everyone at WDP. We launched the policy internally on World Menopause Awareness Day 2021 and situated it within our new pay and reward structure, outlined by our CEO Anna Whitton in a previous issue of *DDN* (November, page 20).

When we put our (Peri) menopause policy out for staff consultation, a colleague within our team at WDP Merton commented: 'I'm currently in the process of managing my own menstrual/ hormonal related issues and their impacts and it feels very reassuring to be in an environment that is progressive in its ways of approaching these topics.'

This policy and the associated toolkit of information and resources, together with briefings and training that will be rolled out over the next few months, are intended to help everyone understand and appropriately support people who are experiencing difficulties with menopause symptoms.

Of course, it's not up to us to 'diagnose' colleagues who may be experiencing menopause transition symptoms, and whether someone wishes to discuss them is up to them. But we do want to help managers and other colleagues to be able to support their team members who are experiencing difficulties at work, by increasing their knowledge of menopause and how to hold positive supportive conversations about it.

A quote from Kellogg's, who recently announced how they would be providing more support to staff experiencing the menopause, expresses what we are trying to achieve: 'We want to create a culture where people feel psychologically safe, so we'll encourage colleagues to be allies to others impacted by these issues.'

The second part of this article will look at how we can improve our understanding of the possible impact of the menopause on our service users and how it can affect their recovery.

Helen O'Connor is service manager at WDP Merton

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Tamara Ivanova / iStock

CHIMES OF FREEDOM

The G-CHIME model of recovery offers huge potential for both clients and practitioners, say **Lisa Ogilvie** and **Jerome Carson**

Recovery is the process of becoming well. In terms of general health, it is often considered a return to healthy function following an illness or accident. In mental health this does not accurately reflect recovery for people who see it as an ongoing endeavour instead of an end destination. Here recovery is more ideological and involves taking positive action to implement lifestyle changes that improve wellbeing.

The concept of recovery as a lived experience was first popularised in Alcoholics Anonymous (AA), through the 12-step programme it advocates. Its success resulted in the proliferation of 12 step programmes to other areas of addiction, for example, Narcotics Anonymous (NA) and Gambling Anonymous (GA). Moreover, the positive testimonies of people in addiction recovery describing experiencing a meaningful life encouraged health professionals to start looking at where people with mental health problems could also embark on a process of personal change. One that could build resilience for living a happy and satisfying life, irrespective of the limitations presented through illness.

BROAD VIEW

Recovery as an approach in mental health takes a broader view of the person than is seen in traditional psychiatry, one that does not aim to treat symptoms or adjust for deficits, instead promoting self-management and the re-assertion of control. A substantial body of knowledge now exists on the use of recovery-based approaches within mental health services. This importantly has the backing of empirical evidence to demonstrate its efficacy. A review of the material resulted in a valued and respected framework for understanding personal recovery known as CHIME: Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment.

This framework lists five significant and supporting components of recovery and has become an important tool for gauging recovery in addition to offering a model for developing interventions and evaluating clinical endpoints. The CHIME model has proved to be adaptable, for example, C-CHIME considers using creativity to promote recovery, CHIME-A is an adaptation specifically for adolescents and children, and CHIME-D considers recovery in terms of the difficulties overcome.

GROWTH

This presented the opportunity to consider what can be appropriated from this model and returned to where the idea of recovery started – addiction. One such study used CHIME-D to look at recovery in terms of the difficulties overcome, however this found that difficulties did not generally fall into their own classification, instead being more relevant to the other components of CHIME. Here we discuss an adaptation to the model that includes a sixth dimension important to addiction recovery, Growth, resulting in G-CHIME.

If the five components of CHIME fit so succinctly with addiction recovery, then why adapt the model to incorporate a dimension for growth? Perhaps this is best explained by the stages of change model commonly referenced in the field of addiction, where personal growth is recognised through a series of changes that demonstrate an individual's disposition to learn, improve and continue to develop, rather than remain in the same mental and emotional state.

This willingness to adapt and learn, to personally grow, is a

'Recovery as a recognised approach to improving wellbeing started in addiction services and offered an alternative way to live. An approach that when transferred to mental health helped shape how people with mental illness were viewed and treated.'

fundamental principle in 12-step programmes, where recovering addicts are encouraged to keep an ongoing inventory of their conduct and when appropriate accept responsibility for wrong doings and make positive changes to support a morally strong and motivated way of living. In psychological terms, this is an example of practising reflective thinking, where an individual can compassionately look at their strengths and weaknesses and use this evaluation to constructively inform their future choices. Furthermore, research has shown this is an essential ingredient for personal growth and development. For recovering addicts, following a path of continuing self-improvement, along with having the ability to enact constructive change, safeguards recovery. Negative behaviours and ways of thinking are reflected on, unhelpful ways are left behind, to be replaced with more positive equivalents that strengthen recovery.

For practitioners working with people in recovery, such as those engaged with addiction services, the G-CHIME model is multi-faceted. It can be used for targeted interventions when it is felt that an individual has a deficit with one or more of the components, for example, promoting mutual aid meetings and recovery activities for clients feeling lonely or disconnected or running workshops to help clients who are prone to negative bias foster a more hopeful and optimistic outlook in decision making and goal setting. Similarly, it could be extended as a treatment approach, in a similar way to that seen with the Five Ways to Wellbeing, where the components are grouped together to offer a more holistic package of support, in this case encouraging a broader perspective on resilience in addiction recovery.

RAISING AWARENESS

G-CHIME can provide an itinerary for raising client awareness and educating them on the key aspects of recovery, as well as helping them understand where personal responsibility lies. As a framework, it offers a structure for assessing client development, as well as tracking progress over time to support addiction recovery as long-term endeavour. Matching appropriate scales to the six components of G-CHIME, such as, the Perceived Hope Scale, the Office for National Statistics personal wellbeing questions, or the meaning in life questionnaire, will enable practitioners to evaluate the personal resources held by their clients for each of the components.

The G-CHIME model is currently being used to study addiction recovery through a series of first-hand accounts of addicts living in recovery. Each story is unique to the experience and circumstances of the individual author. For each, a structured interview is conducted based on the six components of the G-CHIME model. This provides a basis to standardise the different accounts in relation to the common and necessary components of successful addiction recovery. In addition to this, G-CHIME is being used to promote the use of positive psychology in addiction treatment services, to disseminate positive addiction recovery to clients as an achievable lifestyle choice.

MEANINGFUL LIVES

Recovery as a recognised approach to improving wellbeing started in addiction services and offered an alternative way to live. An approach that when transferred to mental health helped shape how people with mental illness were viewed and treated. This has seen a move from an assumed dependence on traditional psychiatric treatment to one that supports and encourages people with mental health problems to live a meaningful and satisfying life that is not defined by the challenges presented through illness.

From this, important knowledge has been acquired about the components necessary to support recovery, resulting in the advent of the CHIME model. G-CHIME takes the existing recovery components of Connectedness, Hope and optimism in the future, Identity, Meaning in life, and Empowerment, and adds Growth. This adaptation enhances it for addiction recovery where personal growth and development are a necessary part of sustaining recovery as a prolonged lifestyle choice. We commend it to colleagues.

Lisa Ogilvie is a PhD student and Jerome Carson is professor of psychology at the University of Bolton

CHIME COMPONENTS

The CHIME model represents five necessary components for mental health recovery – these are equally important, with an enduring body of research that is testament to this

CONNECTEDNESS, a key component in recovery communities that offers a supportive alliance to recovering addicts. This is evident in the local, national, and international membership of organisations such as AA and NA.

HOPE AND OPTIMISM about the future, summarised by the well-known AA recovery adage 'living a life beyond your wildest dreams,' which conveys a message of what recovery means to those living it. Describing an addict's transition to a happy and free life beyond the constraints of addiction, where everyday possibilities are seen as attainable.

IDENTITY, in 12-step programmes, the starting point is admitting you are powerless in addiction. Identifying as an addict is part of the recovery process, along with the transformation that happens in identifying as someone who lives in recovery, as opposed to someone defined by addiction.

MEANING IN LIFE, lost to those in active addiction, when purpose is driven by obsession with a substance or substances. Finding meaning is important to experiencing a renewed enthusiasm for life, and is necessary in having the aspiration to maintain recovery. Research has shown that meaning in life correlates with the longevity of recovery.

EMPOWERMENT, is minimised in addiction where choice is narrowed, having been limited by unhealthy behaviours and thought patterns relied on. The freedom of having a choice no longer restricted by active addiction is empowering. This is apparent in the many accounts recounted by recovering addicts telling of mended relationships, a return to education, finding employment, and forming new friendships.

DRUGS OF CHOICE

To take psychoactive drugs or not – that is the question, says **Andria Efthimiou-Mordaunt**

In 2008, in a boring-looking room, a psychiatrist gave me a diagnosis I could have done without. She made an assessment, asking me many questions, and after 88 minutes concluded I had 'a lesser form of bipolar affective disorder' (bipolar type 2). Somewhat shocked, but definitely terrified, I looked at my 15-month-old daughter, and began to fret. Then the processes of grief kicked in as I thought I was being told I would not be able to think well.

In one phone call with this doctor, I said, 'Hey, you should research open "addiction" self-help groups. We're all like "that" in there,' meaning that mental health was an issue for almost half of us – hardly surprising as those rooms are full of people in early addiction-healing, not to mention hepatitis C, HIV and other BBVs. She proceeded to suggest I keep taking vitamin D, as it is helpful for people with depression.

I didn't mind the upswing of my newly-diagnosed condition, but the lows often left me suicidal. Try as she might, this poor clinician couldn't get me to take drugs for the bipolar 2 –it didn't help that the psychiatric profession are not sure whether it requires medicine anyway. According to a fellow living with BP1, the main difference between BP1 and BP2 is that when, for example, I think I'm super-woman on a well-day, my 'sane brain' will let me know that is clearly not true. I was 'lucky' – my diagnoses left me with enough connection to reality (as we know it) to protect me from the excessive sex, retail therapy, and other behaviours that often bedevil people living with BP1, getting us into terrible debt, not to mention STDs.

I was already taking low doses of opioids for chronic pain and SSRIs for the suicidal phases of my illness. The idea of taking another medicine was hardly attractive, and let me say there were people in 'the rooms' who were dubious about my decision not to take drugs for the BP2, but it took me nine years to finally 'research' whether lamotrigine actually stabilised my moods.

To this day, I'm unsure whether it did but I, as ever with unpleasant psychoactive drugs, took the lowest possible 'clinical dose.' I was in 12-step and we didn't do those kinds of drugs, right? Wrong. How many of us have utterly ignored the one page in 'the big book' about how when a professional advises us to take a medicine, we should seriously consider it. After all, they are trained to know better than many 'recovering addicts' when a drug is necessary or not. Lots of people 'in-recovery' or not take psychoactive medicines for mental health care, chronic pain and so on. So what's the problem? Several.

When you live within a community whose narrative is anti-psychoactive drugs, and you're enduring countless illnesses, lack of paid employment and sleep, your own thought process will struggle to remain grounded in fact and reality, as most people know it. Then there are the infrequent 'amateur psychologists' who will tell you that you should not take tramadol, SSRIs or anti-psychotic medication as that is a relapse. To be fair, anyone in those rooms who knew me knew I was the last person to advise not to take psychoactives therapeutically as a passionate proponent of harm reduction, but most didn't know me at all.

The only groups I regularly go to now are full of people navigating similar dilemmas. Some opt to take the prescribed medicines, some opt not to and use other tools (yoga, vitamins, meditation) to cope, and a few like myself do both. One thing's for certain. As we age, some of us will hurt, creek and often be challenged by illness, drug prohibition and socio-economic deprivation. Therefore it is our job as responsible citizens to ensure we do whatever it takes to ensure the highest possible levels of self-care.

> 'I was already taking low doses of opioids for chronic pain and SSRIs for the suicidal phases of my illness. The idea of taking another medicine was hardly attractive...'

Andria Efthimiou-Mordaunt is an activist at ACT.UP London, actuplondon.wordpress.com. This article is in memory of Mary P.

GeorgePeters / iStock

OPTIMAL OPTIONS

The **DDN**-hosted The Right Dose session at Constellations heard from Dr Prun Bijral and Peter Yarwood on the vital importance of making sure people were on the dose that suited them

'Everyone's individual needs are individual – and unique,' said Dr Prun Bijral, medical director at Change Grow Live. 'It's about the balance of getting that dose right for them. In a nutshell, we're trying to help people stay comfortable and get some stability in their lives.'

People entering treatment services were often at a very low point, so it was vital to build relationships that were based on trust and honesty in a supportive environment, said Peter Yarwood, founder of Red Rose Recovery and in long-term recovery himself. 'You've got people at different stages, who might not know what's right for them – that's got to be a process, it can't be fixed in one visit.'

'What I will always say to people is, "it's your treatment". It's for us to serve and make that treatment as accessible, practical and useful as possible.'

DR PRUN BIJRAL

TREATMENT QUALITY

Ultimately, whether people felt they were able to speak honestly came down the quality of the treatment, Bijral told the session. 'As a doctor I'm not going to be able to do my job if I don't know what the real issue is. What I will always say to people is, "it's your treatment". It's for us to serve and make that treatment as accessible, practical and useful as possible.' Clinicians had to recognise that entering treatment was very often a 'make or break' situation for people, and it was vital that they did everything they could to make them feel comfortable and informed. 'You have to be there for them, rather than have some agenda of "I'm going to get you on this or that".'

It all came down to the quality of the relationship, added Yarwood. 'Everybody wants to help people improve their wellbeing and get to their destination, but that's not to say we might not get it wrong. But if we do we need to be mature enough to open up a space to explore that without taking it as a personal criticism.'

Bringing about culture change across the sector and addressing sub-optimal treatment depended on education, said Bijral. 'Demystifying treatment – it's not rocket science. Get the dose that helps that person feel comfortable.' Change Grow Live had made the guidance more accessible to its frontline staff, modified its training and, crucially, showed services what their treatment looked like. 'Those same issues persisted, people were underdosed, were using when they didn't want to – we weren't providing the treatment for the need, it was as simple as that. But when you start showing people that, they automatically start to change and have different conversations.'

Stigma remained a significant issue, however. 'The solution is broader than a clinical one, it's a social one,' said Yarwood. 'There's work that needs to be done to educate the community, and then highlight the support available.' People were now able to put their own stories out on other platforms without needing to go via news outlets, however – 'we can counterbalance the negative voices.'

OPPORTUNITY FOR CHANGE

The Carol Black report was a crucial opportunity for change when it came to the central role of peers – 'it's not about hearing that voice, it's about enabling people to take control of things like commissioning, of policy,' said Bijral. This had been one of the few silver linings of the pandemic, he added. 'We can't just go, "Yeah, we're hearing you" now' – the people most affected by the system and change needed to be the ones shaping it. 'Then you're going to have a better system and a better service. It's not going to be easy, it's complex – without question – but you've got to start at the principles.'

Postcode lotteries remained a recurrent issue, but providers had to make sure their practice was in line with the evidence-based guidance, stressed Bijral. 'That's key – not just, "I fancy providing this dose because that's how I woke up this morning." Our services aren't about fancy machines, they're about people, so you're going to get differences. But it comes down to awareness and shining a light on the treatment that's being provided. We've got to move more towards a focus on quality and what people deserve, and view it from people's perspective – not a provider perspective, or a commissioner perspective. It's got to be about the person.' **DDN**

'Everybody wants to help people improve their wellbeing and get to their destination, but that's not to say we might not get it wrong. But if we do we need to be mature enough to open up a space to explore that without taking it as a personal criticism.'

PETER YARWOOD



A SMARTER APPROACH

The latest Drugs, Alcohol and Justice Parliamentary Group invited discussion on more positive initiatives than punishment

It was time to balance necessary enforcement with the support and engagement of people who were being exploited, said police and crime commissioner for Lancashire, Andrew Snowden. Together with colleagues at Blackpool's Project ADDER – the government's programme for Addiction Diversion Disruption Enforcement and Recovery – he was seeing encouraging results from exploring more positive pathways than the criminal justice system.

With 'some of the worst outcomes in the country' in Blackpool and 'top of the leaderboard for ten years' for drug-related deaths, harm reduction lead for public health, Emily Davis, explained how the region was one of the original pilot sites for Project ADDER and had been given the brief last year, in the middle of the pandemic. Partners from criminal justice, public health, lived experience and commissioning had been asked to consider what they would like to see as a model, and had decided with 'a resounding positive' that the outreach model was the way to go, with the individual at the centre.

The Homeless Health Division was seeing many people with health issues relating to their heart, liver and lungs – 'all contributory factors to an untimely death'. The health of the drug using population was getting worse, she said, with conditions such as COPD 'the norm'. People in their 40s were needing end-of-life care.

Project ADDER had given the opportunity to prioritise health-focused interventions, such as treatment with long-acting injectable buprenorphine, and there were 'lots of positive things going on' alongside significant challenges.

Detective chief superintendent Susannah Clarke, head of the Violence Reduction Network, said ADDER was 'the most hopeful project' she'd worked on in her 30 years in the police – a 'holistic offer' that contributed to the goal of trauma-informed practice being a part of treatment. Steven Brown demonstrated how the Lived Experience Team were a vital part of this process, as they knew most of the clients and were talking to them on a daily basis. He and his colleagues were involved in all levels of the project, including job panels and recruitment.

Suzie Hodgson, working at the Young ADDER Project, added that for young people it was an opportunity to build relationships and trust, helping them to get into their own accommodation and teaching them about earning respect and learning how to flourish.

Another perspective on such alternative approaches to drug policy was offered by Michael Collins, strategic policy and planning director for Baltimore City State's Attorney. Baltimore had become known as 'Ground Zero for the drug war' he explained, but building good relationships – such as between the police department and the mayor – had led to stopping arrests for possession. He had worked with researchers to analyse public safety factors, which highlighted that people arrested for drug-related crimes were unlikely to commit more serious offences. The time saved on not prosecuting low level offences could mean dedicating resources to more serious crime.

Taking individuals away from involvement with the criminal justice system meant more work on relationships, including with services – many of which did not have the comparatively 'huge budget' of the police. There was also a need to educate police on the street and members of the public, to counter misinformation about not prosecuting people – and it was 'also about educating drug users themselves, from a situation where they were afraid to ask for help'.

We needed to move from the 'othering' of people who use drugs, where 'people want these people out of sight and out of mind' to a health-based approach, said Collins. **DDN**

NO TIME TO LOSE

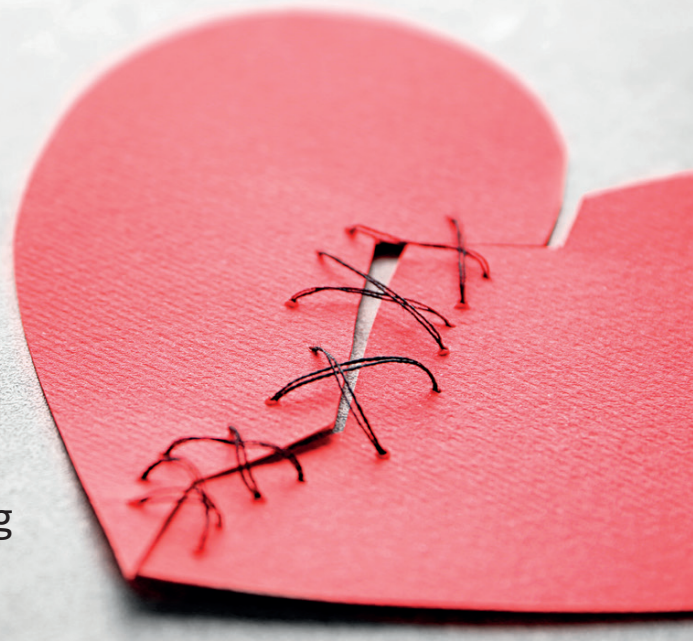
Two safe injection sites have just begun operating in New York City – the first publicly recognised facilities in the country. The 'overdose prevention centers', co-located with established NSPs, will be an extension of the city's harm reduction services as it records its worst year for overdose deaths. The Centers for Disease Control and Prevention projects that US overdose deaths for 2020 will top 90,000, with more than 2,000 people estimated to have died in New York alone.

The city's health department estimates that the sites would save around 130 lives a year, with increased focus from health agencies around the facilities.

'After exhaustive study, we know the right path forward to protect the most vulnerable people in our city,' said New York mayor, Bill de Blasio. 'And we will not hesitate to take it. Overdose prevention centers are a safe and effective way to address the opioid crisis. I'm proud to show cities in this country that after decades of failure, a smarter approach is possible.'

@NYHarmReduction

Picking up the pieces



With the sector – and the country – still reeling from the impact of the pandemic, 2021 was another challenging year for the drugs field

JANUARY

Despite millions still living under tier 4 restrictions – lockdown by any other name – the year starts on a more positive note than the sector has been used to, with announcements of cash injections of £250m for Scotland and £80m for England. Many quickly point out, however, that the latter figure represents just half of the estimated reduction in funding over the last eight years.

FEBRUARY

A report from Release finds that people had little difficulty sourcing drugs or suppliers during lockdowns, with more than one in ten purchases now made on the dark web – many for the first time.

MARCH

'Bold policies' like consumption rooms and decriminalisation are needed to tackle Scotland's ever-worsening drug death crisis, says Edinburgh's Royal College of Physicians, while the Royal College of Psychiatrists calls for urgent funding for young people's services to avoid condemning them to 'a lifetime of dependence'.

APRIL

A landmark, country-wide naloxone awareness campaign launches, using images of people personally affected by overdose, while Europe's drug trade is now more violent than ever, says Europol – a 'booming' cocaine market is increasing the number of 'killings, shootings, bombings, arsons, kidnappings, torture and intimidation'.

MAY

Alcohol-specific deaths in England and Wales hit their highest level for 20 years, up 20 per cent from the previous year, in a month that also sees the 50th anniversary of the Misuse of Drugs Act – legislation that has been a 'disaster', says Transform chief executive James Nicholls.

JUNE

Three quarters of adults are in favour of tighter restrictions on gambling advertising, a YouGov survey reveals, while a University of Nottingham report finds county lines activity is being characterised by ever-rising levels of extreme violence and sexual exploitation.

JULY

The second part of Dame Carol Black's *Independent review of drugs* finally sees the light of day, calling for 'whole system change' underpinned by investment of more than £550m over five years. While that may seem a lot, it 'only takes us back to the levels of 2012', she points out. As if to back up her argument on the importance of investment, Scotland again records its highest ever drug death toll.

AUGUST

To nobody's great surprise, drug deaths in England and Wales also reach their highest level, while Scotland's alcohol-specific deaths mirror those south of the border by rising almost 20 per cent in a year. Though the country has led the way with MUP there's still more to do, says Professor Sir Ian Gilmore, including 'ensuring access to alcohol treatment for all who need it'.

SEPTEMBER

Scotland's lord advocate rules that police can now issue warnings for possession of class A substances in a bid to help tackle the drug death 'public health emergency'. While the Scottish Conservatives brand it 'decriminalisation by stealth' the *Daily Record* welcomes a 'massive step forward in drugs policy'.

OCTOBER

Rishi Sunak uses his budget to introduce the 'most radical simplification of alcohol duties for over 140 years', with plans to tax drinks according to their strength – although campaigners are dismayed by his decision to freeze duty rates for another year in the meantime.

NOVEMBER

The Harm Reduction Consortium's Global Drug Policy Index finds the UK rating fourth when it comes to 'humane and health-driven' drug policies worldwide, although the median score across the 30 countries surveyed is just 48 out of 100. Meanwhile, UNODC warns that the crisis in Afghanistan could see the world's drug markets 'flooded' with heroin.

DECEMBER

Nearly two years on from the start of the pandemic, COVID case numbers are once again rising sharply across Europe. So with hopes that at least some of the Black review's recommendations might be acted on, the sector looks cautiously to 2022. **DDN**

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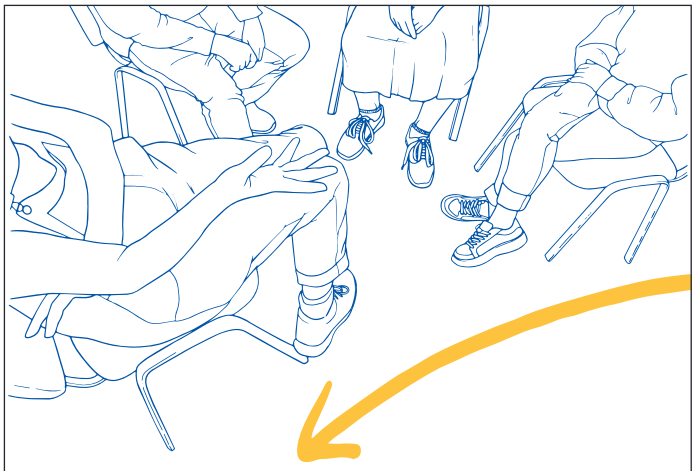

The new **With You** research report **"A system designed for women?"** explores the type of support available to women who use drugs, their experiences of treatment and ultimately, how services can be improved to support these women. Download the report at: wearewithyou.org.uk/womens-research

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