Drink and Drugs News
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DDN

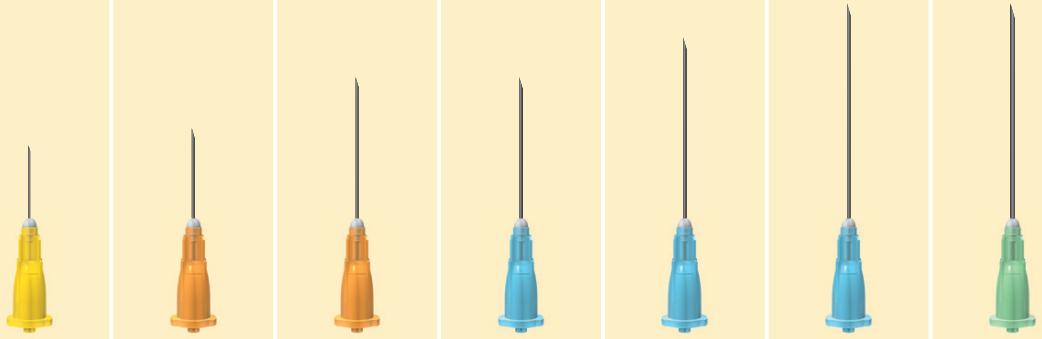
DANGEROUS GAMES

THE RISE IN GAMBLING-RELATED HARMS AMONG WOMEN

NEW!

total dose

Extending our low dead space needle range to include a yellow 30G, 13 mm (½ inch), hypodermic needle.



TY13	**TO16**	**TO25**	**TB25**	**TB30**	**TB40**	**TG40**
Yellow 30G	Orange 25G	Orange 25G	Blue 23G	Blue 23G	Blue 23G	Green 21G
13 mm	16 mm	25 mm	25 mm	32 mm	38 mm	38 mm
[½ inch]	[⅝ inch]	[1 inch]	[1 inch]	[1¼ inch]	[1½ inch]	[1½ inch]

The 30G yellow needle is designed for injecting into surface veins.

For maximum reduction in dead space in a detachable needle/syringe combination use a low dead space needle like Total Dose.

EXCHANGE SUPPLIES

MAKING INJECTING SAFER

DDN

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STAYING STRONG IN PARTNERSHIP

'I've learnt so much about myself – mainly about my sexuality and to be proud of who I am.'

Darren from **The Forward Trust** in our **Partner Updates** at **www.drinkanddrugsnews.com**

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What could we achieve by changing the narrative?

Looking for an escape from reality drew Kelly into online bingo – a few games that led to an all-consuming gambling addiction and financial and emotional devastation (page 6). This addiction may be 'invisible' but the drivers can have much in common with any other form of compulsive behaviour that offers us time away from real life.

'For many people addiction is a response to trauma that has not been dealt with,' Alice Wiseman reminds us (page 18) as she shares a public health perspective that feels like an opportunity to collaborate far more actively with our healthcare partners. We've grasped the need for 'trauma-informed' care – but just look at the outcomes we could achieve if we focused our attention in a really robust way on reducing ACEs, as she suggests, changing the narrative from punishing and criminalising to understanding the causes of behaviour.

Looking for the reason for tragedies never makes for easy reading, but The Suicide Prevention Consortium's research on alcohol-related suicidal behaviour (page 16) and Martin Smith's look at causes of drug-related deaths (page 14) are two articles that could have an important role in informing our actions.

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

Police Scotland rolls out naloxone programme country-wide

Police officers across the whole of Scotland are to be equipped with and trained in the use of naloxone, Police Scotland has confirmed. The national roll-out follows pilot schemes in Caithness, Dundee, Falkirk, Glasgow and Stirling that saw more than 800 officers trained to use naloxone and more than 650 volunteer to carry nasal spray kits.

All operational officers across the country will now carry naloxone spray, says chief constable Iain Livingstone, following an independent review last year by the Scottish Institute for Police Research. The roll-out extends to all officers in response and community roles, along with armed police, dog handlers, public order and road police up to the rank of inspector. Any other officers or staff are also free to undertake the training, says Police Scotland. Scotland's drug death rate has long been by far the worst in Europe, and remains three and a half times greater than the UK as a whole. There were more than 1,300 drug-related deaths in Scotland in 2020, and while provisional figures for 2021 show a slight decrease these are taken from initial police reports rather than the official statistics from National Records of Scotland, which are based on death certificates and pathologist reports.

'We have a purpose and remit which goes beyond law enforcement,' said Livingstone. 'We have a positive legal duty to improve the lives of our communities. Equipping and training officers with naloxone will contribute to that mission.' It was also crucial that 'timely and sustainable support is available to provide treatment for those suffering addiction', he stated.

'Police officers are often first on the scene of a suspected overdose and are well placed to act quickly and potentially save a life – the pilot has shown this,' added the Scottish Drug Forum's strategy co-ordinator for drug death prevention, Kirsten Horsburgh. 'Expanding naloxone carriage by police to cover the whole of Scotland is significant, and an obvious next step. It has been positive to hear frontline police recognising that this is part of key policing duties to preserve life.'

bordertelegraph.com

'We have a purpose and remit which goes beyond law enforcement.'
IAIN LIVINGSTONE

Alcohol deaths in Scotland rise despite falling sales

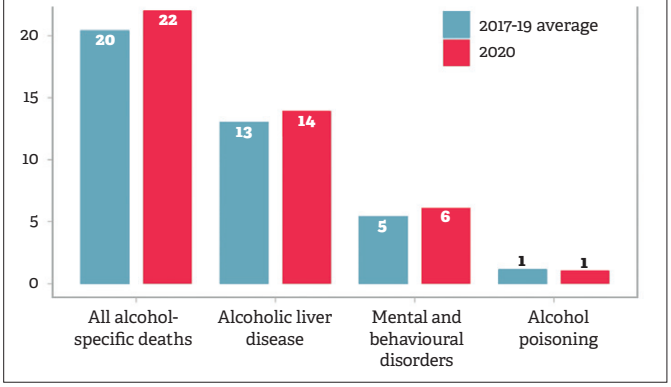
ALCOHOL-RELATED DEATHS in Scotland increased during the pandemic despite lower drinks sales, according to analysis by Public Health Scotland (PHS). While rates of alcohol-related hospital stays fell, the increase in deaths was driven by people aged 45-64, mostly men – 'groups that experienced the highest rates of deaths caused by alcohol prior to the pandemic'.

The analysis is based on data for alcohol sales up to May 2021, hospital stays to March 2021 and deaths to December 2020. The increase in deaths is despite sales for 2021 being almost 10 per cent lower than the 2017-19 average, and 16 per cent lower for the January-May period.

Despite the overall fall in sales during the pandemic, population-level consumption was still above recommended levels, says PHS, with 17 units of pure alcohol per adult sold every week, representing enough to 'put every adult in Scotland over the chief medical officer's low-risk weekly drinking guideline'. Scotland's rate of alcohol-specific deaths for 2020 was 22 per 100,000 population, 8 per cent up on the average for 2017 to 2019 and 'higher than any individual annual rate in the study period.'

Deaths rose by almost a fifth between 2019 and 2020 (*DDN*, September 2021, page 4), following a decline the previous year, prompting campaigners to call for the minimum unit price to be increased to 65p. *Alcohol sales and harm in Scotland during the COVID-19 pandemic at www.publichealthscotland.scot*

Alcohol-specific death rates in Scotland by cause



Lax labelling

'WOEFULLY INADEQUATE' LABELLING is keeping consumers in the dark about the sugar and calorie content of their drinks, according to analysis commissioned by the Alcohol Health Alliance (AHA).

It was possible to consume almost the entire recommended daily limit of sugar from two medium-sized glasses of popular wines, the researchers state. The study involved analysis of 30 bottles of leading-brand red, white, rosé, fruit and sparkling wines, none of which displayed sugar content on their labels, despite this being a requirement for non-alcoholic drinks.

Just 20 per cent of the labels, meanwhile, displayed the wine's calorie content. A 175ml glass of Barefoot Bubbly Pink Moscato was found to contain 13.8g of sugar, almost half of the government's 30g a day guideline, while bottles of Yellow Tail Shiraz, Hardy Stamp Shiraz Cabernet, Campo Viejo Rioja Tempranillo and Casillero Del Diablo Cabernet Sauvignon all contained close to 600 calories each, with AHA describing alcohol's exemption from food and drink labelling regulation as 'absurd'. *Wine survey 2022 at ahauk.org*

Two new NHS gambling clinics will help meet spiralling demand

NHS England is set to open two new gambling clinics, it has announced, following 'record demand' for specialist support. The clinics, in Southampton and Stoke-On-Trent, will open in May and take the number of NHS specialist gambling services to seven. Almost 700 people with the 'most severe gambling addiction issues' were referred to NHS support between April and December last year, a 16 per cent increase on the previous year. The pandemic has seen a huge increase in the number of people gambling online, with the closure of betting shops during lockdowns and the widespread shift towards working from home. Almost 625,000 more over-65s are also now gambling online at least once a month than before the pandemic, according to analysis by the Royal College of Psychiatrists.

Research published by Public Health England (PHE) in 2021 estimated that almost 250,000 people were likely to have some form of gambling addiction, with around 2.2m classed as 'at risk of addiction'. PHE's evidence review into gambling harms estimated the annual cost to England alone at more than £1.2bn, almost £620m of which was 'an estimate of the economic cost of gambling-related suicide'. The announcement of the new clinics comes as the NHS has written to GambleAware stating that it will be 'fully funding its own gambling services' from April, following concerns about conflicts of interest around the industry's funding of treatment.

'Gambling addiction is a cruel mental health condition that can devastate people's lives – our pilot clinics are already having a lasting impact in helping people to take back vital control of their lives,' said NHS mental health director Claire Murdoch. 'The opening of two new gambling clinics in May, as a part of our £2.3bn investment into mental health services, will mean we can help even more people with the most serious gambling problems.'

> 250,000 people are likely to have some form of gambling addiction, with around 2.2m classed as 'at risk of addiction'.

See feature, page 6

Home Affairs Committee investigates drug legislation

THE HOME AFFAIRS COMMITTEE is to investigate the impact of legislation designed to restrict drug use, including the Misuse of Drugs Act 1971 and Psychoactive Substances Act 2016, it has announced. The investigation will form part of a wider inquiry to 'examine illegal drug use in the UK and its effect on society'.

The Misuse of Drugs Act's 50th anniversary last year saw it labelled 'past its sell-by date' and 'not fit for purpose', while the 2016 act was also highly controversial. The inquiry also intends to look at the effectiveness of government strategies to address drug use and drug-related deaths and crime, including the new ten-year strategy launched late last year.

Questions the committee will consider as part of the inquiry include whether the current framework needs to be reformed, should a 'right to recovery' be enshrined in UK law, and which international policies and approaches could work in the UK. 'First and foremost we want to see how well we are supporting those who are struggling with drug addiction and understand what more can be done to support them,' said committee chair Dame Diana Johnson.

Details on how to submit evidence at https://committees.parliament.uk/call-for-evidence/724/. Deadline 24 March

NI drug deaths up

THE NUMBER OF DRUG-RELATED DEATHS registered in Northern Ireland in 2020 was the highest on record, according to the Northern Ireland Statistics and Research Agency (Nisra) – as was the number of drug-misuse deaths, which increased from 165 in 2019 to 182. More than half of the deaths were among men aged 25-44, with opioids the most commonly mentioned drug type on death certificates. Two thirds of deaths involved two or more drugs, with death rates highest in the most deprived areas.

Local News

Johanna Cuomo | Dreamstime.com

SLOW PROGRESS

The number of people sleeping rough fell by just under 10 per cent between 2020 and 2021, and is down 43 per cent since 2019, according to the Department for Levelling Up, Housing and Communities. However, the figures are still 38 per cent higher than in 2010, with almost half of all people sleeping rough in London and the South East.

TRIED AND TESTED

Forward Leeds has been offering service users free, non-invasive liver tests with instant results, using FibroScan machines. 'Often people aren't aware of the damage that regular drinking can cause,' said area manager Anne-Marie McMullan. 'Alcohol-related liver disease doesn't usually have any symptoms until your liver has been severely damaged.'

GETTING ONBOARD

More than 20 Glasgow taxi drivers have now applied to carry naloxone as part of the ongoing Stop the Deaths campaign (*DDN*, February, page 5). 'During the '80s I worked in some of the city's worst affected areas,' said chair of Glasgow Taxis Dougie McPherson. 'The current drug death figures serve as a stark reminder that the problem has not gone away, and any way of reducing the number of deaths is worth supporting.'

MaddieRedPhotography | Dreamstime.com

THE LOSING HAND

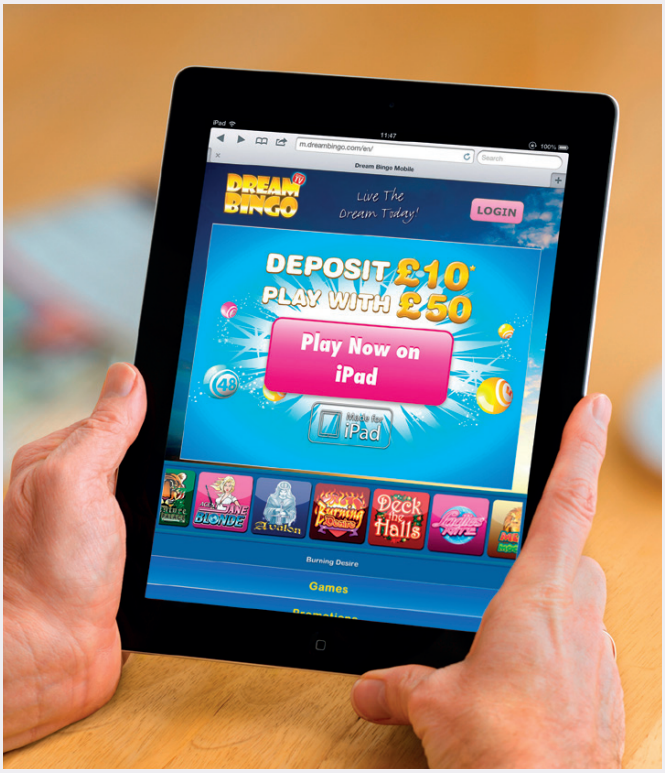
Just as lockdowns saw drinking shift from physical venues to home, so it was with gambling. But the exponential rise in online gambling – where anyone with a smartphone has instant access to a vast casino that never shuts – is hitting women particularly hard. **DDN** reports

The hearing into the role gambling played in the death of 24-year-old Jack Ritchie has once again put gambling addiction in the headlines, and coincides with the NHS informing the GambleAware charity that it would no longer be accepting funding from the industry for its gambling clinics (see news, page 5). Ritchie had started gambling while at school, using his dinner money to play on fixed-odds betting terminals (FOBT), dubbed the 'crack cocaine of gambling'. Just seven years later he took his own life, with his parents arguing that he was addicted to 'products licensed by the start'.

Last month NHS mental health director Claire Murdoch wrote to GambleAware confirming that the NHS will fully fund its own gambling services from April onwards, following unease among clinicians and patients around the perceived conflict of interest of industry funding for treatment. May will see the NHS open two new gambling clinics, in Southampton and Stoke-on-Trent, to complement its existing services in Leeds, London, Manchester and Sunderland, as well as the national children and young person's clinic.

The two new facilities are to help meet the 'record demand for specialist support for gambling addiction', the NHS states, with rates of online gambling in particular rising over the last couple of years, as people worked from home or found themselves with huge amounts of time on their hands after being furloughed. A study led by the University of Bristol found that, while lockdowns meant that overall people were gambling less frequently as physical premises closed their doors, use of online poker, bingo and casino games increased six-fold among people who were already regular gamblers.

Online games have also made gambling much more accessible to women, who may have been unlikely to visit high-street betting shops. A YouGov poll of almost 10,000 women using the Problem Gambling Severity Index found that up to 1m women may now be at risk of gambling harm, and according to GambleAware the number of women receiving treatment for problem gambling has doubled over the last five years to just under 2,500 – a figure that's likely to represent 'a fraction' of those experiencing gambling-related harms, the charity states. Just under 40 per cent of women may also 'refrain from seeking help or treatment' as a result of the stigma surrounding the issue, with GambleAware launching its first harm prevention scheme



IanDagnall / Alamy

KELLY'S STORY

The intimidating men-only environments of betting shops meant that problem gambling was largely a male problem, but the rise of online gambling has changed all that. Kelly Field describes how what started as a few games of online bingo led to financial and emotional devastation

I started with online bingo sites in around 2012. I was looking for an escape from reality, and you'll find that with a lot of women you speak to – they want escapism from day-to-day life or from trauma. I think I realised I had a problem early on, but you cross that invisible line of it becoming an addiction.

Within six months I'd spend ten and a half grand on one credit card, no questions asked. There are triggers for harm data which would have flagged me up and they should have followed their duty of care, but rather than using it to signpost people to help and prevent them getting into trouble they use it to exploit them. The credit card company didn't say anything either, and it's taken me seven years to pay the debt off.

John Muggenborg / Alamy

'We conducted a rapid evidence assessment which found that much of the academic research on gambling has long focused on men, or assumes that only men may develop problems with gambling.'

aimed specifically at women earlier this year.

'Gambling behaviours manifest themselves differently in women than men,' said gambling addiction counsellor Liz Karter. 'For example, we know the easy availability of online gambling leads many women to games which appear innocent and socially acceptable. The games seem safe and familiar, as they are so similar to the free play digital games we are all now used to playing. In addition, the hopes of financial gains can prove a powerful motivator. While gambling doesn't always lead to harm, it's vital women are aware of early warning signs including losing track of time, incurring increasing debt, or a tendency to hide gambling from others or gambling to forget their problems.'

As almost all literature on gambling harms has so far focused on men, GambleAware has commissioned IFF Research, the University of Bristol and GamCare's Women's Programme to carry out a three-phase research project, *Building knowledge of women's lived experience of gambling and gambling harms across Great Britain*, which will run until the end of this year. The project will explore why women take part in different types of gambling, the effect on their lives, and their experiences of treatment and support.

'We conducted a rapid evidence assessment which found that much of the academic research on gambling has long focused on men, or assumes that only men may develop problems with gambling,' said Prof Maria Fannin of the University of Bristol. 'This is starting to change as we learn more from women themselves and their experiences. We want to know more about how gambling becomes part of women's lives and how their experiences may differ from men's. Ultimately, we want our work to change the public perception and awareness of who can develop problems with gambling and ensure women's needs and concerns are taken into account.' **DDN**

But I spent a lot more than that overall.

You sort of know you've got a problem, but you think "I'll win the jackpot and pay it back and I'll be alright." You have these delusional thoughts of "everyone's a winner", because that's how it's portrayed. A lot of people assume it's just a financial issue but it's not just money you lose – it's self-worth, self-esteem, self-confidence. My mental health was at rock bottom and I put on loads of weight because I just isolated myself in the house playing these games. My son didn't get the things he wanted, we didn't go on holiday. There were times when we had £20 a week to live on. You lose more than money.

People have this stigma and embarrassment, and they're not telling anybody. They've got all this debt and can't tell people how they got it and it causes people to take their own lives, because they'd have to admit they've got a gambling addiction. I became suicidal – you get in such a dark place with it and it just consumes your whole life. It takes over and you think the only way out is to end your life, because then it'll stop.

At the time there were very few support services. There was basically only Gamblers Anonymous, but I'd never have gone to that as a woman because it's a completely male-dominated environment. The lived experience people who work for the services and charities now are still predominantly men, so when they go into schools and colleges speaking to young people it just reinforces that message that it's still a male-dominated addiction. But you can see how women are targeted in the daytime with the pink and fluffy bingo adverts and then in the evening it's all casinos and football – they know exactly what they're doing. Every other advert is a gambling advert, and they're using celebrities to endorse it. You couldn't put adverts for pornography on TV because there'd be uproar, but the gambling advertising on TV and social media normalises it for young people – these are adult products.

The point I knew I needed treatment was when I'd maxed out all the credit cards but I managed to get a £1,600 overdraft on our joint account, and within 50 minutes I'd spent all of it on slots online. I was devastated and disgusted and ashamed, and I had to ring my partner and tell him I'd done it again after promising to stop so many times. I just snapped the card up and started cutting at my wrists. The GP gave me pills and got me a counselling appointment but the counsellor didn't turn up the first time so I never went back. I carried on gambling for about another 18 months before I found a local service and got a 12-week talking therapy.

I've tried to turn a negative into a positive and I've campaigned to get credit cards banned for gambling and to raise awareness of gambling addiction, particularly with women. I relapsed once early on but I've got [blocking software] Gamban on my phone and I stay away from all forms of gambling. It would be like an alcoholic saying they'll just have one drink – it would soon be a bottle of vodka. In some ways gambling addiction is easier to hide than with drugs or alcohol, because there's no substance. You can be in all this debt and about to lose your family and your home but you can put a smile on your face and no one will know. But we have far, far too many suicides that are directly linked to gambling addiction.

Kelly Field, as told to ***DDN***

A NEW MODEL

February's Westminster Social Policy Forum seminar heard from experts including Professor Dame Carol Black on re-shaping the sector in the wake of the government's new financial commitment

'My greatest worry about my review and its potential is can we deliver it at the local level,' Professor Dame Carol Black told the Westminster Social Policy Forum's *Tackling drug dependence and improving delivery of services* seminar. 'We've acquired the investment – that was of course crucial, but there must be much greater accountability for the spend.'

The Treasury fully intended to 'hold us to account', she stated, echoing warnings from others in the field (*DDN,* February, page 8). Local authorities would need to work with wider health, employment, housing support, criminal justice and social care, and develop joint commissioning plans and joint needs assessments. Years of austerity had meant that the idea of creating a whole systems-approach 'wasn't able to happen', she said, 'and what I'm hoping from my review is that we'll now be able to do that, because it's absolutely needed.' This would require at least six departments of state to be 'truly and sustainably involved', she said. While it 'wasn't that they hadn't been interested before', competing priorities meant that it had always been low on their agenda.

All but one of the 32 recommendations in her *Review of drugs: phase two* report had been taken on board in the government's new drug strategy, which was 'very pleasing' – and accompanied by a financial settlement that was 'probably 70 per cent of what I'd asked for in the original part two review' and 'very big' ambition. 'But I don't want, now that we've got more money, to just do more of the same,' she stated. 'This is a unique opportunity to really think about what does a very good treatment and recovery service look like.'

STARTING FROM A LOW BASE

It was important to be aware that in some places 'we're starting from a low base, and we'll need to support and enable improvement in some of our local areas,' she said. The sector was facing a challenging journey, not least in terms of re-building the workforce. 'That's going to require a really sustained focus – we can't just do it overnight.' Similarly, research had been 'bottom of the pile' in almost every aspect of addiction, with a corresponding lack of financial support.

Workforce was a 'critical challenge', agreed head of inclusion at Midlands Partnership NHS Foundation Trust, Danny Hames. There was promising evidence of positive cross-sector working, but providers needed to be 'brave and a bit humble', he said. 'We need to open ourselves up to accountability and be transparent, but we also need to be sure we're working in the best interests of patients. Collaboration is absolutely key.'

'How do we keep this energy up... There's a willingness to think about doing things differently.'

DAME CAROL BLACK

'We need to be sure we're working in the best interests of patients. Collaboration is key.'

DANNY HAMES

MOVING FORWARD

'We're at the point where we have to look at the competence of our own clinical practices and commissioning process so we can move the field forward,' said head of King's College London's National Addiction Centre, Professor Sir John Strang. One of the major challenges would be improving the quality – as well as the quantity – of treatment, and there

Irina Zadvinskaya / iStock

‘We have to look at the competence of our own clinical practices.’

PROFESSOR SIR JOHN STRANG

‘It’s surprising to find myself on a platform saying the politicians have delivered.’

ROSANNA O’CONNOR

was a significant challenge around training need. ‘We need to look at how to support and improve the development of the general workforce, so that somebody entering treatment is being seen by someone with a good, broad knowledge of the treatment field and how to integrate medical and social interventions,’ along with developing a cadre of specialists for the future.

From a research point of view, what was needed was a serious commitment to a much more practice and policy-orientated research agenda, he said. ‘If you look at the National Institute on Drug Abuse in the US, we don’t have anything comparable – which means we don’t have that critical science perspective.’

While the strategy committed to building a world-leading evidence base there was no mention of consumption rooms, said Release executive director Niamh Eastwood, despite evidence of their effectiveness and ability to provide access to treatment and other support. The strategy was a ‘tale of two competing directions’, with ‘once again an over-focus on criminal justice responses’ – something that undermined the ambition to get people into treatment. ‘When we treat people first and foremost as criminals, it’s very hard to address their health needs.’

THE EVIDENCE BASE

‘We’re traditionally seen as the enforcers,’ deputy chief constable of Lincolnshire Police, Jason Harwin, told the seminar. ‘And let’s be very clear, we have significant numbers of serious organised criminals who are exploiting young and vulnerable people, who we have to continue to enforce the law against. But we do need to make sure we’re diverting individuals to effective, evidence-based treatment services that we know reduces their vulnerability and their likelihood to continue to commit offences.’

‘From my own experience of addiction I’ve lived a definition of madness, which is doing the same thing over and over again and expecting a different result,’ said the Scottish Recovery Consortium’s lived experience officer, Michaela Jones. ‘The only solution in these circumstances is to stop and recognise the need for radical and sustained change – in this case it’s to accept that the resilience and flexibility of the drugs market make it almost impervious to enforcement activity.’

There had in fact been extensive, informal decriminalisation, said Strang. ‘It’s not been driven by laws, it’s driven by changing attitudes within different police forces and within society, and that’s a much more important level at which to engage.’

DEPRIVATION

In terms of preventing dependency, Release had consistently argued for re-allocating some of the ‘endless resources’ for law enforcement into trauma-informed counselling in schools from an early age, said Eastwood. ‘We know adverse childhood experiences are one of the biggest drivers for drug dependency. That could have a massive impact – addiction isn’t all about the drugs, it’s very much a response to abuse, neglect, deprivation.’

MARKET FORCES

Legal and illegal drug markets went ‘back and forth’, said Dr Keith Humphreys, professor of psychiatry at Stanford University, advisor to the Carol Black review and former drug policy advisor to President Obama. ‘It was legal companies that flooded our healthcare system with a 400 per cent increase in per capita prescribing, and many, many people got addicted to those drugs. Heroin traffickers then realised “there’s gold in them thar hills”, started to expand to different cities and began getting as customers people who were addicted to legal drugs like oxycontin.

‘If you believe that full legalisation, as is commonly said, will only bring good things then you have to be candid about what we’ve learned about the legal drugs we have’, he continued, as tobacco and alcohol killed far more than all illegal drugs combined. ‘If you’re going to argue – as many bright people have – that we should have corporations like the tobacco industry sell methamphetamine and cocaine, you should explain why those drugs wouldn’t then be up there at the top of that list.’

REDUCING DEMAND

In terms of reducing demand, while it was possible to use the media to encourage people to access services or give them factual information, advertising campaigns to discourage drug use simply didn’t work, he said. ‘Demand responds to supply, as is well demonstrated across all kinds of industries. Within the prescription system, where we at least putatively have a huge amount of control, if we don’t exercise that wisely we’ll get a lot more demand as we’ll make many more people dependent on – in the US and Canada – opioids, but also benzodiazepines, stimulant medication and so on.’

Ultimately, putting the person at the centre of services was vital, stressed Black. ‘We would do that with any other condition, and this really is a chronic disease with remissions and relapses. The real issue for me now is how do we keep this energy up, and enable it to go forward, keeping the government’s foot on the peddle and making sure it really is a whole-systems approach. We really have the opportunity to improve a quite dire situation when it comes to treatment and recovery. There’s a willingness to think about doing things differently. But everyone also recognises the hill that needs to be climbed.’

LANDMARK OPPORTUNITY

‘This is a landmark opportunity for a system transformation that will help us save lives and improve outcomes for individuals and the communities in which they live,’ said Rosanna O’Connor, director of addictions and inclusion at the Office for Health Improvement and Disparities (OHID). ‘It’s a very significant moment.’ It was also important to put aside concerns about the criminal justice focus, she said. ‘It’s through the criminal justice lens that we’ve landed ourselves such significant investment in treatment and recovery.

‘It’s surprising to find myself on a platform saying the politicians have delivered, and it’s now in our hands as a sector. We have to collaborate to deliver, and really up our game across the whole system if we’re to have any chance of having this investment sustained. We can do it, but we have to do it together.’ **DDN**

THE LONG GAME

In the last of their three-part series on the past, present and future of buprenorphine, **Dr Georges Petitjean** and **Deanne Burch** look at the opportunities, and challenges, presented by long-acting Buvidal injections.

The long-acting buprenorphine injection Buvidal was introduced in 2019, providing an opportunity to treat patients who would benefit from longer-term and stable dosing. Since its introduction, Buvidal has not yet been fully utilised as a treatment option in many drug treatment services.

Despite Buvidal being a welcome additional option within OST prescribing there are perceived difficulties and important considerations with regards to cost, implementation and ensuring equitable access for patients across national drug treatment services.

Long-acting injectable buprenorphine clearly has a place but can present financial challenges and complexities in implementation, as well as pose concerns about continuity of prescribing for patients who move to different areas because of inconsistency in prescribing rates. If long acting injectable buprenorphine is going to become a more common treatment option, then the issues which have been outlined need to be addressed. However, the ongoing exploration of how it may work within drug treatment services in the form of pilots is a positive sign towards its uptake in the future.

Dr Georges Petitjean is the substance misuse medical lead for Inclusion, part of Midlands Partnership NHS Foundation Trust. Deanne Burch is the hepatitis C elimination coordinator for the NHS Addictions Providers Alliance (NHS APA). www.inclusion.org / www.nhsapa.org

The authors have not received any financial or other support from pharmaceutical companies and the articles are their own opinion.

A CONVERSATION WITH DR JAN MELICHAR

Jan K Melichar, MD FRCPsych, is an NHS consultant addiction psychiatrist, visiting senior lecturer at Bath University and visiting professor at the University of South Wales. In 2020, he put in a successful bid to the Welsh Government to fund nationwide use of Buvidal. Working together with colleagues, he has rolled it out to more than 1,000 patients and has personally given more than 400 injections to over 100 patients.

What were your fears and expectations when you first began prescribing Buvidal?

To be honest, I was excited to start it as I saw it as a big step forward for many patients. Having worked at getting the most out of buprenorphine for the past two decades, I knew it would be great for settling the peaks and troughs you see with daily dosing. That understanding had led to me to using daily buprenorphine for outpatient detoxification ('detox-in-a-box') and seeing it as valuable in the opioid analgesia dependency (OAD) field. Some OAD patients were on so many short and medium and long-action opioids they were in a constant up and down of opioid effects. So I was very excited about seeing it in action, in terms of smoothing things for people on daily opioids and becoming an amazing detoxification option.

What has been your experience as a clinician?

Much more amazing and unexpected – life-changing for nearly everyone who is on it. Being on Buvidal did more than just settle the expected daily peaks and troughs – it utterly flattened most people's cravings and settled their anxieties so they simply moved on with their lives. It was as if the daily grind of heroin/methadone/buprenorphine kept them trapped – it was a daily reminder that they were 'an addict' and all their emotional energy each day went to dealing with that. Being on Buvidal freed them from that and released their recovery capital to simply move on. And this was regardless of which opioid they were on at the start. We recently looked at the Kaplan-Meier survival curves for them and found, regardless of sex/age/addiction severity or present drug use – were they on methadone/buprenorphine/heroin/codeine/tramadol before Buvidal? – that four in five benefited. This answers the question, 'Who is Buvidal for?' – it's for everyone.

What changes have you seen in your service users?

It was, and continues to be, life-changing for most who try it. It suits at least four in five of those who try it – they stay on it, turn up

and have used it as the missing link to their recovery.

They've moved on with their lives. One week after their first injection, they turn up, some having already re-engaged with their families, got back to work, got on with their lives. That persists over the months they are on it. Our fear of bringing out their past traumas – given trauma is the gateway drug, with them self-medicating with heroin and then developing maladaptive coping strategies – have proven unfounded.

About half just move on, able to just live their lives again. Of the remainder, about two thirds need to have here-and-now psychological support as past traumas/current issues surface – ably provided by the drug service workers in the coming year as Wales rolls out trauma-focused training for all workers. About 10 per cent need more psychological support. Crucially, though, they have reduced craving, reduced anxiety and therefore have the energy and capacity to engage with that support in a timely way.

What has been your experience of implementing Buvidal in your service?

We initially thought it would be fantastic for the pandemic – we asked both English and Welsh governments to fund it during that period and the Welsh Government stepped up to the plate – the roll-out across Wales has been fantastic. It's easiest to summarise in the feedback we get week in and week out – 19 out of 19 nurses we surveyed who had seen it in use wanted to continue using it, the receptionists love it as patients turn up happy, on time and even phone if they're running late for whatever reason.

There was, because of the pandemic, a flexibility in the bureaucracies to support service development at pace. So we implemented fast and developed how we gave Buvidal faster than similar developments in the past – it took years to move out of the shadow of slow-motion starts for oral buprenorphine 20 years ago and we've done similar in less than a year. Although there will always be resistance to new things and practices in services, once staff saw the dramatic changes in people they'd long given up on they were equally enthused.

What learning would you share with others who are considering prescribing long-acting injectable buprenorphine?

Just do it. Get commissioners to fund ten – it can be in the homeless services, primary care, prison releases. Make sure you measure how well they are before starting – quality of life, attendance records, A&E records, engagement with work or family and so on. Measure those again on Buvidal. You should see four in five make improvements, with the majority being significant. Commissioners like engagement figures so note that they attend every injection.

Figure out how to run their appointments alongside their injections as there is a risk they will not turn up for appointments outside of that time. Not for the reasons we automatically assume with oral opioids – assuming the worst. instead they miss those appointments as they're well, getting on with their lives, working, engaging with their families, and don't need to see anyone.

It's easy to use – a small injection of 0.5ml given subcutaneously. If an old consultant psychiatrist like myself can do it, anyone can. We've developed and evolved the practicalities so now we start people on either a weekly dose of 24mg – equivalent to around 16mg of oral – 20-30 minutes after a trial dose of 4mg of oral buprenorphine, so they've come in on the usual withdrawal for that, or have a two-day oral buprenorphine dosing of 8mg daily. Then straight to monthly 96mg, also equivalent to around 16mg oral. For the ones that start at weekly 24mg, we then offer a monthly dose the week after of 96mg or 128mg.

What are your views on the cost of long-acting injectable buprenorphine?

It is roughly £200 more annually than oral buprenorphine so this isn't actually an issue, especially as Dame Carol Black's report notes how much, when untreated, opioid users can cost the government per year. Confusion arises as commissioners sometimes forget to include the dispensing and other fees commercial pharmacies get for giving methadone and buprenorphine. Unfortunately, those dispensing fees are sometimes hidden in other budgets or given to commercial pharmacies as a difficult-to-disentangle block grant. So commissioners forget this extra £1,000 that is added to the cost of oral buprenorphine annually and fear the cost of Buvidal as it's 'much more expensive'. I don't think £200 per year more is that much more expensive, do you?

How do you see the future of long-acting injectable buprenorphine in services?

Massively expanding – we didn't expect it to be this good, this life changing and this effective. A true game changer which will see services pivot from 'script and chaos management' to finally having the capacity to help these people move on from having made the mistake of self-medicating to deal with their childhood traumas and being stuck with that mistake for decades. It's wonderful to see them suddenly getting back to swimming in the sea of life after so much time simply spent in a daily drowning as they worried about how long they had before they needed their next dose of daily opioid.

I suspect we, in the UK, are at the forefront of seeing the changes as we've given Buvidal to patients due to the pandemic rather than the select few already stable on oral buprenorphine. I think its remarkable action – the reduction in craving and anxiety and the return of normality – is, in part, due to novel allostatic pharmacology, with us finally seeing kappa antagonism, but that's another story!

Inclusion is running an innovative pilot in partnership with HMP Chelmsford to facilitate a smooth prescribing transition for people being discharged from prison to local drug and alcohol services. We asked Kevin Malone, public health programme manager in Thurrock and commissioner of the local Inclusion drug and alcohol service, for his thoughts on the pilot.

What are your hopes for the Buvidal pilot happening across Inclusion Thurrock and HMP Chelmsford?

My hopes for the Buvidal pilot are positive. For the right client, can we provide a solution that better meets their needs, mitigates the risk of relapse and breaks the cycle of recidivism? It may not be the solution for everyone, but the broader the range of support available, the more choice we can offer our diverse treatment population. The main legwork with this intervention is ensuring that preparation takes place prior to release, not just for the client but for the range of multi-agency staff that need to play their part in the community, however large or small that role is in supporting the client. I shall have a keen eye on future evaluation data for what is an interesting and exciting opportunity.

ON MESSAGE

Chemsex can be risky, but how do we get harm reduction messages to people who are young, 'invincible' and having fun? **DDN** reports

'The Gay Men's Health Collective have been running a pilot project of making their chemsex resources available in A&E. What we discovered was that staff were saying they could finally give people something to take away with them.'

PATRIIC GAYLE

'A lot of harm reduction information is coming through specialist services, and you have to be quite far down the road before you pitch up at a specialist service,' – something that applied equally to hepatitis C, drug use or chemsex, said Leila Reid of the Hepatitis C Trust. 'So how do you reach people at the beginning so that they know to look for harm reduction information?'

People who were 'younger and feeling invincible and having fun' wouldn't necessarily want to hear these messages, said Patriic Gayle of the Gay Men's Health Collective. Many of the victims of serial killer Stephen Port, however, who used GHB on his victims (*DDN*, February 2020, page 4) were so unaware when it came to drugs issues that they could 'be lured into a situation where they could be given fatal overdoses', said Bob Hodgson, independent advisor with the Metropolitan Police Service.

SERVICE INTEGRATION

A key point was integration of services, said Reid, not just with drugs and sexual health but across the board, and there had been excellent work in London and elsewhere around integrating HIV and hepatitis C testing and using those chances to deliver harm reduction information. 'There's a lot of opportunity when you've got that person there. For hep C at the moment there's a bit more of a focus and energy around it, so maybe we're reaching people who aren't normally reachable by health systems. From a general public health perspective, there's this idea of making every contact count, which is quite well established in some parts of health and social care as well as housing – there are a lot of agencies that come into contact with people at different, difficult times.'

VITAL RESOURCES

The Gay Men's Health Collective had been running a pilot project of making their chemsex resources available in A&E, said Gayle. 'We know that in one A&E you're looking at between five and ten admissions on a weekly basis for GHB overdose, and in terms of what they're rather disparagingly calling "frequent flyers", they'll quite often have return visits.'

The material was an accessible, cost-effective tool, and the plan was to roll the programme out further, he said. 'What we discovered was that staff were saying they could finally give people something to take away with them.' Healthcare workers often didn't feel confident discussing certain issues with patients, said Reid – 'something like this can really open up a discussion in a much easier way'.

Information detailing people's rights on arrest was also important, said Hodgson, especially when someone overdoses. 'If someone's read a "bust booklet" when they're not already taking drugs and are able to absorb the information then that's there when they're thinking "should I or shouldn't I call an ambulance?" So they know they're not just subject to the whim of whatever policeman turns up at the door, they have rights and there are protocols and people they can contact. When the paramedics get there you do need to take a leap of faith – you need to tell them what they've taken so they can treat them properly – but, with good will and sensible policing and ambulance services, they'll concentrate on the health needs and not bother about the drug.'

As Dame Carol Black's report pointed out, sizeable gaps remained around harm reduction when it came to communities who didn't really identify with the injecting population, said Reid, 'particularly MSM involved in chemsex, people using steroids and performance-enhancing drugs.'

'Harm reduction, public health, wellbeing messaging around safer drug use and chemsex would be helpful in terms of hopefully reducing the number of people who end up being admitted to hospital,' said Gayle. 'We don't have that, and it worries me that in the present climate it's struggling to get traction. I understand why, but if we don't do something about it we have a perfect storm.'

'You're reducing the stress on the police force, the ambulance services,' said Hodgson. 'It's a small amount of money that should save a lot down the line.'

PREVENTION

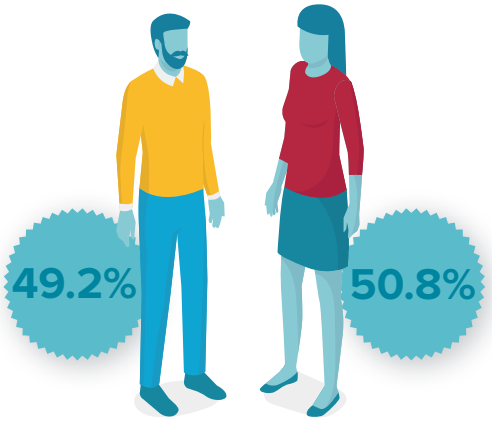
Prevention was always vastly more cost-effective than treatment, agreed Reid, but less easy to make the business case for, 'particularly if it's a population that a lot of people don't have a great deal of sympathy for. But if you can engage people you can address mental health and whatever else is there – early intervention and being proactive means you can prevent hep C, HIV and overdose and work really constructively with people. That's what's important if we want to really change people's outcomes on a big scale.' **DDN**

CONSTELLATIONS

DDN was reporting from the HRI Constellations session *'Chemsex harm reduction in London – another perfect storm'*. See more reports on our website, **www.drinkanddrugsnews.com/hri-constellations-2021/**

DrinkCoach Alcohol Test Impact

DrinkCoach is a digital alcohol service that supports people with their drinking. Our services, including our two-minute Alcohol Test and 1-2-1 Online Coaching sessions, have supported tens of thousands of people during the pandemic and has provided our commissioned areas with reliable digital interventions for their residents.



8%

Increase in follow up actions after completed AUDIT
(Compared to 2018-2019)

15

Commisioned areas across the UK

over

85K

AUDITS Completed

£

Estimated cost savings of over

1,200,000

to the health and care economy*

Data from January 2020 - December 2021

*Based on the PHE estimate of £27,000 savings to the health and care economy for every 1,000 Increasing Risk/ Higher Risk drinkers who receive IBA.

Commission DrinkCoach Today

Email innovation@humankindcharity.org.uk or visit our commissioning page for more information.

DrinkCoach is delivered by Humankind | humankindcharity.org.uk
Reg charity: 515755 | Ltd company: 1820492 | Reg office: Sapphire House, Aycliffe Business Park, Horndale Ave, Newton Aycliffe DL5 6DS

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BEHIND THE

With death rates rising across services, Derbyshire Healthcare NHS Foundation Trust decided to dig a little deeper into the statistics. **Martin Smith** reports

Around 2013-14, like many in the sector we began to see a rise in deaths within our services. As with other providers we were beginning to see a rise in all-cause mortality deaths, so we decided to take a closer look. Our task was to investigate the complexity of risk factors for premature all-cause mortality within the treatment population, and the impact of current clinical management.

There were 316 deaths of people engaged with Derbyshire Healthcare NHS Foundation Trust's (DHCFT) substance misuse services – or up to one year post-discharge – between 1 January 2012 and 20 August 2020. The data cut-off point meant we only had a partial year for 2020 so it wasn't included, but deaths in 2020 and 2021 exceeded those for 2019.

OVERDOSE

Overdose (predominantly opiate) was by far the most common cause of death at 115 cases, constituting 40 per cent of deaths for which the cause was known. The cause of death was unascertainable or not yet known in 21 cases (7 per cent). After heroin or opiate toxicity, drugs such as diazepam, temazepam, gabapentin, mirtazapine and increasingly pregabalin were frequently highlighted under section 1b ('underlying cause' of the main cause of death) on the death certificate. All other deaths were physical health-related with the exception of suicides, of which there were 20 (6.3 per cent). The most common causes of physical health deaths were predominantly liver disease, COPD, bacterial infections and cancers.

The highest number of deaths occurred in the 35-39 age group, followed closely by the 40-44 age group. The age profile of overdose deaths followed the same pattern, but with a more pronounced peak in the 35-39 age group. The data suggests that those aged 50 and over are more likely to die from a physical health condition than an overdose – in the 50-plus age group 19 per cent of deaths were due to overdose, compared to 39 per cent of deaths in those aged 35-49.

When only chronic causes of deaths are analysed (brain-related illnesses, cancer, cardiovascular illness, diabetes, liver disease, lung conditions and kidney disease), the age profile becomes slightly older, with a peak in the 45-49-year age bracket. However, the data shows many deaths at a young age from these causes, with 58 per cent of deaths occurring in those aged under 50 and 22 per cent in those under 40.

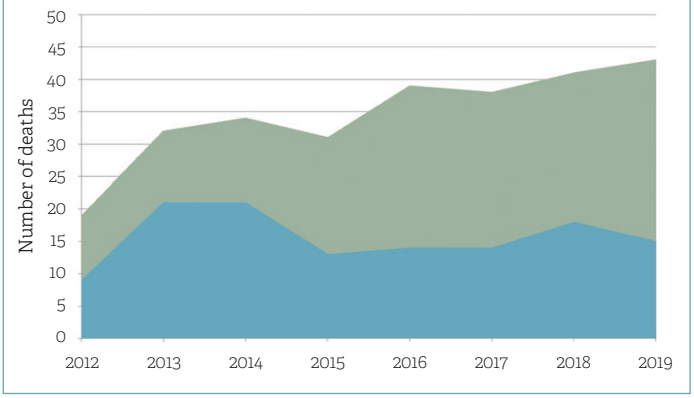
The data shows that most individuals (161, or 52 per cent) were found alone, while 37 per cent (115) died in a hospital, hospice or care home. Most deaths in hospital were caused by physical health conditions – only 11 were due to overdose. Twenty-six of the people that died in hospital were receiving end of life care. Only 11 per cent of all decedents were known to have died in the presence of friends – of those people who were found alone, 80 per cent were male. Of the 115 people who died by overdose, an even greater proportion (72 per cent) were found alone. Ten per cent of overdose deaths occurred in hospital and 18 per cent in the presence of friends.

PHYSICAL HEALTH CONDITIONS

Physical health conditions were highly prevalent in the cohort that died, with 81 per cent of people (251) having at least one such condition – 60 per cent (186) had two or more. The most commonly occurring conditions were chronic obstructive pulmonary disease (COPD) at the time of death. In this study 243 decedents were under the age of 50. Of these 191 had at least one long-term health condition such as COPD, liver disease, or a heart condition, and 155 had an identifiable mental health condition, such as anxiety and depression disorders, personality disorder, PTSD or psychotic illness. Poor physical health and life-limiting conditions will continue to be a challenge to the sector. Three quarters of the people who died had also had at least one hospital admission in the previous 12 months – a significant red flag and a clear indicator of risk regardless of reason for hospital admission.

In addressing overdoses we started rolling out naloxone in 2015, and it's likely that deaths both locally and nationally would have seen a greater increase without it. However, the prerequisite for naloxone effectiveness is that another person is present and available to administer it at the time of an overdose. With the number of people using drugs alone, living in isolation, and dying alone it is becoming clear that further interventions will be required, and it is highly likely that technology will play a key role.

Deaths of substance misuse service users from any cause



DATA

With the number of people using drugs alone, living in isolation, and dying alone it is becoming clear that further interventions will be required.

SPECIALIST CARE

A partnership between Derbyshire Healthcare NHS Foundation Trust and ImpACT+, the specialist respiratory/COPD team based at the Royal Derby Hospital, was created to address a recognised need for access to specialist respiratory care for those using our services. This service is now delivered from within two of our treatment bases. More people have been diagnosed and commenced on treatment regimes, with one case of TB identified and treated. Many with symptoms but undiagnosed have been identified and received appropriate investigations for symptoms they had previously not addressed or been unable to access their GP to discuss. One client was identified to be suffering from a range of conditions including a DVT and heart failure and is only alive today because the health improvement nurse had access to the specialist team who were able to act accordingly on her concerns.

We continue to work in collaboration with several hepatitis C ODNs and peers alongside our nurses to eliminate hepatitis C – in the last two years only one person had hepatitis C referenced on their death certificate. We also introduced on-site ECG testing in Derby, with tests uploaded and results received within 30 minutes. A recent audit showed 33 per cent needed a follow-up referral, and the system is fully integrated with GPs, hospitals and our own data system. We will soon be rolling this out across the county. Future research should also examine the impact of opioid substitution treatment on mortality.

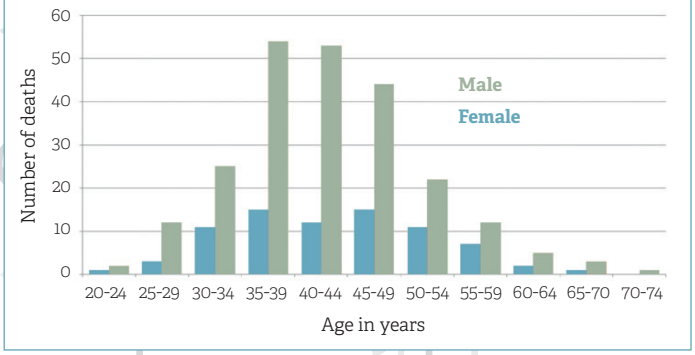
ENGAGE AND RE-ENGAGE

In order to keep people engaged in treatment we employed an outreach worker to re-engage those who had dropped off their prescription and stopped attending appointments, and optimisation of medication is encouraged to allow people to find a dose that's comfortable for them. More outreach workers were employed in the city and county to work specifically within the homeless community, and in the city we have an outreach worker to work specifically with females who are at risk.

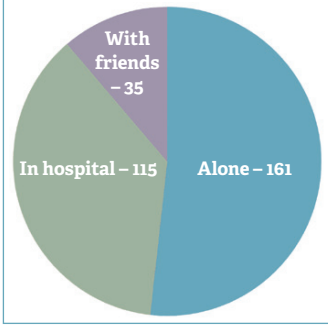
One of the challenges the sector faces is not just deaths through overdose but deaths through physical health conditions. It sometimes appears that it is acceptable to talk about deaths in general but it's still unusual to see services openly discuss all-cause mortality within their services. As we move into 2022 the full impact of COVID-19 on this client group is currently unknown, but it is reasonable to assume that the isolation and inequalities that they experienced pre-COVID would have intensified throughout 2020-22. As we all see a rise in the cost of living as always it is those with the least that will be most affected.

Martin Smith is recovery lead at Derbyshire Healthcare Foundation Trust

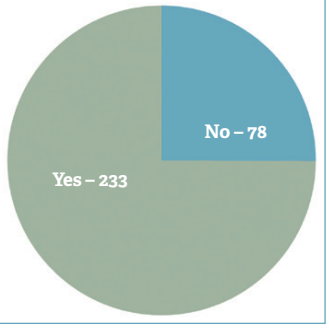
Age and gender profile



Circumstances of death

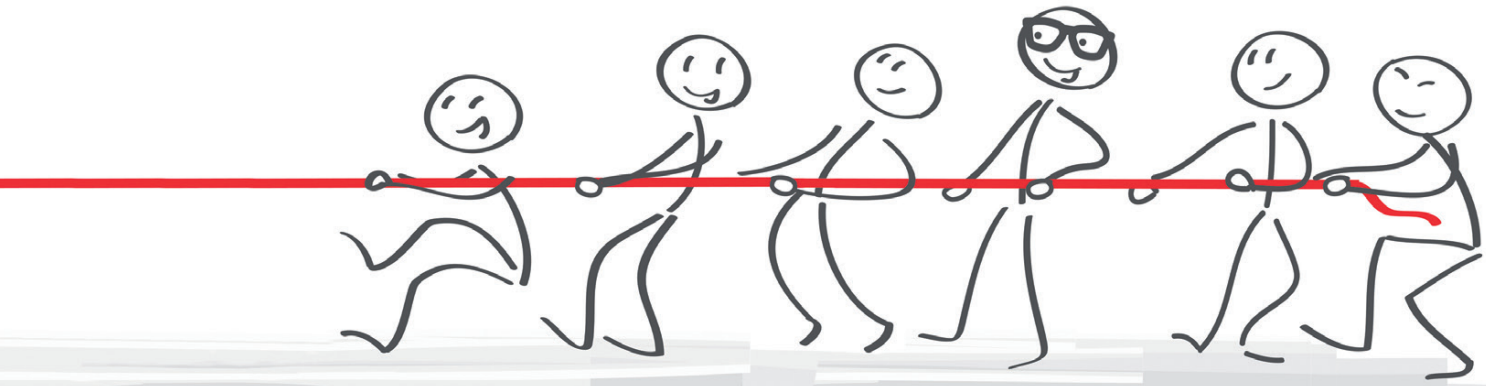


Hospital admissions in previous 12 months



Key findings and red flags

- Male gender (75%)
- Living in isolation (67%)
- Problematic alcohol use (50%)
- Being unemployed or retired (94%)
- Smoking (97%)
- Living in deprivation (77% living in the top 40% most deprived postcodes)
- Current or previous intravenous use (83%)
- Hospital admission/s in the previous 12 months (75%)
- Prison release within the previous 12 months (11%)
- Mental health difficulties (64%)
- Additional prescribed medications (gabapentinoids/benzodiazipines/opiates etc) (71%)
- Comorbid health conditions (81%)



STRONGER TOGETHER

Integrated treatment services could prevent many alcohol-related suicides, suggests a new survey of people with lived experience. **DDN** reports

The relationship between alcohol and suicide is complex. But research collated for a new report by the Suicide Prevention Consortium shows that people who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population. Nearly half of patients under the care of mental health services who die by suicide in England have a history of alcohol misuse. The pandemic brought an additional wave of higher risk drinking with its detrimental effects on mental health.

'I knew I had to address alcohol to start getting better. I just wished that they had noticed sooner that I had other deeper problems.'

With the statistics highlighted in their report, *Insights from experience: alcohol and suicide*, the consortium wanted to find out more about the relationship between alcohol and suicide by talking to those with personal experience – from suicide attempts while intoxicated, through to long-term alcohol use and dependency. What needed to change to make sure people were better supported by healthcare services?

A clear finding that emerged was that the relationship between alcohol and suicide was different for everyone, with no 'one-size-fits-all' treatment. People often felt unable to get past eligibility criteria and found themselves excluded from the support they needed from overstretched healthcare services. They responded to staff who genuinely listened to and trusted them, and the consortium identified the need for investment in alcohol and mental health services to give them the capacity to respond to people's individual needs.

'Alcohol used to take all of the bad feelings away for the moment but always left [me] sad after. Depression hits the day after I drink.'

It became clear that for many people, alcohol use was not an isolated issue but part of a wider picture of trying to cope with their feelings around mental health, trauma and suicidal thoughts. Isolating alcohol use from these other issues was a barrier to treatment: 'Lots of the people who responded to our survey told us they want services to treat them as a whole person, rather than isolating different issues they were experiencing from one another,' said the consortium.

While some people were treated with empathy and respect by healthcare services following a suicide attempt, others felt dismissed and judged by staff because of their alcohol use. There was a clear training need for staff in all healthcare settings – based on evidence from people with lived experience – so that they fully understood the complex role alcohol could play in suicide attempts.

'They [A&E staff] just said I would feel better once I sobered up.'

Various issues emerged through the survey – the impact of the pandemic, life experiences, past trauma – but there was not enough evidence in these responses to draw conclusions about the impact they had on people's relationship with alcohol.

An important next stage was to carry our further work with people with lived experience to develop a better understanding of the relationship between alcohol and suicide and look at risk, protective factors, and effective interventions. 'An understanding of the factors that might put people at greater risk of harm is crucial so that help can come earlier, long before people reach a crisis point,' said the consortium.

https://www.samaritans.org/about-samaritans/research-policy/alcohol-suicide/

'I once attempted suicide whilst drunk, was taken to A&E and treated with disdain by the nurses because they just saw a drunk young girl... What they didn't ask/know was that I'd been planning to die for months.'

THE SUICIDE PREVENTION CONSORTIUM is made up of four organisations – Samaritans (lead), National Suicide Prevention Alliance, Support After Suicide Partnership and With You. As part of the VCSE Health and Wellbeing Alliance, it aims to bring the expertise of its member organisations and the voice of those with lived experience to policymakers, to improve suicide prevention in England.

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A NEW VISION

Let's reduce harm, stand up for social justice and empower change, says **Charlie Mack**

This month, I have been delighted to launch our new five-year strategy, website and brand that underpin our commitment to empowering people and empowering change. Cranstoun is a social justice and harm reduction charity working across the areas of substance use, domestic abuse, criminal justice, housing and young people. Our vision is to be a world-class leader in rebuilding lives. We recognise that everyone is different and has different goals, so at Cranstoun we meet people at the point of their need, delivering evidence-informed solutions to get the best outcomes for every individual.

The refreshed branding and website reflect our ambition at Cranstoun to innovate and be courageous on behalf of the people who use our services. We believe that people in the UK and Ireland deserve the world's best practice. We are hungry to apply solutions here that are proven to work elsewhere, and to create home-grown solutions to export to other parts of the world. For example, we are advocating and directly campaigning for overdose prevention centres (OPCs) as part of a whole-system response to drug-related deaths, and we have also invested in new technology proven to reduce deaths in Canada. Our Cranstoun BuddyUp app ensures that no-one has to use alone, helping to save lives and reduce harm to individuals, communities and society.

Ambitious and committed to influencing positive change, we believe in creating system change by doing – shaping public opinion and policy to make a lasting difference to the systems and policies that make the greatest impact. You can read a bit more about some of our latest work and our strategy in action below, or find out more on our website. We'd love you to support us to drive forward system change.

THE CRANSTOUN STRATEGY IN ACTION

At Cranstoun, we mean business when we talk about harm reduction. We are committed to reducing the harms associated with substance use in every way we can imagine – from our naloxone supply, injecting equipment provision and our BuddyUp app to diamorphine-assisted treatment, overdose prevention centres and our DIVERT pre-arrest drug diversion programme.

BUDDYUP

The idea is simple – people who use drugs (PWUD) alone can download the app and be connected to a Cranstoun volunteer, with whom they can build a rescue plan in the event of an emergency. The plan is only activated if the person using the app becomes unresponsive. It will then send emergency instructions, triggering the appropriate medical attention, with the aim of preventing avoidable, fatal overdose.

In line with our new vision of developing and delivering world-class services, we have partnered with technology co-op Brave to build on the evidence base developed in Canada and bring that evidence back to the UK. We will be rolling out the app in a number of areas, with the intention that the service will be available across the UK and Ireland. We would love to collaborate and partner with other organisations who work with PWUD and could benefit from this support.

Cranstoun is pleased to partner with Drug Science and Release in this venture, with links in the app to both organisations for reliable information, informed support and legal advice. If you want to support us consider becoming a Buddy, and volunteer with BuddyUp to become a lifesaver. You can also support us by making a donation on our website.

OVERDOSE PREVENTION CENTRES (OPCS)

There is a wealth of evidence across the world that OPCs save lives, and sadly the UK lags far behind in this respect. As leaders and experts in harm reduction, Cranstoun have developed a blueprint to deliver OPCs in the UK, providing full clinical oversight and monitored and evaluated by a leading academic team. Excluded from support, many people who inject in public, semi-public or hidden areas die in dire conditions in abandoned buildings, parks and alleyways. Our goal is to make safe places a reality across every country in the UK and to embed OPCs as a core part of our service offer.

Cranstoun have long supported this intervention. Before our project lead Peter Krykant joined Cranstoun, he operated the UK's first OPC in Glasgow, and although this was an unsanctioned service it operated for ten months, supervising hundreds of injections and saving multiple lives. This added to the international evidence and pushed political change in Scotland.

> Our goal is to make safe places a reality across every country in the UK and to embed Overdose Prevention Centres as a core part of our service offer.

Our commitment is to empower people, and OPCs give us that opportunity. They are the ideal place to offer harm reduction advice on safer injecting practices, transition to smoking rather than injecting, and many other options for people that traditional drug services cannot reach.

Charlie Mack is chief executive at Cranstoun

GeorgePeters / iStock

'Why treat people and send them back to the conditions that made them sick?'

SIR MICHAEL MARMOT

THE HEART OF THE PROBLEM

Working with a public health approach can reach beyond treatment, hears **DDN**

'A healthy person isn't somebody who's just free from disease but somebody who has the opportunity for meaningful work, secure housing, stable relationships, high esteem and healthy habits,' Alice Wiseman told the Drugs, Alcohol and Justice APPG.

As director of public health in Gateshead and addiction lead at the Association of Directors of Public Health, she had been invited to share her perspective of a public health approach to addiction. Quoting Sir Michael Marmot (above) she said sustainable interventions involved looking behind a problem or illness to understand what was driving it.

TRAUMA

'For many people addiction is a response to trauma that has not been dealt with,' she said. 'Trauma comes in many shapes and sizes and people respond and react differently. The substances give people an opportunity to block out negative experiences they've had.'

Data showed that addiction was significantly more common in communities that were experiencing other hardships, such as poverty, lower educational attainment and vulnerable employment – conditions that often resulted in psychological distress and led to using substances. The patterns of illness showed that 'addiction is considerably more complex than individual behaviour choices', she said.

CHILDHOOD EXPERIENCES

Research on adverse childhood experiences (ACEs) showed how they disrupted a child's nervous, hormonal and immune development and led to social, emotional and learning problems – contexts in which addiction could thrive. But there were prevention opportunities throughout this pathway and 'nothing is set in stone', said Wiseman. She used research from Bellis *et al* in 2014 to show the impact we could have on the poor outcomes we wanted to tackle: 'If we focused our attention in a really robust way on reducing ACEs we could reduce heroin and crack use by 66 per cent, incarceration by 65 per cent, perpetration of violent crime by 60 per cent and high-risk drinking by 35 per cent.'

She demonstrated the human cost by sharing the case of a local man who had died in his late 20s. His was one of the many cases reviewed by a multi-agency panel in her area which was working closely with the coroner to look at the six months prior to each person's death and see if there was any learning that could help services reduce the risk of drug-related death.

'The panel were able to see that the man had been known to services as a child due to trauma and neglect,' she said. 'He'd been in the care system and moved into the criminal justice system as a young person and had become an adult while in custody. When reviewing his past in this way, it was no surprise that as an adult he presented as someone who had little or no trust in the services we provided.' Services that had had contact with the man had found him to be aggressive, hostile and hard to build a rapport with. He had recently been released from prison, 'which we know puts people at a higher risk of drug-related death' and had been released to premises in another local authority before returning to his local area. This had meant re-registering at the GP and changing treatment providers, 'and as a result we needed to restart engagement, support and try to build a trusting relationship all over again'.

While decisions had been made to try to protect this man, there was also acknowledgement that processes to remove one type of risk could result in the exacerbation of other risks. 'There was also an acceptance that to prevent a drug-related death we absolutely need to focus our attention on those underlying causes of addiction and ensure that people are not let down repeatedly in their earlier life,' she said. Acknowledging the 'significant' pressure on child social care, she said we needed to provide 'robust support for families very early on, as soon as those problems start to manifest', as well as offering interventions for children who had been affected. 'We label their behaviour as bad. We punish and criminalise them rather than understanding the causes of this behaviour and showing compassion. But we must invest in them in a robust and sustainable way,' she said.

MENTAL HEALTH

Treating criminal behaviour separately to mental illness amounted to 'fail[ing] to recognise what we're asking them to do,' she said. 'By asking them to give up drugs we're asking them to give

jeremy sutton-hibbert / Alamy

up the only mechanism they have for coping with the trauma they've experienced... we may need to accept that using substances at that stage in life is the only thing that's keeping that person going.' Focusing on building a relationship with that person needed to go hand in hand with harm reduction, working out 'what good looks like for them' and making sure the response was 'holistic, person centred, flexible and able to meet different needs at different points in life.'

> 'By asking people to give up drugs we're asking them to give up the only mechanism they have for coping...'
>
> ALICE WISEMAN

SAVING LIVES

'You have to want to save people's lives long enough to get them off drugs,' agreed Maggie Rae, president of the Faculty of Public Health. And one evidence-based intervention that we could, and should, be using was supervised overdose centres.

'We have failed to influence the government to change legislation and allow these centres to operate,' she said. 'The drug strategy will simply not be effective unless we get these centres up and running, because we will not get everyone to give up drugs right away... the more we can work closely with them, the more we can get them into treatment.

'We can throw money at drug treatment but we will still have the deaths because we will not be able to stop the deaths in the time it takes people to come off drugs – especially when we release people from prison with nothing – no drug orders, no treatment services. We're just not on this the way we should be.'

EVIDENCE BASE

The evidence base clearly supported the need for legislation to save people from dying, and would also save the NHS 'an absolute fortune' in treating people at the emergency stages.

Seeing the 'vile and disgusting' places where people were injecting with dirty needles – someone's daughter, someone's son, someone's brother, someone's sister – was a stark reminder that this should not be going on, she said. She hoped that the whole of the UK took on the legislation – and that the devolved nations would go ahead 'and shame those who will not move forward.' **DDN**

ROWDY YATES

We were saddened to hear of the death of Paul 'Rowdy' Yates, on 14 February, aged 71. He shared his surname with the Clint Eastwood character in the TV series *Rawhide* and was always known as Rowdy.

'He was a teacher, a researcher, a mentor, a musician, a role model, a leader, and a confidant,' say Phoenix Futures, with whom he worked – one of many influential roles within the sector. From using drugs and 'getting kicked out of bands' he set up a support group which merged with another to become Lifeline – 'a radical and adventurous project' – where he worked for 23 years. 'Under Rowdy's influence Lifeline became a radical and adventurous project that gained national recognition. It was characteristic of Rowdy to stretch the boundaries and develop new ways of working,' say Karen Biggs and Bob Campbell in a heartfelt tribute.

Later he became director of the Scottish Drugs Training Project, a founding member of the Phoenix Scotland Board and supported setting up therapeutic communities all over the world. He wrote many papers and articles (including in *DDN*) and retained his passion for music, inspiring residents and staff with his folk songs.

Read the tribute at https://www.phoenix-futures.org.uk/about-phoenix-futures/spotlight-on-recovery/phoenix-news-and-views/rowdy-yates/

WE NEED TO TALK ABOUT...
ATTITUDES

Why are widespread libertarian views on issues like vaccine passports usually at odds with the same people's opinions on drug prohibition, asks **Nick Goldstein**

Just when you thought it was safe to read *DDN* again... I'm back! Harm reduction is as much a chronic relapsing condition as addiction, and after being hopelessly involved in harm reduction for far too long I'd decided I deserved a sabbatical, maybe even a permanent vacation.

So, I'm on sabbatical/vacation minding my own business and everything is tickety boo, but early in 2021 I started to feel uneasy. Something was bugging me and I couldn't figure out what. This seemed more than your average pandemic blues, and I noticed the unease intensified whenever I watched the news or read a newspaper. Everyone feels mildly nauseous while watching the news these days, so I put it down to general anxiety. But this felt different.

Epiphany and diagnosis finally came while watching the Beeb's one o'clock news with, of all people, Andrew Bridgen MP discussing public health laws in the form of vaccine passports, which he harrumphed were 'a major infringement of civil liberties!' I was fairly amazed by his attitude, as anyone who's been arrested, charged or even imprisoned for breaking another of those public health laws, like, I don't know, a drugs offence perhaps would be.

Ironically, I remember, back in the day, meeting my old friend Jimmy on his way to court. I asked how he thought it would go and he replied 'nothing good's going to happen. Whatever happens my civil liberties will be flouted'. He was joking, but the judge saw it differently and told him so – while flouting his civil liberties. This was long before Mr Bridgen saw the light, so no one was there to question the court's approach to civil liberties and public health.

Public health laws are government, at various levels, trying to improve the health of the general public with policy and legislation involving environmental health, community health and epidemiology, among others. Public health laws are never popular because they amount to a blunt tool that inevitably limits behaviour, but up until recently they were accepted as necessary for the greater good. Public health laws have been introduced for a wide range of issues ranging from tobacco and alcohol use to zoning and quarantine laws and, of course, drug prohibition, employing policy tools from taxation to criminalisation.

No one likes being fined or jailed, but public health laws and the penalties they engendered were accepted as necessary – the price we all paid to be part of a society. That was until recently. You see Mr Bridgen's not alone in his re-evaluation of the relationship between the state and the individual, and its impact on public health. Mr Bridgen is just one of what appears to be a growing group of people with a very libertarian take on events – a whopping 126 MPs voted against the public health legislation around vaccine passports. MPs across the political spectrum voted against enacting a law the primary aim of which was the protection of their constituents' health – ranging from Jeremy Corbyn (natch) to Sir Graham Brady to Caroline Lucas. They were cheered on by a large section of society, from hardcore anti-vaxxers to lapsed Nazis to aged socialists all protesting public health laws as infringements that compromise their liberties.

> It's simple, we either believe in protecting society or we place an individual's rights before all else.

None of these people seem to have considered how their attitudes to public health might impact other areas – like drug prohibition. I mean, we have laws to protect everyone's health. You can't claim that one deadly disease should be prohibited and punished with criminalisation and then claim another should be ignored because action infringes your liberties. It's simple, we either believe in protecting society or we place an individual's rights before all else. It appears that a little consistency in our elected representatives' attitudes to public health laws is asking too much.

I guess on the plus side that inconsiderate comments from our political masters regarding the iniquity of public health laws and primacy of civil liberties reveal a sea change in attitudes to the ethos of the state and the individual – or to put it another way, you can't talk shit about rights without it impacting on other areas of public health policy, like substance misuse treatment. With a little luck this change of attitude and growth of libertarianism might spark a wider discussion on civil liberties and public health laws. Well, I feel a lot better for working out what was bugging me. Now... back to my sabbatical.

Nick Goldstein is a service user

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