DDN

Drink and Drugs News
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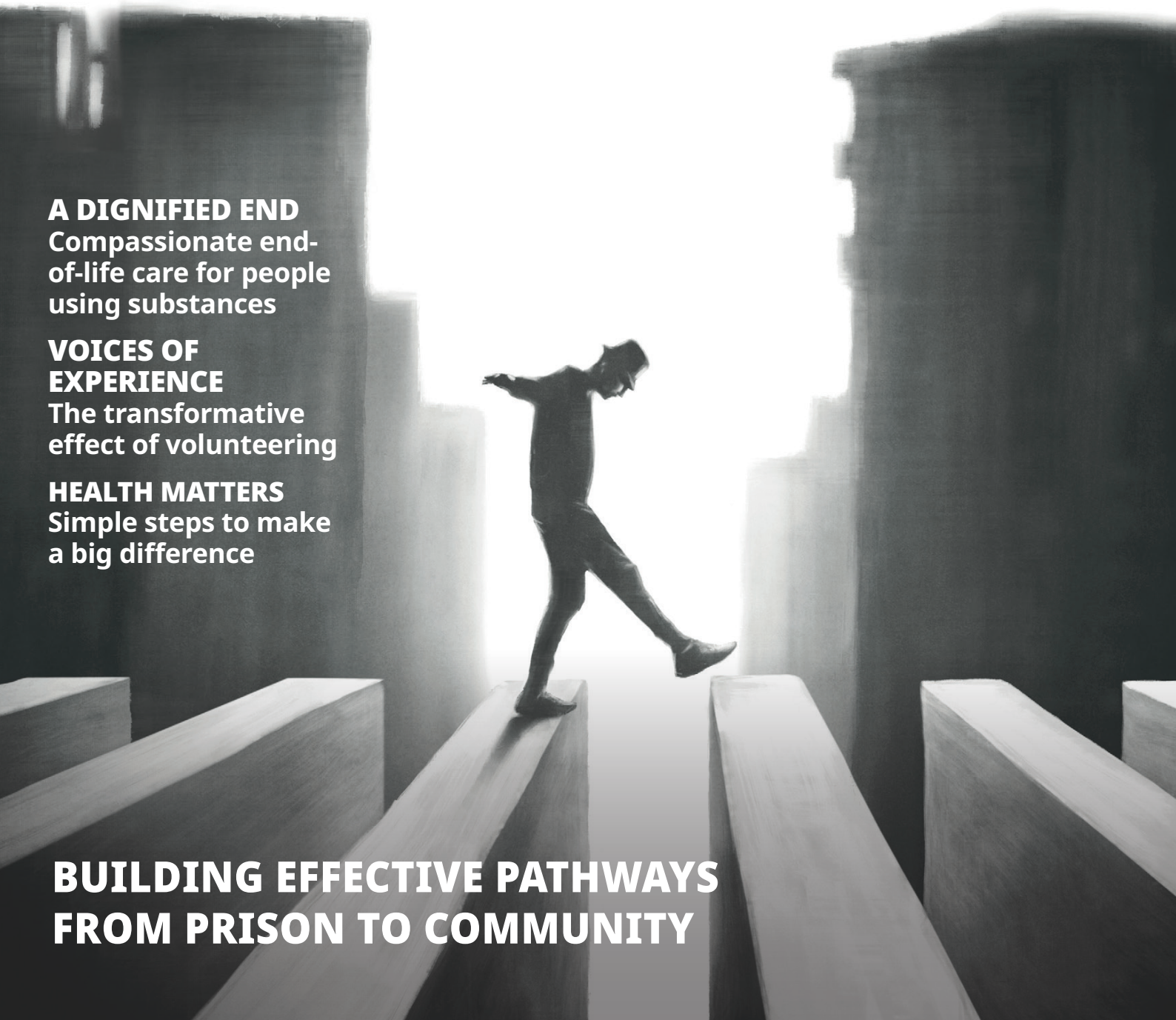
EVERY STEP COUNTS



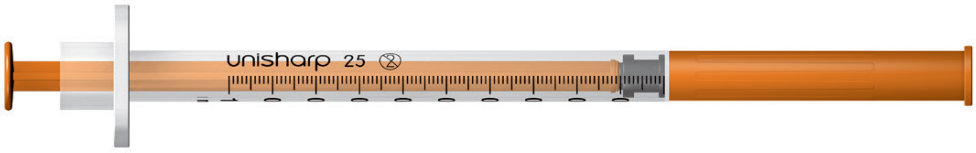
A DIGNIFIED END
Compassionate end-of-life care for people using substances

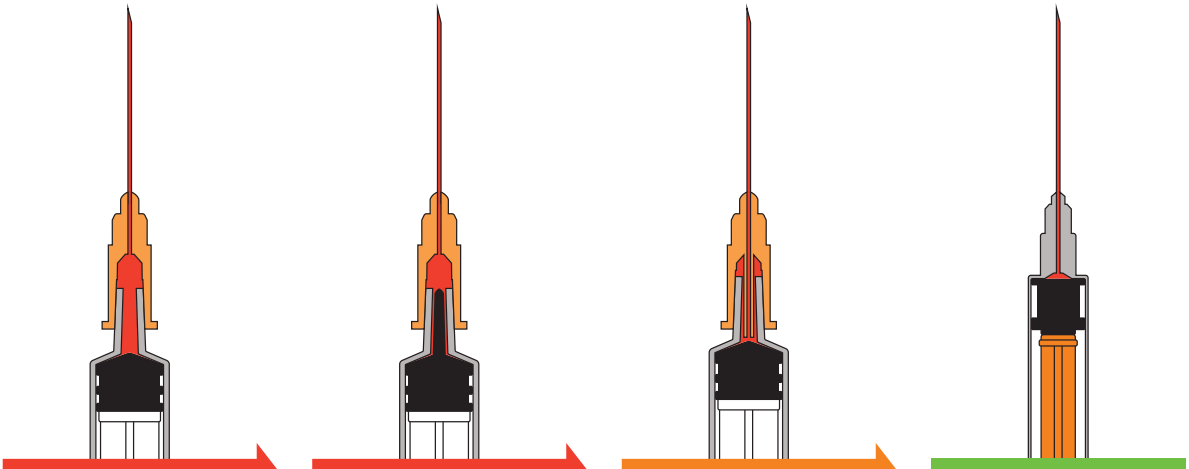
VOICES OF EXPERIENCE
The transformative effect of volunteering

HEALTH MATTERS
Simple steps to make a big difference

BUILDING EFFECTIVE PATHWAYS FROM PRISON TO COMMUNITY

The first 1mL fixed 1 inch orange Low Dead Space (LDS) syringe for people who inject drugs





High dead space	Reduced dead space	Low dead space needle	Low dead space syringe
High dead space 2 mL syringe	Modified 2 mL syringe	High dead space 2 mL syringe	1 mL syringe
High dead space needle	High dead space needle	Low dead space needle	Fixed needle
Dead space typically **92 µL**	**Dead space** typically **59 µL**	**Dead space** under **35 µL**	**Dead space** under **5 µL**

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Recovery Street entries are now open for 2023

'Everyone will gain from sharing experiences'

We're in the final run-up to the annual *DDN* Conference on 13 July. We'll hear from people with personal experience of all the issues reflected in our pages, including making a path from the criminal justice system – a key theme of this issue.

In February 2008 I wrote in my editor's letter, following the first *DDN* Conference (in partnership with The Alliance, back then): 'Reactions to our first *DDN*/Alliance service user conference have been illuminating, interesting and inspiring for the next attempt. Most of the responses have been overwhelmingly enthusiastic; it's on the online forums that discussion gets more open. Some contributors suspected there was no point to the event, as nothing would change. Others found it a less than polished experience compared to a standard conference format. Some didn't go – but were sure it couldn't have been worth it. That's the most frustrating comment to hear!'

So where are we 15 years later? Still hosting the dialogue and convinced that everyone will gain a lot from sharing very diverse experiences –see Anna's article on p22. I still hear the occasional comment 'it isn't for me' – but these days I want more than ever to know, why not?

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

Government complacent on 'appalling' toll of alcohol harm

It was unacceptable that the number of people receiving treatment for alcohol issues has been falling despite alcohol-related deaths increasing by almost 90 per cent over the last two decades, says a damning report from the House of Commons Public Accounts Committee.

Around 10m people regularly exceed the recommended alcohol guidelines, and around 600,000 are estimated to be alcohol dependent. However, a 'staggering' 82 per cent of dependent drinkers are not in treatment, despite success rates of around 60 per cent and clear evidence of cost effectiveness. Alcohol is linked to more than 100 illnesses and 42 per cent of violent crime, yet there has been no new alcohol strategy since 2012, the committee points out. The Department of Health and Social Care's (DHSC) inflation-adjusted estimation of the annual total cost of alcohol to the NHS and society – £25bn – also dates back to the same year.

DHSC, as lead department, does 'not have sufficient understanding' of the total cost of alcohol harm, the document states. Drinking patterns were changing with the young 'generally drinking less' and older people drinking more. 'Based on analysis dating back to 2012, the department put the annual cost of alcohol harm to the NHS at £3.5bn, and to wider society at around £21bn – or around £25bn adjusted for inflation. This analysis is over a decade out of date, and we are concerned that these estimates may not reflect the full scale of harm. The department's understanding of the prevalence of dependency also dates back to 2018–19. As overall owner for alcohol policy, it is for the department to coordinate a cross-government effort to understand how and where costs are rising to inform an effective response.'

DHSC needs to 'secure a consensus' and act on the best evidence for what works around price, availability and marketing, the report urges, as well as address barriers to accessing treatment and local variations in outcomes. The committee was 'surprised and disappointed' that DHSC was not taking a 'more proportionate and serious' approach to addressing the issues, it said. 'The harms from alcohol are appalling and the benefits of every £1 spent on treatment are immediate and obvious,' said committee chair Meg Hillier MP. 'But the government has had no alcohol strategy in place since 2012 and abandoned its latest effort in 2020 – just as deaths from alcohol began to rise sharply over the terrible, unacceptable toll it was already taking. What more does DHSC need to see to act decisively on this most harmful intoxicant? In doing so it must give local authorities the certainty and stability over funding to maintain and improve the treatment programmes that are proven to work, and stop dithering over the evidence on industry reforms.'

> 'The harms from alcohol are appalling and the benefits of every £1 spent on treatment are immediate and obvious.'
> MEG HILLIER

historica.fandom.com

The government's record on alcohol harm was one of 'policies scrapped and promises broken', added committee member Dan Carden MP. 'In recent years, there has been a concerted and somewhat successful effort from the government to implement strategies aimed to tackle obesity, gambling, tobacco, and illicit drugs. Arguably the most harmful and legal drug, alcohol, remains unchallenged. During the public accounts inquiry, the department provided no credible justification as to why alcohol remains a conspicuous outlier.'

Alcohol treatment services report at https://publications.parliament.uk/pa/cm5803/cmselect/cmpubacc/1001/report.html

Mandatory alcohol labelling for Ireland

IRELAND WILL BECOME THE FIRST COUNTRY to introduce mandatory comprehensive labelling for alcohol products, after its health minister Stephen Donnelly signed the Public Health (Alcohol) (Labelling) Regulations 2023 into law.

The regulations, along with the Public Health (Alcohol) Act, mean that all alcohol labels will need to state the calorie content and number of grams of alcohol in the product. They will also be required to include warnings about the risk of liver disease and alcohol-related cancers, as well as drinking while pregnant. The same information will be made available to people drinking in licensed premises, the government says, with the laws coming into force in May 2026. Health campaigners in the UK have long been calling for similar measures to be introduced here.

'This law is designed to give all of us as consumers a better understanding of the alcohol content and health risks associated with consuming alcohol,' said Donnelly. 'With that information, we can make an informed decision about our own alcohol consumption. Packaging of other food and drink products already contains health information and, where appropriate, health warnings. This law is bringing alcohol products into line with that. I welcome that we are the first country in the world to take this step and introduce comprehensive health labelling of alcohol products. I look forward to other countries following our example.'

> 'We are the first country in the world to take this step and introduce comprehensive health labelling of alcohol products.'
> STEPHEN DONNELLY

New DWP scheme for people with experience of dependency

A new peer mentoring programme that will place people with experience of drug or alcohol dependency in Jobcentres to help others get back into work has been launched by the Department for Work and Pensions (DWP). The £3.7m scheme will be trialled in 40 Jobcentres across England, says DWP.

The mentors will be contracted by the department following recommendations from partner organisations. They will then 'draw on their lived experience of drug or alcohol dependency to support people in the same position', the government states. The aim is that people will feel comfortable in disclosing dependency issues 'without fear of reprisal' and be signposted to appropriate support, as well as equipped with skills to access training, volunteering or employment.

The programme is open for referrals to Jobcentres in locations including Hull, Liverpool and Portsmouth, as well as the London boroughs of Camden, Croydon, Hackney, Islington, Lambeth, Newham, Tower Hamlets and Westminster. DWP will also be expanding its individual Placement and Support programme for drug and alcohol dependency to all local authority areas in England by 2025, it says. 'Our new peer mentors are proof that work can be a crucial part of someone's journey out of substance dependency, transforming their life,' said social mobility minister Mims Davies. 'Their lived experience will help them provide expert one-to-one advice and support from DWP in our Jobcentres, helping people recovering from addiction move into work. This new form of support will not only give people in recovery the tailored help they need to get on in life and prosper, but it will also help grow our economy by getting more people back into the workforce.'

> 'Our new peer mentors are proof that work can be a crucial part of someone's journey out of substance dependency.'
> MIMS DAVIES

Free hep C tests on NHS

PEOPLE AGED OVER 18 and living in England can order free confidential home tests for hepatitis C via the NHS – the self-sample testing process involves taking a few drops of blood from the finger.

According to the most recent UKHSA report on hepatitis C, around 81,000 people in England are currently living with a chronic HCV infection, down from almost 130,000 in 2015. More than 60 per cent of these are people with a past drug injecting history, while 27 per cent are 'current or recent PWID'. As injecting drug use is the main driver of HCV transmission, it was concerning that 'a significant proportion of PWID remain unaware of their HCV infections', the report added.

'If you are concerned about hepatitis C, it's never been easier to find out if you have it,' said Hepatitis C Trust CEO Rachel Halford. 'Free, at-home testing kits will give anyone who is worried about hepatitis C the ability to find out their status quickly and confidentially.'

Tests available at https://hepctest.nhs.uk/

> 'If you are concerned about hepatitis C, it's never been easier to find out if you have it.'
> RACHEL HALFORD

Crackdown on youth vaping

THE GOVERNMENT IS SET TO CLOSE A 'LOOPHOLE' that allows shops to give free vape samples to young people, it has announced. It has also launched a review into banning the sale of 'nicotine-free' vapes to people under 18.

While selling vapes to under-18s is already illegal, the government intends make it easier for trading standards officers to issue on-the-spot fines to retailers selling the products to children illegally. The risks of vaping will also be included in Relationships, Sex and Health Education (RHSE) lessons, the government said, while OHID is also developing a vaping resource pack for schools.

'Whilst vaping can be an effective quitting tool for smokers, it is important that non-smokers are not encouraged to start vaping,' said chief medical officer Chris Whitty.

Local News

Roger Harris Photography

MEMORY LANE
Clouds House is celebrating its 40th year with a free reunion event on 10 June. The day will include speakers, live music and more. Full details at *www.eventbrite.co.uk/e/clouds-house-reunion-2023-tickets-549071185697*

SHEFFIELD SUPPORT
Humankind has been awarded a new contract to deliver drug and alcohol support in Sheffield from August, in partnership with Project 6. 'We'll be working closely with commissioners and other partners across the city, as well as listening to the people we will be supporting to continually develop and improve the service,' said Humankind's executive director of operations Ted Haughey.

CITY CONNECTIONS
International delegates gathered in Middlesbrough last month for a Recovery Connections event exploring the potential of recovery cities. While the true value of recovery was 'grounded in a community of lived experience', said Recovery Connections CEO Dot Smith, 'we need policy makers, business leaders, health professionals, the education sector and the wider public to play a role too'. *www.recoveryconnections.org.uk*

JOINING THE DOTS

Improving systems to ensure that people leaving prison are motivated and supported to engage with community services is a priority for both the government and the sector. **Ilo Edwin** and **Sarah Clowes** describe how the Forward Trust is trying to address the challenge

The high risk of relapse and reoffending amongst substance-misusing offenders and their susceptibility to drug-related death in the period following release from prison has been understood for many years, and underlined by the 2017 evidence review of drug treatment in England. Therefore, an integrated and seamless care pathway from prison to the community is necessary to both reduce risk for those recovering from substance misuse and address reoffending rates.

With more than 30 years' experience of delivering services across the prison estate, The Forward Trust (formerly RAPt) recognises the importance of continuity of care (CoC) in reducing risk, and achieving and/or maintaining recovery goals. We strongly believe that continuing support following release contributes to enhancement of wellbeing and subsequent reduction of overdose risks. One example: more than 20 years ago Forward established a team of volunteers to act as a 'meet and greet' service at the prison gate – overseen by our recovery support team – and accompany people to community appointments.

Sarah recalls why she stayed with the Forward Trust having started as a volunteer in 2012. 'I attended a RAPt event as

Evgeny Gromov | iStock

Recent data shows that successful continuation of treatment from prison into the community remains low.

we were then presenting on through-the-gate,' she says. 'It was this presentation that inspired me to apply for a job with Forward, seeing the care and responsiveness to the needs of those leaving custody and/or indeed involved with the criminal justice system. I share the belief that we need to collectively address these issues if we were ever to reduce re-offending'.

More than ten years later, Forward's determination for supporting CoC continues. Forward now manages three RECONNECT services (Suffolk, Norfolk and Essex), which reinforces our mission to contribute to reducing inequalities faced by those leaving custody and the impact this has on their health, wellbeing and re-offending rates. RECONNECT practitioners conduct bespoke needs assessments up to three months before release and supports people to integrate into the community and access the services they need to reach their full potential.

Recent data shows that successful continuation of treatment from prison into the community remains low, however. Undoubtedly work to embed the government's *Guidance for improving the continuity of care between prison and the community* was impeded by COVID, with release planning and CoC practises having to be adapted accordingly.

The key areas of challenge to CoC from our experience include:

- Unknown and/or wider geographical release areas, which delay community integration.
- Limited or no accommodation options for released prisoners.
- Unplanned releases from court, impeding services' ability to make referrals and community pick-ups.
- Varying interpretations of 'structured treatment' between community and prison providers – we've seen that prioritising only those on OST as being in structured treatment presents a challenge to CoC efforts.
- In response to the new CoC target of 75 per cent, Forward Trust's service development team, alongside service managers, worked on a CoC best practice strategic framework to support services to achieve the best-post release outcomes for their service users, providing structure, guidance and support to our prison and community-based employees.

Alongside this, within prison service delivery we have:

- Embedded through-the-gate workers (where funding permits) to support with release planning and follow-up engagement on release, as well as supporting re-engagement where necessary and signposting/referral to support services.
- Managers proficient in training staff on CoC procedures are actively identifying their main release areas in order to build relationships/CoC protocols. For example, our service manager at HMP Wormwood Scrubs chairs a bi-monthly CoC forum with key stakeholders across London, and our Brixton service manager carries out 'data match' meetings with key release areas.
- Practitioners who are dedicated in liaising with other key agencies such as OMU and dependency and recovery staff, flagging barriers and utilising digital technology, telephones and face-to-face methods to facilitate post-release appointments.
- Continuing the 'meet and greet provision' by our recovery support service.

Undoubtedly, the sector is responding positively towards the 75 per cent target. We have seen the input of Collective Voice London workshops, centred on CoC, and also Surrey county's drive towards improving communication and partnership working – of which Forward Trust are committed members.

But more effort is needed to drive forward treatment retention and recovery outcomes. Reaching this target is ultimately dependent on the motivation of prisoners to want to stay in positive and meaningful contact with services, which in turn is dependent on what happens while they are in prison. Prisoners who are genuinely engaged in treatment, and motivated towards recovery, are much more likely to stay in contact with services.

Ilo Edwin is head of custodial substance misuse services and Sarah Clowes is regional manager for Essex services at Forward Trust

Through its recovery support division, Forward Trust also offer variety of other support mechanisms that exemplify its CoC commitment, including:

Forward Connect peer support: nationwide community for current and former clients. Membership includes:

- *Access to online mutual aid meetings, social activities, peer advice and support.*
- *Access to Fuse online learning platform containing self-help materials.*

Reach-out service: our online chat support function provides free, confidential advice on a range of issues including signposting to local support services.

Probation dependency and recovery service: commissioned to support people on probation engage with relevant community substance misuse support upon release. Although its main focus is community engagement, each region has a number of prison link workers who are engaging with prisoners while in custody and who support continuation of care on release. Referrals for this service come directly from probation, and are an important link for prison substance misuse services by supporting teams with coordinating post release support.

Reconnect (Norfolk, Suffolk & Essex): a care-after-custody service seeking to improve CoC of vulnerable prison leavers by increasing access and uptake of support services for individuals who would otherwise struggle to engage – with a focus on engagement whilst in custody and supporting continuation on release.

SEAMLESS SYSTEMS

Strong partnerships with community teams are just one of the elements needed for successful continuity of care after prison, say **Jim Barnard** and **Avril Culley**

A seamless transition from prison to community is important for those prisoners being supported in their recovery from substance misuse. Evidence suggests that prisoners who relapse on release from custody are more likely to reoffend, resulting in a return to custody. It's also important as people being released from prisoners are – in the first six weeks – four times more likely to overdose on opiates, resulting in high drug related deaths in this group. This is something that was recognised by Dame Carol Black's review, which stated the importance of 'keeping prisoners engaged in treatment after release – improved engagement of people before they leave prison and better continuity of care into the community.' Furthermore, it's one of the performance indicators in the public health functions agreement to which NHS England monitor compliance.

At Inclusion we are a provider of both community and prison drug and alcohol services, so we see the issues of continuity of care from both sides of the fence. We always thought we were doing this quite well until the national figures came out, suggesting that the number of people successfully continuing their treatment in the community after leaving prison was only in the mid-30 per cent range. We felt that it was a high priority to improve this, so we tasked our prison and community services with concentrating on this area. This focus was increased when the national target of 75 per cent successful transitions was announced.

PSYCHOSOCIAL INTERVENTIONS

The psychosocial intervention (PSI) pathway no longer ends when an individual leaves the prison gates – our health in justice (HIJ) psychosocial substance misuse teams are committed to ensuring their journey continues into the community when the need is identified. Our teams embraced the wider drug strategy agenda and began monitoring continuity of care, having a keen focus to support success for release – once individuals were released, we started contacting

Mrsash174 | Dreamstime

Our teams linked with communities to ensure continuity of care for court releases, which included educating remand patients on this pathway and creating discharge packs for those attending court.

community drug and alcohol teams to follow up attendance. This gave us real-time information, which allowed us to be responsive to themes and respond to barriers affecting continuity of support and treatment.

The continuous demand on the prison population has also meant that the majority of sites have seen an increase in the number of prison releases. Given individuals are most at risk of overdose following periods of abstinence while in custody, the need for the psychosocial teams to commence effective release planning and coordination of continuity of care is crucial, and there has been an increase in the numbers of naloxone kits, training and harm reduction advice disseminated to patients prior to release.

PATIENT FEEDBACK

Patient feedback has been paramount to determining the next steps on this journey – our teams tried to further understand the barriers to continuity of care upon release, enabling them to respond accordingly. For example, patients feedback typically suggested they would like to meet their community worker prior to release, and our teams where possible were able to support community prison link workers accessing the prisons to meet people as part of their release planning process.

Supporting and coordinating specialist community staff to access the prison to provide a collaborative seamless approach to care has seen an increase in the number of patients attending their community appointments following release.

Alongside this, since the pandemic the prison substance misuse teams are seeing an increase in the demand for support with alcohol and non-opiate substances, mirroring drug trends in the community. We've implemented collaborative non-opiate patient release pathways, which include obtaining an appointment upon release and a stringent transfer of care for this population.

Another example relates to feedback around the length of time elapsing between release and a community appointment – it was recognised that an increased period of time until the appointment corresponded to lower attendance rates.

COMMUNITY TEAMS

Our teams made a conscious effort to strengthen our excellent connections with community teams, which has supported joint working and outreach for those individuals who do not attend. Prison leads met with community leads to review the continuity of care process, sharing ideas, innovation, and physically cross referencing each individual release each month to provide assurance regarding the accuracy of the NDTMS data.

They have been collectively working with teams in the community to strengthen this pathway, and working alongside OHID to complete data exercises to improve accuracy and overall support for the people in our care. Consideration was given to how our services can replicate the community model – providing assurance that the people in our care in custody had access to the same quality of care, as well as accessibility to a varying range of interventions. Staff feedback was also compiled, and further training and guidance provided to teams to support the transitional NDTMS data metrics compilation.

SERVICE USER PATHWAY

Another area of development included the service user pathway for remand prisoners. Our teams linked with communities to ensure continuity of care for court releases, which included educating remand patients on this pathway and creating discharge packs for those attending court. These responded to service user feedback and positively promoted patient choice, identifying treatment/support options available following release from custody.

The standardised PSI pathways have also strengthened how our services respond to need and how our services engage individuals at different stages of their recovery. These pathways embed evidence-based interventions that provide structure and guidance, and strengthen recovery capital in preparation for release. We recognised that our patients at different stages of their recovery require varying levels of support and intervention. We developed needs-led, strengths-based interventions within flexible service user pathways. Our HIJ teams recognised that preparation for release must begin as soon as a prisoner arrives in custody, with treatment plans focused on long-term recovery and continuity in the community.

COLLABORATIVE APPROACH

Within our Yorkshire and West Midlands HIJ sites we saw an impressive increase in the number of individuals attending their community appointments. Last quarter, the cumulative average from local data of individuals engaging with the community treatment providers and continuing on their recovery journey following release increased to 72 per cent for Yorkshire prisons and 69 per cent for HMP Hewell, West Midlands – given the current national average is approximately 37 per cent, these results highlight the effectiveness of a collaborative approach to recovery.

However these statistics are not always being replicated by the national figures, which we think is a problem for many services nationally. For instance, from following up all service users who left HMP Hewell it was found that 83 per cent had attended their appointment in Telford, while the national statistics put Telford at around 41 per cent in terms of successful transition. We think this may be partly the result of people being discharged to a different locality initially and so not showing up on our data or theirs. We are also aware that this is an issue that affects many services where the actual successful transition rate is much higher than the national data would suggest.

We feel that the target of 75 per cent successful transitions as achievable, but that the problems with how the data is collected will need to be resolved first. We are shortly meeting with NDTMS to try to begin resolving this.

Jim Barnard is deputy head of operations for community drug and alcohol services and Avril Culley is deputy head of operations for health in justice services at Inclusion

HEALTH MATTERS

There's much more that services could be doing to increase the focus on health, says **Steve Taylor**, including raising awareness, making referrals and offering simple tests like blood pressure checks

People who use drugs and alcohol are dying prematurely of diseases that could be prevented or treated.

Dame Carol Black's drugs review found that 'many drug users have poor overall health' and that the NHS is 'poor at engaging with the wider health needs of drug users with medical co-morbidities (for example, hepatitis C, HIV, heart and lung disease), many of whom are ill-equipped to navigate complex pathways, and feel stigmatised'.

The issue is equally pressing for those using alcohol. They suffer many of the same conditions but we are particularly concerned about a continued rise in liver disease.

Smoking, meanwhile, is probably the single biggest contributor to premature mortality for people who use drugs and alcohol. The review also found that for many people, 'mental health problems and trauma lie at the heart of their drug and alcohol dependence. However, they are too often excluded from mental health services until they resolve their drug problem and excluded from drug services until their mental health problems have been addressed.'

The drug strategy commits government to work with the NHS to improve the provision of physical healthcare and mental health treatment through better care pathways, targeted and co-located interventions, and more joined-up service planning and commissioning.

The Office for Heath Improvement and Disparities (OHID) is working at national level on ways to improve integration between NHS specialist care and drug and alcohol treatment – including actions to reduce drug and alcohol-related deaths, and work on specific health topics such as respiratory health and hepatitis. Tackling stigma cuts across much of this work, and ADDER sites will be piloting a programme to measure and reduce stigma in healthcare settings. But there is much more that can be done to increase the focus on health.

As part of all this, the Press Partnership is a collaboration between government and the country's news publishers. It raises awareness of the prevalence and risks of diseases that are preventable or treatable and encourages people to take the first step to get checked or get help. It covers 350 national, regional, local and multicultural publications reaching 28.6m adults daily. It has covered mental health and cardiovascular disease already and will move onto other topics. It targets the general population who read mainstream media, which might include some drug and alcohol service staff, but it will inevitably miss many people who use drugs and alcohol and who are at greater risk from some of these conditions.

Cardiovascular disease (CVD) is one condition covered recently in Press Partnership articles, which all echoed the message that the first step in preventing and treating CVD is to check for high blood pressure. That's a simple, regular step in the healthcare assessment that every drug and alcohol service should be offering.

Other conditions with high mortality rates – and often simple tests – in people who use drugs or alcohol include:

- *liver disease – both hepatitis C in people who have injected drugs and alcohol-related liver disease in people who drink at harmful or higher-risk levels*
- *respiratory disease – smoking-related (primarily tobacco but also cannabis, crack and heroin), TB (especially in those sleeping rough)*
- *bacterial infections in those who inject drugs*
- *cancers, especially those related to smoking and alcohol*

WHAT **YOU** CAN DO...

Talk to service users about their health. Assess people when they enter treatment and regularly throughout – healthcare assessment for people who use drugs is detailed in the clinical guidelines *(CG 2.5 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf#page=34])*. Later this year OHID will publish the UK clinical guidelines on alcohol treatment which will include healthcare assessment for people with alcohol-related health conditions.

Be wound aware *[https://www.gov.uk/government/publications/wound-aware-a-resource-for-drug-services]* so that injection infection is spotted early and treated before it leads to complications.

Prescribe thiamine to people drinking at harmful and dependent levels to prevent alcohol related brain damage caused by Wernicke Korsakoff syndrome.

Work with primary and secondary care, and through Combating Drugs Partnerships, Integrated Care Partnerships and other mechanisms, to better integrate care. This might include bringing secondary care services on site into alcohol and drug treatment services to screen and treat people.

Make supported and active referrals for lung, liver and breast cancer, alcohol-related brain damage, and other screening and treatment, using peer supporters wherever possible.

Refer people to IAPT *[https://www.england.nhs.uk/wp-content/uploads/2018/06/the-nhs-talking-therapies-manual-v6.pdf]* if they need help with depression or anxiety.

Spend more on making these things happen – the menu of interventions for the Supplemental Substance Misuse Treatment and Recovery Grant includes a whole section on better and more integrated responses to physical and mental health issues.

And, last but by no means least, offer smoking cessation, including switching to vapes, for services users AND staff.

Steve Taylor is programme manager, addiction & inclusion at OHID

Improving understanding of the stigma and discrimination experienced by all people harmed by drug and alcohol use.

Many organisations and individuals are doing and have done amazing, impactive and creative work to address stigma. The Anti-Stigma Network builds on this work by bringing individual people, families, communities, educational institutions, charities, businesses and policymakers together to share, learn and create.

For more about ASN, visit www.antistigmanetwork.org.uk

ANTI-STIGMA NETWORK

We are V-i-a

Anna Whitton, CEO of Via (formerly WDP), shares the news about changing their name and brand, the story of why they've made this big step, and what's next in their journey

This year WDP (Westminster Drug Project) turns 30 and, at this milestone, we're also changing our name.

For people who know us and what we do, the decision to make this change will probably make sense. We aren't a drugs project in Westminster anymore, and haven't been for some time. Our services are now delivered in lots of different areas across England. These services also now include young peoples' services and IPS services, for example, as well as the integrated community and residential drug and alcohol services that people know us best for. So our growth and development have led us to a really positive point where we've outgrown our original name.

In saying this, changing the name of an organisation is a big decision and finding a new name is not easy. Because of that, we invested time in listening to what people had to say about who we are, how we do things and what makes us different. We wanted to know what people really thought about our name and brand, both now and with an eye on future changes and developments.

Asha & Co led this piece of work for us and spent time with people who use our services, those who work and volunteer for us, and commissioners who know us well – along with those who don't. They conducted one-to-one and small group interviews to explore in detail perspectives from a diverse group of people across a number of different roles, as well as undertaking broader research, review and reflection work.

The feedback from this initial phase was really clear and consistent. People told us that they wanted a name that was more discreet, that was simple, clear and not tied to any particular geography or substance. Importantly, they also told us to reflect our humility in our name and brand, that the work we do is inspiring, but that claiming this in a name can be off-putting and doesn't really reflect the way in which we already communicate. So, the task for any new name and brand was not a simple one and came with many requirements, including not losing the legacy of the last 30 years and our development over time.

Via reflects that we are part of a journey, that everyone's journey is different, and that we work with people along their individual route.

Our new name and brand were developed by Asha & Co, utilising the research they had undertaken, and the strong perspectives communicated from many different voices. Critically, while our senior team and board of trustees have known about the new name and brand for several months now, other than participating in the final approval process, our influence over its development was no more significant than anyone else who contributed to the original research phase. This was important to us – we wanted a name and brand that really reflected who we are, not what I or we as the 'senior team' thought it should be.

OUR NEW NAME IS VIA

Via reflects that we are part of a journey, that everyone's journey is different, and that we work with people along their individual route. Our logo reflects that too. You'll see that it changes, signalling the different paths that people take and choices that can be made.

You'll also see that our logo is black and white. It is clear, simple and easy to recognise in its different forms. It changes as you click through our new website and on our different service materials, but it is very clearly us.

The colour in our brand comes from photography. That photography reflects the real world, not a perfect world. Our headline photographs purposefully don't include faces, as we think that can feel limiting or excluding and so instead the images reflect moments, beauty in the everyday and people connected to the world that they live in. In effect, real life and lived experiences.

The way that we're using photography means that over the next 12 months we want to move to a position where all of our headline photographs are taken by the people who use our services, or who work or volunteer for us. We want to have a brand that can really feel owned by those who are central to what we do. That's something we're really excited by and I hadn't anticipated that a change of name could bring such compelling opportunities to connect our work.

The new name and brand also support changes across our service premises. We aren't just changing the external signage but are taking the time to enhance our internal spaces too. Many already have murals that have been co-developed with people who use our services, so we've thought carefully about how the new brand works with those spaces and we're excited about how it all comes together to support safe, welcoming and positive service environments.

There has been lots to do to implement this initial but big change, and we're really lucky to have had a great team of people to make that happen. We've got an exciting programme of work ahead of us, building on much of the progress that we've been making over the last few years. It's important that we don't lose sight of that, and that we continue on our really exciting and important journey too. This includes completing the implementation of our women-only inpatient detoxification unit (more to come on that soon) and a new learning and development offer, which builds on the work we've completed to shape our values and approach very explicitly into our employment offer.

You can check out our new website here – www.viaorg.uk – which includes links to our social media channels, a short film that explains our decision to change the organisation's name and why we think Via is a good fit for us. And, as always, if you've got feedback about what you like and don't like or suggestions about next steps, please get in touch. We hope that you like our new identity as much as we do!

Anna Whitton is CEO of Via

Concept artwork

'The way that we're using photography means that over the next 12 months we want to move to a position where all of our headline photographs are taken by the people who use our services, or who work or volunteer for us. We want to have a brand that can really feel owned by those who are central to what we do.'

A SOCIAL PREMIUM

In the latest part of our careers series with Addiction Professionals, **Kate Halliday** describes how social work can be a hugely rewarding way to make a difference in the drugs sector

Some people choose to develop a career in social work in order to pursue a career in addictions, while there are also social workers who become interested in specialising in addictions as a result of coming into contact with people with addiction issues in their working lives. In order to practice social work practitioners are required to register with a professional body depending on whether they practice in England, Scotland, Northern Ireland or Wales.

When I studied social work I had no intention of moving into the addictions field. I was interested in working in the criminal justice system and on qualifying I got a job in a prison. As a newly qualified social worker, despite the fact that my training had prepared me for many of these issues, I was shocked by the number of clients who described such similar patterns of childhood trauma, substance use and poverty. My experience made me really keen to see if I could be part of the process to support people with addictions to make changes, and I also learnt so much from the clients I was working with and felt a strong sense of empathy.

The next step was to work in a community setting and when the opportunity came to be part of a drug and alcohol team I was delighted to get the job. Having done most of my work within the controlled environment of a prison, it felt liberating to work in the less predictable community environment where there were such a range of different organisations, systems and groups to link in with – employment, education, peer support, and the full range of community groups A key standard of social work is to promote the strengths, rights and wellbeing of individuals, families and communities, and community drug and alcohol teams are a great place to do this.

SPECIALISATION

Another great thing about working in a drug and alcohol team is the opportunity to specialise in different areas. When the chance to work from a primary care setting came along, I didn't look back. I moved from working across a large town, to working in a much smaller community. I felt like I knew everyone, and they all knew me, making joint working so much easier. This was such a rewarding time for me in so many ways – primary care is the least stigmatising place I've worked, with clients receiving support for their addictions alongside other patients waiting for appointments at their GP surgery. For most clients it was a short walk from home, compared to the two buses many people had to take to get to the drug and alcohol team. My attendance rates improved dramatically.

As primary care is so family focused I got to know all the clients' children, as many were happy to bring them along to the surgery – drug team waiting rooms face a much bigger struggle to be so family friendly. I discovered that the GPs had often know the clients from birth, and also tended to know other family members – understanding family systems is an important part of social work, and this knowledge was invaluable at times in supporting clients to reach their goals.

KNOWLEDGE BUILDING

It was a steep learning curve to update my knowledge on some of the health issues, but I found this really added to my skills. The ability for clients to get their general health seen to alongside their drug and/or alcohol treatment in primary care is amazing – it felt really great to see people get all sorts of issues dealt with, from blood-borne virus testing, immunisation and contraception to long-standing health issues like asthma which clients hadn't prioritised.

> 'As a newly qualified social worker... I was shocked by the number of clients who described such similar patterns of childhood trauma, substance use and poverty.'
>
> KATE HALLIDAY

Working in the addictions sector provides a great opportunity to practice social work skills and values, build your knowledge, work in multidisciplinary teams and specialise across a range of areas. But most of all, you will get to learn a huge amount from clients, and you can be lucky enough to stand beside people as they make amazing changes to their lives and communities – which is the most rewarding part by far.

Kate Halliday is executive director of Addiction Professionals

TRAINING REQUIREMENTS

Social workers are required to have a social work degree or equivalent (there are some older vocational qualifications that are also be applicable). There is currently no accreditation for social workers working in addictions.

FURTHER DEVELOPMENT

Some social workers choose to study addictions at Masters level and/or are supported in supported at work to specialise in an area of special interest.

VOICES OF EXPERIENCE

Two Humankind volunteers describe the transformative effect that volunteering can have – on themselves and the people they work with

JULIET'S STORY

Juliet is a volunteer on the peer-to-peer naloxone programme in Humankind's London services. Here's what she has to say about her volunteering role

'Naloxone is a drug which can reverse the effects of an opioid overdose and it saves lives. We currently only distribute the injectable version, but we're soon going to start offering the nasal version which is great because a lot of people are not as comfortable with needles, and we need to give as many people as possible access to this live saving medicine in any form.

The model of peer-to-peer naloxone has been used in many places around the world including the UK and is a research-backed strategy for getting naloxone into the hands of the people who need it the most. The idea is that people who already engaged with services at Humankind are eligible to be 'peers' in the programme and are best suited to talk to people about naloxone because they already have the life experience and knowledge around opioids and naloxone, whether that be personal or otherwise.

I go out on outreach once a week with peers to talk to people we meet about naloxone. If people are interested, we offer them training and a naloxone kit on the spot. I also have experience as a researcher, so I help with the data side of the project. I'm from the United States, which has incredibly high rates of drug-related deaths. Things like opioid substitution treatment, naloxone distribution and education, and drug consumption rooms are all evidence-based tools for addressing this crisis. I've been engaged in research, advocacy, and direct services in efforts to increase access to these services for the past five years in the US. I moved to London last year to pursue my Masters in public health and wanted to engage in similar volunteer work here. I was very excited when I found out Humankind was in the beginning stages of starting a peer-to-peer naloxone programme and wanted to learn about the process of creating and sustaining a successful programme. It has been amazing!

I believe that nobody deserves to die prematurely, and an opioid overdose is a completely preventable death. Yet still, there were nearly 5,000 drug-related deaths in England and Wales in 2021. I'm so grateful to be so graciously accepted as a volunteer in a group of incredible peer educators where we get to educate and offer people a drug that can and does save people's lives every day around the world. The evidence is there – naloxone saves lives. Our jobs are just to get it into other people's hands so people who use drugs (and the people around them) will keep each other safe.

I'm also so grateful to the people who accept naloxone from us because they are so generous and patient with me and the peer educators as we endeavour to learn about their life experiences with drugs, drug treatment services, and harm reduction tools like naloxone.'

Kubkoo / iStock

D'S STORY

D is a volunteer mentor in the segregation unit at Humankind's Reconnected to Health service in HMP Frankland

Before D entered HMP Frankland, they relied on alcohol every day and drank four times more than the recommended weekly amount.

Because they went to work every day, they didn't think they had a problem with alcohol, and didn't realise how much it affected their family life. When they entered HMP Frankland, D wanted to do something positive with their time and decided to engage with the Reconnected to Health DART (Drug and Alcohol Recovery Team).

After speaking to a coordinator, they signed up. D engaged with in-cell work, awareness group sessions, and programmes. This made D realise how much they were drinking, how it impacted them, and how it impacted people around them.

D applied to become a DART mentor after completing this work, to help others move forward with their recovery and to give back. They started as a mentor in the segregation unit, completing inductions for individuals that had been transferred there while providing support and advice to increase people's motivation. They received positive feedback from DART staff based on their work supporting prisoners with their substance use. D also distributed information and awareness leaflets and display posters in the unit to promote harm reduction.

D took this experience further and co-facilitated spice awareness sessions aimed at staff in the unit. These sessions were attended by senior officers and custodial managers, raising awareness of spice, its effects, and its harms. About their volunteering role, D said: 'Being a DART mentor is a privilege. It's a role where you can pass on your knowledge to other prisoners to help them move forward too.'

VETERAN VOICES

Listening to people with lived experience is vital when providing support for veterans with substance issues, says **Chris Barnes**

Across Change Grow Live's services we're continuing to support an increasing number of veterans who've been affected by their service and the return to civilian life, and who are struggling with alcohol or drugs. We know that many veterans affected by substance misuse don't know about the specialist support available to them, and are often unable to reach out and seek help.

Since signing the Armed Forces Covenant – which aims to ensure veterans are treated fairly – in 2021, we've been committed to making sure that veterans can access support that understands their needs, from launching a working group co-produced by veterans, to developing new referral pathways into treatment with the NHS. Now, we're extremely pleased to be working with Tom Harrison House, the UK's only residential rehabilitation service specifically for people who've served in the armed forces.

Tom Harrison House will now be a part of Change Grow Live's national framework for inpatient detoxification and residential rehabilitation. Residential detox and rehabilitation services can play a life-changing part in people's drug or alcohol treatment journey, and our national framework ensures that the people who use our services have access to the highest quality of care.

Tom Harrison House was founded by Paula Gunn, whose grandfather was Tom Harrison, a decorated Royal Navy veteran. Both Paula and her grandfather have been passionate advocates for supporting veterans with substance misuse, and Tom Harrison House makes this support a reality with a programme specially tailored to their needs. The focus of Tom Harrison House is helping veterans with the loss of social support, connection and camaraderie they can experience when leaving the armed forces. The support they receive at Tom Harrison House is designed to help them rediscover their purpose and meaning. Overall, it provides a space that understands and accommodates the unique lived experience of the residents who stay there.

Partnerships such as this, as well as the development of specialist pathways, can play a crucial role in breaking down barriers to treatment and ensuring more people get the right support for them. There's already so much support out there for veterans – it's up to us to ensure they know that these services exist, and that they are able to access them as they need to.

> If any providers of support for veterans would like to work with us, we'd be delighted to hear from you.

Supported by Liverpool John Moores University, we plan to undertake and publish research that will help the entire sector better understand the barriers faced by veterans engaging with services. We've already shared insights with policy makers and the Royal British Legion, and will continue to do so in the future. We've worked closely with veterans who use our services to coproduce accredited training that raises awareness of their specific support needs and the services available to them, and through all of this our work has been informed and driven by the voices of people with lived experience. Veterans who access our services have been a vital co-production partner, and our decision to sign the Armed Forces Covenant was based on their feedback. As a result of developments such as these, we've seen a 20 per cent increase in veterans using our services in the last 12 months alone.

Improving treatment outcomes, reducing drug related harm and death, and increasing the number of people in treatment are at the heart of the UK's ten-year drug strategy. The most effective way we can achieve this as a sector is to listen and respond to the voices of those affected by drug and alcohol use.

If any providers of support for veterans would like to work with us, we'd be delighted to hear from you. If you'd like to find out more, please contact our veterans support working group: veteransupportworkinggroup@cgl.org.uk

Chris Barnes is a veteran and national service user lead at Change Grow Live

Jason Salmon | Dreamstime

A lot's changed in the last 30 years, and that includes us.

We're still delivering the same great services with the same brilliant team of staff and volunteers.

But now we've got a new name and identity that really captures who we are and what we do.

We're part of a journey, and everyone's journey is different.

We are Via.

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v-i-a

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THE SKY'S THE LIMIT FOR RECOVERY STREET

Submissions are now open for this year's Recovery Street Film Festival, which is fast approaching its tenth anniversary

'These films are going to make a big difference, because if people can get support without shame it will keep them alive and it will make such a difference for generations to come,' says the winner of last year's Recovery Street Film Festival, Ceri Walker.

Now in its ninth year, the festival is designed to challenge stigma, celebrate recovery and increase access to support. 'What I'm doing now is for my children and their children,' says Ceri, who is a spokesperson for the National Association for Children of Alcoholics (NACOA). Her stop-motion animation, *Understanding the Child in Me*, focused on the impact her mother's drinking had on her when she was growing up. 'I'm a mum without a mum and it's 20 years next year since I lost her,' she says. 'I know that I'm in this for the long haul – I know my recovery is lifelong, and I'm OK with that.'

This year's theme is 'The sky is the limit', which is about seeing recovery as a gift of opportunity – the opportunity to 'heal, grow, travel' and 'find freedom, meaning, love and kindness,' say the festival organisers. 'Recovery journeys can take us to places we never thought possible.'

Entries should be between one and three minutes long, and the organisers are keen to stress that 'the sky is also the limit when it comes to the type of film you want to create – whether you want to showcase a short drama with actors, a stop motion animation, a documentary-style piece, a personal story, a monologue, a song, a poem, or anything else you can dream up.'

John Paul Chapman, whose *My Head Feels Like a Washing Machine* was in last year's top three, describes how the process has given him back his confidence. 'In the past, it was always done with a drink or drug inside me,' he says. 'In the space of the year since we've done it, things have worked out incredibly. It's indescribable really. I can't believe how much things are pushing forwards. We started a creative hub on the back of it.'

Paul stresses that the films are judged solely on their quality, creativity and how they relate to the theme, so there's no need for expensive equipment – he filmed his entry on his phone, then edited it on an 'old, knackered laptop'. There are plenty of tips on everything from storyboarding to shooting and post-production at https://rsff.co.uk/how-to-make-a-short-film.

After the shortlist has been announced, screenings will take place across the country during recovery month, with the top ten entries also available to view on the festival's YouTube channel. The overall winner will receive a £300 Amazon voucher, with the second and third-place entries receiving £150 and £50 vouchers respectively – they'll also have their expenses paid to attend the award ceremony in September.

Films entered into the competition over the last nine years have now been viewed by well over a million people. 'By giving people the opportunity to experience through film a diverse range of real-life stories from people affected by recovery, it may help reduce the stigma,' say the organising partners, who include representatives from Adfam, Humankind, Phoenix Futures, Steps 2 Recovery, Project 6 and Turning Point. 'We want to demonstrate through the medium of film the diverse issues that are faced by people during their recovery processes and how those around them can be affected. The aim is to empower people affected by substance use disorder by giving them a voice.'

Submissions are open until 1 August, with full details at https://rsff.co.uk/competition-information. Anyone who'd like to support the festival but doesn't want to make a film can also help out by hosting their own screening: https://rsff.co.uk/host-a-screening.

'No matter how you choose to get involved with the Recovery Street Film Festival 2023, we hope you'll join in spreading the word about the incredible achievements of people with lived experience during Recovery Month and beyond,' the organisers state. 'Let's challenge stigma and celebrate the power of recovery together.' **DDN**

https://rsff.co.uk/

Check out last year's shortlisted films at: https://www.youtube.com/playlist?list=PLQeUqmCikGyZ6uC0uGq95QI8OgRAqnx1T

Last year's Recovery Street Film Festival winner was Ceri Walker. Her stop-motion animation, *Understanding the Child in Me*, focused on the impact her mother's drinking had on her when she was growing up.

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Supportive recovery housing in the London borough of Lambeth is waiting for you

WE HAVE PLACES AVAILABLE IN OUR SUPPORTIVE RECOVERY HOUSING

- A calm homely environment for people that are homeless and single
- Skilled & dedicated team to support
- A small but supportive recovery community
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- We accept referrals from anywhere in the country
- Person centred support including one-to-ones
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- Great location with good transport links into central London

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- Access to treatment services
- Skilled and dedicated team to support you
- One-to-one support and action planning
- A safe, supportive environment to live and focus on your recovery
- A wide range of practical advice and support
- Support to identify and access suitable move-on accommodation
- Close to the City Centre
- Local connection is not required

IF YOU'RE LOOKING TO RETURN OR RELOCATE TO NEWCASTLE, OR YOU JUST WANT TO MAKE A FRESH START IN ONE OF THE BEST CITIES IN THE UK, CALL US ON 0191 273 6839

PHOENIX FUTURES

A DIGNIFIED END

Compassionate end-of-life care for people using substances has often been sadly lacking, says **Sarah Galvani**

People who are at, or near, the end of their lives deserve to die with dignity, care and compassion. But this is often not the case for people using substances, particularly if they are homeless too. Many people using substances have few, if any, options about their care towards the end of their lives. The care they receive from some professionals can be poor and their families, friends and carers are left wondering how to cope – usually without adequate information and support.

In 2019, a team of researchers from Manchester Metropolitan University (MMU) started to develop a new approach to care for people using substances – alcohol and other drugs – who were approaching the end of their lives. This was done in partnership with people with lived experience of substance use and loss, through our community partner VoiceBox Inc., and in partnership with ten social and health care providers in Liverpool and Sefton.

Liverpool is fortunate to have some dedicated professionals working together, particularly for homeless people or people living in hostels. These include

Talking about future plans when we become ill doesn't have to be scary or depressing – we can just focus on the practical.

Some of the resources on the website have information on advance care planning (ACP) – something we all should do regardless of age, substance use, ill health or ability. The advantage of ACP is that it gives us the best chance of controlling what happens to us if we become ill, have an accident or there are other circumstances in which we might face life-threatening conditions. It's not complicated but it does mean we need to think about what we might want at the end of our lives. It suggests we consider things like:

- Who would we choose to make decisions about our care if we were unable to?
- Do we have any fears or worries about our care at the end of our lives? If so, what are they?
- Given a choice, where might we want to spend our final days and with whom? For example, home, hostel, hospital, or perhaps you don't care (assuming a beach in Barbados is not an option...).
- Is there any type of treatment we wouldn't want?
- Do we have any spiritual or religious beliefs we'd like taken into account?
- Is there anyone we'd like to know if we were ill or dying?
- Are there practical matters to sort, such as looking after a pet, sorting out belongings or property?
- Do we want to be resuscitated if our heart stops?
- What would you like to happen to your body after you die – donated to science, cremation, organ donation, burial?
- Who do you want to know about these wishes – GP, specialist/ consultant, family, friends, colleagues, hostel staff?

kazuma seki / iStock

the Brownlow group of GPs, Marie Curie Hospice staff, With You and Ambitions Liverpool staff, and housing agencies such as the Whitechapel Centre and YMCA. However, across the wider system and away from the hard work of these agencies there is a genuine ignorance about how to support someone who is using substances and approaching the end of their lives.

To develop a new approach, the team asked people about their experiences of living or working within the existing system. Finding out what worked and what didn't was an important first step in developing a different way of working. What we heard were examples of shocking and prejudiced 'care', with only a few examples of good practice.

The research team worked alongside people with lived experience of substance use, as well as families, friends and carers, and social and health care practitioners to develop the new model of care. Through a series of online workshops, the group agreed the short-, medium- and long-term goals for a new model.

THE LONG-TERM GOAL:

'To provide compassion-focussed palliative and end-of-life care for people using substances, and their families and carers, which addresses current health inequalities.'

This doesn't mean the responsibility lies just with palliative and end-of-life services; it means that no matter where the person is in the 'system' when they become seriously ill, the people around them should be better equipped to have conversations with them, whether that's a substance use practitioner, family member, hostel worker, or medical staff. It also means family members (we use the term loosely – it could be a close friend or neighbour) should be better supported, both in their own right and in terms of the information and emotional support to help them in their caring role.

To reach the long-term goal there are a series of 'stepping stones' including short- and medium-term goals. For our short-term goals, the working group said everyone needed more knowledge and understanding of the issues people faced, information on how to talk to someone about end-of-life wishes or substance use, and that families, friends and carers – paid and unpaid – needed better support. This meant providing knowledge and resources to professionals, family caregivers and people who are unwell, including examples of good practice of how to raise the subject with someone else and information on end-of-life care and/or substance use. As a result, a range of booklets, practice pointers, leaflets and podcasts were developed and uploaded to the project's website: https://endoflifecaresubstanceuse.com

The resources also offer suggestions on how to challenge a GP or other professional who might not be helpful, such as taking someone else to the appointment or saying, 'I think I could be seriously unwell. I know I drink/use drugs, but it's more than that. I need someone to take my concerns seriously.'

Of course, talking or thinking about dying is still taboo, despite the fact that it's an experience we're all guaranteed to share. The resources also include pointers on raising the subject with family and friends, as well as suggestions for professionals and family members about how to start conversations.

Depending on the circumstances of our ill health we may not always be able to get things the way we would want them at the end of our lives but there's a far better chance if we've given it some thought ahead of time, written it down, and told some other people.

The research team heard that what was important was having someone who listened properly and didn't judge, someone who clearly cared about them and wanted the best for them, and professionals who were direct about what was going on but kind at the same time. They also wanted care in a holistic way, where professionals considered all of their needs rather than just one. Family caregivers and practitioners wanted to know how to take care of their friend, relative or patient well and where to go if they had questions or needed support.

Perhaps the main message from the group and the wider research is that people deserve a 'good death' and to die with dignity, with as much control as they want, and with as much choice as possible. Making sure that happens is everyone's responsibility.

Sarah Galvani is part of the SUAB (substance use and associated behaviours) research group at Manchester Metropolitan University. Email: s.galvani@mmu.ac.uk

There are five clear steps to advance care planning (ACP)

Adapted from what's known as the Gold Standards Framework, 2018

1	THINK	Think about the future: what's important to you, what do you want to happen (or not happen) if you became unwell?
2	TALK	Talk with family and friends and ask someone to be your spokesperson or lasting power of attorney (LPA) if you could no longer speak for yourself.
3	RECORD	Write down your thoughts, including who your spokesperson is, and store this safely.
4	DISCUSS	Discuss your plans with your doctor, nurses or carers. This might include a further discussion about resuscitation or refusing further treatment.
5	SHARE	Share this information with others who need to know about you – through your health records or other means, and review it regularly.

Free resources at https://endoflifecaresubstanceuse.com

The website has three main sections:

1. If you are unwell
2. Practitioner support
3. Family caregivers (family in the broadest sense of the term – may be a close friend for example)

It also has information about the research and links to our project reports, practice guidance and policy standards documents.

MY ROAD, MY CHOICE

Will you be at this year's DDN Conference, asks **Anna Millington**

This year the *DDN* conference name is important. It recognises that there are many roads users (of both drugs and alcohol) walk and many different destinations we seek to get to. For some users this is recovery and abstinence, for others it is having a stable base line – controlled use. Others want medication and to be substance free. Then there are those who simply want effective harm reduction. All of them are valid, all roads should be included.

It's not mine or anyone else's role to tell users what's the best road – that's a personal choice that they must make for themselves. It's the role of organisations, activists, representatives and providers to give users a clear, evidence-led useful and effective map... not to tell users what they 'should' be doing/thinking or what 'should' be happening. This is the benefit of the *DDN* conference – its focus is not on a particular road whether that's recovery, criminal justice, *etc*. It's a conference about the needs and wants of users, the choices offered to us and the specific work being carried out by us or with us. Sometimes we will agree with it, sometimes we won't.

The conference theme this year was developed with users walking different roads, organisations, and providers offering different things. If you are a user who wants to get involved, have your say, develop your voice and better understand this sector then you should be at the conference. If you are an activist, it shouldn't matter what you are acting on behalf of (abstinence, recovery, the end of prohibition, safer consumption sites) you should be at this conference. If you are a harm reductionist it is vital you are involved because there are so many innovative new approaches – you should be at this conference. If you are an organisation or provider you should have no real set agenda apart from users' wants/needs and so should be listening to, taking part in and responding to this conference.

It is vitally important that we set aside our personal opinions and look at the bigger picture. Who do you represent? Who/what are you fighting for? What is it you are really trying to achieve? We will continue to fail to make radical change unless we work together. Let us not move backwards a decade to when we allowed others to pit us against each other.

We often talk about stigma in a very narrow way but stigma happens within the using communities, it happens in relation to the choice of substance or how you take the substance, it happens within organisations. The most effective way to combat stigma is by recognising it. This occurs when we talk, when we share, when we really listen – when we disagree on which road we walk, but can agree that issues like saving people on any road are important.

If you are a provider or an organisation that offers funds to support user inclusion and empowerment, please try to make sure that you helping ALL users to attend who wish to.

Anna Millington runs a non-funded, non-affiliated support network for mothers who use drugs

HOW DO I BOOK?

SCAN THE QR CODE OR VISIT OUR WEBSITE WWW.DRINKANDDRUGSNEWS.COM

WE'VE KEPT PRICES AS LOW AS POSSIBLE. YOU CAN BOOK TICKETS VIA OUR WEBSITE EITHER AS AN INDIVIDUAL FROM AS LITTLE AS £75 OR GET IN TOUCH TO DISCUSS BRINGING A GROUP ALONG.

To get funding, approach your local commissioner or service, explain the benefits of being there and ask them to support you. and your group to attend.

HERE ARE SOME QUOTES FROM THAT VERY FIRST CONFERENCE IN 2008...

'If we wait for things to come to us, we could be waiting ages. We need to get a collective voice.' Si Parry (Morph user group, Southampton)

'If you can spend money putting me in prison, or rehab, or a straitjacket, why can't you spend money putting me on an IT course?' Delegate

'What could policymakers do better? They could trust service users to set and fund their own agendas. They would then be in a better position to do what they wanted to do.' Delegate

'We need to come up with focused ideas that have high impact... A lot of people don't put enough bloody effort into user involvement. Some people have done this spectacularly well. Don't reinvent the wheel – use what works. We need to bring up the next generation of user involvement; it's up to us.' Jimi Grieve (NUN)

'Let's be productive in changing what we can change, rather than spending months on what we can't.' (Delegate)

'A lot of potential talent and experience is lost due to the use of inappropriate language – where folk tend to switch off rather than try to work out its meaning. First impressions last and are hard to dispel.' Delegate

'There's a strong feeling that we want to communicate through user groups and not be sterilised by government procedures.' Delegate

'Peer-led services provide better services – it's a fact. If funding was pulled for service user involvement, we would see an increase in lapses.' Delegate

'There needs to be more cohesion between service user groups to get a national service user voice. Delegate

'I see the way forward as service users being an independent network. Outcomes should be based on service users, not commissioners.' Kevan Martin (NERAF)

'Every service user group should meet up and bounce their ideas off each other.' Delegate

'The key things for service users are: be less confrontational and more dynamic; keep knocking on doors; be realistic about what can be changed.' Delegate

'Why am I the only commissioner from my area being funded to come to this conference?' Delegate

CREATIVE OUTLET

I was very moved to read Jody Lee's story (Poet's Corner, *DDN*, May, p18) and his explanation of how poetry has helped him express himself and talk about some of the dark parts of his addiction and how having a creative outlet has helped him process the grief and anger at the time he has lost through his addiction.

Having an outlet for creativity is a huge benefit when it comes to processing your emotions. While a lot of services provide art therapy and other ways of doing this it doesn't always have to be a formal process and can be something that can be done in private or as part of a club or support group.

You meet many very talented creative people who are in recovery or still using, some of whom have written for national publications, worked in film or TV, or have had books published, there are people I have met in treatment services who have played with world famous bands in front of large crowds and there are artists in recovery communities who have exhibited around the world.

While it is fantastic that talented people like Jody are sharing their thoughts in a way that can help and inspire people in similar situations, it is important to remember not having a recognised talent shouldn't stop you engaging in a creative hobby to improve your own wellbeing.

Just because you haven't drawn a picture since primary school, that the last poem you read was a limerick about Devizes, or the closest you have come to performing musically was with a kazoo in a Christmas cracker it really doesn't matter. No one will judge you, there is no right or wrong, just have a go and maybe you will find the process itself rewarding.
Miriam Tench, by email

BARE MINIMUM

There seems to be some confusion among the great and good about the rate of alcohol deaths in Scotland. On the one hand, we have more than 30 charities and medical experts saying that the country is 'sleep walking back to record levels of alcohol deaths' (*DDN*, May, p4), yet many of these are the same organisations that have been heralding the success of minimum unit pricing north of the border. In that case, just how high would deaths have gone without it?

MUP seems to be one of those areas – a bit like Portugal's drug policy – where the results are seemingly so muddy and inconclusive that both sides can use them in their arguments. Studies have shown that MUP, unsurprisingly, has had little impact on the amount of alcohol consumed by dependent drinkers, who will often go without essentials like groceries and heating to find the extra money. Surely if a policy isn't helping those most desperately in need then there isn't much use to it? The Scottish Government's consultation on restricting alcohol marketing is all very well, but I have a suspicion that ultimately these things don't have all that much impact either. I agree that seeing an alcohol ad might be triggering for someone in recovery, but problematic use of substances is the result of life circumstances, not adverts.

Maybe the Scottish Government needs to ask some fundamental questions about why the levels of drink- and drug-related deaths in its country are still so shockingly high. It may well be, as many predict, that the drug death levels are about to start coming down after the SNP government belatedly realised that it had 'taken its eye off the ball' and started putting some money into it, and I'm sure if that happens the government will be shouting about it from the rooftops. But, as Dave Liddell says in the same issue (P16), the rates have been so astronomically high that a fall at some point is 'inevitable', and even if the number does go down 'it's still colossal'.
Paul Roberts, by email

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