DRINK AND DRUGS NEWS

ISSN 1755-6236 **SEPTEMBER 2018**

DDN

CHASING THE BIG WIN

WHY IS GAMBLING TREATMENT STILL A LOTTERY?

PLUS: Getting naloxone out through community action

UNDERSTANDING INSPECTION

Best practice for substance misuse services

Wednesday 17 October 2018
10.00 a.m. - 4.00 p.m.
Holiday Inn, Bloomsbury, Central London

A conference considering the latest developments in CQC inspection.
Topics will include:

- how the CQC Key Lines of Enquiry reflect up to date good practice
- how CQC will be introducing ratings for substance misuse services for the first time in 2018
- factors to consider when preparing for an inspection
- whether your service should aim for Good or Outstanding ratings.

The conference will include a variety of speakers with wide ranging knowledge and experience of inspections; and workshops on how to apply these topics to your service in practice.

Speakers:

Patti Boden: Inspection Manager, CQC.

David Finney: Independent Social Care Consultant specialising in the regulation of substance misuse services. Formerly national policy lead for substance misuse services, Commission for Social Care Inspection (CSCI).

Violeta Ainslie: Quality Manager, Turning Point. Formerly National Policy Advisor for substance misuse services in CQC

Zoe Martindale: Registered Manager, Streetscene

Dr Julia Lewis: Consultant Psychiatrist, Addictions Specialist. Participant in the review of the "Orange Book" clinical guidelines for the treatment of substance misuse

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EDITOR'S LETTER

'The call for support on gambling has to be heard'

You're in the casino chasing the big win. Everything you ever wanted could be yours. The wheel spins and the ball jumps from red to black to red to black... you've risked everything... so what if the unthinkable happens? Owen's story (page 6) gives valuable insight into this potentially problematic recreation, adding to last month's gambling feature that many of you found useful. The call for support has to be heard and incorporated more widely into our treatment system so we can offer help at the first sign of struggle.

The theme of peer-to-peer expertise runs deep through this month's issue. Local user groups are networking with naloxone initiatives (page 16), while EuroNPUD are rolling out a far-reaching overdose prevention project. We'll follow its progress with interest.

Three minutes isn't long to tell your story, particularly when you need to convey the significance of the 'lightbulb moment' when you decided to do things differently. But that's exactly what entrants to this year's Recovery Street Film Festival achieved (page 15). Each film was astonishingly powerful and I would urge you to visit the YouTube channel and watch them for yourself. Any one of them would demonstrate the case for investment in drug and alcohol services.

We hope you've had a good summer. As the autumn approaches it's time to start planning in earnest for the next DDN conference – the best place ever for peer-to-peer networking. Put 21 February in your diary and please join the consultation through our website!

Claire Brown, editor

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

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RECORD DRUG DEATHS FOR ENGLAND AND WALES

ENGLAND AND WALES have once again recorded their highest ever number of drug-related deaths, according to the latest figures from the Office for National Statistics (ONS).

There were 3,756 deaths related to drug poisoning in 2017, a slight increase on 2016's figure of 3,744 (*DDN*, September 2017, page 4) and the highest number since records began. However, while drug-related deaths rose by 'a statistically significant amount' each year between 2012 and 2015 – mainly driven by heroin-related fatalities – rates since 2015 have only increased slightly and remain 'broadly stable', says ONS.

Two-thirds of deaths were among men, and once again the North East had a 'significantly' higher death rate than any other region. While the figures relate to both illegal and legal drugs, almost 70 per cent were classed as the result of 'drug misuse', with the highest rate of these in the 40-49 age group.

Although deaths from 'most opioids' have remained steady, fentanyl-related deaths have continued to rise – to 75, from 58 in 2016 – while deaths related to cocaine have now increased for six consecutive years. There were 432 cocaine-related deaths in 2017, up from 371 the previous year. The number of deaths related to pregabalin, meanwhile, has risen from just four in 2009 to 136, although NPS-related deaths halved between 2016 – when the Psychoactive Substances Act was introduced – and 2017, to 61 from 123.

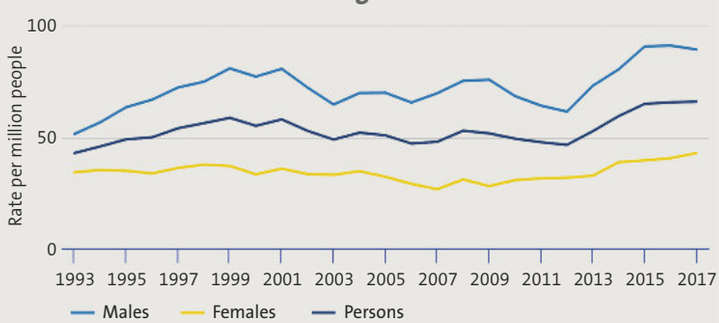
Release said the death rates were a 'national crisis' requiring a coordinated public health response.

'The government is driving this devastating public health crisis by punishing people for their drug use instead of implementing compassionate, evidence-based policies,' said executive director Niamh Eastwood. 'By criminalising people for drug possession, the government is dissuading people who want help from seeking it. This, in turn, is fuelling drug-related deaths. The government has also slashed funding to essential treatment services, leaving thousands of people at the mercy of a postcode lottery as to whether their local authorities will provide the support that they need.'

'The continuing high rates of drug-related deaths and the emerging threat of overdoses associated with fentanyl points to a national need to improve the balance of harm reduction initiatives,' added a spokesperson for Change Grow Live (CGL). 'We know what effective harm reduction consists of: rapid access to effective substitute opioid prescription; supporting take-home naloxone programmes; robust identification systems for those most at-risk, as well as addressing existing health conditions wherever possible. It is essential that harm reduction is prioritised as a core and essential element of treatment, giving people support to reduce the harms from drugs and achieve sufficient stability to keep themselves safe and alive.

Deaths relating to drug poisoning in England and Wales: 2017 registrations at www.ons.gov.uk. See overdose awareness feature, page 16

Deaths related to drug poisoning, by sex, registered between 1993 to 2017. England and Wales



Source: ONS – Deaths related to drug poisoning in England and Wales: 2017 registrations

LEVELLING OUT

THERE IS NO SAFE LEVEL of alcohol use, according to a study published in the *Lancet*. Almost 3m deaths worldwide were attributed to alcohol use in 2016, including 12 per cent of deaths for males aged 15-49. 'The health risks associated with alcohol are massive,' said senior author Dr. Emmanuela Gakidou. 'With the largest collected evidence base to date, our study makes the relationship between health and alcohol clear – drinking causes substantial health loss, in myriad ways, all over the world.' *Study at www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31310-2/fulltext*

FATAL FENTANYL

PROVISIONAL FIGURES show that more than 72,000 people died from drug overdoses in the US last year, the highest number ever. The figures from the Centers for Disease Control and Prevention (CDC) represent a 10 per cent increase on 2016, as the country's 'opioid epidemic' continues, with almost 30,000 people dying as a result of a fentanyl-related overdose. 'Provisional counts are often incomplete', warns CDC, with the numbers likely to be an underestimate of the final totals. *Statistics at www.cdc.gov*

TIME TO RELAX

REGULATIONS on the licensing, prescribing and advertising of e-cigarettes need to be relaxed, says a report from the cross-party Science and Technology Committee. Despite being thought to be 95 per cent safer than conventional cigarettes (*DDN*, September 2015, page 4) e-cigarettes are 'too often being overlooked as a stop-smoking tool by the NHS', it states, and recommends reconsidering tax levels to encourage more people to switch from ordinary cigarettes. 'E-cigarettes are less harmful than conventional cigarettes, but current policy and regulations do not sufficiently reflect this,' said committee chair Norman Lamb. *E-cigarettes at www.parliament.uk*

CHANDOS CLOSURE

BRISTOL'S CHANDOS HOUSE treatment centre is to close after 35 years. A campaign to raise funds for the residential facility, backed by Will Self and Russell Brand among others, has fallen short of its target – however, executive director James Dickinson said the campaign 'remains open, optimistic of a reprieve. We will continue our work until our closure, and we remain hopeful for the miracle that might yet revive our fortune.' *Campaign at localgiving.org/charity/chandos-house-addiction-treatment-centre/*

HIDDEN MESSAGES

DRINKS MANUFACTURERS are putting health messages on their products in places 'where drinkers are least likely to see them,' says a report from the University of South Wales (USW). While people rarely look beyond the front label, unit information and warnings are routinely placed on the sides and backs of bottles and cans, and in small, hard-to-read fonts, it says. 'The facts that could help us make an informed choice are out of sight and out of mind,' said Alcohol Concern's director for Wales, Andrew Misell. *Investigating the potential impact of changing alcohol product labels at www.alcoholconcern.org.uk*

'The facts that could help us... are out of sight and out of mind'

ANDREW MISELL

FOCUS ON PREVENTING DEATHS, URGES NEW SCOTS CAMPAIGN

A NEW INITIATIVE launched at the Scottish Drugs Forum's (SDF) annual conference is calling for a national focus on preventing drug deaths, and reinforces the message that 'prevention is possible and we all have our parts to play'.

#StopTheDeaths, which was timed to mark International Overdose Awareness Day on 31 August, wants to see all stakeholders make the agenda a priority and also offers a 'message of hope' – that 'we can respond to record drug deaths by developing a world-leading response to this national challenge and aspire to eliminate drug overdose deaths'.

The last three years have seen record drug deaths in Scotland, with 867 in 2016 – 23 per cent up on the year before, and almost double the figure from a decade ago (*DDN*, September 2017, page 4) – rising by a further 8 per cent to 934 in 2017 (*DDN*, July/August, page 4). The #StopTheDeaths initiative also focuses on drug-related fatalities that are not the result of an overdose, such as those caused by the health effects of chronic drug use. The campaign is aimed not just at policy makers and service providers, but people who use drugs and their families and communities.

'From speaking to our members across Scotland, it is clear that the number of drug-related deaths continues to rise at what now seems an exponential rate,' said SDF's CEO David Liddell. 'This means that in 2018 Scotland will almost certainly suffer over 1,000 preventable overdose deaths. #StopTheDeaths is a call to refocus our actions and to draw attention to evidence-based approaches and protective factors that can be deployed now.'

These included making sure people had fast access to, and were retained in, high quality treatment services, as well as provision of a wide range of therapies – including heroin-assisted treatment – and improved access to take-home naloxone. SDF is also launching a free e-learning course to coincide with the campaign, covering how to recognise an overdose and use naloxone to reverse it.

'The good news is that drug deaths are being prevented every day in Scotland,' Mr Liddell added. 'However, we need a step change in terms of a co-ordinated approach and further innovation that can meet the scale of this challenge if we are to avoid the course we appear to be on. The Scottish Government's new national drug strategy is an opportunity to show leadership, redirect the nation and decide to end this tragic situation.'

www.overdoseday.com

Naloxone course at www.sdfworkforcedevelopment.org.uk

'In 2018 Scotland will almost certainly suffer over 1,000 preventable overdose deaths'

DAVID LIDDELL

CASH GIVE-AWAY

The Home Office has issued a series of posters to alert landlords and letting agents to signs that a potential tenant might be involved in 'county lines' activity. These include offering to pay upfront for a long period in cash, being unable to provided references and renting an inexpensive property despite appearing 'affluent'. *Posters at www.gov.uk/government/publications/county-lines-posters-for-letting-agents-and-landlords*

GUIDELINE LOSSES

DRINKERS consuming more than the government's low-risk guideline of 14 units a week make up a quarter of the population but provide 68 per cent of industry revenue, according a study by Institute of Alcohol Studies (IAS) and the University of Sheffield. If all drinkers stuck to the guidelines the industry would lose around £13bn, says *How dependent is the alcohol industry on heavy drinking in England?* 'The government should recognise just how much the industry has to lose from effective alcohol policies, and be more wary of its attempts to derail meaningful action through lobbying and offers of voluntary partnership,' said lead author Aveek Bhattacharya. *Study at onlinelibrary.wiley.com/doi/full/10.1111/add.14386*

BLATANT USE

DRUG TESTING suggested that a third of prisoners in HMP Birmingham are using illicit drugs, according to an inspectors' report. The prison was made the subject of an 'urgent notification' to the justice secretary after an inspection in August, and a governor and management team from HM Prison Service have since taken over its running from G4S. 'I have inspected many prisons where drugs are a problem, but nowhere else have I felt physically affected by the drugs in the atmosphere – an atmosphere in which it is clearly unsafe for prisoners and staff to live and work,' chief inspector of prisons Peter Clarke wrote to justice secretary David Gauke. 'Our own observations confirmed to us that the use and trafficking of illegal substances was blatant.' *Full inspection of: HMP Birmingham 30 July – 9 August 2018 at www.justiceinspectorates.gov.uk/hmiprisons/*

HCV DEATHS DOWN

DEATHS FROM HEPATITIS C-related end-stage liver disease fell by 11 per cent last year compared to 2016, according to PHE. The fall, after a decade of continuous increases, is 'most likely' due to the growing use of new antiviral medications available on the NHS – these 'have the potential to cure the condition in most cases' and also have fewer side effects than previously used medications such as interferon. The number of people accessing treatment is also up by 19 per cent compared to the previous year, and by 125 per cent on pre-2015 levels. 'The fall in deaths from hepatitis C related advanced liver disease in the last year suggests that more people are accessing new, potentially curative treatments and shows we're making positives steps towards reaching our overall goal of elimination of hepatitis C as a major public health threat,' said PHE consultant epidemiologist Dr Sema Mandal. *Hepatitis C in the UK: 2018 report at www.gov.uk.* *See October's DDN for an eight-page pull out on hepatitis C*

ALCOHOL AWARENESS

CHANGE IS THE THEME of this year's Alcohol Awareness Week, which runs from 19-25 November – 'change is necessary, change is possible, change is happening'. *For more information, visit www.alcoholconcern.org.uk/alcohol-awareness-week.* Meanwhile, minimum pricing has now become law in Wales after the Public Health (Minimum Price for Alcohol) (Wales) Act received Royal Assent. The act was approved by the country's National Assembly earlier in the summer (*DDN*, July/August, page 4) with the minimum pricing regime expected to come into force in mid-2019.

IN A SPIN

With the depth of painful personal experience, **Owen Baily** explains why gambling treatment is still a lottery

With sweaty hands, deep physical anxiety in my chest and a sense of panic, I committed to placing my last bit of money on the roulette terminal in the casino. With acute anticipation, I watched the ball spin chaotically around the wheel and waited for it to land. It landed, as the ball always eventually does, but not on a number I had placed the bet on. I lost, and I had no more money. Literally.

Right there and then, the emotional roller coaster of a journey I had been on for the past two months came to a sudden and abrupt stop and it hurt badly. I was winded. I couldn't breathe. The panic turned to dread. Starting to comprehend what I had just done and not quite knowing what to do I walked, numb to my surroundings, out of the casino, completely consumed in a self-flagellating internal dialogue.

Two months earlier things couldn't have been any better. Just a few days before Christmas I was in the same casino and had fulfilled a fantasy – I had had a 'Big Win'. Confident, flush, feeling powerful and with the freedom of having so much money to spend, I had a very enjoyable Christmas.

It was not to last. I became intensely consumed with recapturing the potency of emotions attained by the 'Big Win' and I began to gamble as often as I could, dangerously and chaotically. For the next two months, my dopamine levels were experiencing unnatural and extreme peaks and troughs, ending abruptly with that moment when I placed my last bit of money on the roulette wheel and lost.

That experience was 17 years ago. I was 18. And the experience of the 'Big Win' and subsequent loss of all the money I had was, and said with no exaggeration, traumatic. I became depressed, with no confidence or self-esteem and even became suicidal. To cope I escaped and bought into the fantasy of going on a working holiday in Europe. I quit my job, left home, put my belongings in storage, bought my ferry ticket to Holland and went.

Naturally excited, I boarded the ferry, forgetting the past and looking forward to the adventure that lay ahead – except, when I explored the ferry, I came upon a roulette table. Unaware and unable to challenge the gambling thoughts and cravings, and despite my previous experience, I began to play.

A few hours later the ferry docked into the Hook of Holland. And again, I lost all my money. Only this time, I was in a foreign country, with no home and no job.

After spending a day talking to the British Consulate in Amsterdam, I was given enough money to travel back to the UK. Fearing being

street homeless in London I got off the coach at Canterbury, Kent. I sought help from the nearest homeless shelter and with what I had just put myself through, I found a will to seek help to try to stop gambling.

But I came up against a problem. I realised that there was no accessible face-to-face support at all for those who have gambling problems. And what became evidently clear as well, was that knowledge and awareness around problematic and excessive gambling behaviour among staff was very poor, bordering on non-existent. Here I was, with a serious problem, desperately wanting help, but because there was no help and staff were unknowledgeable, I felt excluded and marginalised.

Unintentionally, and by some odd fortune, I developed an alcohol dependency. And straightaway, treatment options opened for me. I was referred to what was then a dedicated NHS alcohol Treatment service and periodically, for the next few years, I participated in a whole array of help and support that is commonly found in addiction treatment services. And because I was engaging in treatment, I was able to take a good look at my gambling behaviour too.

I managed very successfully to address my alcohol use and in a matter of months was able to get to a point where I was able to abstain – and I stayed stopped for four years. My gambling, however, persisted. I felt something was missing and I still felt marginalised. I wasn't getting something from the all the treatment I was receiving through the alcohol service.

'I became intensely consumed with recapturing the potency of emotions attained by the "Big Win" and I began to gamble as often as I could.'

As with thousands of other people facing the challenges of overcoming addiction, I had a serious relapse – time for rehab. I began the search in October 2009 when I was 27 and come March 2010 I was walking up the drive to the therapeutic community where I stayed for 20 months. It was a therapeutically difficult and painful experience but one which I am so grateful for. But still I felt marginalised because I had a predominant gambling problem – and just as with my experience of the workers in the homeless hostel, I felt this recurring sense that awareness and understanding of gambling-related harm (GRH) was inadequately low.

Although I'd make positive advances in areas of my being and recovery, I struggled to maintain my 20-month abstinence from gambling, and relapsed.

This was when, after ten years of trying to get a handle on my gambling, I decided to approach the Central and North West London NHS Foundation Trust (CNWL) National Problem Gambling Clinic (NPGC) – currently the only dedicated NHS service that provides gambling-specific support. I self-referred and in a few weeks joined an eight-week cognitive behavioural therapy (CBT) course.

Unlike all the hours of CBT I had done previously, this course has been brilliantly modified and refined to meet the needs of individuals with gambling problems, just as the person with issues relating to alcohol or opioids needs tailored support. Furthermore, I was able to meet others like me and for the first time didn't feel excluded or marginalised. I found the something that was missing. And I haven't looked back.

GAMBLING WITH PUBLIC HEALTH

Let's increase the chances of a good outcome, says **Lord Victor Adebowale**

Gambling is a common part of everyday life, accessible online 24/7 and unavoidable across media and advertising platforms. Yet for some people, it can become harmful and problematic, affecting relationships, housing, employment and health.

The timing of the recent APPG on Complex Needs and Dual Diagnosis meeting on 'harmful gambling' coincided with the football World Cup – four weeks of sporting action that gripped the nation and over which it was expected that the amount spent on gambling in the UK rose to £2.5bn; an alarming figure.

In the UK nearly 9m adults will gamble over any four-week period, of which 430,000 can be identified as 'problem gamblers'. It is an addiction that impacts all pockets of society, yet one which only now is starting to be addressed as a public health issue.

Dr Steve Sharman from the University of East London presented his recent research findings on the correlation between homelessness and gambling – a pocket of society many would not commonly associate with gambling, despite 82 per cent of homeless problem gamblers interviewed experiencing these issues prior to homelessness. He explained how 24/7 casinos, which provide a warm, safe haven for those otherwise on the street, and incentives such as free bathrooms and hot food and drinks, become attractive but are only available if you are gambling – a morally corrupt pay-off in my opinion.

Lawrence Goode from the Gordon Moody Association, a charity that provides advice, education and high-quality innovative therapeutic support to male problem gamblers and those affected by problem gambling, reiterated the wider non-direct impact gambling can have on families and children. Of the 74 people who went through their residential treatment last year, 72 relationships broke down and 69 children were temporarily without a father.

The government is making some effort to address harmful gambling, for example recent government policy has cut the maximum permitted stake on fixed-odds betting terminals from £100 to £2 – a controversial move welcomed by some in the bookmaking industry – and PHE have committed to carrying out a review of the damage to health caused by gambling. However, to make any real and effective progress it is obvious that more funding, research and treatment options are needed to address the health and social concerns harmful gambling presents in the UK.

Addiction is addiction, whether drugs, alcohol or gambling. It's a behaviour pattern and what the sector and NHS commissioning services need to realise is that we should be providing holistic support, treating the person rather than an individual problem.

Lord Victor Adebowale is co-chair of the APPG on Complex Needs and Dual Diagnosis, and CEO of Turning Point

LETTERS AND COMMENT

DDN WELCOMES YOUR LETTERS

Please email the editor, claire@cjwellings.com, or post them to DDN, CJ Wellings Ltd, Romney House, School Road, Ashford, Kent TN27 0LT. Letters may be edited for space or clarity.

'We provide support to around 30,000 people per year via the HelpLine and NetLine, and around 8,000 people each year also receive support through our network of treatment services.'

PROBLEM SHARED

I am writing regarding your recent feature on problem gambling (*DDN*, July/August, page 12). The article states that treatment provision for those affected by problem gambling is still sparse, which is a point we at GamCare would like to address. GamCare operates the National Gambling HelpLine, providing information, advice and support for anyone affected by problem gambling (including family and friends). Advisers are available seven days a week from 8am to midnight on Freephone 0808 8020 133, or via web chat at www.gamcare.org.uk.

We also offer a range of free treatment (face to face, online and over the phone) across England, Scotland and Wales, as well as a moderated forum so that people can speak to others experiencing similar issues and seek support. Our support services are funded by GambleAware.

We provide support to around 30,000 people per year via the HelpLine and NetLine, and around 8,000 people each year also receive support through our network of treatment services. We are also able to refer into the CNWL National Problem Gambling Clinic and the Gordon Moody Association (who both also receive funding via GambleAware) when clients have more complex needs.

Catherine Sweet, head of marketing and communications, GamCare

REFERRAL ROUTES

It was great to see the July/August issue of *DDN* devote two pages to a profile of the Central and North West London NHS Foundation Trust's clinic for problem gamblers. Staff working in substance misuse services or other addiction services can refer service users to the CNWL clinic and the other services which make up the national problem gambling treatment service by calling the National Gambling Helpline on 0808 8020 133. Self-referrals are also welcome.

Treatment across Great Britain is funded by BeGambleAware.org and carries no cost for referring organisations or service users. People who do not need treatment for problem gambling can also use the same contact details to obtain advice on safer gambling.

John McCracken, director of commissioning, GambleAware, London

MEDIA SAVVY

The news, and the skews, in the national media


NEWS
ETHICAL MILLENNIAL DRUGS FOR GUNS HYPOCRISY

MILLENNIALS AND THEIR SUCCESSORS, Generation Z, wear their ethical credentials on their sleeves. They like their coffee Fairtrade, their fur fake and their chicken free range. They pride themselves on being responsible consumers – yet many are happy to help sustain the most brutal trade on Earth. These cocaine-snorting hypocrites rail against 'elites' and the 1 per cent, yet their habit lines the pockets of cartel kingpins who display their gold-plated guns and pet tigers on Instagram, #narcostyle. They want to save the Earth and balk at the use of plastic straws, yet for every gram of coke they put up their nose, four square metres of rainforest are destroyed. They want to tear down statues of long-dead men who were involved in the slave trade, yet their cheeky line at the weekend fuels a trade closely linked to modern slavery.
Clare Foges, *Times*, 1 August

IT'S CLEAR THAT WESTERN COCAINE USERS HAVE TO ACCEPT THEY ARE CONTRIBUTING TO VIOLENT CRIME that has left hundreds of thousands dead in Latin America over the past decades, and is spilling on to British streets. Perhaps the carnage in Latin America is a comfortable distance away from those snorting coke at weekend parties across the UK. If your money funds the market, you are complicit in the consequences.
Iman Amrani, *Guardian*, 1 August

IT IS CLEAR THAT OUR CURRENT LAWS AND PROGRAMMES ARE NOT WORKING... The answer may well be tougher sentences for pushers – but treatment, rather than prosecution, for chronic users. It may even be worth a look at experimenting with decriminalisation. And we definitely need an answer to the 'county lines' drug trade. Regardless, the deaths and the drug-related gang violence must end. Without change we are sleepwalking towards catastrophe.
***Sun* editorial, 7 August**

THE BLAME FOR THE BLOODSHED, the chaos, the carnage and the deaths lies with politicians who refuse to face reality. Prohibition does not work – and they should stop attacking others for the tragic consequences of their own grotesque failure.
Ian Birrell, *London Evening Standard*, 10 August

HEALTH ADVICE TOO OFTEN FOLLOWS THE PRINCIPLE OF THE NOBLE LIE. Rather than being told the plain truth, we are told what the authorities believe will lead us to behave properly, when 'properly' means not just in the way that is most prudent for ourselves, but what is seen to be morally appropriate. This means that whatever the truth about healthy drinking or drug taking is, we can't trust government health advice to provide it. When the best current scientific evidence meets moralising paternalism, it is truth that starts to bend.
Julian Baggini, *Guardian*, 3 August

NO QUICK FIX

We need to rethink our relationship with pain, says **Dr Simone Yule**

It's becoming a well-told and oft-repeated story: a patient that either had an accident or injury or a major illness is started on high dose opioids for pain relief in hospital, and is discharged with a prescription of something like the highly addictive liquid oramorph. They are offered little explanation of how to treat this drug and then have an expectation that they need it and will be prescribed it until the pain stops.

Because of how opioids work, the body builds up a tolerance and if the prescription does not facilitate that pain relief then patients will take more and more to reach the same level of relief. This can then result in patients seeking the medication through alternative sources such as buying illicitly or online. Wherever there is demand, there is supply.

Unless we rethink how we tackle pain management and pain relief we will hear this narrative more and more. It has become a regular story in my work with Action on Addiction, with the number of patients at our treatment centre seeking help from prescription medication addiction now matching those seeking help from illicit drugs.

This is not one person's fault – not the surgeon, the GP, the patient, the outpatient care nor the treatment centres. But every part of this chain needs to come together to create a healthy and holistic solution to pain management that quickly gets patients off drugs and back to living a realistic pain-managed life.

DRUG EDUCATION

We have seen many more patients, particularly orthopaedic patients, prescribed high-dose opioids such as the fast-acting liquid oramorph, with no clear guidance of how long they should be on this medication and no clear understanding of what it does and how powerful it is. In my experience, patients are often discharged with a significant amount of medication and no direction given to the primary care team as to what the ongoing treatment plan is.

We need better education for the patient, and better planning and communication between hospitals and the primary care team regarding the patient's discharge, so the whole team including the patient are part of the process and understand the required outcome.

PRESCRIPTION MANAGEMENT

GPs could improve methods for policing repeat prescriptions. In our surgery group we have strict monitoring of opioid prescriptions and we now have a warning on our computer, for anybody on a long-term prescription to be reviewed.

I saw a patient recently who had previously suffered a major road traffic accident and was quite debilitated and on high-dose opioids. It was highlighted that he was requesting more than he should be, so I brought him in. It turned out that he was desperate to get off medication, but because he had not had the support from physiotherapy and the rehab service following his accident, he had no alternative other than to continue taking painkillers. Without a warning system it could have been many more months of repeat prescriptions before his desperate situation was clinically managed.

BETTER ACCESS TO REHABILITATION

I fully believe in the holistic approach to pain management. The drugs are a quick fix and should only be used in the immediate aftermath of an accident or illness. I think true rehab, where you are looking at the psychological aspects and physical rehabilitation to manage and help alleviate the pain, is not nearly accessible enough.

I have one patient, in significant pain, who has to travel 25 miles to their nearest rehab centre. Taking the time and considerable effort to make that journey once a week for him was not possible and so his recovery time extended, meaning his time on high dose painkillers also extended. In some parts of Britain the distance is much further than 25 miles.

'The number of patients at our treatment centre seeking help from prescription medication addiction now match those seeking help from illicit drugs.'

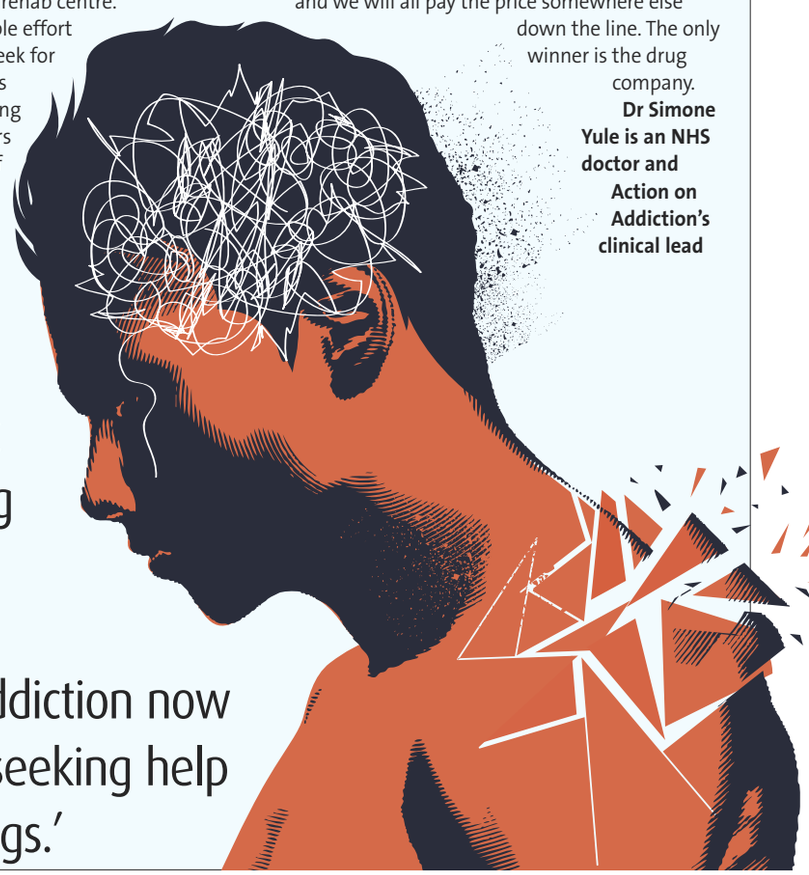
DE-STIGMATISING TREATMENT

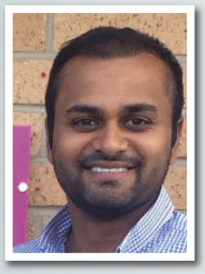
There is still a public perception that drug treatment centres are for illicit drug addiction and somehow patients should be able to come off prescribed drugs without help. We need a lot more publicity about prescribed medication treatment and how you can access it, and the long-term benefits of seeking this treatment.

At Clouds House, the treatment centre run by Action on Addiction, we are seeing considerably more people coming in addicted to not only opioids, but drugs like pregabalin, a prescribed non-opiate medication. The fortunate ones who seek help, or are guided to that help by a GP or family member, come to realise that this addiction is serious but with the right treatment it can be overcome.

Obviously, to create healthier planning around pain management, making it accessible for all patients, requires funding. The pressure to discharge patients quickly, to reduce waiting times in GP clinics and to cut outpatient services, all means we reach for the quick fix and we will all pay the price somewhere else down the line. The only winner is the drug company.

Dr Simone Yule is an NHS doctor and Action on Addiction's clinical lead





Treating people as individuals, coupled with genuine multi-agency working, is the key to addressing problematic synthetic cannabinoid use, says **Minesh Patel**

THE PERSONALISED APPROACH

THE USE OF SYNTHETIC CANNABINOIDS HAS BECOME A VISIBLE PROBLEM in many town centres, as their side effects – which can include confusion, dizziness and loss of muscle control – are often more noticeable than those of other substances.

Synthetic cannabinoids are having the most severe impact among individuals with multiple vulnerabilities, particularly rough sleepers. Synthetic cannabinoid mixes are cheap, strong and readily available – commonly referred to as 'Spice' or 'Mamba', these names point to a range of mixes with different chemical concentrations and markedly different side effects.

In late 2017, visible synthetic cannabinoid use in the town centre of Worksop, Nottinghamshire led to serious concerns being raised by elected council members, shopkeepers and others. Increased levels of anti-social behaviour and crime were being linked to synthetic cannabinoids and the result was a call for a multi-agency response, funded by Bassetlaw District Council and the office of the Nottinghamshire police and crime commissioner (PCC). This multi-agency project came to be known as Project Steppingstones.

Project Steppingstones started with a process to identify the individuals in most need of support. Information gathering was co-ordinated by Bassetlaw DC with support from Change Grow Live (CGL), the social care team at Nottinghamshire County Council, the police, probation services, DWP and local NHS mental health teams. Secure protocols for information sharing were put in place, and 40 people with longstanding connections to Worksop were identified – all 40 were displaying signs of problematic Spice use, and some were sleeping rough.

Bassetlaw DC then constructed detailed profiles of the 40 individuals, which highlighted multiple long-term vulnerabilities including repetitive low level offending and antisocial behaviour, as well as physical and mental trauma often linked to childhood experiences. These profiles would form the basis of an individualised programme of support.

The aim of the project was clearly defined from the outset – to support the identified cohort to make positive changes in their lives by reducing their substance misuse, improving their mental

Adfam and London Friend are offering much-needed support to families whose loved ones are experiencing chemsex addiction, as **Robert Stebbings** explains

PERFECT PARTNERS

AN INNOVATIVE NEW PROJECT FROM LONDON FRIEND AND ADFAM is piloting support for families, partners and friends of people that are engaging problematically in chemsex. Three new face-to-face support groups are starting this month in London, while an online information resource will soon be available and free to download.

Chemsex is the use of drugs during sex to enhance an uninhibited experience. It predominantly takes place between men in the gay community and the drugs typically involved are methamphetamine, mephedrone and GHB/GBL. Sometimes the drugs are injected, known as 'slamming'.

It can encourage risky behaviours such as condomless sex and sharing needles, putting people in danger of HIV or other sexually transmitted infections. There is also the evident risk of drug use combined with sexual activity reducing people's ability to keep themselves safe, while there is also the significant risk of overdose when using GHB.

Supporting a friend, partner, or family member affected by problematic alcohol or drug use can be difficult, including when a loved one is engaging in chemsex. It can have a hugely detrimental impact on the wellbeing of affected others, whether that's families, partners or friends.

London Friend's drug and alcohol service Antidote already provides lots of support for chemsex users but there has been no support for partners, friends or family who are affected by their using. Although family support groups exist, they are not generally LGBT specific, and people attending may not feel comfortable talking about a same-sex partner, or about sensitive issues such as chemsex. People often become increasingly isolated, with nowhere to turn.

> People may not feel comfortable talking about a same-sex partner, or about sensitive issues such as chemsex

This important intervention will provide those affected with the specific support they need and the space to meet and share with others affected by this issue, who can properly associate with what they are going through.

To achieve this we are piloting three different groups: a weekly group for parents (six weeks); a weekly group for friends/partners (six weeks); and a monthly informal drop-in (four sessions). All sessions are hosted by London Friend at 86 Caledonian Road, King's Cross, London N1 9DN.

If you are based in or close to London and interested in attending one of these groups and would like to find out more, visit our website: www.adfam.org.uk/our-work/supporting-families/chemsex or get in touch with Jason@londonfriend.org.uk.

Robert Stebbings is policy and communications assistant at Adfam

health and reducing their offending behaviour. Key to this would be treating people as individuals, not as a problem group. According to Gerald Connor, community safety officer at Bassetlaw DC, 'the idea was meeting people where they are – wherever they live, socialise and interact with their friends and community. The approach was then to build trust and relationships by showing an individual that they matter.'

It was immediately apparent that providing people with a place to live would be critical to achieving success. For those living on the streets in and around Worksop, easy access to Spice – driven by aggressive drug dealers – undermined all serious efforts to reduce its use, and the most meaningful conversations and care planning initially took place with individuals serving custodial sentences.

Many individuals had been excluded from local authority housing, but it was clear that independent tenancies would not offer sufficient support. In response, a progression pathway was developed – Project Steppingstones would help people to move into supported accommodation, then transition accommodation and finally into an independent tenancy.

To support individuals on this journey, everyone would receive a mental and physical health assessment and care plan, together with specialist substance misuse support from CGL and life-skills training from adult social care professionals, focusing on independent living.

Pictured, from left: David Price (recovery co-ordinator, CGL Nottinghamshire), Minesh Patel (services manager, CGL Nottinghamshire), and Gerald Connor (community safety and safeguarding manager, Bassetlaw District Council).

According to Minesh Patel, services manager for CGL in Nottinghamshire, 'partnership played a central role in resourcing this project, as well as enabling effective sharing of information'. High-level discussions facilitated by the Bassetlaw CCG and involving Nottinghamshire County Council directors of public health and social care focussed on ensuring accessible thresholds for adult social care services. A community psychiatric nurse and support worker were also seconded to the project, and one-bedroom local authority housing stock was set aside for supported accommodation.

Of the initial cohort, 18 individuals are currently in supported accommodation, and two have transitioned from supported accommodation to full independent living – one of whom is currently in employment. This client has emphasised the importance of intensive support and counselling: 'In 11 years I've not had the help I've had over the last four months, and that has meant I've gone from taking a large amount of drugs daily and living under a bridge cold, wet and hungry – not to mention in despair – to being in my own place, drug-free, in full time employment and having hope.'

All agencies working on the project remain ambitious for the remaining cohort not yet in supported accommodation. 'It's early days and we're not resting on our laurels,' says Gerald Connor. 'We are seeing a difference on our streets and with the clients, but it's a slow, steady journey.' Twenty-two people are currently receiving specialist substance misuse support with a view to moving into supported accommodation, and among this group there are high levels of engagement with mental health and adult social services.

There are continuing challenges, in particular ensuring the right accommodation is available at the right time. However, after eight months Project Steppingstones has demonstrated that hope can be brought to the most vulnerable populations when multiple agencies work together to provide holistic, non-judgemental support.

Minesh Patel is services manager at CGL Nottinghamshire

A new e-learning module and web chat facility will boost support for over-50s experiencing issues around problem drinking, says **Julie Breslin**

AGE-SPECIFIC ADVICE

DRINK WISE, AGE WELL is a National Lottery funded programme led by Addaction that helps the over-50s make healthier choices about alcohol. We offer face-to-face support in five areas of the UK, and collect evidence to inform future prevention work.

However, our digital offer has now been enhanced with the addition of a web chat facility at https://drinkwiseagewell.org.uk/webchat/, and we have also made a short e-learning module available to help anyone who works – or comes into contact – with older people to help them recognise and respond to alcohol harm: https://drinkwiseagewell.org.uk/e-learning/

The interactive module is designed to help people respond in a way that is supportive and non-judgemental and takes around an hour to complete, making it convenient for practitioners and frontline staff such as social workers and housing officers, as well as carers and family members.

The web chat facility, meanwhile, means that people over 50 who are worried about their drinking can get personal support and confidential advice from professionals trained to help older adults, and at a time that suits them.

The UK is currently experiencing a generational shift in alcohol use, with harmful drinking declining in every age group except the over-50s. The reasons for this are complex, but an ageing population having grown up in a culture of drinking is part of it, as is use of alcohol to cope with later life transitions.

A major study for Drink Wise, Age Well showed that approximately one in three older adults with an alcohol problem developed it later in life, with 40 per cent saying it was due to retirement and 26 per cent citing bereavement. A further 20 per cent say they are drinking more now than in the past due to losing a sense of purpose.

Above: Drink Wise Age Well, web chat professional advisers at work in their Glasgow base

A more recent study also showed that health practitioners were reluctant to intervene and help older drinkers because older adults were 'too old to change', or simply because they didn't want to deny them a pleasure they had grown used to. The number of people at risk from poor physical and mental health in later life as a result of their drinking means this cannot continue.

Julie Breslin is head of Drink Wise, Age Well

IN SAFER HANDS?

When should the Mental Capacity Act be used to make decisions on behalf of vulnerable people? **Mike Ward** unpicks a complicated issue

In my June article (*DDN*, June, page 23) I highlighted how the UK's Mental Health Act poses problems when managing high-impact and change-resistant dependent drinkers. However, the piece of legislation which more commonly causes problems is the Mental Capacity Act (2005).

Let's start with a real-life case.

Joe is a 55-year-old man who is chronically dependent on alcohol. He lives in a small housing association flat. His drinking is a problem, but the real concern is that drinking 'friends' are entering his flat and causing a nuisance. This causes worry to neighbours and landlords. In addition, Joe appears to be giving them money, alcohol and even his belongings. He has been warned about allowing these people into his flat, and he has spoken in his more sober moments about his desire and intention to stop it happening. However, nothing has changed, and the landlords are serving him with eviction notices.

The Mental Capacity Act's primary purpose is to provide a legal framework for professionals acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. For example, can a paramedic take a resistant patient to hospital for treatment? Can a social worker manage the finances of someone with a learning difficulty?

The act is decision-specific: it does not enable professionals to make a general statement that someone lacks capacity (although this often happens). It only allows the worker to say that a person lacks the capacity to make this particular decision at this point in time. If an adult can be assessed as lacking the capacity to make a particular decision, professionals can take appropriate action in the best interests of the individual.

The act does apply to people with alcohol and drug problems; a person can be assessed as lacking capacity because of intoxication. However, the act suggests that if someone is likely to regain capacity in the near future, *ie* become more sober, then the capacity assessment should wait until that point, if possible. Herein lie the problems.

Alcohol Research UK has analysed 11 Safeguarding Adult Reviews published in 2017 which related to the deaths of people either with chronic alcohol problems or alcohol use surrounding their death. These reviews suggest that the understanding of the act is poor in general. However, more specific problems exist in relation to people with alcohol misuse. The application of the Mental Capacity Act was a concern in all 11 cases.

For example, a review from Waltham Forest highlights that:

'The Mental Capacity Act advises you need to wait until a person is sober before you think about capacity. However, when a person is a chronic alcohol user it could be argued that they are never sober. More so that their ability to reason about whether they want to stop drinking is significantly impaired due to the addictive nature of their alcohol use. Therefore, is someone who is a chronic alcohol user ever in a space where their addiction is not impacting on their ability to reason?'

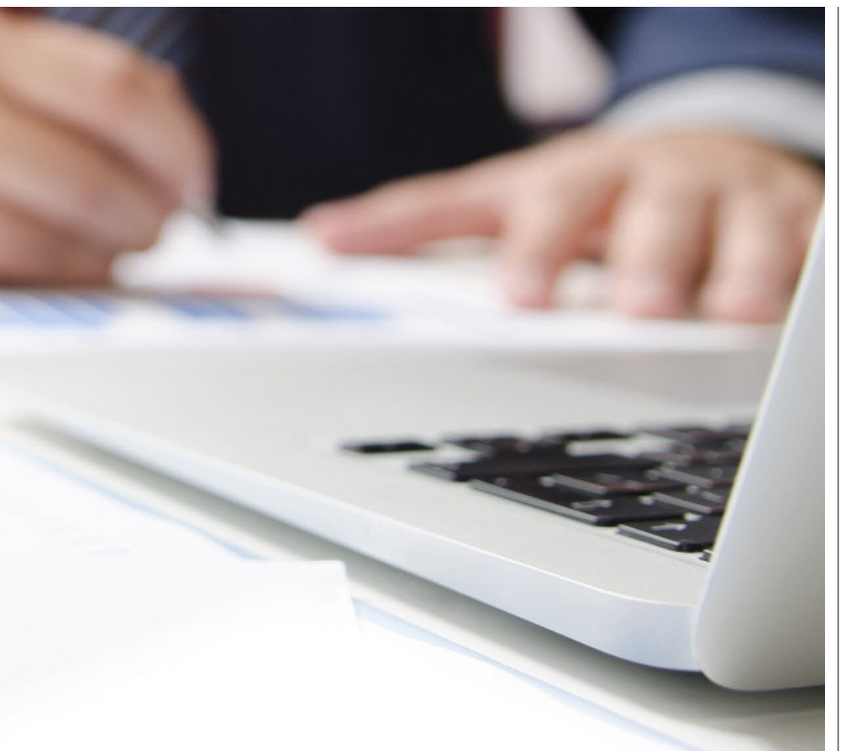
A review from Newcastle highlights that workers' attitudes can also impede capacity decisions:

'agencies... see Lee as more troublesome than troubled, a nuisance offender, an abuser of alcohol and drugs who chose a lifestyle that laid him open to risk. The fact that he did not have the mental capacity to make such choices was not recognised by some of the professionals who had contact with him.'

The biggest problem is that people like Joe continually move in and out of capacity due to their repeated intoxication: they have 'fluctuating capacity'. A more sober Joe will demonstrate that he understands the problem of allowing people to come into his property and wants to do something about it. Four hours later he will be drunk again and will do none of the things that he has discussed. Does he have the capacity to manage his property and prevent the potentially abusive behaviour of his 'friends'?

This is not merely an interesting legal debate – for people like Joe this can be a

More on mental health at www.drinkanddrugsnews.com



The act does apply to people with alcohol and drug problems; a person can be assessed as lacking capacity because of intoxication.

matter of life and death. The most crucial example of this is the review of the death of 'Carol', who was beaten to death by two teenage girls in Teesside. They were among a number of people who were regularly exploiting Carol's vulnerability and using her property through coercion.

The review into her death suggests that it is important to assess both decisional and executive capacity. This concept has been proposed by Braye, Orr and Preston-Shoot (2011). A person has decisional capacity when they can understand, retain, use and weigh up the information needed to make a decision. This is covered by the Mental Capacity Assessment outlined in the act. However, executive capacity is the ability for a person to actually carry out that decision, which can be impaired by alcohol misuse.

For an individual such as Carol or Joe, the assessment of executive capacity is unlikely to be straightforward. When more sober they may appear able to take rational decisions, but repeated history shows they are never able to put these decisions into effect. Do they have the executive capacity to manage situations, for example where unwanted people are entering their property?

In part, the problems highlighted here are about training and understanding. Every local authority area in the country should be bringing professionals together to ensure a shared understanding of how the act applies to people with alcohol and drug problems. However, the notion of executive capacity is not mentioned in the act. There is a need to consider new guidance on the act, or even revised legislation, if we are going to protect some of the most vulnerable people in our communities.

Mike Ward is senior consultant for the charity formed by the merger of Alcohol Concern and Alcohol Research UK, www.alcoholresearchuk.org. His next article will look at criminal behaviour orders.

CLINICAL EYE

A SENSE OF PURPOSE

Nurses have to be resilient in the most difficult situations, says **Ishbel Straker**

IN LATE JUNE, a children's nurse was arrested in connection with 17 neonatal deaths and 15 collapses between March 2015 and July 2016. These incidents occurred at a hospital in Chester – however, at the time of writing this column, the concern had also spread to her connection with another hospital.

When I heard about this tragic situation, my thoughts went to the parents of the babies and also to the staff who had worked with this nurse. Investigations are an unpleasant experience at the best of times for all involved – especially those who may have blown the actual whistle in the first place, suspected for some time that conduct was questionable, and had done their best to support before realising they were left with no choice.

'We have an obligation – one that, if we don't fulfil, can also result in our own conduct coming into question'

A close family member has recently qualified as a nurse. She made the decision to go into the profession because of her caring nature and practical spirit.

Yet I fear this is being significantly damaged by repeated poor practice that she is having to witness, and her attempts to support and gently report to her line manager to no avail.

We have spent time discussing at what point this may become a whistleblowing situation and I can see her sadness at this seemingly fast approaching reality.

We have talked about this not being the reason she went into nursing, and her disappointment at not being free to get on and look after her patients because she is dealing with so many other issues.

After a period of reflection, I have come to the realisation that part of being a nurse is to maintain a professional standard and yes, when our colleagues let us down that is incredibly frustrating. Yet it still remains our duty to elevate this standard in whatever way we can. The Nursing and Midwifery Council (NMC) tells us this is our duty according to the Code and so we have an obligation – one that, if we don't fulfil, can also result in our own conduct coming into question.

This is a heavy weight for a professional to carry and one that our colleagues in the field, who may not be nurses, need to recognise. When it looks like we are being finicky or difficult, they need to realise we have a duty that we are registered to fulfil.

Ishbel Straker is a clinical director, registered mental health nurse, independent nurse prescriber and board member of IntNSA

More guidance on CQC at:
www.drinkanddrugsnews.com

David Finney gives his guide to understanding the next phase of CQC Inspection

IN SEARCH OF EXCELLENCE

The Care Quality Commission (CQC) has begun a new phase of inspections, where the legal authority to award ratings to providers of substance misuse treatment services will come into effect. Also, some of the lessons learned will begin to impact upon the knowledge bank which inspectors are accumulating.

These ratings, once awarded, have to be published and displayed, according to the regulations – so there will be no hiding place if your service is failing in any way. Commissioners and people who wish to use your service will definitely be able to find out how you have fared.

Most providers honestly believe that their service is a good one, but I believe that many are providing an outstanding service – they just don't realise this or give it that name. The question is, can you convince CQC that a service is good, or even outstanding?

First of all, ensure that all the basics are in place. There is no point in trying to highlight some excellent practice if matters such as health and safety, staff training and supervision, medication administration, quality assurance, governance arrangements etc are not being well run.

Secondly, look to the NICE guidance which is relevant. This will be a secondary document that CQC will refer to when assessing practice. This is especially important for detoxification services.

Thirdly, examine the CQC rating characteristics listed in their methodology, (otherwise known as the Key Lines of Enquiry). When you write the pre-inspection material required from you by CQC, directly refer to their own criteria. This is a chance to shine and highlight what is outstanding about your service.

Fourthly, look at other CQC inspection reports to see what has already been identified as good practice and ask whether CQC would find that in your service or not. If not, is there any way that it could become part of your practice?

Meanwhile, these are some of the areas that may demonstrate good practice:

UNDERSTANDING RISK

CQC criteria are that risks are proactively anticipated and that service users are actively involved in managing their risks. Good recovery involves people building and owning their resilience to maintain sobriety or whatever goals they have chosen. To do this, an awareness of risk and an ability to personally own the strategies to overcome their risk factors are vitally important and could be demonstrated through documents as well as conversation with service users.

DEVELOPING STAFF SKILLS AND KNOWLEDGE

CQC criteria involve the continuing development of staff skills, competence and knowledge alongside proactively supporting staff to acquire new skills, use transferable skills and share best practice. There are examples of opportunities to share best practice in staff briefings, and skill development is actively encouraged through clinical supervision and in-house workshops. Also, many services actively encourage external training and development.

ACCESS TO SUPPORT NETWORKS IN THE COMMUNITY IS ACTIVELY ENCOURAGED

Many services offer regular opportunities to be involved in AA, NA, Smart Recovery etc, as well as their own after-care, which offer ongoing community-based support.

> 'Most providers honestly believe that their service is a good one... many are providing an out-standing service – they just don't realise this or give it that name.'

INTEGRATED PERSON-CENTRED PATHWAYS OF CARE

Many treatment services effectively combine the wide-ranging complex needs of their clients in one integrated care plan, which enables people to understand and build their own recovery.

LEADERSHIP

This is a crucial domain for CQC, so demonstrating that staff are passionately motivated in their work and that there are robust quality assurance processes in place will score highly.

There are many more examples to explore further. Our conference in October will seek to discuss ways to prepare for the next phase of inspection. (See advert on the inside front cover of this issue.) We hope that there will be a representative from CQC present alongside other key professionals to assist us.

David Finney is an independent social care consultant who has worked with government inspection bodies

In brief, the ratings that could be awarded are:

OUTSTANDING
This is where a service is seen to go the extra mile, providing something above and beyond the usual standard of service.

GOOD
This is the expected outcome, where everything about the service works OK.

REQUIRES IMPROVEMENT
This means that some elements of the service are below standard.

INADEQUATE
This means there are many failings.

More personal stories at www.drinkanddrugsnews.com

This year's entries to the Recovery Street Film Festival were all winners in bringing powerful personal stories to the screen. **DDN** reports

MOVING PICTURES

'Discrimination is fuelled by ignorance. We hope the festival is part of the solution'

Eleanor is funny and engaging. As she takes to the stage to introduce the Recovery Film Festival awards, she takes us back four years to her life as a 'recovering alcoholic'.

'I came through the 12-step rooms and I felt very lost and hopeless,' she said. 'I couldn't manage the world. I had a high ego but a very low ego at the same time. The only skills I knew were how to get drunk and find drugs. Recovery has helped me find other skills.'

The film festival was 'a voice, a network', she said. It gave the opportunity to work on something consistently – 'and consistency is important to someone like me.'

For those who had put their work 'out there' through making a film, 'it's scary', she said. But committing a personal story to film was extremely powerful as people embraced vulnerability and began to understand what was going on underneath.

'You're all winners,' she added. 'Those stories will help people.'

'My family was soaked in booze – so I escaped to the film industry, which was also soaked in booze. Great literature and great films come from a place of struggle,' said Jason Flemyng, the *Lock, Stock and Two Smoking Barrels* actor, as he presented awards to the winning film-makers. The theme this year was 'My Lightbulb Moment' and entrants were invited to explore what inspired them to change and embark on a recovery journey.

Flemyng announced that third-placed winner was Jeremiah Quinn's film *The Underpass*, in which Darren's words of advice from a friend, as they lie drinking and drug-taking in an under-pass, send him home to change his life.

Second place went to *Karen's Story*, which gives touching emotional insight into what her recovery journey means to her and her family.

And in first place, *Understanding Me* gave Ceri's story, an unflinching account of her turmoil growing up as the child of an alcohol-addicted mother. As a mum herself, she reflects on her resolve not to let the past define her and to be the best parent she can to her two young children.

'It was only after getting involved in NACOA [National Association for Children of Alcoholics] that I realised that being a child of an alcoholic was a "thing",' Ceri told *DDN*. I had been trying to change myself for so many years, but now I know that it's ok. All the time I was hearing about cycles. I needed to hear that I didn't have to repeat them, and could be confident in my parenting.

'My mum died in 2003 but after my son was born the grief returned. I had two young children who were healthy and happy, and it was only my inner voice that was stopping me. The film was the next stage in helping me and this was also what I wanted to give my mum.'

As well as inspiring many people with their recovery, the festival had another vital role in confronting the stigma of addiction, said James Armstrong of Phoenix Futures, one of the festival's organising partners.

'Discrimination is fuelled by ignorance. We hope the festival is part of the solution, bringing people together to learn through film.'

The Recovery Street Film Festival website is at www.rsff.co.uk

Watch all of the shortlisted films at the RSFF YouTube channel: https://bit.ly/2Nh1vKY

Peer-to-peer naloxone initiatives are proving an effective way to tackle overdose risk. **Lee Collingham** describes how SCUF are grasping the opportunity in Nottingham

HEIGHT OF AWARENESS

The latest release of worsening statistics has kept drug-related deaths (DRDs) at the forefront of everyone's mind, whether treatment providers, family members, friends or peers.

In May Nottingham's user-led campaign group, SCUF, was approached by the European Network of People who Use Drugs (EuroNPUD) to discuss the possibility of a partnership. The suggestion was to work together for a three-month period to promote peer-to-peer distribution of naloxone.

The initiative started on International Remembrance Day on 21 July, when drug using communities across the world come together to remember those we've lost during the year and highlight the war on drugs – especially with budget cuts and services being decommissioned.

Local service users came together for action, and through working with neighbouring specialist support services, the P2POD (Peer to Peer Overdose) group was formed. We have the firm belief that it will be beneficial to all in reducing the unnecessary deaths of our friends and peers by ensuring all users, as well as their families and carers, have access to naloxone – the drug that temporarily reverses the effects of opioid overdose and buys time for medical professionals like the ambulance service to arrive.

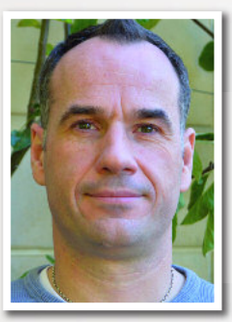
A lack of knowledge around naloxone has meant that there has often been confrontation when the ambulance arrives, and we believe by informing service users properly we can avoid this.

P2POD group have met a number of times this year. We arranged events for International Remembrance Day on 21 July and Overdose Awareness Day on 31 August, as well as organising naloxone training for our local harm reduction week at the end of August. We have been able to raise awareness, distribute naloxone to peers, and cement future working relationships for peer-to-peer distribution of naloxone in Nottingham. This also demonstrated once again how important engaging with service users is to the success of any project and the annual release of DRD figures only cemented the group's commitment.

Local service providers and commissioners came along to the events, where service users were trained in basic overdose response. Participants were shown how to administer naloxone by one of their peers and issued with a naloxone kit before leaving, and were told exactly what happens when it is administered. It's our firm belief that if people understand what's going on, and that it momentarily reverses an overdose, they are less likely to hit out at the person administering it. This information also prevents the person from running off to score again, only to collapse as the effects of the naloxone wear off.

We are grateful to the team at EuroNPUD and local service providers, not only for their support, but for backing the possibility of peer-to-peer distribution of naloxone in Nottingham.

> 'A lack of knowledge around naloxone has meant that there has often been confrontation when the ambulance arrives'



Mat Southwell shares EuroNPUD's strategy to spread the initiatives far and wide

PEER TO PEER

The European Network of People who Use Drugs (EuroNPUD) has undertaken a project to understand barriers to accessing naloxone in the UK. The project has been funded by an unrestricted educational grant from Martindale Pharma, which has also enabled us to explore peer to peer overdose prevention training and naloxone supply.

We began by selecting three areas with at least twice the average number of opioid overdoses and where we have strong local peer partners – Liverpool, Burnley and Blackpool. The partners in these areas initially undertook a mapping exercise identifying local planners, service providers and community stakeholders.

EuroNPUD and our local peer partners then ran a focus group in August, with eight to ten local community stakeholders in each area. This involved a range of drug users and family members with different experiences of drug use and drug services. We also trained the local peers to deliver a mystery shopper activity, testing access to naloxone for drug users and family members.

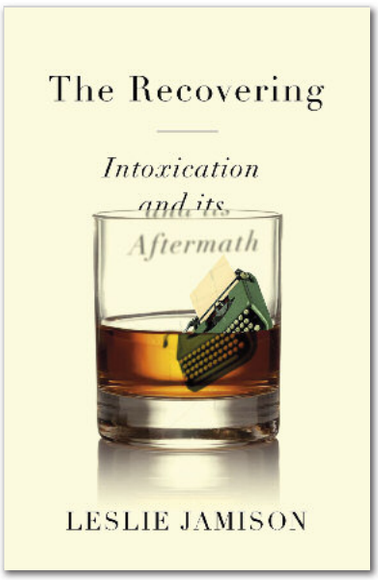
Drawing on case studies from London and Glasgow in the UK, Kachin in Myanmar, Minnesota in the USA, and Canberra in Australia, EuroNPUD has researched and written a technical briefing on the peer-to-peer distribution of naloxone. This gave examples of drug users distributing naloxone to their peers and shared good practice tips from the peer experts that have been interviewed for the project.

The peer-to-peer technical briefing provided the focus for a second local event in on 31 August, International Overdose Awareness Day – a lunchtime briefing that targeted peers, families and professional

partners. Its purpose was to engage stakeholders in hearing the findings on local drug users' assessment of access to naloxone. This also supported an advocacy planning exercise to design a peer-led advocacy initiative, which has been backed up with a £1,000 local advocacy grant.

The EuroNPUD project team has also produced a report describing the methodology and learning, launched at a media event alongside the naloxone technical briefing, where peer experts from across the UK showcased peer-to-peer distribution of naloxone. We are now producing an open source standard toolkit, supporting the delivery of this activity in other areas or national settings.

THE DARKEST MUSE



Leslie Jamison's book 'The Recovering' prompts **Mark Reid** to explore the relationship between writers and their addiction

This is a thorough evaluation of alcohol addiction and recovering, and their relation to writers. Jamison is an American academic who is in recovery. She did much of her drinking in Iowa City, where it seemed alcohol could be a creative muse; a 'proof of wisdom'. Authors, including John Berryman and Raymond Carver, appeared to have built a literary tradition which amalgamated alcoholism and profundity. For a while, Jamison drank to this lineage which went back to Jack London and his 1913 novel *John Barleycorn*. London saw a 'white light' in alcohol granting access to truths.

A 1967 edition of *Life* magazine glorified the poet, Berryman, who wrote *The Dream Songs*. The piece began: 'Whisky and ink. These are the fluids he needs to describe his penetrating awareness of the fact of human mortality'. (In the end, he committed suicide by jumping off a river bridge.)

For now, *Life* put Berryman on a pedestal: 'Apart from a compulsion to take home a bottle of whiskey every night, he has a true intellectual's indifference to material things.' With his analyst (to whom he owed money) the poet worried that solving his emotional issues would curb his imagination. Away from the hype, Berryman was a standard issue drunk, typified by low self-esteem: he rang his students in the middle of the night, worse for wear, to check he'd been 'brilliant' in his lecture the morning before.

The narrative that alcohol lets writers see the otherwise invisible was knocked down in 1944 with Charles Jackson's *The Lost Weekend*. The plot is summed up by Jamison: 'a guy named Don Birnam gets drunk. Don isn't broken by the fallen world, or the horrors of war, or the cruelties of love. There's no emotional suspense, his drinking was nothing'.

Among the protagonist's prospective titles for the book he, in turn, is trying to write, is 'I don't know why I'm telling you this'. *The Lost Weekend* is the dull truth about drinking. Jackson went on to have many more lost weekends himself, realising that writing a bestselling book was a way of being his 'own hero': 'too self-absorbed, too self-infatuated... I drank'.

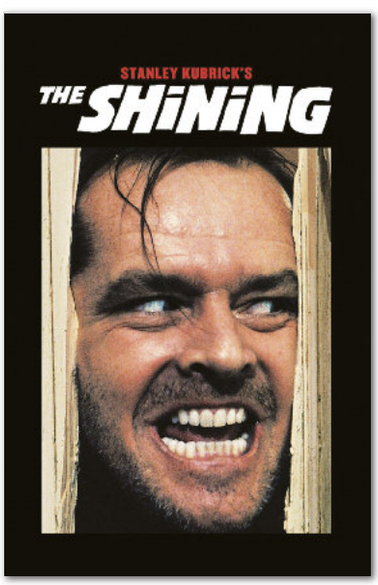
His on-off relationship with Alcoholics Anonymous is a very clear example of how a writer can get confused in recovery. Sometimes he liked AA's call to humility, ordinariness and getting outside himself. He also felt AA would 'flatten him out' in years of 'empty wellbeing and blank sobriety'. When *Life* magazine looked to profile Jackson, they loved the road to ruin part, but the solution bit was too tepid. The pieces didn't run.

Billy Wilder's 1945 film version of *The Lost Weekend* won four Oscars, including Best Screenplay. Critics hailed its portrayal of alcoholism as 'uncompromising'. In fact, the film did compromise the ending of the novel, which pointed to the main character drinking himself to death. (Jackson himself committed suicide from an overdose of barbiturates.) The Hollywood 'happy' ending finds a sudden belief that the love of a girlfriend, and a desire to write about his bad experiences, could stop a drunk from drinking. As Wilder put it: 'If he can lick his illness long enough to put some words on paper, there must be hope.'

Women writers who drink, argues Jamison, do not fit into the male club. Jean Rhys 'deforms the icon of the drunk genius' in *Good Morning, Midnight*. Desperate female characters who stand accused of abandoning their gender roles as carers for others, 'take cheap rooms in dead-end streets'. They cry their tears of self-pity in public. Long after Rhys went missing presumed dead (from drink), she resurfaced in her mid-seventies with *Wide Sargasso Sea* – a classic work, irrespective of her alcoholism.

Raymond Carver was bounced into a vigorous lifestyle by recovery, and his writing was resuscitated. He said his later poetry was 'tied up with feelings of self-worth, since I quit drinking' (There were battles, though, with his editor who wanted to keep things bleak, and pruned Carver's words by almost half).

Jamison is inspired by 'Carver, pounding at his typewriter at home, and facing the wind in his sailboat, catching big fish under bigger skies'.



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'I have a thing / for this cold swift water

just looking at it makes my blood run/

and my skin tingle'.

Carver found himself 'loving everything that increases me'. And many in recovery will identify with losing (and finding) themselves in the power and beauty of nature; in Carver's 'open spaces'. The great outdoors contrast with the claustrophobic demands of drinking, in sordid places or isolation. Jamison describes alcoholism as 'making the world small, the narrowing "this, only this".'

So, there can be uplift in writing from recovery – a lens of creativity alcohol insidiously suggests, but cannot provide. One note of caution to Carver's optimism. Proof of Leslie Jamison's talent as an essayist comes in a brilliant piece on the ex-drinker writer Stephen King – his monstrous dry-drunk, in *The Shining* endlessly writes 'all work and no play makes Jack a dull boy'. The character may be abstinent, but he's not happy and can't express himself. He concocts a binge and an axe-wielding rampage.

If you are keeping a recovery journal, try to enjoy it.

The Recovering – Intoxication and its Aftermath, by Leslie Jamison; published in April 2018 by Granta, ISBN 9780316259613.

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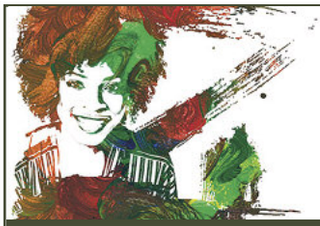

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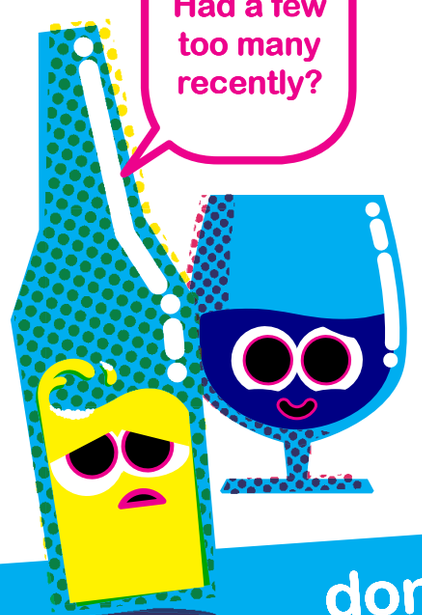

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