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Drink and Drugs News
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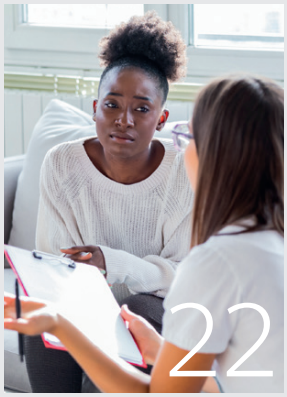

Nursing careers

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Transformational mental health treatment

STAYING STRONG IN PARTNERSHIP

'We are excited to be working with Phoenix to ensure that the Ley Community's legacy will carry on.'

Darren Worthington in our partner updates, **www.drinkanddrugsnews.com**

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

We can't assume that all drug use is driven by choice

The most recent drug-related death figures make a mockery of the government's proposed *Swift, certain, tough* approach to possession offences. According to the ONS (p16), DRD stats focus on a particular generation, people who are now in their late 40s. Furthermore, regional data show death rates are up to seven times higher in the most deprived areas of England and Wales.

The more we understand about those who are dying, the more we can be equipped to support instead of punishing. Underlying factors are complex including trauma, stigma and lack of opportunity. Mental health issues have been a huge piece of the jigsaw, particularly during lockdown. Fastest rising substances in the league table include an anti-depressant – how could this fit with an assumption that all drug use is driven by choice? Stats underline that we have a lot of work to do in tackling stigma (p8) and offering the right targeted support – and yet again our best option is effective teamwork, from mental health services (p20) to nursing (p22) to commissioning (p12).

DDN is 18 this issue and we'd like to thank you for your support. Whatever challenges we all face, it's heartening to see lived experience is now shaping policy. If you've been with us since November 2004 we'd love to hear from you!

Claire Brown, editor
www.drinkanddrugsnews.com and @DDNmagazine

More countries implementing harm reduction services

The number of countries implementing key harm reduction services has increased for the first time in almost a decade, according to the latest *Global state of harm reduction* report from Harm Reduction International (HRI).

The increase has been driven by the launch of new NSP services in five African countries, as well as officially sanctioned consumption rooms in four new countries. Opioid agonist therapy has been introduced for the first time in three countries, while the number of countries with take-home or peer-distributed naloxone programmes has also increased, says HRI.

More than 90 countries worldwide now have needle and syringe programmes, the document states, with 87 offering opioid agonist therapy. Consumption rooms are operating in 16 countries, and more than 100 countries officially support harm reduction in their national drug policies. The document warns against any complacency, however, stating that the 'coverage and scale of harm reduction is still limited'. Huge inequalities remain both within and between regions and countries in terms of access to services, with people in rural areas particularly poorly served.

While the vast majority of counties in Western Europe, North America and Eurasia implement both NSP and OST, these are still 'more absent than present' across Africa, the Middle East, Latin America and the Caribbean. Harm reduction in prisons also remains limited and has seen little expansion in over a decade, says HRI.

COVID-19 has 'tested the resilience' of harm reduction services, the report states, with many services forced to close or scale down during the worst of the pandemic. The invasion of Ukraine and the Taliban retaking control of Afghanistan have also had significant impacts on harm reduction provision, while funding remains an ongoing global challenge. The findings of HRI's monitoring of investment have been 'consistently dire', says the organisation, and this remains the case in the latest report.

Only a few international donors fund harm reduction, and their investment appears to be shrinking. 'In low- and middle-income countries, funding for harm reduction is only 5 per cent of the level needed to meet the estimated service needs for people who inject drugs by 2025,' says the report.

'*The Global state of harm reduction 2022* shows the positive changes that communities and civil society are making among people who use drugs through evidence- and rights-based harm reduction services,' states UNAIDS executive director Winnie Byanyima in the document's foreword. 'The good news is that change is possible and within reach, as long as governments and donors invest in community-led solutions that work. It is not only the right thing to do, it is their duty. Access to healthcare is a human right for all of us.'

Report at https://hri.global

www.unaids.org

'The good news is that change is possible and within reach, as long as governments and donors invest in community-led solutions that work.'

WINNIE BYANYIMA

Welsh drug deaths increase by almost half

MORE THAN 320 DRUG POISONING DEATHS were registered in Wales last year, an increase of 44 per cent on 2020's figure, according to Public Health Wales. Sixty-five per cent of these were classed as drug misuse deaths. Two thirds of the drug deaths involved a combination of drugs, including prescription medications and alcohol.

As is the case with Scotland and England's ongoing drug deaths crises, drug misuse deaths were disproportionately concentrated in deprived areas, with the death rate five times higher among those living in the most deprived quintile.

Opioids were reported in more than 70 per cent of the deaths, of which more than 90 per cent involved heroin/morphine. Most of the deaths were in the 40-44 age range, although there were 13 among the under-25s. Although the overall ratio of male to female deaths was around 3:1, 2021 saw the highest ever number of female deaths, at 57.

'Premature deaths from drug use are preventable,' said head of substance misuse at Public Health Wales, Rick Lines. 'Whilst the impact of drug deaths is experienced by the whole socio-economic spectrum, they are more than five times more likely to occur in those living in the most deprived areas in Wales compared to the least deprived.'

Deaths involving cocaine had more than doubled over the last five years, he added, while the increase in deaths involving benzodiazepines was also concerning. *Harm reduction database Wales: drug-related mortality at https://phw.nhs.wales*

KEY FINDINGS

- As in previous years, the most commonly reported substance group was opioids, reported in 150 deaths (71 per cent), of which 93 per cent involved heroin/morphine.
- Other substances reported were diazepam, cocaine and methadone. Poly-drug use was reported in 62 per cent of drug misuse deaths.
- In 2021, the ratio of deaths among males and females was around 3:1. Drug misuse deaths among females was the highest recorded in 2021, with 57 deaths.
- Most deaths occurred in those in the 40-44 year age group reported in 18 per cent of all drug deaths in 2021.
- There were 13 drug deaths in people under the age of 25.
- There remains considerable geographic variation in the age-standardised rates of drug misuse deaths across Wales, with rates ranging from 1.4 to 13.5 deaths per 100,000 population.
- Drug misuse deaths were over 5 times higher among those living in the 20 per cent most deprived areas compared with the 20 per cent least deprived areas in Wales.

Urgent call for review of alcohol harms

More than 50 organisations along with MPs and Lords have written to the prime minister calling for an independent review of alcohol harm. Coordinated by the Alcohol Health Alliance and Drugs, Alcohol and Justice APPG chair Dan Carden MP, the signatories are calling for an alcohol equivalent of Dame Carol Black's *Independent review of drugs*, which went on to shape the subsequent government drug strategy. The last UK government alcohol strategy was published a decade ago.

'Alcohol harm is a public health crisis that requires immediate government intervention,' said Mr Carden. 'With the highest alcohol-specific deaths on record, thousands of families destroyed and the enormous cost to the public purse, people are right to ask why there is no government plan to tackle alcohol harm. The financial and social uncertainty of the cost-of-living crisis is expected to increase alcohol consumption at harmful levels. Government must prioritise improving public health and evidence-based policies and move beyond simply reinforcing damaging ignorant rhetoric. An independent review of alcohol harm is the only way we can understand the scale of the problem and provide targeted recommendations to reduce the devastating harms of alcohol.'

Meanwhile, a new liver cancer support service has been launched by The British Liver Trust in response to rapidly rising cases of the disease. Liver cancer incidence rates have increased by 45 per cent in the last decade, while the death rate has increased by 40 per cent, making it the fasting rising cause of cancer death in the UK.

More than 6,000 people are diagnosed with liver cancer in the UK each year, with almost half diagnosed in emergency settings like A&E. The disease is most common in people who already have liver disease, especially cirrhosis, which is most often caused by alcohol, hepatitis or obesity. *https://livercanceruk.org/*

'An independent review of alcohol harm is the only way we can understand the scale of the problem.'
DAN CARDEN

Afghan opium up

THE 2022 OPIUM CROP in Afghanistan is the 'most profitable in years', according to UNODC, with cultivation up by almost a third and 'prices soaring'. This is despite a background of 'cascading humanitarian and economic crises' in the country, says *Opium cultivation in Afghanistan – latest findings and emerging threats*.

The report is the agency's first on the country since the Taliban took over power last year and later banned opium cultivation. While this year's crop was largely exempt from the ban farmers now face uncertainty around 'how the de facto authorities will enforce the ban' says UNODC. 'Afghan farmers are trapped in the illicit opiate economy, while seizure events around Afghanistan suggest that opiate trafficking continues unabated,' said UNODC executive director Ghada Waly. *Report at www.unodc.org*

'Afghan farmers are trapped in the illicit opiate economy, while seizure events around Afghanistan suggest that opiate trafficking continues unabated.'
GADA WALY

On safer ground

SAFE GROUND, which delivers group work across UK prisons to help reduce re-offending, is the latest charity to join the Social Interest Group (SIG), which supports organisations to maximise their income through the sharing of resources and learning.

'I am immensely grateful to Charlie Weinberg, CEO of Safe Ground, for building evidence-based programmes that make a difference in people's lives,' said SIG CEO Gill Arukpe. 'I am committed to supporting the good work of Safe Ground to ensure it continues to grow and make a difference in people's lives.' *www.socialinterestgroup.org.uk/*

Local News

RESIDENTIAL POTENTIAL
Phoenix Futures is joining forces with The Ley Community to develop a new residential service in Oxford. 'This is a partnership with huge potential,' said Phoenix chief executive Karen Biggs. 'This new service will offer vital additional residential treatment beds and life-saving and life-changing opportunities for recovery.'

BOX CLEVER
WDP service users in Redbridge will have access to free gym passes as part of the organisation's Capital Card scheme, thanks to a partnership with sporting charity Box Up Crime. 'The young people we work with in Redbridge will really benefit from these inspirational sessions and access to their leisure facilities, to help improve both their physical and mental health and wellbeing,' said WDP's Max Griffiths.

UNIQUE INSIGHTS
More than 30 graduates of SDF's addiction and recovery worker training projects celebrated their achievements at a ceremony in Glasgow, with almost all now in paid work. 'The unique insights offered by those with lived and living experience of substance use are critical to tackling drug deaths and harms,' drugs minister Angela Constance told the event.

TIME TO BREATHE

With poor respiratory health so prevalent among people who use substances we should seize the opportunity for intervention, as **Dr Abida Mohamed** explains

Chronic obstructive pulmonary disease (COPD) is one of the leading causes of mortality in the 21st century and is also associated with a high prevalence of comorbidity. It is a progressive illness, but early intervention improves quality of life (National Institute for Clinical Excellence, 2021).

The main causative factor of COPD is smoking tobacco, and the level of smoking is higher among people who are in substance misuse services than the general population (PHE, 2021). Poor respiratory health was also found to be more prevalent among opioid users (Hulin, 2019).

In the National Drug Treatment Monitoring System (NDTMS) 2020-21 report, 68 per cent of people entering substance misuse treatment in England smoked tobacco. In the 2016 NDTMS report, 45 per cent of people treated for illicit opioid use smoked crack cocaine and 17 per cent smoked cannabis (Hulin, 2019). Despite the high levels of smoking, only 2 per cent of people were recorded as having been offered referrals for smoking cessation interventions (PHE, 2021).

Alcohol, although not a direct cause of COPD, can weaken immune systems, and research has shown that it reduces the production of antioxidants that protect the lung (Kershaw, 2008).

WHAT IS COPD?

The research confirms that COPD should be considered a serious health risk as it is the second highest cause of emergency admission in hospitals in the UK. So, what exactly is COPD, and what can we do about it?

COPD comprises emphysema and chronic bronchitis, which are both thought to be directly linked to inhalation of substances, commonly tobacco, but can also include a wider range of inhaled toxins. There are several mechanisms by which opioids may contribute to the cause or consequences of respiratory disease, including suppression of neural respiratory drive, increased airway resistance and as an irritant stimulating histamine release.

Pascalkfl | Dreamstime.com

People with COPD present with the following symptoms:

- breathlessness, which can typically be persistent, progressive over time, and worse on exertion
- a chronic/recurrent cough
- regular sputum production
- frequent lower respiratory tract infections
- wheezing

Collaborative working between services will improve life expectancy and respiratory health outcomes for people with substance misuse problems.

Some environments can contribute to the risk of developing COPD, such as air pollution or working with dust and toxins, while people with genetic lung diseases or asthma are also at increased risk.

SIMPLE DIAGNOSIS

If left untreated COPD can progress from mild to severe, which can present with weight loss, breathlessness, loss of appetite and heart failure. Most GP surgeries can diagnose COPD with a simple test called spirometry, which looks at how the lungs are functioning and initiate and tailor treatment. The treating clinicians might also request a chest x-ray and blood tests, which will help determine if any co-existing conditions need to be considered.

COPD management firstly aims to reduce the risk factor by promoting smoking cessation, looking at environmental causes and physical health issues. The basic treatment is with inhalers, and regular follow-ups with your GP practice to assess the progression and need for any changes in medication. At Blackpool with Darwen we have lung health check machines, where service users can check their lung age and be referred to stop smoking clinics.

COPD AND SUBSTANCE USE

Research and meta-analyses of COPD in people who use substances are limited. A meta-analysis undertaken by Hulin *et al* in 2019 showed a predicted prevalence of 17.9 per cent of COPD in people who inhaled opiates, compared to the estimated general prevalence of between 2-3 per cent.

Conclusions drawn from research highlight the importance of considering the effects of environment and substance use on COPD. Primary health care, housing and substance misuse services should also explore improving living conditions and developing integrated respiratory health surveillance and promotion, while collaborative working between services will improve life expectancy and respiratory health outcomes for people with substance misuse problems (Hulin, 2019).

HOLISTIC CARE

As clinicians, we need to treat patients holistically and focus on all aspects of comorbidity. A range of skills is essential to promote holistic care, and Delphi recruits staff from a broad multidisciplinary background and encourages this approach to clinical management. A biopsychosocial approach that advocates opportunistic health promotion and intervention forms part of our ethos and drive to improve the quality of life of the people we work with.

COPD is a treatable (not curable) condition, and multi-agency psychosocial and health providers must promote access to resources to bridge the gap between health accessibility and service delivery to improve patients' quality of life.

Dr Abida Mohamed is clinical lead at Delphi Medical

THE RIGHT TECHNIQUE

As an NMP, **Pamela Lang** has a vital role in helping COPD patients to help themselves

In my previous role as a community nurse practitioner, I often provided treatment, care and education for respiratory patients experiencing COPD exacerbation. It was vital to advise when to commence their 'rescue' medication or how to use their prescribed inhalers correctly, as it contributed to self-management of a long-term condition. I could transfer and apply the skills and knowledge I had acquired in my previous job to substance misuse clients.

When clients are admitted to the detox unit, they often present with COPD, which is caused by long-term regular smoking and the smoking of heroin/crack cocaine. Education to aid self-management is paramount for our clients as they are only with us for a short period and must be allowed to understand the importance of taking their medication correctly. This, in turn, contributes to compliance and benefits long-term health outcomes.

James was a 38-year-old man who had smoked heroin for the past 12 years. His daily use was between two and three bags, and although a relatively young man, he had a recent diagnosis of COPD after a CT scan showed he had 'moderate to severe' upper lobe emphysema. James had been prescribed two inhalers by his GP but very rarely used them, as although he had been shown how, he had forgotten and just used them ad-hoc.

I explained to James that I would assess his technique and teach him when and why he should use his inhalers. He agreed to this. Firstly, I described the differences between the two inhalers. Salbutamol is a short-acting bronchodilator, and the 'pink' one (Fostair) is long-acting, and therefore must be taken twice a day, as the effects last around 12 hours.

Pamela demonstrates an aero-chamber to recovery worker Chris.

I explained that the 'blue' one, also often referred to as a reliever, was the one that he should have on his person to use when needed, but also pointed out that overuse of the inhaler could result in feeling shaky and anxious, developing a headache and experiencing a fast heartbeat.

James's technique was very poor, so he was not getting his metered dose when using it and having the impression that it did not work. I introduced an aero chamber and demonstrated how to use it effectively. He struggled at first but eventually began to feel the benefit of the medication and commented that he could feel the difference. Advice was also given on how to clean the aero-chamber and to renew it every six to 12 months.

Pamela Lang is a non-medical prescriber (NMP) at Delphi Medical

LOUD and PROUD

Addiction Awareness Week is a chance to get together on a far-reaching campaign, says **Mike Trace**

Forward Trust campaigns to raise public awareness around the causes and nature of addiction, raise support for people struggling with the condition, and instil a sense of belief in the potential for change and recovery. Part of this campaigning and communications work is the 'Taking Action on Addiction' campaign, built around an annual Addiction Awareness Week in the first week of November.

Now in its second year, this large-scale, multi-partner, public-facing campaign reframes existing perceptions of addiction. It builds awareness of the causes and nature of addiction, improves understanding, reduces prejudice and enables more people to ask for and receive help. With our founder partners – NACOA, Music Support, FAVOR UK, Phoenix Futures, Amy Winehouse Foundation, Steps 2 Recovery and Kaleidoscope – we joined forces with providers across our sector to promote all our work through a range of events and media activities.

You will have seen the campaign across social channels, engagement with sporting and music partners, publication of a new piece of polling on the cost of living, and high-profile messages of support which amplify our cause and the voices of the people we help.

We can't match the glitz provided by last year's campaign launch at BAFTA in Piccadilly with our royal patron the Princess of Wales and national treasures Ant and Dec. But we are at least hoping that Tony Adams has given us a mention on *Strictly Come Dancing*.

Behind all this is an attempt to move the dial on public perception, which still primarily views addiction as a moral weakness and lifestyle choice and believes that people struggling with addiction are not capable of change. A secondary audience is made up of people in the helping professions (including our own) who are sceptical about individuals' capacity to confront the root causes of their addiction, to break the cycle, and live positive and fulfilling lives.

I recall seeing a survey result saying that, when asked what percentage of people receiving treatment for addiction are capable of overcoming it, the average answer from healthcare professionals was 7 per cent. Forward Trust's answer is 100 per cent – not everyone will have the strength or support to turn their lives around at any given point, but everyone has the potential. And it is our job to do everything we can to strengthen their self-belief, and support them in whatever changes they want to make.

Forward Trust has just gone through a process of refreshing our strategic statements on vision, mission, beliefs and values. Prompted by the need to articulate a unifying purpose to an increasingly diverse set of services and client groups, we've tried to describe what we believe about social exclusion and emotional pain in our society, why we're motivated to do the work we do, and how we organise our services to remain focused on our mission.

Through stating our beliefs we're making a statement of why we believe our clients are often victims of their circumstances, as well as responsible for their own choices. The poverty, social injustice, alienation, emotional pain and despair felt by our clients is real, and represents a strong driver of risky, self-destructive or anti-social behaviour. This is a difficult concept to articulate without stereotyping or further stigmatising our clients, but we know that childhood abuse, neglect and trauma, or mental health problems such as anxiety, loneliness or depression, are highly represented in the people who need our services.

I would guess that most people in our sector are attracted to this work because they see these injustices and want to help people overcome them. It's why I came into the field back in the 1980s, and why I still love my job now. But we have to shout it louder, and that's why Forward Trust are putting more effort into campaigning. In addition to Addiction Awareness Week, our 'More Than My Past' website and podcast showcase dozens of life stories and our Forward Connect peer recovery network goes from strength to strength with activities around the country.

So please do all you can to learn about Addiction Awareness Week, but also use your skills, expertise and passion to push these messages out to your networks throughout the year. We at Forward Trust have started to get busy on this challenge and know there will be loads of creative ideas that we can work together on. If you or your organisation wants to pursue an idea or develop campaigns together, please get in touch with me.

Mike Trace is chief executive of Forward Trust, mike.trace@forwardtrust.org.uk

There are several public-facing activities that we can all support, simply by sharing, liking, or clicking on content, even after the week has passed:

TAKING ACTION ON ADDICTION social media assets have been running through the week. Please continue to interact with our channels: *@actiononaddiction* on Instagram, *@ActionAddiction* on Twitter and *@ActionAddictionUK* on Facebook – tag and share away.

SHARE THE HASHTAGS – *#AAW2022 #NotAChoice #RecoveryIsPossible #SupportNotStigma*

CONTACT LOCAL MEDIA to promote your service, linking to the messages of the campaign and using details from the polling to show the impact the cost-of-living crisis and the aftermath of the pandemic is having on addiction and recovery.

DISTRIBUTE THE CAMPAIGN POSTERS, which encourage people to reach out and ask for help, a message that we want to share well after Addiction Awareness Week is over. Please email *takingactiononaddiction@forwardtrust.org.uk* to request copies.

ASPINDEN CARE HOME

ASPINDEN CARE HOME is a specialised residential service supporting those individuals that are living with the effects of long-term alcohol misuse and/or addiction, are resistant to change, and exhibiting behaviours that challenge other services.

We have a team of personal health and wellbeing practitioners, recovery coordinators, in-house nurses, and senior management. The service provides accommodation and care with fluid and nutrition management through our own commercial kitchen.

Our work is person-centred to support individuals who have chosen to continue to drink alcohol by helping them live and thrive within a harm minimisation model, using a managed alcohol programme approach.

The service is based in Southwark, it consists of a purpose-built, 25 bed, mixed-gender facility providing 24-hour care with regular nursing and GP input to support residents' physical and mental health needs.

"Staff are around 24 hours a day. Anything you need to know or want, just ask the staff. They are always here."
Michael, resident

WE PROVIDE AN ENVIRONMENT THAT ENABLES OUR RESIDENTS TO:

- Manage their alcohol intake
- Better manage their safety, health and wellbeing
- Build and develop personal resilience
- Develop positive social relationships
- Spend time with their families and important others
- Prepare for independent living or move on, if that is their goal
- Benefit from long-term care and support where they are living with Korsakoff syndrome
- Benefit from short-stay respite and refresher stays

TO MAKE A REFERRAL:

020 7237 0331 enquiries.ach@equinoxcare.org.uk
www.socialinterestgroup.org.uk 1 Aspinden Road, London, SE16 2DR

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Social Interest Group

WAR WITHOUT END

This year's HRI *Constellations* event featured a conversation between David Simon, creator of *The Wire*, and former mayor of Baltimore, Kurt Schmoke, on harm reduction, decriminalisation and the ongoing drug war

'The problem we had wasn't drugs, but folks being hooked on drug money,' Kurt Schmoke, the first African-American mayor of Baltimore, told *Constellations*. 'We need a way of addressing this that would take the profit out of distribution.'

As mayor he'd tried to move towards a public health, and away from a criminal justice, approach to drug issues, he said. Although much of this – such as needle exchange programmes – was now mainstream, at the time the reaction had been 'that I was crazy and ought to be impeached'. This was particularly the case when he started to openly discuss decriminalisation, and when he left office in 1999 after 12 years his successor reverted to a hardline approach.

ARMY OF OCCUPATION

This shift had destroyed community relations with the police, said author, journalist and creator of the Baltimore-set *The Wire*, David Simon, as they had effectively become an 'army of occupation – and nobody talks to an army of occupation'. The city's most vulnerable communities were now simultaneously over-policed and under-policed, he stated. 'They're over-policed on that which shouldn't matter, which doesn't involve crimes against persons, and grossly under-policed when it comes to taking the shooters away who are terrorising these neighbourhoods.'

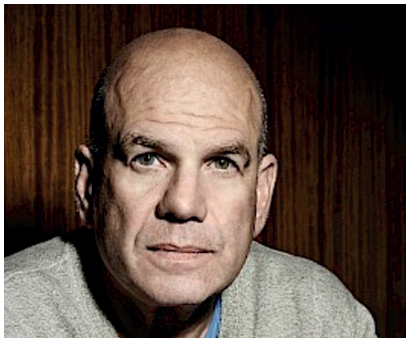
All this 'stark period' of mass arrests had achieved was to make the city more dangerous, he said, as an entire generation of police had been trained in how to fight a drug war rather than in the skill set needed to investigate violent crime, with the result that the clearance rate for murder had halved. 'When you train police to emphasise mass arrest and to credit a drug arrest – as meaningless as it is in a city like Baltimore – as meaningful police work, you're also training a generation of police how not to do the things that you really need police to do.'

The conversation about drug laws, however, was now changing at a local level, said Schmoke, as the explosion of addiction to prescribed drugs like OxyContin meant more and more people knew someone who had a problem – but it remained largely unchanged at a national level. 'It's still being driven by politics rather than science.' The fact that addiction to synthetic opiates had 'reached into the white community in a very big way' meant that 'suddenly the notion of a draconian war on drugs becomes less tenable', added Simon, while the era of fentanyl also meant that harm reduction measures like overdose prevention sites were more necessary than ever.

UNSUSTAINABLE VIOLENCE

Schmoke had seen the attitudes of some police leaders change over time while he was mayor, he said, with more becoming sympathetic to his ideas. 'When police were in the midst of their career they wouldn't speak openly to their cynicism about the drug war, but when they got to the end of their career and looked back they could be blunt as hell,' added Simon. 'There is a cost to decriminalising drugs because some of them genuinely are dangerous and they will have a negative effect' in terms of overdose deaths, he acknowledged. 'But doing what we're doing is creating levels of violence that are completely unsustainable for cities.'

The drug war in the US had its origins in demonising the Chinese community in the late 19th century, Simon stated – 'the yellow peril of opium' – and very little had changed. 'The drug war is a function of fear. It works for politicians as an operation that requires and savours the fear of the body politic. And what better fear is there in America than the fear of the other race? If you're trying to get people to vote out of fear what can work better than, "These terrible drugs, they're endemic in this other community of people who are not like you, and they're coming for your kids." That's a raw political message. And the only way you demystify it is by talking about overtly.' **DDN**



'The drug war is a function of fear... And the only way you demystify it is by talking about it overtly.' DAVID SIMON

'The fact that synthetic opiate addiction has now reached the white community makes the notion of a draconian war on drugs less tenable.' KURT SCHMOKE

FAMILY MATTERS

Introducing Harper House, Phoenix Futures Scotland's new specialist family service

The new Care Inspectorate registered service will provide drug and alcohol treatment that considers the impact on each member of the family and the family unit as a whole. We are the only service of our kind across Scotland that welcomes dads as part of the programme as well as mums. Families stay together at the service, meaning that parents remain the carers of their children whilst taking part in a therapeutic treatment programme to address their substance use.

Parents with drug or alcohol problems can find the complex range of appointments for drug treatment, housing, healthcare, and childcare very difficult to keep up with in their home setting. Lack of appropriate childcare and housing is frequently identified as a reason parents struggle to get the support they need. This new service removes that barrier by enabling parents to access all the care their family needs in one residential setting.

Our flexible programmes at the Specialist Family Service are responsive to families' needs and last between 12 and 26 weeks. Each programme brings together three main elements – therapeutic interventions, parenting and childcare responsive to the individual needs of each family.

The service provides care based on a comprehensive assessment of child development and wellbeing, as well as making observations around parenting. Children have access to our on-site Children's Day Care Centre, and our integrated teams ensure support for the whole family.

Our community members benefit from direct access to the highly experienced childcare team who utilise bespoke specialist techniques developed through our unique experience, alongside accredited assessment, and monitoring tools, in accordance with the *Pre-birth to three* guidance document and *Curriculum for Excellence*.

The service is set in a large newly refurbished building located in Saltcoats, North Ayrshire, near the town's beautiful beach and promenade. Each family will have their own large family suite with access to a kitchen and ensuite accessible bathroom facilities. Outside there is an enclosed dedicated play area for children and a large garden space for outdoor activities including our Recovery Through Nature programme.

This service has been developed in partnership with the Scottish Government and therefore there is no cost to local authorities or families resident in Scotland for a placement at the service.

For further information please use the QR code or visit our website. Alternatively email us on ***specialist.family@phoenixfutures.org.uk***

'The new service will help families affected by a parent's drug and alcohol problems to remain together while receiving the appropriate support to help them flourish, thrive and reach their full potential. We will provide a homely environment that is safe, secure, supportive, and stimulating. Our approach is person centred and innovative with a dynamic approach to play and learning to ensure that all families using the service feel loved and respected. Our aim is to benefit the lives of the families who utilise our services, reduce drug-related deaths and provide early intervention to help prevent intergenerational cycles of trauma, adverse childhood experiences and substance use disorders.'

Kerry McGhee, registered manager, Specialist Family Service Scotland

ON THE SAME TEAM

In the second of our three-part commissioning series we look at creating effective operating partnerships between commissioners, providers and people with lived experience

In the wake of Dame Carol Black's landmark *Independent review of drugs,* the government announced almost £800m of new funding to rebuild and revitalise the country's ailing treatment system. But for the money to genuinely transform the treatment on offer the right commissioning structure needs to be in place.

In part one of this series we surveyed the commissioning landscape after years of budget cuts (*DDN*, October, page 12), and in part two we look at how the sector goes about creating genuine partnerships between commissioners, service providers and – crucially – people with lived experience.

The Carol Black review set out how people with lived experience would need to be central to any treatment system that met the needs of those depending on it, while the new Commissioning Quality Standard (CQS) says that local areas will know they're achieving the desired level for strategic and commissioning partnership when people with lived experience are included in their partnership structures. But how close are we to achieving that?

'It's for commissioners and providers to work in collaboration to create the fertile ground for that to happen, and make sure it's not tokenistic,' says operations manager at WDP, Craig Middleton. 'You don't want it to be "we've ticked that box, we can move on now" – it's about how we actually make this work authentically. It's not easy to do well, but it's not impossible.' This means getting 'all the right people in the room' and having strong co-production elements with commissioners, service users and providers, he says.

DOING IT TOGETHER

Effective commissioning is always a relationship, stresses joint commissioning manager at Cornwall Council, Kim Hager. 'Some people see it as a transactional, top down/directional approach, and transactional approaches don't deliver. We have to do it together. And it's not just service users and experts by experience – the bit that gets missed out is families and communities. It's really important that they're part of that. We need to stop seeing drugs and alcohol problems as happening in isolation because by the time you've developed problematic use, you've accumulated a bunch of other problems like offending, housing, mental health.'

With some bid processes the involvement of service users is explicit, says executive director of development at WDP, Graham Howard. 'It will tell you the name of the group that's been involved, how they've done it, and there'll be an element of the bid where they've set a question, or you go to a presentation and there's a service user panel there. It's clear that it's happening.'

However, consultations with service users to create a needs assessment or specification can often be followed by confusion around how they're actually going to be included in the process. 'Bidders may be informed that service users are on the marking panel or something like that, but unless it's black and white in the bid – or you go to a presentation and you're presenting to service users – it can be hard to know what their levels of involvement are.'

WHAT IS GOOD PRACTICE?

So what does genuine good practice look like when it comes to involving people with lived experience?

'One tender I was involved in recently was excellent,' says

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'Commissioning is always more effective when there's genuine engagement with the people the services are commissioned on behalf of.'
KIM HAGER

'A lot [of LEROs] are doing a huge amount of work that goes unrecognised and unfunded.'
DOT SMITH

'...make sure there's a requirement within service specifications for contracts that LEROs are an active part of.'
SARAH ALLEN

'On the provider side it's really about trying to get the balance right between nurturing and being able to share power.'
CRAIG MIDDLETON

Howard.' It was very clear how they'd done it – the service users had set a question, they were presented to, they were facilitated to ask questions, and they were supported by the commissioners. There have been pockets of best practice like that in tendering for the entire time I've been doing it, but hopefully with the new commissioning standard it will become the norm.'

Another example was a bid where providers were asked to describe their offer to service users, which would then be marked by the service users themselves. 'Instead of trying to give service users the whole bid and them having to get to grips with everything that's going on, responses described the overall offer, assessing whether the service model would appeal to them directly,' he says. 'That felt like really good practice.'

Commissioning is always more effective when there's genuine engagement with the people the services are commissioned on behalf of, rather than an 'ivory tower' approach, Hager states. This means it's vital to avoid service users being told 'we'd like you to be involved' and then nothing is done about facilitating how that can realistically happen – 'the structures of meetings, or enabling people to participate. It's not easy, but there's a wealth of experience out there depending on who you work with and how. Engagement has to be meaningful.'

One of the things her council did that had the biggest impact – 'and I had to be convinced to do it' – was creating jobs for experts by experience, she says. 'We created 12 in the first instance, as sessional workers to be properly employed by the council so that they can contribute to any agenda as part of co-production and collaboration – not just the drugs and alcohol agenda – and be properly paid and supported to do so. It's been the most impactful thing we've done to date.'

LOCAL LEROS

Another very obvious way to put people with lived experience centre stage is via lived experience recovery organisations (LEROs). However there aren't very many areas where the local authority has a direct arrangement with the local LERO, says chief executive of Recovery Connections, Dot Smith. 'We're really one of the fortunate ones because we've been directly commissioned by the local authority for six years.' This is partly down to the way the tender was put out, with the commissioner separating the recovery element of the contract, but her organisation also has a very strong relationship with Change Grow Live in other areas where it works on specific parts of contracts – a more typical arrangement.

'Unless it's black and white in the bid – or you go to a presentation and you're presenting to service users – it can be hard to know what their levels of involvement are.'
GRAHAM HOWARD

CLERO is also developing its own quality standard for services, with the website due to go live soon. 'There are different sized LEROS nationally, but a lot of them are doing phenomenal work without any payment,' says Smith. 'We've developed some core standards about what a LERO is, and the quality framework we're working on will fit behind that. Because if you want to be commissioned you've got to jump through a few hoops and fulfil a fair few criteria for a local authority to be able to release any sort of funding.'

Many LEROs won't be in a place where they can do that, she says, at least not yet. 'There's a lot of indirect costs if you want to position yourself as an organisation to take on a local authority contract – things like insurance are really expensive – and you need an infrastructure to be able to deal with money that comes with obligations and governance.' All of this means that a lot of support and capacity building will be needed to develop the LERO landscape to a point where it's the norm to have well-funded, well-equipped LEROs in each area.

Back in 2018, chief executive of Build on Belief Tim Sampey told *DDN* that peer-led organisations with strong track records were often excluded from tendering unless they subcontracted their services to a large provider, or else were levered in as 'added value' with specifications 'so fuzzy as to become meaningless' (https://www.drinkanddrugsnews.com/the-right-focus/).

RECOGNITION

So have LEROs been marginalised up to now? 'I think we have, for sure,' says Smith. 'A lot are doing a huge amount of work that goes unrecognised and unfunded.' The issue isn't so much that commissioners haven't been taking LEROs seriously enough, but rather that they often don't understand the concept, she points out. 'That's not a criticism – it's purely because there are still a lot of areas where there isn't a mobilised recovery community doing this stuff, so why would they know?'

'Contracts tend to be for whole systems, and that's not the offer

that LEROs want to deliver,' adds executive director of new business at With You, Sarah Allen, whose organisation has long-standing partnerships with LEROs such as Double Impact in Lincolnshire. The role of LEROs is 'very specialist and the value they bring is really important', she says. 'I think one of the things we can do better is make sure there's a requirement within service specifications for contracts that LEROs are an active part of.'

One of the challenges is around funding and allocation, she states. 'If there are always going to be sub-contracted organisations to a large provider then there needs to be a commitment that it's a long-term relationship, and we absolutely make that commitment with our LEROs. They need that stability and investment in their own infrastructures. A lot of the conversations we have with LEROs are around "if you're taking on this additional work, what is it you need to support you to do this?" I would welcome it if commissioners ring-fenced money for LEROs in contracts. We also work with LEROs where they have a specific contract in their own right – not every area has a LERO, and as large organisations I think we have a responsibility to not step into that and say "we'll do everything".'

Rather they should be looking at how they can support the community to develop their own LEROs so they can retain an independent function away from larger providers, she says.

BOX TICKING

It's also important to avoid any situations where simply including a LERO in a contract potentially risks being reduced to its own form of box ticking. 'What I worry about is things coming out of the centre like "you need to have a LERO in your area",' says Hager.

'I'm always worried by single organisations, because how inclusive and representative are they? The challenge is true representation and inclusivity – how far can you stretch that? Are women adequately represented? People with multiple vulnerabilities? That's the challenge – how meaningful is it, how inclusive is it, and how far are you prepared to cede power.'

Making partnerships meaningful means actually supporting people to participate effectively, not just inviting them to meetings, she says. 'I used to train service user groups across the south west, which included things like what commissioning is and the structures and processes that many of us take for granted.

'As a minimum, it's really important to equip them to understand the environment they're working in, as it can be so alien. Even better, move and change your structures and processes, and involve people with lived experience in making them more effective and inclusive. It's not enough to say it, it's about what you put in place to make it happen, and the skills that the people need to be able to do that. Most importantly, what we learn through that process, together.'

It's clear from the CLERO membership that a lot of people and organisations are 'desperate for somebody to help them to build up that expertise and grow their experience', agrees Smith – 'help them position themselves where they can then be commissioned to do the work that generally they're already doing, but to be paid fairly and equitably.'

Part of the imbalance is that national organisations clearly have much more 'collateral' when it comes to bidding for tenders, she says. 'They just have such a huge infrastructure compared to a local LERO', while the mechanics of a bidding process can appear impenetrable to anyone with little experience of them.

WHAT ELSE CAN WE DO?

So what else can commissioners be doing to improve the situation? 'In terms of support to aid development they can ensure that when they're commissioning LEROs the funding available is enough to provide equitable salaries, because the staff they have are as qualified if not more qualified than staff in some of the larger organisations,' says Smith. 'Some of our staff are qualified to masters level – it's fundamentally wrong to pay minimum wage for a recovery worker. And where there isn't a LERO visible, the commissioners and larger commissioned organisations need to be looking out to see where there's one emerging and help them mobilise and grow so that at some point they're able to have some equity in terms of the commissioning.'

'I've worked in a couple of areas where we partner with well-established service user groups, which now you'd call LEROs,' says Middleton. 'On the provider side it's really about trying to get the balance right between nurturing and being able to share power, being open and embracing it. That's where it's happened well. I can see developing more elements of co-assessment in the future – getting people in as part of inspections and audits to tell us how they're experiencing services and what could be done better.'

'I think there's a lot more we can do as providers to support service users, because it's invaluable that they're part of this process,' agrees Sarah Allen. 'Without them we won't get the same quality. In terms of the commissioning standards themselves, we have lots of volunteers within services and peer mentors, and we've also developed specific paid lived experience roles within the organisation. I think that's a really good step in terms of working towards those standards and starting to embed them. Yes the commissioning standards are there at the point of the contract, but they need to be there through the life of the contract. That's how we're going to know if we're achieving this – by having that continual review.'

'I think we're on the right path for lived experience, and the commissioning framework will help,' says Smith. But for this to work a lot of it comes back to 'building trust and brokering relationships', she says. 'Trust really is a key word – we've got to trust people and trust small organisations. The work that we're doing as CLERO is just trying to help LEROs build in a way that's going to position them to be able to get a piece of this pie, because what I'd hate is if they were overlooked because they don't tick the boxes. That would be an absolute shame.'

But ultimately, when it comes to genuinely involving people with lived experience, 'you have to be honest about the limits of your ambition – how far you're willing to give up power or have it taken,' states Hager. 'In Cornwall, our ambition for co-production is high. I'll know I've succeeded when they take my job.'

See next month's DDN for the final part of the series

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


COMMISSIONING

THE RIGHT FOCUS

An effective review of commissioning will need input and inspiration from everyone involved – practitioners, commissioners, and especially those using services. **DDN** reports

GOALS

RESEARCH

It's a lose-lose situation for commissioners, providers and most importantly service users as tenders are issued where it is just not possible for even the leanest organisation to deliver...

Back in 2018, chief executive of Build on Belief Tim Sampey told *DDN* that peer-led organisations with strong track records were often excluded from tendering unless they subcontracted their services to a large provider, or else were levered in as 'added value' with specifications 'so fuzzy as to become meaningless'.

www.drinkanddrugsnews.com/the-right-focus/

GAME CHANGER

Learning that opioids can be linked to a dramatic drop in testosterone is essential knowledge, says **Richie Moore**

I'm quite an 'expert patient' when it comes to methadone maintenance therapy (MMT) and opioid substitution therapy (OST). I've been on various forms of OST/MMT for the past 22 years and, when my story begins, I was taking a dose of 100ml methadone daily. This worked brilliantly in silencing the nagging voices of craving that were ever present when I was on a dose of 40ml and it helped me create a more stable life with my then partner and our rescue cat, Honey.

On the outside things looked pretty good for me and my partner, who I'll call Kika. We were both working – I was an advocate for drug users using local treatment services. I've struggled with depression throughout my life and I'm also a survivor of a few traumatic attacks, so I was used to trying to deal with low mood. Nonetheless, I was feeling more depressed and very sluggish with low energy. Our sex life which was great at the start had dwindled to nothing for a few years, and for this I had a nagging sense of guilt. I'd read about opioid-induced androgen deficiency (OPIAD), a condition which affects men and women who've been taking opiates/opioids for some time and causes a dramatic drop in the production of testosterone. I learnt that testosterone is vital for us to feel energised and motivated for all aspects of life, not just sex.

At this time my treatment was under the care of my GP. I've been very lucky to have all three of my GPs happy to treat me, but my longstanding and much-loved GP had just retired and it took me some time to convince my new GP to test my testosterone levels as he believed I was dealing with depression. When he did, the test demonstrated that my testosterone levels were on the floor – or at castration levels, as the research says. He started my testosterone replacement treatment but sadly my long-term relationship with Kika was already on the rocks and it was too late to row back, despite my libido returning. Thankfully we remained very close friends.

Now I'm certainly not claiming that testosterone replacement is some sort of magic bullet. My contract had ended and my mum had died. I'm not going to claim that having a libido back as a 50-year-old shortish jobless man was always easy. It was other aspects of having my hormones right that have been, ultimately, a game changer for me. Having more energy helped me take up the offer of a gym partnership from another long-term friend who's now in abstinence-based recovery. Alongside a short local run which I do most days, this has helped me fight off the low mood which dogged me.

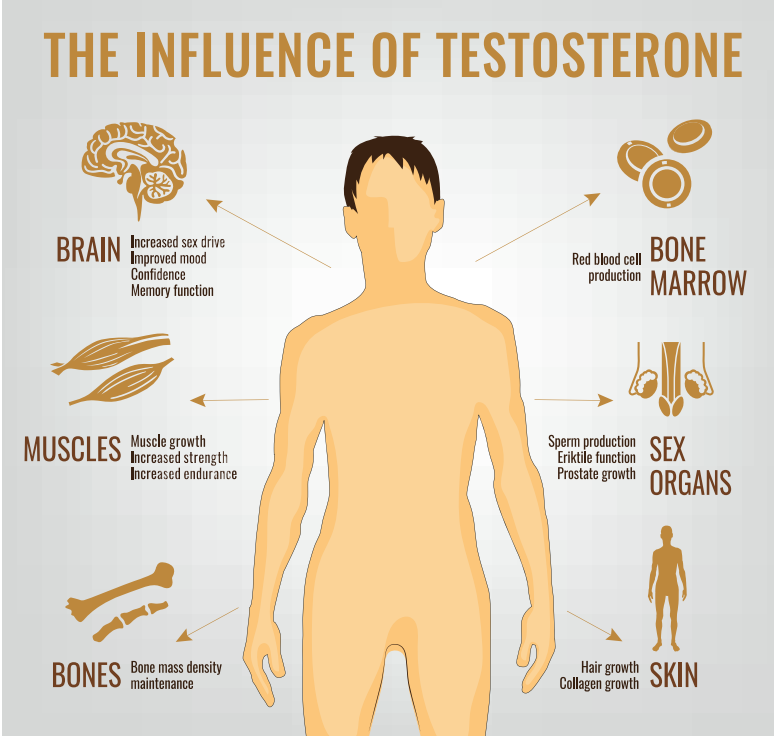
The reason I wanted to write this article is because I've found that knowledge of OPIAD is lacking among many doctors and drug workers. People who are on long-term opioid treatment, either for pain or drug dependency, are having the symptoms of an androgen deficiency misdiagnosed as being purely related to their mental health. They are much more likely to be treated with antidepressants than have their blood tested for abnormally low testosterone.

Even less well known is the vital function of testosterone in women, and the impact that this can have on women either suffering from OPIAD or living through the menopause. The level of testosterone in women is about one tenth to one twelfth of its level in healthy men, but it still has a vital role.

One last but significant point is that when myself and Kika first started seeing each other I was on a high dose of buprenorphine which, for me, didn't seem to have the same impact on my sex drive. More thorough research than this anecdotal report would obviously be needed to establish whether buprenorphine has the same effect on testosterone production.

For a fully referenced research paper on OPIAD visit https://www.painphysicianjournal.com/current/pdf?article=MTcxMg%3D%3D&journal=68

People on long-term opioid treatment... are much more likely to be treated with antidepressants than have their blood tested for abnormally low testosterone.



newannyart / iStock



CALL TO HARMS

Our approach to drug-related deaths is dangerously out of date, says the Drugs, Alcohol and Justice APPG. **DDN** reports

'Stigma has profound public health implications,' said Dr Adam Holland of the Faculty of Public Health. 'It can be internalised and cause mental health problems, and it can also mean people don't want to go back to services to seek support.'

The Greeks used the term stigma to refer to bodily signs – cuts or burns to show the person was a slave, a criminal or a traitor. 'In modern society we don't brand people who use drugs, but we punish them by giving them a criminal record and diminishing their life chances,' he said.

Since decriminalisation in 2001, Portugal had seen a reduction in problematic drug use, he said, and demonstrated that 'it's not necessary to criminalise people who use drugs. There are other ways.' Punitive measures could lead to more risky behaviours by driving drug use underground and reducing the potential for harm reduction interventions, such as clean needles.

'We treat drug use differently from any other public health issue and use stigma as an instrument,' he said. 'But we need to think about things that are outside people's control that make them more likely to use drugs in harmful ways.' Drug use and drug-related harm were not the same thing, he emphasised, 'so there is not a direct link between reducing both'.

He called on everyone to sign an open letter calling on government to rethink the approach of the *Swift, certain, tough* white paper relating to drug possession offences – the letter has been supported by individuals and organisations working in drug policy, health and social care, criminal justice and human rights.

> 'We need to make it safe to talk about drug policy, about creating an environment where people can put their head above the parapet without being shot down.'

DRUG-RELATED DEATHS

Paul Breen from the Office for National Statistics (ONS) presented detail on the latest drug-related death statistics – the 2021 registrations of deaths related to drug poisoning in England and Wales. The figures included drug poisonings and deaths related to drug dependencies (but didn't include accidents that happened while under the influence of drugs).

The 4,859 deaths related to drug poisoning represented a 6.2 per cent increase on the previous year – a rate 76.6 per cent higher than a decade ago. It represented a record high, for the tenth year in a row since 1993.

There was a clear link between deaths and deprivation. In England the death rate for males was seven times higher in the most deprived areas and about six times higher for females. Separate data for Wales showed almost identical trends. Regional variations in England maintained the clear north-south divide, with the North East still worst and the East of England and London with the lowest rates.

The map of mortality rate age groups for 1993-2021 showed that the problem was focused on a particular generation – people who were born in the first half of the 1970s and were now in their late-40s. 'So for the roots of the high death rates today, the causality goes back 20 or 30 years,' said Breen.

DRUG TRENDS

Looking at the trends in specific substances, opiates had always dominated the drug deaths data, with roughly 60 per cent of the deaths involving an opiate, but this was starting to level off. While heroin and morphine had fallen slightly, there had been 'quite a sharp rise in methadone, which might be related to the pandemic and cutting off people's access to drug treatment services,' he said. 'They might be doing more of it unsupervised'.

The fastest rising substances in the last five years were pregabalin and gabapentin – known as gabapentinoids and often taken alongside benzodiazepines and opiates, cocaine, mirtazapine (an anti-depressant) and methadone. Also of interest were new psychoactive substances (NPS) and some benzos were categorised as NPS.

FALLING BEHIND

Discussion among members of the APPG, chaired by Dan Carden MP, focused on unacceptably high statistics, a call to redouble efforts to remove barriers of stigma,

TO SIGN THE LETTER calling for a government rethink on *Swift, certain, tough*, scan the barcode

and the urgent need to kick-start politicians into realising that we were falling behind other countries – including the US – in shifting our approach to drug policy.

'This increase in deaths should not be acceptable to any of us,' said Evan Chiswell of Humankind. With demands for support continuing to rise, the cost of living crisis having a very real effect and inequalities gaps widening, investment was ever more vital. 'Only with sustained support can our sector and our lived experience partners continue to work towards preventing many of these tragic deaths,' he said.

Stigmatisation could be addressed through good diversion schemes – and knowing what these looked like, suggested Megan Jones from Cranstoun. It was an opportunity that 'should be rooted in harm reduction education and directing away from the criminal justice system' and was 'a chance to work much more collaboratively and consistently across police force areas'.

'Something needs to be done about the DBS [Disclosure and Barring Service] added John Graham, who worked for 25 years in primary treatment 'where a lot of deaths take place'. 'People who offended society were branded and stigmatised, but the current protocols in the DBS with regard to disclosure are the modern equivalent of that kind of branding,' he said. People in recovery who had 'moved on from their old behaviour' were still branded by the need to disclose criminal offences from when they were in active addiction, which might be many years old.

Embracing a trauma-informed approach was also essential, said therapist Liz Martin. 'The reality is we're condemning people who are ill. I've yet to meet anyone in prison who doesn't have trauma in their background.'

'We need to make it safe to talk about drug policy, about creating an environment where people can put their head above the parapet without being shot down,' said James Nicholls, senior lecturer in public health, while Yasmin Batliwala of WDP called for political parties to stop looking backwards. 'In this country we've stopped thinking, we've stopped looking at possibilities and potential,' she said. **DDN**

'Until my detention six years ago, despite drinking anti-socially alone every day of every week, I refused to accept that I was an alcoholic.'

STIGMA IN PRISON

Until my detention six years ago, despite drinking anti-socially alone every day of every week, I refused to accept that I was an alcoholic. Now almost 2,200 days in recovery I am proud to be part of our integrated substance misuse service team (ISMS) supporting others here at The Verne.

EDP is the charity organisation that offers a whole range of services that includes in-cell workbooks, SMART groups, First Steps programmes as well as arranging fortnightly AA meetings and bi-monthly recovery talks.

However, as one of two ISMS peer reps here I cannot help but feel that a stigma is attached to those suffering issues of addiction, as only one in 12 here use our services for their recovery. This is especially strange in that while we all accept that we're here because of conviction for the whole spectrum of sexual offences, there remains some who are perhaps afraid to show weakness to others because of an addictive illness.

If anyone has any comments or views on how I can 'promote' acceptance or suggestions of a promotional activity we've not thought of, I'd be grateful if you could share.

Name supplied, HMP The Verne

INVOLVE US INMATES!

What you need at *DDN* is to involve serving prisoners and offer help and good advice to us who are locked away from the (freedom) world – who are limited in our ability to get the real help that we so desperately need and so desperately want. Please will you do this with *DDN*, because right now your magazine is absolutely useless to all inmates in every single prison/jail in the whole wide world.

All the advertisements are for people on the outside world and most ads are about jobs that none of us inmates can ever get and the only way to contact any of the ads is by phone or internet – there's no address for inmates to be able to write to.

It does have some stuff inside for ex-convicts on how they can stay safe when they take drugs or turn back to the bottle. One thing that I really do not like or agree with is that you seem to advertise drug paraphernalia – drug equipment such as injecting needles, boiling spoons, rubber bands to tie around arms so that you can get a nice big fat juicy vein for injecting into and other information on how to safely take/do drugs and drink. It is extremely wrong and barbaric. You should be giving vital information to drug addicts, alcoholics, ex-drug addicts and ex-alcoholics on how they can get off the evil nasty stuff, get themselves clean and stay clean for the rest of their lives. You are making users crave and want to use again and chase the buzz – fact!

I'm not saying your *DDN* magazine is purely negative because I've seen some positiveness such as charities helping users and ex-users on the outside world. But seriously, if you're not willing to involve us prisoners, us human beings, then I no longer wish to be a part of you and do not want to receive your *DDN* magazine. Are you willing to look at finally involving us prisoners in your magazine?

Name supplied, HMP Wakefield

DDN editor responds

DDN regularly receives letters from people writing from prison – your contributions are invaluable. Only by giving us your feedback do we know what you want to read. I hope our readers and advertisers take on board your advice on inclusivity.

On your point about paraphernalia: we're 100 per cent committed to harm reduction and the guiding principle that no one can recover if they're dead. This doesn't diminish our belief in great support services and the vital work around recovery, but these are tools in a very necessary toolkit for many people, and everybody should have the knowledge to save lives.

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

/ddnmagazine @ddnmagazine
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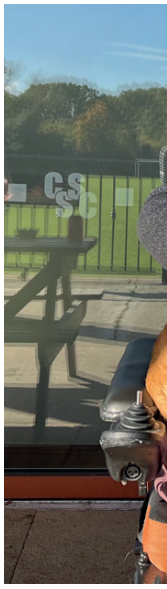
A NOSE FOR DUTY

The job of detecting drugs in prisons falls to a very keen team, as **DDN** discovers



It's Tuesday morning at the village sports and social club. Three people stand in a line inside the venue, about two metres apart. A man in dark clothing – who turns out to be a prison officer – watches from the side. The door from the outside terrace opens and a police officer steps inside with a young black labrador. The people in the line stiffen slightly and the dog wags at them enthusiastically.

The dog handler asks whether anyone has anything on them they would like to declare, then explains that she will conduct a brief search. She moves the pup to the first person, gently guiding him towards their shoes, their pockets, their clothing. She asks a tall man to sit on a chair so the dog can sniff his pockets and hood more easily. The dog concentrates and moves to the points indicated by his handler, rising very gently to sniff the higher points on each person's body.

Suddenly the dog tenses and remains completely still, rooted to the spot, focusing intently on the last man's pocket. He has indicated, successfully, that there's a gram of coke in it. The tense atmosphere breaks, the handler unclips her dog from the lead and rewards him with heaps of praise and a joyful game with a squeaky ball, before taking him outside for more ball play on the field.

TRAINING TECHNIQUES

The people in the line swap over to a different three, another dog handler appears with a different dog, and the exercise begins again. This is the format you would see in different settings throughout the criminal justice system to detect drugs, but today it's a training exercise and the dogs are young pupils learning the techniques alongside their handlers.

They are introduced to people of various sizes and ages, including a child. Different people are brought into the line-up, the drugs are moved around the participants, and the handler sometimes asks people to sit on a chair for the search. The dogs encounter a motorised wheelchair for the first time and Paul is asked to move forward and turn his chair

Photos from top left: Dog handler Wilkes with his three-year old black lab and dog handler McColvin with her 18-month-old springer spaniel.

Andy Baskett, HM Prison Service national dog trial champion, with Penny, best search dog in the country

Nikki with puppy Charlie, dumped by the roadside at 12 weeks but now getting used to the prison environment to prepare him for training.

Charlie has the opportunity to encounter Paul's wheelchair after the older dogs' training has finished.

off before the dogs are gently encouraged to sniff all around the wheels and the mechanism before moving on to his pockets and clothing. They are rewarded when they find 3g of cannabis hidden in his shoe and the appearance of the squeaky ball dispels any nerves about the chair.

DOG CHAMPIONS

Andy Baskett has been a prison officer for 32 years, and a dog handler for 17 of them. Between the changing line-ups he steps out from the corner where he has been watching, encouraging and giving some subtle feedback to the officers, to explain what's going on. He's been training dog handlers for four years, alongside his colleague Martin, and has been the HM Prison Service dog trial champion for seven years – a fact that's revealed by team members who clearly value his expertise enormously. However reluctant he is to blow his own trumpet, he's immensely proud of his labrador who has been 'best search dog in the country' for the past four years.

The training programme covers the whole of the South East and includes 70 handlers and 100 dogs, he tells *DDN*. The dogs are mainly found at rescue centres and dog dealers' premises and are often the ones rejected by families for being too naughty or challenging. This energy and 'prey drive' can convert successfully to working for the reward of a ball, and an 'interview' with a pup can take the form of testing reactions with a ball. 'We want it to use its nose, so we play with a tennis ball and then hide it,' says Andy. 'They have to scent it out, and if they can find it, they can hunt out drugs.'

THE BEST BREEDS

Labradors are the favoured breed for becoming a passive people-searching dog, 'because we want a dog that looks friendly. Whether people are old, young, disabled – everyone likes labs, the Andrex dogs. They look friendly but they have a hunt drive.' Collies are 'too smart' as they don't see the point of searching the same person twice in a training exercise, but a collie-lab cross can make the best dog with a mix of both breeds' traits. The more hectic springer and cocker spaniels have all the right traits for searching areas so are the best choice for active roles, he explains.

Once matched with their new handler, the pup goes to live at their home so that they are with them night and day. Everything – kennelling, transport, upkeep – is paid for by the service, and their training can begin right away if they are old enough, which is generally about 15 months. The service usually takes dogs up to two and a half years old, 'but we'll take them older if they have the drive'. Sometimes they meet them as puppies, such as a recent prospective recruit who was found dumped by the roadside. The life ahead of them represents the most amazing transformation of fortune.

> Suddenly the dog tenses and remains completely still, rooted to the spot, focusing intently on the last man's pocket. He has indicated, successfully, that there's a gram of coke in it.

Each handler will get two dogs, a passive lab and an active springer, says Andy, and the dogs always belong to the service. The passive dogs usually work for five to six years and the active ones eight to nine years, at which point the handler can choose whether to keep the dog or rehome them with friends and family.

When they begin their training, the passive dog will learn to search in different prison environments and will have to get used to noise, including gates crashing. They will learn to search prisoners, prison visitors and sometimes staff as well, in pop-up searches.

The six-week training course (four weeks for the active dogs) leads to a year's licence from the Inspectorate, for which they must have completed searches of a minimum of 30 people, and the development training is ongoing. They learn to search for cocaine, heroin, amphetamines, cannabis and NPS (mainly spice).

Watching the dogs and handlers train together demonstrates the remarkable bond between the two. Afterwards, while the dogs are rewarded with ball games and socialisation with the team, the dog handlers tell me that of many years working in the police, this recent role is 'the best job ever'. **DDN**

With thanks to Charing Sports and Social Club

NEW HORIZONS

Delivering mental health treatment requirements through drug and alcohol services can be transformational, says **Eve Potts**

With You has been working with Cornwall Council to deliver drug and alcohol treatment requirements within the judicial system for more than nine years. In 2020 a unique opportunity to combine mental health treatment requirements (MHTRs) with drug rehabilitation requirements and alcohol treatment requirements was identified by NHS England, the mental health commissioner in NHS Cornwall and the Isles of Scilly, and Kim Hager, joint commissioning manager for the Cornwall Drugs Partnership. Kim commissioned With You to deliver this combined service - a first for a drug and alcohol treatment provider.

An MHTR aims to provide an alternative to short-term prison sentences for those directly affected by mental health issues which could contribute towards their offending behaviour. This new combined approach of commissioning one service gives those in the criminal justice system access to dual diagnosis. So for the first time, those struggling with poor mental health as well as drug and alcohol issues could receive personalised, blended support.

DUAL DIAGNOSIS

'Before we introduced MHTRs in Cornwall to support people in the judicial system with clear mental health needs, no one had been successfully able to implement a dual diagnosis approach,' explains Kim Hager. 'Not only might a person be at risk of short-term prison sentences, but they would also have to go to two separate services for mental health and drug and alcohol issues. The system was not dealing with the whole person or their true situation, which naturally had a ripple effect.

'In Cornwall specifically, rurality can also have an impact on mental health and the ability to access help,' she continues. 'While on the outside it might seem to be all jam and clotted cream, blue sky and sandy beaches, the reality is sadly, starker. Cornwall has some of the most deprived areas

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IN CORNWALL, more than 250 people have been assessed for an MHTR in the last two years. With You's 2021 data highlighted that of the 54 people who completed MHTR orders this past year, 50 have shown mental health improvements following pre- and post-clinical assessment.

'There was initially some scepticism [but] what's now evident is that our steering group of police, probation, the bench, and the NHS can all see the benefit of this approach.'
KIM HAGER

in the UK, but also in Europe. A lack of employment and housing, and adverse childhoods put the county on a par with Bristol and Manchester rather than neighbouring Devon, for example.'

Cornwall's long history of deprivation goes hand-in-hand with higher rates of drug and alcohol use and other complexities.

'So, when the opportunity arose to implement combined MHTRs and drug and alcohol orders in Cornwall alongside With You, which already has extensive experience in supporting drug and alcohol issues, we were always clear that we didn't want this to work is silos. It would certainly benefit those affected, the system and those who operate within it by reducing pressure on them and overarching costs. The approach has also had a positive impact on the individual in the system who may otherwise have experienced a very different outcome in the first instance or be at risk of reoffence. There was initially some scepticism from other agencies around combining the orders and how effective this would be. However, what's now evident is that our steering group of police, probation, the bench, and the NHS can all see the benefit of this approach.'

ONWARD REFERRALS

As part of a combined order, With You can support people with moderate anxiety, depression, and personality disorders, but not with serious mental illness (which is eligible for a secondary MHTR). In these situations, there would be an onward referral to an appropriate mental health service. During the assessment, the team will review individual circumstances and the 'why' behind every case, which often sees them take a trauma-informed approach and acknowledge the role that this might play in their daily life.

Taking a trauma-informed approach can help break down the stigma and fear around mental health and identify any link between this and people who struggle with drug or alcohol misuse. We have provided additional training to upskill our team to enable them to deal with lower-level mental health issues, working holistically with a personalised approach to see what motivates the individual.

We haven't thrown the rule book out, but we don't sit behind a desk in a meeting room if we are supporting someone who struggles with formality and authority. We get out and meet people where they are in their lives.

We're in a strong position of offering combined community sentence treatment requirements (CSTRs) which includes MHTRs, so we have a unique perspective of knowing the right time to start the drug treatment or mental health treatment. For some people we support, it's about teaching them to recognise when they're struggling with daily life and teaching simple breathing techniques, mindfulness, or CBT. For others, it's about harnessing the power of the outdoors and nature with activities such as sea swimming or coarse fishing. Our approach is holistic and adaptive to the individual's needs.

HEARING FROM A SERVICE USER

Jason (name changed), was referred to With You during lockdown and had struggled with his mental health for many years. However, it wasn't until he was given an MHTR that he got the support he needed.

'I've been told had I not been arrested during lockdown, I'd probably have been given a community order. Getting arrested turned out to be a blessing in disguise. I completed the MHTR order over a year ago, but I'm still doing everything my support worker recommended. It's made me feel so much more in control of my life.

'I've lived with my mental health issues for so long I never thought I'd be able to manage them. I feel much more resilient now to deal with things. It lifted my mood and I've learnt to share my emotions and not keep them locked inside.'

HUGE POTENTIAL

It's apparent – and concerning – that those engaging with us have never received support for mental health issues before. One of the stand-out learnings for us is the use of functional analysis tools which are an integral part of MHTRs, helping to identify the root of the problem before developing a personalised solution for the individual. The potential for this kind of solution is stratospheric, and at a basic level is something that's been right under our noses for too long.

'If we don't deal with trauma and mental health, we are inevitably going to see future generations facing similar issues, finding drugs and alcohol as solutions,' adds Kim. 'Our data shows us how important it is to look at the individual - what they need and when – because everyone's needs will differ.

'Many service providers don't realise the link between neurodivergent conditions such as Aspergers, ADHD, depression, and low-level offending, or recognise that these individuals are increasingly finding it more difficult to access pathways to basic support, such as health, housing, and benefits.'

CULTURE CHANGE

Mental health is everyone's responsibility, and the biggest mistake support providers can make is to treat everyone who offends the same. With You has introduced training for all frontline workers - not just those working directly on MHTRs - to help them better understand the link between mental health and drug and alcohol misuse.

There is an urgent need to address neurodiversity and recognise the role it plays in why people offend. The experience of the last two years has shown us that if you create a 12-week person-focused plan for someone with anxiety and no neurodivergent issues, this same plan would likely fail someone who has anxiety and untreated ADHD who is self-medicating with alcohol.

All our workers are able to adapt their practice and delivery to individuals with neurodivergent conditions, so that they can engage effectively in their CSTRs. The combined MHTR and drug and alcohol orders are working because the individual is at the centre of their own journey.

Eve Potts is operations manager at With You

For more information about With You Cornwall and the MHTR service visit: https://www.wearewithyou.org.uk/services/cornwall-truro/

VITAL AND VARIED ROLE

A nursing career offers many skillsets and opportunities. This month our careers series, in partnership with Addiction Professionals, revisits nursing to demonstrate that loving the job can go hand in hand with the medical expertise and compassion.

Email your Qs for our Careers Clinic to the DDN editor

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CONFIDENT AND COMPETENT

Every day is different for a non-medical prescriber, says **Jane Milliner**

As an NMP my role is to provide high quality clinical assessments to diagnose and prescribe opiate substitute treatment (OST) – the role also includes alcohol assessments to establish and diagnose dependency, supporting alcohol detox, and decision-making for either in-patient or community detox.

The role requires a nurse qualification and NMP course completion. A qualification in substance misuse is preferable and some experience is desirable, however the service is happy to develop nurses to fulfil this role and training and peer support is ongoing. A thorough induction is completed with support from our doctors and other nurses/NMPs to ensure that new staff feel confident and competent to carry out this varied role.

Every day is different – some are extremely busy, others are spent waiting for clients to attend. We see unexpected releases from prison and urgent referrals from GPs, and we cater for clients who often have a diverse range of complex needs. There are numerous other aspects to this role which include assessment of the liver via fibro scans and blood results, assessing the risk for IV drug users and putting a plan of care in place to minimise this risk. We raise awareness of blood-borne viruses, and provide a vaccination service for those at risk as well as onward referrals for hep C treatment.

The role also includes student mentorship, recovery worker support and liaising with other agencies such as GPs and mental health teams to deliver a person-centred approach. We have new initiatives, including piloting the buprenorphine injection/depot, Buvidal.

We aim to provide a service which we would all be happy for our family/loved ones to attend. The most rewarding part of the job is to see people making positive changes and maintaining these changes. I enjoy working with people who have previously been judged and have little self-esteem

We see unexpected releases from prison and urgent referrals from GPs... clients have a diverse range of complex needs.

– to witness our clients gain confidence in themselves to turn their lives around is very satisfying and makes the work worthwhile. This is a very fulfilling role. If you are caring and want to make a difference, this is the role for you.

Jane Milliner is an NMP with Forward Trust. This piece was incorrectly attributed to Susan McCutcheon in last month's DDN – apologies to all concerned.

BECOMING A MENTAL HEALTH NURSE

Kerrin Thompson gives the nursing career path that has led to her most satisfying role

At 36 years old I'm now an RMN-registered mental health nurse. I worked on an acute inpatient 28 bed ward for 13 years and managed a lot of drug and alcohol addiction.

My career story began at 19 when I was at university and had the chance to pick one of my student placements. I chose Phoenix Futures Wirral residential and stayed for four months. I absolutely loved my time there and I always told myself that if Phoenix ever decided to take on a nurse that I would apply. (At this time nurses were not employed at Phoenix).

In 2018 a job finally appeared for Phoenix – I was so happy. I applied straightaway, had an interview and was offered the job. I've now worked here for four and a half years.

People who develop problems with substance use tend to self-prescribe with medications or alcohol to help them manage their mental health symptoms and struggles – whether psychosis, schizophrenia, bipolar disorder, emotionally unstable personality disorder (EUPD), post-traumatic stress disorder (PTSD), eating disorders, anxiety and depression, or childhood traumas.

On a typical day I help with the assessment process for residents needing treatment and oversee the physical/mental health aspect. I support clients' needs, which might mean taking them to hospital appointments for bloods and x-rays, and administer their medication.

I give in-house training to staff about medication and mental health issues, and also train on naloxone, opiate withdrawal, alcohol withdrawal and eating disorders.

I work closely with people regarding their mental health, administer any depot injections required and liaise with the mental health teams.

I have a good working relationship with our doctors. I oversee all doctors' clinics and any physical health needs of clients, and have one-to-ones. I carry out a daily nurse triage with those who may have physical, mental or general health needs and give medication reviews and weekly medication audits to ensure clients' needs are being met.

> What would I say to anyone considering a similar career? Just go for it. I did, and I'm the happiest I have ever been in a job role.

I also complete a lot of other tasks that aren't in my job role, but as a staff team we all do this. We have such an amazing staff team that I call my family.

The most rewarding part of my job is when a client comes into the service very unwell and leaves treatment to live the life they deserve and find happiness.

One important thing I would like to change is the stigma associated with substance misuse and people's perceptions of this. I would also like to change how people engage with services, as funding should be available for everyone and in an easier way to access.

What would I say to anyone considering a similar career? Just go for it. I did, and I'm the happiest I have ever been in a job role.

Kerrin Thompson is a mental health nurse at Phoenix Futures

MEETING PEOPLE WHERE THEY'RE AT

As an advanced nurse practitioner, **Susan McCutcheon**'s outreach role sees her engaging with people where they most need it

As a registered general nurse with Cranstoun, a significant part of my role is outreach – largely working directly on the street. This involves going into the community and getting to know the local population of individuals who use substances – often the people I meet have little or no contact with services and street inject. It's all about meeting people where they're at – going to the car parks, bus shelters and town streets.

This engagement leads to being able to give harm reduction interventions such as providing injecting equipment and discussing safer injecting practices. It can also lead to individuals entering Cranstoun's treatment service. It enables conversations about people's physical and mental health needs that have often been unaddressed for some time. Typical issues encountered include abscesses, deep vein thrombosis, leg ulcers, respiratory problems, depression and people with chronic conditions without medication. Sometimes I identify serious conditions that require urgent attention, including hospital admission which I help facilitate. In this role I'm able to advise and treat individuals for some of their conditions. On other occasions it's about acting as a link between the individual and health services and supporting them to attend appointments and access medical treatment.

Many people I encounter in this role are often described as 'hard to reach' or 'non-engagers' – I would challenge that thinking. My experience has taught me that individuals will often readily engage via the street setting and want to access support around their health needs and the injecting equipment on offer. To be in a car park with a group of people around me waiting for antimicrobial handwipes and water for injections before leaving to use, then later returning to sit and talk through health concerns they have, is satisfying. They're accessing something they often wouldn't otherwise and are starting to think about how they can be safer.

I'd say that crucial to this role is being passionate, having a commitment to meeting the people where they are and increasing access to healthcare. I'd love this to be a standard approach nationally to reach individuals who services are currently not accessing.

Susan McCutcheon is an advanced nurse practitioner at Cranstoun

STRENGTH in numbers

Women recover differently and need space to heal, says **Annalice Argyle**

Rebecca Marwood Photography

I'm a woman in long-term recovery (13 years) from alcohol, substance misuse and surrounding issues. I am also a mother, daughter, partner and sister – a change-maker, a person with purpose and a social entrepreneur. I'm lucky and privileged enough to be a position to be able to shout about recovery and happy to be a voice for those who don't have one.

Seven years ago I set up my own grassroots independent advocacy charity, The Recovery Advocates and Consultants UK (TRAC UK) to provide a voice, education, peer advocacy and empowerment. During COVID the service naturally morphed into a safe and supportive place for women to recover for as long as they want to engage. We find that women love the women-only space to establish healthy relationships with themselves and other females who want to reclaim their lives, which can prove to be a very powerful and empowering healing experience.

We are based in Teesside but through our online women-only recovery and wellbeing hybrid hub we work with women nationally and internationally, offering female-orientated paths. We believe that each person will have a different path to recovery and our holistic approach allows us to offer clients choice in their own journeys.

We believe that women recover differently to men. We are not 'people in recovery', we are women in recovery who need to be free from shame, stigma and misunderstandings. We need to manage and heal our trauma and have the space to talk about women-specific coexisting issues. We need to be heard and feel safe. Many women have completed our programmes, confidence-building projects and recovery in the community, and are able to confront the barriers they face. We believe that recovery is much more sustainable if the foundations are firmly rooted in their local area with their children and alongside a community of supportive women.

> We sustain our charity through an event we set up called WoW – Women Only Wellness – which showcases the many ways to wellness through workshops and healthy food.

We sustain our charity through an event we set up called WoW – Women Only Wellness – which showcases the many ways to wellness through workshops and healthy food. It's accessible to all women from the age of 16 as we are passionate about breaking the generational cycle.

We began to be recognised for our work in 2019 when we started winning awards, and TRAC UK has since been a finalist in the prestigious Tees Business Awards, where I won in the 'inspiring others' category. Recently we were nominated for a Northern Power Women Award for the second year running and I was shortlisted for a national She Inspires award for the work I do to help women recover.

I was absolutely delighted to be a finalist as even though the nomination is for an individual it raises TRAC UK's profile, spreading awareness and giving hope to others as well as showcasing the work that we do. Entries came from countries including Denmark, India, South Africa, the US, the UAE, Australia, Malaysia, Sri Lanka, Pakistan, Egypt and Bangladesh, as well as from across the UK. The awards offered 'a special way of recognising truly amazing women from around the world,' said founder Gulnaz Brennan. With over 2000 nominations in 17 categories, she said it was 'incredibly challenging' to draw up the shortlist.

It feels great to be recognised for a job well done. It's not that we need to be validated but we do believe our work is special and makes huge differences to one of the worst areas for alcohol and drug problems, and where women suffer particular stigma. It's been an outstanding couple of years for TRAC UK and we continue to go from strength to strength, building our vision of a women's recovery movement reaching women around the globe and showcasing the many ways to recovery and wellbeing.

It's the people involved in TRAC UK that deserve the praise – the staff and volunteers today and over the years, and the women and men who are part of our movement wherever they are on their journey and who help to shape the service. The work that goes into ensuring that the service develops and doesn't stagnate is phenomenal, and the trustees are behind the scenes allowing us to grow and move forward together.

I've come a long way and have worked very hard to reclaim my life. I'm proud of that and hope I inspire others to do the same and find a way out their situation.

Annalice Argyle is founder of Lobster Recovery CIC and TRAC UK, www.tracuk.uk

The She Inspires awards are being held on 24 November at Bolton Whites Hotel live and online. More information at sheinspires.org.uk

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A comprehensive job description is available on the NHS Jobs Website. For further information and to arrange a visit please contact Dr Salvaji, Consultant Psychiatrist (Tel: 03000213900) or email: abhijeetha.salvaji@nhs.net or Stuart Green Aspire Drug and Alcohol Services, email: stuart.green4@nhs.net

Closing Date: 9 December 2022
Interview Date: TBC