Drink and Drugs News
September 2023
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MANY ROADS
Full round-up and pics from DDN's 2023 conference

CONTROVERSY AND CONFUSION
The burning issue of tobacco harm reduction

OVER TO YOU

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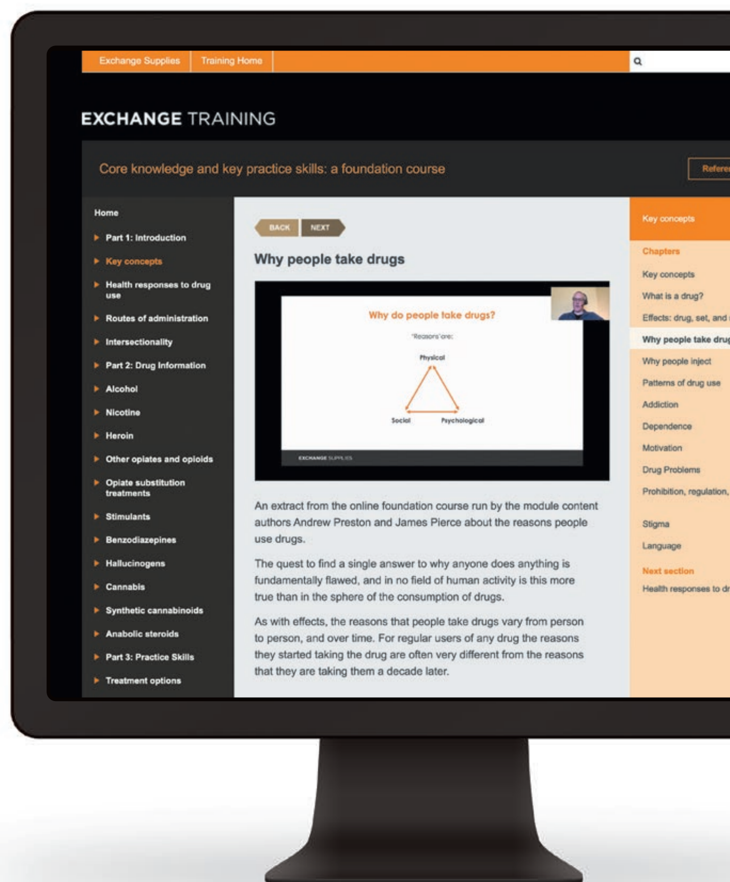

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DDN

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STRONGER TOGETHER AT DDN

'The Hep C U Later team had a great time, there was so much interest in hep C elimination which was wonderful for us, and I don't think I've ever spoken to that many people in one day before.'

Deanne Burch, Hep C U Later

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

Remember how much impact we can have

As we go to press on this issue it's International Overdose Awareness Day and we're never far from thinking about everyone we've lost. Our collective efforts on harm reduction will make the world a safer place – from collaborative commissioning (p18) to distributing naloxone (p14 and 24). This issue's articles remind us of the struggles, but demonstrate how much impact we can have.

The conference coverage – and pics! – are not just a souvenir of a grand day out in Birmingham, although it was wonderful to see everyone. The level of engagement and participation was extraordinary, even with such exceptional speakers. *The Big Conversation* (p20) not only gave us a snapshot of experiences across the country but also many thoughtful and constructive ideas. It absolutely confirmed that there are many roads to doing things – in the way that matters to each of us.

Putting on an event of this nature is hard work for all involved and we would like to thank everybody who gave their time to be a part of it, from the consultation on the programme to support and participation on the day. Please help us to strive for more by giving us feedback on your experience at https://bit.ly/3Z369Pg

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

Calls for shift to 'public health-based interventions'

The 1971 Misuse of Drugs Act is outdated and should be reformed to support 'greater use of public health-based drug interventions', says a report from the House of Commons Home Affairs Committee.

The committee wants to see a new legislative framework that includes consumption room pilots and drug testing at festivals, with better joint working between health, social services and police. However, there should also be an 'appropriate' criminal justice response, it states, with law enforcement doing all it can to 'stamp out the illicit trade of controlled drugs' – bolstered by a stronger public health framework that keeps people out of addiction and prison.

While the government's drug strategy has helped to shift the focus towards public health, it is unlikely to achieve its aims without a 'significant expansion in the range and availability of health-based interventions', the report warns. The government should learn from locally developed schemes that are having a positive impact, it adds. However, the document also expresses concern about the long-term sustainability of funding for the sector, questioning whether the two-year period of the latest funding allocation is enough for service providers to 'embed change'.

The drugs classifications system should be reviewed by ACMD to make sure it accurately reflects the risk of harm – with additional reviews carried out every ten years – the document states, with psychedelic drugs reclassified to support research into their therapeutic use. However, the committee does not believe that cannabis should be legalised or regulated for non-medical use.

Among the report's other recommendations are a UK-wide, postal-based anonymous drug checking service, centralised funding for diamorphine-assisted treatment, a national naloxone programme for England, and more use of schemes to divert people away from the criminal justice system. Trauma-informed practices should be used by all police forces when dealing with drug offending, it adds, with more done to ensure that vulnerable young people exploited by county lines gangs are kept out of the criminal justice system.

'Whilst the drug strategy is moving in the right direction, it requires much more meaningful action to tackle the broad range of drug-related problems,' said committee chair Dame Diana Johnson.

'The criminal justice system will need to continue to do all it can to break up the criminal gangs that drive the trade in illicit drugs. However, it must also recognise that many children and young people involved need to be supported to escape, not punished for their involvement.'

Report at https://committees.parliament.uk/committee/83/home-affairs-committee

David Woolfall / Wiki

'...children and young people involved need to be supported to escape, not punished for their involvement.'

DAME DIANA JOHNSON

Drone deliveries

PROJECTS USING TECHNOLOGY SUCH AS AI or drones to help prevent fatal overdoses have been awarded a share of £5m funding from the Department of Health and Social Care and Department for Science, Innovation and Technology.

The projects will explore how AI wearable technologies can detect overdoses and alert healthcare professionals or family members to provide lifesaving care, or how naloxone can be dispersed via drone.

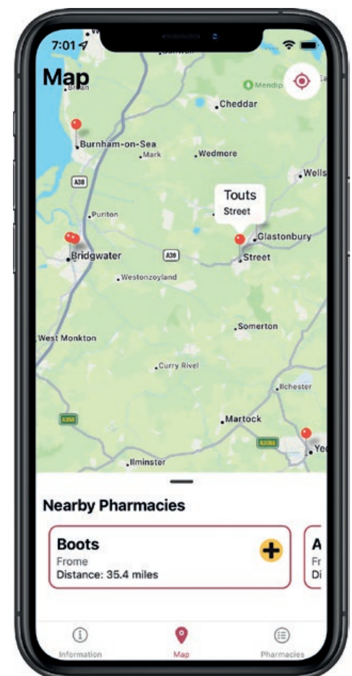
Twelve projects will receive funding from the Office for Life Sciences, as part of the Reducing Drug Deaths Innovation Challenge. Among the innovations are a chest-worn biosensor that can detect the onset of life-threatening respiratory depression and which alerts emergency services and nearby carriers of naloxone, a controlled-release patch for naloxone and flumazenil delivery, and a handheld device for self-monitoring benzo use.

Naloxone finder

AN APP THAT USES GOOGLE MAPS to highlight places such as pharmacies and needle exchanges that offer free naloxone has been launched by Turning Point and Somerset Council.

The Carry Naloxone app, which was developed in partnership with Bristol University, also provides short videos on how to recognise an overdose. The scheme is being piloted in Somerset and will be rolled out nationally if successful, and launches at the same time as on online click-and-deliver scheme for people unable to collect a kit.

The campaign will also feature posters that include a QR code to help people find the nearest place stocking naloxone. 'Carrying naloxone is really important, not keeping it in a cupboard,' said senior lecturer at Bristol University Dr Jennifer Scott, who developed the app. 'No one can predict when the medication might be needed and the quicker it is given, the more likely it is to save someone's life.' *See feature, page 24*



Scottish drug deaths down by a fifth

There were 1,051 deaths as a result of drug misuse in Scotland last year, according to statistics released by National Records of Scotland. This represents a reduction of 21 per cent from the previous year. The fall by almost 280 deaths from 2021 means 2022's figure is the lowest since 2017. The number is still almost four times higher than in 2000, however.

Opiates and opioids – including methadone – were implicated in more than 80 per cent of deaths and benzodiazepines were implicated in almost 60 per cent, with people in the country's most deprived areas almost 16 times more likely to die from drug misuse compared to those in the least deprived. While men were still twice as likely to die a drug-related death than women, the fall in deaths in 2022 was much larger among men than women.

'While I am pleased to see that hundreds of families have been spared this agony and lives have been saved, every life lost is a tragedy and the number of deaths is still too high,' said Scottish drugs minister Elena Whitham. 'I will never underestimate the scale of the challenge we continue to face, including responding to new threats such as synthetic opioids and stimulant use.'

Meanwhile, the number of alcohol-specific deaths in Scotland rose by just over 30 to 1,276 between 2021 and 2022, according to Public Health Scotland – an increase of 2 per cent. The figure represents the highest number since 2008. While the number of deaths among men remained unchanged – and men continue to account for two thirds of all alcohol-specific deaths – the number of deaths among women increased by 31 to 440.

As with drug deaths, people in the country's most deprived areas are more likely to die an alcohol-specific death. Earlier this year more than 30 health organisations and charities issued a call for urgent action to stop Scotland from 'sleep walking' back to the record levels of alcohol-related deaths it saw in the early 2000s, including tightening of marketing restrictions and 'increased and sustained' investment in treatment.

www.gov.scot

> 'I will never underestimate the scale of the challenge we continue to face.'
> ELENA WHITHAM

Misuse of stats

THE GAMBLING COMMISSION has become 'very concerned' at what it sees as a significant increase in the misuse of statistics, as 'different parties seek to make persuasive arguments', according to an open letter from its chief executive Andrew Rhodes.

Various groups and individuals have been trying to influence opinion during the development of the government's gambling white paper, the letter states, adding that it is not the commission's place to 'referee' the debate. 'However, much as everyone is entitled to present their arguments, what is wholly unacceptable is the misuse of statistics to support that argument.'

The commission had seen misuse of statistics 'from gambling operators, trade bodies, charities, media outlets, sporting venue owners and others', the letter says. 'All parties seeking to rely on statistics to advance their arguments must do so accurately and in the correct context.'

The gambling white paper was published in April, nearly two and a half years after the government first launched its review of the 2005 Gambling Act, which was designed to update legislation for the 'smartphone era'.

The white paper's proposals – which are now subject to further consultation – include a mandatory levy on gambling firms, revised stake limits for online slots games and improved player protection.

The most common misuse of statistics has been around conflating problem gambling and gambling-related harm, Rhodes' open letter states – 'two separate, but linked, experiences'.

> 'The most common misuse of statistics has been around conflating problem gambling and gambling-related harm.'

Local News

OPEN COMMUNITY
Community Drug and Recovery Services (CDARS) is holding an open day event on 19 September at the Poppy Factory in Richmond, south west London. Speakers will include Mike Ward of Alcohol Change UK on supporting hard-to-reach people, and Dr Sally Adams of Birmingham University on the links between addiction and neurodiversity. *Contact Joanna.miskiewicz@cdars.org.uk by 10 September.*

HAPPY ANNIVERSARY
The tenth anniversary of the Recovery Games is being held in Doncaster on 16 September, hosted by Aspire Recovery. Around 40 teams will be competing, with last year's event seeing attendances top 1,000 people. *For more info contact stuart.green4@nhs.net.*

SHEFFIELD SUPPORT
A new service providing people in Sheffield with free, confidential support has been launched by Humankind and Project 6. The Likewise service will play a 'vital role' in supporting people and communities impacted by drug and alcohol use, said Greg Fell, director of public health at Sheffield City Council, which commissioned the service. *www.likewisesheffield.org.uk.*

RISING TO THE CHALLENGE

The 15th DDN conference, Many Roads, kicked off with a powerful session exploring how we can all challenge stigma. Additional photography throughout by **nigelbrunsdon.com**

'It's no longer socially acceptable to stigmatise people with mental health conditions or people who've experienced domestic violence,' said chief executive of Phoenix Futures and co-chair of the Anti-Stigma Network, Karen Biggs. Attitudes to people who used drugs, however, hadn't changed.

There were constant examples of overtly stigmatising language across the media, health and social care, and policy domains – most of which went unchallenged, she stated. 'If we're to make real progress in helping people whose lives are impacted by addiction, we need our governments, our media and our public servants to understand stigma, how it's created, and the pernicious effect it has on so many people's lives.'

It was a process that would take time and commitment. 'We all need to act against stigma and ensure that our work doesn't inadvertently or purposefully perpetuate it.' Establishing the Anti-Stigma Network had involved talking to people with direct experience of stigma, service providers, academics and others. 'Our mission is to end stigma,' she stated – 'some people say that can't be done, but our view is that our ambition can't be anything else but to end the discrimination that limits the opportunity to thrive in life, that creates inequality, and takes away people's basic human rights. We'll do it by collaboration and co-production – we won't always be right, we'll make mistakes, and we hope to be able to learn together.'

The approach was rooted in lived experience, and the stories on the network's website were about people, she stressed – 'drugs and alcohol are a feature, but they're not the story.' Instead they were about lives, experiences, journeys and barriers faced. 'We believe this is a powerful way to educate people about what stigma is. It's the shaming, the prejudice, the discrimination people face in accessing health, housing and employment, and it's the policies and procedures that make it difficult for people to create the life they want.'

WHY THIS, WHY US, WHY NOW?

In establishing the network she'd frequently been asked, 'what makes you think this will make a difference?' she said. 'The question for me is bigger than that – it's why this, why us and why now?'

It should have been done 'a long time ago', she stated. 'Maybe we wouldn't be in the situation we are now, with the highest ever number of people dying from a preventable condition.' In some parts of the UK, even with the new drug strategy, this showed no signs of improving. 'But we know more now about what approaches work. The next level of progress will be when we create something bigger together than we can do on our own. We'll learn how to do this as we go, and we're a broad church – with different life experiences and values.'

The network's starting point for naming, understanding and calling out stigma was the health and social care sector, she said – including drug and alcohol treatment. 'We all have examples of how services and pathways stigmatise people.' Alongside structural stigma, this was also down to individual assumptions

> 'Society judges women who use drugs more harshly than it judges men, and it judges them pretty harshly.'
>
> APRIL WAREHAM

and actions, she stressed. A recent report into women's experiences in the North East of England found that 64 per cent of women looking for help for domestic violence, substance use or homelessness had experienced discrimination from practitioners, she pointed out – 'the very people they were looking to for help. So we're calling on all of us to get our own house in order, which will give us the strength to tackle the wider societal and structural stigma which will be critical to our success.'

WOMEN'S TREATMENT

When it came to women's treatment, the Dame Carol Black review – while a welcome and valuable document – didn't focus enough on the specific needs of women, said Hannah Shead, chief executive of Trevi, a partner in Collective Voice's Women's Treatment Working Group. 'As 52 per cent of the population, sometimes our needs aren't thought about in a specialised, specific way. We can sit and talk about this stuff for ever, but we need to see things change.' The working group was interested in the views of both women who used services and those 'who don't come to our services, because they don't feel it's safe', she said. 'Women who won't reach out for help because of the stigma, and because of the way our services work.'

'Society judges women who use drugs more harshly than it judges men, and it judges them pretty harshly,' April Wareham, director of Working With Everyone, told delegates. 'Even among people who use drugs, women are judged more harshly. Women have told me that there was an assumption that they were sex workers even when they weren't.' And mothers who used drugs were subject to particularly harsh judgement, she added. 'I've heard of women being told by hospital staff just after having a miscarriage that "it was probably for the best, wasn't it?" For most mothers who use drugs that I speak to there's a massive fear of getting help because they're scared they'll lose their children.'

At a recent women-only workshop she'd been involved in, all ten participants reported being survivors of domestic abuse, physical abuse and emotional abuse – 'with a side order of gaslighting', she said. Eight out of ten also reported financial abuse, sexual abuse or sexual assault from an intimate partner. 'You talk to women and they'll say, "I thought this was normal".' Women were reluctant to ask for help for domestic abuse, fearing they'd be blamed because they used drugs, she stated.

Most women reported that they're weren't offered the choice of a male or female key worker, she continued, and would not talk about issues like abuse to a man. Many areas also didn't have women-only fellowship meetings,

> 'When we give people the time and space to tell their own stories on their own terms, we can begin to deconstruct the stigma they encounter.'
> CALLIE DAVIDSON

and any female attendees could often be the only woman in the group. 'I hear from women who are terrified that there won't be a woman available to sponsor them.'

Women felt that there were defined gender roles throughout the drug world, she said. 'I remember user involvement groups in the NTA days – when I agreed with the men I was a princess, and when I disagreed I was a bitch. I still go to events now where I'm asked to write my name, phone number and email address on a piece of paper that will then be passed around the room.' Society was structurally and institutionally sexist, so it was little surprise that treatment services had been designed around the needs of men, she added. 'Whether they meet men's needs or not is a discussion for another day, but time and time again I hear women telling me that this one size doesn't fit anyone.'

Sometimes doing the smaller things could be the beginning of significant changes, said Hannah Shead – 'creating women-only spaces in your services will start to show women that there's somewhere safe. Think of those small changes you can make, and have the courage to make them. And when we're delivering, designing, planning, let's think about the women in our services – and think about the women who perhaps aren't coming to our services because of the way we design and plan them.'

THE STORIES WE TELL

Callie Davidson, programmes coordinator at Safe Ground – a national organisation that delivers arts-based group work to people in prison and community settings – then shared the experiences of stigma among people the organisation works with. 'We know that our participants are capable of far more than they're given credit for,' she said.

Her organisation was concerned with 'the stories we tell ourselves, the stories we tell one another and the stories that are told about us,' she said. Concepts of identity and relationships were central, and participants were encouraged to reflect on, and learn from, their own lives.

'We work hard to create a space in which biases and preconceptions are acknowledged and interrogated. But the goal of our methodology and the way we approach our work is to make room for participants to be themselves. So I want to encourage you all not to wait for an annual conference to invite people's stories. Every day we're presented with the opportunity to hear people's stories and discover the wealth of experience, creativity, reflections and ideas they have to offer. When we give people the time and space to tell their own stories on their own terms, we can begin to deconstruct the stigma they encounter.' **DDN**

For more information on the Anti-Stigma Network, or to join, visit: https://www.antistigmanetwork.org.uk/about-anti-stigma-network

Find out more about the Women's Treatment Working Group at www.collectivevoice.org.uk and Safe Ground at socialinterestgroup.org.uk/our-services/safe-ground/

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PARTNER POWER

Many roads
The 15th DDN Conference

The second session of the DDN conference explored the countless benefits and opportunities of partnership working

'I've lost a lot of people who drug treatment doesn't work for,' harm reduction content creator at Cranstoun, Alistair Bryant, told the conference. 'If you can get to any of our doors, you're already halfway through what you need to do. I think it's time to work with that community who can't come to us, or who are just happy where they are. So how do we do that, and how do we embrace harm reduction as a whole?'

Cranstoun's Worcestershire service had developed a peer-led naloxone team, PACKS – 'peer-assisted community knowledge and support', he said (*DDN*, April, page 16). 'They have keys to the community that we don't have. I can now take harm reduction and support to people who need it the most – that's why we all need to start working with the people on the other side of our door.'

Cranstoun had recently launched a pouch containing two naloxone injections that was specifically designed to be visible. The commissioners had been impressed and provided further funding, and the PACKS team then packed 'an entire room' of pouches. 'We probably packed 500, and we got them out there. It was amazing to see the potential of a group of people who treatment, volunteering and peer mentoring has ignored for the last ten years. There are damn good people with skill sets who treatment haven't embraced because they "might be too risky".'

PACKS videos on social media had now had more than 1.5m views, he added, with the content most popular among 18 to 35-year-olds. 'In Worcester, that's the age range who don't stay in treatment because they don't find it meaningful. Yet the appetite for being safe is very much there.' It was also vital to pay people, however. 'If you want people to do something, pay them to do it. Pay peers, rep the underdog, and change the system.'

APP-BASED SERVICE

Cranstoun was also piloting a new app-based service to reach those people 'not inside the treatment doors, and behind their own closed doors when they use drugs', said his colleague, assistant director for business development, Luke O'Neill. More than half of people who died a drug-related death died alone, he said. Cranstoun had approached a Canadian software developer to ask if they'd help develop a UK version of an app they'd launched in Vancouver, he

said – the result was Cranstoun's Buddy Up (*DDN*, May, page 5).

Buddy Up was a low-threshold harm reduction app that had been created specifically for people using drugs alone, to put them in touch with someone who could send help in case of a suspected overdose. The service was anonymous and private, with callers able to create multiple rescue plans if they used drugs in different locations. While the pilot currently used paid staff, volunteers and peers would have a role to play in scaling up and improving it, he said.

Discussions with the organisation's insurance broker about 'what is essentially a digital safer injecting service was an interesting one to navigate', he told delegates, and there had also been ethical considerations. 'At the moment our supporters will send an emergency ambulance response in the case of an overdose, but in North America people can nominate a rescuer' – such as a next-of-kin.

'There's scope to do that here, but we need to think carefully

> 'I think it's time to work with that community who can't come to us, or who are just happy where they are.'
>
> ALISTAIR BRYANT

about how we get opt-in and consent, and make sure they feel supported and safe if we're informing them of an overdose and potentially sending them to an address they might not know much about, and where they may be risk factors that we're not aware of.'

COMMITTED SUPPORT

People with lived experience had been central to setting up treatment services, from the 12-step fellowships onwards, said programme manager for alcohol and drug treatment and recovery at the Office for Health Improvement and Disparities (OHID), Laura Pechey. 'The key is relationships, authenticity, and honesty.' The government was fully committed to supporting thriving recovery communities and networks of recovery organisations, she said.

Last year OHID had commissioned a national workforce census (*DDN*, April, page 6) and asked treatment providers, local authority commissioners and lived experience recovery organisations (LEROs) about their workforce – there were 640 peer support roles in treatment services, four out of five of which were volunteers, she said. This compared to one in three of the lived experience workforce being volunteers. 'Volunteering can be amazing – it can help the person who's volunteering and certainly the people they're working with – but when we did a consultation last year we did hear reports of people in peer support roles who didn't have the right support and training to do that role and to benefit from it themselves.'

OHID had also developed guidance with recovery champion Dr Ed Day and the CLERO to try to give this part of the sector 'its moment in the sun', she said. It included a section on how to contract lived experience organisations, including minimum standards, as 'for commissioners, I imagine if they've never commissioned a lived experience organisation there's a nervousness about that.' Sometimes that was inevitably the result of stigma, she said. 'It's worth noting that contracting isn't the only way to do this – we've heard a lot about building reciprocal relationships, working together to a shared purpose, and supporting each other.'

ASSET BASED

The commissioning process needed to take account of the feedback that asset-based community development organisations were getting from the ground, stressed Ged Pickersgill from the Well Communities. 'We know our community. There needs to be a wider acknowledgement that we need to listen to what people need, not purport to know what they need.'

'The community knows what the community needs,' agreed Lanre Babalola, chief executive of

> 'Unlocking people's talents and providing opportunity through positive change... will profoundly develop success in recovery.'
> CHRISTIANNE JENKINS

BUBIC (Bringing Unity Back Into The Community). His organisation had built a strong relationship with commissioners and treatment providers, he added. 'It's not us and them – it's us together – because the most important person is the client.' In the early days of the organisation it had been challenging, however, said his colleague Adé. 'The clients told us more than they told anyone else, but when we'd go meetings there'd be no data sharing.'

'Eight years ago I was in a rehab thinking my life was over – I'm managing SUIT today,' said Marcus Johnson of Wolverhampton-based SUIT (Service User Involvement Team). He'd started as a volunteer himself, and in the last 18 months or so his organisation had managed to get 30 of its volunteers into paid employment – something that was achieved through partnership working with local clinical organisation Recovery Near You. 'We're into our sixth year of working with them. Sometimes the partnership's a bit like the Conservatives and the Lib Dems, but it's getting better. And for organisations like ours to continue to exist, it's all about funding.' Everybody at SUIT had lived experience, he stressed. 'They all bring something you can identify with. For me, the power of identification and lived experience saved my life.'

LIVED EXPERIENCE

Alcohol use in the South Asian community was a 'massive' problem, said his colleague Sanjiv, and it could be hard to engage with this population group. Issues facing the community included older generations not understanding addiction, pressure to succeed in academia and pressure to enter arranged marriages. 'People do turn to drink and drugs to relieve this pressure, and the language barrier is a big problem. I can speak Punjabi – having an understanding of where they've come from and being able to speak the language helps.'

SUIT volunteer Karolina Sowinska was able to use her lived experience to engage with the Polish and Eastern European community, she told the conference. Overall, there were 10,000 people in Wolverhampton whose access to services was limited by a language barrier – 'Punjabi, Polish, Czech, Slovakian, Lithuanian.' While previously, there were just two Polish people – from a local population of more than 3,400 – in local services, since SUIT's outreach work with Karolina, four had been registered in June alone. 'And I hope in the future I can make those numbers much bigger.'

Recovery through creative and collective processes was also encouraged and celebrated at SUIT, said volunteer and PhD student Christiane Jenkins. Peer-led support could show that transformation was possible, she stated. 'Unlocking people's talents and providing opportunity through positive change in a social group will profoundly develop success in recovery. Recovery is contagious.' SUIT had now also developed a creative arts collective, she said. 'Exploring the arts can mean discovering lost skills, identifying emotions and communicating our feelings – especially for people coming from multiple disadvantage.' It was the 'outreach of opportunity' to those who would otherwise be excluded. **DDN**

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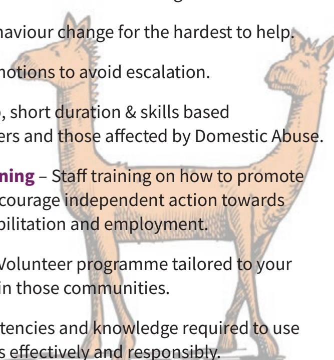

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PRIDE AND PREJUDICE

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As Overdose Awareness Day approached, the millionth kit of injectable naloxone was distributed. *DDN* looks back at the story of this lifesaving intervention

Naloxone was first developed in the 1960s and used by the emergency services to reverse opioid overdose. It wasn't until 2005 that it was made available under UK law to be administered by anyone for the purpose of saving a life – but it would be another ten years before drug services could supply naloxone without a prescription.

Evidence swiftly mounted on the success of pilot programmes, showing overdoses were reversed each time it was used. By 2008 we were hearing from groups of clinicians and user groups who were championing the cause with tangible results – but without national guidance or support. The Scottish Government, in recognition of ever-escalating drug-related death statistics, recommended the provision of take-home naloxone (THN). But there were still concerns about legislation and the practicalities of obtaining a 'prescription-only medicine' and anxiety around using it.

At this point naloxone didn't feature in National Treatment Agency (NTA) targets, but the following year the NTA announced that families and carers of injecting drug users would be trained to administer naloxone in 16 sites across England. There were calls for the pilot to be extended to drug users and their peers – those most likely to be present at the time of an overdose. By 2012 a ruling in Scotland allowed homeless hostel staff to hold naloxone ready for emergency use without prescription; there was optimism that a wider rollout could be getting closer for the whole of the UK.

The first licensed THN product, launched in 2013, pushed open the gate to widening access. Its distribution was still a postcode lottery and there would still be many hurdles to overcome, but pressure was building on commissioners, clinicians, treatment services and prisons to take naloxone seriously and to incorporate it as essential harm reduction.

YOU NEED TO GET ANGRY

By 2014 Scotland, Wales and Ireland each had national programmes of naloxone distribution in place, but in England it had been left up to localism. Activism was audible – 'you need to get angry. You should all be persuading your commissioners that we need naloxone.' Some prisons took the initiative on naloxone, but many didn't. Those which introduced a THN programme to equip prisoners on release took a massive step towards protecting those vulnerable to overdose.

GPs joined the call for everyone to spread the word on naloxone. 'We need those of you who work with clinicians, those who commission services and those who provide education to recommend the prescribing of naloxone,' said our regular GP columnist Dr Steve Brinksman, while Dr Judith Yates told us: 'I believe that it may come to be seen as negligent to prescribe methadone without also prescribing a take-home naloxone kit.'

The Naloxone Action Group (NAG), a group of service users, treatment workers and medical professionals, examined the 'postcode lottery' through a survey and vowed to challenge every area of the country that was slow or reluctant to roll out distribution or training.

Release were ready to challenge non-provision through legal action, with 'very strong right-to-life and human rights arguments,' said Niamh Eastwood. Outreach worker and activist Philippe Bonnet, who delivered naloxone training at the 2015 DDN Conference, urged: 'Identify champions and knock down doors, and make use of the service user groups and advocacy groups that can do that on your behalf. But don't take no for an answer.'

But there was still no national programme or requirement to provide naloxone in England, and the postcode lottery continued. Chris Rintoul, then lead trainer for Street Rx in Northern Ireland, was in no doubt that the Scottish Drugs Forum (SDF) had 'watered the seeds of take-home

'Overdose is reversible, death is not.' George Charlton's alter ego Naloxone Man makes an appearance at the DDN Conference 2023

There are still too many people who have never heard of naloxone, let alone been trained in what to do with it. Do you carry a kit?

naloxone' and allowed them to kick-start the programme in NI. 'Before that we had no naloxone, and no sight of it,' he said. 'Some of the action involved aggressive campaigning', developing partnerships with all stakeholders.

DROP IN OVERDOSES

When a change in the law in England allowed outreach services and hostels to give out naloxone, as well as pharmacies, a significant drop in overdoses seemed like no coincidence. Meanwhile on the international stage, the EMCDDA published a Europe-wide review of the case for distributing naloxone, which included good practice and training examples, as well as looking at the legal barriers to distribution.

As the record number of drug-related deaths dominated DDN conference debate in 2017, Alex Boyt drew attention to the fact that 'people who are dying are not in service, while the naloxone doses are being given to those who are in service. But we're in a situation where the budgets are being cut so severely that people are just clinging on to what they do and not trying anything new. We need to be saturating the drug-using community with naloxone.' A few months later Alex Stevens, professor of criminology at the University of Kent said he was 'saddened and angry' that commissioners hadn't got the message that naloxone should be provided to anyone who comes into contact with a person who could be at risk of overdose.

The Local Government Association (LGA)'s *Naloxone survey 2017* showed that 90 per cent of English local authorities were making THN available, through treatment services, hostels and outreach workers. But Release examined the THN statistics through freedom of information requests and found that just 12 take-home kits were being given out for every 100 people using opiates. Levels of naloxone provision by local authorities were 'chronically inadequate' they stated, as statistics showed opiate-related overdose deaths to be the highest since records began.

Concern was not limited to the sector. Calls for change were being heard from senior police and crime commissioners, who said a 'grown-up conversation about drugs' needed to involve equipping the police with naloxone. And while we found some examples of highly effective prison healthcare, treatment providers were finding it rare for any of their service users to have been provided with naloxone on release from prison. The government confirmed in 2018 that there were no plans to make this a mandatory requirement for prisons.

UPWARD TRENDS

Activism scaled up further in response to diminishing treatment budgets. 'Imagine what the drug-related death figure would be if naloxone wasn't about,' said Mick Webb, while George Charlton – whose alter ego Naloxone Man would become a regular sight – said: 'If we're not giving out naloxone, we're giving the message that it doesn't matter if you die. Overdose is reversable, death is not.'

In examining the 'substantial upward trend' in drug-related deaths, the Drug, Alcohol and Justice Cross-Party Parliamentary Group concluded that naloxone was 'simply not reaching the people who need it the most'.

The COVID-19 pandemic brought new fears – lockdown measures were compromising the purity of many drugs and dwindling budgets were having an impact on naloxone provision. As 2021 dawned, the government announced an £80m investment in drug treatment in England. Targeted at reducing crime, its 'system-wide approach' would include funding naloxone provision for 'every heroin user in the country that needs it'. Partnerships with police teams and custody suites were encouraging police officers to carry kits.

Scotland swiftly followed with a pledge of £250m to tackle its record high rates of drug-related deaths and would use some of the money to widen naloxone distribution. A *Stop the Deaths* campaign included a dedicated website where people could order kits, and Police Scotland confirmed that officers right across Scotland would be equipped with naloxone.

FURTHER PROVISION

Alongside the government's announcement that 50 of England's most deprived areas would receive significantly more funding came the opportunity to further widen naloxone provision in 2022, and the ACMD identified a key role for community pharmacies. Scotland's Drugs Death Taskforce said developing the world's most extensive naloxone network was still a key aim in a very necessary public health approach.

As we entered 2023 the SDF shared evaluation of pilot peer-to-peer programmes in three settings – one urban, one rural and one in prison – which showed the power of peer involvement in saving lives with naloxone. Reporting on initiatives from across the UK in *DDN* has confirmed the essential role of peers, right up to inspirational presentations at the DDN conference.

As we commemorate another Overdose Awareness Day there is much to acknowledge – the millionth injectable naloxone kit being distributed to save yet another life – yet still much to do. There are still too many people who have never heard of naloxone, let alone been trained in what to do with it. Do you carry a kit? **DDN**

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

A WOMAN'S PLACE

Women's treatment needs have been overlooked for too long, says **Carly Dawson**

Jellypics

The differences between women and men who access treatment are widely documented. We know that women are more likely to be involved in sex work and have more extensive histories of trauma and abuse, as well as greater care giving responsibilities. Women are also more likely to encounter additional barriers such as stigma, housing instability, lack of childcare and fear of losing custody.

Women present with higher levels of distress, mental health needs and complex inter-related family issues. Traditional treatment services tend to be male-dominated environments that overlook the specific gendered needs of women. Despite widespread acceptance of the need for women-only treatment services, there is a distinct lack of them. Women-only environments can help foster healthy attachments, provide positive peer reinforcement, strengthen self-expression and help individuals to develop skills.

Ophelia House, delivered by Phoenix Futures, is a trauma-responsive therapeutic community developed to meet the needs of women who require abstinence-based residential treatment in a safe and therapeutic environment.

The programme, delivered by an all-female staff team, is based on the therapeutic community model where social relationships, daily structures and a variety of activities are all deliberately designed to support health and wellbeing. Women live together and learn from each other. The community helps individuals emotionally and supports the development of healthy living behaviours, attitudes and values. The structure supports the whole person and acknowledges that substance misuse is not an issue than can be addressed in isolation.

We've worked with partners across the substance use sector and alongside women with lived experience to develop the service, creating an environment to better serve those who have experienced trauma. The majority of women we spoke to felt it was crucial that there were onsite counsellors and mental health support. The Ophelia House programme aims to provide a safe and empathic therapeutic environment to address gender-specific needs and develop social skills such as validation, empowerment and empathy.

Our model has been developed using evidence and best practice around trauma-informed approaches to care, with staff trained to recognise and respond sensitively to the effects of trauma. Being trauma responsive we have carefully considered the layering of holistic group programming, the needs of the physical environment, our use of language and our values.

Our history of providing gender-specific residential treatment has showed us that women-only services, characterised by both all-female residents and staff, can provide a specially designed environment and programme that – when delivered by an appropriately trained staff team – can help women feel safe. This sense of safety and trust enables honest and open discussions about shared issues, creating a community of support and empowerment and a focus on building individualised skills and resources to aid long term recovery.

The service offers a minimum three-month programme incorporating a range of sessions aimed at supporting recovery from trauma as well as accredited workshops and a range of health and wellbeing activities, including regular yoga and gym sessions and participation in Recovery through Nature.

Our Recovery through Nature programme enables people to come together with a common purpose to complete conservation projects. Being with others, exercising together and working to create a positive environmental impact is proven to aid a sense of belonging and wellbeing. We bring together these core interventions, and other specialist interventions such as one-to-one counselling in a blended approach.

The team at Ophelia House is made up of a psychologist, counsellor, registered nurse and therapeutic workers in a multidisciplinary team. They work together across different disciplines to deliver coordinated and personalised trauma-responsive care, bolstered by the peer support of a therapeutic community.

Women-only services, characterised by both all-female residents and staff, can provide a specially designed environment and programme that... can help women feel safe.

Ophelia House offers 26 single ensuite bedrooms, inclusive of those adapted for women with mobility needs. We listened to those with lived experience who expressed that the physical environment can impact an individual's sense of identity, worth and dignity, and the role it plays in individual mood and wellbeing. We mobilised the design concept to ensure the physical space promotes a sense of safety and is calming for people accessing treatment and those who work there.

Carly Dawson is head of quality and performance at Phoenix Futures. Contact: opheliahouse.residential@phoenixfutures.org.uk

OPHELIA HOUSE

TRAUMA RESPONSIVE RESIDENTIAL TREATMENT FOR WOMEN – OPENING AUTUMN 2023

A community that EMPOWERS WOMEN

CREATED BY women FOR women

Situated in a quiet Oxford village Ophelia House has been specifically developed to meet the needs of women who require abstinence-based residential substance use treatment in a safe and therapeutic environment.

Ophelia House is set in a psychologically responsive environment and run by a dedicated and experienced staff team. The programme is based on the Therapeutic Community model where social relationships, daily structures and a variety of activities are all deliberately designed to support health and wellbeing.

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PARTNERS IN CRIME

In the second of our series looking at strong partnerships in commissioning, we focus on the transformative effect they can have in the criminal justice sector

Everyone in the drugs sector knows that the period immediately after release from prison is a crucial one. People who start using again when their tolerance has decreased are at far higher risk of overdose, meaning that effective continuity of care from prison into the community is vital.

Of course, robust partnerships across the treatment and criminal justice sectors can also reduce deaths *before* people are released, as was highlighted in a 2022 report from the Independent Advisory Panel on Deaths in Custody in partnership with the Royal College of General Practitioners Secure Environments Group, *Protecting lives*, which identified cross-agency working as a central issue in preventing drug-related deaths.

COMMUNICATION

The government is fully aware of the importance of strong partnership working across the drug and criminal justice sectors – its cash boost for the drugs field in the wake of the Black review and subsequent drug strategy included £28m for Project ADDER, which aimed to improve lines of communication between treatment providers, courts and prisons as well as offering housing and employment support and aiming to reduce drug-related reoffending by getting more people into treatment (*DDN*, February 2021, p4). There was also extra money for the RECONNECT service, with its focus on continuity of care post-prison.

Other ways of improving outcomes across the two sectors include increasing the use of both drug rehabilitation requirements (DRRs) and alcohol treatment requirements (ATRs), and building on the work of probation health and justice teams. Much like the drug treatment field, however, both the prison estate and probation service have been losing experienced staff – often to burnout. However, there are some strong partnerships in place between treatment and criminal justice agencies that are getting very impressive results in terms of reducing reoffending, diverting people into treatment and providing support in that crucial period after release.

ARREST REFERRAL

Social justice and harm reduction charity Cranstoun is involved in an extensive partnership with criminal justice and other agencies across the West Midlands region, a major element of which is the Cranstoun Arrest Referral Service. Commissioned by the West Midlands PCC, this went live three and a half years ago and covers seven local authority areas.

'The services we now have in the West Midlands, like the arrest referral service which is in custody consistently across the whole West Midlands police force area, are a really good example of co-commissioning,' says director for new business and services at Cranstoun – and former head of policy at the Office of the West Midlands Police and Crime Commissioner – Megan Jones.

NO ONE GETS MISSED

The police estate in the West Midlands is split into a series

Nuthawut Somsuk/ iStock

of 'super blocks', she explains. 'One might cover, say, three local authority areas. So you might have one person in Sandwell there two days a week but they're only going to pick up people from Sandwell, whereas this service picks up absolutely everybody who comes into a police custody suite in the West Midlands – they could be from the West Midlands or Manchester or London. No one gets missed.'

TEST-ON-ARREST

Home Office guidance for police forces states that a positive test for heroin, crack or cocaine is a 'valuable gateway' to ensuring people can access the support they need. But it's the follow-up that's crucial, Jones stresses. 'Because we're not the police, people talk to us about their drug use really openly. Although test-on-arrest is being pushed out by government, what's important is what comes next. If you test people and you've got no support or follow on, then there's not really a benefit of doing that.

'Last year we supported 1,800 people into treatment who otherwise wouldn't have gone to their local drug and alcohol services,' she continues. 'We run a pre-arrest drug diversion scheme across the West Midlands as well for anyone caught in possession, and we've had more than 8,000 people go through that.'

DIVERSION PROGRAMME

As part of the DIVERT pre-arrest diversion programme for people caught with small quantities of drugs, Cranstoun has an app installed on officers' mobile devices – part of a streamlined referral process that takes just five minutes. Each use of DIVERT is estimated to save more than four hours of police time, and as well as keeping young people found in possession of small amounts of cannabis out of the criminal justice system it also means that any other issues – such as potential vulnerabilities or exploitation, for example – can be picked up on before it's too late.

Alongside arrest referral, Cranstoun also provides naloxone for people leaving custody, and late last year launched a new treatment service in HMP Birmingham – 'so we've brought this together as a whole-system approach', she says.

In terms of structure, the criminal justice interventions sit at the OPCC level, while Cranstoun's partner for its drug and alcohol treatment provision is Sandwell Council. The importance of ensuring effective partnership working was highlighted last month when the West Midlands – along with many other areas – became aware of dangerous synthetic opioids in circulation. The coordinated response was led by the West Midlands Local Resilience Forum Strategic Coordinating Group, which involves the local authorities, West Midlands police and ambulance services, OHID and others, with the local directors of public health actively working with treatment partners to raise awareness and reduce the risk of harm.

REMOVING BARRIERS

Removing barriers is a key aim of the West Midlands partnership arrangements, along with complete consistency across the police force areas. This means that officers don't have to remember different policies and procedures for seven different localities – not just for drugs and alcohol but also for housing, homelessness or domestic violence.

'We run a pre-arrest drug diversion scheme across the West Midlands... for anyone caught in possession, and we've had more than 8,000 people go through that.'
MEGAN JONES

A REAL OPPORTUNITY

'There's a real opportunity to link in at that police force level,' says Jones. 'In the old DIP days there were things that worked really well, and things that didn't, but what works well in terms of this arrest referral service is we don't duplicate the drug and alcohol services that happen locally. They like it, because we're increasing referrals to them, whereas before you had a bit of a postcode lottery.'

There have been two main areas of impact, she says. One is the support and engagement of people, and where possible referring them into treatment, while the other is a huge increase in DRRs and alcohol ATRs – which are issued instead of short-term sentences. 'What we do is we front-load it so we've got people in custody and we do the assessments there and then for a pre-sentence report.'

ONE ASSESSMENT

The beauty of the model is 'really the collaboration with the seven local authority areas, because we have one assessment', she continues. 'So if somebody then goes through to treatment, those treatment providers – whether it's Change Grow Live or NACRO in Wolverhampton – accept our assessment, and we've worked with them to do that. So people aren't continually assessed, because we know the impact of that. And it's the same with the pre-sentence report – they're not continually assessed throughout the system.'

There are regular criminal justice meetings involving the partners and facilitated by the OPCC, as well as a reducing reoffending delivery group of which Cranstoun is part. 'So that area of collaboration – not only with the treatment providers but the further system of probation, courts and others – is a real strength of this approach.'

A lot of the operational liaison, particularly with drug and alcohol treatment providers across the seven areas, is on a near-daily basis, she points out. 'Because our teams are co-located in custody, they're working in exactly the same space as police and police staff, so you get that co-location. It's the same with working with the liaison and diversion teams in custody, and any other provision. It's that collaboration that's key.' **DDN**

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

VOICES OF EXPERIENCE

The afternoon at Many Roads was a lively interactive session, where delegates explored treatment choice, stigma, the power of peers, and more

EXPERIENCES OF TREATMENT

How do we challenge 'one size fits all'? In London, for example, there had been entire boroughs with just a single treatment modality – and a lot of this simply came down to poor commissioning. Services had been declining over the course of the last decade across every indicator, resulting in a severe lack of choice. The funding system after drug treatment's move to public health also meant that more money was being spent on bureaucracy, with many projects abandoned simply because they weren't big enough.

'It's the abandonment of empathy,' said one delegate. In some areas, people were required to do around nine weeks of group work prior to a detox – 'they'd lost interest by then'. Another thought that the drugs issue had been framed in a way – 'as is often the case with politicians – that we need to make people jump through hoops to solve it', ignoring the fundamental truth that it should be about choice. 'You can't let service providers off the hook, either', another delegate stated. 'There's often an attitude of "this is what we do here".' People who were using on top of their prescriptions could be thrown off a service despite the fact that 'these are exactly the people you want in here.'

WORDS FROM THE FLOOR

'If you're a menopausal woman living in temporary accommodation on your own, or an 18-year-old person surrounded by a supportive family, one size fits all won't work. There's a lack of engagement with the individual, and far too much ticking boxes.'

'I'm wondering what's happened to outreach services. During the pandemic it was exciting that we could go out and find people and do testing on the street, or at least be talking to them. I think more drug services should be proactive in getting out there.'

'We need to have staff and peer support from different backgrounds, ethnicities and experiences.'

'We have to challenge "one size fits all" – everyone is different and LGBTQ+, women, and diverse communities are underrepresented. We need up-to-date NDTMS information to show who is actually accessing treatment.'

'There were nine weeks of group work before getting access to detox... and too many hoops to jump through to get seen.'

'We are all different, and we all have different needs. Throughout the years I've observed that many treatment centres have one approach for all clients, and that's wrong.'

'We need a robust referral and assessment process to ensure the right treatment at the right time for the right person.'

'There should be treatment tailored to fit a specific cohort – ex-forces veterans, male and female. It would need agreed boundaries to be effective.'

'We need to challenge "one size fits all" treatment through different

treatment options and being open-minded, non-judgemental, diverse in our offering, and through outreach – meeting people at their point of need.'

PEERS SAVE LIVES!

The drugs sector in the 1990s had 'more of a wild west feel, an energy'. Ten years later it had obviously become more professional but had also lost some of the initiative – a lot of outreach work had disappeared with recommissioning and the later move to public health. 'In the pandemic there was lots of great outreach work – including giving out naloxone – but it was being done by homelessness and housing charities,' one delegate stated.

WORDS FROM THE FLOOR

'It's about trusting people who take drugs. In Wales we have peer-to-peer naloxone, which means making sure that people who are taking drugs – and so are more likely to be there when someone overdoses – are given the tools and training to deliver naloxone. And give the drug dealers as many needles as you can, to keep people safe.'

'I've been impressed with what happened in Birmingham in the COVID year. Our drug-related death rate was 20 per cent lower than in 2019 – and that's because we had the outreach. Go to people where they are, and help them to get whatever they need.'

'If peer-led initiatives are given sufficient support, they bring connection and hope.'

'Through Turning Point I was introduced to a peer-led recovery community called Dear Albert, and my whole journey from there to now has been in that community. If it wasn't for people with lived experience I wouldn't be here today.'

'Peers enable relations with hard-to-reach communities, eg the traveller community.'

'The peer group initiatives that work are those that are loved by the people involved.'

'Peer-led hospital in-reach and prison through-the-gate are so effective.'

'Lived experience is needed everywhere – services should adopt a person-centred approach and not treat people based on their coping mechanism. Ask about them, not the alcohol and drugs!'

'Peers can identify areas – hot spots – that are prone to homelessness and drug use, and work with other partnerships for better communication.'

'Peer-led recovery means lived experience working alongside professionals.'

'Peer-led work offers outreach, lived experience, and a humane approach.'

'Do not work in isolation, work with peers. We are all social changemakers after all.'

LET'S TALK ABOUT STIGMA

More and more jobs at drug services were now requiring DBS (disclosure and barring service), one participant explained, as they involved access to vulnerable

people. 'There's this attitude of "you can't trust people". People who just want to do their jobs are being prevented from doing it – attitudes haven't changed'.

WORDS FROM THE FLOOR

'Train social services and Job-centre staff… let them hear real stories of hope from those in recovery.'

'Every time someone writes some bullshit about us, get on social media and respond to it. We need positive depictions of people who use drugs.'

'People's personal stories are what changes people's minds.'

'McDonald's won't employ people with criminal records – what chance do people have if they can't even get a job serving burgers? A criminal record held me back for years – I put my faith in God. Give people chances; reach out to all communities. Educate services that people can and do change.'

'Move society away from seeing drug use as a moral failing. Substance use is part of normal human behaviour!'

'I experienced stigma when I was accessing treatment. I was in and out of hospital, and constantly judged by medical staff. When I got sober I was asked to help educate doctors and nurses about how it made me feel – we need to do more of this, and challenge people on their language and beliefs.'

'Medical staff and police need more training. There's a need for compassion, fairness and to treat everyone as a human being. Be kind.'

'I'm still facing stigma around my gambling past. The opposite to stigma is not "no stigma", but openness, inquisitiveness and compassion. We need to challenge stigma with openness and gentle directness. Language matters. We realise we are change makers and compassion is contagious.'

'The stigma of being a mum in recovery – we think we can't parent. Getting help is scary. We don't want to lose our children so we don't access services.'

ME, MYSELF, I… WHERE DO WE GO FROM HERE?

Drug treatment hadn't been a political priority for a long time, but services still needed to interact with politicians, one delegate stressed. 'Get the MPs and local councillors out to talk to service users.' Human stories were powerful, as had been seen with medicinal cannabis and the Anyone's Child campaign. 'It all comes down to the way things are framed, and in the grand scheme of things it's pennies so it's worth getting it in front of them. There's an election coming up, so they want to be everyone's friend – it's worth a try.'

WORDS FROM THE FLOOR

'We need to be radical and transformative in who we network with, whether that's on social media or in person.'

'Ex-forces veterans in recovery are helping veterans still struggling with their addictions. We created a "buddy system" to support NHS addiction and mental health staff better engage with veterans in crisis. Many beneficiaries are now in recovery as a result of this initiative.'

'Make it safe for staff, volunteers and peer support workers to have open conversations about substance use. Make a better space for living experience rather than waiting for lived experience.'

'Politicians like a good anecdote – get your MP or councillor to meet local migrants who use drugs. They live in another world, but do love to come and meet and hear stories – and will use the stories. Now is the time to meet them for influence before the election.'

'We need to campaign for change, advocate for women, and never give up – harm reduction, safer sex, safer injecting. Stay in touch and connected, and offer support in other services.'

'We need to work together. Be consistent, disciplined, and clear in communicating what we're trying to achieve. Educate, don't berate.'

'Employ more people with lived and living experience. How honest can staff be disclosing their own lived and living experience in the workplace? Stigma has stopped all of us at some point, but perseverance and challenging this has helped.'

'Compassionate troublemaking is the way forward. We need to connect with new people as well as checking in with each other, and form local action groups.'

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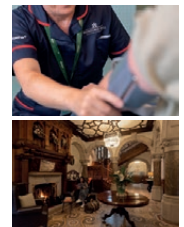

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SIMPLE SOLUTIONS

Naloxone is safe and easy to use. So let's get lots more people trained up and carrying it, says **Deb Hussey**

Part of my role as Turning Point's safer lives lead is expanding naloxone provision, and as an organisation we're committed to ensuring that naloxone is available to anyone who may need to use it.

I'm passionate about service user involvement, so the DDN conference is always a highlight in my calendar. For this year's conference I was delighted to showcase our Carry Naloxone co-production campaign alongside providing naloxone training to almost a hundred attendees.

Our Carry Naloxone campaign started back in 2021 after an international review highlighted the low numbers of people carrying a naloxone kit on a daily basis. Most overdoses are thought to occur with someone else in the room or nearby, making early intervention possible – but that person needs to have a naloxone kit. Alongside colleagues Jennifer Scott and Jo Kesten from the University of Bristol – and funded by Somerset Council – we aimed to develop a project to increase awareness and carriage of naloxone.

We started by running a short survey with people who use Turning Point services in Somerset, to see if the numbers reported in the 2021 study were borne out locally. The results were sobering – 87 per cent who responded said they had a naloxone kit but only 26 per cent carried one. Forty-six per cent had experienced an overdose, with more than half having overdosed between two and five times.

USER INVOLVEMENT

For this project to be a success we knew that we needed to actively involve the people we wanted to reach, and we recruited five people who were using our services to work alongside us as part of a co-production team.

We held our first focus group last summer. Recruitment had initially been challenging – people thought it was a tick-box exercise, that their opinions wouldn't be listened to, and it probably wasn't until the second group meeting that they began to see their ideas were being taken seriously.

That's my favourite part of co-producing projects – the moment when you see people start to understand that their contribution has meaning. Entering this project, I fully expected that our focus would be on making naloxone easier to carry. That's why it's so important to come to the table with a willingness to adapt, and why people with lived experience should always be consulted in projects that affect them.

STIGMA

Ease of carriage was raised as an issue, but as the consultation progressed a larger issue emerged – stigma. The co-designers felt that carrying a naloxone kit identified them as someone who uses drugs, so the need to challenge public perceptions and normalise naloxone as a first aid medication became our primary objective.

Working with artist Michael Linnell, the co-designers' ideas were developed into three posters – there's also an app

SIMPLY SAVING LIVES

The effectiveness of naloxone and the simplicity of administering was highlighted by the recent case of a member of the public using it in an emergency situation. Tom – who has no medical background or training – learned about naloxone from his wife, a Turning Point employee, and found himself in a situation where he had to administer it.

'I was just coming home with my daughter and found there was a woman sort of leaned up against the front of our house,' said Tom. 'She was not responding at all and totally out cold.' The woman had overdosed.

Local people had managed to flag down paramedics who were on their way to hospital with another patient. 'The paramedic seemed quite worried,' said Tom. 'He tried to communicate with the woman, but she was unresponsive. I told them that my wife had naloxone at home and they asked me to go and get it. However, the paramedics had a patient with a broken leg and they had to get them to the hospital. The paramedics said they had to go, so they left me to do the injection, which was quite scary.'

Tom read the instruction leaflet that came with the naloxone and administered two doses, which enabled the woman to regain consciousness. Another ambulance came but Tom's effort saw the woman walk away without needing further assistance.

Though it's still an emotional memory for Tom, he urges others to embrace naloxone, especially if they live in an area with a high-prevalence of drug use. 'It's important to know that you can't overdose on naloxone. There's very little you can do wrong, and you could well save someone's life.'

'That's my favourite part of co-producing projects – the moment when you see people start to understand that their contribution has meaning.'

to direct you to the nearest naloxone supplier that can be accessed via a QR code on the posters, an idea from one of the co-designers. The app is currently only available in Somerset but we have a set of posters without the QR code that can be used nationally. Getting to showcase the posters at DDN's conference was a great opportunity to introduce them to a wider audience.

At a concerning time for the sector with the increased overdose risk from synthetic opioids, this Carry Naloxone campaign is part of Turning Point's wider commitment to increase naloxone training and carriage rates among family members, friends, people who inject drugs (whether they're in treatment or not), and people working in services and across key parts of the public sector including health, housing and criminal justice.

At present, under the Human Medicines Act 2015, only those 'employed or engaged in the provision of drug treatment services' are able to issue the medication without prescription. While we wait for policy to shift, we're doing all we can to develop more joined-up approaches and increase training and carriage rates across all groups.

CLICK AND DELIVER

A new naloxone click and deliver service available through the Turning Point website launched on International Overdose Awareness Day in Somerset. This allows people to order naloxone kits online and have them delivered straight to their homes, and will be particularly beneficial for those who may be reluctant to collect a kit from the pharmacy. Following a trial period, we hope to roll the scheme out across Turning Point services nationally.

PRISON TRAINING

At one of our services, HMP Thameside in south-east London, as well as running drug and alcohol rehabilitation programmes, we train prisoners and prison officers in how to use naloxone. Seamus Tobin, Turning Point's senior operations manager at the service, has been stressing the need for naloxone for prison leavers for almost a decade. Even if someone leaves prison and dies within six weeks, it's still classed as a death in custody. After securing a six-month naloxone pilot through NHS England in 2020, the Turning Point team at HMP Thameside trained and handed out around 450 naloxone packs in that period.

The programme at HMP Thameside is now permanent thanks to funding from NHS England. 'The people carrying the naloxone packs – it's not their lives they're going to be saving, it's someone who's using in their community and overdoses,' said Seamus.

Deb Hussey is national safer lives lead at Turning Point

CONFERENCE CONNECTIONS

The DDN conference is the perfect chance to share ideas and make connections, says **Stacey Smith**

As a DDN conference veteran, it's a pleasure to share my experience of this year's conference. Preparation for the event always starts early and this year was no exception, with a focus group forming online a few months ahead to ensure it could be as inclusive and all-encompassing as possible.

First things first, I had an amazing team of Changes UK and SIAS (Solihull Integrated Addiction Service) crew by my side who helped prepare the delegate bags the day before the conference. It's always nice to offer the opportunity to people who have never been before, and everyone giving their time has their own unique lived experience.

On arrival, the Hep C Trust were doing a sterling job of welcoming delegates. Continuing our perfect example of partnership working, our Changes UK stall neighboured SIAS and the atmosphere was buzzing and busy. A diverse range of organisations had set up stalls, showcasing their services and projects – from harm reduction campaigns to community treatment and private rehabs, representing a spectrum of UK services.

Lynn Porter is one of our success stories. She's now working with us as a recovery worker and came to the conference for the first time. 'I found it invaluable to connect with other services that I will be able to signpost people to outside of our area,' she says.

The passion in our field means that discussions can get heated in social media circles, and rightly so – without dialogue, nothing will change. Unfortunately, dialogue isn't always heard by the people that need to listen, but we can strive. The DDN conference offers an opportunity to bring everyone together, and creates a safe space for discussions and to hear presentations from a diverse line-up of engaging speakers on stage.

Stigma was, as always, a key issue, and the day was a good time for reflection on what action is needed to overcome the barriers that continue to exist. How can we ensure we break down those barriers? Not only how we get those messages out to wider society, but how to make sure services are accountable for messaging and terminology, and how can we be as inclusive as possible and respect people's choices for their own road to health and wellbeing.

A big shout out to the catering staff who kept us all in refreshments, a hot lunch, and cakes throughout the day! There also seemed to be quite a few stalls with cupcakes and sweets which of course I resisted. Should sugar addiction be on the agenda next year..?

> 'A diverse range of organisations had set up stalls, showcasing their services and projects... representing a spectrum of UK services.'

I left the event with warm and fuzzy feelings, a croaky voice from my incessant chattering, and a renewed sense of purpose and commitment to continue advocating for the people and issues that matter. Events to instigate connections and reconnections are vital, and not just once a year. If the DDN conference does anything it should inspire all in the field to open our minds to what is truly important. If you get a chance to attend next year, I'd strongly encourage you to do so. Let's keep people alive and thriving. Until next year!

Stacey Smith is a freelance trainer who manages volunteers with lived experience for Changes UK

LANGUAGE MATTERS

In the latest in our social work series, **Jennifer Prikockis** explores the impact of language on people who access services

I've always enjoyed working with people, and I love being a social worker for the simple reason of being able to work with so many different people and provide a moment of hope for someone. Social work has many challenges but the days that give me a buzz and the feeling of 'that's why I do my job!' are the days I work through all the challenges of failing systems, organisational limitations and feeling helpless in not being able to make everything better for someone.

I work with adults who use substances, supporting them to go to rehab, and I oversee the work my colleagues do in keeping our clients and others safe. I see the impact my role can have on those using substances when they want to go to rehab, and I recognise how rehab can be the 'last resort' for many people who are in a cycle of behaviour. I can see how important this opportunity is to our clients, and what it means to them.

The language we use, and our understanding of social work within the substance use sector, matters a lot to me. Using terminology such as 'substance misuse' or 'abuse' indicates that a person is doing something wrong. Most people don't start using substances to develop a problem – they use to help with physical and emotional discomfort, to block out trauma, even to sleep.

Someone once said to me that alcohol has been a good friend to them – it's been there for them when needed and allowed them to drink their days away, avoiding the thoughts they desperately didn't want to have. In the same moment, they said they're ready to embrace a new way of thinking and a fresh approach. They shared that their experience of being supported has given them hope – I don't see that person's experience as something 'wrong', but something they recognise they want to change. I feel honoured to be a small part of that change.

The language that has an impact on those who access our services can also include something as simple as me being introduced as a 'social worker'. Many times a person has disengaged because they've heard this – it's something that can bring up triggers, possibly as a result of them being in the care system themselves, having their children removed from their care, or other reasons. To me, building a relationship is key in contributing positively to someone's recovery, and while I celebrate social work I can also understand that for some the term 'social work' can be sensitive. I wonder what simple words we can change to make accessing support a little bit easier for someone.

Working in the substance use sector provides autonomy and that's a great opportunity for being creative, thinking outside the box and learning about the person we're working with. One approach doesn't work for everyone and having the autonomy when working with a person to find their own path is why I love working in this sector.

Jennifer Prikockis is a senior social worker at Change Grow Live

LETTERS AND COMMENT

HOPES FOR THE FUTURE

I read 'My road, my choice' (*DDN*, June, p22) and would like to say that from my point of view, as a parent, it was encouraging to see physically how the future might look for a practising substance user and in some cases those in recovery. There was a vibrancy, a sense of hope, of optimism, of shared goals and ambitions, of progress in the public arena, of ground gained in service provision, of acceptance by those with fingers on budgeting agendas, policy makers, influencers...

In my opinion, it is never a good idea to take a foot off the pedal once momentum has been gained. It's that thing about overcoming initial inertia. I hope the *DDN* initiative continues to thrive and grow.

Jenepher Parry Davies (Simon's mum – may his dearest soul rest in peace.)

WISHFUL THINKING

Like a lot of people in the sector I've been a strong supporter of minimum unit pricing (MUP) for alcohol since its inception. I see the devastating effects that alcohol can have on a daily basis, and I support any moves to try and address that – pricing and tax mechanisms, restrictions on marketing, and crucially, better-funded, more accessible treatment.

So I followed the endless saga of the Scottish Government attempting to implement it despite the drinks industry's repeated attempts to block it, and was pleased when it was finally put in place. But the hard truth is that MUP doesn't appear to have worked. As with almost anything these days, it's virtually impossible to get the facts by reading one section of the press. In the right-leaning media, it's simply repressive nanny state legislation designed to thwart our personal freedoms, and in the left-leaning media it's a progressive policy that's saved hundreds of lives. Except that doesn't seem to be the case.

When Tory MSP Dr Sandesh Gulhane said that Public Health Scotland's final report into MSP had 'overstated' its impact, campaigners were quick to protest – but it does seem that he had a point.

Scottish alcohol deaths are at a fifteen-year high, and simply saying 'they would have been higher without MUP – just look at England' doesn't seem all that scientific to me – especially as England's latest figures aren't even out yet. Campaigners may well be right when they say the 50p rate hasn't kept pace with inflation and should be higher, but even the staunchest defenders of MUP acknowledge that it's had precious little effect on dependent drinkers – some of whom have simply chosen to spend less on food. I, like a lot of people, wanted MUP to work. But it does no one any good to simply pretend that it has, when the evidence clearly suggests otherwise.

Stephen Elliot, by email

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

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DDN would like to thank our sponsors and supporters – Accord, Camurus, Ethypharm and nal von minden – and all our exhibitors. Huge thanks to our volunteers, to inspiring colleagues for help and ideas, and to each one of you who came to the conference and made it a success.

For more coverage and to view video from the DDN Conference 2023 please use the QR code or go to www.drinkanddrugsnews.com/ddn-national-conference-2023/

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DDN visited the Global Forum on Nicotine in Warsaw to hear about the challenges of mainstreaming tobacco harm reduction

IGNITING DEBATE

Earlier this year we looked at tobacco harm reduction and observed that smoking still causes 8m deaths a year. Why had there been so many false starts on finding safer ways to use nicotine? Despite brilliant innovations and the launch of safer products – thanks to consumer-driven breakthroughs in tobacco harm reduction (THR) – we learned about inertia in public health, varying resistance through global politics, conflicts within the tobacco industry, and confusion surrounding tobacco control organisations, who resisted the notion that safer nicotine products could be used recreationally (*DDN*, February 2023).

So when *DDN* was invited to the tenth Global Forum on Nicotine (GFN), it seemed like an interesting opportunity to see key players in active debate. As the event's co-founder Paddy Costall said, 'Ours is the only conference in the smoking, tobacco and nicotine arena that welcomes all the players involved in tobacco harm reduction – consumers, regulators, parliamentarians, manufacturers and scientists – with no bans on who can attend or who can speak.'

A SENSE OF OPTIMISM

The event was born from a sense of optimism, said co-founder Prof Gerry Stimson. 'We thought we were on the cusp of a breakthrough, and that with safer nicotine products, millions of premature deaths from smoking could be avoided. If played right, we felt sure that harm reduction for tobacco could be a huge individual and public health success.' The last ten years had been a challenge, with regulators, parliamentarians and legislators changing the pace of progress. But he still remained confident that 'it's not a matter of whether tobacco harm reduction will happen, but when'.

Fifty 'thought leaders' from the field were invited to speak. They looked at the milestones of the last ten years, assessed a complex political, regulatory and scientific environment, and debated the challenges of the future. The flavour of the event was energetic and respectful, and characterised by a willingness to listen. Despite the great divide between countries that were being constrained by poor policy and regulatory obstacles and those buoyed by a wave of progress and consumer interest, there was a sense that sharing the science could translate into helpful take-home messages.

There were bound to be more questions than answers. A session called 'The Big THR Conversation', chaired by UK public health expert Clive Bates, asked: How can the last decade influence and inform the next?'

> 'Nicotine doesn't cause cancer and when we make people realise this then we can discuss lower levels of harm of the products.'

What are the dynamics? What causes success or failure? Why does the World Health Organization (WHO) do what it does? Why is the science a mess? Why is there such indifference to that? What role should the industry play? How do we see the world of nicotine in 15-20 years?

ENTRENCHED POSITIONS

As delegates from different countries gave their thoughts, we heard about narratives

Photography: GFN

Left: Clive Bates hosts The Big THR Conversation at GFN23. Above: GFN co-founder Professor Gerry Stimson speaks from the floor. ***Photography: GFN***

changing – or positions becoming more entrenched. In some countries there were very active communities of users, linked by social media; in others, vaping was still new to politicians accompanied by 'a lag in public health awareness and understanding'.

Comments from a Swedish delegate illustrated this. He had been in the Court of Justice when consumers challenged a ban on snus and said, 'What happened in court made me decide the ban on snus [a smokeless tobacco pouch, placed under the top lip] was 100 per cent political. A hundred pages of scientific evidence were ignored.'

There was discussion about the reasons for banning THR products. Bans made good headlines (delegate from the US); bans make politicians look like they have potency (Clive Bates, session chair); prohibition and a ban is a much easier sell to the public (Fiona Patten, former politician from Australia). There were different routes to prohibition, from changing the law to making the products as unappealing as possible.

THE TOBACCO INDUSTRY

The involvement of the tobacco industry in THR, primarily vaping, had been a double-edged sword. Alongside their innovations, they 'brought their reputational baggage into the room', which hardened attitudes towards vaping products. The Foundation for a Smoke Free World, set up to 'end smoking within a generation', belonged to Phillip Morris and was launched at a tobacco industry event. No wonder there was cynicism.

But in this forum, the industry was a welcome contributor to the debate – a partner in driving up product standards and keeping illicit (and possibly dangerous) products outside of the marketplace. New products to emerge included nicotine vapes, Swedish-style snus, and nicotine pouches – none of which burned tobacco, and all of which had been shown to be significantly safer than combustible cigarettes. An estimated 112m people used these products worldwide.

SUCCESS STORIES

In some countries, 'amazing progress' had translated into public health success stories; for instance in New Zealand Maori smoking had plummeted after introducing vaping. The Philippines had 'got over the line' with vaping because of consumer advocacy, and a turning of the tide meant it would soon be legal to vape in Malaysia and Thailand.

For others, progress was being frustrated. Last year Mexico banned vapes on World No Tobacco Day – a decision that was 'science-free and a political gesture', according to Bates – while in South Africa a new tax on vaping was likely to push people back to cheaper tobacco and Australia was also cracking down on vaping. In England there were positive signs of free vaping kits being distributed – but also a media-driven narrative about young people becoming addicted.

The WHO continued to oppose safer nicotine products for smoking cessation and to publicly deride tobacco harm reduction. All eyes were on the WHO Framework Convention on Tobacco Control Tenth Conference of the Parties (COP10) in Panama this November, which GFN feared could have 'grave implications for global public health'.

We needed to be mindful that 'science has become subordinate to the political argument,' said Bates. But the endgame was that the THR debate was very useful – it could solve COPD, cardiovascular disease and cancer while involving a stimulant that people enjoyed using.

For many, the debate served to re-energise efforts to take THR to the next level. 'We need to keep kicking those doors,' commented a delegate. 'It's easy to be negative, but we've done incredible work.'

'Nicotine doesn't cause cancer and when we make people realise this then we can discuss lower levels of harm of the products,' said another. 'There is not one single golden bullet.' **DDN**

HEADLINE RUSE

Don't believe everything badged as research, said Roberto Sussman

'**I UNDERSTOOD INDOOR SMOKING BANS** – that people needed to be protected from my smoke. But not outside bans. Bullshit alert!' Dr Roberto A Sussman waved his arms around theatrically and the audience responded to his lively presentation. A full-time senior researcher and lecturer at the Institute of Nuclear Sciences at the National University of Mexico, Sussman had nipped across from the world of cosmology to write peer-reviewed research on e-cigarette aerosols.

'There's a nasty short circuit in tobacco science that would never have happened in physics,' he said. 'Outdoor smoking bans are social engineering, and their goal is not health driven. It's about eradication of conduct.' The question was – could this be justified for vaping? 'Are we going to allow denormalising of vaping as was done on smoking?'

'There's a nasty short circuit in tobacco science that would never have happened in physics.'
DR ROBERTO SUSSMAN

Tobacco harm reduction was seen as a Trojan Horse of the tobacco industry, he said, 'a way of bringing in young people, young addicts.' There was a toxic academic environment in which technically sloppy papers were published to support policy.

'Research ignores that most usage is experimental,' he said. 'Frequent vapers tend to be those who have tried tobacco and/or smoking. The vaping youth epidemic is a political construct.'

Find resources from the Global Forum on Nicotine at gfn.events.

Use the QR code for more coverage and view video from the Global Forum on Nicotine 2023.

DIGITAL DELIVERY

Change Grow Live's digital pathway has opened up support to whole new populations, says **Trudy Sealy**

Jellypics

When it comes to the work of drug and alcohol services, innovation isn't just a buzzword – it's a lifeline for the people we're here to support. At Change Grow Live's Spectrum service in Hertfordshire, the innovative digital pathway offered by our telecoms team is helping to take the pressure off our frontline staff and make treatment more accessible than ever before. By embracing technology and giving people more options for how they access support, our new pathway has seen a 14 per cent increase in people accessing non-opiate treatment, and impressive completion rates of up to 96 per cent.

This new remote offering began with the creation of our engagement centre – a digital front door that streamlined communications and service requests. This team acted as a hub to efficiently manage calls, emails, and referrals, making it easier for individuals to access services without facing the usual barriers. We wanted to break down the walls that geographic distance or societal stigma often build around support.

The new team's success paved the way for further innovation during COVID. The telecoms team began delivering advice and support to people online at a time when their ability to visit a service in person was extremely limited, and we saw such potential in this approach that we decided to expand it after the pandemic. With funding from Hertfordshire County Council commissioners, we took the opportunity to reach individuals who might not engage through traditional methods.

We knew from experience that there are many people out there whose drinking or drug use is negatively affecting their health and wellbeing, but who might not be dependent and don't see themselves as needing the support of a service like ours. Then there are people who don't live close to one of our hubs, or who may simply find it too daunting to make that first step and visit a service in person.

The digital pathway offers these people a way to reach out and engage – we originally focused on non-dependant drinkers, but over time our mission has expanded to include people who are using cocaine and cannabis.

> There are many people out there whose drinking or drug use is negatively affecting their health and wellbeing, but... don't see themselves as needing the support of a service like ours.

A standout feature of our approach is its structure. Once someone has had their assessment, they are guided through interventions tailored to their specific situations. For instance, those scoring eight to 15 on an audit tool might receive a brief intervention, while people scoring 16 to 19 can access a comprehensive programme delivered entirely online.

The impact of the new pathway has been substantial. Our approach helps people to engage by accommodating different schedules and preferences, and enabling them to access support that's convenient for them. Since launching, around 90 per cent of people accessing support through this pathway stick with it through to completion, with as many as 96 per cent of the people seeking support for alcohol and cannabis completing all their sessions. At the same time, the feedback we've had from the people who use the service has been glowing – people like that speed and efficiency, and the ease with which they're able to get the help they need.

But our success goes beyond numbers. By providing tailored interventions and streamlining processes, we've begun to tackle the challenge of the UK drug strategy's simultaneous demands for lower caseloads and increased accessibility. We've lightened the load on our frontline staff and helped us to reach people who might never otherwise have taken the step of accessing support.

People face barriers to support, from the pressures of their work life to travel limitations and social stigma. By streamlining our processes and tailoring our interventions, the telecoms team is making major advancements in breaking down these barriers.

As the landscape we operate within continues to evolve, embracing innovation and creating new ways for people to engage will play a major role in making sure people get the support they need. We are keen to share our learnings with others – if you would like to know more about our digital pathway and the work of the telecoms team, please contact raymond.jay@cgl.org.uk.

Trudy Sealy is services manager at Hertfordshire Spectrum

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Supporting people in prisons or on probation is a rewarding and meaningful career. At The Forward Trust we believe that everyone can live a fulfilling life, whatever their past. If you share these beliefs we want to hear from you.

Do you have transferrable skills and would you like to join us in our work?

We are currently recruiting for Band 5, 6 and 7 nurses across our prisons in London, Surrey, Middlesex and Essex. We also have number of non clinical positions including practitioners for health and wellbeing, dual diagnosis and drugs and alcohol as well as management positions available.

Why not join us today to support people in achieving lasting change?

WE OFFER COMPETITIVE SALARIES AND GREAT BENEFITS INCLUDING:

- Flexible working
- Up to 30 days annual leave
- Training and career development
- Therapy allowance
- Health Care Plan
- Life Assurance and Critical Illness cover
- Wellbeing days

Plus a range of other great benefits

View these vacancies and more at **www.forwardtrust.org.uk/support-us/work-for-us/** or scan the QR Code. Why not follow us on Facebook by searching **Forward Trust Careers**

Work-life-balance

Come and work with us and we'll support you in the life moments that matter most. From paid time off for your child's first day at school, your birthday or for home emergencies, we'll support you.

"I was super grateful to be able take an extra day's paid leave for my child's first day of school. It's such an important day so not having to rush around in the morning and then being able to pick them up from the gates really meant the world to both of us."

Karen, Business Manager, Via - Passmores House

viaorg.uk

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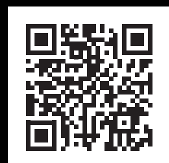

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