Spring 2023

QAADRANT

Quaker Action on Alcohol & Drugs

Canada: Winds of change

Keeping Count – Should the UK be following Canada's new drinking guidelines? *pages 3-4*

British Columbia launches a three-year decriminalisation trial *pages 4-5*

Funding increased for treatment and housing support *page 2*

The government plans to ban Nitrous Oxide *page 6*

Being a QAAD Trustee *page 7*

Increased funding for drug and alcohol treatment and housing support in England

In February, the Department for Health and Social Care announced an extra £421m to be shared by all local authorities in England towards improving their drug and alcohol treatment and recovery services over the next two years. It follows an extra £95.4m provided this year - a total increase of 40% by 2025. Priority will be given to areas with the highest needs, such as drug-related death rates; deprivation; high prevalence of opiate and cocaine use; and crime. In addition to creating 50,000 treatment places, the aims include supporting the recruitment of more front-line staff; helping prison leavers to access treatment/recovery services; and improving the quality of treatment provided.

The increase stems from commitments made in 'From Harm to Hope', the national 10-year drug strategy, which responded to Dame Carol Black's independent inquiry into drugs in 2021. This recommended a strong focus on prevention, treatment and recovery, backed by a significant increase in funding. According to the Office for Health Improvement and Disparities (OHID), 84,697 people were treated solely for alcohol issues in 2021/22. Whilst this was 10% more than in the previous year, numbers have fallen from 91,651 since 2013/4.

In a separate announcement, OHID confirmed it is allocating up to £53m to 28 local authorities to provide targeted housing support for people in drug and alcohol treatment between 2022-25. Initiatives will be tailored to local needs e.g. specialist housing workers and peer supporters, and it is hoped that these will demonstrate how help with housing can improve people's longer-term recovery. Commenting on the announcement, OHID's Director for Addictions & Inclusion, Rosanna O'Connor, said: *'We have known, for too long, that people in drug treatment with housing problems do less well in their recovery. What we know less about is how to address these problems. For the first time, dedicated funding is available to improve housing support.'*

Carol Black's report stressed the need to rebuild treatment services by increasing the number of places and improving the recruitment, training and support of front-line staff. It is to be hoped that this extra funding will help to reverse the impact of years of cuts for all those affected. QAAD will share details of how local authorities use the extra funding and what difference this makes.

Drug-driving arrests

Last December, over 550 people were arrested for drink and drug driving in West and North Yorkshire. Drug-driving statistics showed 168 arrests in West Yorkshire over Christmas (75% higher than for the previous year) and 40 in North Yorkshire. Substances included cannabis, heroin and cocaine and a higher proportion of 17–25-year-olds tested positive. Superintendent Emma Aldred said *'Despite all the campaigning and warnings about the consequences, there are still those individuals who are willing to take the risk. This is not just being slightly over the limit either, it's three or four times, which is absolutely disgraceful.'*

Keeping Count - should the UK be following Canada's drinking guidelines?

The Canadian Centre on Substance Use and Addiction (CCSA) issued revised guidance on the level of alcohol deemed low-risk to drinkers' health recently. Here, Andrew Misell (Cardiff LM and Director for Wales at Alcohol Change UK) asks if this is a step in the right direction.

The outrage was predictable. The Toronto Sun called them 'nanny state lecturing'. The Daily Mail called them 'extreme'. The Portman Group said they were '*at odds with the vast majority*' of expert opinion.

What they were all talking about was the new guidelines from the CCSA, published in January, on the safe consumption of alcohol. Except that the CCSA's very clear message is that there is no such thing as safe drinking: *'Drinking alcohol, even a small amount, is damaging to everyone'*. It's a stronger reiteration of what the UK's Chief Medical Officers said in 2016: *'There is no level of regular drinking that can be considered as completely safe'*.

To be fair to the CCSA, they aren't just telling everyone to stop drinking. What they've come up with is a scale or spectrum: 'Low-risk' drinking is two standard Canadian drinks or fewer per week. That's equivalent to 3.4 UK units (a bit more than one large glass of wine) per week; 'Moderate-risk' drinking is between three and six standard drinks per week (up to 10 UK units or one bottle of wine); 'Increasingly high-risk' drinking is anything more than that. The new limits are lower than we're used to in the UK. Our current guidelines set the low-risk level at 14 units per week or less – 'increasingly high-risk' levels in Canada. The CCSA's reason for setting a lower risk threshold than the UK did in 2016 is simple: every year, we learn more and more about the health harms that can come from drinking alcohol.

The stated aim of the new guidelines is to enable people to *'make more informed decisions about alcohol use…assess their personal risk and consider reducing their alcohol use'*. Alexander Caudarella, CCSA's Chief Executive, was keen to emphasise that *'any reduction helps…it's never too late or too little.'* Professor Peter Butt (University of Saskatchewan), who co-authored the guidelines, said that they were '*fundamentally based on the right to know'*. So far, so good.

So, should the UK be following suit? Maybe, but we shouldn't expect miraculous results if we do. The Canadian guidelines are based very much on the idea of the more knowledge, the better: *'People living in Canada must be aware of important information about alcohol and health'*. It's hard to argue with that. But a

lot of us don't make all (or even most) of our decisions on the basis of knowledge. We're emotional, habit-bound, and subject to social pressures. Knowing that our drinking habits could harm us doesn't necessarily change our drinking behaviour – any more than knowing that something is fatty or salty stops us from eating it. The intellectual effort required to clear all that emotion and habit out of the way, and reach what Alexander Caudarella calls *'a risk level [you] are more comfortable with',* is not an effort we will always be willing or able to make.

Plus, whilst the guidelines' statement that *'it's better to drink less'* is true from a health point of view, future good health is not always at the front of everyone's mind when they're drinking. Many people will say that the more they drink, the more fun they have. For others, it may just be that the more they drink, the less socially awkward they feel, or the less they worry. We all know that alcohol is not an ideal way to make yourself feel at ease. We might want to help more people to be happy without it. But telling those people that they could shift their health risk to 'low' by drinking less may not be what they need to hear from us in the first instance.

So, yes, the Canadian guidelines are solid and scientific. They probably will help some people to make healthier drinking decisions. They could be a useful complement to broader work to reduce alcohol harm. But we should never fall into the trap of thinking that, if only people have enough of the right facts about alcohol, they'll be equipped to avoid alcohol problems. For that we need a more holistic approach – dare I say, a more Quakerly approach – recognising people's complex reasons for drinking harmfully, and being willing to sit with them patiently whilst they work out their route to healing.

Decriminalisation: British Columbia launches a three-year trial

In January, British Columbia launched a three-year trial to test the impact of decriminalising people in possession of small quantities of opioids (including heroin and fentanyl), cocaine, MDMA and methamphetamine. The decision follows several years of campaigning by the province's drug reform advocates, and follows Canada's legalisation of recreational cannabis in 2018.

People aged 18 years and above can now possess up to 2.5g of the specified drugs without arrest, charges or confiscation. Instead, the police will provide details of local treatment and recovery services. The drugs will remain illegal, as will their possession in school grounds, childcare facilities and airports. In addition, training and resources will be provided to around 9,000 front line police officers. Over the trial period, its impact on public health and public safety will be evaluated.

British Columbia has one of the highest drug-related death rates in North America and is at the epicentre of Canada's opioid crisis: the province declared a public health emergency in 2016, since when a further 9,400 deaths have been recorded. The adulteration, and consequent increased toxicity, of illegal drug supplies remains a serious concern – according to one study, testing of opioid samples found 90% had been cut with fentanyl.

Reformers stress that these drugs' illegal status leads many people to use them when they are alone. This can underpin their

reluctance to seek help and increase the risk of fatalities. Commenting on the launch, Jennifer Whiteside (Minister of Mental Health & Addictions, British Columbia) stated: *'Given the increasingly toxic drug supply, using alone can be fatal. Decriminalising people who use drugs breaks down the fear and shame associated with substance use and ensures they feel safer reaching out for life-saving supports.'*

Some experts have welcomed the trial as a step in the right direction, including Michel Kazatchkine (a member of the Global Commission on Drugs Policy) who suggested that it may lead to future, more extensive change: *'The overall way towards reforms in this so-sensitive area of drug policy will be accumulated evidence from real-life experiments and trials.'* Others have called for wider access to safe injection rooms and drug checking.

There are also those who have been more critical, describing it as a 'sticking plaster' in response to a major public health issue. Some argue that the 2.5g limit is likely to discriminate against higher tolerance drug users; people sharing purchases to reduce costs; and fentanyl users, due to its short-lasting effects. An unintended consequence of the limit could be to incentivise an increase in drug potency. Furthermore, if drugs have been adulterated with benzodiazepines (which are not included in the trial) unbeknownst to the purchaser, they will still be arrested once their supply has been tested. The 18-year age limit is also criticised, given that so many people start using drugs at a younger and more vulnerable age.

Gambling White Paper: update

As we go to print, the White Paper has still not been published, despite having been promised since 2019. We understand that this is now likely to be in March and it is rumoured that the government may have rejected the introduction of a mandatory levy, long called for by many campaigners, including QAAD. We hope to provide a full account of the proposed changes in the next issue.

In January, the Office for Health Improvement and Disparities (OHID) updated its 2021 study which drew together evidence on the prevalence, harms and economic and social costs linked to gambling in England.1 It estimates the total annual cost at between £1bn-£1.77bn: the excess direct financial cost to the government (around £413m) and health impacts (between £635m and £1,35m). The report acknowledges that this is likely to be an underestimate. In its conclusions, it highlights a clear need for improved evidence on the costs of gambling-related suicide and the impact of harmful gambling on family members and friends.

The Republic of Ireland's government passed a new Gambling Regulation Bill in November, which has been designed to protect consumers, people who gamble harmfully and children. It establishes a Gambling Regulatory Authority, which will begin later this year and will licence all physical and online operators. The Bill will introduce a mandatory levy to finance a Social Impact Fund (the level has yet to be announced). This will be used to support education, awareness and treatment for people harmed by gambling. New, strict rules will also

apply to advertising, marketing, promotion and sponsorship. For example, social media advertising will be banned, together with incentives such as ‘free bets’ and hospitality. A TV and online advertising watershed will be introduced between 5.30pm- 9pm, and children will banned from all gambling premises. Breaches of the new legislation will attract fines of up to EU20m or 10% of takeover.

1 https://www.drugsandalcohol.ie/37911/1/The-economic-cost-of-gambling-related-harm-in-England_evidence-update-2023.pdf

NEWS: Government plan to ban Nitrous Oxide

The government is planning to ban the sale and possession of nitrous oxide for recreational use within its antisocial behaviour strategy, due in the spring. It is the second most popular drug amongst 16–24 year olds (after cannabis) and concerns have been rising about health risks, particularly for heavy and frequent users. If the ban is introduced, sanctions for possession could include up to two years in prison or an unlimited fine.

Consultant neurologist, Dr David Nicholl (Sandwell and West Birmingham NHS Trust) is calling for a ban, raising his concerns via TikTok: ‘*It’s just endemic…There’s nothing worse I see than a young person with long term disabilities when it is completely avoidable. This was a neurological rarity five or six years ago, and now it’s common as muck, and that is just such a tragedy. People we see leave hospital in wheelchairs or need help walking.’*

Meanwhile, recommendations from the Royal London Hospital’s research into the diagnosis and treatment of spinal cord damage caused by nitrous oxide were immediately adopted as clinical practice guidelines by the Association of British Neurologists[1]. Typically, patients do not mention using the drug due to stigma or not realising that it has caused their symptoms. The Association’s president, Professor Tom Warner, said *‘Recreational use of nitrous oxide carries a significant risk of damage to the nervous system, particularly the spinal cord, which is treatable if picked up. These important guidelines lay out how to recognise, diagnose and, most importantly, treat those people … with such symptoms, and prevent long-term neurological disability.’*

However, the Advisory Council on the Misuse of Drugs (ACMD) published its review on the drug’s risks and harms in March, concluding that current evidence does not justify a ban and the proposed sanctions would be disproportionate. It suggests strengthening measures under the Pscychoactive Substances Act 2016, which already makes it illegal to produce, supply and import the drug for recreational use, but not possession. Further recommendations include extra powers for police to confiscate canisters; monitoring traffic accidents and fatalities relating to the drug’s use; adding health warnings to packaging; a national campaign on harms; and providing information and guidance for health professionals.

The Home Office thanked the ACMD for its report, whilst restating its determination to *‘crack down on drug misuse in our communities’*. It will now consider the recommendations before confirming its decision.

QAADRANT Spring 2019 included a feature about nitrous oxide’s history and impact. A copy of the article is available from our Director.

1 https://www.qmul.ac.uk/media/news/2023/smd/surge-in-nitrous-oxide-abuse-new-guidelines-to-help-clinicians-recognise-cases-and-prevent-spinal-cord-damage.html

Being a QAAD Trustee

We are currently seeking to appoint some new trustees. This is the third in a series of short articles written by current trustees which, we hope, will give Friends a flavour of what the role entails. Here, Tim James (Andover LM) describes his recruitment and longstanding experience of contributing to our work.

One Sunday in the late 1980s I was surprised when the Clerk of the small Meeting I was attending asked me if I would represent the Monthly Meeting at that year's QAAD conference. Surprised because, although I had found attending Meeting a very positive experience, I had not expressed any intention to apply for membership.

Later that year, I found myself engaging with a large, disparate group of people at Woodbrooke for the residential weekend. Here were those in recovery; others who had supported and suffered the impact of addictive behaviour; professionals involved in caring for those with such difficulty; and some who were simply concerned to understand and be involved. The one common factor was that they all had Quaker connections and Quaker values. During the weekend, I was approached by Michael Crewdson, then responsible for QAAD nominations, who asked if I would consider trusteeship. As a practising GP, I was very aware of the problems and the implications of those being discussed. I also observed the quiet, solid commitment of the people around me. It felt good to be a part of the event.

Over the years, I have come to know the people who participate in QAAD's 'community': those who gain support and those who contribute to it - often the same people. I have seen QAAD's achievements in informing the Society at large, supporting individuals within it, and networking with other organisations with similar concerns to influence wider society, demonstrating an informed, coherent, objectivity that commands respect.

I then come to ask myself, 'How is that achieved?' I think that the answer is twofold. Firstly, from the beginning, I was impressed by seeing the Quaker business method in operation: attentive listening and reflective decision making with none of the competitive, discursive cross chatter to disrupt the individual's thinking that I was used to in my GP practice meetings. Secondly, in trustee meetings and all our events, participants are a largely self-selected group who find a benefit in the experience of Meeting for Worship.

I continue to find trusteeship a fulfilling, worthwhile activity. As the years go by, emphases change and we attempt to respond to the world around us. Although we managed to stay in touch during COVID, the absence of face-to-face contact constrained our usual method of trustee recruitment. We are currently a board of six, but could be double that number, as in the past. If you share our concerns, and feel that you could thrive within the Quaker ethos, why not make yourself known?

Contacting QAAD

If you would like to contact QAAD for any reason, please write to our Director, Alison Mather, by post: PO Box 34, Bristol BS6 5AS or email: alison@qaad.org You are also welcome to call her: 0117 9246981. All contact is held in strict confidence.

QAAD events in 2022: We are planning to hold some more online meetings over the next few months. If you would like to be added to the events mailing list, please contact our Director, Alison. Details will also be posted on our website and in future issues of QAADRANT.

Thank you for your support

We have felt cheered and supported by the generous donations we have continued to receive from individuals, Meetings and Trusts during this difficult time. Donations are significant in two ways - they make us feel that our work is valued, and they give QAAD a longer-term future. In order to continue our work, we need to continue to draw down from our reserves which, of course, are not unlimited. Please send your donation to: **Ron Barden, Treasurer, 33 Booth Lane North, Northampton, NN3 6JQ.** Alternatively, if you would prefer to donate using a BACS transfer, our banks details are:

Account Name: Quaker Action on Alcohol and Drugs

A/C No: 31452673 Sort code: 400327.

If you can Gift Aid your donation, it will be enhanced by 25p for each £. Please complete the form below and return it with your donation.
I am a UK Taxpayer and want QAAD to treat all donations I have made for the past four years, and all future donations I make from the date of this declaration, as Gift Aid Donations until I notify you otherwise.

....

I understand that I must pay an amount of Income Tax and/or Capital Gains Tax for each tax year that is at least equal to the amount of tax reclaimed on my donations in the appropriate tax year. I understand that if I pay less Income and/or Capital Gains Tax to cover the amount of Gift Aid claimed on all my donations in that tax year, it is my responsibility to pay back any difference.

Name .... Signature .... Date ....

Address ....

.... Postcode ....