DDN

Drink and Drugs News
Dec 2019-Jan 2020
ISSN 1755-6236

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County lines, funding fears and more record drug deaths

SHUTTING UP SHOP
Residential services reach crisis point

A DIFFERENT PERSPECTIVE

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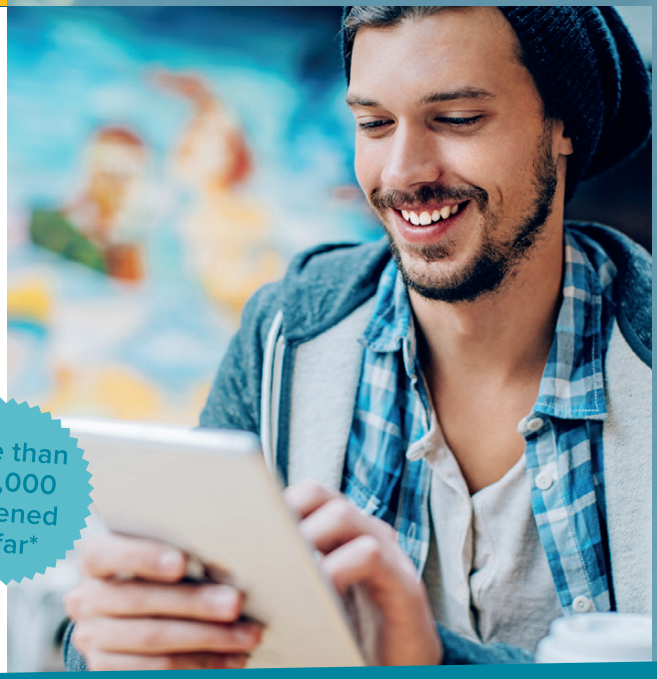
DIGGING DEEP AT THIS YEAR'S HIT HOT TOPICS

PLUS – What's it really like to spend Christmas in rehab?



DDN

Drink and Drugs News is published by **CJ Wellings Ltd**, Romney House, School Road, Ashford, Kent TN27 0LT
t: 0845 299 3429

Editor: Claire Brown
e: claire@cjwellings.com

Advertising manager: Ian Ralph
e: ian@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

website:
www.drinkanddrugsnews.com

Website support by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover by Marstockphoto

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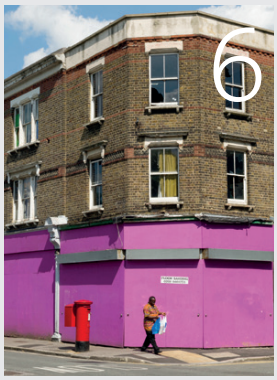


PROUD TO WORK IN PARTNERSHIP

'Choices are pleased to be a partner with DDN as the leading news source for this sector. We are hoping to be able to profile all our members in the coming year, so please watch this space!'

Hannah Shead, CEO of Trevi House

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.

'Connecting can revise our response to a world gone mad'

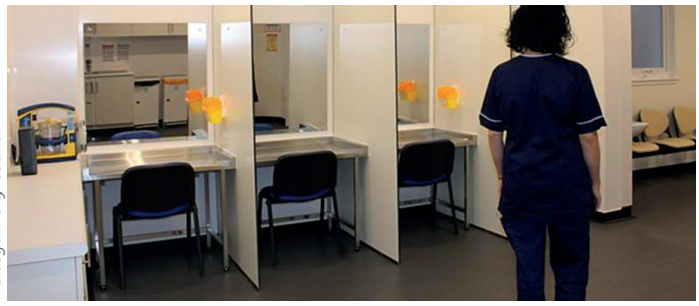
THIS MONTH'S ISSUE went to press on polling day, and we brace ourselves for the result. It brings to a close months of being pounded by the same rhetoric without much hope that our opinions count.

The HIT Hot Topics conference (page 8) is familiar with this sensation. Speakers travel across the world to share frustration at opportunities for harm reduction being squandered and governments driven by greed and ignorance. It would be easy for any one of us to think our voice didn't matter – but actually it does, how seemingly insignificant the context. Against a backdrop of world problems, ideas were sparked and it was heartening to realise that the thought of connecting – with ourselves and each other – can revise our response to a world gone mad.

There's plenty in this issue that we hope will connect with you, not least the deeply personal stories from those finding their way through prison and treatment. And in response to your requests for more information on problem gambling, we've compiled an in-depth guide (centre-page pull-out) to help you support anyone affected by this devastating addiction.

We hope you have the festive season you wish for and we'll see you back in print on 3 February. Please keep in touch!

Claire Brown, editor
Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine



Glasgow City Council

Heroin assisted treatment pilot launches in Glasgow

Scotland's first heroin-assisted treatment service has been launched in Glasgow, the city council has announced. The Enhanced Drug Treatment Service (EDTS) will treat people with the most severe, long-term and complex problems with 'pharmaceutical grade diamorphine'.

'This service is aimed at people with the most chaotic lifestyles and severe addictions who have not responded to existing treatments.'
Susanne Millar

The service is operated by the Glasgow City Health and Social Care Partnership (GCHSCP) and has been licensed by the Home Office. Based in the city centre alongside homeless health services, the aim of the project is to reduce rates of overdose and public injecting, as well as the spread of blood-borne viruses. Clients will receive treatment for other health conditions, and there will be a 'holistic assessment of their social, legal and psychological needs'.

The £1.2m service is expected to treat around 20 clients per day in its first year and 40 in year two. Clients will need to attend twice a day, seven days a week and be 'totally committed to the treatment', says the council. Injectable heroin-assisted treatment will be supervised by trained nursing staff and restricted to people who are already involved with the city's Homeless Addiction Team. While a pilot heroin-assisted treatment programme was recently launched in Middlesbrough (DDN, November, page 5), Glasgow's plans to establish a drug consumption room have long been stymied by the Home Office's refusal to change legislation to allow it, despite the backing of the Scottish Government.

'Sadly, Glasgow suffered a record number of drug-related deaths last year and there was also an increased number of non-fatal overdoses,' said interim GCHSCP chief officer Susanne Millar. 'This challenging social issue demands innovative treatments and this gold standard service is leading the way in Scotland. It is aimed at people with the most chaotic lifestyles and severe addictions who have not responded to existing treatments.'

The service will be evaluated by scientists from Glasgow Caledonian University, who will be based at the facility for two and a half years to study its implementation, collate the views of service users and staff and develop good practice guidance.

Drug misuse poisoning continues to rise

LAST YEAR saw more than 18,000 hospital admissions for poisoning by drug misuse in England, according to NHS Digital, an increase of 6 per cent on the previous year and 16 per cent since 2012-13. Admissions for drug-related mental and behavioural disorders fell by 14 per cent, however, to just over 7,300, although this is still 30 per cent higher than a decade ago.

Latest statistics from PHE show a 7 per cent reduction in the number of young people in contact with alcohol and drug services,

The latest statistics from PHE, meanwhile, show a 7 per cent reduction in the number of young people in contact with alcohol and drug services, to 14,485 – down 40 per cent from a decade ago. Almost 90 per cent of young people accessing treatment did so for cannabis, with 44 per cent for alcohol, 14 per cent for ecstasy and 10 per cent for powder cocaine. Less than 1 per cent sought treatment for opiates, although the number was up from 187 to 216 compared to the previous year.

Statistics on drug misuse, England, 2019 at digital.nhs.uk; Young people's substance misuse treatment statistics 2018 to 2019 at www.gov.uk

Cocaine seizures highest since records began

SEIZURES OF COCAINE in England and Wales are up 12 per cent compared to last year, according to Home Office figures, while seizures of crack increased by 20 per cent. More than 9,600kg of cocaine was seized in 2018-19, the largest quantity since records began in 1973, while the quantity of crack seized was the highest since 2004. The quantity of ecstasy seized was also the highest since 2006-07. Meanwhile, Europeans are spending at least EUR 30bn per year on drugs at retail level, according to an EMCDDA/Europol report. Almost 40 per cent of spending is on cannabis, just over 30 per cent on cocaine and a quarter on heroin. MDMA and amphetamines account for 5 per cent each.

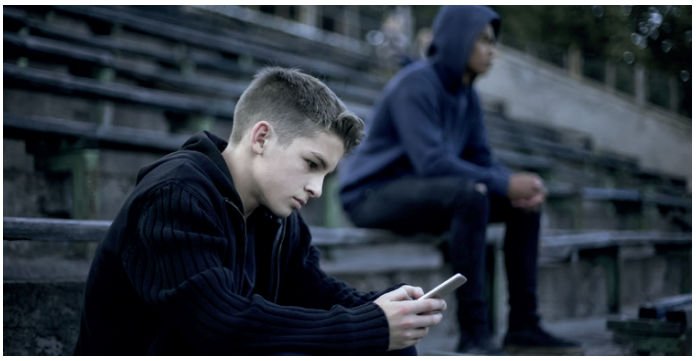
Seizures of drugs, England and Wales, financial year ending 2019 at www.gov.uk

EU drug markets report 2019 at www.emcdda.europa.eu

Alcohol deaths second highest since millennium

LAST YEAR saw 7,551 alcohol-specific deaths registered in the UK, according to ONS. While this was lower than the previous year's total of 7,697 it was still the second highest since the time series began in 2001. Alcohol-specific death rates remain almost double for men than women, and were highest among men aged 55-59. Scotland had the highest death rate, followed by Wales and England. The highest proportion of alcohol-specific deaths were the result of alcoholic liver disease.

Alcohol-specific deaths in the UK: registered in 2018 at www.ons.gov.uk



Motortion/iStock

Almost 70 per cent of 20-year-olds gamble

Sixty-eight per cent of 20-year-olds had participated in gambling in the last year, according to a study by GambleAware. While this fell slightly to 66 per cent for 24-year-olds, the study found that more than half of 17-year-olds had already gambled in the previous year.

To protect these vulnerable young people from gambling harm requires a combination of education, legislation and appropriate treatment services

The findings are part of an in-depth longitudinal study commissioned by the charity, which measures young people's gambling habits at 17, 20 and 24 years of age using samples of more than 3,500 for each group, as well as survey data and interviews with parents. Regular weekly gamblers were more likely to be male and had already 'developed habits and patterns of play' by the time they were 20, researchers found.

Young people whose parents gambled were more likely to gamble themselves, and regular gamblers were also found to be more frequent users of social media. Regular gamblers were also likely to have lower wellbeing scores, smoke cigarettes daily and drink more alcohol. Buying scratchcards, playing the lottery and placing private bets with friends were the most common forms of gambling behaviour overall, although levels of online betting activity rose sharply from 9 per cent at 17 to 35 per cent at 20 and almost 50 per cent by the age of 24.

'Although many young people gambled without any harm, a small minority of males showed problem gambling behaviours associated with poor mental health and wellbeing, involvement in crime, and potentially harmful use of drugs and alcohol,' said emeritus professor of child health at Bristol Medical School's Centre for Academic Child Health, Alan Emond. 'To protect these vulnerable young people from gambling harm requires a combination of education, legislation and appropriate treatment services.'

According to NHS Digital's latest *Health survey for England,* meanwhile, almost 40 per cent of adults said they had participated in some form of gambling activity during the last year, excluding the National Lottery. Fifteen per cent of men had taken part in online gambling, compared to 4 per cent of women.

Health survey for England 2018 at digital.nhs.uk

See centre pages for our supplement on gambling-related harm

Let's do this, says Hepatitis C Trust

URGENT SUPPORT IS NEEDED FOR SUBSTANCE MISUSE SERVICES to deliver hepatitis C care, says the Hepatitis C Trust's manifesto, *Leave no one behind*. This should include 'immediate investment after years of funding cuts', it states. The manifesto also calls for changes in legislation to allow hep C medication to be dispensed by community services such as pharmacies, guidance to improve the system for transferring prisoners' care and a nationwide strategy to reach the estimated 100,000 people still living with hep C without knowing it. *Manifesto at www.hepctrust.org.uk*

Frontline staff need domestic abuse training

DISCUSSING ISSUES OF DOMESTIC VIOLENCE is a key skill for frontline staff and more work needs to be done to train professionals at substance misuse services, the government's domestic abuse commissioner Nicola Jacobs told delegates at Adfam's national conference. While the Domestic Abuse Bill had been delayed by the election, Ms Jacobs was hopeful that it would be passed in the new parliament as all parties had committed to it in their manifestos. The bill would improve understanding of what constitutes abuse and will encourage more victims to come forward, she stated.

womensaid.org.uk

More work needed to train professionals

Nicola Jacobs

Local News

LIT UP

The Blue Light Project in Sandwell has won the public health and wellbeing category of the Guardian Public Service awards. This follows an RSPH healthier lifestyles award for the project, which focuses on 'hard to reach' clients with co-occurring alcohol and mental health issues.

ASPIRE TO IT

Eight more people have graduated from Doncaster-based Aspire Drug and Alcohol Service's 15-week volunteer mentor programme. The skills they acquired would 'play a vital role in connecting and supporting people throughout their recovery journey', said Aspire volunteer and mentor coordinator Lydia Rice.

OUTSIDE IN

The Outside Edge theatre company is offering a limited number of free drama and creative writing 'taster sessions' in 2020. 'Participation in our workshops helps to build recovery capital by increasing self-esteem and confidence,' says the organisation. *For more information email Molly at admin@edgetc.org*

SHUTTING UP

The crisis in funding has dominated the sector for years, but with many big names now closing their doors the situation for residential facilities is reaching crisis point. **DDN** reports

It's more than two years since the ACMD declared that funding cuts were now the 'single biggest threat' to recovery outcomes (*DDN*, October 2017, page 4) – two years in which drug-related death rates have continued to rise. Residential rehab facilities have been particularly hard-hit. According to the latest PHE figures while the number of adults entering treatment in 2018-19 was up by 4 per cent on the previous year, the number receiving treatment in residential and inpatient settings has fallen to less than 17,000 from almost 26,000 in 2014-15.

This year had already seen the closure of City Roads (*DDN*, April, page 4) and Broadreach House (*DDN*, July/August, page 12) when Phoenix Futures' Grace House became the latest casualty. Rated outstanding by CQC, the specialist residential service provided 'trauma-informed' treatment for women with complex needs, many of whom had experienced domestic violence, homelessness or sexual exploitation.

Phoenix Futures chief executive Karen Biggs sees its closure as a 'bellwether of what's happening across the country', she tells *DDN*. 'An outstanding service that served a group who are acutely under-served – it demonstrates perfectly the lack of equality of access that people increasingly have to healthcare, certainly people who experience drug issues.'

While she's grateful to Grace House staff for being 'brilliant throughout' and the 46 local authorities that referred there, she believes the concept of a national health service is increasingly becoming a fallacy for some people. 'I don't say that lightly. Our analysis shows there's a huge discrepancy across the country. Funding cuts are obviously having an impact, and drug services aren't unique in that, but what I'm speaking out about is how in a localised framework it's increasingly evident that there's an inequality of access for any treatment, but particularly for residential'.

Hannah Shead, chief executive of Trevi House and chair of the Choices Rehabs group, agrees. 'Our group began six years ago and we've seen our membership decline at the same time as we've seen the need for our services increase. It's heartbreaking – we've got members saying they have people phoning them who are absolutely desperate but not able to secure the funding.'

Clearly, problems in the substance misuse client group are not limited to drugs and alcohol. According to PHE, a fifth of people entering treatment last year had problems with housing (rising to a third among those being treated for opiates), while more than half were struggling with mental health issues. A fifth of all people starting treatment were living with children, while 31 per cent were parents not living with their children (44 per cent among women in treatment for opiates). So while the argument is often made that residential services are closing because they're expensive, there's a stronger case that they're cost-effective.

> Phoenix Futures' Grace House has become the latest casualty. Rated outstanding by CQC, the specialist residential service provided 'trauma-informed' treatment for women with complex needs

'When we resource addiction services effectively we take the strain off other services like criminal justice and mental health,' says Hannah Shead. 'It's about vulnerable people – often trauma survivors – getting back on their feet and into society. If you take a wider perspective it's really good value for money.' Hospital admissions for these clients also invariably involve a detox, adds Karen Biggs. 'But the commissioners making decisions around cuts to treatment are not the same people footing the bill for a four grand detox.'

Another crucial issue is not just reluctance to fund but the process that vulnerable people may have to go through to get that funding, she stresses. 'Most decisions around rehab are now done through panels and for women trying to access Grace House that was a dehumanising process – to have to sit in front of a panel of professionals when you're in a really poor state of physical and mental health and try to argue why you're worthy of funding. That's not a national health system as most people expect it.' It's also discouraging some community services from putting people forward, she adds. 'They don't have the confidence that they're going to get the funding, and if they do it's only going to be for a limited time based on budgets rather than clinical assessment.

'I don't want this to turn into a "rehab is best" argument – we're way beyond that,' she continues. 'But there is a cohort of people, as all the evidence shows, who benefit from residential care. I get how hard it is for some local authorities, and there are pockets of excellence across the country. I also understand that when people are making day-to-day decisions they're not

Alex Macnaughton/Alamy

'We've got a number of asks, but the biggest is that we need some proper national leadership.' ***Karen Biggs***

'When we resource addiction services effectively we take the strain off other services like criminal justice and mental health.' ***Hannah Shead***

necessarily thinking it's going to result in another rehab closing. But I don't want a situation where the only way you can get residential rehab is to pay for it yourself, and increasingly we're getting to that point.'

Many services are having to be more creative, says Hannah Shead. 'We've sort of accepted that we're not going to be able to meet our running costs from local authorities so we've set up a bursary scheme, and I know other rehabs have done the same. The days of thinking we'll be able to keep going because we've got enough residents in are long gone.'

So what happens now? 'We've got a number of asks, but the biggest is that we need some proper national leadership,' says Karen Biggs. 'As a sector we're passionate and committed and we've got a really clear national and international evidence base. We just need some effective national leadership to pull all that experience and skill and energy together.'

That's not about moving policy to DHSC, as recent select committee reports have recommended, she says. 'For me what's going to make the difference is some form of engaged national leadership that can steer and direct at local level – when the decisions were made to lose that we were in a very different time. But we do have a public health emergency, and we do know how to respond to it. All the ingredients are there, we just need to pull that together.' **DDN**

Adult substance misuse treatment statistics 2018-19 at www.gov.uk
More on Choices Rehabs at www.choicesrehabs.com

POST-ITS FROM PRACTICE

ONE SMALL STEP

Every opportunity, however slight, can be an important healthcare moment, says **Dr Steve Brinksman**

Most of the work we do in primary care isn't treating acute illness, but managing those with long-term conditions. I – like most GPs – spend a lot of time trying to support patients to change behaviours that are, or may be, damaging to their health. This could be smoking cessation, dietary advice and exercise for diabetics, and of course helping those who are having problems with illicit drug or alcohol use.

Some colleagues tell me they are reluctant to work with this group as they feel success is unlikely and people will relapse back into problematic use. I have always found this attitude somewhat bewildering as I see at least as much resistance to change in all the other patient groups and I suspect it is another manifestation of the stigma that our cohort of patients face on a daily basis.

Almost 30 years as a GP has however taught me a number of things and I can now accept that some people won't change just because I want them to. The desire, and then the ability, to change comes from within an individual and is contingent on a whole range of factors in someone's life. Our role is to support and inform and help build self-esteem for our patients.

Successful change often isn't measured in big leaps and bounds but in small incremental improvements in people's lives and acknowledging this is important. It is also vital to never give up on someone – they may not be ready for change on the numerous occasions you meet over many years but then have the capacity to surprise.

> I can now accept that some people won't change just because I want them to.

An example was Rob. He had a 15-year history of problematic cocaine use, bouts of heavy binge drinking and daily cannabis use. I hadn't seen him for over a year and he came in looking the best I had seen him in a long time. He told me he had stopped his cocaine and alcohol use but still has the 'odd spliff'. I was delighted but also curious and asked him what had changed. He gave me a big smile and showed off his new dentures and said, 'I went to a dentist and he took my horrible teeth out and gave me these. Now when I go out, I don't think people are looking at me and judging me all the time.'

I hadn't realised what a negative effect his teeth were having on his self-esteem, but fortunately his dentist did! And because of that, he also treated Rob's problematic alcohol and cocaine use.

Steve Brinksman is a GP from Birmingham and clinical lead for SMMGP

DIFFERENT PERSPECTIVES

We need to dig deep for inspiration and redouble our efforts against reactionary policies, heard this year's HIT Hot Topics. **DDN** reports. Photography by **nigelbrunsdon.com**

'Let me take you to Columbia,' said Sanho Tree, fellow at the Institute for Policy Studies and a director of its Drug Policy Project. 'Here farmers grow coca because it makes economic sense to them,' he said. 'They don't stand a chance of growing other crops and coca is one crop that doesn't require much infrastructure.' Yet the government had been trying to eradicate coca for decades, primarily through crop dusters – aircraft that sprayed the area with a potent form of Roundup, a herbicide that caused rashes, vomiting and illness as well as the death of crops and animals.

The drugs that cost pennies to produce would be worth thousands by the time they hit our streets, thanks to the politics of prohibition, which inflated their value at each risky link in the drug trafficking supply chain, he said.

Then there was the 'pogrom' mentality – 'if you get rid of these people, it will be ok' – as seen in the Philippines, where Duterte had presided over 30,000 deaths.

Meanwhile President Trump's wall was failing to have any impact on preventing drugs from crossing the border between the US and Mexico, with the many other smuggling methods including tunnels, planes, torpedoes bolted under freighters and drones – not to mention the four-inch gaps between slats that enabled drugs to be handed through the wall itself.

So how do we end up with such reactionary policies? 'Because they sell', said Tree. 'People want easy answers.' But we needed to step back from the 'madness'. 'We need to ask why we do what we do,' he said.

'We've built a fundamentally sick society, and when I think about this in terms of drug use, I wonder if it's a predictable response to a world gone mad,' he said.

SUPERFICIAL ACTION

According to Pavel Bém, commissioner at the Global Commission on Drug Policy, we had become used to 'acting only on the surface of the problem'. As former mayor of Prague and drug czar of the Czech Republic, he had been instrumental in bringing about a period of decriminalisation.

'There is evidence that drug policy is wrong and needs to be reformed,' he said. 'But this is not enough. We need never-ending passion. For good policy reform we need heroes.'

The hero in his country, at the time, was former president Vaclav Havel, he said. 'At this time I was the drug czar. He asked me, "why aren't smokers in jail?" It was the human rights angle, the 'emotional momentum' that introduced harm reduction services, including needle exchanges and outreach.

As president of Caso Drug Users Union, Rui Coimbra Morais had witnessed the evolution of the decriminalisation model in Portugal – its progress and its paradoxes.

'The country is not a paradise for users, but it's better,' he said. 'But stigma doesn't change overnight, globally and from society.'

We were so busy 'creating illusions that we fit and should be normalised', but we needed to change these narratives. 'I felt all my life that I don't fit – and now I don't want to fit,' he said. The important thing was to get back to basic things – the knowledge that you are not alone. 'We are many, we are not alone,' he said. 'We have to connect much more with the levels of freedom I find in different places.'

VITAL CONNECTIONS

Biz Bliss from The Psychedelic Society suggested that 'sometimes we need a reboot, remembering what's important, connecting with the self.' She invited her audience to 'connect with the heart space', by looking deep into the eyes of the person (probably a stranger) next to them.

The idea was to put people in vulnerable situations where they were forced to be uncomfortable. 'We try to create spaces to remember what it's like to connect,' she said.

Through a 'beautiful retreat centre' north of Amsterdam, she tried to create the 'perfect set and setting' through an intimate sharing circle with music, enhanced by taking mycelium truffles in ginger tea. Once people learned to get familiar with their feelings, including grief and pain, the idea was to learn to 'use this space' without psychedelics and 'access the experience'.

Photos, clockwise from top left: audience questions, Sanho Tree, Pat O'Hare, Megan Jones, Biz Bliss, Harm Reduction Union, Support Don't Punish, Mick Webb, Prun Bijral, audience participation, Pavel Bém, questions, Rui Morais and Lizzie McCulloch, Katy McLeod.

The idea that we can support each other through talking was not isolated to a retreat. Katy McLeod of Chill Welfare met many people in festival settings who were experiencing intensive psychedelic interventions. The network of volunteers offered practical and therapeutic support and 'de-escalation', which involved 'being careful around questioning, humour, refocusing and distraction'.

The purpose was to keep people safe but was also an opportunity for early interventions – a chance to talk to relevant drug services. The specialist interventions included a dedicated mental health response team, which appreciated that people sometimes had an experience they hadn't expected. They supported them 'in that moment' and worked holistically as a team of volunteers to provide a safe space.

These initiatives were invaluable in a climate of massive cuts to drug services, and equally important was the progress being made in some areas by police and crime commissioners. Megan Jones, policy manager for West Midlands PCC said reducing harm was a key driver to strategy, alongside reducing crime and cost to the community. Birmingham officers were now saving lives through carrying nasal naloxone and their eight-point recommendations included heroin assisted treatment (HAT) and drug consumption rooms, alongside diverting people away from the criminal justice system. Liaising with schools and colleges was creating a new dialogue with young people.

Lizzie McCulloch of Volte Face also emphasised the power of talking in 'mobilising and engaging' and inspiring change. Their campaign to legalise cannabis had engaged people from all affiliations. 'People underestimate how influential it is having these conversations,' she said.

THE TIDE IS TURNING

The positive developments explored at the conference – which included research on agonist medications for treating problematic stimulant use, interesting research on microdosing, and promising progress on drug-checking initiatives that led to harm reduction interventions – gave a strong flavour of optimism that prompted the conference's creator Pat O'Hare to say 'the tide is turning on harm reduction'.

But the event's purpose was also to remind us to redouble efforts against the backdrop of an appalling – and preventable – drug-related death rate.

Prun Bijral, medical director at Change Grow Live, was invited to give a provider's perspective and acknowledged that, with the current public health crisis, 'we are in a very hostile system for people who use drugs.'

The 'whole person' approach was crucial he said, and this relied on using people's experience. A lot of the data capture in this sector was meaningless, but a good system relied on 'bottom up' feedback – learning about, and from, the service user's journey.

'Data is really important, but it's about making space for people to get together, off the hamster wheel, to collaborate,' he said. 'We need to do things better, work better together, be open and share what we have, and welcome all perspectives.'

'Harm reduction saves lives, but what we need is more perspectives' concluded the session's chair Gill Bradbury. 'There are lots more tools in the box – let's use them.' **DDN**

NO TIME TO LOSE

'WE ARE NOT AHEAD OF THE CURVE by a long shot,' warned Mick Webb, project coordinator at CDF Bristol.

'Drug-related deaths are at record levels and the government's response was to slash the treatment budget. When NDTMS data was released on drug-related deaths, why wasn't something done?

Imagine what the drug-related death figure would be if naloxone wasn't about.'

'We can all talk, but 12 people in the UK will die today,' said George Charlton, leading the event's naloxone workshop. 'Only 16 out of 100 people using opiates across England are given take-home naloxone. If we're not giving naloxone, we're giving the message that it doesn't matter if you die.

Locally, in the north east – 'the drug death capital' – their peer network had been helping to create momentum that things were changing.

'There's a palpable sense that harm reduction is returning,' he said. 'So let's fucking do it. Overdose is reversable, death is not.'

HOPE AFTER CHAOS

It's time to 'get busy living', says **Tom**

Srdjanns74/iStock

I had a good childhood and my parents provided all that I needed. My first years at school were great and I made a lot of friends. However, things became difficult and I was diagnosed with colour blindness and dyslexia at six. Specialist help was not readily available and eventually I was sent to a special school. I left after three years and was sent to boarding school where it was thought I would be better helped.

Boarding school was like a prison to me and I was massively homesick. I did make one friend, though. She helped to make things better, but sadly passed away. This led to a suicide attempt when I was 14. The school did their best but didn't really know how to help a troubled teenaged boy through puberty. I started drinking with my friends at 15 as we could get into pubs.

I left boarding school and went to college for about a year. There, I started smoking cannabis. This led to cocaine use, but I never felt I was addicted. I started taking pills in my late teens too, but my drinking was not an issue at that point as I was involved in the clubbing and party scene. At 20, I met a girl and fell in love. I went to work in a pub, which is when my problems with alcohol started as pub life naturally revolved around drinking.

I took a job in sales but the pressure told on me, and was reflected in my drinking. I was drinking more than two litres of vodka per day by this stage. My girlfriend broke up with me after seven years together and shortly afterwards I was made redundant. I started drinking even more heavily along with taking pills, using cocaine and anything else I could get my hands on.

I got another job and met another girl, who would later become my wife. I started to work from home and my drinking was easy to hide. I lost my job two weeks after the wedding as my drinking affected my job performance. My drinking was out of control and my wife threw me out. I became homeless and spent three weeks on the street in sub-zero temperatures.

I tried different dry houses, but they couldn't allow me to stay as I continued to drink. I spent weeks on the streets and eventually called my parents who allowed me to move back to stay with them with the understanding that I would get help. I got involved with RISE which was helping, when my parents sold up and moved to Bournemouth. This led to me starting to drink heavily once more.

I stayed with a friend for three months but stayed drunk enough to feel stable. My wake-up call was when I had a seizure. That's when RISE referred me to Churchfield. Here, I have one-to-one sessions and take part in activities. This has been my first period of stability in a long time. Though I still drink to maintain myself. I have been offered a detox and rehab placement in Bournemouth, which will become a reality once the funding is agreed.

I've spent too long destroying myself. I want to live on my own by the time I am 40 and go back to college. I want to help others who are going through some of the things that I have. My favourite quote is from *The Shawshank Redemption* – 'get busy dying, or get busy living.' I want my life back! I have hope after chaos.

Churchfield & Cherington is one of four services run by the Social Interest Group, specifically geared towards treating drug and alcohol misuse. The other services are Aspinden Wood, Brook Drive and Brighton Women's Service.

'I've spent too long destroying myself. I want to live on my own by the time I am 40 and go back to college. I want to help others who are going through some of the things that I have. My favourite quote is from *The Shawshank Redemption* – "get busy dying, or get busy living." I want my life back!'

DDN

Drink and Drugs News
WIDER HEALTH SERIES

GAMBLING AND HEALTH

Gambling is available 24 hours a day and can become a devastating addiction, affecting people from all walks of life. This guide will help you recognise when someone might need help, and identify routes to appropriate support.

Supported by GambleAware

For many people gambling is an occasional, harmless pastime, but for others it can lead to financial ruin, relationship breakdown or even suicide. And for those who do experience problems, specialist help has too often been hard to find

HIDDEN IN PLAIN SI

Problem gambling is often called the 'hidden addiction', as there will frequently be no outward signs that someone is struggling with addictive behaviour. The social and financial impact of the UK's gambling problem, however, is becoming ever more visible.

Many people gamble in some form, and most without experiencing any adverse effects. In a given year almost 60 per cent of British adults will gamble, including on the National Lottery, slot machines or online betting sites – there are currently 33m active online gambling accounts in the UK.[1]

However according to the Gambling Commission – the government body responsible for regulating the gambling industry – there are around 2m people experiencing some level of gambling harm, and 340,000 who could be classified as problem gamblers.[2]

WHAT IS A PROBLEM GAMBLER?

A problem gambler is someone experiencing addictive behaviour defined by the World Health Organization as a gambling disorder.[3] This is characterised as a 'pattern of persistent or recurrent gambling behaviour' where gambling can take precedence over other interests or daily activities and where people have impaired control over the frequency, duration or intensity of their gambling.

The behaviour patterns associated with a gambling disorder can be severe enough to lead to 'significant impairment in personal, family, social, educational, occupational or other important areas of functioning', states WHO. The mental health issues associated with problem gambling, meanwhile, can be severe enough to result in suicide.

COUNTING THE COST

It's not just on the individual where the impact is felt, however. An analysis by the IPPR think tank of the health, welfare, housing and criminal justice costs associated with problem gambling put the combined price tag at up to £1.16bn per year for the UK as a whole.[4]

One particularly concerning aspect is the number of young people who could potentially go on to experience problems. While the minimum legal age for most gambling in the UK is 18, people can buy scratch cards and lottery tickets at 16 and many gaming machines in amusement arcades and other venues have no age limit. Young people experiencing gambling issues are more likely to truant and perform poorly at school, and, crucially, are also more likely to develop a gambling disorder in adulthood.[5]

DEVELOPING HABITS

A 2019 Gambling Commission report found that almost as many 11- to 16-year-olds had spent their own money on gambling in the previous week than had drunk alcohol, taken drugs or smoked cigarettes.[6] Just under 2 per cent of this age group were already classified as problem gamblers.

Worryingly, while problem gambling can remain hidden from family, friends and colleagues for years, the issue has also largely been unseen by addiction treatment providers, wider health professionals and policy makers. Currently less than 3 per cent of people with a gambling disorder are receiving treatment for their addiction.

GAMBLING REGULATION AND LEGISLATION

High street and online gambling providers need a licence issued by either the Gambling Commission or local authority, while gambling advertising is subject to the Advertising Standards Authority's (ASA) primary advertising regulations and augmented by the 2007 Gambling Industry Code for Responsible Gambling.

Gambling legislation recently made national headlines after the government cut the maximum stake it was possible to place on controversial fixed odds betting terminals (FOBTs) – often called the 'crack cocaine of gambling' – from £100 to £2, while a 2019 paper published in the BMJ argued for a revision of the 2005 Gambling Act to include a compulsory levy on the industry to support people with gambling problems.[7]

Gambling behaviour

- Gambling encompasses a broad range of activities, ranging from the National Lottery to casino games, slot machines, and online betting.
- Around 58 per cent of adults in GB gambled on at least one of these activities in the past year.
- Approximately 0.7 per cent of adults (about 340,000 people) in GB are problem gamblers and a further 1.1 per cent (about 550,000) are at moderate risk of harms related to gambling.
- Online gambling – on casino or slot style games and sports betting – is the largest growth area in the sector, accounting for over a third of the market. There are over 33m active online gambling accounts in GB.
- The prevalence of online gambling has increased from less than 1 per cent in 1999 to 9 per cent in 2016, with many online gamblers holding multiple accounts. This makes online gambling as popular as traditional betting on horses and more popular than playing slot machines or visiting casinos.
- 14 per cent of children aged 11-16 have gambled in the past week, with around 55,000 reporting problems from their gambling behaviour.

Source: www.bmj.com

There are around two million people experiencing some level of gambling harm

NATIONAL STRATEGY

Growing concern around problem gambling also led the Gambling Commission to launch its three-year *National strategy to reduce gambling harms* in April 2019.[8] A partnership between regulators, health organisations, charities and the industry, the strategy's aim is to coordinate efforts to 'bring a lasting impact on reducing gambling harms' through a combination of enforcement and adoption of evidence-based approaches. To coincide with the strategy, Public Health England (PHE) announced that it would be conducting a major evidence review on the impact of problem gambling on people's health and wellbeing.

The strategy's two priority areas are 'prevention and education' and 'treatment and support', with the first concentrating on creating the right mix of interventions and the second on delivering 'truly national treatment and support options that meet the needs of users'.

National Gambling Treatment Service

NATIONAL GAMBLING TREATMENT SERVICE

Treatment provision for people with a gambling disorder has improved significantly in recent years, not least with the advent of the National Gambling Treatment Service. Commissioned by GambleAware and provided by a network of NHS and voluntary sector services across GB, it provides free, effective treatment that can include anything from counselling and brief interventions to psychotherapy, psychiatric care and residential rehab.

The service works closely with partner organisations to map out care pathways and referral routes, with many referrals coming via the **National Gambling Helpline** – **0808 8020 133**. This free helpline also provides confidential advice and support from trained advisors for those who don't necessarily want to access treatment. Available every day via phone or live chat, the service explains the treatment options available in the caller's area and can also advise on support for family members. There is also an active user forum for peer support. In the year to March 2019 the National Gambling Treatment Service treated 10,000 people, while the helpline received 30,000 calls and online chats. A major new digital awareness campaign will also launch early in 2020.

Treatment for problem gambling is currently not regulated under the legislation that governs the work of the Care Quality Commission (CQC), although GambleAware is working with the Department of Health and Social Care (DHSC) to explore options for an equivalent level of quality assurance.

Going public

The importance of a public health approach

A 2019 paper published in the *BMJ*, *Gambling and public health: we need policy action to prevent harm*, stressed that 'Simply stating that gambling is a public health problem is not enough'.[9] It must also 'be treated as one by policy makers', it said, and called for increased funding for both treatment and prevention.

When the Gambling Commission launched its national strategy one of its two main strategic priorities was 'prevention and education – making significant progress towards a clear public health prevention plan.'

At the same time, PHE announced its large-scale evidence review on the public health harms related to gambling, and the NHS made clear the link between problem gambling and stress, depression and other mental health issues. The 2019 *NHS long term plan* also pledges to work with partners to tackle gambling issues 'at source' as part of its commitment to prevention, as well as to expanding specialist help.[10]

GambleAware believes that a public health approach to reducing gambling harms can be split into three different aspects – primary prevention, which is aimed at the whole population; secondary prevention, which is aimed at groups with a higher prevalence of gambling harms, and tertiary prevention, aimed specifically at people with a gambling disorder.

Prevention services are commissioned by GambleAware across three areas of activity. The first is the National Gambling Treatment Service, which includes the National Gambling Helpline and a network of voluntary sector and NHS providers.

RAISING AWARENESS

The second area is public health campaigns and practical support for local services such as GP surgeries, mental health services, prisons, debt advice agencies and youth workers.

GambleAware has funded initiatives by Citizens Advice and the Royal Society for Public Health (RSPH) to raise awareness of gambling issues and the specialist treatment available among healthcare professionals and staff in other local agencies.

There is also the national prevention campaign, Bet Regret, which encourages people not to gamble when drunk, bored or in order to 'chase' their losses. The third area is commissioning research and evaluation to build a database of evidence-based good practice, which has so far included more than 40 separate peer-reviewed research projects.

Identifying gambling problems, links to other addictive behaviours, and when to refer to specialist treatment

ON THE LOOKOUT

Like any other addiction, problem gambling doesn't discriminate. It can affect anyone, from any background, and of any age. Men, however, are more likely to be classed as problem gamblers than women, and studies have also shown that people are more likely to develop a gambling disorder if they started gambling at a young age or have a family history of it.

According to the Royal College of Psychiatrists,[11] people can 'lose control' of their gambling for a variety of reasons. 'You may gamble to forget about responsibilities; to feel better when you feel depressed or sad; to fill your time when bored (especially if not working); when you drink or use drugs; when you get angry with others – or yourself. Or, you may have started gambling early – some people start as young as seven or eight.'

TELL-TALE SIGNS

Key indicators that someone is developing a gambling problem include overt signs such as spending more money or time gambling than they can afford, finding it hard to stop, or gambling until all their money is gone. Other behaviour can be similar to that associated with drug or drink problems – losing interest in other activities, neglecting work, school or family needs, and borrowing money, selling possessions, stealing or not paying bills.

As with substance issues, many people will also become defensive or angry if questioned about their gambling behaviour, as well as experiencing anxiety, depression or guilt.

Another characteristic in common with alcohol or drugs is the impact gambling can have on loved ones, including relationship breakdown and child neglect.

The NHS website has a questionnaire for people who are concerned that they may have a problem, along with self-help advice and links to support services,[12] while the Gambling Commission is currently developing guidance for gambling operators on identifying customers who may be at risk and how to intervene.[13]

The commission stresses that frontline health professionals and people working in agencies where problem or at-risk gamblers may present, such as Citizens Advice and debt advice centres, should be trained to identify them in order to refer on to appropriate support.

Overall, however, despite the fact that people presenting with substance misuse or mental health issues are likely to also be vulnerable to gambling harm, awareness levels among wider health professionals have often been low and people have generally not been screened for gambling-related problems.

You may gamble to forget about responsibilities; to feel better when you feel depressed or sad; to fill your time when bored; when you drink or use drugs; when you get angry with others – or yourself

Do you have a gambling problem? Try this questionnaire

- Do you bet more than you can afford to lose?
- Do you need to gamble with larger amounts of money to get the same feeling?
- Have you tried to win back money you have lost (chasing losses)?
- Have you borrowed money or sold anything to get money to gamble?
- Have you wondered whether you have a problem with gambling?
- Has your gambling caused you any health problems, including feelings of stress or anxiety?
- Have other people criticised your betting or told you that you had a gambling problem (regardless of whether or not you thought it was true)?
- Has your gambling caused any financial problems for you or your household?
- Have you ever felt guilty about the way you gamble or what happens when you gamble?

Score 0 for each time you answer 'never'

Score 1 for each time you answer 'sometimes'

Score 2 for each time you answer 'most of the time'

Score 3 for each time you answer 'almost always'

If your total score is 8 or higher, you may be a problem gambler.

Source: www.nhs.uk

CO-MORBIDITY

Studies have shown that for males with a gambling problem, alcohol consumption is heavier than for those classed as non-problem gamblers, and they are also more likely to be smokers. Statistics from an earlier Health Survey for England quoted in a 2018 Gambling Commission briefing paper, *Gambling-related harm as a public health issue*[14] shows that almost a fifth of male problem or at-risk gamblers drink more than 35 units per week, while a third are smokers.

Clearly the links between alcohol – and other substances – and gambling are strong. People are not only more likely to gamble when their inhibitions have been lowered by alcohol, they may also turn to alcohol to cope with gambling-related guilt or stress, or 'drown their sorrows' after incurring a heavy loss. 'In addition to the well-documented evidence of the potential for dependency in both drinking and gambling there is an increasing evidence base for the co-occurrence of pathological alcohol consumption and gambling behaviour,' states the Alcohol Change UK website.[15]

ONLINE ADDICTIONS

The internet has revolutionised many aspects of our lives, and one of these is access to gambling. There's no longer even a need to visit a bookmakers' – gambling is available instantly, 24 hours a day, on the smartphones in our pockets. The internet has also dramatically increased the opportunities for advertising and marketing, with one in eight young people now reported to be following gambling companies on social media.[16]

What's more, as video games and online gaming become ever more sophisticated, it's no longer necessary for money to be involved in order for people to experience problems. The 11th revision of WHO's International Classification of Diseases now includes 'gaming disorder',[17] a pattern of behaviour characterised by 'impaired control over gaming, increasing priority given to gaming over other activities to the extent that gaming takes precedence over other interests and daily activities, and continuation or escalation of gaming despite the occurrence of negative consequences'.

Taking its toll

The impact of problem gambling on individuals and families

Problem gambling can have a devastating impact on both the gambler and their family. Gambling can become an obsession, leading people to neglect their work and their loved ones. Bills can go unpaid, debts can accumulate, and in extreme cases people can face bankruptcy, lose their job or home, or even resort to criminal activity.

According to the charity GamCare, there is a 'higher number of people identified as problem gamblers in the criminal justice system than the wider population, especially if those going through the system possess vulnerable characteristics such as ADHD, impulsivity, poor mental health, and substance abuse'.[18] While the most common offences committed by problem gamblers are 'income-producing crimes' like fraud, theft or drug dealing, offences can sometimes be more violent, the charity adds, including domestic abuse.

FAMILY BREAKDOWN

The stress associated with a gambling disorder can obviously have a devastating effect on family and other relationships, eroding closeness and trust. People with a gambling disorder can become withdrawn and isolated, or angry and defensive, and marriages and partnerships can be irrevocably damaged. Children are 'heavily impacted' both financially and emotionally by the gambling of a family member, says a Faculty of Public Health position statement.[19] 'This "ripple effect" of gambling leads to a number of feelings for children which are hard to manage, including anger, guilt, helplessness, shame and feeling neglected,' it states.

The toll on mental and physical health can also be significant. 'We know that problem gambling can have a major impact on health,' says the government's July 2019 green paper *Advancing our health: prevention in the 2020s*[20], adding that the government now 'has an active agenda on this'. Sleep and appetite can suffer, and the impact on mental wellbeing can be severe. As well as anxiety and depression, the psychological issues associated with addictive behaviours, such as guilt, shame and stigma, can compound feelings of isolation. In extreme cases, and often when significant sums of money have been involved, people can be driven to suicide.

WHEN TO REFER

The Royal College of Psychiatrists' 2014 report *Gambling: the hidden addiction*[21] recommends that drug and alcohol treatment services and wider health professionals such as GPs should routinely screen 'high risk' patients for problem gambling issues, with anyone recording a positive score first offered a brief intervention and then referral to specialist care.

Widely used for people considered to be drinking at risky levels, ten- to 15-minute brief interventions are designed to stop people moving from being 'at risk' to developing a full disorder. 'They are also helpful when working with patients who are currently unwilling to seek formal or more intensive treatment for their disorder,' the document states.

What does effective treatment for problem gambling look like, and how do people go about accessing it?

GETTING IT RIGHT

'Availability of the right support, in the right place, at the right time,' is how the *National strategy to reduce gambling harms* describes its goal for gambling treatment in the UK. Fully achieving this will require better care pathways via primary care and social care, it says, along with improved commissioning arrangements and support for people who have other mental health issues alongside problem gambling.[22]

While waiting lists for gambling treatment tend to be short compared to those for drug or alcohol treatment, provision remains comparatively restricted in terms of geographical coverage, reach and funding, the strategy adds.

THE RIGHT MIX

Treatment services should be providing 'the right mix of a broad range of options' to address identified needs, states the national strategy. These options should include individual, group, residential and online treatment and support, alongside peer support and help for loved ones and 'affected others'. More understanding is also needed around people who do not access treatment, it stresses, to help identify barriers to access. This is especially important when it comes to the stigma that is still strongly associated with all forms of addiction.

According to a 2016 evidence review by the Royal College of Psychiatrists,[23] while the evidence base for treatment had remained limited so far, interventions that had proved effective include cognitive behavioural therapy (CBT) – when delivered by CBT-trained professionals – motivational interviewing and practitioner-delivered treatment interventions.

There was relatively little evidence when it came to group psychological interventions, and the paper also recommended that research be carried out into whether abstinence-based programmes were more effective than 'those without a total abstinence goal'. It clearly stated, however, that gambling treatment services should have 'parity of esteem with other mental disorders'.

REFERRAL ROUTES

People can self-refer to gambling treatment, often via the National Gambling Helpline, or they can be referred by health professionals, usually their GP.

However, while primary care and other NHS services are currently 'diagnosing and treating people for co-occurring challenges or conditions such as alcohol dependency or mental ill health', data on people who have accessed gambling support this way is limited, says the national strategy, and lack of awareness of treatment options among professionals such as social workers or GPs remains a key issue.

BETKNOWMORE UK

Betknowmore UK founder Frankie Graham describes how he was able to use his own experience of problem gambling to help others

I started to gamble from a young age, and by the time I was in my late teens I had an addiction, usually gambling until every penny was gone.

When I committed to recovery it was built around volunteering for a mental health charity, as well as therapy. I retrained and went on to manage community projects with young offenders for the YMCA. Noticing that some of the young people were presenting with gambling problems, I took redundancy and enrolled on a business start-up scheme to develop Betknowmore UK.

My plan was to replicate the young offender work – mentoring programmes with a focus on health, wellbeing and empowerment – and remodel that for gamblers.

Treatment services should be providing 'the right mix of a broad range of options'

Although GamCare has been in operation for more than 20 years, until recently the two treatment services more known to health professionals were Gordon Moody Association, which offers 12-week courses of residential care, and Central and North West London (CNWL) NHS Trust's London Problem Gambling Clinic.

As recently as 2018, the Gambling Commission stated that the 'absence of any other dedicated NHS provision is striking'.[24] Now, however, a wider network of options is being provided by the National Gambling Treatment Service. This includes another service designed to help people with more serious and complex needs – as with CNWL – which is delivered by Leeds and York Partnership NHS Foundation Trust in partnership with GamCare. Further services funded by NHS England are scheduled to open in Manchester and Sunderland in 2020, with more to follow.

The first dedicated NHS gambling clinic for children has also been announced as part of the *NHS long-term plan*, to be provided by CNWL.

Easy and isolating

Michelle felt vulnerable and took comfort in some 'harmless' gaming, but a destructive habit was taking hold

My gambling began in 2014. When I started talking to a counsellor I got my laptop out and went through my emails. I thought I'd used two companies – I'd actually used nine. I lost £550,000 on games in less than three years.

I had a history of trauma and being abused and had been diagnosed with PTSD. I would drink and have always felt 'up and down'. National Lottery Scratchcards triggered my gambling. I took out loans – it was so easy and shouldn't be. I did things I regret every day and eventually I lost the house. My partner is older than me and has had to stop work with arthritis, so we'll have to go on housing benefit. If I didn't have my daughter, I wouldn't be here.

Gambling is the most devastating, fast, destructive thing. It changes everything, every relationship, and not for the better. Every day I feel bad about it – the devastation I caused others by my actions doesn't make sense. Everything you don't want to be, you become.

With online gambling it's so easy and isolating, and you can spend a loan very quickly. After I spent £440,000 one of the companies finally did an affordability check, but they make you a VIP when you are spending at high levels. And if I tried to stop they'd give me incentives – money in my account, Argos vouchers, Red Letter Days – to start again.

I thought I'd used two companies – I'd actually used nine. I lost £550,000 on games in less than three years

We established our first gambling peer support hub in 2014, the first accredited outreach programme for gamblers the following year and in 2016 we launched the Don't Gamble with Health project, which set up support referral services inside betting shops, trained shop staff, and received an award from the Royal Society for Public Health.

We now have a second support hub and are launching a peer support programme in partnership with GamCare called Peer Aid, where people with lived experience will be co-designing and managing the project. We also provide training and consultancy work – with the gambling operators but also with sectors like finance and housing.

Time and again we hear from clients that they'll only expose their gambling when they can speak to someone... who understands the associated shame and isolation

Community work is funded through grants and donations, while training and consultancy services provide another income stream. Our accredited training courses include themes such as safeguarding and understanding gambling co-morbidities – tough issues tackled by combining lived experience with evidence-based approaches. One of our key strategies is upskilling other organisations to work with this issue – we work with health, community and charity partners to train staff and enhance awareness.

Our support is very much person-centred, addressing co-morbidities and triggers. What we're really proud of is that we have staff who've been through our services and are now employed by us. Time and again we hear from clients that they'll only expose their gambling when they can speak to someone who is going to be non-judgmental and who understands the associated shame and isolation. We treat referrals as a 999 call. We know it could be the next gambling binge that loses that person their home or their savings, and we'll respond with an offer of support within 48 hours.

We're huge advocates for the power of lived experience. We don't just want people telling their story – it's also about creating opportunity for those who've lived through trauma and now want to help prevent gambling-related harms.

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The Wider Health series is written and produced by Drink and Drugs News (DDN), the free, independent monthly magazine for the addictions sector. www.drinkanddrugsnews.com

Contacts

National Gambling Treatment Service
whose services include:

BeGambleAware.org

GamCare *www.gamcare.org.uk*

Gordon Moody Association
www.gordonmoody.org.uk

Leeds and York NHS Partnership Foundation Trust (LYPFT) *www.leedsandyorkpft.nhs.uk*

CNWL London Problem Gambling Clinic
www.cnwl.nhs.uk/cnwl-national-problem-gambling-clinic

National Gambling Helpline
0808 8020 133
www.gamcare.org.uk/get-support/talk-to-us-now (online chat)

Other useful contacts:

Betknowmore *www.betknowmoreuk.org*

Citizens Advice *www.citizensadvice.org.uk*

Every Mind Matters
www.nhs.uk/oneyou/every-mind-matters

Fast Forward *www.fastforward.org.uk/gamblingtoolkit*

Gamblers Anonymous
www.gamblersanonymous.org.uk

NHS Northern Gambling Service
www.leedsandyorkpft.nhs.uk/our-services/services-list/northern-gambling-service/

Public Health England
www.gov.uk/government/organisations/public-health-england

The Gambling Commission
www.gamblingcommission.gov.uk

The NHS Website *www.nhs.uk*

GambleAware

GambleAware is a registered charity regulated by the Charity Commission for England and Wales and the Scottish Charity Regulator (OSCR) that commissions prevention and treatment services on a national scale underpinned by research and evaluation to keep people safe from gambling harms. The charity is wholly independent with a board of trustees with expertise in commissioning, public health and NHS healthcare provision. GambleAware is funded by voluntary donations from the British gambling industry according to a framework agreement with the Gambling Commission. With around £45million of funding under active management, the charity works closely with the Department for Digital, Culture, Media and Sport (DCMS) and the Department of Health and Social Care (DHSC), and has established advisory boards in Wales and Scotland to guide future commissioning arrangements.education and treatment services'.
www.about.gambleaware.org

BREAKING THE MOULD

A new award-winning and cost-effective treatment for alcohol dependence is available, and your service can sign up for an introductory trial

It's not often that something completely different comes along in the field of alcohol treatment. However, in October 2019 a British company won the 'Breaking the Mould' Future Enterprise award from Keele University for a new treatment system. If you were designing a new system from scratch, at the very least you would want it to be effective, time saving, easy to use and to offer significant cost savings. For people who are really struggling to break free from addiction perhaps you'd also like it to improve adherence to medication and offer psychological support, every day, wherever that person happens to be. Welcome to the Zenalyser®.

We're looking for clinics to try out the Zenalyser® system at a reduced rate so that we can gather feedback from as many services as possible. The cost advantages of the system are huge – three months of daily Zenalyser® treatment cost just £600, including medication and staff time. Compare that to a single one-hour consultant review, which costs the NHS more than £200, plus over £90 for a nurse and travel fares for the client. Residential rehabilitation, meanwhile, costs around £1,000 per week – much more in private units.

HAS ANYONE USED IT?

The Zenalyser® has been successfully used in clinics in Shropshire, Gloucestershire and in some parts of the US, and it really shines in high-risk situations. Mothers have been able to prove to the courts that they are both abstinent and complying with treatment, and so have been able to keep their children, while military personnel in locations far from treatment centres and family help have been supported remotely. It has also been possible for alcohol-dependent medical and nursing staff under formal regulatory procedures to remain in their jobs by using the Zenalyser® every day. For people using the system, NHS post-detoxification abstinence rates were 90 per cent over a one-year follow up period, with 100 per cent relapse free[1].

SO WHAT EXACTLY IS A ZENALYSER®?

A Zenalyser® is a dual sensor hand-held breathalyser that detects disulfiram (Antabuse) metabolites and alcohol on a breath sample[2]. It connects to a small computer tablet that sends the sample result to a central database. The result is then analysed and automated feedback is given immediately to the client, for example a smiley emoji and the message: 'Well done, good result'. If a daily breath sample has not been provided a reminder is sent, twice if necessary. Once the patient has blown into the Zenalyser® the result is sent to the clinician by email or SMS, and the clinician is also informed if a test sample has not been given. At any time the treatment team can access the database, view a photo of the client blowing into the Zenalyser®, and send a personalised message back – tips, encouragement, education, appointment review, whatever is helpful.

WHY MIGHT YOU WANT ONE?

This new system can maintain abstinence from alcohol at an all-in cost of less than £50 per week. For the alcohol dependent client this can be achieved from the comfort of their home, while looking after children, or at work. The Zenalyser® system provides this mix of feedback, psychotherapeutic support, monitoring, and supervision of medication in a process that takes less than one minute per day for the user. The time required for the treating team to view results and provide personal messages of support, information and advice, is about 5-10 minutes a week. The system's ability to work remotely also greatly reduces the need for face-to-face reviews, so taking more pressure off busy staff.

The Zenalyser® has been successfully used in clinics in Shropshire, Gloucestershire and in some parts of the US, and it really shines in high-risk situations

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1 **Fletcher K**, *Disulfiram and the Zenalyser: teaching an old dog new tricks. Alcohol and Alcoholism* (2015).

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ZenaMed

WANT TO GIVE IT A GO?

If you would like to sign up for a trial, receive more information, or have a demonstration of the Zenalyser®, then please contact ZenaMed Ltd via their website *www.zenamed.co.uk*. For the trial the Zenalyser equipment will be loaned free of charge and you will simply pay £400 for 100 breath tests.

INSIDE OUT

When delivering recovery services to prisoners, demonstrating impact is a complex but vital process, says **Carwyn Gravell**

Forward's range of structured, abstinence-based treatment programmes (which we refer to as the 'RAPt' programmes) have supported thousands of people into lasting recovery. Our range and type of programmes have grown and diversified since we first began helping people from a portacabin in HMP Downview in the early '90s. So too have the tools we use to measure their impact. Our recently launched annual *Impact report* includes a summary of the research on the impact of these programmes.

The first published study into the RAPt programmes was *Drug treatment in prison: an evaluation of the RAPt treatment programme* by Player and Martin of Kings College London in 2000. This gave the first evidence of our successful impact in reducing reoffending – a one-year rate of 25 per cent amongst the 274 completers of our programme, compared with 38 per cent for non-graduates. A second study, *Effectiveness of the rehabilitation for addicted prisoners trust (RAPt) programme*, published in 2014 and using data from the Police National Computer (PNC) database, showed a 31 per cent reconviction rate for graduates of our programmes in male prisons, an 18 per cent drop in reconviction rates and a 65 per cent reduction in the volume of re-offending.

> We have seen a decline of 58 per cent in the number of people starting programmes over the last three years

The establishment of the Justice Data Lab (JDL) in 2013 has provided us with a national framework to evaluate the success of all our interventions in reducing reoffending. We have so far submitted two cohorts of data for analysis by the JDL, with our most recent results being published in October of this year. A JDL study into our Women's Substance Dependence Treatment Programme (WSDTP) showed that women who completed the programmes reported a one-year re-offending rate of just 18 per cent, while a similar study into our less intensive Alcohol Treatment Programme reported a reoffending rate of 37 per cent.

Just how positive is this impact? There are methodological limitations in estimating the likely reoffending rate for a comparison group of drug or alcohol dependent offenders who do not access these programmes. For example, the Justice Data Lab comparison groups (with re-offending rates of between 35 and 40 per cent) are based on a criteria of frequent drug/alcohol use, rather than dependence, leading to significant underestimates. Other estimates of the reoffending rates of drug/alcohol dependent offenders range between 58 per cent (participants of all accredited drug/alcohol programmes in prison, according to an MoJ Analytical Series study from 2013) and 76 per cent for ex-prisoners who reported using class A drugs post-release (in the same study). Taking this upper-end estimate as a comparison, RAPt programmes could potentially reduce reoffending by nearly 60 per cent.

Yet despite this significant impact, we have seen a decline both in the number of people starting programmes (a reduction of 58 per cent over the last three years) and in programme quality. The increasingly challenging prison environment (an aggressive prison drug market, lack of space on dedicated 'recovery wings' to run group programmes, prison 'lock-downs' preventing programme delivery, and placing of inappropriate referrals onto programmes) is part of the reason. That being said, we have also realised, through consultation with staff and service users, that we need to improve the way we prepare applicants for the intensity of our programmes.

The development of our Stepping Stones courses (a shorter intervention that gives people a taster of the kinds of things covered in more intensive treatment) has helped. For example, at HMP Send –where we run WSDTP – the introduction of this stepped model has led to a 25 per cent increase in programme completion.

The process of quantifying the impact of our work is not always straightforward. Maintaining programme integrity in a hostile prison environment – and designing accurate research methodologies – remains a challenge. But it is worth it. Because proving that our work can – and has – helped thousands of people to turn their lives around is essential to building a reliable evidence base for this sector.

Carwyn Gravell is divisional director of business development at The Forward Trust

Women prisoners working in the garden and on the farm at East Sutton Prison. Mike Abrahams/Alamy.

SYLVIA'S STORY

The progress of women at HMP East Sutton Park speaks for itself. **DDN** heard Sylvia's story

My mother was alcoholic as I grew up, and I was in charge of my siblings. I hated alcohol and never thought I'd be an alcoholic.

I got married and started drinking because I was lonely – my husband worked a lot. My drinking pattern progressed and I became more depressed, then hooked on antidepressants from my GP. I had my first cocaine at 30 and it got progressively worse.

I had three children when my husband asked me for a divorce. I was drinking in public toilets and was found guilty of causing grievous bodily harm with intent. I was looking at nine years.

I knew going to prison would save my life. I was taken straight to healthcare at Bronzefield, very unwell, drunk and on diazepam and suffering from pancreatitis.

When I was accepted at Send Prison, Forward couldn't wait to get me onto their RAPt Wing. I stayed there for five months and the peer support was amazing. I thought, 'that's what I want to do.'

I didn't trust social services and police before – I've been let down so much. But coming to East Sutton Park, I was able to work and build up my trust.

> I knew going to prison would save my life. I was taken straight to healthcare... very unwell, drunk and on diazepam and suffering from pancreatitis

I volunteered and have now been on an apprenticeship for seven months. It's hard work but I love it and I'm gaining confidence to work elsewhere. I find it amazing that I am where I am and I'm very grateful.

Forward have supported me to live out my dream. I have my own flat, my own cat. I am responsible for my children. I am needed. I'm on a licence, but I'm trusted to live my life. **DDN**

CLINICAL EYE

LET'S GET MOVING

Exercise could become a valuable part of the treatment plan, says **Ishbel Straker**

I have recently started to work with a personal trainer, which got me thinking – how much does exercise form a part of your treatment plan when seeing patients? Are we influenced by our own patterns of behaviour when considering this, ie if you exercise, do you recommend it to people?

It's been at the forefront of my mind in conversations with patients. When we consider exercise and addiction it seems to be something that is placed on the backburner when dealing with significant physical issues – but does this need to change?

We know that exercise increases serotonin and dopamine levels in our brains, creating a more balanced state of mental wellbeing. So why don't we encourage our addiction patients in the same way that psychiatric services do?

I asked myself about the last time I talked with a patient about exercise, in line with discussing nutrition. Am I influenced by my own levels of exercise? Do I feel competent to recommend exercise despite the evidence? I think the answer is clearly yes, and this needs to change.

The moral of this story is that there is no other area that I feel I have to know more about before I refer to a specialist. If a patient walks through the door with coexisting cardiology issues, I know I'm not the expert and feel comfortable to assess the markers and refer on. So I'm going to challenge myself to do the same with physiotherapists, sports psychologists or personal trainers.

> It seems to be something that is placed on the backburner... Why don't we encourage our addiction patients in the same way that psychiatric services do?

With dwindling resources, am I flogging a dead horse? Possibly. But what may be more appropriate is, while we look at smoking cessation, vaccinations and nutrition, let's also consider the element of exercise and discuss with GP surgeries the option of tapping into exercise on prescription within our gyms. We could even consider taking it one step further by connecting with local gyms and offering some addiction training, so in unity we could all increase our skills to produce better outcomes.

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

THE PRESENT OF A

Rawf8/iStock

Imagine a very different version of this year's festivities. **Liam Ward** finds out what it means to spend Christmas in rehab

A roaring fire, a table laid with a lavish roast dinner, a tree groaning under the weight of decorations – a glowing backdrop to the family gathering. However your Christmas looks, what's certain is that you're never missing from the picture.

The reality of Christmas for people in residential rehabilitation can often be quite different. Spending this time of year away from families and loved ones can be difficult. Harder still is the prospect of reframing what Christmas means to you if your memories are dominated by negative experiences of drugs or alcohol. Across our sites in Sheffield, Wirral, Glasgow and at our National Specialist Family Service, we need to ensure that every single person in our care this Christmas is supported through this challenging period.

THREE WISE MEN

I recently talked to three of our graduates from the Sheffield Residential Service about their experiences of Christmas.

Luke and Robert had spent Christmas 2017 with us and Jake had been here in 2018 (names have been changed). Before they entered treatment, all three associated the festive period with being in the company of family, but for each of them it had become a grudging duty. A time of celebration for others had, for them, become a hinderance to their substance use.

Robert comes from a family where Christmas means parties, socialising and honouring traditions. 'In my family, from Christmas Eve onwards, there always seems to be a party at somebody's house,' he said. 'All the men in my family have always gone to the pub on Christmas Day. They still do that

> 'All the men in my family have always gone to the pub on Christmas day. They still do that now... That tradition is one of the hardest ones. I don't know if I'd be able to do that now.'

A FUTURE

now, from 11 until three. You see cousins you only ever see on Christmas Day. That tradition is one of the hardest ones. I don't know if I'd be able to do that now.'

Over time the lively, inclusive Christmas he was raised on became dominated by his substance use and the invitations became fewer. 'One year I got dragged out of my flat by my stepdaughter,' he recalls. 'I drank three bottles of cider before I went for lunch. I ate about two potatoes then stood in the kitchen drinking spirits. The next year, before I went to rehab, I was in a shared house sat with a load of people I wouldn't even call friends and took drugs.'

Luke also saw his substance use affect his relationships with family. 'I'd always make it to my parents' at Christmas, but I'd have had a skin-full before I'd go,' he said. 'I caused a nightmare atmosphere with everybody.' Luke's family never considered drinking to be a big part of their Christmas – which is now a welcome cornerstone in his recovery – but at the time it made being in their company a daunting and isolating prospect. 'I wouldn't drink in the house when I was there, I'd just eat my dinner and slope off,' he said. 'Eating was a chore – the last thing you want to think about. I probably never got through a full Christmas meal.'

Like his peers, Jake found his substance use put him at odds with the way his family celebrated. 'I hadn't had a sober one for a long time,' he said. 'The year before [coming to Phoenix Futures] I was supposed to go for a big family Christmas, but I drank way too much, so I spent Christmas on my own.'

These experiences clearly left a lasting mark, so it was a surprise to hear them speak positively about Christmas spent in residential rehabilitation.

'Going into Christmas I was quite anxious, but at the same time I felt safe as well,' said Luke. 'The temptation wasn't there.'

'I was a bit nervous, but it was an opportunity to enjoy Christmas for what it was and I felt safe in the house,' said Jake. 'People put any problems to one side and everyone realised it was a tough time, especially for those with kids.'

Robert said he was buoyed by the mood of the house. 'We had a good laugh,' he said. 'You forget where you are for a little time.' He focused on the positives and said it was nice seeing people getting visits from their children. He had a visit from his own daughter and granddaughter.

What helped the community through this difficult period was having lots of things planned – Laser Quest, theatre, cinema, panto, bowling. New Year's Eve was a party night without the drink and drugs and 'chaotic but a good laugh'.

Robert and Luke still have photos from the New Year's Eve they spent together in the Sheffield Residential Service, fondly recalling the community members and staff dressing up, joining in the karaoke and 'making a good night of a difficult time'.

This year they are all back home for Christmas. 'It's going to be really challenging,' acknowledged Luke. 'Nobody in my family really drinks, but it's just spending that first Christmas back there again sober. But for me the big thing about going home is my parents and brothers actually wanting to see me.'

Robert plans to repeat what worked for him last year – chilling out at his mum and dad's. 'Last year I enjoyed seeing my brother's young kids, playing with them and their toys,' he said. 'Before I'd have just rolled in pissed five minutes before dinner was on the table.'

Jake will celebrate his first Christmas after graduating this year. 'In the past I isolated myself,' he said. 'I'm looking forward to spending time with family and seeing those I haven't seen for years. I'm going to a New Year's Eve party, but I'll only go for an hour. There's no point putting myself in any risky situations.'

A MOTHER SEEKING REFUGE

Other residents are gearing up to their first Christmas in treatment. Mi and Ma are both mothers who will be staying with us at our National Specialist Family Service.

'I am excited to celebrate my first English Christmas,' said Mi. 'And I am looking forward to singing Polish Christmas songs to my little princess.' Mi's youngest daughter is placed here with her, however her older daughter is with her father this Christmas. 'It is emotional for me being far from my family, and hard that I can't be with her this year. But I already feel as though the people here are like my family. I have good people around me.'

She places much value on her future with her daughters. 'My kids are my gift,' she said. 'The best necklace I could get is my baby's fingers on my neck.' If she wasn't at the family service, things would look very different. 'Without this placement and my baby, I would drink,' she said. 'I would drink and I would die.'

'It is emotional for me being far from my family, and hard that I can't be with my daughter... But I already feel as though the people here are like my family. I have good people around me.'

Ma will also be at the family service over Christmas, along with her partner and their newborn son. 'Last year we spent Christmas Day in a hostel smoking crack,' she said. 'I know that's what I would be doing this Christmas if I wasn't here.'

She was looking forward to the chance to start building new memories during a time of year she found distressing. 'My dad died in December 2016, so this time of year is hard. But even before that, in my family, we had the presents but we didn't have the love,' she said. 'I want to make Christmas for my little boy about the nice things I remember.'

'I can be open here,' she added. I'm happy. I still have the issues, but now I have a different thought process, I have structure.'

During these conversations I was stunned by the honesty and moved by the strength of character shown by each person. With so many challenging emotions about the past and the future, each seems to have made peace with their place in the present.

Liam Ward is residential marketing manager at Phoenix Futures

Scootercaster/Alamy

'We must provide appropriate interventions to reduce harm to people wherever they are on this spectrum and not where we think they should be. Harm reduction is... a set of principles and a movement for social justice.'

CALL FOR COMPASSION

I fully agree with the letter 'Thorny Issues' written by Users Voice (*DDN*, October, page 14). This followed up Nick Wilson's great article 'Agents of Change' (*DDN*, September, page 6) that we need a rebirth of harm reduction and harm reduction activism.

I feel compelled to add further comments about harm reduction. It is exactly what it says it is, whether for those people who continue to use drugs in the most chaotic way or for those who want complete abstinence. We must provide appropriate interventions to reduce harm to people wherever they are on this spectrum and not where we think they should be.

Harm reduction is not just a list of practical strategies like NSP and DCRs, essential as they are, but it is a set of principles and a movement for social justice.

There are many but here are a few that I feel should be adhered to:

- Treat all people who use drugs with the same care and compassion as anyone else.
- Never judge people just because they use drugs.
- With people who use drugs being the primary agents of reducing the harms caused by their drug use they must be allowed a real voice in their own treatment and proper input into the development of treatment services.
- Give real recognition to the reality that poverty, class, racism, social isolation, past trauma, gender-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

Are we adhering to these principles? In a word, no. This is not to say many are not trying, but with what has taken place over the last decade – including dramatically reduced funding, reduced training and politics leading treatment rather than evidence – it has become very difficult.

A few examples:

1. Jane who was caring very well for both her child and disabled partner, was very stable on 120mg methadone. She asked me to speak to her drug worker because he was insisting that she reduce her dose by 10mg a fortnight simply because he said she had to. When I spoke to Justin, the worker, he had no understanding of the evidence for OST and didn't know what harm reduction was – and thought a quick road to abstinence was the only option. Thankfully, this story turned out well in that Jane is now back on her 120mg and Justin has enrolled on RCGP Part 1 Certificate in Drug Dependence.

2. Kieron requested an increase in his buprenorphine from 8mg to 10mg. The doctor agreed but on attending the pharmacist he found he had been changed from weekly pick-up to supervised consumption, without any discussion. This was impossible for Kieron as he worked and dropped the kids at school most mornings.

3. Jim, who was in his 70s, had health problems of his own and cared for his disabled wife. He found using opioids, originally started for arthritis, and diazepam, helped him through the day. As the Users Voice letter says some people, (especially older ones, ones who have mental health issues and other previous health conditions) 'require modest doses of mood-altering substances to live reasonable and functional lives'. His GP explained about dependency and wanted him to come off his opioids. Understanding the evidence, Jim wanted to remain on them.

How many stories like these are being played out around the country? We need to fight for change and regain our care and compassion.

Chris Ford, clinical director, IDHDP

PERSONAL PLAN

In response to the comment (*DDN*, October, page 14) on my Post It from Practice (*DDN*, September, page 11), I am, and always have been, a strong believer in harm reduction and believe it should be taken literally – ie that each individual I see needs a plan that reduces the risks to them.

For some this involves continuing long-term medication and so I have patients that I have prescribed opioid substitution medication to for over 20 years. However for others, a risk is in continuing high-dose medication where no benefit is shown. The patient mentioned in this Post It has no history of using illicit opioids and I do not feel he is likely to start doing so if we proceed – with caution – in reducing his medication load. There is no intention of completely stopping his prescribed medication, but the fact remains that he is at significant risk due to the dose he is on and after discussion with him he was willing to try reducing his overall opioid dose.

The word 'deprescribing' is used increasingly in primary care. Put simply, its definition is to approve outcomes for patients for whom their prescribed medication is having a negative effect on their health. Working in primary care allows for a long-term individualised approach to each patient to be taken, and it is this that I was aiming to convey, within the constraints of the column word count.

Dr Steve Brinksman, clinical director, SMMGP

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.

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They said what..?

Spotlight on the national media

leics.police.uk

SO FAR, the government's response to county line drug dealing has been to point the finger of blame at the middle classes, alleging that their cocaine use is fuelling the rise in knife crime, which they erroneously also link to county lines. While it makes for an easy headline, it neatly distracts attention away from the underlying social problems that an increasing number of young people face but appear to be invisible to politicians. This cohort of young people have been abandoned by the state at a time when state intervention is most needed.
Ian Hamilton, Independent, 7 November

As a society, we need to do more to recognise county lines exploitation before the offer of support turns to punishment.

THE TRAUMA of being involved in county lines can leave deep scars. Young people drop out of school, become alienated from their peers, and witness and execute extreme violence. Many enter the criminal justice system once they turn 18, often becoming locked into a revolving door of criminality, their chances of living a normal life reducing with the passing of time... As young people get older, the way people perceive them shifts from being the victims of crime to perpetrators. As a society, we need to do more to recognise exploitation before the offer of support turns to punishment.
Sonya Jones, Guardian, 25 November

PROBLEM DRUG USE IN SCOTLAND has been allowed to fester into a scandal, thanks in no small part to the perpetual and circular row over reserved and devolved powers waged between Edinburgh and London for decades. Even in our current febrile political climate, with a general election looming and debate raging over Scotland's constitutional future, that cannot go on. But it will.
Martyn McLaughlin, Scotsman, 6 November

WHEN WILL WE EVER LEARN just how much damage the unrestrained use of marijuana is doing to our society? When will we ever do anything about it, as wiser countries do? I make no apologies for coming back to this subject, as I remain amazed by the growing support of ignorant politicians and media for the legalisation of this terrifying poison. If they get their way it will take us straight into a nightmare version of the third world, with all the misery but without all the sunshine... Far from legalising marijuana, we should be ferociously enforcing the laws against its possession, and driving it out of use, as the sensible governments of Japan and South Korea still do.
Peter Hitchens, Mail on Sunday, 10 November

CHOICE WOULD BE A FINE THING...

As we approach 'Dry January' **Amy Dresner** asks, 'Can sobriety be both a health trend and a matter of life and death?'

Months ago I innocently tweeted: 'I'm all down with the new sobriety/sober movement but please let's not forget among the mocktails, the trendiness and the tees with cutesy slogans that for many of us, sobriety wasn't a health trend, lifestyle choice or a socio-political statement but a matter of life and death.'

I got dozens of shares and 'amens!' and an equal amount of people coming after me with flaming pitchforks accusing me of 'gatekeeping sobriety' or sarcastically consoling me that 'sorry being sober isn't punk rock anymore'.

For those of you who aren't familiar with the 'new sobriety,' it is a new trend to not drink, to be sober but not because you're alcoholic necessarily. It was born out of 'Dry January' and alcohol-free events with the precept of exploring your relationship with alcohol. It's primarily intended for people in 'grey area drinking' – not full-blown alcoholics, but people who might send some stupid texts, occasionally regret how much they drank, or not be as fully functional as they'd like the morning after.

If you want to take a break from drinking to see if you can be social without liquid courage or not be hungover for your 7am spin class, I fully support that. And if you can stay stopped because of that, fantastic. I am not at all saying that you need to wrap your car around a pole or have your parents remortgage their house to send you to treatment half a dozen times before you realise that your life is infinitely better without getting loaded.

But all the coverage of the 'new sobriety' in the media is missing an important piece of the story: if you CANNOT do a full month without drinking or if your life gets exponentially better when you stop drinking... you might actually be an alcoholic. And sorry but there ain't nothing trendy or cool about that. And 'alcoholic' and 'alcoholism', the words that really need to be de-stigmatised, are being left out of this conversation and, frankly, the whole movement.

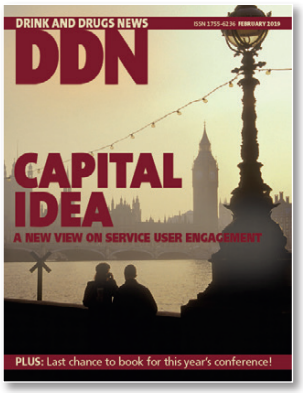
Granted, I'm a recovering blackout drunk and IV drug addict so a 'Dry January' was pretty implausible unless I was locked up in a rehab or a psych ward. For us alcoholics, the idea of 'moderation', the myth that we can stop or start at will, is an ethereal dream that takes many of us out of recovery and keeps us experimenting over and over again till we hit rock bottom or die.

I'll be honest, when you're an alcoholic this 'new sobriety' feels a bit like people choosing to be gluten-free because it reduces inflammation or whatever, when you actually have to thanks to your celiac disease. And the popularity of this idea that you can just CHOOSE not to drink undermines the current science that for many people there's a genetic component to their alcoholism, an anomaly in the reward system of the brain that makes that choice... well, pretty much impossible.

This is an extract of Amy Dresner's article for RecoveryWrx, a site about recovery, for people in recovery, by people in recovery. www.recoverywrx.org

CASH STRAPPED CHRISTMAS

Battered by Brexit, the public goes to the polls yet again. In the treatment sector, meanwhile, more long-established facilities are forced to close their doors as the funding crisis goes on.



JANUARY
The year starts with a warning from the National Crime Agency that more and more children and vulnerable adults are being exploited by county lines gangs, an issue that would remain in the headlines throughout 2019.

FEBRUARY
Alcohol-related hospital admissions in England are up 15 per cent in a decade, says the NHS, while Birmingham plays host to *Keep On Moving*, the 12th *DDN* service user conference. 'Every single person sitting in this room makes people like me look good,' Turning Point chief executive Victor Adebowale tells delegates. 'You're the people with frontline understanding.'

MARCH
Funding pressures see City Roads close after 40 years, while Release warns that the amounts of naloxone being provided by local authorities and prisons are 'drastically insufficient'. PHE and the Home Office, meanwhile, report a 'statistically significant' increase in crack use, driven in part by aggressive marketing.

APRIL
The government launches its three-year strategy to tackle gambling-related harm, while the NHS strikes a 'world-leading' deal with drug companies to work together to eradicate hep C.

MAY
Scotland's drug-related death statistics are released, and yet again the number is the highest ever recorded. Ed Day is appointed the first ever drug recovery champion.

JUNE
The number of over-40s in treatment for opiate use has tripled since 2006 says the ACMD, while the Global Commission on Drug Policy states that international drug classification continues to be influenced by 'ideology, political gains and commercial interests'.

JULY
Broadreach House becomes the latest residential facility to close its doors through lack of funding, while ex UKDPC boss Roger Howard pens an open letter to the new drug recovery champion in *DDN*. 'First, ditch any idea that you can make any significant impact on local collaboration,' he advises.

AUGUST
The Children's Society warns that children as young as seven are being targeted by county lines gangs and, three months after Scotland's figures, ONS announces another record-breaking drug death toll south of the border.

SEPTEMBER
PHE's long-awaited prescription medicines review finds that more than 11m people are being prescribed potentially addictive drugs – up to a third of them for three years or more. Meanwhile an LJWG report warns that data sharing will need to be radically improved if the hep C elimination target is really going to be met.

OCTOBER
A report from the Health and Social Care Committee states that drug policy is 'clearly failing' and should be radically overhauled, while ONS figures show that two in five deaths of homeless people are now drug-related. Nick Goldstein tells *DDN* readers that Brexit could mean even more cuts for drug services – 'there isn't much salami left to slice,' he warns.

The year starts with a warning from the National Crime Agency that more and more children and vulnerable adults are being exploited by county lines gangs, an issue that would remain in the headlines throughout 2019.

NOVEMBER
After the summer's bleak drug-related death statistics, NHS Digital figures show that hospital admissions for poisoning by drug misuse have risen by 16 per cent since 2013. The Scottish Affairs Committee becomes the second group of MPs in a fortnight to call for an overhaul of drug laws, while *DDN* celebrates its fifteenth anniversary with a brand-new look.

DECEMBER
On the day *DDN* goes to press Britons are dragging themselves to the polling booths for the third general election within five years, while research commissioned by GambleAware finds that 68 per cent of 20-year-olds had taken part in some form of gambling in the previous year. Meanwhile, the *DDN* team is hard at work putting together the line-up for next year's service user conference – watch this space!

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Change Grow Live