DDN

Drink and Drugs News
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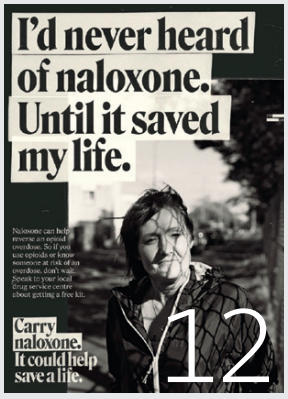

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STAYING STRONG IN PARTNERSHIP

'As we slowly ease out of lockdown there are many valid worries and fears that you may be experiencing...'

Turning Point offers quick and valuable tips to handle stress triggers in our latest **Partner Updates** – all at **www.drinkanddrugsnews.com**

The 'whole person' is at the root of everything

'The healthcare system doesn't care. It sees me as an unnecessary expense.' Hearing feedback from people who are perceived as 'hard to reach' (p10) gives direction on offering more effective treatment. But more than that, it gives clues on why people often don't connect with the most appropriate service to help them move forward.

Seeing the 'whole person' is at the root of everything, as we hear in this issue – from teams working in substance misuse and mental health, GPs, and people sharing their experiences of treatment (including what really helped them). We've moved on from passing the parcel in 'dual diagnosis' and learned that many complex issues manifest in many different types of behaviour, so it makes absolute sense to integrate our approach. One of the big challenges ahead will be to safeguard addiction specialisms as we grasp the opportunity to coordinate care pathways (page 6).

Looking back over 25 years of events (p10) SMMGP have realised how far they have come in listening to lived experience. We aspire to do likewise, and have personal stories on trauma, recovery, and peer-led action. For some unflinching first-hand views on drug treatment, turn to p22. We asked for feedback and we got it!

Claire Brown, editor

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

Drug control a health and human rights 'disaster', says IDPC

The global drug control regime represents 'a shocking health and human rights disaster' according to a report from the International Drug Policy Consortium (IDPC) to mark the 60th anniversary of the Single Convention on Narcotic Drugs. Around 2.5m people are in prison for drugs offences, at least 475,000 of which relate to personal use only, while the annual drug-related death toll now stands at 585,000. Only one in eight people with drug dependence has access to treatment, the document states, while billions have limited or zero access to pain relief 'due to repressive drug laws'.

While the 1961 Single Convention on Narcotic Drugs represents 'the legal foundation' of international drug control, last month was also the fifth anniversary of the 2016 UN General Assembly Special Session (UNGASS) on drugs, which saw countries commit to a 'public health, rights-based' approach to drug policy (*DDN*, May 2016, page 4). Comparing these commitments with evidence on the ground reveals 'a widening gap between rhetoric and reality,' says IDPC. Enforcement of drug laws continues to disproportionately affect women and ethnic minority groups, fuelling poverty and inequality, the report says, and calls for a full review of drug laws and policies to 'remove all punishments for drug use and possession for personal use' and ensure proportionate sentencing and 'meaningful' alternatives to incarceration.

'The 60th anniversary of the global drug regime gives us little cause for celebration' said IDPC executive director Ann Fordham. 'In the past five years, some progress has been made, as countries moved to adopt welcome initiatives on the decriminalisation of people who use drugs, and the legal regulation of cannabis. However, in most parts of the world, governments remain wedded to draconian policies that have had a catastrophic impact on communities, and have resoundingly failed in their stated purpose of eradicating drug markets, or reducing illegal drug use.'

Taking stock of half a decade of drug policy – an evaluation of UNGASS implementation at idpc.net

'In most parts of the world, governments remain wedded to draconian policies.'
ANN FORDHAM

Countrywide homeless outreach launched

EIGHTEEN NEW HOMELESSNESS OUTREACH SERVICES, employing 130 staff, have been launched across England by Change Grow Live. Alongside access to drug and alcohol treatment, the specialist teams will offer wrap-around holistic support including wider mental and physical health, as well as help with housing and benefits. The teams will provide street interventions for people sleeping rough – with no requirements to attend appointments – in locations across London and throughout the country. People will be able to access support straight away with no need to wait for referrals from a third party, says the charity.

The services represents a 'landmark moment', said Change Grow Live's national homelessness lead, Lesley Howard. 'Each service will help us to provide effective, evidence-based support for people struggling with homelessness and substance misuse.' The project was the 'first fully wrap-around offer I have seen for homeless people,' added national lived experience volunteer Tony Lee. 'As a person who was homeless for 12 years in London, I can also say that the impact an approach like this will have will be life changing. Homeless people will be engaged in their own environment and not asked to come into an office or building. Just this alone will increase the engagement tremendously and better engagement means better outcomes.'

'Each service will help us to provide effective, evidence-based support for people struggling with homelessness and substance misuse.'
LESLEY HOWARD

Half of Scots drinking more

A SURVEY BY WITH YOU has revealed the 'huge impact' of COVID-19 on alcohol consumption in Scotland, with 49 per cent of respondents saying the pandemic has led to them drinking more. The survey of almost 5,400 people also found that 30 per cent were consuming ten or more units 'on a typical drinking day', with the same proportion reporting using alcohol to deal with stress and anxiety. Researchers found that more than a quarter of respondents' drinking fell into the increasing risk, higher risk or possible dependence categories, with a third reporting concerns about their drinking during lockdown. The size of the survey 'provides a thorough snapshot' of current drinking levels, says the charity, with respondents given a score based on the Alcohol Use Disorders Identification Test. Almost 95 per cent of those who responded said they'd never accessed support for their drinking.

With You has also launched a new search engine for people to find information about needle and syringe services in their area. Accessible via the organisation's website, the tool provides full details of local NSPs sorted by postcode.

www.wearewithyou.org.uk/needle-syringe-services/

Europol: Europe's drug trade more violent than ever

The use of violence in the illegal drugs trade has 'escalated notably in recent years', according to Europol's *European Union serious and organised crime assessment – EU SOCTA 2021*. Competition between suppliers has intensified, leading to an increase in both the frequency and severity of violence, it says.

The SOCTA, which is published every four years, identifies shifts in serious and organised crime activity based on analysis of thousands of cases and intelligence provided to Europol. The COVID-19 pandemic and 'potential economic and social fallout' could create ideal conditions for criminal organisations to thrive and expand, it warns, with serious and organised crime posing a greater threat than ever before.

'A key characteristic of criminal networks is their agility in adapting to and capitalising on changes in the environment in which they operate,' it states. 'Obstacles become criminal opportunities.'

Around 40 per cent of criminal networks are active in drug trafficking, the report states, with the production and distribution of drugs by far the EU's largest criminal business. The scale of money laundering from drug supply and other activities has also been previously underestimated, it adds, with launderers establishing a 'parallel underground financial system' and using 'any means to infiltrate and undermine Europe's economies and societies'.

Global manufacture and seizures of cocaine remain at record levels (*DDN*, July/August 2019, page 5), with purity of the drug at retail level also the highest ever recorded. More criminal networks are moving into the huge European market for cocaine, says the report, attracted by higher prices and lower risks than in North America. 'Latin American criminal networks are expected to continue collaborating with international EU-based criminal networks,' the report states. 'In the EU, high cocaine availability, low wholesale prices and a high level of purity are expected to remain features of the market in the short term. The booming cocaine market has entailed an increase in the number of killings, shootings, bombings, arsons, kidnappings, torture and intimidation. The nature of the violence appears to have changed – a growing number of criminal networks use violence in a more offensive way.' *EU SOCTA 2021 at www.europol.europa.eu*

> 'More criminal networks are moving into the huge European market for cocaine... attracted by higher prices and lower risks'

Prescribe exercise not pills, says NICE

PEOPLE WITH CHRONIC PRIMARY PAIN should be offered a range of treatments to help manage their condition, says new guidance from NICE, rather than being started on drugs such as benzodiazepines or opioids. Chronic primary pain is defined as pain lasting more than three months and where the cause is unclear – pain caused by an underlying condition such as arthritis or ulcerative colitis is known as chronic secondary pain. The guideline emphasises the importance of shared decision making and 'putting patients at the centre of their care'. Treatments known to be effective in managing chronic primary pain include exercise, cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT).

People who have been prescribed drugs for chronic primary pain are not being asked 'to simply stop taking their medicines' without being provided safer alternative options, stresses NICE. Anyone prescribed drugs not recommended in the guideline should ask their doctor to review the prescription 'as part of shared decision making'.

Chronic pain (primary and secondary) in over 16s at www.nice.org.uk

Nationwide naloxone awareness

A NATIONAL NALOXONE and overdose awareness campaign has been launched using posters of people personally affected by overdose and who now carry naloxone themselves. The billboards are being displayed across London as well as in Birmingham, Bristol, Cardiff, Edinburgh, Glasgow and Manchester.

The campaign highlights the importance of making naloxone available to anyone at risk of opiate overdose – or likely to witness one – as well the need to properly understand overdose risks, with everyone featured in the campaign having been trained in overdose prevention.

'What this campaign demonstrates beautifully through its anti-stigma approach is the human face of people with real lived experience,' said Release executive director Niamh Eastwood. 'It is this humanity that is often ignored by politicians, the media and other agencies who seek to dehumanise and "other" this vulnerable population, and this allows for their lives to be seen as expendable. This has to end – we must recognise that stigma kills.'

See feature, page p12

Local News

SPACE TO CREATE

Manchester-based charity Portraits of Recovery's Sounds at the Edges project is bringing together people in recovery and local contemporary artists for a series of creative workshops using accessible materials and processes. 'Engaging with making in this way can play a vital role in wellbeing for us all,' said creative producer Jenny Walker. *portraitsofrecovery.org.uk*

DESTINATION HOLYROOD

Harm reduction activist Peter Krykant – who made national headlines after setting up a mobile consumption room in a van (*DDN*, November 2020, page 5) – is standing as an independent candidate for Falkirk East in the forthcoming Scottish Parliament election. 'The most startling aspect after record deaths in 2014 and 2015 was the Scottish Government cutting budgets for alcohol and drug partnerships, and since then drug deaths have doubled,' he told the *Falkirk Herald*. 'As the only candidate ever to run for Holyrood elections with an open background of mental health issues, addiction and street homelessness, I feel that I could hold the government to account to make sure we don't ever again make these dreadful decisions, which have caused so much pain for thousands of families right across Scotland.'

RIGHT PLACE, RIGHT TIME

A stressful year is giving rise to a fresh approach to mental health at Phoenix Futures, as **DDN** reports

'People in treatment are keen to say they're ok, but a significant amount of people have really struggled over the past year,' says Phoenix Futures' chief executive **Karen Biggs** of more than 12 months in lockdown.

'Our residential services are where we've traditionally seen those with the most complex needs and where they will have an opportunity to engage with the appropriate medical help and psychological support,' she says. So Phoenix made two key decisions, and the first was to stay open throughout, 'because I knew the need was out there and if there was ever a time people needed access to rehabs it was during the pandemic.'

The second key decision was that 'we were not going to take our foot off the pedal in our mental health work'. There were two important strands to this – a refresh of clinical interventions, and a specific look at what else they could be doing to make sure people could access the right interventions at the right time.

'People with substance misuse and mental health conditions get passed from pillar to post, struggling to engage with substance misuse services and then mental health services at the same time,' she says. With the expertise of the team's psychologist and senior mental health nurse, the plan was to develop the team's skills to 'hold' people and start to address their issues while they were in treatment – then to improve links with other services, 'so there's a really good pathway of support when they move out'.

Nothing has stalled over the past year – quite the opposite. Biggs is 'terrified' of what's to come on drug-related death statistics as 'there's so much we don't know about the experience of people in treatment over the last year'. Add to that the stigma, not just in the media but in the 'everyday decisions made by professionals in the healthcare system', and there is much to do. 'Stigma is preventing people from accessing help,' she says. 'It prevents people from accessing substance misuse services and put together with a mental health condition it's so hard. We need to speak out about it and support health professionals to understand the impact of their decisions.'

'There's so much we don't know about the experience of people in treatment over the last year'

As the pandemic escalated, Biggs was acutely aware that her staff had support needs of their own, whether out on the frontline or adapting to the challenges of virtual support from home. Half of Phoenix's staff continued to work face-to-face in the pandemic, in residential and housing services, and there was 'a lot of fear' to begin with, facing risk, adjusting to new protocols to keep everyone safe, and fighting for PPE, testing and access to the vaccine. (A particular challenge, says Biggs, as while residential rehabs are registered care homes, they were not viewed as priority.)

The decision to stay open was a 'massive ask' of team members and redoubled her commitment to staff welfare. She recognised that 'there was a very real need for the staff to decompress', particularly without the usual opportunities to get together, laugh, cry, hug, and share the load, so a much-valued wellbeing programme was introduced and has been extended indefinitely. 'We have to continue to recognise that staff have been going into work and risking their lives every day,' she says.

Phoenix has also taken the opportunity to learn from the pandemic by beginning a research partnership with Liverpool John Moores University. The aim is to study the impact of COVID on residential rehabs through surveying staff and service users, and results will be interpreted in June and fed into the organisation's review of practice.

The other area for development – and something Biggs feels hopeful about – is the prospect of addiction services becoming part of the wider health and social care sector, post PHE restructure. 'The pathways into and out of addiction services and how we are able to support alongside our health and social care partners should be made easier,' she said. But she adds a strong note of caution: that we must not allow the specialism of addiction to get lost 'within the broader health and social care tent' – a real risk. 'We've got to be braver and more confident as a sector in our communication on it,' she says. **DDN**

peshkov / iStock

As head of clinical interventions, **Gabrielle Epstein** is at the forefront of the revitalised mental health strategy and clinical review.

'People working in substance misuse manage people with mental health issues really well whether they realise it or not,' she says, and we should be building on these strong skills.

An experienced psychologist, she talks of the 'whole person' arriving in treatment with various issues to address and is very keen to move away from the label 'dual diagnosis'. Mental health needs were identified in 60 per cent of people admitted into Phoenix's residential services – 66 per cent were found to have depression and/or anxiety, 7 per cent had PTSD and 12 per cent were diagnosed with a personality disorder/affective disorder.

People with mental health needs are 'our bread and butter, this is who we've always treated', says Epstein, but it's not always straightforward. 'Some substances are very good at masking the positive signs of mental illness... So heroin for example is quite good at dulling down the psychotic symptoms of schizophrenia, which is sometimes why people use it. If the substances are masking the symptoms, when you detox they will emerge.'

Many diagnoses were identified by GPs and mental health services before admission, but other people had mental health needs that had not been formally diagnosed. With a system of 'dynamic assessment' in place, their needs are reviewed regularly and the treatment plan adjusted to bring in the relevant expertise. Referrals are made swiftly and incorporated into risk assessment and care planning – an approach that's working. Data on completion shows that those with a mental health issue are as successful as anyone else in completing the rehab programme.

The registered mental health nurse (RMN) is an important member of the team and a key to keeping the door open between substance misuse and mental health. Training for the entire team includes a full set of skills to recognise and manage mental health issues, and some of the nurses are dual qualified as CBT therapists. Everyone is switched on to helping people engage in treatment, explains Epstein, and that might mean clinical supervision, medical interventions or cognitive behavioural therapy (CBT) at different points in their journey. Anxiety, for example, 'yields very well and relatively quickly to CBT interventions' and a few sessions usually enable the person to engage in treatment.

> 'Some substances are very good at masking the positive signs of mental illness... when you detox they will emerge.'

The other major part of staff training is in trauma-informed care, because, says Epstein, 'we know that nearly everyone who comes into residential treatment has an experience of trauma'. This has to include supporting staff to recognise their own triggers, as well as being fully aware of the risks of retraumatising people in their care.

The team is looking at some very promising (and cost-effective) interventions such as eye movement desensitisation and reprocessing (EMDR) – 'evidence based and economical, because it's a brief intervention with very good outcomes', according to Epstein. While the intervention itself is brief, she adds, there's a 'long preparation period where people have to be stabilised enough to be able to engage in it', which once again shows the need for close-knit working within the multi-disciplinary team and beyond.

The community mental health team form another essential link in the chain of care, and Epstein is hopeful that changes within the Department of Health and Social Care will give greater capacity for the multi-disciplinary team approach, including joint case conferences that support residents beyond discharge from rehab. It makes all-round (including financial) sense, she says. 'People who come into residential treatment may have had frequent contact with the police and be frequent flyers with A&E. But we know that if you're successful with your treatment and continue with your aftercare, those presentations to A&E will decrease and there's an overall cost benefit to the health system.' **DDN**

Colin Underhill / Alamy

A SPORTING CHA

On his retirement from Change Grow Live, **Chris Bruce** reflects on the impact of trauma and the power of sport as a recovery tool

At 66 it was time to go. After emerging from detox in 1980 I would never have imagined in my wildest dreams what an incredible journey it has been, but in this article I wish to concentrate on two themes – trauma and how it affected me, and sport as a recovery tool.

In 1969 my father, a consultant physician, committed suicide. At the time I was at a boarding school in Sussex. This did not immediately lead me to start misusing drugs and alcohol, but it did have a severe impact on my outlook on life and on my fellow human beings. No one spoke to me about the 'event' –even the family remained silent. Friends stayed away and psychologically my view of people and life changed.

A serious injury at school kept me out of sports for a year and my elevation to the 1st XI football team was halted. Going up to London in 1972 on the outside I presented as 'cool' and 'laidback' but on the inside I was rudderless and angry. Searching for a father figure with my trust blown away, getting stoned and having fun. That's where I wanted to be. In the end of this particular downward journey I ended up with six years of addiction to diazepam after being prescribed them by a GP when complaining that I was unable to sleep coming up to college exams. The irony of it now seems incredible – a drug that slowed me down and eventually emptied me out, leaving me a paranoid wreck. Working through this 'residue' has taken time. AA plus NA and counselling and ten years of abstinence after my detox allowed my brain to start a healing process. It has been challenging at times. And on it goes.

Sport growing up was at the centre of my life. I was fortunate to be good at most that were on offer. My eye for a moving object was excellent. Football and tennis were my top two games, especially football. One of my great humiliations was being sacked from my college team in 1974 for turning up to a match still high from the night before. In 1980 prior to going into detox, when I lay in a snow drift in Yorkshire simply wishing for it all to end – most certainly my final rock bottom – I was mentally and physically gone. Then as I remember clearly to this day into my head came a powerful light with a question attached to it: What happened to the person who won his school colours? Where was the fighting spirit? On the first day in hospital I signed up for the gym and vowed I would play football again.

In 1991 I completed a three-year BA in sports and American studies, played football again for the college team and captained the tennis team, even winning an international tournament. On a personal level I was back, but the mental recovery was still ongoing.

At college I attended many sessions with the college counsellor, and my first job was a sports-focused one with West Yorkshire Sports Counselling Association. I was one of four sports leaders, supporting clients on probation to engage in sport as a way out of their offending behaviour. One of my clients fancied getting some proper coaching at badminton and every week we met at the sports centre – he became a good player, improving week by week, and his motivation and self-worth improved. Time and again I saw for myself the positive outcomes for those who were signed up to our service.

In 1997 I won a Winston Churchill Travelling Fellowship to the US, and the research I carried out was 'can positive strategies help divert drug abuse and offending behaviour?'. This too focused on sports as a way of re-engaging individuals in society through positive activities. When I returned, highly motivated, I took up the post of day care co-ordinator at Harrogate Alcohol and Drugs Agency, where I arranged outdoor activities, including hiking and

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‘In 1980 prior to going into detox, when I lay in a snow drift in Yorkshire simply wishing for it all to end... I remember clearly to this day into my head came a powerful light with a question attached to it: What happened to the person who won his school colours?’

football, for our service users. So a circle had been completed – I was now giving back because of something I had experienced for myself. Seeing it work for others was what inspired me to continue to deliver sports activities to my service users throughout my working life.

And as part of the other healing circle, three years ago I met an amazing individual Dr Sharon McDonnell giving a presentation around the issue of bereavement. She now runs Suicide Bereavement UK based at Manchester University, and asked me to take part in their study on the effect of suicide on children, which is due for publication soon. Attending the Suicide Bereavement UK conference in 2019 was an incredible and moving experience for me – there are so many wonderful projects out there. One basic message from the day was ‘just let someone know you care’. This resounded massively with me.

For the last two years I have been running a community sports session at the Lytham YMCA, which has attracted ages from 35 to 83. Everyone attending has loved the variety of activities on offer, and I’ve witnessed people taking up something new and developing their skills. Now that we are (hopefully) coming out of the worst of COVID, there is going to be an even greater call for activity community groups, and improving mental health is also going to fall within this remit.

I was so pleased in my latter days with Change Grow Live that I saw them recognise the importance of offering all kinds of outside interventions including sport with the Community Sports Initiative (CSI), and the massive move forward in seeing trauma as a major cause of ‘meltdown’ in many people’s lives leading to alcohol or drug misuse.

In ‘retirement’ I’m going to continue with my sports groups and have other project ideas on the go. And finally, quoting from one of my favourite bands, the mighty Black Sabbath: ‘Is this the end of the beginning or the beginning of the end? We will see.

If anyone out there would like to contact me please email: Bruce.C2@sky.com

To contact Sharon McDonnell: www.suicidebereavementuk.com

MATCH HIGHLIGHTS

BEST JOB For not only my introduction to working with probation clients but also helping me to achieve so many things in my own life: The WYSCA 1993-96 Team. From left to right: John Wheeler (Manager), Paul Kendall (sports leader), Marion Oldham (secretary), (the late) Mark Milner, Adrian Tolan and Chris Bruce (sports leaders)

PROUDEST MOMENT The then ex prime minister John Major presenting me with my Winston Churcill Fellowship medallion at the Guildhall, Westminster in 1999. He said the ‘normal’ congratulations text to me, then I asked him if he thought Michael Owen would start for England.

MOST BIZARRE MOMENT Wimbledon 2015 – My brush with fame! *Daily Mirror* picture of me sat with a certain David Beckham and son (he sat down with me by the way!). Seeing all the cameras focused on him as he sat down was something I shall always remember. Now I know what fame feels like! I was asking whether his son played tennis.

BETTER PRACTICE

The last 25 years has seen the treatment of people with substance misuse issues in primary care change beyond recognition, hear delegates at RCGP and SMMGP's annual conference

Julian Claxton / Alamy

'The GPs said, "You can treat their abscesses but don't talk to them, because they're deceiving and they're liars",' Dr Chris Ford told delegates at the 25th RCGP and SMMGP Managing Drug and Alcohol Problems in Primary Care conference. She was describing the situation when seeing her very first patients with substance misuse issues as a trainee in Kilburn, north west London. 'And all the books were very much psychiatric-led and about how this is a mental condition and you've got to keep people under control.'

When she and her colleagues first proposed the idea of a primary care substance use conference, however, the RCGP were 'incredibly supportive', she said – 'although they might have thought we were a bit mad.' Treating substance issues was now a normal part of general practice, she stated. 'But back then it wasn't, and I think through the network and the conference and SMMGP we've mainstreamed these ideas and normalised care of these patients within general practice. And that's really important.'

'What an amazing achievement – 25 years of the conference and 25 years and more of SMMGP,' added Dr Clare Gerada. 'The conference was set up because at the time GPs had signs on their doors saying things like "no drug users treated here" and intravenous drug users were dying all over the place.'

The conference had challenged commissioners that more could be done to reduce drug-related deaths, said chair Dr Stephen Willott, and that money spent on drug and alcohol services offered 'such a good return' on investment. 'But actually it's the right thing to do – to look after the vulnerable. Ultimately drug use is far more of a health issue than a criminal justice issue.'

April Wareham's speech as director of Working with Everyone demonstrated the central part now played in the event by people with lived experience. The project work of her organisation fed in from 'all sorts of disparate communities' and conveyed the message that people wanted better treatment, whatever their circumstances. 'It's not just about drug use, but about many other needs,' she said. But everyone needed access to good healthcare.

This year, with COVID 'at the front and centre of everyone's thinking', everyone had been talking about inequalities, and we needed to 'be specific about which inequality we are talking about and who is affected by it'. The 'stark inequalities' in services were responsible for huge gaps in treatment outcomes and life expectancy.

'The view from the system is that people are hard to reach and difficult to engage,' she said. 'We talk about frequent flyers, but not as a reward – it's a derogatory statement. The system sees these people as difficult and expensive.'

'Treating substance issues is now a normal part of general practice... But back then it wasn't, and I think through the network and the conference and SMMGP we've mainstreamed these ideas.'

DR CHRIS FORD

In many cases people had very low expectations of their own health, particularly where they saw people around them who were worse off than they were. The project heard views such as 'we're doing ok because we're still alive, so many [people we know] aren't'. When asked why they didn't go to the GP sooner, another answered, 'because everyone hates us and we know it'. Someone else commented that 'the experience of being turned away by the receptionist felt like being back in prison'. There was a common feeling that health services were too difficult to access and engage with, and didn't care about them.

'Shared care is one of the biggest tools in our toolbox for reducing inequalities,' said Wareham. 'Don't be afraid of complexity,' she urged GPs. 'This is where you could be having the biggest impact. Let people set their own priorities and listen to the patient – they know their own health. We know when something is abnormal for us.'

There needed to be a shift in perception, to seeing them as a person instead of a problem. The very necessary conversations about trauma had to move away from 'what is the matter with you?' to 'what happened to you?' and GPs needed to appreciate that their priorities might differ, 'so don't push everything at them at once'. They might not be ready for smoking cessation right now, for example.

Building a trusting relationship would give many more opportunities for the patient to come back and a much greater chance of making vital progress. **DDN**

Sipa US / Alamy

'While I agree with decriminalisation, let's be honest – even in the unlikely event it were to happen, it's not going to make much difference to drug deaths is it? Alcohol and tobacco are legal, and last time I checked they were doing quite well at killing people...'

TO BOLDLY GO...

So another day, another drug report calling for 'bold policies', this time from the Royal College of Physicians of Edinburgh, as they ponder how to tackle Scotland's world-beating drug death tally (*DDN*, April, p4). While I agree with decriminalisation, let's be honest – even in the unlikely event it were to happen, it's not going to make much difference to drug deaths is it? Alcohol and tobacco are legal, and last time I checked they were doing quite well at killing people, thank you very much. Ditto consumption rooms – in the equally unlikely scenario that they were legalised I doubt it would amount to much more than a drop in the ocean. They might prevent some overdoses but lots of people who use drugs wouldn't go anywhere near them, as has been pointed out in the pages of *DDN* in the past (*DDN*, November 2018, p10).

The reasons behind Scotland's drug deaths are, as anyone with any sense knows, poverty and despair – ingrained problems that aren't going to be fixed by tinkering with drug policy, however well intentioned. It may be that the Scottish Government are belatedly recognising the drug death crisis and acknowledging that they took their 'eye off the ball' – it's debatable whether it was ever on it – but I really don't see what a 'dedicated' minister is realistically going to achieve on this. Good luck to them, obviously, but I'm not holding my breath.

So we await the next set of figures, which everyone seems to think will be the worst yet, and so on and so on. And as was also pointed out in your magazine, for the Scottish Government to still be blaming Westminster for the problem despite devolution happening in the last century is a bit rich to say the least (*DDN*, November 2020, p6).

You can argue that decriminalisation would reduce stigma and encourage more people into treatment, but wasn't one of the problems that the treatment sector wasn't getting the funding it needed anyway? If people feel hopelessness and despair they're going to turn to substances to numb the pain – substances that may well end up killing them – and it doesn't really matter whether they're illegal, decriminalised or legal. The end result is always the same.
Peter Gordon, by email

IN MY OWN WORDS

I completely agree with the editor's opinion quoted in Setting The Tone (*DDN*, April, p13). There is definitely a huge case for giving people in addiction agency over how they see and term themselves. As you say, who are we to redefine them.

And of course, arguably the biggest group of people who stay well, in 12-step programmes, do so by acknowledging they are alcoholics and addicts, even when they have put down their drug of choice. As it says in the AA 'Big Book', alcohol is only a symptom (and dealing with the 'isms' goes on, a day at a time).
Mark Reid, by email

HAVE YOU BEEN AFFECTED BY GAMBLING?

I am part of the newly formed expert link panel and we are aiming to create a nationwide network for those affected by gambling harms.

We have co-produced a survey ***https://t.co/f7hFEVKWVI?amp=1*** and are seeking as many responses as possible from those affected by gambling harms to help shape and inform our work going forward – and as part of this process I am desperately keen to reach out to those who will have co-existing issues with alcohol and other drugs.

All responses are hugely welcome – please follow the link to complete our short (one minute) survey by Monday 10 May.
Owen Baily, by email

UPDATE: Carol Black report

AS PART OF AN ONGOING SERIES OF ONLINE EVENTS organised by the **College of Lived Experience Recovery Organisations** (CLERO) Dame Carol Black shared a preview of what to expect in the much-anticipated part two of her independent review of drugs.

The second part of the review is now with the prime minister's office awaiting approval and Black hopes it will be published in late May following the local elections. While she was unable to give details of the contents, she mentioned 32 proposals relating to creating system change.

Part one of the review, released in February last year (*DDN*, March 2020, p4), outlined key issues facing the sector – a 'perfect storm' of increased supply, austerity driven cuts to support services, rising crime, increased homelessness and the record high levels of drug-related deaths. **Part two of the report will outline the next steps and recommendations** – see next month's issue.

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

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Be well aware

A powerful new national naloxone and overdose awareness campaign is using the faces of people with lived experience to get its message across

'For me it's about saving a life,' says harm reduction activist Lee Collingham, one of the faces of the landmark, country-wide naloxone awareness campaign launched last month (see news, page 5). 'Some areas still haven't got access to naloxone, and until we have a national programme we need to get the basic messages across.'

What makes the campaign unique is that everyone featured in its posters carries naloxone themselves – having been personally affected by overdose – and has undergone the simple training needed to use it effectively. 'I was approached about this campaign because of my interest in saving lives,' says Collingham. 'I come from a drug-using background and I know that simple things like giving chest compressions and calling an ambulance immediately are so important.'

His input extended well beyond simply posing for a picture, he stresses – healthcare communications group Havas Lynx discussed his experiences with him in detail and took 'plenty of shots', before he chose the one he was happy with from a smaller selection. 'They mocked it all up with the message and explained how it would look in different spaces,' he says. 'I look like a normal guy on the poster, rather than a homeless person – the whole point of it for me is about getting people on board and making it more personable. You say "save the life of a heroin addict" and most people will walk by. There's always been a hierarchy, and heroin is at rock bottom.'

The campaign also reinforces the importance of understanding overdose risks, and the fact that it's been co-produced with people who may have been at risk of overdose themselves is key, the organisers state. 'I'd heard of naloxone but I didn't know what it was,' says Andy (pictured left, with bulldog), who was also part of With You's peer-to-peer naloxone programme in Redcar and Cleveland. 'We were educated on signs of overdose, what to say, how it worked. Even if I only give out one pack I could have saved one life down the line – that makes me buzz. It gives me confidence.'

The idea behind a public-facing campaign was to deliver something 'impactful, emotive and engaging', says Stephen Malloy, strategy and public affairs lead at Ethypharm, who provided funding. 'Accidental opioid-related overdose deaths are recognised as a public health matter and they are largely avoidable and preventable. That's what

TALKINGDRUGS is encouraging people to share their pictures of the billboards. Take a picture and tag *@TalkingDrugs* and *@Release_drugs* and they will share it on their socials.
Photo: www.talkingdrugs.org

the campaign is about – motivating people to find out more about overdose prevention and intervention with naloxone.'

The initiative has been welcomed by Release, whose executive director Niamh Eastwood states that widescale availability of naloxone and public education on how to use it should be at the 'cornerstone of any response' to the UK's 'shameful' record on protecting the lives of people who use drugs. Previous research by the organisation had found that while all but three of the 152 local authorities who responded to an FoI request on naloxone provision now supplied it, the amount actually being given out remained 'drastically insufficient'. In 2017-18, just 16 take-home kits were provided for every 100 people using opiates, with many areas failing to provide kits to the people most likely to need them (*DDN*, March 2019, page 4).

The hope is that with more money finally coming into the system, some of it specifically earmarked for naloxone provision (*DDN*, February, page 4), access can be improved. 'Drug service staff can provide naloxone to anyone without a prescription, and the availability of nasal naloxone now makes it easier for more people to use naloxone,' PHE's alcohol and drug treatment and recovery lead Pete Burkinshaw tells *DDN*. 'It's vital that local areas have good naloxone supplies in place and government recently provided additional drug funding to local authorities, some of which will be used to increase the provision of naloxone. We know that getting more naloxone into the community will help save lives by preventing unnecessary opiate overdose deaths. This campaign will help to raise awareness of the life-saving potential of naloxone through powerful real-life stories.'

The aim now is to allow the campaign to continue to develop and hopefully be rolled out again, says Malloy. 'It may be that it inspires government public health agencies to see the importance of public-facing communication around accidental overdose, much in the same way as it does other public health matters.'

'It's about putting your passion behind a campaign that's giving people the opportunity to save and improve lives,' says Collingham. 'But the journey isn't finished. Beyond the "save a life" message is the ambition for a nationally funded naloxone programme. It should be as second nature as giving out methadone.' **DDN**

See the full range of posters at https://naloxone.org.uk/

This article has been produced with support from Ethypharm, which has not influenced the content in any way.

GET IT OUT THERE

The recent SMMGP conference heard how both the police and the ambulance service were helping to improve access to life-saving naloxone

'The unfortunate and startling reality is that the drug-related death rate in Scotland is three and a half times that of our neighbours in England and Wales, and the worst of any European country,' Julie McCartney, clinical effectiveness lead for drug harm reduction in the Scottish Ambulance Service, told the conference.

More than 90 per cent of deaths involved someone having multiple substances in their system, she said. 'Poly-drug use, unfortunately, is certainly the norm in Scotland, and more often than not it's a toxic mix – a combination of central nervous system-suppressant drugs that contribute to the fatality.' The use of naloxone to 'remove opiates from the poly-drug use equation' was enough to keep someone alive until the emergency services arrived, she said.

Each year the Scottish Ambulance Service received around 20,000 calls related to overdose and drug poisoning, and in 2019 responded to 5,000 calls where naloxone was administered by the ambulance crew. 'Our naloxone administration has almost doubled since 2015 – following the trend of drug-related deaths, unfortunately,' she said.

The Scottish Ambulance Service had a seat on the Scottish Government's Drug Deaths Taskforce, and an ability to provide naloxone kits to people and communities that could be hard to reach by other services. It had also run a successful pilot project in Glasgow where paramedics distributed take-home kits to people at risk – and provided training in responding to overdose – which had now been re-launched on a national level.

The national training programme had a variety of options to allow the service's 3,100-strong crew to complete their training in the most convenient way, including face-to-face and digital sessions, with Ethypharm providing extensive training materials. 'The partnership approach and robust communication pathways that we're putting in place are absolutely essential in our national fight to reduce drug-related deaths,' she said. 'We'll continue to work alongside health boards and alcohol and drug partnerships across the country to make sure we're able to share really relevant and meaningful data to support the allocation of resources where they're needed most.'

As well as a take-home programme, Durham Constabulary had been using naloxone in its custody suites and officers were also carrying kits themselves, said temporary chief inspector Jason Meecham. 'Problematic drug use is a significant issue in our area – according to ONS the North East has had the highest rate of drug misuse of any English region for the past seven years.'

There had been a spate of opiate overdoses in the force's custody suites in 2018-19, he said. 'In conjunction with the county council's public health team we looked at bringing naloxone into the suites, as that's what the ambulance crews were using.' Working in partnership with the county council, local drug services and Ethypharm, all custody staff were trained to safely administer naloxone, including after-care.

More than 200 police officers and civilian staff had now been trained, he said, with naloxone 'used across all our sites really successfully'. After the pandemic led to concerns around increased numbers of methadone prescriptions potentially leading to more overdoses, the decision was made to provide personal issue naloxone kits to officers in a position to respond quickly. 'We now have a wide spread of police officers around County Durham and Darlington who carry naloxone, and it's been used on quite a few occasions, either in police stations, out on the street, or where we've responded to reports of overdoses before the ambulance crew. It's important to say we're not replacing the ambulance crews here – it's just if we happen to be there first.'

A third strand of the work was take-home naloxone, he said. 'We'd identified quite a lot of people we see in custody who quite clearly don't have frequent contact with their GP or drug treatment services, but who do have problematic drug issues.' The programme had been rolled out following extensive legal discussions, he explained. 'I believe we're the first force in the country where trained and authorised police officers are giving it away – there are others where custody staff are doing it – and it really is a partnership approach with the county council's public health team. Between us we agreed on the identification criteria for possible recipients, and the training and guidance requirements.'

While people could view a training video and receive appropriate referral material for drug treatment services there were 'absolutely no strings attached', he stressed. 'If they want a kit and they're eligible – and it's quite wide eligibility – they will get given a kit, and there'll be no further contact from us or treatment services. It's all about trying to get it into the hands of people who need it the most.' **DDN**

Due to overwhelming DEMAND

With rates of alcohol-related illness continuing to rise, **Charlie Parker** and **Ian Webzell** describe the vital work of the Substance Misuse Specialists in Liver Transplant (SMSLT)

The heaviest drinkers buy most of the alcohol sold in the UK, with 4 per cent of the population consuming 30 per cent. Despite a decline in average consumption there has been a paradoxical increase in certain alcohol-related harms, including a 400 per cent increase in deaths due to liver disease. This peaked in 2015-18, with 60 per cent of these deaths attributed to alcohol.

In 2018, more than 4,500 people died due to alcohol-related liver disease, but the work of liver transplant centres has suppressed this number by performing around 1,000 liver transplants per year. The demand for liver transplantation for alcohol-related liver disease is such that liver transplant centres have employed substance misuse specialists to assist in the assessment, monitoring and treatment of people with alcohol use and substance misuse disorders. These individuals have worked together to uphold national standards and formed a group called the Substance Misuse Specialists in Liver Transplant (SMSLT).

We are a group of substance misuse specialist nurses working across five of the seven transplant centres in the UK. We see patients with alcohol-related liver disease (ArLD) and other substance misuse disorders who are being considered for liver transplantation. We work closely with alcohol liaison nurses from referring hospitals and community drug and alcohol services. We actively encourage engagement with peer support and mutual aid services such as AA and SMART, and involve families in the transplant assessment and work-up period. We use motivational interviewing and relapse prevention interventions to enhance the patient's recovery capital and reduce the risk of relapse.

Patients must have been abstinent for at least three months – but the longer the better – in order to be considered for liver transplant, and are required to commit to lifelong abstinence from alcohol. For people struggling with symptoms of liver disease, liver transplantation offers the opportunity for improved quality of life and longevity.

ArLD is an umbrella term describing a range of alcohol-related liver injury including fatty liver, fibrosis and cirrhosis. Cirrhosis can be compensated or decompensated – compensated means the liver can continue to work and function, whereas decompensated disease results in symptoms such as ascites (fluid in the abdomen), jaundice, hepatic encephalopathy (confusion and memory problems caused by a build-up of toxins) and sarcopenia (muscle wasting). A liver transplant may be required when someone has decompensated cirrhosis or hepatocellular carcinoma (HCC).

Anyone diagnosed with liver disease should avoid alcohol, but this is particularly important for people with ArLD as ongoing alcohol use will continue to cause damage to the liver. Drinking after a transplant can cause serious issues, including recurrence of cirrhosis and liver failure which can be fatal. Across Europe, around 50 per cent of liver transplants are wholly or partially related to alcohol use.

During a liver transplant assessment, the substance misuse specialist will undertake a comprehensive assessment of candidates including a detailed drug and alcohol history. This allows them to formulate a risk assessment and provide an opinion to the team regarding the risk of relapse. If a patient is considered to be at a relatively high risk of relapse then we would offer interventions to engage the patient in their recovery journey. As the transplant centres are regional services we often see people from a wide geographical area, which is why we rely upon support from local alcohol recovery services, even when people are abstinent. As a result of the COVID pandemic telephone or video appointments are increasingly offered.

Nationally agreed guidelines recommend that patients are abstinent from alcohol, stop smoking and do not use any illicit drugs including cannabis. Prescribed opioid substitution therapy is not a contraindication to transplantation. Patients will be screened throughout their assessment and time on the waiting list. Any positive screens will be taken seriously by the liver transplant team and may result in removal from the waiting list. Being on the waiting list can be a period of uncertainty for candidates – these are periods of poor health, during which recovery is beyond the control of the individual. They may feel anxious or low in mood, and it is our job to continue to review people, provide support and work through any difficulties.

The recovery period following a transplant is focused upon people's physical health during the first six months and over time

Liver transplant journey

- **Patient is seen by gastroenterology or hepatology at their local hospital and diagnosed with liver disease**
- **Patient with decompensated cirrhosis and three or more months abstinence is referred to transplant unit**
- **Patient is seen in outpatient clinic or as inpatient depending on severity of disease**
- **Patient has multi-disciplinary transplant assessment (inpatient or outpatient)**
- **Patient is discussed at liver transplant MDT meeting**
- **Patient is either listed, not listed or listed pending further investigations or interventions**
- **Patient engages with substance misuse nurse specialist, alcohol liaison/community alcohol services, peer support and mutual aid (this may have happened before assessment)**
- **If MDT in agreement patient can be placed on liver transplant waiting list**
- **Alcohol levels are monitored before, during and after transplant**
- **Patient remains under lifelong follow with transplant centre/ local hospital**
- **If patient lapses/relapses aim to re-engage with alcohol services to support abstinence**

‘If a patient is considered to be at a relatively high risk of relapse then we would offer interventions to engage the patient in their recovery journey... we rely upon support from local alcohol recovery services, even when people are abstinent.’

their health and independence returns. Recipients may need support from family, friends and local services during this period, and we work closely with patients and their support networks to ensure that they feel supported in their recovery. Longer term, liver transplant recipients can expect a good quality of life and people resume their usual activities.

Occasionally, people relapse in terms of their alcohol or drug use. It is our job to work with people around their relapse, explore their situation and contemplate their options for modifying their substance use. Over time, people’s focus shifts from their physical health to their psychological and social health, and it is our role to support them with achieving their goals. The liver transplant centres often provide peer support in the form of mentoring or group support to provide additional support from those who have been through transplantation.

As a group, the SMSLT work together to promote equitable access to liver transplantation. We contribute to audits, research, conferences and national working groups. We support each other with supervision and aim to provide improved access for people with alcohol-related liver disease to a life-saving treatment. For those who go through with transplantation the journey is extraordinary. Following a transplant, patients are required to take immunosuppressant medication every day for the rest of their life (usually tacrolimus). This stops the body from rejecting the transplanted liver but can mean the patient is more at risk of infections. The tacrolimus level is monitored closely as if it is too high this can cause toxicity and if it is too low this can cause rejection which can be fatal. Patients must therefore attend regular liver clinic appointments and have regular blood tests.

It is important for patients to have a supportive network of friends, family and local services. We work closely with patients and their support networks to formulate a relapse prevention and recovery plan. We work as part of a multidisciplinary team including hepatologists, surgeons, dieticians, physiotherapists and transplant co-ordinators – some centres also have addiction psychiatrists whereas other services are nurse-led.

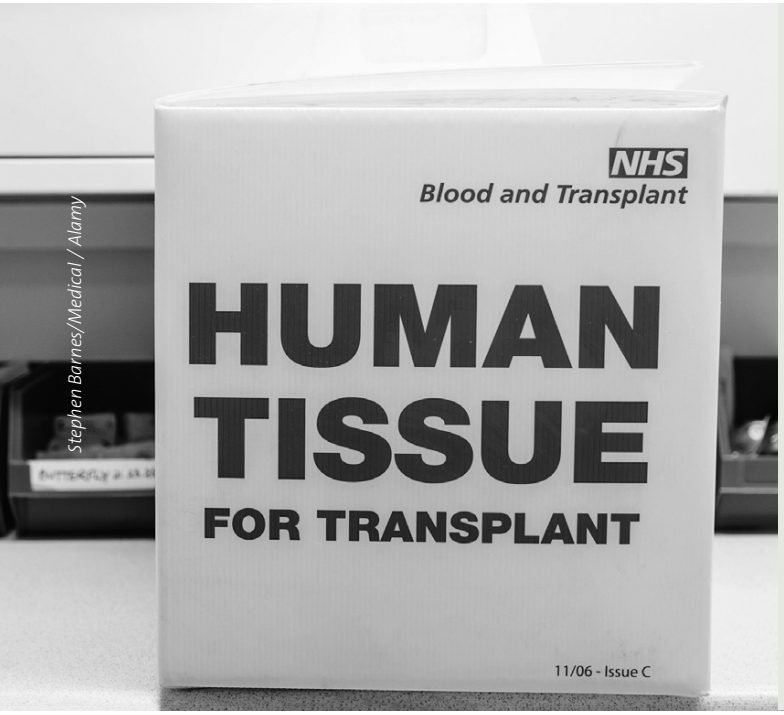
Recommendations for referral for liver transplantation in alcohol-associated liver disease

1. **Assessment for liver transplantation should be made in a specialist multidisciplinary clinic**
2. **Contraindications to liver transplantation include:**

- **Active ongoing alcohol use**
- **Drinking alcohol on the waiting list and during the period of transplant evaluation**
- **A history of repeated non-adherence with advice to abstain from alcohol**

3. **Relative contraindications to liver transplantation.**

- **Evidence of apparently deliberate poor adherence to medication or clinical care including frequent missed medical appointments.**
- **Inadequate patient support or social network where this is likely to undermine the patient’s ability to maintain abstinence and engage with treatment.**
- **Evidence of severe and enduring mental health problems that, in the opinion of the transplant team, will undermine the likelihood of a good clinical outcome and graft survival despite optimal psychiatric input.**
- **Two or more episodes/periods of alcohol relapse within two years despite clinical advice to abstain and in the knowledge of harm.**
- **A recent history of cross-dependence (stopping one substance of addiction but replacing it with another).**
- **Refusal to engage in a smoking cessation programme following transplantation.**



Stephen Barnes/Medical / Alamy

TIM’S STORY

I WAS REFERRED TO THE LIVER UNIT and saw a hepatologist, dietician and substance misuse nurse specialist. The support I received was amazing and they treated me with kindness and compassion. I worked so hard as I wanted to prove that I was taking their advice seriously. They offered me different options and tailored the support to suit me. We settled for an online recovery programme with online meetings, which went well. The assessments were good and all explained in layman’s terms. After the second assessment, I knew I was dying but there was a problem with my blood tests. That was me over and I almost gave up. However the hospital phoned me and said there was still a chance, and over the next three months I worked so hard with them. This brings me to four and a half months post-transplant, feeling like a new man and applying for jobs, all down to the support I received.

Charlie Parker is an addiction psychiatry clinical nurse specialist and SMSLT chair, Queen Elizabeth Hospital Birmingham; charlotte.parker@uhb.nhs.uk. Ian Webzell is alcohol and substance misuse clinical nurse specialist at King’s College Hospital

Written on behalf of SMSLT

Change is always possible, say **Lisa Ogilvie** and **Jerome Carson**, as they share their own journeys to recovery

Final des

EACH PERSON'S RECOVERY JOURNEY IS UNIQUE, and the process is nonlinear. So what makes our two stories different? Lisa used alcohol to make her mark on the world, or so she thought. Being able to consume extraordinary amounts of alcohol was a coveted talent when you were a young professional working on high-budget IT projects in the 2000s, and Lisa used this to justify chronic heavy drinking. Common sense tells us this is not sustainable, and that it puts one on a path toward alcoholism, something Lisa had to learn at great cost.

Jerome was a mental health professional, whose own father was an alcoholic. He could always falsely reassure himself that he was not as bad as his father. Following his move from the Institute of Psychiatry to the Maudsley Trust in 2006, Jerome spent the next five years working in mental health recovery. He co-developed a number of recovery initiatives, including co-authoring three books, the best known of which is probably, *Mental Health Recovery Heroes Past and Present*. This used patient narratives to share individual journeys and show that recovery is possible. In this vein, we humbly offer our own stories.

LISA'S STORY

I clearly recall when my relationship with alcohol began – a relationship that endured for nearly 30 years. I was 15 and working a Saturday job stacking shelves in a supermarket. I enjoyed being with people who I felt had 'proper lives,' by virtue of not being at school. They regularly went to the pub, and when an invite was extended to me, I discovered a social life encompassing alcohol. It gave me confidence, it made me funny, clever, popular. I was no longer just a teenager wanting to fit in. There were so many positive possibilities.

As life unfolded, the same underlying principle continued. Alcohol was an enabler of good times, friendship and success. I had excelled at university, been head hunted by the age of 25, and rewarded with an unreasonably large salary. Alcohol had proved to be a steadfast comrade – it let me show off, helped me stand out, and I believed it had even opened doors by oiling career-building conversations. A dependence had formed. I was aware of it, but actively welcomed it.

As time progressed, my dependence evolved. Alcohol increasingly became a crutch instead of an enabler, an excuse to socialise, a reason to relax, and sadly the source of what I believed happiness to be. In reality, it was an attempt to maintain the humorous, successful and caring employee, wife, daughter and mother I wanted to portray, all the while satisfying my growing need to consume alcohol at every possible opportunity. It worked for a while, so I thought – until it didn't.

For many years, I had been sinking, using alcohol to manage the psychological and physical fallout of an addiction that I had unwittingly cultivated to the best of my ability. Time passed, the consequences grew, and not just for me. I was a damaging force to be around, especially to those I cared for. I was desperately trying to survive, and to survive I had to have alcohol.

'Alcohol was an enabler of good times, friendship and success. I had excelled at university, been head hunted by the age of 25, and rewarded with an unreasonably large salary. Alcohol had proved to be a steadfast comrade – it let me show off, helped me stand out.'

There was no coming back. My fulltime vocation, 24/7, was as an alcoholic. It could not be hidden or denied anymore – it was too obvious, the consequences too embarrassingly typical. I faced a simple choice, one which was incredibly difficult to make – stop drinking or lose everything that mattered. In recovery, some would call this the gift of desperation, and for me making that choice did indeed turn out to be a gift.

I began my recovery. It was not easy, and involved lots of tears, guilt and shame. As my brain started to function without alcohol, further buoyed by support from people who understood addiction, my thoughts moved toward responsibility and acceptance. I started to feel hope, even optimism, when those I cared

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about recognised that I was growing, improving and learning new behaviours.

Since then, my world has grown in wonderful and unexpected ways – because of recovery, not in spite of giving up alcohol. I regained a sense of what it was like for people to value my contribution. This was something I didn't even know I had lost, but which proved to be a striking discovery in what recovery looks like to me. That is to contribute valuable and respected research in the field of addiction recovery, work that will promote and enable others to engage in recovery, as a positive and life changing experience. I have now found my source of happiness, and it is unequivocally, embracing life in recovery.

JEROME'S STORY

Professionals are told not to let their personal lives intrude into their work lives. Here, Lisa and I are both allowing our personal lives to intrude into our storytelling. My father was an alcoholic. His father was teetotal. Why did I choose to follow my own father, rather than my grandfather? In truth, I rather envied my father when I was a teenager. He could be a charmer with the ladies, which I yearned to be, and had a wonderful singing voice, which generally only emerged when he was drinking.

My own formative years were spent in the North East. There were the usual adolescent drinking binges, which continued into university where I took up with a small group of young men for whom drinking became an occupation. In the first year on 'beer race day' we drank 16 pints, and over the years I became an episodic binge drinker, drinking until I could drink no more. As most of this drinking was conducted in small groups, where it was culturally normative, it was never considered excessive.

In my middle age, beer gave way to good wine. I would only go out occasionally, as by

> 'The fact that I had to wait until I was 59 to make this choice shows the degree of denial I was in. For some of us, there really is only one choice.'

then I had a family of four children. One of my medical friends and myself would meet every couple of months for a meal in a posh restaurant, washed down with four bottles of wine. I think we both considered ourselves to be mentally stable and that our drinking was nothing to be concerned about. It was only in later years that I realised that by the criteria of the Diagnostic and Statistical Manual (DSM V), I met the criteria for an alcohol use disorder. My AUDIT score was also indicative of problematic drinking and I scored two of out four on the CAGE screening tool. After a very heavy drinking session with two university friends and our wives I became so unwell that I actually gave up drinking for three years. This was actually easy, as I was psychologically but not physically dependent.

On my 59th birthday I drank too much, had an argument with my partner and was given an ultimatum, the relationship or the alcohol. For once, I saw the effect that my drinking was having on someone close to me. This was the third such episode, and for her it was the last straw. I was in the proverbial last chance saloon and I decided to leave the bar.

At the time of writing, now four years, seven months and 20 days down the track, I have not had a single lapse. I will never go back. I have never been to a single AA meeting and never will, as I have managed on my own, though I have huge admiration for their work. I would never say, 'I have done it, you can do it too.' The fact that I had to wait until I was 59 to make this choice shows the degree of denial I was in. For some of us, there really is only one choice. That's not red or white. It's abstinence.

TWO STORIES OUT OF MILLIONS

Why might our stories be any more remarkable than anyone else's? They probably aren't. Yet as humans we have a need for stories to nurture, inspire or encourage us. Change is possible. It was the one life lesson that Jerome's father failed to learn. In the end alcohol killed him while his own teetotal father had lived until his eighties. How many years does alcohol take from us? For Lisa and Jerome, giving up alcohol has opened up life's possibilities in a way they never envisaged.

Lisa Ogilvie is studying for a PhD at the University of Bolton, having graduated with a distinction in her MSc in counselling and positive psychology.

Jerome Carson is professor of psychology at the University of Bolton.

Visit their website at positivelysober.org

TREATING THE WHOLE PERSON

While treatment to help problem gamblers is still being developed, the principles – and much of the cohort – are the same as with problem drug and alcohol use. 'You can manage the addiction, but then you need to manage the other bits,' Dr Clare Gerada tells the SMMGP conference

'We don't have a single patient who has a primary gambling problem,' Dr Clare Gerada, co-lead of the Primary Care Gambling Service and medical director of the NHS Practitioner Health programme told the conference. 'Gambling is sometimes coincidental to their other problems – alcohol or cocaine misuse, or that they're victims of domestic violence – or it's part of a whole gamut of disadvantage. It has to be seen in the context of people with multiple problems and co-morbidities.'

Only about 10 per cent of problem gamblers ever made it into treatment, she said, and in recent years there had been a diminution of some of the more traditional forms of gambling – such as in high-street betting shops – combined with an explosion of online gambling, with people gambling on their phones and computers in their own homes. 'It's now really a hidden problem, and a solitary problem.' Online gambling was also very possibly even more addictive than traditional forms, she said – 'you get intermittent positive reinforcement repeatedly, and very quickly'.

Gambling had been the first behavioural disorder to be classified as an addictive disorder, she told delegates. 'And there are many, many similarities between gambling and substance use disorder – so the patients that

you're seeing with alcohol or drug misuse have much more in common with gamblers than you might think. A gambler will suffer withdrawal, for example, and they'll also develop tolerance.'

HIGH-RISK GROUPS

More than 95 per cent of people with a problem gambling disorder also have a psychiatric disorder, whether anxiety, depression or co-existing problem drug or alcohol use, she said. 'There are some high-risk groups – individuals from black communities, people with past histories of trauma, and, as with drugs and alcohol, it's also linked to disadvantage. You're more likely to have a gambling problem if you're brought up in socioeconomic deprivation or have a family history of abuse.'

The sheer level of co-morbidities – whether substances, psychiatric disorders or the very high proportion of gamblers who smoked – meant that 'these are very sick people,' she stressed. 'That's why, especially with male gamblers, they're so prevalent when we look at suicide rates.' One key difference that had emerged was that while men were more likely to gamble in the belief that they may win, women were more likely to report engaging in 'non-strategic' gambling, which they tended to do as 'negative reinforcement', such as to try to stop depression or anxiety.

TIME FOR PARADIGM SHIFT

Having spent 15 years running a shared care drug service she felt that the time had come to 'do a paradigm shift around how we can manage gamblers', she said. 'There's absolutely no point telling GPs to do a screening test if, having screened patients for the problem, there's nowhere to take them.' She'd helped to set up the new, integrated Primary Care Gambling Service (PCGS) in London with her colleague Emma Ryan, which is supported by GamCare. 'We've tried to create a very simple referral pathway, and we try to bring people into treatment as quickly as we can. What our patients want is to be treated with dignity and compassion, and that's what we try to provide.'

When it came to comorbidities, gambling was also making existing problems worse. 'People are spending all their money and not looking after themselves', she said. 'We're picking up many, many people with gambling problems who have serious physical health problems, so gambling shouldn't just be seen as an isolated health problem – it really has to be seen in the context of people with multiple co-morbidities.' The system that best able to manage those patients was GPs and primary care, she told the conference.

'I'm not suggesting that every GP in the country manages patients with gambling addiction,' she said. 'But what I am suggesting is that we ensure that GPs are equipped to identify those with gambling problems, and that in the future we do what we did with intravenous drug users – create the network of doctors and nurses willing and able to run local services or bolt it on to their existing services, so we actually start to get gamblers seen as quickly as possible in a skilled service.'

JUST ASK

One key measure that could make a huge difference was simply to 'get GPs asking the question', she stressed. GPs needed to be asking about gambling whenever anyone presented with debt, or was a smoker, or who had schizophrenia or bipolar disorder. 'It is a sensitive question, but just ask. It's the most important independent factor for suicide amongst men, and yet how many GPs ask about gambling when they see men who are depressed?' There were also simple, practical

> 'More than 95 per cent of people with a problem gambling disorder also have a psychiatric disorder, whether anxiety, depression or co-existing problem drug or alcohol use.'

interventions that GPs could recommend, such as Gamstop, a free self-exclusion service that blocked people from using gambling sites and apps for a set period that they chose themselves.

PEER SUPPORT VITAL

As with drugs and alcohol treatment, peer support also had a vital role to play, she said. 'They help by really holding people's hands and bringing them into treatment.' However, when it came to treatment to help stop gambling, it was 'still in its infancy', she acknowledged, 'whereas there's so much research into how to stop opiate addiction going way back into the 1960s.' The mainstay of treatment remained CBT, plus a range of other psycho-social interventions. 'On the whole it's very similar to drug use – you can manage the addiction, but then you need to manage the other bits. If you just manage the heroin bit with methadone you're not going to get anywhere – you've got to manage the homelessness, the worklessness, the self-esteem. We manage our patients in a holistic way, and sometimes success isn't about getting them to stop gambling, it's about a harm-reduction approach.'

Issues around advertising and promotion also needed to be addressed, she stated, but as with alcohol, the vast majority of people who gambled did so safely. Stigma however remained a major barrier to people seeking treatment for problem gambling, especially among ethnic minority communities and women.

HARM REDUCTION

Overall, the problem was much more prevalent than had been acknowledged, she believed, and there was now a 'normalisation' of gambling. 'Spread betting on the stock market is gambling – you can lose hundreds of thousands if you don't cap it – as is Bitcoin. It's everywhere around us – on the TV, in the "loot boxes" on your children's video games.

'We know that most of what we do is harm reduction,' she said. 'We know we can't make better a traumatic, troubled childhood or abusive parents, but what we can do is nudge somebody back into health. A tiny bit of attention can make people so much better.' **DDN**

PROFESSOR DAME CLARE GERADA

Since 1991 Dr Gerada has worked as a principal in general practice although she has maintained her interest and expertise in the addiction field. Dr Gerada writes, teaches and lectures widely on the subject of the role of general practitioners in the care of substance misusers. Since 1993 Dr Gerada has been the lead clinician for the Consultancy Liaison Addiction Service which provides support to general practitioners so they are able to deliver effective care to people who use drugs.

Dr Gerada has held a number of national roles, including, senior policy advisor Department of Health, Drugs and Alcohol, director of RCGP substance misuse use unit and was chair of RCGP national expert group on substance misuse.

She was awarded the DBE in the 2020 Queens Birthday Honours for services to general practice.

Biography at practitionerhealth.nhs.uk

Yuliya Baranych / iStock

Face to face

We may be experiencing fatigue after more than a year of Zoom sessions but we still need to brush up those online skills, says **Angela Calcan**

DrinkCoach has offered online interventions since 2014 so we were well equipped when COVID arrived. Prior to the pandemic there was often scepticism from other professionals – you can't engage people properly online, digital doesn't work and it will never take off. Out of necessity, both the sector and service users have embraced the use of technology throughout the pandemic, and while the initial enthusiasm all round was high it's interesting to hear about the drop-off in online attendance as time has gone on. We know that online working is much more nuanced than it may first appear.

There is much potential for technology to enhance the treatment offer, but when done poorly it can be equally damaging. There is also the real issue of digital exclusion for some service users, which often dominates discussions. Online interventions will not be appropriate for everyone, but digital aspects may enhance services or bridge an existing gap. There are many service users who will still require face-to-face contact.

Despite the increased use of Zoom groups, Teams meetings and video calls, it's been interesting to observe people's behaviour online. It's important when using this technology to put some thought into how to get the best experience from it – there's so much to pay attention to, and we're using different skills to make up for the loss of cues that we rely on in face-to-face settings. All this while paying attention to how we are perceived by others. No wonder we're exhausted.

> 'It's important that careful consideration is made each and every time we are on camera. It does involve being organised and putting yourself in the shoes of the person on the receiving end.'

Whilst most mistakes are unintentional they are usually avoidable and relate to poor set up – lighting, sound, camera angles, proximity to the screen, distracting backgrounds and difficulty using platforms. And let's not forget the unexpected Zoom bombs from pets and children (I've certainly had this happen a few times in my home). Then there's the poor etiquette observed – which has included people lying in bed during training, vaping mid meeting, or forgetting to mute microphones while holding unrelated conversations off camera.

We also fail to recognise how off-putting it can be for a trainer/presenter to be talking to a screen of small blank boxes rather than seeing

'We know that there are digital exclusion concerns for many service users, but we also know that many hard-to-reach service users may be more inclined to engage via this method.'

people's faces. Some of these could pass as rookie errors early on but it's disappointing to see them continue as time passes. I get it – online work is fatiguing and sometimes we can't face putting our videos on. Sometimes it's the equipment failing to support the work – poor Wi-Fi connection, microphone issues, camera not working. These aspects are so important to sort out before you can really commit to online working. I regularly encourage people to ask themselves – would I do this if I was in a face-to-face setting? If the answer is no, then the same should apply to our online etiquette too. You would wait for the break to grab a drink or have a smoke, and you make eye contact and introduce yourself to a guest that is attending your team meeting. We do need to make the same effort in the online world.

Switching to online working is not merely substituting the meeting room for a virtual one. There has to be consideration for the nuances of this work and the challenges it ultimately brings. Expect adjustments to the way we work and the workload – organisations should embed a support structure for the workforce to ensure that online work is conducted in the safest and most supportive way possible. It almost seems that we have more meeting demands as geographical boundaries are removed, and there's now the expectation that you will squeeze every minute of your day into some online interaction.

We know that there are many challenges to remote working including online fatigue, so it's important to schedule those 'watercooler' moments or small breaks into our day just as we would in the office environment. Block out your diary to protect your time – after a morning of running online groups book in ample debrief and note-writing time, and if you know your concentration levels may be lower in the afternoon protect that time in your diary so it's not hijacked for another meeting.

It's important that careful consideration is made each and every time we are on camera. It does involve being organised and putting yourself in the shoes of the person on the receiving end. We do need to think about the context. Whilst I am more relaxed with my colleagues I have different standards for any external meetings, training or online interventions I attend or deliver. With the rush to get online it seems that the considerations for set up may have suffered.

It's essential that we ensure data protection for our service users and that starts with the policies and procedures that support online working. It also means that when remote working we must take confidentiality as seriously as we would in person. We should ensure a confidential space where the conversation will not be overheard or interrupted, and if you can't guarantee this, then some adjustments need to be made. I have two young children and I appreciate the challenges that this year has brought to privacy and disruption in the home. Although many service users are forgiving of interruptions we do need to protect that virtual therapeutic space. Over time these blips can add up, and if not properly addressed cause the service user to lose confidence in the system.

Finally, although online fatigue is a real issue at the moment I would encourage those interested in working effectively online to continue this work. We know that there are digital exclusion concerns for many service users, but we also know that many hard-to-reach service users may be more inclined to engage via this method. At DrinkCoach we have been able to engage women and a younger cohort as well as working professionals through our online work. I hope the sector can continue to offer online as an option and maximise the benefits of online interventions, not just out of necessity but because it has value to our [potential] service users.

Angela Calcan is operations manager for DrinkCoach at Humankind Charity

TIPS: IMPROVING YOUR ONLINE WORK

1. I know this seems obvious but **PAY ATTENTION TO YOUR SET UP**. It takes just one tenth of a second for someone to make a judgement of you. This is influenced online by all aspects of lighting, sound, camera angle, and your background!

2. **BE CONFIDENT IN YOUR ABILITY TO USE THE TECHNOLOGY**. Be familiar with the platform you are using. This can be achieved through practice and watching online tutorials. Over apologising or making comments about not knowing what you are doing puts doubt in the other person's mind, even when you are handling things well.

3. **TALK TO THE CAMERA**. This is by far the trickiest part of online working and the most fatiguing part too. It also takes a lot of practice and initially feels very awkward. The most natural thing for people to do is look at the other person (or yourself) on the screen. However if you consider how you look to the person, you may look disinterested or like you are talking to their chest. Remember when you look into the camera you are connecting to the other person through appropriate eye contact which helps to build rapport and shows you are listening and engaged.

4. **HAVE EVERYTHING TO HAND THAT YOU NEED** before you start the call. This includes paper, pen and any documents you want to refer to in the session. **KEEP A CLOCK IN SIGHT** as time passes very quickly online.

5. **VIRTUALLY WALK YOUR SERVICE USER IN AND OUT OF THE ROOM**. We spend time in face-to-face settings greeting the service user, making them a cup of tea and asking about their journey. Incorporate this into your online routine to make them feel comfortable. At the end spend a few minutes checking their plans for the day/week to gauge how they are feeling. This small talk can often soften the harsh ending of the online call.

6. **KEEP CONFIDENTIALITY AND DATA SECURITY IN MIND** at all times. This includes where you deliver the session, where and how you store your notes, how you send and receive information and what devices/platforms you use to communicate. Your organisational policies and procedures should guide you on this. Any deviation from your organisational guidelines can risk an unintentional data breach.

7. Reflect on the experience of working online and **CREATE A FEEDBACK LEARNING LOOP**. Collect service user feedback and take a problem-solving approach. Collate the questions/ comments and put together a guide to mitigate the common occurring ones. This puts confidence in your service and can help to address barriers for service users.

WE NEED TO TALK ABOUT...
THE PURPOSE OF DRUG TREATMENT

Who exactly is drug treatment designed to benefit, asks **Nick Goldstein**

The genesis of this article was Priti Vacant's (Patel's) recent bung of £148m to cut drug crime and introduce project ADDER (*DDN*, February, page 4). ADDER is yet another treatment service acronym standing for 'addiction, diversion, disruption, enforcement and recovery', although if history is anything to go by shouldn't it really translate to just another dumb drug exercise? It doesn't really matter what it stands for, because the odds are it will end up in the government policy wastebasket with all the other failed new agendas.

ADDER doesn't inspire confidence. Little of the money is 'new money' and on a close reading it can only really be described as grossly depressing. In fact its only saving grace is we've heard it all before, which makes the depression seem like an old acquaintance – like meeting a cop who's arrested in you in the past.

Although the actual document is meaningless pap there were several interesting comments from the rogue's gallery of ministers who were rounded up for its release. Our esteemed minister for health and social care, Matt Hancock, got the ball rolling with 'addiction and crime are inextricably linked' and followed up by pointing out that Priti's bung was 'the largest increase in drug treatment funding in 15 years'. While being true, it said more about the savage cuts of the last 15 years than anything else.

The esteemed minister was rapidly followed by Priti herself, who reminded everyone that she was determined to cut crime. She was especially keen to announce her personal war with county lines gangs, who are rapidly becoming the folk demon du jour. Priti suggested she was 'restoring confidence in the criminal justice system' so that people could live their lives knowing their family, community and country is safe – from drug users. Thankfully she remembered not to say the last part out loud!

Next up at the podium was the headlining act, the grand fromage himself, the prime minister. Boris, as ever, blustered on about making the streets safe and tackling criminal gangs by 'cutting the heads off snakes' amongst many other favourite platitudes from drug policy and/or treatment speeches over the years. Boris finished up with 'I am determined to fight crime'. The whole event, the policy release and speeches engendered nothing more than mild depression, just like the last policy release, the one before that and all the others – just more of the same thoughtlessness that has been failing for years. It's just more criminal justice solutions with some ill-defined recovery thrown in to make the policy palatable. I swear, if politicians were banned from mentioning crime in a discussion on drug use they'd be forced into silence.

Depressing though all of this may be, it is of value because it perfectly illustrates a fundamental flaw in drug treatment and policy that really does need commenting on, because it's the root cause in much misunderstanding. It's this – drug treatment is not for drug users, rather it is an attempt to protect society from drug users. I appreciate some readers might be wincing or exhibiting anger at this point, but hear me out.

Let's look back over the last few decades to the '80s when I first

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stumbled into treatment with a grade A heroin habit and a whole host of illusions just waiting to be shattered. The treatment system back in the '80s featured injecting or rather the desire to stop injecting – the reason for this was nothing to do with healthcare for drug users and everything to do with stopping drug users spreading HIV to polite society.

In the '90s the arrival of New Labour – tough on crime, tough on the causes of crime – moved the aim of treatment onwards, and now maintenance prescribing became vogue. Scripts and script sizes multiplied and grew to ensure drug users were nodding at home rather than out robbing your car. Again, the change in policy was more to do with cutting crime statistics than improving the lives of drug users. As an aside, if you described a society in which dissidents were made to take a heavy psychoactive drug, like methadone, you'd presume the country was some Eastern European cold war dive, not England. Yet it happened here.

Then came the coalition government and their recovery agenda which – call me cynical – I believe was mainly about reducing the cost of treatment by producing economically productive members of society out of drug users, no matter how hard it was to force drug users into sobriety, and productivity, as the graveyards attest.

Project ADDER and the above pronouncements suggest current changes will be a case of it being, in the words of the late, great Yogi Berra, 'deja vu all over again'. It's yet more policy from politicians who don't really care about something they don't understand or really care to understand, and its aim is most definitely not about helping drug users. It's not really surprising drug use and users are always an afterthought for politicians – there aren't enough of us (about 300,000 in treatment) when compared against other vulnerable groups.

As well as being short of numbers, drug treatment also falls victim to being short of time too. Policy runs on a four-year electoral cycle and many changes to drug treatment won't bear fruit quickly enough – if you're the minister for health or the home secretary what's the point of enacting policy, often at great expense, if it doesn't show positive results before the next election?

> 'Drug treatment is not for drug users, rather it is an attempt to protect society from drug users. I appreciate some readers might be wincing or exhibiting anger at this point, but hear me out.'

Whatever the reasons, it's clear that drug treatment is primarily about protecting wider society. If ADDER is good for anything it's as an illustration of policy aims which are yet more of the long-failed criminal justice-based policies. ADDER might be new, but it's philosophy and aims are old as the hills.

Any considerations of the needs of drug users are secondary – an afterthought. Here's a parlour game to prove the point. Get a pen and piece of paper and design a basic treatment system that promotes drug users' health and wellbeing. I bet it looks fuck all like the system we have. A system that hopelessly fails drug users on any reasonable terms, and ironically doesn't do much for wider society either. It might be time for an honest conversation about the true purpose of drug treatment, for everyone's sake.

Nick Goldstein is a service user

They said what..?

Spotlight on the national media

> 'It is incredible that he cannot, or will not, see the link between poor communities ripped apart by gang warfare, wrecked lives of people unable to access safe supplies or treatment, and his own pathetic policies of prohibition.'

SPIN DOCTORS TELL JOURNALISTS the prime minister, who has taken drugs in the past, as have prominent ministerial colleagues, thinks they 'lie behind not just crime but a host of social problems', while he fights a culture war over cannabis. It is incredible that he cannot, or will not, see the link between poor communities ripped apart by gang warfare, wrecked lives of people unable to access safe supplies or treatment, and his own pathetic policies of prohibition. Meanwhile, the pandemic has fuelled mental health problems and substance abuse, storing up long-term problems including fresh addiction cases.
Ian Birrell, inews, 12 April

THE TRUTH IS that legalisation is inevitable. Every day that our politicians put it off they cause more harm. Another child is sold strong skunk on the street. Another young girl is groomed into using hard drugs by being offered some new clothes and a 'bit of weed'. Another young man is stabbed to death in some stupid dispute over territory, the sort of argument that is dealt with by normal business methods in places where cannabis is legally regulated.
Peter Reynolds, Express, 8 April

TERRIBLE THINGS SOMETIMES HAPPEN, true enough, but parents know full well that the worst impact that any soft drug use is likely to have on their children's futures will come not from taking it but from the legal consequences to which that might lead. For the most part the public doesn't want cannabis to be illegal, the police don't want to routinely arrest people for using it and the government doesn't particularly have the stomach to ask them to. And yet still we pretend.
Hugo Rifkind, Times, 12 April

ONE OF THE STRONGEST ARGUMENTS against legalisation is that its track record is decidedly mixed. When Canada became the first leading economy to legalise in 2018, it was predicted there would be a 'green rush' – a cannabis-inspired economic boom. That has not materialised. Nor has legalisation destroyed the illegal market, as many of its proponents claimed it would. In the first year after the law change, fewer than a third of Canadian cannabis smokers obtained all of their supplies legally. Sales of legal cannabis in Canada have more than doubled in the past two years but the legal industry is still having to cut prices to compete with the illegal one.
James Forsyth, Times, 9 April

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The Hepatitis C Trust will be seeking passionate and skilled peer leads with excellent communication, engagement, and organisational skills to be part of a history making journey to eliminate the virus. Experience of working within drug services and with volunteers, having been affected by hepatitis C or having supported someone who has hepatitis C are all desirable if you feel that you or someone you know may be interested.

DDN will be hosting a series of job adverts with details of how to apply over the coming months so please look out for an opportunity in your area.

www.drinkanddrugsnews.com/jobs

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