DDN

Drink and Drugs News
July/August 2023
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Spotlight on intelligent commissioning

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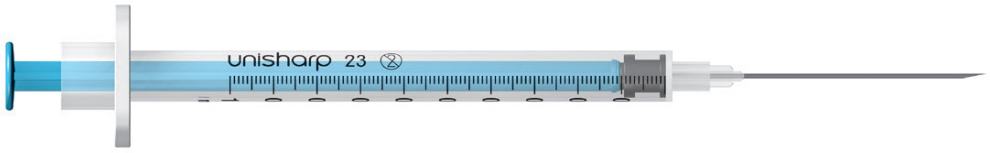

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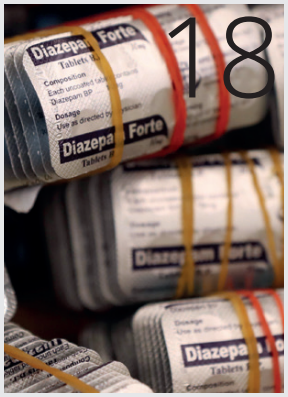

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Helping people prepare for release from prison

If we can't fit in, we 'become the problem'

British South Asian women with addiction problems are often a community within a community within a community, hidden from view, says Shinasa Shahid (p6). Her article teaches us much about the 'shame and blame' that fuels stigma. When our families and communities give us a role we can't fit into, we become the problem – which is why support services must be ready with the knowledge and sensitivity to respond.

How different might Raymond's life have been if he'd had an early intervention for his problematic drinking (p12)? Now in a supportive environment at last, he's lost the ambition to see life as 'more than okay'. Opportunities do seem to be opening up for the candidates leaving prison on a pathway towards long-term paid employment, however (p14). This approach of 'personalised, blended support' has also taken root in Cornwall, where mental health, drug rehabilitation and alcohol treatment requirements are considered as a treatment partnership (p16) – a theme also explored in our new commissioning series on p10.

And we're delighted to reopen Release's casebook in this issue (p18), with the ever-popular regular column. There's no better way to demonstrate the value of challenging poor treatment than through effective advocacy support.

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

‘Cheap and easy’ synthetic drugs transforming markets

‘Cheap and easy’ synthetic drugs are ‘changing drug markets with lethal results’, according to UNODC’s *World drug report 2023*. Fentanyl has ‘drastically altered the opioid market in North America with dire consequences’, it says, with the majority of the country’s approximately 90,000 opioid-related overdose deaths in 2021 involving illegally manufactured fentanyls.

Fentanyl’s potency means reduced costs and legal risks for traffickers, as they can ‘more easily conceal smaller quantities of pure fentanyl in place of larger volumes of heroin’, the document states – ‘it has been estimated that as little as a few tons of pure fentanyl would be needed to satisfy the annual consumption of illegally sourced opioids in the United States, in contrast to about 50 metric tons of heroin.’

The purity-adjusted, low-level wholesale price of illegal fentanyl powder fell by more than half between 2016 and 2021, the report points out. The Taliban’s ban on opium cultivation in Afghanistan could result in a drastically reduced harvest this year, it adds, which may see a further shift towards synthetic drug manufacture – the country is already a major producer of methamphetamine.

Based on new data, UNODC estimates the global number of people who inject drugs at 13.2m as of 2021, 18 per cent up on previous estimates. The total number of people who used drugs in 2021 is estimated at almost 300m, an increase of nearly a quarter on the previous decade, while the number of people with a drug use disorder is now thought to be almost 40m – a figure that has ‘skyrocketed’ by 45 per cent over a decade.

> ‘We are witnessing a continued rise in the number of people suffering from drug use disorders worldwide.’
> GHADA WALY

www.un.org

However, the demand for treating drug problems remains ‘largely unmet’, with only one in five people with drug use disorders in treatment in 2021 and ‘widening disparities’ in access to treatment across regions. ‘Public health, prevention, and access to treatment services must be prioritised worldwide, or drug challenges will leave more people behind,’ UNODC states.

‘We are witnessing a continued rise in the number of people suffering from drug use disorders worldwide, while treatment is failing to reach all of those who need it,’ said UNODC executive director Ghada Waly.

Document at www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2023.html

Record cocaine seizures across Europe

MORE THAN 300 TONNES OF COCAINE was seized across EU member states in 2021, according to EMCDDA’s *European drug report 2023*. Almost three quarters of the total was seized in three countries – Belgium, the Netherlands and Spain – with the trafficking of large volumes through European seaports in commercial containers ‘driving the drug’s high availability’, says EMCDDA.

Provisional figures for 2022, meanwhile, show that the amount seized in Antwerp – a European hub for cocaine trafficking – increased from 91 to 110 tonnes from the previous year. Around 3.7m European adults used cocaine in the last year, making it the continent’s most commonly used illicit stimulant, and evidence suggests that organised crime groups are ‘increasingly targeting smaller ports in other EU countries as well as countries bordering the EU’, EMCDDA says.

More cocaine is also being manufactured in the EU itself, the report states, with 34 cocaine laboratories dismantled in 2021 – eleven more than the previous year – some of them large-scale operations. More than 40 new NPS were identified through the EU’s early warning system last year, bringing the total being monitored by the EMCDDA to 930, and a total of 74 new uncontrolled synthetic opioids have also been identified in Europe since 2009, says the document. While fentanyl derivatives and highly-potent nitazenes play a ‘relatively small role’ in the European drug market compared to the US, there are growing problems in some areas.

European Drug Report 2023 at www.emcdda.europa.eu/publications/european-drug-report/2023_en

England on track to end new HIV transmissions by 2030

NEW HIV TRANSMISSIONS in England have fallen by nearly a third since 2019, with the country on track to meet its target of an 80 per cent reduction by 2025 – and an end to new transmissions by 2030. Increased testing levels also mean that fewer people are unaware of their HIV status, says an update to the HIV action plan for England from DHSC, UKHSA and NHS England.

As part of the action plan, NHS England is investing £20m in the three years to 2025 to expand opt-out BBV testing in emergency departments in areas with high HIV prevalence. The expanded testing helped to diagnose 2,000 BBV cases in the first year, says the update, including more than 340 people living with HIV.

Cases of AIDS have also fallen by more than a fifth since 2019, the document adds. According to the original action plan, however, while rates of new HIV diagnoses were falling among many groups, they remained stable among ‘people who probably acquired HIV through injecting drug use’ – at around 100 per year.

HIV Action Plan: annual update to Parliament at www.gov.uk/government/publications/hiv-action-plan-annual-update-to-parliament/

MUP cut alcohol deaths by 13 per cent, claims report

The introduction of minimum unit pricing (MUP) in Scotland has reduced deaths directly caused by alcohol consumption by 13.4 per cent, according to Public Health Scotland's final report on the subject. It has also cut hospital admissions by 4 per cent, it says, with the most impact seen in the 40 per cent most deprived areas.

'There is strong quantitative evidence that MUP was associated with a reduction in deaths wholly attributable to alcohol consumption, relative to England where MUP was not implemented,' the report states. 'A smaller, and less certain, relative decrease was seen in hospital admissions wholly attributable to alcohol.'

However, the document acknowledges that for people with alcohol dependence there was 'limited evidence of any reduction in consumption', and some evidence that people with alcohol dependence on low incomes prioritised spending on alcohol over food.

MUP has led to a 3 per cent reduction in alcohol consumption at population level as measured by retail sales, the report says. This was particularly driven by the increase in price for off-trade cider and spirits. Despite the introduction of MUP, however, Scotland's alcohol death rate in 2021 was the highest for almost 15 years, at 1,245.

> 'MUP alone is not enough to address the specific and complex needs of those with alcohol dependence.'
> CLARE BEESTON

A recent letter from more than 30 medical organisations and charities warned that Scotland could be 'sleep walking' back to record levels of alcohol deaths without increased and sustained investment in treatment and action to tighten marketing regulations *(www.drinkanddrugsnews.com/scotland-could-be-sleep-walking-back-to-record-alcohol-deaths/).*

MUP was implemented at a level of 50p per unit in 2018, with a 'sunset clause' in the legislation meaning that it will lapse next year unless the Scottish Parliament votes to renew it. Health campaigners have long argued that the rate should be increased in line with inflation.

'MUP alone is not enough to address the specific and complex needs of those with alcohol dependence who will often prioritise alcohol over other needs, and it is important to continue to provide services and any wider support that addresses the root cause of their dependence,' said lead for the evaluation of MUP at Public Health Scotland, Clare Beeston.

Evaluating the impact of minimum unit pricing for alcohol in Scotland: A synthesis of the evidence at https://publichealthscotland.scot/publications/evaluating-the-impact-of-minimum-unit-pricing-for-alcohol-in-scotland-a-synthesis-of-the-evidence/

Government to miss rough sleeping target

MORE THAN 30 LEADING HOMELESSNESS CHARITIES have signed a letter to the prime minister warning that the government is not on track to meet its 2024 target for ending rough sleeping in England. The signatories include Homeless Link, St Mungo's, the National Housing Federation, Cranstoun and others.

The organisations had been encouraged by Rishi Sunak's commitment to the target of ending rough sleeping 'despite the economic circumstances', the letter states. 'However, almost a year down the line, the data shows that we are going backwards in terms of meeting the goal.'

The government's 'Everyone In' strategy during COVID was praised by charities for requiring councils to move everyone sleeping rough – or at risk of sleeping rough – into temporary accommodation, with an August 2021 report from Shelter stating that it showed 'just how much can be achieved with the right political will and investment.' However, rough sleeping actually rose by 26 per cent between 2021 and 2022, the letter to the prime minister states, the biggest year-on-year percentage rise in almost a decade.

'As service providers, we are seeing these numbers play out on the ground, with more and more people needing our support,' it says. The high rate of inflation means that many providers are trying to manage annual shortfalls 'in the hundreds of thousands of pounds for commissioned services', it adds, with many scaling back services or at risk of closure.

The average age of death for someone experiencing homelessness is 45 for men and 43 for women, the letter points out – according to the Office for National Statistics (ONS), almost two in five deaths of homeless people are the result of drug poisoning (https://www.drinkanddrugsnews.com/two-in-five-deaths-of-homeless-people-drug-related/).

Letter at https://homeless.org.uk/news/32-homelessness-charities-sign-letter-to-rishi-sunak/

Local News

spectrum-cic.org.uk

LET'S CONNECT
The RECONNECT Hub in Durham has been officially opened by former prison minister Lord Bradley. The hub provides accessible support – including health, paperwork or even phone-charging – for people leaving prison, and is part of the Reconnected to Health partnership, which includes Tees, Esk and Wear Valleys NHS Foundation Trust, Humankind, and Rethink.

ICONIC SERVICE
A new programme to support people with both mental health and substance issues has been praised by Dame Carol Black. The ICoN (Integrated Co-occurring Needs) initiative in Staffordshire includes local authority, NHS, voluntary and community sectors in a single approach. 'I think it is excellent that Staffordshire has linked this support together,' she said.

IT WENT SWIMMINGLY
Humankind members took part in the Great North Swim at Lake Windermere last month to raise money for the organisation. 'Congratulations to our five inspirational participants,' said Humankind's corporate fundraising manager, David Barlow. 'The funds raised will directly improve the lives of those we exist to support.'

WHAT WILL PEOPLE SAY?

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Shame, stigma and inappropriate services are serious barriers to recovery for South Asian women, says **Shinasa Shahid**

There is evidence to suggest that gaps in treatment provision and lack of culturally sensitive addiction recovery services in the UK are making it difficult for South Asian (SA) women to access the support they need. According to a rapid needs assessment report from 2005, 70 per cent of white staff who were working in substance misuse settings admitted that they often felt uncomfortable because they were aware that their white clients and those from minority ethnic backgrounds had different needs.

Within SA – in particular, Punjabi – households, there is an unspoken cultural acceptance of alcohol use as a norm, something that continues to have a dangerous impact on this community, and many people who experience addiction can feel powerless to improve their situation. The current second and third generation of British Asians are becoming the new casualties of untreated alcohol addiction, compounded by the recent pandemic.

There are significant cultural barriers of shame, stigma and denial – many families feel compelled to send their loved ones to India, Pakistan or Bangladesh for drug and or alcohol treatment. Social barriers include institutional racism and little or no consideration given to the needs of SA communities in commissioning decisions, treatment and service planning. Community barriers, meanwhile, include the location of services and the lack of culturally appropriate information about services.

HONOUR AND SHAME

'Izzat' (family honour) and 'sharam' (shame) frequently keep SA women from looking for help. Due to the stigma associated with drinking, many SA women do it covertly, with a debilitating effect on confidence and constant worries about 'what will people think if they find out about my addiction problem?' This means that British SA women with addiction problems are often a community within a community within a community.

In some cases, religion can also contribute to stigma and discrimination against those in active addiction and recovery. In

SA women can face racism and discrimination from mainstream healthcare providers, peers, and society.

Some have faced situations where the language used was hurtful or judgmental. This contributes to a sense of isolation and a lack of trust in the healthcare system, making it more difficult to seek help and engage in the recovery process. Some specific recommendations that may be helpful include:

>> **Community-based support**
SA women may benefit from community-based support groups and resources that address their unique cultural and societal pressures. These groups can provide a safe space for women to share their experiences and receive support from others who understand their struggles.

>> **Culturally sensitive therapy**
Therapy should be tailored to meet the specific needs of SA women. This may involve using culturally sensitive approaches that consider the impact of culture and tradition on mental health.

>> **Family involvement**
Involving family members in the treatment process can help to address cultural and societal barriers to recovery – they can be educated and encouraged to provide support to their loved ones.

>> **Empowerment and advocacy**
SA women may benefit from empowerment and advocacy programmes that help them to assert their needs and boundaries. These can provide education and resources on self-care, assertiveness, and advocacy, and help women to overcome cultural/societal barriers to recovery.

>> **SA women-led lived experience recovery organisations with holistic healthcare services/women-led spaces**
Peer recovery champions and peer-led groups can provide opportunities to develop leadership skills and become advocates for addiction recovery in their communities. They can also help to cope with cravings, and find healthy ways to manage triggers. Such lived experiences can also help to inspire hope and motivate others.

some SA religious communities, addiction is often viewed as a lack of faith, which further creates a culture of shame and blame, with women ostracised from their families and communities.

Culture and religion are not separate in SA communities. For instance, most religions prohibit alcohol and drugs, and there is often a strong emphasis on family and community values, with women expected to be caregivers and maintain social harmony. This further creates feelings of guilt and shame when they struggle with addiction – they feel they're letting down their families by engaging in behaviours that are stigmatising. SA cultures place a high value on conformity and respect for authority, and family members often play a central role in decision-making – particularly regarding marriage, education, and career choices. Women may face pressure to conform to traditional gender roles and expectations, making it difficult for them to assert their needs and boundaries.

BARRIERS TO ACCESS

'Many women from Black, Asian and ethnic minority communities feel that mainstream services do not listen to, or understand them,' said a 2021 report from WithYou, *A system designed for women? Understanding the barriers women face in accessing drug treatment and support services*.

'They expressed a preference for receiving support from culturally-aware, culturally sensitive services that are Black, Asian and ethnic minority community-led, services led by people with lived experience,' it added. 'They also felt that services led by people with lived experience were better able to understand and respond to their needs.'

There are only a handful of culturally responsive organisations that offer recovery support for ethnic women in the UK, such as BAC-IN (Nottingham) and Nilaari (Bristol) and there is a dire need to create more peer-led culturally appropriate recovery organisations as those that do exist have limited access.

Funding for these organisations is also limited, which impacts their ability to provide a comprehensive range of services and reach a larger number of women in need of support. Sohan Sahota in his book *Shades of Recovery* mentioned how local and national commissioners often underestimate the need for culturally appropriate treatment services among ethnic communities. There is also a diverse range of languages in the SA communities, including Hindi, Urdu, Punjabi and Gujarati, which could be a barrier preventing many women from accessing services.

'There are only a handful of culturally responsive organisations that offer recovery support for ethnic women in the UK.'

JOINT WORKING

Changes in policy, attitudes, and fit-for-purpose service offers must be a joint effort and community-driven. They must be included and consulted on in all structures of the treatment system – specialist and peer-led services, decision-making, training, service design and so on, before we lose another generation to untreated substance use.

We also need better data, and my current research on *Recovery from substance use disorders in black, Asian and ethnic minority groups in the UK* will explore what recovery entails for women in these groups and contribute to a better understanding of what helps them to sustain it. My study will focus on lived experience, and how they navigate their recovery journey.

Shinasa Shahid is a PhD student in addiction recovery

I encourage women in recovery to participate in my PhD research study with the following criteria:

>> Particular attention to women from the African/African-Caribbean, Asian British/Asian communities, but also including white women who will make up the control group for the study.

>> Women who are fluent in English and are 18 years and above.

>> Anonymity and confidentiality will be maintained at all times.

ON THE RIGHT TRACK

England's world-leading hepatitis C programme is working but we mustn't miss the key target, says **Elliot Bidgood**

NHS England recently announced that the country is on track to eliminate hepatitis C by 2025, five years ahead of the World Health Organization 2030 target. It also said that the country's 'pioneering' elimination programme has helped find and cure more than 70,000 people of this potentially fatal virus.

This means that England could become one of the first countries to eliminate the virus – a real example for the rest of the world and for other areas of public health. But with 74,000 people in England still believed to have the virus and current funding for the programme requiring renewal in April 2024, it also means we must not rest on our laurels in these crucial two years.

TAKING THE INITIATIVE

Earlier this year HCV Action – a network coordinated by The Hepatitis C Trust – released *Taking the initiative: how England is eliminating hepatitis C*, a report exploring the elimination programme and some of the main initiatives that have been developed under it. These have included efforts by NHS bodies, voluntary sector organisations and pharmaceutical industry partners to find, test and treat people in community settings, the criminal justice system, primary care, drug services, emergency departments and more.

A key finding has been the widespread value of peer-to-peer workers and volunteers with lived experience of hepatitis C or substance use in finding and supporting people with hepatitis C. Figures from The Hepatitis C Trust show that since the current programme started in 2019, 29,000 people at risk of hepatitis C were tested and 3,800 were supported into treatment thanks to this kind of work. In recognition, health minister Lord Markham recently commented that, 'Almost every [hepatitis C] elimination initiative that NHS England manages and commissions... has peer involvement. NHS England consistently finds that people with lived experience are excellent advocates and are crucial in developing therapeutic alliances to support people into testing and treatment who may have felt excluded from traditional healthcare and other settings.'

SHARING DATA

The UK Health Security Agency (UKHSA) cites injecting drug use as a risk factor in most hepatitis C cases. This is why collaboration in drug treatment services has been developed under the programme to help cut across commissioning boundaries, simplify pathways and bring together service providers that often find themselves in competition. A Hepatitis C drug treatment services provider forum was established to strengthen data sharing across organisations, improving access to treatment for people using services. Initiatives during the COVID-19 pandemic saw drug treatment services adapt to include home testing, remote monitoring and targeted testing of homeless populations, and these types of efforts recently saw the provider forum receive a *Health Service Journal* award for its 'outstanding dedication to improving healthcare and effective collaboration'.

> '...with the programme having found many of the more reachable cases, in the final stretch we're now seeing additional work to find outlying cases.'

However, with the programme having found many of the more reachable cases, in the final stretch we're now seeing additional work to find outlying cases. The HCV Action report touched on NHS England plans for an online portal where people can order a discrete and remote home testing kit. This scheme – aiming to broaden access to treatment for people neglected by, or physically further from, services – has since been launched and is accessible at hepctest.nhs.uk/.

A NEW STRATEGY

With funding for the elimination programme coming to an end at the end of March 2024, a new strategy will be needed to ensure that the work so far doesn't go to waste, and that elimination is achieved by 2025. This is why The Hepatitis C Trust's message for World Hepatitis Day 2023 on 18 July will be 'don't miss the target', to keep up momentum and to ensure that years of work and £1bn of investment are built upon.

Even beyond this, we'll need strong and vigilant harm reduction measures – such as needle and syringe exchange programmes and regular testing of people from higher-risk backgrounds – to prevent new infections, alongside continued commitment to testing and treating those at risk. This will safeguard the legacy of England's hepatitis C programme, ensuring that we achieve elimination and sustain it for everyone thereafter.

Elliot Bidgood is policy and parliamentary adviser for The Hepatitis C Trust and Coordinator for HCV Action

Andrii Zorii | Dreamstime

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BRINGING IT TOGETHER

In a follow-up to last year's commissioning series, we look at how the elements of a strong partnership can fit together

Last year we ran a three-part series looking at what's next for commissioning in the wake of Dame Carol Black's *Independent review of drugs*, the drugs strategy and the new money that followed it (*DDN*, October 2022, p12; November, p12, and December-January, p14).

Commissioning had become fragmented, said the Black review, with deteriorating partnerships between local authorities, housing and criminal justice agencies, among others. The government's Commissioning Quality Standard (CQS) then set out what it thinks good commissioning should look like, with a vision of a person-centred treatment system and integrated approach – a document that was broadly welcomed by commissioning staff. So when it comes to commissioning, what does a strong partnership look like?

CONNECT WILTSHIRE

Connect Wiltshire is a new service that integrates drug and alcohol treatment from Turning Point and the Nelson Trust with homelessness charity Julian House and DHI (Developing Health and Independence). The latter, which was originally set up to help bridge the gap between substance misuse and housing services, operates its own social lettings agency, as well as offering supported housing, while the Nelson Trust has a strong focus on women's services.

The service launched on 1 April this year, so it's 'still in its infancy', public health principal for building resilience at Wiltshire Council, Kelly Fry, tells *DDN*. 'There's been a lot of scoping, a lot of stakeholder engagement. We've co-produced the specification based on local need and prevalence, but also being mindful of the Dame Carol Black review recommendations, so for us it's been an amalgamation of various different strands that have come together into that one specification.'

INCLUSIVE SERVICE

Turning Point is lead provider, and has sub-contracted arrangements with Julian House, DHI and Nelson Trust. 'That was because we felt there would be better collaboration, better resilience, better working practice, and we're already seeing evidence of that even though we're in those early stages,' says Fry. 'We wanted more of an inclusive life-course model rather than having silos for young people and adult services.' One key aim was to address the potential for people to fall through the cracks when they turned 18, she says, 'so we've factored in an 18-25 service as well which should help keep people in treatment and support when they need it. The idea is that it's based on need, so they'd move with their key worker throughout their journey.'

'I'm pleased with how the service is working,' adds senior operations manager at Turning Point, Tina Roberts. 'We've worked previously with our partner agencies Julian House, DHI and Nelson Trust but now we're working as an integrated, collaborative service. Even though it's only been a few months, I would encourage other commissioned services to combine and work together. We're taking a holistic life-course model where there's support for adults, young people, and supported housing to ensure continuation of care – the clients don't have to retell their story by going from one service to another.'

VITAL LINKS

When it comes to those vital housing links, Julian House has a wide client base after working in Wiltshire for a number of years, so there's a full journey 'in terms of early intervention, support, prevention, harm reduction advice, right the way through to supported accommodation and recovery', says Fry. 'We've also given Connect our prescribing, supervised consumption and pharmacy elements as well – again, we just felt that it made sense as they're the clinical leads. We can oversee it as commissioners, but they know what's working well and what isn't.'

FORWARD MOMENTUM

At the moment the partners are still meeting every two weeks, which is a 'really important as part of mobilisation', Fry stresses. 'We're really keen to keep the momentum going, making sure we're all on the same page.' There will be at least monthly meetings, as well as the regular meetings around grants, meaning 'constant discussion with the key partners', she says.

One concern about re-commissioning was the potential for a dip in service provision, Fry says, 'so we really want people to invest in Connect.' This has meant a keen focus on getting the message out about new identity and culture, and so far the partnership arrangements have been bedding in well, she says. One example is the supported accommodation element from

Nuthawut Somsuk/ iStock

'We haven't removed a service, we're creating a more inclusive service for everyone – a new service based on real need.'

KELLY FRY

Julian House – while previously there were voids, since the organisation has been a sub-contractor for Turning Point 'we've been full, which is phenomenal. It just shows that developing those relationships has really paid off.'

Although it's still early days for the service itself, what's in place is the result of an intense 18-month period of work and planning. Aside from the usual processes and legalities of a project like this, it was also about 'collating evidence, hearing from service users about what's working, what isn't, how we can improve local delivery,' Fry stresses. 'We co-produced specifications, so while public health are the lead commissioner we co-commission it alongside the Office of the Police and Crime Commissioner (OPCC) and we also sought support from internal services' including children's services, adult social care and housing. So it really did feel very collaborative.'

OUTREACH

Wiltshire is a rural county, making travel to community hubs difficult for some people – how much of an influence did this have on shaping the service? 'It's something that we're really mindful of,' says Fry. Money from the supplementary substance misuse grant and rough sleeper drug and alcohol treatment grant enabled the service to provide outreach buses, and Connect is also looking at much more collaborative working with GPs. This additional funding for rough sleepers 'enables us to have a team of people that are able to go out and access a different cohort of clients that may struggle to access treatment', says Roberts. 'We're able to take treatment to them.'

CRIMINAL JUSTICE

There's also a strong criminal justice element to the service, with workers funded through the supplementary substance misuse treatment and recovery grant. 'We also have the money through from the OPCC so we've got really good continuity of care from the prisons – we really hone in on that pathway,' says Fry.

A clear outcomes framework has been developed for the joint combating drugs partnership, meanwhile, as 'it's an area that touches on so many different organisations as well as our lead providers – it's about what data can you bring,' Fry continues. 'What's happening with county lines, drug arrests, A&E admissions – are those pathways working? We're very data-driven, and everything's shared at the combating drugs partnerships so we're clear about whether we're doing well or if we have to potentially support to improve that performance – or just hold partners to account.'

Peer mentors and service user reps also attend the joint combating drugs partnership meetings, while commissioners attend the service user council, so there's constant feedback. 'The service users are very frank, they're very open – if it's not working they'll say,' she states.

SERVICE LEVELS

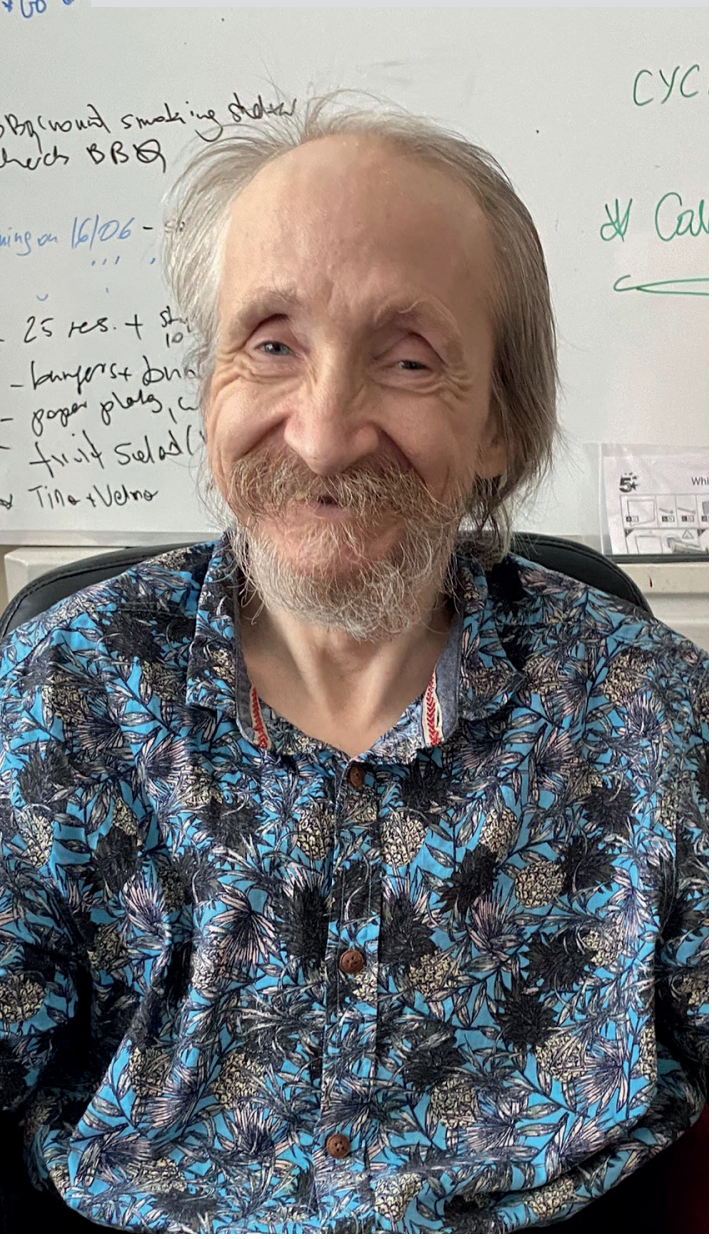
While there were some initial worries around what would change and if people would keep the same keyworker, the service was determined to communicate clearly from the start. 'What we didn't want to do was start losing people from treatment,' says Fry. 'It's just having that continuity and discussions with service users and staff and partner agencies. The feedback is we're getting more referrals from the 18-25s which we really wanted to see, and just the fact that we've got more people going through that supported accommodation pathway is testament to the fact that service users are feeling happy, feeling supported.' To ensure that clients were aware they'd 'still be receiving the same level of service under the Connect Wiltshire umbrella, we sent out information via email, letters, leaflets as well as speaking to clients face-to-face and updating our stakeholders in strategic meetings,' adds Roberts.

ONE HOLISTIC MODEL

So in the time since the Carol Black report said that partnerships were deteriorating, is there a sense that things are improving on a national level? 'I think so,' Fry says. 'There's a lot more governance, a lot more scrutiny, a lot more accountability now. There are national commissioners' calls, regional commissioner meetings, SRA (senior responsible officer) meetings and more to share learning. A great deal has been put into it.'

And when it comes to lessons learned, what advice would she have for other areas trying to do similar things? 'I think the lead-in time is really important, but now it's about making sure that we have that life-course approach and one joined up, holistic model. I think that takes time to embed, and it can be a culture change from the way partners may have worked in the past. For example, we're now calling them Connect rather than Turning Point and DHI. So while you're employed by that agency, the service is called Connect. They're their own providers with their own cultures, but for us it was about joining up so we really did create that ethos of that one service approach. It's about letting people we know that we haven't removed a service, we're creating a more inclusive service for everyone – a new service based on real need.' **DDN**

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



IT'S MY LIFE

Drinking can become a way of life. But it's nobody else's business if it does, says **Raymond Bond**

I was very young when I started drinking. I'm sixty-three now, so that's a long time.

My childhood was okay. I grew up in Greenwich with my parents and seven siblings. Then my mum and dad died when I was still young, and social services suggested we go into care. But my older sister and her husband decided to look after the younger ones.

I didn't do any exams. I just left school at about sixteen and found a job in a factory – packing and assembling – which I did for just over ten years. I met a guy at work, and we started drinking together. We used to go to the pub on Fridays after work. Then we took turns visiting each other's houses at the weekends.

After that, we moved in together, and drinking became a lifestyle. We drank every day, working during the day and drinking in the evenings. I never felt it was a problem. We drank anything and everything, beers, spirits, wines – you name it.

After ten years at the factory, I told the boss where to go and left, as I'd had enough. After that, I drank day and night as I had nothing to do and nowhere to go. The drinking just got worse. I was signing on, so I had money to buy alcohol. I did that for a long time.

Then as we got older, my friend had a hip operation which didn't go so well. He came out of hospital, and a few months later I went upstairs to take him a cup of tea one morning and couldn't wake him. So, I had to call the ambulance and the police. He'd died in his sleep.

After he died it was pretty lonely, and a social worker got involved as I wasn't looking after myself properly. I was in my late thirties to early forties then. I'd never learned to cook or do anything and was just drinking. When he died, I didn't have anyone to drink or do anything with, and life became a bit difficult. So, I went into a home and there, I could drink moderately. Then I went from there to another home before I was sent to Aspinden Care Home (ACH).

Since I've been at ACH, they've put me on a programme to cut my drinking down. So, I cut way down.

> 'I'm ok with my life... Sometimes the staff talk to me about whether I want to cut down on my drinking even more, but right now, I want to continue as I am.'

It was difficult at first, but I've gotten used to it. I stick to my allowance most of the time, but sometimes if I have money, I go down to the shop and get a can.

My life is okay. I haven't thought of what a good life would be. I just take life as it comes. Most of the time, I just stay in, but I sometimes go to the park with the staff or join in the activities they have.

I like living at ACH. I see the doctor regularly, and the nurse. The staff here are quite helpful. If I have any troubles, I go to them, and they help me. They help with letters, forms, benefits, my banking, and everything. I get all my meals cooked, but I don't always eat as I am fine with one or two meals per day. But food is here when I need it.

Sometimes there are trips to the seaside or amusement parks, and I go to those. There are also things to take part in during the week like board games, which I join in with, or sometimes celebrations for different things. As for my family, one of my brothers came here once when I moved in, but I don't know where my other siblings are. We sort of all went our separate ways, so they haven't been in touch.

I'm ok with my life, and I want to stay here for the rest of my life. I have no other plans for the future. I have my drink when I'm allowed, and otherwise, everything is ok. Sometimes the staff talk to me about whether I want to cut down on my drinking even more, but right now, I want to continue as I am. It's my life, and what I do with it is my business.

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BACK TO LIFE

Turning Point's volunteer scheme to help people prepare for release from prison has been a pathway to paid employment – and a source of highly valued staff for the organisation, says **Eoin Bolger**

When Billy got arrested with five kilos of cocaine on the M5 in 2019, he could never have imaged that four years later he would be using his experience to support others as a recovery worker at health and social care provider Turning Point.

The 46-year-old is still in the process of completing his sentence of almost ten years. However, after managing to become abstinent from substance use, he was able to complete an educational programme which has given him the skills and knowledge to support other prisoners, as well as members of the general public with alcohol and substance use issues. 'This course has changed my life and it's changed my future,' says Billy. 'I will continue doing this once I leave prison.'

CHASE (Collectively Heighten Awareness of Substance Misuse through Education), an 18-week programme designed by award winning tutor Neville Brooks, provides an educational and employment pathway that helps prisoners prepare for release. Prisoners can gain NVQ Level 3 qualifications and valuable work experience placements with the aim of long-term paid employment.

The programme is offered at HMP Prescoed, a category D open prison in Coed-y-paen, Monmouthshire. Turning Point was initially offering voluntary work to prisoners on the CHASE programme but soon realised that they could use it as a pathway to fill paid employment vacancies at their Herefordshire drug and alcohol service.

'The plan was to offer a volunteer pathway for people so they will be gaining knowledge through the CHASE programme and then they would get practical experience by coming on board with us as a voluntary placement for a couple of days a week,' says Chris Franks, operations manager at Turning Point, Herefordshire. 'This would allow them to marry "what am I learning in the classroom" with "how do I apply learning in the real world with actual people", with the view to be able to move into paid employment as it became available. I had three vacancies in the service. We identified three people on the programme and offered them these paid positions and that was the start of the partnership. They do meaningful work in line with our organisational values.'

Just 17 per cent of ex-offenders manage to get a job within six months of release, even though many employers recognise the significant benefits of employing prison leavers – with 86 per cent of employers rating them as good at their job, according to government statistics.

BILLY

For Billy, the programme, and the opportunity of full-time work with Turning Point, was another stepping stone in going back to becoming the man he used to be. He'd been an insurance broker and then a car salesman for 20 years. His cocaine use, which he reveals was prevalent in the car industry, saw his relationship with his then partner and two children suffer.

'While I was taking cocaine, I became very isolated, very antisocial,' he says. 'After I wasn't getting it anymore, I became me again, I became normal again, what I feel was normal, and I liked the way that felt. Previously, I liked the way cocaine felt because I thought it made me a better person. But once I was clear from the drug, I realised

JellyPics

Pictured (from left): Mike Thomas, Chris Franks, and Neville Brooks outside HMP Prescoed.

> 'I expressed an interest in working with clients on the criminal justice side, as they're going through what I've been through.'

that the person I was 20 years ago is the real better person.'

Very early into his prison sentence, Billy decided to be 'proactive and make some changes' with the first step being giving up cocaine. He then became the healthcare orderly at HMP Cardiff, which involved sorting out laundry, serving food, general cleaning, and helping the nurses with anything that wasn't clinical. He also trained as a Samaritan and became the listening coordinator in the prison.

The positive changes Billy made saw him put on a release on temporary licence (ROTL), which is an important part of the process for the resettlement and rehabilitation of prisoners coming close to the end of their sentences. It gives them the chance to organise work, housing and re-establish relationships with families and their communities.

Billy's first job on the ROTL was working for DHL, packing shopping – before he heard about the CHASE programme from two friends and realised it was an amazing opportunity. However, despite being accepted on the course, it looked like he might have to pull out due to an unfortunate incident.

'About two weeks after I started at Turning Point, I actually fell in the prison and broke my leg, shattering it just below the knee. I had 12 individual fractures in my tibia and fibula. I was in hospital for six-and-a-half weeks,' he says. 'I'd just started the online induction and training. Chris Franks actually drove from Hereford to the hospital in Newport with a laptop for me so I wouldn't miss out. I did all my induction and training from a hospital bed.'

After completing the course, Billy joined Turning Point in Herefordshire as a trainee recovery worker, and is now a full-time recovery worker.' I expressed an interest working with clients on the criminal justice side as they're going through what I've been through and I thought maybe I could help because I've got insight into it a little bit,' he says.

'In my role now, I primarily deal with alcohol treatment requirement (ATR) and drug rehabilitation requirement (DRR) assessments with clients. My clients are either prison leavers or people who have been given alcohol or drug treatment requirements and are on probation. I have three-way meetings with social services, probation and with the courts. Through one-to-one and group sessions, our focus is for clients to reduce and give up their drug or alcohol addiction.'

He also runs a 12-week recovery skills programme (RSP) every Tuesday evening, which is a treatment pathway for both alcohol and drugs and we also offer evidence-based treatment for people who are already abstinent or are controlling their use. 'We look at coping mechanisms, we look at behaviours, relationships with people, with substances, we talk about different methods of controlling or reducing intake,' he says.

Billy is now just a year away from being released. He is happily married to his wife, a schoolteacher, and the pair share a son and are expecting a daughter in a couple of months. He is adamant that there should be more programmes like CHASE, saying that, 'Being able to come to work through the CHASE programme, it's opened opportunities that I think are essential'.

JOHN

Another member of the programme, John, says he's finally found direction in his life thanks to the skills he has learnt through CHASE, which he now puts to use as a recovery worker at Turning Point Herefordshire. The 28-year-old is serving a ten-year sentence for manslaughter which was the culmination of a troubled young life.

'I had my stomach pumped at 11-years-old due to alcohol intake,' he says. 'My mother was a heroin user and an alcoholic and passed away when I was 18 because of a heroin overdose. I carried on drinking and taking more drugs until this sentence when I decided enough was enough. I really wanted to change my life and get on the straight and narrow and live a normal life. I put myself into rehab and have not used any drugs or alcohol for several years now.'

John felt the CHASE programme would be perfect for him because it would give him the opportunity to help others, something he says he is passionate about. 'Since I've stopped using drugs, I recognise the damage that it created in my life. I'm just so passionate toward helping others,' he says. 'I work with individuals who are struggling with some form of addiction with alcohol and drugs, some more severe than others. I also run group workshops every Tuesday evening and that's spent delivering an evidence-based programme to clients online.'

He added: 'I'm forever grateful that the knowledge that I've gained through the programme was a tremendous step forward for this line of work. I am thankful for the opportunity that was created for me to get this job. I feel like someone has finally given me a chance to move forward in my life without judging me because of what I have done and given me an education and knowledge to achieve in my life. To be able to get paid for doing this and the opportunities that this job has given me is amazing.'

John has his first parole board hearing in August and plans to move from Wales to Hereford to continue working for Turning Point on release.

Some names have been changed for anonymity

Eoin Bolger is regional head of operations at Turning Point

BEGINNING AGAIN

Addressing underlying issues instead of imposing custodial sentences for low-level offences is transforming lives in Cornwall, says **Eve Potts**

Combining mental health treatment requirements (MHTRs), drug rehabilitation requirements (DRRs) and alcohol treatment requirements (ATRs) is having a transformational impact in Cornwall following their introduction in 2020. Driven forward by Kim Hager, joint commissioning manager for the Cornwall and Isles of Scilly drugs partnership, it means that instead of imposing a prison sentence on people who've committed a low-level offence while suffering from mental health issues, an MHTR enables them to get the help they need.

Delivered by drug, alcohol and mental health charity WithYou, this approach of commissioning one service gives those struggling with poor mental health as well as drug and alcohol issues a chance to receive personalised, blended support. We know that substance problems are often rooted in complex trauma, childhood abuse and PTSD.

MHTRs offer a trauma-informed solution that gives people a chance to address the root causes of their issues, which they've been telling us they've wanted for a long time – but instead they were caught up in a merry-go-round of having to work on one issue before they're allowed help with another.

One person who's experienced an MHTR in Cornwall first-hand is Andrew. Andrew describes his childhood as 'problematic', with his family suffering physical and verbal racial abuse. Andrew experienced several incidents of trauma as a child, including the death of a close family member and the death of a friend, which led to the family fleeing their home.

Andrew joined the army at 17 years and, following basic training, he served in an infantry regiment in Iraq, where he was in regular combat. On his return, he engaged in harmful behaviours which led to him being discharged from the military. He returned to Cornwall and set up a successful landscape gardening business.

Following a disagreement with his partner one night, however, he decided to sleep in his car to get out of the house. He was arrested and breathalysed, found to be over the limit, and thus to be drunk in charge of a vehicle. On paper, Andrew was a successful family man with lots to look forward to, but he was dealing with issues with drugs and alcohol while also trying to combat the severe trauma of his past.

At the time of his arrest, he was in a relationship and living with his two children. The relationship ended, leading to him living temporarily in his car and then a caravan. 'I was struggling to manage my anger and emotions, and I was suffering from flashbacks and intense, intrusive memories,' he says. 'I started self-medicating by drinking, but I was becoming angry and violent very easily.'

Andrew lost his driving licence following his arrest and could no longer work as a landscape gardener. But he was assessed for an MHTR by the team at WithYou, and that single decision has turned out to be a lifeline for Andrew and his relationship with his family. He has fully engaged with the service and, with support, has focussed on managing his anger and emotional responses. He's also become more reflective and is considering counselling to explore his childhood trauma further.

> 'Instead of imposing a prison sentence on people who've committed a low-level offence while suffering from mental health issues, an MHTR enables them to get the help they need.'

'The tools that WithYou has given me have helped me to deal with the pressures and hurdles life has thrown my way,' he says. 'They also referred me to Combat Stress, and I'm now in a more stable relationship with a new partner. I'm building a positive relationship with my children and their mother and I have a new job, but I'm hoping to get back to landscape gardening soon. As strange as it sounds, the night I was arrested, my life changed for the better."

Sadly, Andrew's story isn't unique, and if the WithYou team had been unable to step in with the MHTR service, things may have been very different. Every week, men and women in Cornwall come into contact with the police and/or the courts for minor offences like affray and being under the influence and can end up with short custodial sentences. This fails to deal with any underlying issues, and means that people don't have the support they need to deal with their trauma, which in turn contributes to high reoffending rates.

Currently, 81 people are in the MHTR programme in Cornwall run by WithYou and more than 300 people have received an MHTR since its introduction. WithYou's January 2023 data highlighted that 273 individuals have been sentenced to an MHTR in court and that 75 per cent of those who have successfully completed their orders have shown mental health improvements following pre- and post-clinical assessment.

When appropriate and tailored support is provided, as with the MHTR programme, there are far-reaching effects, and not just for people like Andrew and his children. We're working alongside organisations like Devon and Cornwall Police, the Probation Service, Cornwall Council and other agencies to support people with this combined approach and alleviate pressures on the system. The biggest mistake providers can make is to treat everyone who offends the same. We think, because of our personalised approach, we're starting to see a positive shift in Cornwall.

Eve Potts is operations manager at WithYou

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

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Solomon, Recovery Practitioner, Via – R3 – Redbridge

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Rough treatment

Introducing a new regular column from Release, **Shayla Schlossenberg** shares a case study demonstrating the effects of inflexible and ineffective treatment for benzos

Release is the national centre of expertise in drugs and drug laws. We were founded in 1967 – potentially making us the world's oldest drugs charity – and we provide free, non-judgmental, specialist advice and information to the public and professionals on issues related to drug use and drug laws. We also fight for drug policy reform, so that in the future people who use drugs are treated based on principles of human rights, dignity and equality. To achieve this, we advocate for evidence-based drug policies that are founded on principles of public health rather than a criminal justice approach.

We provide frontline services via our legal clinics around the country. We also provide direct advocacy support to people who use drugs, to ensure that those in drug treatment are receiving person-centred care. Over the years, we've advocated for the rights of many different groups of drug-using people. In some cases, matters are swiftly and positively resolved for all involved – with others, issues can sadly drag on for years at the expense of the service user, who is subjected to inadequate or ill-fitting treatment plans throughout this lengthy process.

Release actively works towards a world where our drugs advocacy service becomes obsolete, and where people who use drugs are heard when they need changes to their treatment plans – not because they've brought in 'a national expert' to sit in on their medical review, but because their needs are respected. To make this vision a reality, we've embarked upon a mission to create, publish and widely distribute our own advocacy toolkit, so that people can more readily advocate for themselves and their communities.

Of course, our toolkit won't account for everything, and we still find ourselves regularly stumped on advocacy cases. Much of what we've achieved would not be possible without help from others in the harm reduction world, who have generously shared examples of good practice, specialist resources, and strategy ideas for our advocacy cases. We want to return that kindness by sharing with our community what we have been through and learnt, in the hopes that future services can improve their practices and people can more easily access high quality treatment.

For this reason, every other month, Release will publish a case study in *DDN* from our advocacy work, including relevant guidelines and pieces of evidence we used. Our aim is to promote better practices for *DDN* readers who work in services, and to give people tools to challenge their own treatment decisions, if they find themselves in similar circumstances.

Nick's Case

For our first case study, I'd like to introduce 'Nick' – not his real name, but a very much real and recent situation. Nick is a 42-year-old man who was dependent on street benzos, mainly diazepam, when he contacted Release. His benzo supply has not been regular, and when he has accessed drug testing via WEDINOS he has seen that at least on one occasion his supply was bromazolam as opposed to diazepam, which is what it supposedly was when purchased.

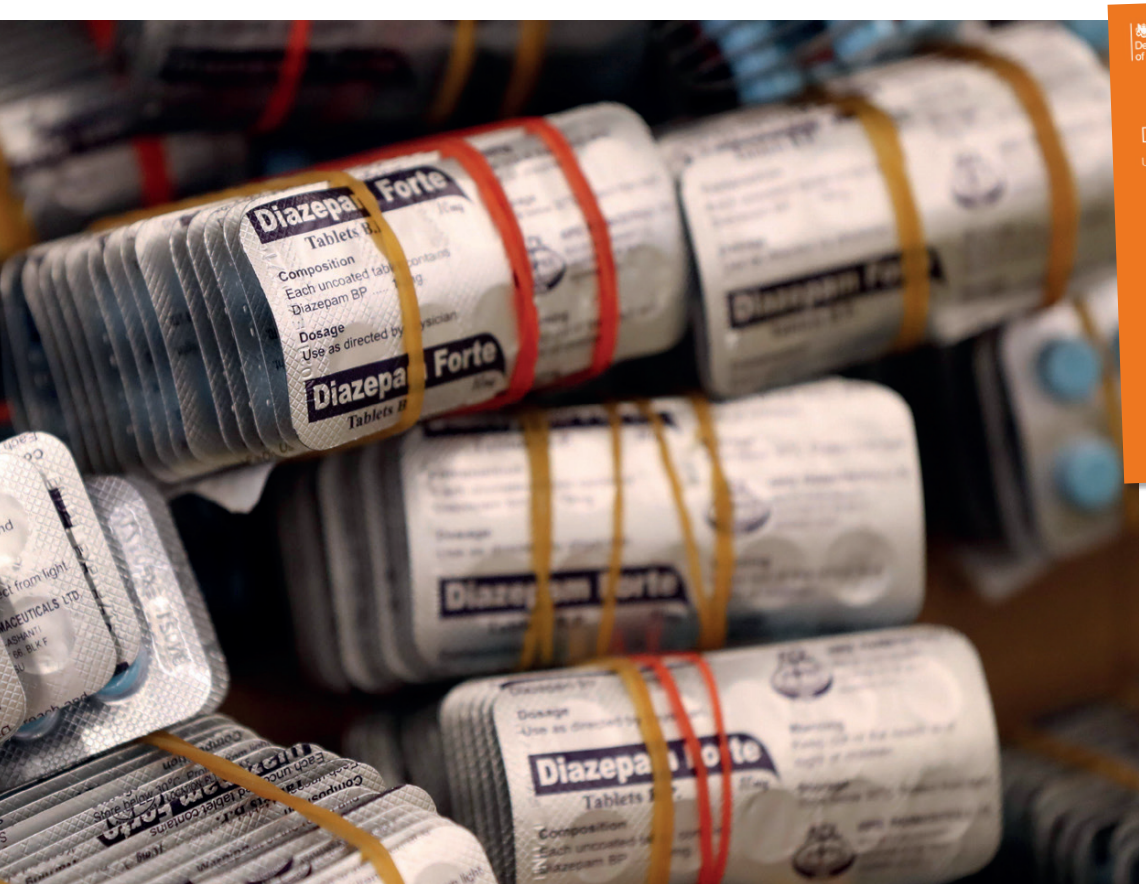
Nick has used benzos for six to seven years, on and off for the first few years. He is not sure how long he has been 'dependent', although he believes this has been since around lockdown. During lockdown, Nick's overall quality of life deteriorated, and his drug use increased. In 2021, he admitted himself into a private rehab clinic, staying there for two months. He was consulted by a virtual clinician for 20 minutes who was based abroad, then immediately put on only 30mg of diazepam when he was previously on a much higher dose of street benzos. The withdrawal was difficult to manage, impacting his sleep and his ability to take part in psychosocial interventions, causing him eventually to leave the rehab.

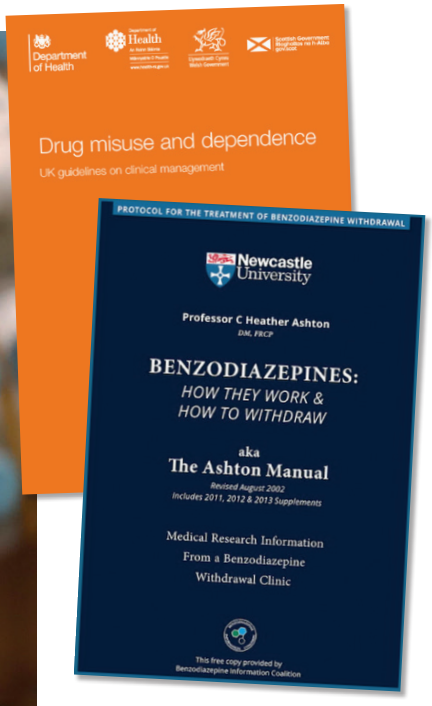
PA Images

Nick has been in drug treatment twice, not counting his time in private rehab. His first time was around 2019. During lockdown, he returned to drug treatment and has been there since. However, since the end of lockdown, Nick's service has been recommissioned, causing significant staff turnover. Nick was assigned a new key worker every few weeks, negatively impacting his ability to build a therapeutic relationship and make progress in his treatment plan. At this point, Nick reached out to Release, with the goal of safely working towards becoming abstinent from benzos. However, his treatment service says they won't prescribe benzos to him to use for this reduction as it is against the service's policy.

What do the guidelines say about Nick's case?

Regarding the care Nick received at his private rehab, the *Drug misuse and dependence: UK guidelines on clinical management*, otherwise known as the Orange Book, states that: 'For those who are benzodiazepine dependent,





The Orange Book details how clinicians should treat people with drug misuse and drug dependence problems. The Ashton Manual contains protocols for tapering safely off different benzodiazepines.

Release actively works towards a world where our drugs advocacy service becomes obsolete, and where people who use drugs are heard when they need changes to their treatment plans – not because they've brought in 'a national expert' to sit in on their medical review, but because their needs are respected.

sudden cessation in their use can lead to a recognised withdrawal state. Good assessment and care planning – and adherence to local protocols – are prerequisites for considering prescribing benzodiazepines. Prescribing benzodiazepines to drug misusers requires competencies in this form of treatment and appropriate supervision.'

As for the commissioned drug treatment provider, the same guidelines say that to 'prevent symptoms of benzodiazepine withdrawal, the clinician should continue a current prescription but the dose should be gradually reduced to zero... The aim should normally be to prescribe a reducing regimen for a limited period of time.'

When Nick contacted us, he was already quite knowledgeable about the Orange Book and other resources such as the Ashton Manual, which contains protocols for tapering safely off different benzodiazepines. We obtained permission from Nick to contact his treatment provider and request their benzodiazepine treatment policy. They then produced a policy which allowed for prescribing, but only for a very short period of time – there was little room for flexibility in how a person can detox safely and comfortably.

Once again, the Orange Book states that: 'While full detoxification can proceed without difficulty within weeks or within 2-3 months for some patients, NICE expert review has noted that withdrawal may take three months to a year or longer in some cases. An optimal speed or duration of dose reduction is not known.'

Ultimately, Nick ended up doing the taper himself with his illicit supply rather than continuing to battle his service to access care. His goal now is to share his story and influence treatment systems to better support people who use benzodiazepines. Nick worked with Release to turn his story into a case study to share with attendees of the Managing Drug And Alcohol Problems In Primary Care Conference, to promote more understanding amongst prescribers, and has given permission for its use here.

Shayla Schlossenberg is drugs service coordinator at Release

Release
Drugs, The Law & Human Rights

If you are reading this and could use similar support, please get in touch – there are three ways you can contact us for help and advice.

By phone – 020 7324 2989
The telephone help and advice line is open from 11am—1pm & 2pm—4pm Monday to Friday. A message service is available 24 hours and we will return your call within one business day.

By email – ask@release.org.uk
Emailed help and advice messages will be answered as soon as possible including weekends.

By web form – www.release.org.uk/helpline
Please complete the help and advice form and don't forget to enter your contact details. Messages will be answered as soon as possible.

INSIDE VIEW

Anti-stigma campaigns in prison settings can have a huge impact, says **Lashandra**

My name is Lashandra, and I work for an addiction treatment charity inside a prison. Working in this setting I often witness stigma against people who use substances – it's so commonplace that you could easily become resigned to it. I often hear people who use drugs being referred to in demeaning, labelling, and dehumanising terms. Words can hurt and they can poison, or they can empower and build people up.

'I was in the meds queue one morning to get my methadone,' says a member of the prison stigma forum. 'An officer was manning the queue and as "banter" said to me, "yeah, but you're just a crackhead". He laughed, and I laughed along with him. This really hurt me, and I went back to my cell and it went round and round in my mind. In that moment I felt like I wasn't worth anything. The officer thought he was being funny, and he didn't realise how it made me feel. Since being part of the Stigma committee and attending our meetings, I feel like I would be able to challenge him in an appropriate way.'

The people we support generally tend to agree that it's ok for them to self-identify as something – an 'addict', for example – but that doesn't mean it's okay for someone else to use that term to describe them. In order to create behaviour change, stigmatising language needs to be called out and challenged. Many people who use substances, however, don't challenge it because they've internalised these labels throughout their lives, and their confidence and self-esteem are so low that they start to believe that is all they are.

Whether I'm talking to someone using our services, a prison officer, another colleague, a family member, or the public, I'll educate them as to why the terminology used isn't respectful or inclusive. I explain the impact of stigma, offer insight into how it makes people feel, and suggest alternative terms.

I started to have conversations in the prison with the people that we support to better understand how stigma impacts them, and through these I understood there was a definite need to act. We created a stigma committee made up of people with lived experience, and it meets regularly to discuss ideas and feedback. We've also implemented stigma forums which are used as safe spaces to discuss issues relating to stigma and substance use – it's a place where people can come and talk about their issues openly. Through these forums we've found that many people have been in denial about their substance use, or kept it a secret because they don't want to be treated differently. We've also learnt that some people on scripts will collect their meds late because they don't want others to look down on them for being on medication.

We've seen a great response to the stigma forums from both people who use substances and the wider prison population. It's been impactful to see the benefits for those who are gaining support, self-esteem and confidence, and I've also noticed a move away from the acceptance of certain words and behaviours. The committee is currently working on co-producing our own anti-stigma campaign, and we're also developing awareness-raising leaflets, posters and an educational video that shares lived experience.

We're also delivering training to staff and the wider prison community. To make anti-stigma education as accessible and inclusive as possible, the committee has developed an approach that suits different learning styles – as part of that we're putting on a play for the prison staff and governors. It will then be put onto a digital platform for the wider prison community to watch.

Reaching out far and wide, breaking down barriers to accessing support, and offering education to those who don't fully understand stigma are important tools in facilitating change. We must speak up on behalf of the people we support. Even when they have the confidence and self-belief to advocate for change themselves, it's all of our responsibilities to find innovative and inclusive ways of amplifying their voices and making sure they get heard.

Lashandra works for a treatment charity in a UK prison. Join the Anti Stigma Network at www.antistigmanetwork.org.uk

HERE ARE MY TOP THREE TIPS FOR STARTING UP A STIGMA CAMPAIGN

Do background research.
Don't presume to know how people feel. Have open and honest conversations and listen to people.

Don't have a top-down approach.
It was important that the people joining the committee had an equal seat at the table – we garnered a lot of support and interest from peer-led conversations.

Co-creation is important.
As a committee we value everyone's voice, and all decision are made as a group.

EVERYBODY COUNTS

Peter Martin remembers David Tomlinson, a tireless campaigner for the government to properly fund drug treatment and rehabilitation

David Tomlinson sadly died on 7 June. He counted in the struggle for government resources to fund and run drug treatment and rehabilitation.

In the late '70s he was a pioneer along with others to persuade the government to invest serious money to support both existing and fledgling drug services across the UK. Along with the late Dave Turner from SCODA (the Standing Conference on Drug Abuse, latterly DrugScope) and the South London Consortium, a collective of voluntary agencies who persuaded the then government to invest in drug treatment when addiction became a political concern after the Misuse of Drugs Act 1971, David participated in the ACMD report on drug treatment and rehabilitation.

At the time nobody really believed that there was a cure for heroin addiction. David went to Phoenix House in the early 1970s as a resident to tackle his own addiction to heroin, having been a face in the '60s art world. He completed the tough programme and went on to become a senior staff member – when the director resigned in 1976, he was appointed director of Featherstone Lodge, the first of the Phoenix Houses.

Phoenix House was an experimental rehabilitation centre based in Forest Hill. Originally it had a very harsh but caring regime. Dave T, as he was known, set about changing the extreme methods into the foundation of how Phoenix operates today. He was influenced by Maxwell Jones of the Henderson hospital, a famous therapeutic community.

His creativity started the development of several Phoenix Houses around the country funded by the Department of Health. The first of these was in Sheffield, and subsequently South Shields, the Wirral and Bexhill were opened all with their local management committees. In time a Phoenix House therapeutic community was opened in Scotland, and family units were introduced at several centres including Brighton.

David had a holistic view of rehabilitation, which advanced all areas of living in the community without recourse to addictive behaviour – including training and employment, independent living skills and social skills. He formed the first re-entry and independent living houses with group support at each of the projects. It made sense for Phoenix House to become a housing association, which he pioneered.

David was good with people. He was an excellent networker, and following the national development of Phoenix House he joined the World Federation of Therapeutic Communities (WFTC) – a worldwide association for advancing drug treatment and rehabilitation around the world. He quickly became a board member.

> In the 1970s David was a pioneer... at a time when nobody really believed that there was a cure for heroin addiction.

Projects in Australia, India, Indonesia, Greece and a host of other countries opened and were supported with training and development.

David was dedicated to starting, along with others, the European Federation of Therapeutic Communities (EFTC). When he was president in the late '80s and '90s, many new rehabilitation centres started all over Europe. Staff exchanges, research and an annual conference all brought fresh thinking into our fledgling drug field. He was also actively involved in the Labour Party in Lewisham.

His legacy includes many lives being saved (including my own) from chronic drug addiction but also many of the great workers in all areas of treatment have come through the Phoenix House model or been influenced by its therapeutic approaches.

David was great fun to be with and an inspiration for residents. He leaves behind the love of his life, his wife, Caroline; daughters Candida and Jemima; and his grandchildren.

SOCIAL NETWORKS

Building strong relationships is at the core of social work, which plays a vital role in supporting people in treatment services, says **Ellie Reed**. The first article in a new series on social work in a changing world

I noticed a deep sense of calm in myself on the morning of our cross-sector event, *Social Work in a Changing World*. The event was a collaboration between Change Grow Live, Adfam, Addiction Professionals, Collective Voice and The British Association of Social Workers, bringing people together to explore the possibilities of social work, and have conversations on how best to respond to the drug strategy. I had a sense that I was walking into a collective of people who all wanted the same thing – to be able to offer the best social work for people who use services.

Dame Carol Black's recommendation to increase the number of social workers in drug and alcohol services is clear, and the drug strategy also provides fresh possibilities around the impact of social workers.

We created the space to have the conversations that mattered – to explore the role of social work, learn, and hear new ideas and diverse perspectives.

We wanted diversity of thought – we wanted to hear the ideas and questions that hadn't been heard before. The invitation for this event went out far and wide, and we gathered as a diverse group – not just social workers but people with lived experience, social work students, policy makers, strategists, regulators, educators and academics. Yet our job titles weren't important – we were there as people who wanted to explore the role of social work in the drug and alcohol sector.

As a collective we crafted questions that were taken into open space discussion groups. Some strong themes were shining through – purpose and professional identity, involving people with lived experience, and offering the best support so that people are truly empowered to make the changes they want.

As we were nearing the end of the day, we spoke about what we wanted to do next. People wanted more connection and conversation, more in-depth exploration of what we'd started, sharing of ideas and insights, creating a movement, making a difference, and celebrating social work.

Together we are energised to influence social work developments and changes, to improve what we do, to respond to the changing contexts and to be alongside people. We can share stories of good practice, celebrating the impact the profession has, and promoting a shared understanding of the role for effective collaboration.

We can help to define the social work role in the sector to maximise positive impact for people who use services and wider teams, contributing to the delivery of the drug strategy and Dame Carol Black's recommendations. We want to share our learning and experience, as well explore our way forward, so that we create a social work role that is fit for purpose in our ever-changing landscape.

We reflected on the importance of social work values, skills and knowledge at this time where health and economic inequalities are creating layers of complexity and compounding social exclusion of the poorest people in society. People need us to be alongside them, to listen to their experiences, to be flexible to respond, and most importantly to create meaningful relationships.

There are multiple factors that are shifting the foundations of how we live. People are facing extraordinary challenges. The economic and health inequalities that we see in society now bring a level of complexity that calls for social work values, knowledge, and skills.

I've met many wonderful new people as a result of arranging this event; I've created new relationships and we're having fresh conversations. We are forming a new Social Work Community of Practice, across the sectors, and I'm really excited to see where this will lead us – great things can happen.

The economic and health inequalities that we see in society now bring a level of complexity that calls for social work values, knowledge, and skills.

Thanks to everyone who supported the event: Jennifer Condron at Warm Data Wandering, Bec Davison at Rippleshift, Kate Halliday at Addiction Professionals, Viv Evans and Rob Stebbings at Adfam, Luke Geoghegan at BASW, Oliver Standing at Collective Voice, Tom Bailey, and Zac McMaster, Helen Thompson, Danielle Hickey, Rebecca Pettifort and Peter Furlong at Change Grow Live.

If you'd like more information on the new Social Work Community of Practice please contact Ellie.Reed@cgl.org.uk

Ellie Reed is head of social work – principal social worker at Change Grow Live

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