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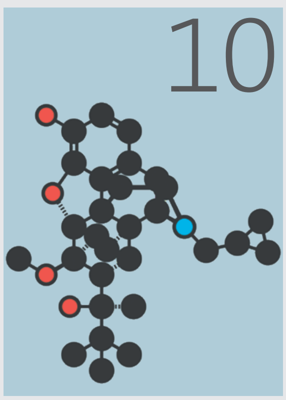

STAYING STRONG IN PARTNERSHIP

'Since I became the recovery peer mentor coordinator for Medway, I have been working along with the peer mentors to engage with clients that are struggling... it's a win-win all round.'

Donna from **Social Interest Group** in our **Partner Updates** at **www.drinkanddrugsnews.com**

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Voice of experience is vital to infrastructure

Service user involvement, co-production, peer-led initiatives – whatever the terminology, we're glad to see the renewed efforts to make the voice of experience a vital part of the infrastructure of services. Almost two decades ago when we started *DDN*, the two-year rule – a nebulous guideline about an amount of time required to be drug-free and therefore stable enough to enter full-time work, and grasped by many as a reason not to put service users on an equal footing – was a real barrier to admitting people back into employment and an equal status.

Now many organisations, including the Scottish Government, have realised the value of people with authentic experience in collaborating on the 'national mission on drug deaths' (page 5). The LJWG are among those to go further by making the case for peers as the best people for the job with the highest chance of attracting participation in these vital services (page 6). With the grassroots knowledge and experience embedded in major service providers (page 16) and a keen appetite for collaboration between partners in health, substance use, police and social care (page 20), the time is ripe for making focused, cost-effective – and representative – decisions that will transform the outlook for many.

Claire Brown, editor

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

Heaviest drinkers bought significantly more alcohol during lockdowns

People who were already at risk of alcohol harm bought 'significantly' more alcohol during COVID-19 lockdowns, according to a study by Newcastle University and the National Institute for Health Research (NIHR). People in the top fifth of households for alcohol purchases bought 17 times more alcohol from retail outlets than the bottom fifth, says The COVID-19 alcohol paradox: British household purchases during 2020 compared with 2015-2019.

The research covers the March to June 2020 lockdown period and echoes previous studies which found that those already drinking the most increased their consumption during lockdowns. Households in the North were buying the most alcohol, the study found, with the North East of England consistently recording the highest alcohol-related death and hospital admission rates.

Researchers analysed shopping data from almost 80,000 households over a five-year period, which included around 5m purchases of alcohol. The average purchase per adult in the top fifth group was around 38 units per week – however, as this was averaged out per household it could mean that people in some households were 'drinking much more than this amount'. Households in the North East and Yorkshire and the Humber regions increased their purchases more than in any other part of the UK, 'with the suggestion that this is probably because the North has more socially disadvantaged, heavier-purchasing households'. Less pronounced purchasing increases in Scotland and Wales could be down to the implementation of MUP, say the researchers.

'Our analysis has highlighted that the heaviest drinkers and those living in some of the most deprived communities in the UK have increased their household alcohol purchases significantly during COVID-19 lockdown periods, with undoubted consequences for both physical and mental health – and in many thousands of cases sadly leading to death,' said lead author Professor Peter Anderson. 'This suggests that a focus on policies to reduce high levels of drinking are even more important in extraordinary times, such as those we've seen since March 2020 – where a complex range of factors can lead to higher and potentially dangerous levels of longer-term drinking.'

The findings have renewed calls for MUP to be implemented in England. 'The alcohol harm crisis will continue to deepen if the government doesn't take action now,' said Alcohol Health Alliance chair Professor Sir Ian Gilmore. 'By failing to implement minimum unit pricing as part of its plans for public health, England is now falling further behind the rest of the UK in the race to tackle alcohol harm.'

Study published in the scientific journal PLOS ONE at https://journals.plos.org/plosone/

A focus on policies to reduce high levels of drinking are even more important in extraordinary times.
PROF PETER ANDERSON

'Perfect storm' in young people's services

THOUSANDS OF YOUNG PEOPLE with substance issues are 'falling through the cracks' thanks to a perfect storm of the pandemic on top of years of cuts, according to the Royal College of Psychiatrists (RCPsych). Analysis of NDTMS data shows that the number of under-18s in treatment fell by almost 25 per cent between 2019-20 and 2020-21 to just over 11,000 – 55 per cent fewer than in 2008-09.

Most young people are in treatment for problems with cannabis (89 per cent), followed by alcohol (41 per cent), ecstasy (12 per cent) and powder cocaine (9 per cent). Further analysis of data from the Department for Levelling Up, Housing and Communities found that the amount spent on young people's substance services had fallen in real terms by more than 40 per cent since 2013-14, from almost £74m to just over £43m. Every region in England had made real-terms cuts over the period, including of more than 60 per cent in the West Midlands.

'Children and their families up and down the country are having their lives blighted by drug and alcohol use due to drastic cuts, workforce shortages, and the impact of the pandemic,' said vice chair of RCPsych's addictions faculty, Dr Emily Finch. 'Addiction is a treatable health condition. Intervening early will mean many kids won't go on to have an addiction in their adulthood, keeping them out of the criminal justice system and helping them to live full lives. It's now time for the government to act on their promise and deliver the multi-million-pound investment into drug services.'

Spending on young people's services has fallen by more than 40 per cent since 2013.

Speaking from experience

A NEW 'NATIONAL COLLABORATIVE' HAS BEEN LAUNCHED by the Scottish Government as part of its attempt to tackle the country's ongoing drug-related death crisis. The collaborative will 'ensure the views of people with lived and living experience are reflected in all aspects of the national mission on drug deaths', the government says, and will be chaired by Professor Alan Miller, an expert in human rights law.

Regular forums allowing people with lived experience to make recommendations about improving treatment services will be chaired by Miller, with the rights of people affected by substance use 'recognised in all relevant policy and practice in accordance with the new human rights framework for Scotland'. The country's drug death rate is three times higher than it was a decade ago and remains the worst in Europe by a significant margin. 'Successful delivery of the national mission requires a better way of listening to, and acting on, the voices of those with lived and living experience,' said drug policy minister Angela Constance.

Strong case for peer-led needle exchange service

There is a strong case for a peer-led needle and syringe exchange service in London, according to a report from the London Joint Working Group on Substance Use and Hepatitis C (LJWG). The group has been working with Hackney Council to look into the feasibility of developing a peer-led and delivered NSP with added hep C awareness and testing facilities, using focus groups and interviews with specialists (DDN, December/ January, page 5).

Peers are able to use their lived experience of injecting drug use to deliver education and advice, says LJWG, with a peer-led service able to fully 'embed leadership'. More than 40 per cent of people who inject drugs still report sharing equipment, with hepatitis C infection levels remaining high.

The report, which was funded by Hackney Council as part of project ADDER, looks at the feasibility and acceptability of a peer-led NSP, as well as practical considerations. It found a high level of support among peers, people who inject drugs and commissioners, with an initial three-to-five-year funding commitment able to provide stability for the new service. The facility would be welcoming and non-judgmental, says the document, with people signposted to other essential services. Monitoring and evaluation mechanisms would need to be embedded, with peers delivering the service via clearly defined roles – both paid and unpaid – with training and supervision.

John Birdsall / Alamy

'There is clear support from people who inject drugs, people who work with people who inject drugs, commissioners and from public health specialists for an innovative, peer-based needle exchange service in London,' says the document. 'This will support important public health goals including reducing health inequalities, reducing harms from drug use, and reducing hepatitis C and other BBV transmissions. There are complexities in developing and delivering such a service, which would need to be designed and led by a cross- stakeholder steering committee which will include peers. Robust evaluation mechanisms should be put in place so this service could become a blueprint for services across the UK and beyond.'

> The facility would be welcoming and non-judgemental with people signposted to other essential services.

Scoping project – a peer-based needle exchange service in London at ljwg.org.uk

See feature, page 6

Europeans using more cannabis since pandemic

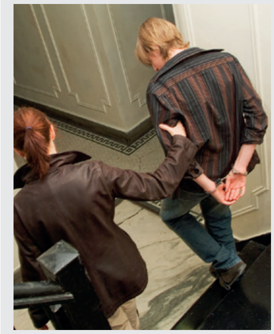
PEOPLE ARE USING MORE CANNABIS since the COVID-19 pandemic, according to a survey of almost 50,000 people by EMCDDA. Cannabis and MDMA were the drugs most impacted by COVID-19 restrictions, it found, with use of 'party drug' MDMA unsurprisingly falling during the same period.

The European web survey on drugs ran during March and April 2021 when many countries were under lockdown restrictions, with responses from across 21 EU member states and Switzerland. The survey targeted adults who had used drugs, with the aim of understanding patterns of use – more than 90 per cent of respondents reported using cannabis during the previous 12 months, with 32 per cent saying they were now using more (herbal) cannabis. More than 40 per cent, however, said that they were using less MDMA/ecstasy.

Last summer harm reduction organisation The Loop warned clubbers and festival-goers to 'pace themselves' as venues started to re-open after lockdown restrictions, particularly as their tolerance may have reduced after a period of abstinence. There have also been reports of an MDMA 'drought' in the UK since lockdowns ended, with production falling due to lower demand and suppliers focusing on trafficking more lucrative drugs for which the criminal penalties are the same. While the European web survey data refer to a 'self-selected sample who have used at least one illicit drug in the 12 months prior to the survey' and are not representative of the general population, when 'carefully conducted and combined with traditional data-collection methods, they can help paint a more detailed, realistic and timely picture of drug use and drug markets', says EMCDDA.

Survey at www.emcdda.europa.eu

Local News



Kentannenbaum | Dreamstime

EARLY INTERVENTION
A three-year project by With You will divert young people in possession of drugs away from the criminal justice system. Re-Frame will run in Cornwall, Kent, Lancashire in Sefton, and will be evaluated by the University of Kent as there remains a lack of robust evidence to understand what works in diversion projects. 'Re-Frame will help fill this gap,' says the organisation.

CAB CAMPAIGN
A Glasgow taxi designed by SDF will promote overdose awareness and encourage people to carry naloxone as part of the 'How to Save a Life' campaign. 'We have been hugely encouraged by the positive reaction from drivers, many of whom have volunteered to carry naloxone kits in their taxis in case of an emergency' said SDF strategy coordinator Kirsten Horsburgh.

GOLD STANDARD
Change Grow Live has been awarded the Investing in Volunteers Standard, which recognises the 'value that an organisation places on volunteering' based on areas like recruitment, training and support. There was a 'non-judgmental approach to recruitment and diversity in the roles offered', commented lead assessor Jane Holdsworth, with volunteers having a 'sense of inclusion and belonging'.

A peer-run needle exchange could be far more open and accessible, says **Elliot Bidgood**

PEER POWER

In January the London Joint Working Group on Substance Use and Hepatitis C (LJWG) launched a new report on the case for a peer-based needle exchange in London – designed by, and run by, the people who know how these services can work best (see news, page 5).

Peers have lived experience of injecting drug use and use this to deliver education, services and advice on safer injecting practices to others. A peer-based needle exchange could still work with other services – such as drug treatment, health or housing advice – but would have this experience at its heart.

In 2020, 43 per cent of people who injected drugs reported sharing unclean needles and works, leading to a preventable rise in hepatitis C infections. This was the backdrop to LJWG's idea to seek funding from Hackney Council as part of the national ADDER Accelerator (addiction, diversion, disruption, enforcement and recovery) project to explore how the idea could work in the London borough. If successful, it is hoped the service could become pan-London, and inspire similar projects further afield.

SERVICE USER VOICE

At the core of this research was a series of focus groups with people who inject drugs and peer workers, in order to build it around their experiences with current services as well as what they would want to see. Jason, a peer volunteer who has used services, said, 'There were lots of ideas at our workshop, everyone had something to say and it was great to hear ideas. Why not have availability at night, or why can't we have access at the needle exchange to other support – health, legal or housing?'

Needle exchange is vital to ensure that 'the people who don't get any service would get clean needles instead of just using what's there', Jason felt, but the peer side of it was important to him. 'There's a big difference between being given a needle exchange from a set worker and deciding what the service is yourself.'

Archie Christian, national training and volunteer manager for The Hepatitis C Trust, helped run the focus groups: 'There was a real positive outcome in sitting down, hearing and understanding the experiences of people who are in that community,' he said. 'And they realised it wasn't just one of those simple "tick box" exercises. That produced an enthusiasm – that they were listened to, that they were understood and that they weren't judged. I believe we could develop a programme of services where everyone involved in the production and delivery of the services, or the majority, have lived experience. Our actual service users or peers that no longer inject are still working within that community. Giving people opportunities to volunteer and pathways into employment can be transformational.'

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CONFRONTING STIGMA

Bad experiences with existing services was a common theme in the focus groups, and in the

RECOMMENDATIONS FOR A PEER-BASED NEEDLE EXCHANGE

- A welcoming place with basic comforts provided.
- A full range of equipment, with people encouraged to take what they need.
- Close links to healthcare, drug treatment and other relevant services.
- Peer leadership embedded in development and design of the service.
- A 'leadership steering committee' with commissioners, providers, police and other services.
- Volunteer or paid roles open to those who are still injecting drugs, to give them a clear role and responsibility.
- Possible outreach services – for example vans, or allowing people to deliver clean works to friends.
- Data monitoring, so we know what supplies people need and how well the service is working.
- A three to five year initial funding commitment for stability and a 'pan-London' approach that works across borough lines.

RichVintage / iStock

work peers from The Hepatitis C Trust do generally. 'Having individuals trained who are actually present on the ground in the communities can overcome a lot of the barriers that they feel are presented to them in terms of from discrimination from some pharmacists and feeling that what they're doing is problematic,' said Archie.

Nathan Motherwell, a Hepatitis C Trust peer who organises needle exchange services in Kent, finds the issues the London focus groups raised are commonplace. 'I think the problems with needle exchange are across the board very similar. If people are going into a pharmacy needle exchange, sometimes there's shame and fear and stigma attached to it – sometimes they're not treated very well. Another barrier is people often get their methadone scripts from places where they would be going for exchange, and they worry they'll be asked "are you using on top?"'

A peer-based exchange could offer a way to upend this model. 'Peers working with peers don't present the same sort of barriers to the community who use injection drugs', Archie argued. 'Because of the way society looks at them, they sometimes feel like they're a burden. You don't have that if it's members of the community providing the service. There's no judgement, no being condescending. You have an opportunity to do something different where the ownership of the service delivery is from the peers. You are taking a different approach of encouraging development, giving people responsibilities. They feel responsible, they grow esteem.'

ACCESSIBILITY

There was emphasis in the groups on openness, Archie reported, as well as links to other services: 'It should be community-based, easy access, no limitations on the amount people can receive. A holistic approach to the whole person and services that are provided. At the very least, the needle exchange, if it was mobile, could signpost to a community service user hub where there's access to more care, more opportunity and more support.' There could be an important role for such a hub in supporting people who leave prison with accessing a wide range of holistic services.

Peers, service users and commissioners offered different perspectives on how much data to collect about service users, but it was acknowledged that this should be light-touch to avoid discouraging people. Nathan suggested that, 'if you want to increase the uptake, the fewer details you take the better because we want them to have clean equipment', but 'a very basic bit of info doesn't really damage it', such as their initials and date of birth – 'the ideal needle exchange is just making it more available'.

WIDER PROSPECTS

The work has already led to some changes on the ground and if it works, it is hoped there could be scope to widen the approach. 'We've seen that some things that have been mentioned in this process have led to changes from Hackney, and we're talking about maybe a pan-London approach', Archie said. 'If we get the goodwill and the buy-in from the commissioners and the local health and justice services, and we look at treating this as a community and public health concern, we can make meaningful changes.' This builds on existing work in New Zealand, Australia and elsewhere, he noted – 'The report had lots of good examples of it working internationally.'

For more information please see www.ljwg.org.uk or email info@ljwg.org.uk.

Elliot Bidgood is a policy adviser with the London Joint Working Group on Substance Use and Hepatitis C (LJWG).

CRUNCH TIME

The drug strategy had the potential to revitalise the sector, heard January's meeting of the Drugs, Alcohol and Justice APPG – but now it was time to deliver. **DDN** reports

The government's new drug strategy came after a decade of major disinvestment, an ideological drive towards localism, and a marketisation of the way services are commissioned and funded, Collective Voice director Oliver Standing told the online meeting of the All-Party Parliamentary Group on Drugs, Alcohol and Justice. But there was now a political willingness to 'spend big bucks – on some areas', he said. 'We've got the Treasury backing this with some major investment, for which a big hats off to Dame Carol.' Once again, however, it was crime that had 'animated the strategy and unlocked the funding.'

Overall the strategy was 'really good news', he said, and it was important to separate the policy detail from the political framing that accompanied its publication. 'Although the phrase "harm reduction" isn't leaping off every page, one of the three key metrics that the strategy picks out is about reducing harm and deaths.'

The focus on workforce was 'essential', he said – and getting that right would be a necessary condition for everything else. 'I'd also include commissioners in that – it's become abundantly clear that the commissioning workforce that will enable these things to be funded and commissioned has been absolutely hammered. We need to be clear that investing in those back-office functions is not taking money from the frontline – we need the infrastructure to support the whole system.' In political terms, the move from PHE to OHID was good news in that 'it's relocating our specialist policy function into a government unit that has an explicit mandate to reduce health inequalities'.

While the focus on crime was clearly politically driven, a huge number of people in the criminal justice system had challenges around drug use and 'absolutely need our help', he said. It was important to 'not lose too much sleep' over the launch's punitive framing and instead 'focus on the good stuff'. Talk of middle-class cocaine use might have accounted for much of the media coverage, but 'if you look at the money there's about £5m committed to that, and £700m on treatment and recovery'.

The acknowledgement that addiction was a chronic health condition was also 'really helpful', said Dr Emily Finch, vice chair of the NHS Addictions Provider Alliance and co-chair of LJWG. 'That comes, of course, after years of being told that people have to get off methadone in the next three weeks and that drug misuse is a lifestyle problem.' Although the strategy's talk about preventing stigma was 'perhaps not entirely supported by some of the language' it was 'good that it's there,' she added.

> While the focus on crime is clearly politically driven, a huge number of people in the criminal justice system have challenges around drug use and absolutely need our help.

The commitment to improve treatment capacity and quality included metrics for numbers of places, but it was important to avoid 'bean counting', she stressed. There was still significant emphasis on performance and accounting, and 'we need to be careful that doesn't become more numbers and less actually doing things' as the sector was already the most performance-managed in the whole of health. 'It would have been very nice to have more emphasis on local creativity, and ability to develop your own targets.'

Allocation of the new money would involve a menu of interventions that local areas would be able to provide, she said. 'That sounds good but again there's a bit of me that says, "Is that going to mean we lose any ability to have individualised, patient-focused treatment, and perhaps a word that's become completely alien – choice? You get what you're given in drug and alcohol services, so it would be nice to offer a broader range of treatment.'

The field now had a real chance to come together, said Standing, and it was important that everyone played their role in damping down any potential conflict 'along the old fault lines of harm reduction and recovery – we've clearly got to have both.' In terms of funding, Dame Black had made recommendations for five years, and the spending review's lifecycle meant 'we've got the first three years of that – our job now is to deliver this really successfully for the people who need help.' It was vital to demonstrate that the system was happy to be scrutinised and have accountability, he stressed. 'If we can do that then we're likely to get years four and five.'

'I think it's very important to understand that the mood in which this money's been allocated by ministers – and particularly the Treasury – is of support for the sector, but with patience running out for the delivery of outcomes,' warned Forward CEO Mike Trace. The outcomes framework and accountability systems would need to be 'really robust', he stressed, with accountability focussing on issues like 'have you reduced crime in your area, reduced deaths, eradicated hep C? That's the sweet spot the Home Office and health are trying to find. But it's crucially important that we deliver the outcomes the community and the government want. Because if not, it will end in three years.' **DDN**

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WEIGHING UP THE

In the second of a three-part series, **Dr Georges Petitjean** and **Deanne Burch** explore different buprenorphine preparations, its use during the COVID-19 pandemic and its safety and cost in comparison to methadone.

Different forms of buprenorphine have been developed since its introduction into the drug and alcohol field as an alternative to methadone. Transdermal patches were launched in Germany and Switzerland in 2001 for analgesia, and buprenorphine/naloxone sublingual tablets (also known under the brand Suboxone) were authorised for marketing in 2017 in Europe. The buprenorphine contained within buprenorphine/naloxone is absorbed sublingually but the naloxone component has a 5-10 per cent absorption, essentially leading to a low clinical effect. However, if the buprenorphine/naloxone is injected this would enable a dose of naloxone to induce opioid withdrawal, providing a reduced potential for misuse.

ADVANTAGE

In 2017 buprenorphine lyophilisate (also known under the brand Espranor) was introduced to the UK market. Buprenorphine lyophilisate had the advantage of dissolving on the tongue, enabling quicker supervision by pharmacists and making diversion less likely. Many drug treatment services switched to prescribing buprenorphine lyophilisate amid the increasing cost of sublingual buprenorphine in an effort to manage budgets. The increased bioavailability of buprenorphine lyophilisate presented an initial challenge for drug treatment services who wished to switch patients from sublingual buprenorphine, as the products were not believed to be dose interchangeable.

METHADONE DOMINATION

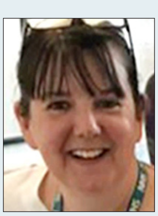
Despite there being good evidence that buprenorphine is as effective as methadone as a form of opiate substitution treatment (OST) for maintenance and detoxification, and its perceived safety, rates of methadone prescribing continue to dominate those of buprenorphine within UK drug treatment services. In regards to its safety, buprenorphine – like methadone – can cause respiratory depression leading to death, but this is more common when buprenorphine is used in conjunction with other sedatives such as alcohol or benzodiazepines.

During the early months of the COVID-19 pandemic drug services closed to minimise the

KEY QUESTIONS

We asked several experts about their views on the differences in cost, the uptake of buprenorphine lyophilisate within treatment services, and the role of the commissioner in supporting the cost-effectiveness of treatment.

What were the differences in cost that presented challenges for drug and alcohol services?



Linda Geddes, lead pharmacist for Inclusion: Around 2019 there was a significant increase in the drug tariff costs for buprenorphine of up to 800 per cent, while methadone costs remained relatively stable. During the same period a number of services saw a reduction in funding received from commissioners.

Affected services needed to review their service model in order to continue to serve the population effectively and give service users a choice on the pharmacological treatment offered. The alternative would have been to employ strict rules on buprenorphine prescribing pathways such as time-limited treatment, having the drug as a second choice on formularies – restricting service user choice – and having stricter rules on testing for illicit substance use.

One solution adopted by a number of services was to implement a buprenorphine pharmaceutical rebate scheme, the application of which did not influence prescribing as the therapeutic intervention already had a place in clinical practice. This provided stability in the cost of the drug, allowing services to manage drug budgets as well as providing significant efficiency savings that could be re-invested into the service. Whilst it is acknowledged that these rebate schemes could undermine the competition required to drive down the costs of medicines, a number of service providers felt compelled to sign up to these schemes in order to remain viable.

Primary care rebate schemes are now a common feature within the UK health system, with a significant number of schemes in operation. PrescQipp (a not-for-profit community interest company set up to help NHS organisations to improve medicines-related care to patients) have created the Pharmaceutical Industry Scheme Governance Review Body (PISGRB) with the sole aim of giving an unbiased view on the available rebate schemes and making a recommendation to commissioners as to whether these schemes can be supported.

Are you able to give us an indication of the estimated savings achieved by drug and alcohol providers following the switch from generic buprenorphine/Subutex to Espranor?

Paul Concannon, senior vice president of commercial operations at Ethypharm: We estimate that since the start of 2019 we have saved the NHS approximately £14,760,000 across all the UK services that have offered Espranor when compared to the generic drug tariff over that period.

BENEFITS

risk of infection within a vulnerable population. Many utilised alternate forms of assessment via telemedicine, and were unable to use drug screens to provide objective evidence of opioid dependence. The result was the rapid increase of sublingual/lyophilisate buprenorphine prescribing due to the perception of increased safety upon initiation. The ability to prescribe buprenorphine in this context enabled service users to continue to receive opioid substitution treatment.

TRANSFORMATION

Rapid changes in practice came with the initial stages of the pandemic, such as the limitations on face-to-face assessments and relaxed daily supervised consumption arrangements at pharmacies. This period brought mixed reports from clinicians and patients, with many patients self-reporting reduced heroin use and more stability on prescribed opioid substitution treatment, whilst many clinicians spoke of concerns around risks.

The transformation of buprenorphine into different preparations has given an opportunity for drug treatment services to respond effectively to changing and emerging risks to patients, but also to organisations. During the COVID-19 pandemic buprenorphine's safety profile was utilised to ensure the continuity of opiate substitution treatment for patients in what was an anxiety-provoking time for clinicians and organisations alike, and lessening the risks associated with not being on treatment.

2019 saw the introduction of the long-acting buprenorphine injection, Buvidal, which has not yet been fully embraced within all drug treatment services nationally. We examine its place in the future of opiate substitution treatment in our third instalment.

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). www.inclusion.org / www.nhsapa.org

The authors have not received any financial or other support from pharmaceutical companies and the articles are their own opinion.

We asked Dr Aldrin De Souza, a GP with special interest in addiction, about his experience of prescribing OST during the COVID-19 pandemic.

THE HALTING OF FACE-TO-FACE CONSULTATIONS in the first lockdown of the COVID pandemic presented a particular challenge on how best to help any new service users. In the absence of the ability to carry out drug screening this process was even more daunting. It involved carefully balancing the risk of prescribing OST in a possibly opiate-naïve individual and the inherent risk of overdose that accompanies that, versus the risk of not prescribing OST and the risk of harm from continued heroin use.

This uncharted territory, with the absence of a drug screen and face-to-face consultation, was unsettling but the recognition was there that we had to adapt to the circumstances, and very careful history taking was even more important than ever. When medication was initiated, buprenorphine was prescribed due to having the lowest risk of overdose in the titration phase. Risk was also reduced further with the benefit of a pharmacist seeing people daily with supervised consumption – robust harm minimisation advice was also given and naloxone kits provided.

Have all drug and alcohol providers switched to Espranor yet? What are the obstacles for some providers who have not switched yet? In your opinion, what would enable them to switch to Espranor?

At this stage, based upon prescription data, we believe that approximately 45 per cent of all oral buprenorphine is prescribed as Espranor in the community in England. In the UK prison estate the percentage is 82 per cent.

The reasons given by the organisations that have not made the move to Espranor include not wanting to use a branded product, not wanting to enter into a rebate agreement and not wanting to engage with a pharmaceutical company. We also had a number of organisations that were planning to move to Espranor in 2020 but were unable to due to COVID. We're hoping to capture further real-world evidence of services that have moved to Espranor to show how easy a change it is, and in particular the patient's positive experience of the product, which we hope will benefit those services not currently using Espranor.

What is the role of the commissioner in finding the most cost-effective drug and alcohol treatments? For example, the switch from buprenorphine or Subutex to Espranor?

Kevin Malone, public health programme manager, Thurrock: Generally I believe the role of the commissioner is to review the available treatments, evaluate the evidence base and design these into a service specification that has structure but leaves space for change/innovation during the life of the contract.

> 'Increased costs for buprenorphine were astronomical and in our case, left the provider carrying the risk due to the terms of our block contract.'

The increased costs for buprenorphine were astronomical and in our case, left the provider carrying the risk due to the terms of our block contract. So we worked together – the provider sought a safe and more cost-effective solution to reduce the financial risk and that had robust medicines management applied, while I sourced additional funding to meet the reduced uplift in costs. This prevented decommissioning elements of the service to afford the increased medicines costs – fundamentally we all want the same outcomes and it was a case of working together during a turbulent period to stabilise service provision and meet the needs of our clients.

What was your experience of working with Inclusion during the COVID-19 pandemic in regards to the increased prescribing of buprenorphine?

During the pandemic we were constantly updated by and reassured that the provider was managing the ever-changing situation. All prescribed clients were assessed for home treatment and storage, and some were retained for daily pick up. Policies and standard operating procedures were routinely revised and proactively provided to myself, reinforcing the sense of safety and transparency at a time when site visits were not possible.

EMOTIONAL SUPPORT

In the second of a two-part article, **Helen O'Connor** talks about the importance of understanding the potential impact of the menopause on service users and how it can affect their recovery.

'It really reminded me of when I was using, and I really hated it...' This quote is from a 2020 TV interview with Davina McCall, who has been open about her history of addiction and has more recently put menopause in the public eye by sharing her experience of the symptoms associated with her own menopause.

As we consider the impact of menopause on our colleagues, we can also improve our understanding of the possible impact of the menopause on our service users. According to the Office for Health Improvement and Disparities (OHID), across our sector 32 per cent of service users are women, and at WDP the largest segment of our women service users is the 35-54 age group, the period where someone is most likely to go through the menopause. How they experience the menopause and how they are supported during it could affect their recovery and mental health.

Perimenopausal women are twice as likely to have depressive symptoms or depression than premenopausal women and suicide rates in women of menopausal age have increased by 6 per cent in the last 20 years despite rates for older women (55+) falling by 28 per cent across the same period. A difficult menopause can affect relationships and often occurs alongside other difficult life events or transitions such as an 'empty nest', divorce, or being a carer for elderly relatives.

If a person's GP does not identify the symptoms they are describing (depression, anxiety, sleep issues, 'brain fog') as being related to the perimenopause, or offer appropriate treatment, that can also be confusing, frustrating, and upsetting.

The largest segment of our women service users is the 35-54 age group... where someone is most likely to go through the menopause.

All of this indicates that the menopause is another factor to consider when assessing risk and developing care plans. This could include looking at how symptoms of the menopause, combined with active substance misuse, might lead to an increase in use as a way of managing moods, increase the risk of suicide or self-harm for some service users, or how menopause symptoms and concurrent life events might introduce an increased risk of relapse for service users who are abstinent.

Hannah Lidsell, an experienced coach and addiction specialist, also feels passionately about these issues. 'Using substances to try and manage debilitating menopausal symptoms, such as anxiety, heart palpitations and hot flushes, can actually exacerbate them,' she says. 'Once you throw in health inequalities, stigma, and unequal access to services, you have the perfect storm for increased use/lapse/relapse.'

In Merton, our service users can access a specialist menopause service. Esha Saha, consultant gynaecologist and lead for this service at St George's NHS Trust, believes that 'asking for help or taking HRT (hormone replacement therapy) whilst undergoing the menopause transition should not be considered as a last resort'. She recommends that women are encouraged to use tools such as the Menopause Quality of Life Scale (MENQOL) to prepare for a discussion with their GP about how their symptoms are affecting their quality of life. It allows them to both validate and score the severity of their symptoms which should be the springboard for a discussion with their GP about the best way to manage their menopause transition. If clinicians, keyworkers, and other professionals are more informed and confident about discussing the relationship between drug and alcohol use and menopause, they can educate service users and signpost them to this tool and other support available.

Fortunately, more information and resources that can improve our understanding of, and empathy for, how symptoms of the menopause transition might affect the individuals we work with are available than ever before. WDP has created a handout of these resources and is combining them with staff lunch and learn sessions to increase confidence about having discussions with service users. The Menopause Charity also offers training for healthcare professionals, some of which is free of charge.

Considering the impact and effects of the menopause should sit within a person-centred and holistic view of the individual. Experiences of menopause can vary – some will have a difficult time with life-changing symptoms whilst others report menopause as being a time of personal growth, or simply a relief and freedom from painful periods.

As we commit to engaging more women into treatment at any age, WDP welcomes the creation of the cross-party Menopause Taskforce, alongside the development of the first ever Women's Health Strategy for England, given our role in supporting people to improve their physical and mental wellbeing, through achieving recovery from problematic substance use.

Helen O'Connor is service manager at WDP Merton

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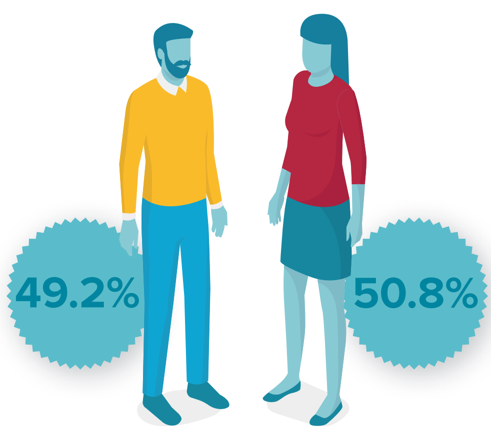
DrinkCoach Alcohol Test Impact

DrinkCoach is a digital alcohol service that supports people with their drinking. Our services, including our two-minute Alcohol Test and 1-2-1 Online Coaching sessions, have supported tens of thousands of people during the pandemic and has provided our commissioned areas with reliable digital interventions for their residents.



8%

Increase in follow up actions after completed AUDIT
(Compared to 2018-2019)

15

Commisioned areas across the UK

over
85K
AUDITS Completed

Estimated cost savings of over
£ 1,200,000
to the health and care economy*

Data from January 2020 - December 2021

*Based on the PHE estimate of £27,000 savings to the health and care economy for every 1,000 Increasing Risk/ Higher Risk drinkers who receive IBA.

Commission DrinkCoach Today

Email innovation@humankindcharity.org.uk or visit our commissioning page for more information.

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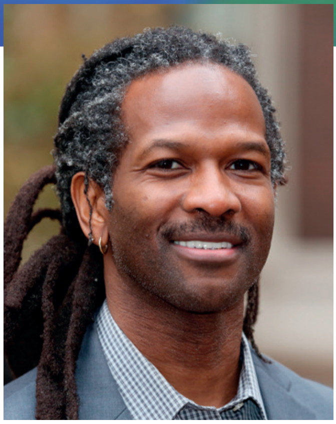
STAND UP… AND BE COUNTED

Drug users have a civic duty to 'come out of the closet' in order to bring about real political change, Professor Carl Hart told Constellations



www.addiction-ssa.org

'Drug control has been used as a tool to subjugate, and has its origins in subjugating specific populations – certainly in the US,' Professor Carl Hart of Columbia University told Harm Reduction International executive director Naomi Burke-Shyne. 'That's why it's important to question the basic assumptions of drug control.'

One of these was that the government 'does not trust you to make the right decisions about what you can put in your body', he said, something that was then backed up with vast amounts of money. 'When you think about all the people who are employed in order to control what you put in your body' – not just law enforcement and prison authorities, but researchers, physicians, the media – 'all of these people have their hand in the cookie jar. That's the real reason this continues, and it helps that the people who are primarily impacted are poor and politically weak.'

Assertions that the 'war on drugs' had somehow failed were therefore wrong. 'It's been a success for the people in control, and the people they give their fruits to' – the 'war on drugs' was essentially a jobs programme, he said. 'If we think that the stated policy is to lessen the availability of these substances in our communities, then at some level it did that. But the unstated goal is to increase the budgets of various groups of people, and it worked there as well.'

One useful aspect of cannabis reform in the US, therefore, was demonstrating to the 'people who have power in our society how they can make money off this endeavour – legally regulating the market,' he said. 'We've seen how the human rights violations, racial discrimination and targeting of poor people hasn't been compelling at all. So we need to really think about how we advocate for change.' There was also a huge amount of people 'who – although we might not agree on a number of political issues – really understand the concept of liberty', he stated. 'At this basic fundamental level of people's liberty, we agree.'

If governments saw drug users as people with political power and a vote 'then maybe we wouldn't have so many repressive laws that have targeted people with less political power', he said, which was why he tried to encourage people to 'get out of the closet' about their drug use as a matter of civic duty. The majority of people using drugs were simply 'seeking to alter their consciousness,' he continued, so 'why aren't we defending their liberty to take them? The vast majority of users of any drug don't meet the criteria for addiction.'

On the question of worrying about who would ultimately control the regulated market, there were more pressing concerns, he told the session. 'We've yet to even have a serious conversation about legally regulating the market. The first goal is to take the chains off, then we can worry about who's controlling it.'

'We've yet to even have a serious conversation about legally regulating the market. The first goal is to take the chains off, then we can worry about who's controlling it.'

PROF CARL HART

There had always been a disproportionate focus on the negative aspects of drug use and it was time to talk about the positive aspects, such as pleasure, he added. 'I upset so many people by saying that sort of thing. Pleasure is a good thing, and it's sad that I even have to say that.'

On the question of changing the language around drug use, while it was as important to be precise 'we don't want to get hung up too much on it', he said. 'Stay focused on the big issue, which is do people have the right to put whatever drug they want in their bodies. There's always risk when you're fighting injustice, but it causes a lot more harm not to do anything.' **DDN**

CONSTELLATIONS

HARM REDUCTION INTERNATIONAL (HRI) is a leading charity dedicated to reducing the negative health, social and legal impacts of drug use and drug policy.

The charity promotes the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies.

Arranged to coincide with HRI's 25th anniversary, CONSTELLATIONS was an online event in November 2021 which celebrated HRI's activism and achievements in the field over a quarter of a century. *DDN* was HRI's chosen media partner.

'Through panels, interviews, town halls, poetry readings, art and music, our community gathered to connect, to explore innovative solutions, to have urgent conversations and to redefine what harm reduction is and what it can be,' said HRI.

For more information: www.hri.global

THE PLEASURE PRINCIPLE

The 'Last night a DJ saved my life' session at Constellations heard from speakers across four different continents on the subject of drugs and pleasure on the dancefloor

'I'm a clubber, and I didn't feel the experience of clubbing was particularly well-represented in mainstream narratives and discourses,' senior lecturer in criminology at the University of Greenwich, Dr Giulia Zampini, told the *Last night a DJ saved my life: a meaningful discussion on the role of drugs and pleasure on the dancefloor* session. 'There was a lot of stigma and misunderstanding.'

She had launched a project called 'People and dancefloors' in order to bring clubbing stories to life, emphasising the positives – including taking drugs. 'It was quite refreshing to see how people were more than willing to share, coming out about their drug use on camera, which in many contexts – including the UK – can have repercussions in terms of reputations and jobs.'

'I've always been an avid partygoer,' Ayodeji Ayoola, a Lagos-based cinematographer, told the session. 'But drug use in Nigeria is generally illegal, including alcohol in some parts of the country where you could get arrested for drinking a bottle of beer.' There was almost no positive conversation about drug use in his country, he said – 'and zero conversation about pleasure. It's sad, but it is what it is.'

'I share with many drug users and women the pressures of guilt in many everyday situations – the personal is political,' said Columbia-based Alejandra Medina of the Acción Técnica Social NGO. Her organisation worked closely with partygoers, party organisers and the media on issues of harm reduction and pleasure enhancement, and to get across the message that 'substance users can actually enjoy themselves without guilt and without risk. As the others mentioned, raving and having fun is stigmatised and seen as immoral, even in the 21st century'. Her organisation was often condemned for being 'promoters' of drug use, she said.

Not being honest about the benefits and pleasures of drug use had been a 'real disservice' to the harm reduction movement, said Mitchell Gomez, executive director of US-based organisation DanceSafe. 'People are so heavily propagandised by the drug war, and taught things that are just demonstrably untrue. Even the term "harm reduction" implies that harms are intrinsic to drug use. It's deeply concerning to me that we focus so heavily on the harms when the vast majority of people are non-problematic substance users – they're just people who use drugs.'

Many of his organisation's activities, such as drug checking, were less harm reduction than 'drug prohibition harm reduction', he said. 'If there were legal, regulated markets, then most of what DanceSafe does wouldn't be necessary. The existing UN declaration on Human Rights is entirely incompatible with governments telling you what substances you can or cannot use – the drug war is fundamentally an anti-human rights policy. As harm reductionists and public health professionals we need to start being very, very honest about the fact that most users benefit and receive pleasure from their drug use.'

'We need to come out of the psychoactive closet,' agreed Medina. 'We want to empower our collective right to have a pleasurable experience, and we need to be able to shake off that guilt that's more about the lack of market regulations and the political will to accept that a drug-free world is not possible.'

While the dancefloor was one place where pleasure-seeking was more allowed than in others, in wider society there remained a 'double social taboo', said Zampini, with both drugs and pleasure itself in many ways still taboo subjects. 'We keep pleasure as a dirty secret,' she said, partly because of a religious underpinning that pleasure was sinful and something to be controlled or repressed.

Although manifested differently, this was shared across all cultures, she said. 'We still carry the remnants of that – this is where we're still at. But we're all driven by pleasure, we're all pleasure-seeking beings.'

People's perceptions of drugs had been framed by prohibition, but it was fair to say that many pleasurable activities, including sports, carried some risk, she continued, and one way to move away from concepts of guilty and risky pleasures was to foreground mental health. 'People are passionate about it, and it gives individuals the power to advocate for their own health. So they can say, "My experience of taking ecstasy is that it makes me feel good'. I feel we should really harness that shift to transform the discussion. Maybe then we can start talking about healthy pleasures.'

'As the years go by there will be change,' said Ayoola. 'Whether it's slow or fast it's change, and we'll take whatever it is we get.' **DDN**

peopleanddancefloors.com

'Both drugs and pleasure are still taboo subjects. We keep pleasure as a dirty secret, but we're all driven by pleasure, we're all pleasure-seeking beings.'
DR GIULIA ZAMPINI

OUT OF HARM'S WAY

Peter Furlong is Change Grow Live's new national harm reduction lead. Here he talks about his career journey and the need to focus on saving lives

After working for Change Grow Live for more than 12 years in various roles I am now starting in the new role of national harm reduction lead, and I fully share the organisation's ambition and commitment to ensuring harm reduction is a priority in our response to the new UK drug strategy. Reducing harm and drug-related deaths must be at the forefront of our minds.

I hope that the debate around abstinence vs harm reduction has run its course, as both approaches can play an important role in drug and alcohol treatment. As we respond to meeting the objectives set out in the strategy, I would like to see harm reduction beliefs and practice at the heart of treatment services, alongside the confidence and hope that abstinence is possible if chosen as a treatment goal. Harm reduction interventions and meaningful support towards abstinence can of course sit within the same continuums of care, with many of the Dame Carol Black report's recommendations reminding us of the need to revisit areas lost to disinvestment or policy changes.

EARLY DAYS

Starting as a volunteer for Merseyside Drugs Council (MDC) in 1996, I knew I that wanted to learn more about drugs and hopefully help some people close to me with their challenges around substance misuse. This was particularly driven by the arrival of cheap brown powder heroin in the '80s and crack cocaine in the '90s. My thoughts and feelings about drug and alcohol treatment at that time included anger and frustration, and of course compassion for the people involved – this anger largely stemming from seeing some people very close to me not getting the support or treatment they needed. This included losing an uncle to an avoidable death from him contracting HIV through his injecting drug use – in the early '80s his illness was treated like a shameful event surrounded by mystery. I came to the stark realisation that better, more humanistic basic treatment and access to clean injecting equipment could have helped prevent his death.

My own rapid affiliation with harm reduction approaches and interventions was again led by poor treatment access in the '90s. It was common to see five-year waiting lists to access specialist substitute prescribing when I began volunteering in Merseyside. Keeping people as safe as possible from all of the harms associated with drug use at the time centred around increasing access to clean injecting equipment, and safer injecting advice. It also involved promoting then-new messages around the risks of BBVs and sharing paraphernalia, as well as outreach methods to seek out people who did not have access to basic health care and support. As an outreach worker and non-clinician, I often found myself sitting with people who had to share drugs to avoid withdrawal, or were forced to attempt self-detox with no clinical support. By default I was providing advice and guidance on things like their injecting practice, more hygienic drug use, and promoting peer-to-peer support and advice when possible.

From volunteering I started work in the well-known Maryland Centre in Liverpool, where I had the opportunity to learn from some great people in the field. I also worked with the activists who established the now globally famous 'Mersey model' of harm reduction and went on to train others in what I see now as an approach grounded in the Hippocratic Oath of 'first do no harm'.

HARM REDUCTION HEROES

Some of these harm reduction heroes, such as Professor Pat O'Hare, Alan Parry and Alan Mathews, led the way in the late '80s, and much of my own learning came from great tutors and influencers such as Alan McGee, Jon Dericott, Andrew Bennet, and many more. The Maryland Centre opened up a whole

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WHAT DOES HARM REDUCTION MEAN?

I was once asked by a group of newly qualified social workers what harm reduction meant to me. Without much forethought, I said something like 'it's a common sense, pragmatic response to someone's drug and alcohol use. It's a bit like all cars being fitted with seatbelts, or dental hygiene and hand washing that we all take for granted, but with the same principles applied to offering people basic compassion and respect in keeping themselves safe.' Of course it means much more than this – from the non-stigmatising language we use to greet and engage people, to easy-access low-threshold services, specialist prescribing and optimised dosing and treatment, treatment has to be both accessible and attractive to the people who need it.

We know the reality of how poverty, class, racism, social isolation, trauma, discrimination and other social disparities affect people's vulnerabilities. The harms that can arise from drug and alcohol use demand a response that is grounded in harm reduction. I regard people who use drugs to cope with trauma with real heartfelt compassion, because that person is me with the winds of fate blowing a different way.

> I would like to see harm reduction beliefs and practice at the heart of treatment services, alongside the confidence and hope that abstinence is possible if chosen as a treatment goal.

new world of learning for me. It taught me about working with the most marginalised and vulnerable groups of people, the many benefits of needle and syringe programmes, street outreach work, low-threshold prescribing and HIV prevention. This experience has stayed with me throughout my career.

For the next 20-plus years I have worked in the third sector in various roles. Thankfully, I've seen significant positive changes and improvements in the delivery and quality of drug and alcohol treatment in the UK. My excitement and ambition for the new role of national harm reduction lead in Change Grow Live are huge, as is the organisation's commitment to reducing drug-related deaths and improving quality of life for people who use substances. We are determined to ensure that people across the sector and partner agencies are informed, confident and competent in offering harm reduction interventions where every contact counts.

We are committed to invaluable cross-sector workstreams such as providing more life-saving naloxone, encouraging more people into treatment, and more outreach, especially for people living alone or isolated from support. More and more evidence points towards the harm that untreated or undiagnosed long-term health conditions can bring to people who use drugs or alcohol, and we want to ensure that people are able to access the mainstream healthcare treatment they deserve.

MEETING OURSELVES WHERE WE ARE

The terminology and language we use to describe approaches and strategy often changes. I personally like 'meeting people where they are' in their own journey and ensuring we provide individualised interventions for each person's presenting needs.

The sector has changed a lot over the last few decades, and harm reduction has not always been as much of a focus as it should have been. Noticing the sector's changing shape, with budgets increasing then shrinking with treatment targets/outcomes changeable and more focused on discharges, and the casualties of staff development, training and key competencies around some harm reduction interventions have not always been as high as we would envisage or aim for.

We must look at the UK and the rest of Europe's approaches to harm reduction, learn what we can from the pandemic, and take on board the recommendations of the Dame Carol Black review. Then we can refocus and revitalise our collaborative approach to harm reduction principles and help to improve the experiences of the people who use our services.

The pandemic stopped us all in our tracks. Every day new situations tested our ability to keep vulnerable service users safe. The very harm reduction principles that have improved our practice over time became more important than ever, and demonstrated the real importance of safe clinical practice.

The new UK strategy allows us the financial and strategic re-investment to ensure the support we offer is grounded in the guiding principles of reducing the harms associated with drugs and alcohol, and helping people to change the direction of their lives.

Peter Furlong is national harm reduction lead for Change Grow Live

GOODBYE DEAR MARCUS

Last month we had to say goodbye to our much-loved friend and colleague Marcus, who died on 3 December from a short and sudden illness. Many of you will have met him as part of the *DDN* Conference team and while working with us over the past 15 years. Funny, original, creative, loyal and great company, he was generous in sharing his own experiences and battles with the treatment system to try and improve services. He is a great loss and not just to those of us who knew him well. Our condolences to his beloved wife and soulmate Maddy, who will always be in our thoughts.

HOW DRY WAS YOUR JANUARY?

'The number one sign of a successful Dry January is that you've learned something about yourself that you can use in the future to take, or keep, control of your drinking,' says Dr Richard Piper, chief executive of Alcohol Concern UK. The charity runs the campaign, which began with 4,000 people taking part in 2013 and has now attracted participation from more than 130,000.

FEELING MOTIVATED

Although I had participated in Dry January before, I had never downloaded the Alcohol Change UK app. By downloading this app, I received motivational emails from Alcohol Change UK nearly on a daily basis and these really did help me feel good about myself and the positive effects that not drinking alcohol was having on my body. Although I only used to drink around eight units on a weekend, the temptation was still there at times, so I definitely did appreciate the 'keep going, you're doing well' emails from Alcohol Change UK!
Cerys Humphreys, by email

MADE ME THINK

I have never taken part in Dry January. I know that many people have a problematic relationship with alcohol, and I appreciate how fortunate I am to be able to enjoy alcohol at a moderate and safe level. Discussing the campaign with my friends and colleagues we agreed the idea of 'giving up' alcohol in the middle of winter was not an appealing one, so I didn't.

Out of curiosity I did read some of the news reports and stories covering the campaign in *DDN* and the national press, and following that I looked at the Alcohol Change website, downloaded the app, and did a quick tally of when I was drinking and why. The result was that I was surprised at the amount I was casually consuming and the occasions that I associate with having a drink.

While I didn't feel the need to commit to a completely dry January, the campaign did help me to look at my drinking and resulted in several positive changes. Did I really need a 'swift one' at the cinema before the film started? Does a gin and tonic really take the edge off a Monday? I also discovered it is possible to meet a friend somewhere other than the pub!

Despite not completing dry January I am grateful to the campaign for helping me to look at my alcohol consumption and as a result make several meaningful changes that will continue with me long after the month itself.
Sarah King, 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.

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OUTREACH GOES BACK ON THE ROAD

5 WAYS members (L-R): Shaar Jackson, Michelle Regan and Nick Davis at the University of Leeds

The Leeds recovery centre 5 WAYS is back to delivering their Recovery Wrx outreach events in person. Due to coronavirus the sessions had moved onto Zoom but they hit the road once more in January, with an event for mental health nursing students at the University of Leeds.

The centre has been running the sessions for five years for a variety of audiences including those in approved premises, universities, charities and social care services. Through real-life experiences and personal stories, its members highlight that recovery from significant problems with alcohol and/or drugs is possible.

'It's about demonstrating visible recovery and challenging some of the prejudices, beliefs and stigma that can go along with problematic alcohol and drug use,' said Helen Mason, senior practitioner at 5 WAYS. 'They show that people can move forward with their lives, free from addiction, and go on to achieve amazing things."

The sessions are very tailored to the audience, she explained: 'Depending on who we are talking to it could be about inspiring others who are still struggling with issues. If we are speaking to health or social care professionals, we focus on helping them see beyond stereotypes and prejudices.'

'Everybody's route to recovery is unique to them,' said 5 WAYS member Michelle Regan, who spoke at the University of Leeds event about her recovery journey. 'We are able to impart three very different experiences of addiction. By speaking to students, we are bringing reality, warts and all, to supplement the classroom theory. In my experience, life certainly isn't textbook ideal. What was great was the students really welcomed us, with a few coming to express gratitude at the end.'

The 5 WAYS team are scheduling a series of face-to-face sessions in West Yorkshire for the rest of the year. For more information email 5ways@forwardleeds.co.uk

I AM A...

Steven Baker is an alcohol recovery practitioner at the Essex ARC service

My working week is currently split between home working and being based in our Harlow office. I provide support, advice and information around alcohol use for adults living in Essex – the work is varied and keeps me very busy.

My diary is normally fully booked two to three weeks in advance, with a mixture of client calls, face-to-face appointments, group sessions, child protection meetings and professionals' meetings, with the odd home visit thrown in for good measure.

While my role deals with issues that arise as a result of alcohol use, I also end up learning a lot more about my clients and why they drink. I try to provide coping strategies so our clients can begin to address these issues rather than trying to use alcohol to resolve them.

My background is group work and I personally find this the most rewarding. I can plan a session as and when required, but I also do some of my best work by thinking on my feet and tailoring the session to the client's needs. When they ask me a question, we take time to reflect on what they have just said and what they have told me previously. Often this helps people find the answer to their own questions. I like to keep the group informal and will always try to end on a positive and with them leaving the room (virtual or physical) with a smile on their face.

To anyone considering making a career within the alcohol recovery sector, I can honestly say that no day is ever the same. Our clients can experience highs and lows which take us all by surprise. The important thing is to be responsive to their needs and available when they reach out for help. This type of work is a chance to put something

'My background is group work and I personally find this the most rewarding.'

back into the community. For those clients that go on to be volunteers or peer mentors, it is extremely rewarding to see the progress they have made.

I have had the privilege of working for Phoenix Futures and Essex ARC for nearly three years now. I am passionate about the job that I do and have worked with some interesting clients and colleagues, all of whom have helped me to develop as a practitioner and as an individual.

OUR 'I AM A...' CAREERS SERIES aims to share knowledge and experience of different careers in the sector. You can take part through the 'get in touch' button on our website: **www.drinkanddrugsnews.com/i-am-a/**


A systems-wide pledge is transforming working practices in North Yorkshire, York and Selby, say **Dr Stephen Donaldson** and **Dolly Cook**

BRIDGING THE GAP

For service users with complex substance misuse and mental health needs, it's common to use terms such as dual diagnosis and co-existing conditions. While language is important, the reality for people who need help is that this debate can lead to a 'chicken or egg' scenario where they, their needs, and their hopes for recovery become lost in the cracks of who offers what within the limits of commissioned services.

Within North Yorkshire, York and Selby, as an attempt to come together across services, we've had in place for many years the Dual Diagnosis Network – with partner agencies from health, substance misuse, social care, police and wider services all collaborating to share learning, training and a hoped-for vision for a better way of joined-up working. However, we've also worked to build connections, offer system-wide supervision, and hear the valued work each other is doing to support a person-first approach. The hope is that by connecting the gaps between us and our services are reduced.

While each service has operational policies to support joined-up working we've acknowledged as a group that there remain times when the care for service users who experience complex dual diagnosis needs is not always as we would like it to be. As a result we decided to build a clear pledge to be better together, as individuals and services, so as to work in a way that truly and collaboratively joins up around the needs of service users.

While this is currently a work in progress, we've been spending time looking at building awareness of the challenges to system-linking, building a network of supportive 'phone-a-friends' and identifying how to share and spread our vision and enthusiasm to make every person's experience of services truly joined up and connected. Many involved in this process highlighted that, while the infrastructure was important, it was the connections with people that made the difference in terms of managing barriers to care across services. For many of us, examples of high-quality patient care were those where clinicians were connected across the system, open to new possible approaches, leaning in at times of challenge, linking in with each other, having a face to a name, feeling safe to challenge the prevailing viewpoint, and asking for help.

By holding our three principles (see box) in all conversations and interactions, we all felt that the quality of care we provide can continue to be improved, and allowed for challenging yet healthy conversations to support the needs of those in our services – so they remain at the centre of what we do.

Working towards system togetherness is not without its challenges – funding, commissioning boundaries and attitudes can impact on what togetherness and system linking can realistically achieve. However, the common goal of supporting those with complex co-existing conditions should always be at our heart. So far, the pledge has been developed and is being signed up to by many of the key partners in our area. Watch this space to find out what we can achieve.

Dr Stephen Donaldson is a highly specialist applied clinical psychologist at Tees, Esk and Wear Valleys NHS Foundation Trust

Dolly Cook is locality manager at Changing Lives

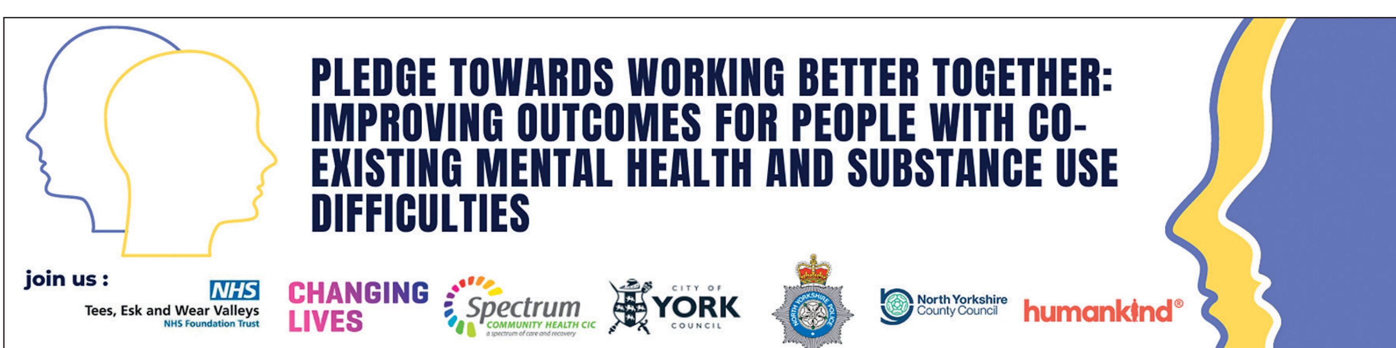
OUR THREE PRINCIPLES

The work we have done to understand and change our practices as system leaders resulted in several key principles to hold in mind when working together. These were:

1) **The person comes first** – Where multiple teams are involved, we will strive to communicate effectively and have an approach where the needs of the people we support are held in mind by all services at all points of access

2) **Let's talk** – The vision is that each agency will be open to offering connection on a 'phone-a-friend' basis, offering to help within their limits to ensure the person comes first.

3) **Commitment to sharing training, learning, expertise and emerging practice** – The vision is that each partner agency will share training, learning and practices with each other to build a wider skill set to support the needs of service users across the system.



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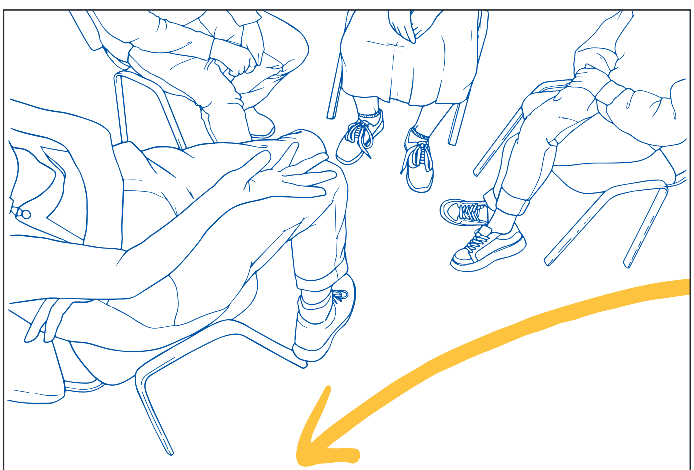

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