DDN

Drink and Drugs News
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FAIR PLAY
Respecting lived experience

RULES OF ENGAGEMENT
Becoming genuinely trauma-informed

EVERY WOMAN

STANDING UP FOR GENDER-SPECIFIC SERVICES AND SPACES

EXCHANGE SUPPLIES

A social enterprise*

***Social enterprise** *v.* **1.** A business driven by a social mission, and using commerce to achieve health and/or social objectives. **2.** A company whose profits are invested in promoting activism or innovation for social good. **3.** An organisation that offers training and employment opportunities to those discriminated against in the workplace.

EXCHANGE SUPPLIES
MAKING INJECTING SAFER

DDN

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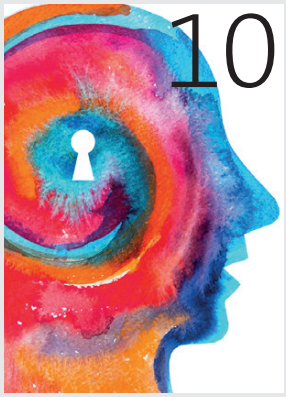

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STAYING STRONG IN PARTNERSHIP

'We are proud of our history but filled with excitement for the future.'

Andy Furlong on the **Swanswell-Cranstoun** merger in our **Partner Updates** at **www.drinkanddrugsnews.com**

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We must be genuine in our efforts to be responsive

The number of women dying a drug-related death has increased by a staggering 80 per cent in the last decade, which is why we're keen to support an initiative to improve women's access to treatment (p6). We need to replace failing practice with a new system that puts women at its heart, says Karen Tyrell – well illustrated by The Oasis Project's inspiring work (p8).

With the vast majority of people in drug and alcohol services reporting mental health problems (p10), similar giant strides are needed in developing services with an integrated approach to mental health difficulties and substance misuse. We're still creating barriers to accessing services – 'address your substance misuse before you can have mental health support' – instead of accepting that there's no neat pattern of behaviour. As the team from Bath explore (p12), most people experiencing addiction have had traumatic experiences in their lives, so we need to be genuine in our efforts to learn about and respond to this.

If there's ever a temptation to create a service model and then expect people to fit to it, the distressing story on p16 should serve as a warning. How much time, money – and sheer anguish – could have been saved by consulting the patients as equal partners?

Claire Brown, editor

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

Fifty areas to get enhanced treatment funding

Fifty of England's most deprived areas are to receive 'significantly more' funding in 2022-23 to bolster their drug and alcohol treatment services, says the Department of Health and Social Care (DHSC). While all local authorities will receive additional funding as part of the government's three-year £780m investment in treatment announced late last year (www.drinkanddrugsnews.com/government-announces-largest-ever-increase-in-treatment-funding), those areas 'most affected by drug-related crime and addiction' – including Birmingham, County Durham and Leeds – will receive additional funding totalling £300m over the three-year period.

The money will help to improve access to treatment and increase the capacity of services, said health secretary Sajid Javid. 'This is a significant step in our commitment to rebuild the drug treatment system, save lives and level up the country.'

'It is encouraging that on top of the additional funding for all local authorities, the 50 authorities most in need will be given further money to support their treatment programmes,' added Dame Carol Black. 'This is crucial to rebuilding the treatment and recovery workforce and enable harm caused by drug misuse in our most deprived areas to be reduced.'

The government has also announced plans to enhance its Project ADDER scheme through 'more intensive oversight' by the criminal justice system. A support package will be provided to all opiate and crack users in ADDER areas, it says, while people who commit 'neighbourhood crimes' like burglary, robbery or theft will be subject to 'joint probation and police supervision', with more frequent contact from the authorities and improved information sharing between agencies. The plans will also see greater use of community sentences with drug rehabilitation requirements, drug testing and 'stronger electronic monitoring options', the government states.

The initial local authorities assessed as being 'most affected by drug-related crime and addiction' include areas in County Durham, Leeds, Birmingham and Devon. Pictured: Foodbank sign in Leeds, March 2022, by riddypix/Alamy

Extent of drink spiking unknown, says committee

LACK OF AVAILABLE DATA means that the 'true extent' of drink spiking in nightclubs and bars remains unknown, says a report from the Home Affairs Committee. The report calls for a focused approach to make sure suspected incidents are better investigated and to build up a knowledge base.

Spiking incidents can include putting drugs such as GHB or prescription medications into someone's drink, or adding more alcohol. Spiking is likely to remain an 'invisible crime' unless more is done to improve awareness and support victims, the document says, with issues around data collection a significant barrier to policing.

The government is currently considering the creation of a new spiking criminal offence, and the committee also wants to see police forces carry out forensic testing more quickly and 'to a quality that can be used in court'. 'There needs to be a concerted effort to stamp out spiking,' said committee chair Dame Diana Johnson. 'Much more work needs to be done to improve understanding and awareness so that people are reassured that the help will be there should they need it.'

Report at https://committees.parliament.uk/

Spiking is likely to remain an 'invisible crime' unless more is done to improve awareness and support victims, the document says, with issues around data collection a significant barrier to policing.

'Lax' drug driving laws

THE DEPARTMENT FOR TRANSPORT (DfT) has launched a call for evidence on whether people convicted of drug-driving should be required to undertake rehabilitation courses before being allowed to drive again. While deaths and injuries related to drink driving are now 'very rare' in the UK, says DfT, more than 700 people were seriously injured in drug-driving collisions in 2020, up from under 500 in 2016.

'Drink-driving is now rightly seen as a social taboo by most of us in this country and we have worked hard to drive down drink-drive related deaths,' said transport secretary Grant Shapps. 'But if we are to make our roads safer still there is no room to be lax on drug-driving, which is why I have launched this call for evidence today. It's only right that drug-drivers must undergo rehabilitation before getting back behind the wheel, helping protect the public from this hidden problem and stamping out drug-driving for good.'

Protecting the public from repeat drug-driving offenders: call for evidence at www.gov.uk until 28 June

Harm reduction focus for first Biden drug strategy

US president Joe Biden has sent his administration's first *National drug control strategy* to Congress, focusing on a whole-government approach to the country's 'overdose epidemic' – almost 107,000 people in the US died a drug-related death in the 12-month period to November 2021.

The strategy is the first to 'champion harm reduction to meet people where they are and engage them in care and services', the White House states, as interventions like naloxone and NSP are often still restricted or underfunded at community level. Less than 7 per cent of the 41m people needing treatment for substance issues were able to access it, according to the *2020 national survey on drug use and health*. The strategy calls for more access to interventions like naloxone, NSP and fentanyl test strips, and directs federal agencies to integrate them into care systems.

The administration's efforts to expand access to treatment will focus on high-risk populations like people experiencing homelessness and people in – or leaving – prison. 'The Biden-Harris administration is committed to deploying an evidence-based approach to policy making,' the White House says, combined with a focus on addressing trafficking and supply.

'We applaud the Biden-Harris administration for taking the historic step to support access and funding for harm reduction services and reduce barriers to life-saving medications,' said Grant Smith of the Drug Policy Alliance NGO. 'Despite over 1m lives lost to drug overdose over the last 20-plus years, this is the first time an administration has included harm reduction in the *National drug control strategy*.

The administration should continue to focus on its promise of equity by decreasing racial disparities in drug policy and the overdose crisis. Criminalisation approaches only saddle mostly Black, Hispanic and Indigenous people with criminal legal records and often incarceration, which increases their risk for infectious diseases, overdose and death.' Prioritising spending on public health rather than enforcement was the best path forward, he stated. With the overdose crisis 'now costing the US economy over $1tn annually we must embrace the evidence-based public health approaches we know work and save lives. But it must be done outside of the harmful apparatus of the drug war to be effective and provide the kind of racial equity this administration has long promised.' *Strategy at www.whitehouse.gov*

'...historic step to support access and funding for harm reduction services and reduce barriers to life-saving medications.'
GRANT SMITH

Gambling ads banned from using content likely to appeal to under-18s

GAMBLING AND LOTTERY ADVERTISING will no longer be able to use content 'likely to be of strong appeal to children or young persons', the Committee for Advertising Practice (CAP) has announced. This means that prominent sports personalities, celebrities and social media influencers will no longer be able promote gambling brands if they are popular with those under 18. The restrictions, which will come into force in October, cover 'all sportspeople well-known to under-18s' – including topflight footballers and those with large social media followings – as well as people from reality TV shows popular with young people, and any references to video game content.

The announcement follows a consultation by CAP launched partly in response to research by GambleAware which found that even advertising abiding by the existing codes had 'more potential than previously understood' to adversely affect children or vulnerable people (*DDN*, November 2020, page 5). The All-Party Parliamentary Group (APPG) for Gambling Related Harm has previously called for all gambling advertising to be banned. 'By ending these practices, our new rules invite a new era for gambling ads, more particular to the adult audience they can target and more befitting of the age-restricted product they're promoting,' said CAP director Shahriar Coupal.

Guidance on gambling and lotteries advertising at www.asa.org.uk

Local News

ONSITE SERVICE

Humankind has opened what's thought to be the UK's first pharmacy technician-led community dispensary embedded in a drug service. Staff at the Home Office-licensed facility at Calderdale Recovery Steps are now able to dispense medications like methadone and buprenorphine onsite. 'We're really pleased to be able to offer another option for people who may otherwise remain at greater risk of drug-related death,' said Humankind's director of pharmacy Roz Gittins.

TALKING THC

Forward Leeds' RespectTHC campaign has been raising awareness on the increasing strength of cannabis and risks of regular usage with city-wide events and a social media campaign. 'We want people to think about whether they have some level of dependence on cannabis and to feel comfortable in approaching us so they can make positive changes,' said manager James Barrie. *www.forwardleeds.co.uk/advice/respect-thc/*

BROAD CHURCH

Glasgow's Woodlands Methodist Church has held a Recovery Rising exhibition and symposium to set out a vision of what a recovery-focused services could look like, attended by drugs minister Angela Constance. The church was exploring ways to bring 'compassion and love' to the debate by 'fighting stigma and blame and fear toward victims of addictions', said its minister Laurent Vernet.

Women in the sector are using their power to collaborate and demand change, says **Karen Tyrell**

STAND UP AND BE COUNTED

Over the last decade, the number of women dying drug-related deaths has increased by almost 80 per cent, yet the number accessing treatment has remained stubbornly static. This means that there are likely to be many women out there who are facing substance use alone and this needs to change.

Despite this gender disparity in terms of the people who access services, from a staffing perspective approximately 70 per cent of people employed in the substance use treatment sector are women and many of them work in services. I was one of those front-line workers when I began my career more than 20 years ago but as I've progressed my career the number of female colleagues around me has dropped.

This lack of women in senior roles has meant that the opinions and experiences of women have often not been heard during decision-making discussions and this, combined with very little gender-specific research, has led to the needs of women not being considered in the design of services. For example, it's a lot more difficult to pick up a script every day or attend a group session if the pharmacy is on the other side of town, you don't have access to a car and you have two children in tow.

Women are also a lot more likely to fall into the category of 'hidden homeless' – sleeping on friends' sofas or staying in bedsits and who therefore won't be connected to services through street outreach staff or hostel workers. Not to mention the fact that women who use drugs or alcohol often face additional stigma which can make accessing services more daunting. A lack of recognition of the inherent challenges that women face has led to:

- *There being no female-only inpatient detox facilities*
- *Vastly fewer choices for women who want female-only residential treatment*
- *No consistent access to specialist midwifery for women in substance misuse*
- *No specialist services for women struggling with both addiction and the menopause*
- *No national minimum standards for women's treatment*

'I'm not sure, with the exception of a few specialist organisations, if we ever had the specialism needed in the sector to fully support women,' says national head of service, public health and substance misuse at Turning Point, Nat Travis. 'Traditionally, providers have always seen a greater proportion of males in treatment, often in the region of two thirds to one third and we need to change this and ensure that we provide the right opportunities for women to engage with treatment, and that our treatment offers them what they need.'

I'm pleased to say that the sector is now working together to address this issue. Last year, I saw Hannah Shead, CEO of Trevi, present about the female-only residential treatment service her organisation runs. She was really compelling and

> 'I feel like I've been able to open up more and talk about more. It means I've been able to properly deal with the trauma. A lot of my problems stem from domestic violence, I wouldn't be able to talk about that with men.'
>
> TREVI SERVICE USER

CASE STUDY

LORNA: 'The women's group I attend is quite mixed in terms of age, ethnicity and life experience. We talked early on about what being a woman means to us as individuals and I think that allowed us to be open with each other. Each woman's story is different but we all share the experience of being a woman and having a woman's body. I believe that those shared experiences allow us to connect better than in a mixed group.

I feel it is a more relaxed atmosphere and that conversations flow more easily without men being present. I know I feel safer, more open and less guarded than in a mixed group. I believe that such safety has been the catalyst for me being able to be more reflective, to listen to other women and to support them. It has made an enormous difference to my mental wellbeing. The group has also helped me to feel a greater sense of personal worth and self-esteem. I feel like I'm getting myself back and that I'm becoming a more whole person.'

Lorna attends HAGA Alcohol Service in Haringey

I reached out for a chat. This got us to thinking about why there isn't a place for women to come together and use our collective power and voices to improve things at the front line for the women our services are here to support. So we decided to set up a women-only space, under the banner of Collective Voice, but with a broader membership (*DDN*, April, page 5).

From the start, we've tried to come at the problem from a different angle than other cross-organisational meetings (which in themselves are a fairly rare occurrence). We are a time-limited group – we've collaborated to build a shared understanding of the problem, and we recognise that focussing on women's issues are a small fragment of our day jobs. We are forgiving, kind and unafraid. We've tried hard to come together with a different perspective. We don't come to the meetings as representatives of our organisations, or to tell each other how brilliant our organisation is. We come together as women. We share jokes and have developed a space for psychological safety. It's given us an opportunity to be bolder and to focus more on the needs of women – something we've all wondered if we could have done more of in our day jobs, or, as in my case, across my career.

Our aim is to improve the treatment offer for women who access drug and alcohol services, by bringing together senior women with a passion to improve things. We want to ensure specialist women's drug and alcohol provision is available to all women, irrespective of treatment delivery type or geography, as a right. This means access to gender-specific (and women only) services and spaces; inpatient detoxification, residential treatment and community service delivery.

'We need to ensure our services not only meet the needs of women but are attractive to women. There is so much more we can do and should do.'

KAREN BIGGS, CEO OF PHOENIX FUTURES

We know our sector is in flux, with the publication of the new drug strategy, changes in the commissioning landscape and a slew of new standards, processes and systems in development. Our group aims to influence commissioning and outcome monitoring to consider needs through the lens of sex and gender. We also aim to influence performance outcomes which OHID may be considering, to ensure they reflect women's health and social care needs. We want to influence workforce development activities as well as advocating for the development of minimum standards for women's services in substance misuse.

There is a risk, in a world of flux, that we end up simply rebuilding the treatment system of the past. That system did not effectively meet the needs of women. We need to create a new system of harm reduction, treatment and recovery for the future, which puts the needs of women at its heart. Women are central to local communities and families and are hugely influential across every domain of life. If we build a women-first or women-centric system, it will benefit everyone within it – not just women.

'We can do more to listen to women's experiences so we can understand better the barriers women are facing. I welcome this conversation and look forward to learning more about the things we can all do to make a difference.'

NIC ADAMSON, EXECUTIVE DIRECTOR, CHANGE GROW LIVE

Basically, we are coming together to stand up for the needs of women, as distinct and separate from men. If you get the chance, please do the same.

For more information, visit https://www.collectivevoice.org.uk/womens-alcohol-and-drug-treatment/

Karen Tyrell is executive director of culture, strategy and external affairs at Humankind, on behalf of the Women's Treatment Group which includes representatives from Bristol Drugs Project, Change Grow Live, Changing Lives, Cranstoun, Humankind, Phoenix Futures, Trevi House, Turning Point, WDP, With You and Working With Everyone

SAFE SPACES

Gender-responsive service provision is more essential than ever at this critical point in the sector's development, say **Francesca Carpenter** and **Laura Ward**

Oasis Project was established in Brighton and Hove over 24 years ago by four women who felt their needs were not being met by mainstream substance misuse services. Since then, the service has vastly grown to provide a range of gender-responsive services to women, children and families affected by substance misuse across Brighton and East Sussex. Oasis is part of the commissioned structured drug and alcohol treatment delivery partnership in Brighton and Hove.

Unfortunately, women's needs are rarely met by generic substance misuse treatment services, which are known to be male-dominated environments accessed mainly by male opiate users. For women who have experienced trauma including domestic/sexual violence perpetrated by men, male-dominated settings can be threatening and overwhelming. Whilst it is widely recognised that experience of trauma is a contributing factor in the prevalence of substance misuse across all populations, there are specific connections between women, domestic abuse and substance misuse. Women who have experienced domestic abuse are eight times more likely to develop a substance misuse problem when compared to the general population and may experience specific forms of abuse in relation to their substance misuse, such as control being exerted over their access to substances and prevention of access to support services.

Oasis' approach includes delivery of treatment in a women-only building, providing a physically and emotionally safe place for women to access support in an environment which recognises the prevalence of trauma and actively seeks to prevent re-traumatisation and promote recovery. Women report feeling more comfortable in a setting they know is women-only, sharing space with peers and drawing on shared connections, without risk of being in groups and settings with a partner, or ex-partner.

Women who misuse drugs or alcohol are often judged more harshly by wider society than their male peers, leading to greater experiences of stigma and shame which can make accessing services more difficult. These experiences are exacerbated further still in the context of parenting, with many women fearing a disclosure of substance use will lead to separation from their children.

Services often work with either adults or with children, which can lead to age-centric thinking and approaches. The context of family at Oasis Project runs through the whole organisation and bridges gaps through wraparound family support for both parents with drug and alcohol misuse needs and children affected by familial substance misuse.

Staff are well-trained and confident in exploring children's needs with parents and potential risks associated with substance use, and Oasis has an organisational strength around child safeguarding through our work. Our approach is to sit alongside parents to proactively reduce shame, listen to their worries and provide targeted support to reduce risks in the family including delivery of POCAR, a programme for parents whose children are in contact with social services. The relationship established with parents continues through any involvement from children's social care, and we support parents to understand local authority processes and their rights as parents.

Alongside adult treatment, Oasis also delivers:

YOUNG OASIS THERAPEUTIC SERVICES to children/young people affected by a parent or family member's substance misuse

A FREE CRÈCHE to provide childcare where families are accessing recovery support and parenting programmes including Mellow Parenting

POCAR, an intensive psychosocial intervention for parents whose children are in contact with social services due to risks around parental substance misuse

TAILORED SERVICES FOR YOUNG PEOPLE AGED 18-25 including a Young Women's therapy service and dedicated support to young adults new to treatment

LOOKING FORWARD, for mothers who have experienced child separation following involvement from family courts

SWOP, a specialist sex workers' outreach service

CASE STUDIES

SALLY'S STORY

Sally (24) is mum to Daniel (3). Children's social services were involved in the family due to concerns about Sally's alcohol use. Sally had also experienced domestic abuse from Daniel's father before Daniel was born. Sally had been in care as a child and found social work involvement with Daniel very difficult. Sally and Daniel's social worker referred Sally to Oasis' POCAR programme. Sally had a dedicated keyworker, and Daniel would use the crèche whilst Sally attended appointments and groups. Sally told her keyworker she was scared that Daniel would not be able to live with her, that she had no other family support and felt lonely. Sally would drink to cope with her worries.

In POCAR Sally learnt new strategies to cope with stress and worry. Sally's self-esteem grew which enabled her to re-connect with old friends. With support from her keyworker, Sally stopped drinking and children's social services reduced their involvement. Sally completed POCAR and continued to use the crèche to give her opportunity to focus on her recovery. Sally is due to start therapy with Oasis to explore some of her past experiences of trauma and build resilience for future.

TAKING CONTROL

'I'm now looking to the future and taking control of my life. It's not been easy at all, and I have made some mistakes, but I'm learning from them. I've got a long way to go but I want to keep getting better and I'm willing to do whatever it takes to get there. I am slowly getting better, I've just got to stick at it and trust the process. I have hope which Oasis has given to me. A massive thank you to my key worker, the Oasis staff, and all the women at Oasis. I wouldn't be where I am today without you.' *Oasis service user*

Childcare is a widely reported barrier for parents who need to access services, and Oasis provides a free crèche for any child affected by parental drug and alcohol use. The crèche is a therapeutic setting for children that recognises the importance of the child's voice, views, feelings, emotions, and personality, giving every child an opportunity for space to thrive. The crèche is also a vital resource for parents, providing the opportunity to participate in activities that support their recovery, including time in the day for themselves.

Oasis provides free arts-based individual therapy for children and young people aged 5-18 years affected by a parent or family members' substance use. This service is restorative to children who have experienced abuse and neglect in their families and seeks to provide a safe space for their own recovery. It's important that the needs of children and young people are considered within the context of substance misuse treatment, and the families' experience held in mind when working with parents. Parents who access Oasis Project tell us they value support being extended to their children.

It is through our specialist experience and dedication to working with women experiencing substance misuse and associated issues that we have been able to embed a responsive and trauma informed culture, practice and environment. Although necessary components, we consider gender responsive care extends beyond the provision of a women-only space, or a women's worker, but relies upon an ethos which prioritises understanding of and responsiveness to the intersectional and specific needs and structural challenges women experience. This requires an organisational and systemic commitment to working with the root causes of addiction such as trauma, and responding through approaches which enhance safety and empowerment to promote meaningful recovery.

The promise of increased funding for treatment services through Dame Carol Black's report and the resulting government drug strategy is really welcomed at such a critical point. Our experience has taught us that to meet the needs of women, children, and families through substance misuse treatment providers, we need gender-responsive service provision, and opportunities for joint children and adult commissioning both locally and nationally. This is essential for breaking down silos and creating greater potential for family focused approaches.

Oasis Project has recently been accredited with the One Small Thing Silver Quality Mark for working with trauma.

Francesca Carpenter is head of client services and Laura Ward is CEO of Oasis Project

It's time to overcome the barriers to both use of psychedelics in mental health treatment and access to treatment for people with co-existing mental health and substance issues, heard the RCGP and Addiction Professionals *Managing drug and alcohol problems in primary care* conference

MENTAL BLOCK

As far back as 2002, research was showing that 70 per cent of people in drug services and 86 per cent in alcohol services had described or reported severe mental health problems in the previous year, said Dr Hauwa Onifade, a forensic psychologist at Turning Point involved in developing services with an integrated approach to co-existing mental health difficulties and substance use. Far too many in this client group were still failing to access the support they needed, she said.

Despite efforts to integrate services, there were ongoing barriers to bridging the gap. In many services there was 'sequential delivery', with clients told to address their substance issues before they could access mental health support, or parallel delivery – clients accessing both, but with difficulties in joining them up. Years of diminishing investment had taken its toll, while the transfer of public health functions to local authorities had also led to an 'accountability gap' across substance and mental health providers. 'And of course COVID hasn't made any of this any easier.'

HIGH RISK

Turning Point had developed a substance use and mental health (SUMH) toolkit for professionals, condensing research and guidelines from PHE, NICE and elsewhere, she said. The organisation had also been working in Leicester, Leicestershire and Rutland on developing an integrated team, with a pilot launching during the COVID period following an audit of more than 3,000 clients. This had identified two significant groups where there were gaps in accessing treatment – populations involved in injecting drug use who were 'frequent flyers' at local hospitals and also presented with high levels of risk around mental health, including self-harm and suicide, and longer-term clients who, although there was little risk of self-harm or suicide, were in high levels of distress and unable to make changes in their substance use as a result.

'We tend to focus on high-risk populations, almost to the detriment of the other group,' she said. 'And even with the high-risk populations we're not necessarily working with them long-term, so they tend to fall into that pattern of re-presenting to services. A lot of services were involved in their care and a lot of people were aware of their difficulties, but they weren't necessarily in treatment for very long.'

NO WRONG DOOR

Turning Point's integrated team had tried to implement the 'no wrong door' concept – that all services should have a fully open-door policy – along with a 'huge focus on engagement and retention', she told the seminar. There was also a need to focus on client needs rather

Kateryna Kovarzh / iStock

than just diagnosis – 'we found that when we focused on diagnosis alone we excluded a high number of clients who were struggling and in distress'.

Turning Point had also conducted a mapping exercise of all the services in the area that could meet the clients' treatment needs. It found that specialist services for domestic violence, for example, would also work with people who had experienced those issues in the past, allowing the building of links to provide support while clients were on a waiting list. 'Establishing those networks and looking at the wider availability of resources is really key,' she said. 'It's astounding the number of peer support groups available', and even organisations like Age UK could address issues of loneliness and provide interim support while clients waited to access other services. 'So really broadening our idea of what intervention looks like for these client groups, which means we're able to filter in a lot more options.'

Focusing on being able to deliver genuinely trauma-informed services was vital, alongside breaking down both stigma and professionals' anxiety around their skill sets. Lack of clinical psychologists in third sector addiction services was a crucial issue, however – 'I'm astounded by the number of services that don't have psychologist input' – and proper support for staff was also a key consideration. 'If you're working with people with those high levels of risk, as a professional you'll likely need some support as well. Without that full structure and that supervision and training element, teams such as this would likely fall apart.'

But barriers didn't just exist when it came to accessing treatment for co-existing conditions. There were also the legal barriers that prevented the use of substances that could provide potentially life-changing help for depression, anxiety, PTSD and other mental health issues.

REVOLUTIONARY

'It was the first great revolution in psychiatry,' said professor of neuropsychopharmacology at Imperial College London, David Nutt, of the widespread use of LSD therapy in the US in the 1950s and '60s. There had been an 'enormous clinical interest' in LSD, and to a lesser extent psilocybin, with around 1,000 clinical papers and 'overwhelmingly positive' results describing safe and effective treatments.

'As far back as 2002, research was showing that 70 per cent of people in drug services and 86 per cent in alcohol services had described or reported severe mental health problems.'

DR HAUWA ONIFADE

For researchers and psychiatrists, psychedelics offered the opportunity to 'ask questions of the brain that hadn't been asked before, and potentially change brain function in a very positive way', he said, and it was 'remarkable' how few adverse effects there had been. 'Lower than you'd imagine for untreated populations at the time and certainly better than any treatment they were getting, which was essentially just barbiturates.'

It constituted a 'remarkable period of enormous enthusiasm', he stated. 'But we don't use them now, because in 1967 the US government decided to ban psychedelics because they thought they were encouraging the anti-Vietnam war movement.' And – as 'we'd always done in drug policy exactly what the US told us' – the UK followed suit, as did the UN.

This meant an end to research, as it was almost always funded by governments, with even those researchers who could access funding from philanthropists unable to get hold of the drugs. It added up to 'a genuine attempt by the US government and UN to eliminate all knowledge and almost all memory of the drugs, because they were seen as being so challenging to the status quo'.

In 2012, however, money finally became available from the Medical Research Council to study the use of psilocybin in treatment-resistant depression, dependent on an initial safety study. 'But even that was easier than getting hold of the drug,' said Nutt. 'In the end, 32 months of our 36-month grant were spent on bureaucracy, which is all about protecting society from the dangers of magic mushrooms. It's completely absurd.'

PESSIMISM BIAS

The study finally went ahead, involving 20 patients who had all failed to benefit from anti-depressants and CBT. 'We gave them one dose, one trip of 25mg, and saw a halving of depression scores within a day.' Even at six months there were still 'huge' effects, with some patients in remission after eight years. 'It opened up the whole field, and now there are 40 different companies working in the field of psilocybin for depression.'

Psilocybin 'changes the way people think', he said, helping to remove the 'pessimism bias' involved in perpetuating depression. A subsequent 'head-to-head trial' of psilocybin versus the widely used SSRI antidepressant escitalopram found that psilocybin was 'at least as good, and probably better' on most measures, with 'remarkably higher' remission rates (www.drinkanddrugsnews.com/magic-mushrooms-may-be-as-effective-as-antidepressants).

While SSRIs worked by enhancing serotonin in the limbic system – 'they are to depression what a plaster cast is to a broken leg' – psychedelics worked in a different part of the brain by disrupting cortical thinking. This helped to break down negative thought patterns and increase wellbeing, without the blunting effect on the emotions that sometimes came with SSRIs.

Studies had now been widened to include areas like anorexia, OCD and pain syndromes, he said. These were 'internalising disorders where people get locked into thinking patterns they can't escape, and psychedelics can help them do that'. The drugs also worked well in treating addiction, he stressed, in that they helped to 'break down the circuits that drive addictive thinking and habit behaviour', and he was now involved in work looking at whether ketamine could be effective for behavioural addictions such as gambling or pornography.

MAXIMUM BENEFIT

MDMA was now likely to become approved therapy for PTSD in the US from the end of next year, he said. 'They've done one phase 3 study, and the second one's on its way – if it's as good as the first I'm pretty sure it'll get a licence, and hopefully we'll then be able to use it in Britain. And maybe in the next three years we'll be able to have psilocybin in the UK, depending on how the next phase 3 trial comes out.' Psychotherapeutic support provided around the psilocybin dosing was essential, however. 'I like the idea that we can bring psychotherapy and pharmacology together to maximise the benefits for people.'

'As George Bernard Shaw said, "Those who cannot change their minds cannot change anything", and I think what's pretty clear is that psychedelics can change the minds of our patients. I'm hoping this research can also change the public's and politicians' minds about psychedelics and bring them back into medical practice, because it was absurd that they were taken from it. It's actually the worst censorship of research and clinical practice in the history of the world. And we should rectify it now.' **DDN**

The SUMH resource pack – working with people with coexisting substance use and mental health issues at www.turning-point.co.uk/reports

GET ENGAGED

Genuinely trauma-informed services are vital to service user engagement, say **Fleur Gill**, **Jenny Scott**, **Charlotte Dack** and **Lee Collingham**

Most people experiencing addiction have had traumatic experiences in their lives. Trauma can cause a range of effects by disrupting a person's sense of self, the way in which they navigate the world and the way they function. They may experience depression and anxiety and struggle to manage their emotions, build healthy relationships or trust others. People who experience trauma are at risk of developing serious mental health conditions including post-traumatic stress disorder. Using drugs and alcohol can help to numb the difficult and overwhelming symptoms related to trauma, but over time this puts these individuals at risk of addiction. Some describe substance use as a means of self-medication.

High quality drug and alcohol treatment can improve and save lives. Such treatment needs to be flexible, depending on the individual's needs – service users should be treated with respect, listened to, receive timely mental health support, have a say in their treatment and feel safe and secure with staff from their treatment provider. This is particularly relevant for those who have had traumatic experiences, as addiction treatment may be daunting and difficult, with the potential to be retraumatising. Services should ensure risks of traumatisation are minimised – the UK clinical guidelines for drug and alcohol treatment (the 'orange book') advocates an approach that aims to achieve this, referred to as trauma-informed care.

Trauma-informed care is not necessarily about treating the trauma or being aware of what has happened. Instead, it's about adopting methods and principles that acknowledge and account for the fact someone may have had traumatic experience(s). This is done by understanding the effects of trauma and the impacts it may have on people. For example, trauma could cause people to become defensive and aggressive, or they may disengage and withdraw, or have difficulties trusting the intentions of professionals.

The key principles of trauma-informed care therefore are to reduce re-traumatisation and improve treatment experience and engagement. These principles aim to create trustworthiness, safety, empowerment, choice and collaboration.

A masters project undertaken by Fleur Gill and supported by Lee Collingham, Charlotte Dack and Jenny Scott at the University of Bath interviewed 15 people with experience of using drug and alcohol treatment services. Twelve men and three women took part – the youngest was 30 and the oldest 68 with an average age of 46. Their experience of treatment services ranged from five to 30

Trauma-informed care is not necessarily about treating the trauma or being aware of what has happened. Instead, it's about adopting methods and principles that acknowledge and account for the fact someone may have had traumatic experience(s).

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years, with an average of 17 years, although we didn't capture this information from five of them.

The study had the aim of understanding whether they had experiences of trauma-informed care within their treatment, and whether they felt this affected their engagement. We used the key principles of trauma-informed care to write the questions, so we could gauge if people's accounts of their treatment experience seemed to embed a trauma-informed approach. The research also aimed to provide insight into reasons for missed appointments, which is an ongoing issue within drug and alcohol services across the UK and may be linked to a lack of trauma-informed care.

The research found that despite guideline recommendations, most people interviewed had not experienced consistent trauma-informed care. Many felt that they had had little control over their treatment, with a power imbalance between them and the service.

> *'I never felt I had any power within any services. I thought they had that piece of blue paper, which was very powerful – the script.'*

Many also felt that their mental health needs were not acknowledged or treated, and that their appointments lacked true purpose and meaning, with a sense of superficiality that impacted on their motivation and willingness to engage.

> *'He does all that "How you feeling, how's life" and stuff, but I think it's just become a case of "yes, no, ok, see you next month".'*

Most participants described missing appointments through forgetting to attend, feeling too intoxicated from using or having other commitments. However, they also described feeling that the appointments weren't important to them because of this perceived superficiality and 'tick box' approach.

> *'Would I forget if I thought it was REALLY important? Would I still forget it?... I've just got to go in for five minutes say "Yeah, I'm fine" and walk out again, and it's not gonna be much motivation for me to try and remember.'*

The relationship with the professionals delivering treatment, regardless of how trauma-informed their care sounded, was important. A good relationship included feeling listened to, not being judged, feeling like they were given time, feeling empathy and for some, feeling the key worker 'went the extra mile'. A good relationship with their key worker meant they were more likely to want to attend.

> *'My last key worker, I believe if it wasn't for her I wouldn't be where I am today... She showed me empathy and support, but I've had some where they've felt like a bit of a number.'*

However, there were consistent mentions of differences among professionals with regards to their approaches and levels of understanding. Many felt that some professionals still seem to display a lack of compassion or understanding towards addiction, despite working in the field.

> *'I can remember the first time I went there he literally said, "Well just don't use drugs" and I'm like, "You tell me how to do that then!", cos it's not that simple.'*

Most participants mentioned how much they value staff members with lived experience, and while there is consistent evidence in published studies of the benefits of having staff with lived experience, some services are known to still adopt an approach where staff don't disclose their experiences.

> *'I've always found it's when I've had drug workers or whatever who've been there and done it, who've got experience, they're always better than the ones who are just textbook.'*

In this study we found accounts that seemed inconsistent with trauma-informed care and we also found that positive relationships with key workers, where the client felt listened to, respected and understood, encouraged attendance. Variability among the approaches and attitudes of professionals, and their levels of understanding of addiction, was an important influence on whether the person engaged with appointments.

The benefits of staff with lived experience in supporting meaningful engagement was a key message in these interviews. By supporting more openness and honesty between staff and service users and hiring more people with lived experience, we may increase trustworthiness, safety, empowerment, choice and collaboration in treatment – key underpinning tenets of trauma-informed care.

Our study chimes with the findings of the second part of the Carol Black review, and the need for services to reorientate their approaches to enable people to engage. Finally, it's important to say that the type of study we did is focused on understanding people's experiences rather than generalising about the experiences of all who use drug and alcohol services. A larger study would be needed to discover if what we have found is true on a wider and more general scale.

Fleur Gill is an MSc student with an interest in addiction research; Lee Collingham is an expert by experience who supported the research project; Charlotte Dack is a lecturer at the University of Bath; Jenny Scott is a senior lecturer at the University of Bath

Caroline Gitsham was appointed chair of Humankind's board of trustees last month. She describes her background and commitment to social justice, and shares her hopes for the sector as she takes up the new role

Making a difference

It's been quite a varied career journey as I've had 15 proper jobs to get to this point. My career started off when I was part of a youth training scheme in Middlesbrough in the 1980s when it was pretty tough to get a job. I then got a job with Middlesbrough Council as a clerical trainee and worked across three different departments. I particularly loved being in the housing team, and that led to me working in the housing departments of three different councils – Langbaurgh, Stockton and Sunderland.

During my time at Sunderland I was invited to be part of Tony Blair's Social Exclusion Unit which aimed to address the barriers faced by people experiencing poverty. Many of the other people in the unit were policy people, but I was able to bring some real-life stories of the impact social exclusion was having on people and I think that was quite eye opening for them. In 2001, Sunderland Council did a stock transfer to Sunderland Housing Group and I was able to continue to combine my passion for housing and addressing the wider issues.

Making a difference on agendas that I care about is what motivates me. I'm passionate about impacting on poverty in all its forms, especially the inequality of opportunity it creates as it means that a lot of people can't do things that many of us take for granted. I'm drawn to work that allows me to address that, as well as tackling the lack of diversity in positions of influence as things can't evolve for the better if all people aren't represented. All contributions matter and I don't like seeing people overlooked.

Many of the issues people are facing are the same ones that existed when I started out in the 1980s. There has been a lot of change over the years but a lot of it hasn't been sustainable – I'd like to see approaches to social exclusion be more joined up and for there to be support for grassroots organisations to drive things forward, as they know what is needed.

I first become involved with Humankind a few years ago when I went to speak at a social entrepreneurs' event and met Paul Townsley, the CEO, and Jim Black, the previous chair. They asked me to conduct a review of Humankind's housing work and while I was doing that I got to know the organisation, and the ethos and commitment of the staff resonated with me. A year later the chance arose for me to become a trustee, and when Jim announced he was going to be stepping back from the board I decided to throw my hat in the ring and fortunately I got the role. I'm really proud to be part of Humankind as I like the people, I like the culture and I like the values. We reach people that other organisations don't and our holistic approach to addressing the barriers people face means we're making a difference every day.

There's a lot that we should be proud of at Humankind, but especially the way we adapted during COVID and the number of innovative pieces of work staff are doing to improve services for the people we support. We have been doing a lot around governance, developing regional networks and increasing our influence for the benefit of our service users

In terms of future priorities, I'm keen to build on our governance work and increase diversity on the board. I also want us to use data and technology to move interventions and support systems forward. We're also working on the new five-year strategy and it's my hope that with that we can create a consistently high standard across all of our services and be at the top of the sector's benchmarks. I want us to be an organisation of choice for staff, service users and funders.

Caroline Gitsham is chair of trustees at Humankind

'Many of the issues people are facing are the same ones that existed when I started out in the 1980s. There has been a lot of change over the years but a lot of it hasn't been sustainable.'

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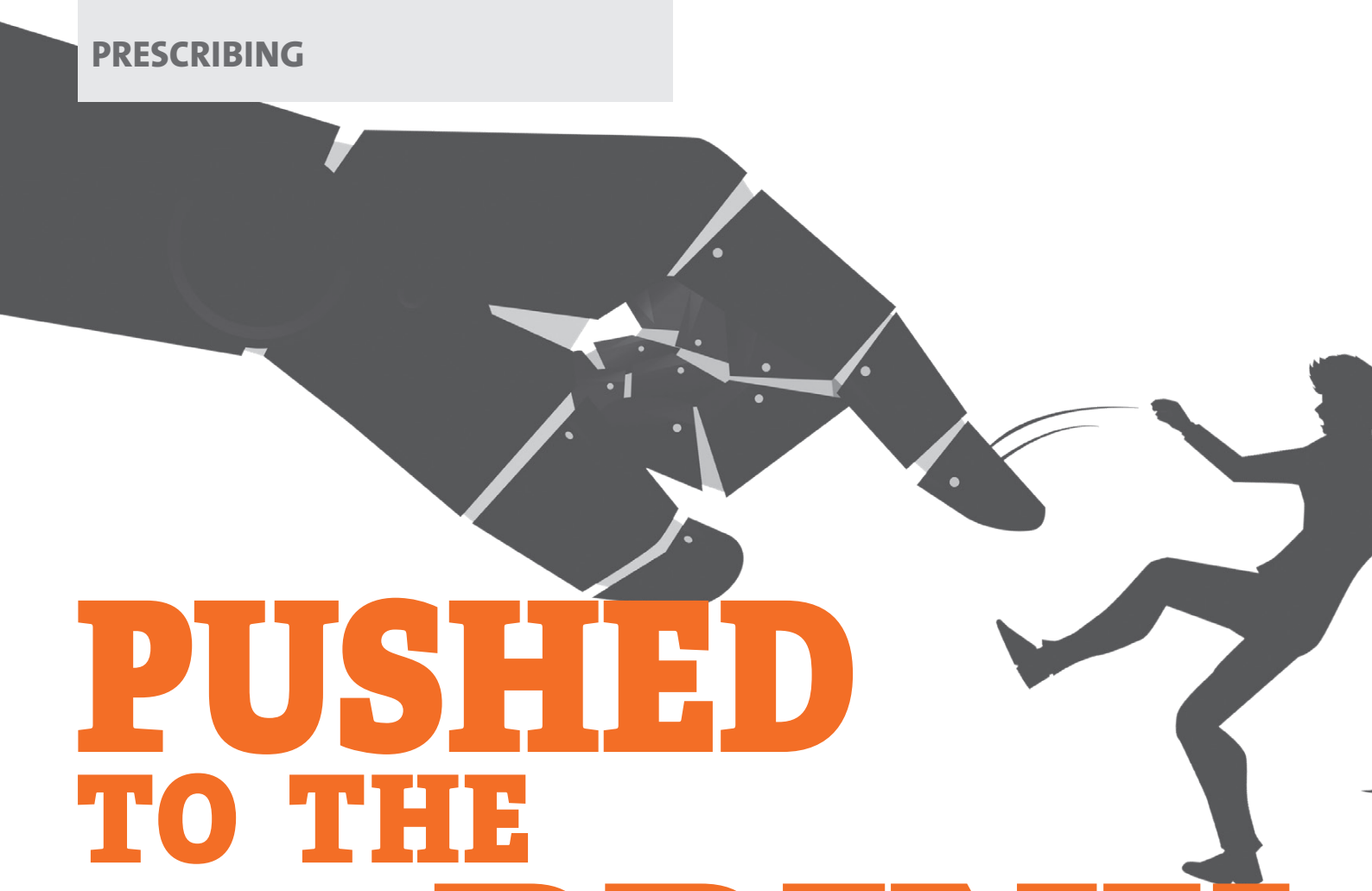

PUSHED TO THE BRINK

A new policy to withdraw diamorphine treatment became a fight for survival, hears **DDN**

Three years ago, nine people in the South West of England were going about their daily lives, just as anyone else might, juggling jobs and family life with all the everyday ups and downs. Each of them was in regular receipt of a diamorphine (heroin) script, which was working well for them in managing their dependence on opiates and giving them a good quality of life.

Then came a letter from their treatment provider – the same letter to each of them, with just their names changed. In line with 'best practice' they must have their treatment changed. They needed to choose a different option – oral methadone, MXL (slow-release morphine tablets), or inpatient rehab.

Four of the nine patients decided they had to challenge the decision. Jill and Helen (not their real names) talked to us about what happened and how it affected them.

'It was clear in the letter that there was no clinical opinion taken on it,' said Jill. 'No individual circumstances were taken into consideration – it was done purely on a cost basis.' She talked to the clinical lead and asked if the patients could have a meeting with the group who had made the decision, 'to go through our opinion on it and how it was going to affect us, because nobody that made that decision had any of the rest of our personal records. I was quite concerned that the people making the decision couldn't even put a face to me.'

Advised to put it in writing, Jill went home and wrote down the questions she needed answering. The reply around six weeks later 'was absolute nonsense' and didn't clarify anything. A few more attempts later, and feeling she was being ignored, she contacted Release for advice.

ADVOCACY

Claire Robbins, Release's nurse advocate and drugs advisor, explains what came next. Release wrote advocacy letters to the service provider on behalf of the patients. They introduced themselves and talked about the case, and quoted Department of Health guidance aimed at protecting patients on diamorphine. 'It talks specifically about that group and says, if anything, their treatment should be reviewed and optimised,' she says.

They wanted to have a conversation; there was none. The provider forwarded the letters to their litigation department and responded: 'sorry you had to raise a complaint'. 'We weren't ever raising a complaint,' says Robbins.

Release continued to advocate for Jill and Helen, but the provider refused to reconsider their decision

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> 'We nursed each other through it – there was no one else I could talk to about it at the time... Claire was my only sanity really and I wouldn't have done it without her. I received no calls to support me through the case from my service, only from my prescriber.'

to withdraw the medication, despite the fact that the patients had been on diamorphine for years and it having a significantly positive impact on their lives. 'All we were trying to do was sit down and communicate with them,' says Jill. 'But they were not wanting to do it.'

At this stage Release involved the law firm, Leigh Day, with a view to bringing legal action against the provider.

'We would normally advocate in a way that is respectful to all parties involved, and with the clients' best interests and rights at the heart of the process,' explains Robbins. 'In the vast majority of our cases, we will resolve a problem in a positive way with the provider and the client.' But it was not possible in this case, so Jill, Helen and the lawyers at Release decided to pursue a judicial review of the decision to withdraw medication. They did this by instructing Leigh Day.

INTIMIDATING PROCESS

As part of the legal process, attempts were made to settle the matter. The patients tried to explain how this was affecting them – even mentioning a situation where it had happened to one of them before and led to a relapse – but felt the service wasn't listening at all.

'We were stressed out, really worried about it for weeks and weeks before,' says Jill.

'I can't stress enough how negative this was for everybody's mental health and the duty of care,' says Robbins. 'The patients were expected to go through this whole process, which was really intimidating.'

SECOND OPINION

With no resolution and the date of the prescription change looming, the law firm took the case to court. A second opinion from an independent consultant would be sought on the provider's clinical decision, and in the meantime the judge gave a clear instruction that the provider must do everything they could to make sure the patients' supply was continued. It was a temporary arrangement that the organisation would have to pay for – more expense for this 'cost-cutting' initiative.

Then came COVID, and the temporary arrangement stretched over a year during which the provider had to continue prescribing, as the independent consultant couldn't meet the patients. When the consultant's decision did come, it stated that prescribing should continue.

The stress of this experience was felt physically and mentally while trying to lead as normal a life as possible. 'I lost a lot of my hair,' says Jill. 'We didn't know from one day to the next what was happening.' But the after-effects of three and a half years of the process have had wider implications for the therapeutic relationship – or lack of it. 'The relationship had completely broken down and the patients had lost trust,' says Robbins.

NO SUPPORT

'We nursed each other through it – there was no one else I could talk to about it at the time, says Jill. 'Claire was my only sanity really and I wouldn't have done it without her. I received no calls to support me through the case from my service, only from my prescriber. He was the one that checked in on us.'

'We had some behind-the-scenes support from workers who felt they couldn't speak up or they would lose their jobs,' added Helen.

Alongside demonstrating that the declared 'best practice' was actually very poor practice, the case cost the service a lot of money – 'the most expensive diamorphine scripts in the world!' says Robbins. But the outcome showed that the legal process had been essential.

'At the core of this issue were a small number of patients who were threatened with having their long-term medication terminated without their consent, or even proper consultation,' comments Stephen Cutter, legal services manager at Release. 'Respect for patients' rights must come first but when it comes to certain treatments, like diamorphine or other OST, this principle seemed to be easily set aside.

'We wish this challenge hadn't been needed but it does demonstrate how the law can protect the rights of people in drug treatment. Given the importance of their medication we're relieved that these people got the help they needed, but it's deeply frustrating it was needed at all and the process caused months of unnecessary disruption and worry to all those affected.'

Relationships are slowly being built, with help of the service's 'amazing' and 'really trustworthy' new doctor, who is doing everything he can to tackle the latest crisis – a shortage in diamorphine supply – and is contacting pharmacies in the area to find out what stocks they have. He has assured the patients that the service will honour their prescriptions with any diamorphine they can get, and work carefully with them on titration if they need to find temporary alternatives.

DUTY OF CARE

But the conclusion stands: that it should never have happened at all and must never be repeated.

'The law on this matter was always clear, namely that a decision to withdraw treatment was imposed upon my clients without regard to the relevant guidance and without securing their consent or engagement,' says Anna Dews, solicitor at Leigh Day. 'They were owed a duty of care by their service provider and had been provided with diamorphine as an established medical treatment for many decades. I hope that the resolution of this matter means that no service provider will seek to repeat this type of decision-making in the future.' **DDN**

I AM A...

There's nothing as rewarding as seeing people make positive changes in their lives, says **Angela Calcan**, who works as a DrinkCoach for Humankind

I work as a DrinkCoach for Humankind, providing one-to-one online sessions to people who want to change their drinking. We work with risky drinkers and mild psychological dependency. It's an engaging and rewarding role as I get to meet people who want to reduce their drinking but for many reasons find it difficult to access traditional services. DrinkCoach sessions are all done remotely, so even before the pandemic I worked within an entirely remote team with colleagues from across the UK.

'Many people we see via DrinkCoach have never spoken to anyone about their drinking so there can be a lot of nerves at the beginning of a session followed by tears of relief at the end.'

Confidentiality is an integral part of our service, so I ensure that my home office set-up is secure for all appointments. As our sessions are online, we don't have the usual social cues we would in a face-to-face service, so it's important that my sessions are set up to engage the client. For example, I use a tripod and webcam to ensure I'm providing appropriate eye contact with the client as this is one of the ways to help build the therapeutic alliance online.

I'll speak to between one and four clients per day with each session lasting up to 40 minutes. Usually, the first session I have with someone is longer as I gather information and conduct a brief history, whilst completing the AUDIT and delivering brief advice. During each session, we review drink diaries shared via the DrinkCoach app or paper diaries if preferred – we then review and adjust the strategies, and set a new target for the next session.

At DrinkCoach, we offer evening and weekend appointments which are covered by some of my colleagues. As a parent, I deliver the sessions whilst my children are at school so I tend to speak to a lot of people on their lunch break or through other people squeezing me into their day.

The most rewarding part of my role is the people I get to meet and support. I really enjoy the variety as I speak to people across the UK so it varies from one session to the next. Many people we see via DrinkCoach have never spoken to anyone about their drinking so there can be a lot of nerves at the beginning of a session followed by tears of relief at the end, having had the opportunity for someone to listen in a supportive and non-judgmental way. Seeing people make changes and build their confidence through achieving their weekly goals is one of the best feelings.

Unfortunately, there's still so much stigma around alcohol and I don't think this is helped by the language used for drinkers and treatment. People still fear being labelled an alcoholic by presenting for help. There is a lot of focus on abstinence which just doesn't fit for everyone. In treatment we often see drinkers being made to prove their motivation but I believe that if you have someone sitting in front of you then they are motivated!

The great thing about DrinkCoach is that we encourage early intervention and support our clients to drink moderately, making reductions to improve their health and wellbeing. Too many people wait for things to get worse before they give themselves the opportunity to get better. This isn't helped by the fact that treatment thresholds are high, and people are being told they aren't drinking enough to get support. This is why accessible services like DrinkCoach are important as they give people a safe and confidential platform to seek help earlier in their treatment journey.

I'd definitely encourage people to think about becoming a DrinkCoach as it's rewarding work, you get to meet a variety of people, the hours are flexible so you can do it alongside other commitments, and we provide all the equipment and training. We're currently recruiting for DrinkCoaches so if you're someone who has worked in the alcohol field, has a passion for helping people and want a flexible job, then you should consider it.

DrinkCoach is at https://humankindcharity.org.uk/service/drinkcoach/

If you're interested in becoming a DrinkCoach you can find out more at https://humankindcharity.org.uk/careers/

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We need to respect, not exploit, lived experience, says **Russell Webster**

We know there is a robust evidence base that many people with lived experience who volunteer as recovery champions and coaches benefit from the experience of giving back, rebuilding their self-esteem and recognising that they have something to offer. Many peer volunteers are provided with the training and ongoing support they need to succeed, including opportunities to progress into paid employment. However, as Dame Carol Black warned, others receive little to no training and support, often have little choice about what role they take as volunteers, and are essentially exploited as unpaid staff members.

In partnership with Revolving Doors, I led a team of people with lived experience to produce a guide that addresses these concerns. It sets out best practice in supporting peer volunteers derived from, and informed by, the lived experience of more than 250 people, and covers a range of topics including training, support and helping people convert their volunteering experience into paid employment.

The guide, which can be downloaded at *https://peervols.russellwebster.com/* is targeted at three groups of people: commissioners, providers and people with lived experience, and this article shares perspectives from all three points of view.

THE COMMISSIONERS' VIEW

By **Simon Whitlock**, senior commissioner, and **Sarah Currie**, substance misuse commissioner, at the London Borough of Newham

THE WEALTH OF EXPERIENCE PEER VOLUNTEERS BRING is invaluable to drug and alcohol recovery services, but severe budget cuts and chronic underfunding of services have meant that the much-needed training, support and development opportunities have largely been eroded.

Peer volunteers contribute in a variety of ways, from shaping services and making them more accessible, to providing relatable experiences to individuals going through similar experiences. In return, it is vital we provide peer volunteers with the right training and support to develop so they can thrive and maximise their potential, whilst continuing to show positive examples of successful recovery and reintegration into the wider community

The guide provides the perspective of peer volunteers – something that's often missed! – and clearly demonstrates the value they can offer any social justice sector organisation. The key issues are laid out and paired with easily adoptable best practice and guidance that comes complete with a range of additional resources. Organisations can use the guide to review existing working practices or develop new ways of working built around their organisation and peer volunteers' needs.

THE PROVIDER'S VIEW

By **Michael Webster**, Forward Trust

INDIVIDUALS WITH LIVED EXPERIENCE and those who have experienced our services can have a significant contribution to make in supporting others to make transformational change in their lives. At The Forward Trust we support some of society's most marginalised people to achieve transformational change, including individuals with histories of profound disadvantage and hardship. We believe that anyone, regardless of their past, can move forward with their lives and we also believe that those who have accessed our services can inspire hope and motivation among others that recovery and rehabilitation is possible. Volunteer placements for those with lived experience also provide a platform to integrate with their communities while further establishing their recovery.

For individuals who want to use their lived experience to support others in a voluntary capacity it's imperative that the provider ensures that they have a thorough understanding of this relationship and robust system in place to so that all parties benefit. When done well the results can be amazing for all involved.

These benefits are starting to become more apparent across the country and can be seen in the growth of Lived Experience Recovery Organisations. However as can be seen in this new report, not everyone always gets it right. The guide is a great place for grass roots organisation that are starting out or established organisations wanting to improve their services. I would definitely recommend a read – it's a great reference point for service providers looking to deliver the best service possible.

THE LIVED EXPERIENCE

By **Bernie Carr**, national volunteer, Change Grow Live

WHEN I FIRST HEARD A TEAM WAS BEING ASSEMBLED to co-produce a new guide for the sector on peer volunteering my interest was sparked on two fronts. The subject matter itself, which naturally affects all I do, and the co-productive process, which our national lived experience group (NLEG) at Change Grow Live has strived to embed into our work. I was delighted to hear that my application to join the team was accepted, as was another colleague's from NLEG – Neil Hipkiss.

We all met Russell Webster separately to discuss the way forward and to establish the skills that we each brought to the project, and the day then dawned when we all first met (online of course, given the COVID pandemic). I was so impressed by the enthusiasm displayed at that first meeting, and excited at how that potential could be harnessed into the co-production of a really meaningful product.

We established the process, and were fortunately not starting from a blank piece of paper as a survey seeking the views of about 250 volunteers across the sector had been commissioned and analysed. After introductions and discussions on the way forward we all separately reviewed the first parts of the survey that would form the basis of the opening section of the guide, with a view to bringing our thoughts to the next meeting for an open discussion on how the text should look. We were aided throughout by Russell's penmanship, suggesting a possible structure section by section.

As the weeks rolled by and we met to discuss the guide section by section, I became acutely aware of how well we were bonding as a team, and that the natural synergy of a group of like-minded individuals was coming to the fore in the creation of our goal. It's amazing to see how wide a range of transferable skills can be gathered together in a group of about ten people. It quickly became apparent that a guide published in 2022 needed to be available on as wide a platform as possible and make use of all forms of media, so a website and new accounts on Twitter, Instagram, YouTube and LinkedIn were created.

Volunteers were sought to make video contributions to the website and YouTube channel. With much trepidation I agreed to do this, so feel free to skirt round that bit! We now have a good stock of videos available from across the sector, and the site is also used to advertise volunteering opportunities.

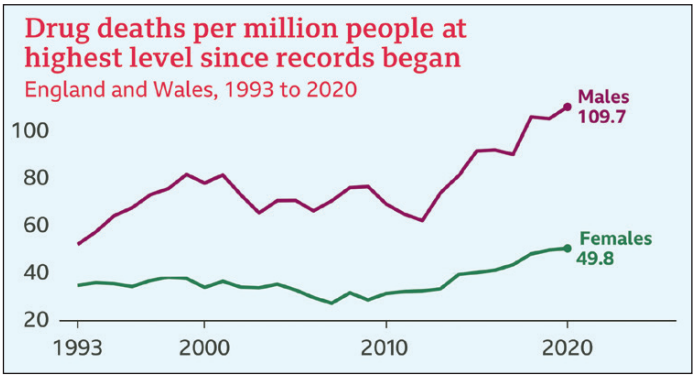
A professional designer (with lived experience of course!) was brought in to design a logo, and much time was spent on choosing the logo's final design and the colours and layout of the website. I had previously been quite cynical about time spent on these issues but appreciate now how satisfying it is to get it just right, and to have overwhelming pride in the final product.

I'd like to also mention the quality control provided by a steering group established by Russell and including providers and commissioners. A couple of the team met with them during the co-production process, and their views and guidance were incredibly supportive in the emergence of the final product.

Please read the guide and pass it on to all you know who may have an interest. We are immensely proud of it and hope it will be of use to you all.

You can find more information as well as job and volunteering opportunities for people with lived experience on the accompanying website: https://peervols.russellwebster.com/

An immensely sad occurrence transpired between our first and second meetings – one of the team, Jahmaine Davis passed away. We were incredibly inspired by Jahmaine's energy and enthusiasm, and amidst the sadness of his loss redoubled our efforts to make the guide an inspiring piece of work in his memory. This final version is dedicated to Jahmaine.



'As your readers will know only too well a public health emergency is occurring in England. In 2020, 4,312 people died because of drug related causes, the highest number since records began.'

AMBITIOUS ACTION ON DRUG DEATHS

As your readers will know only too well a public health emergency is occurring in England. In 2020, 4,312 people died because of drug-related causes, the highest number since records began.

This is a truly intolerable figure, and one that is likely to continue rising without swift and targeted action.

The people we serve often lead lives shaped by stigma and discrimination and face a range of health and social challenges. As treatment and recovery providers we do not have the power to surmount all of these challenges, but we can work to ensure our efforts to reduce drug-related deaths are ambitious, effective and consistent.

That is why we are uniting as senior leaders from third sector and NHS treatment providers at a historic summit in May where we will commit to actions to curb drug-related deaths. The agreed actions will be published as a simple, clear charter embodying our shared intent and pledge. We will also work together to share good practice over the coming year to enable us to enact the actions of the charter.

We would be pleased to provide a more detailed account of the charter in the next issue of *DDN*.

Summit steering group members, Collective Voice and NHS Addictions Provider Alliance

MISSING LINK FOR MENTAL HEALTH

I wanted to share news of how our service users at Aspire have seen their recovery and ongoing abstinence prospects boosted thanks to a pioneering trial with anti-depression therapy.

People needing help for substance misuse problems are often clinically depressed, which impairs their response to drug and alcohol treatment. Through a two-year study at Doncaster's Aspire Drug & Alcohol Services we've discovered that 'behavioural activation therapy' could be a key missing link to improving mental health outcomes.

By deliberately practising certain behaviours we can 'activate' a positive emotional state – so fulfilling activities, such as volunteering or walking, can create a feelgood factor and lead to the addiction being replaced with a healthier alternative.

The study was jointly carried out by staff from Aspire (a partnership between Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and registered charity The Alcohol & Drug Service), University of Sheffield academics Sophie Pott, Dr Jaime Delgadillo and Dr Stephen Kellett, along with Professor Stacey Daughters from the University of North Carolina.

For those that took part, behavioural activation was associated with significantly reduced depression at their follow-up 12 weeks later. Participants also used fewer illicit substances on top of their prescribed medication. The researchers told us that this therapy may add clinical benefit to the care provided for patients who have substance misuse and depression problems but that it is an area which needs further research.

The results are very promising, particularly for people who are trying to hold down a job or reduce illicit use on top of their medications. The study has raised exciting prospects for the care provided for this cohort of people across the country, with potential improvements through the talking therapies on offer, as well as returning potential gains on treatment costs and harm reduction.

The findings were published in March 2022 in the highly influential *Journal of Substance Abuse Treatment*: https://doi.org/10.1016/j.jsat.2022.108769

Stuart Green, service manager, Aspire Drug & Alcohol Services, Doncaster

CALL FOR CULTURE CHANGE

After reading the *DDN* update email (*DDN* Bitesize, every Tuesday) I absolutely agree with you regarding the need for a change of culture. I have been working for 20 years+ with substance users and no one wakes up in the morning and decides they are going to become an addict. Most of my clients have suffered severe childhood trauma and the only way they can cope with their traumatic memories is by using drugs or alcohol.

There are long waiting lists for the talking therapies and rehab. Most rehab stays are not long enough to deal with the trauma and many talking therapies will not work with someone who is using/drinking. The addict is in a catch-22 situation. There is a shortage of therapies but training to be a therapist is expensive.

We need to train more people who understand substance misuse, mainly those in recovery. People must not suffer more because of the suffering they have already experienced. They have a right to be treated with dignity, respect and compassion – the punishment angle is not the way forward.

Liz Abbott, by email

DIAMORPHINE ALTERNATIVE?

I read with interest your article High Impact (*DDN*, April, p22) giving Daniel Ahmed's excellent account of heroin assisted treatment and Dr David Bremner's article about the shortage of diamorphine (p23).

In Canada, which outpaces the UK in drug legislation and treatment in my opinion, they have been trialling hydromorphone (known in the US as Dilaudid) as an excellent alternative to IV diamorphine.

I can only wonder whether there are the same supply side shortages of hydromorphone – and if not, it could be used as an excellent alternative.

Users in Canada in blind trials couldn't tell the difference as it doesn't produce the unpleasant histamine reaction which IV morphine does.

Richard Moore, by email

See p16 for our article on diamorphine script restrictions

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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