DRINK AND DRUGS NEWS

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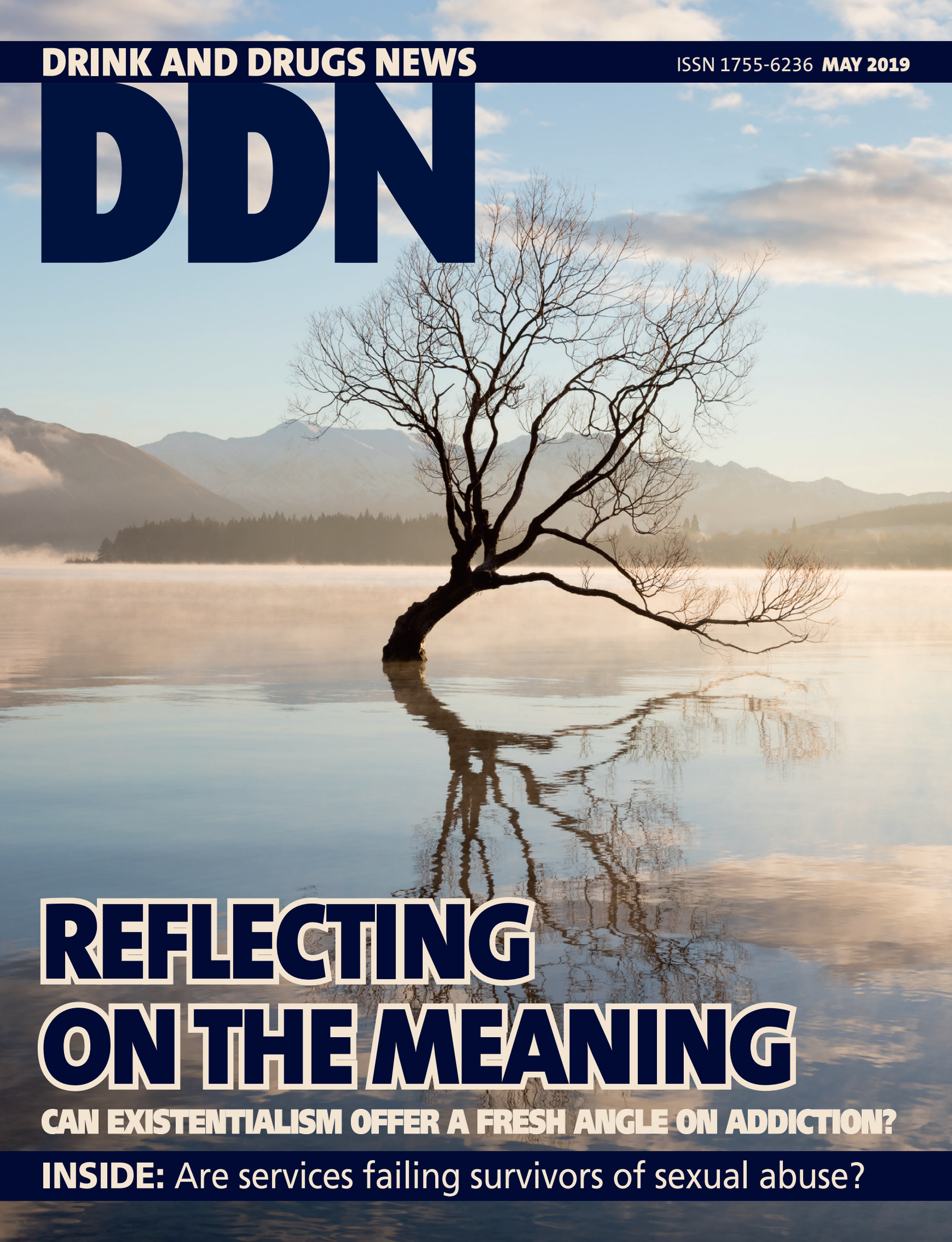

REFLECTING ON THE MEANING

CAN EXISTENTIALISM OFFER A FRESH ANGLE ON ADDICTION?

INSIDE: Are services failing survivors of sexual abuse?

DDN

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'There is no one-size-fits all in addiction treatment... every person needs to find what gives their life a direction, fulfilment and purpose, and the practitioner's role is to support this journey of discovery, not endorse a particular model of living.' Many of us would agree with Lana Durjava's words in this month's cover story (page 6); yet according to Mike Trace (page 8), 'too many people in the sector still see the abstinence/harm reduction issue in binary terms'. We have failed to achieve a balance between healthcare provision and recovery pathways, he argues. Is this your experience?

One certainty is the need to find effective ways to tackle chronic pain without always resorting to opiate medications (page 9). For many people these should not be the default option, yet so often they are. Sharing experiences from a recent pilot scheme, Robert Ralph suggests that with the right system in place and a fully engaged partnership model, the results can be dramatic – not just in achieving the vital pain reduction, but also in improving quality of life.

Recently we've been exploring the links between childhood trauma and substance misuse and this month we take a look at the distressingly common – yet poorly understood – exposure to childhood sexual abuse among people in treatment services. One thing we do know is that staff must be trained to respond to disclosure and be able to support survivors in an appropriate way. We hope you find the article helpful, and if you can add to our understanding of this vital work, please get in touch.

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

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NHS 'WORLD LEADING DEAL' TO HELP ELIMINATE HEP C

THE NHS WILL BE ABLE TO 'FIND AND CURE TENS OF THOUSANDS' more people with hepatitis C as part of a landmark deal with three drug companies, it has announced. The deal will see the NHS work with Gilead Sciences, AbbVie and Merck Sharp and Dohme (MSD) to proactively identify and treat people who may be unaware they have the virus.

More than 30,000 people have already been treated with effective new hep C drugs in recent years, but the deal will see the companies provide them at the 'best price for the NHS and taxpayers' as well as launch initiatives to find and test potential patients and treat those who need it. Reducing health inequalities is a key part of the new NHS long term plan (*DDN*, February, page 5), and the deal will help provide services to isolated and hard-to-reach communities such as the homeless, those with mental health issues and other high-risk groups, says the NHS.

'The Hepatitis C Trust is delighted with this development – 69 per cent of people who have the virus are currently undiagnosed so the funding in the deal to help find those with hepatitis C and support them into treatment is groundbreaking,' said Hepatitis C Trust chief executive Rachel Halford.

'We believe this deal offers a unique opportunity for all stakeholders – patient organisations, pharmaceutical companies, clinicians, prison healthcare and drug misuse services – to work together to reach all those affected. By making sure we reach the most marginalised and hardest to engage we will ensure that no one is left behind and stop unnecessary deaths.'

It was 'not often that the opportunity arises to completely eradicate a disease, but now the NHS is taking practical action to achieve exactly that,' added NHS chief executive Simon Stevens. 'The NHS's sophisticated and unashamedly rigorous negotiation on behalf of both patients and taxpayers means we've now been able to strike affordable deals with our life sciences partners to save many more lives and meaningfully cut health inequalities'.

Deaths from hepatitis C related liver disease fell by 16 per cent between 2015 and 2017, from 380 to 319, according to the latest figures from Public Health England (PHE). While this puts England ahead of the World Health Organization's (WHO) target of reducing deaths by 10 per cent by 2020, around 113,000 people in England are estimated to be living with chronic hep C, with up to 79,000 of them undiagnosed. Improved access to new treatments has also led to a fall in the number of people needing liver transplants, however, with a 53 per cent drop to a ten-year low of just 63. The new treatments have a cure rate of around 95 per cent, says PHE.

'This deal offers a unique opportunity for all stakeholders'

RACHEL HALFORD

Injecting drug use continues to be the most important risk factor for infection, being 'cited as the risk in around 90 per cent of all laboratory reports where risk factors have been disclosed'. However, transmission rates among 'recent initiates' to injecting drug use remain relatively stable, states PHE, with infection prevalence standing at 23 per cent in 2017 compared to 20 per cent in 2011.

NHS long term plan at www.longtermplan.nhs.uk
Hepatitis C in England 2019: working to eliminate hepatitis C as a major public health threat at www.gov.uk

CHEMIST CHECKS

ONLINE PHARMACIES will need to have 'robust processes' in place to carry out identity checks and prevent multiple orders to the same address or using the same payment details, says updated guidance from the General Pharmaceutical Council (GPhC). Additional safeguards will also need to be in place for any medicines liable to 'abuse, overuse or misuse' such as opiates, sedatives, pregabalin or gabapentin.

'We support pharmacy services being provided in innovative ways, including online, as long as the services are safe and effective for people,' said GPhC chief executive Duncan Rudkin. 'But providing pharmacy services online carries particular risks which need to be successfully managed. People can be put at serious risk if they are able to obtain medicines that are not appropriate for them.' *Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet at www.pharmacyregulation.org*

PEER PRESSURE

THE LARGEST EVER TRIAL of peer-led drug prevention programmes in schools is being conducted across South Wales and the west of England by researchers at Cardiff and Bristol universities. More than 5,600 students across 48 schools are involved in the three-year FRANK Friends pilot, which will see year 9 students asked to nominate the classmates they feel are the most influential. The top 17.5 per cent will then be invited to become peer supporters and given training in how to talk to fellow students about the potential harms of drug use.

The schools will be randomly split into two groups of 24, with one group running the scheme and the other not, and researchers collecting information on drug use to evaluate the project's effectiveness. 'There is limited evidence that drug prevention interventions are effective,' said study lead Dr James White. 'Schools provide a systematic and efficient way of reaching a large number of people every year.'

PRISON PRIORITIES

A NEW PRISON DRUGS STRATEGY has been published by the Ministry of Justice, outlining a 'co-ordinated response' to deal with record levels of drug-related violence and with the objectives of restricting supply, reducing demand and building recovery. Developing 'more meaningful regimes', providing constructive ways for prisoners to spend their time and working closely with health and justice partners will help achieve the last two, the strategy states.

While the document was a 'good start', it was important to ensure that the 'people who can make it work are empowered to deliver it', said Phoenix Futures chief executive Karen Biggs. 'Until we as a society accept there are vulnerable people in prison and they deserve the very best care, support and treatment services, I fear we will still be struggling to make the most of the opportunity for rehabilitation that prison offers.' *National prison drugs strategy at www.gov.uk*

It is important that the 'people who can make it work are empowered to deliver it'.

KAREN BIGGS

NEW STRATEGY TO TACKLE 'GAMBLING HARMS'

A NEW THREE-YEAR STRATEGY TO REDUCE GAMBLING HARMS has been launched by the Gambling Commission, the government has announced. The strategy will bring together businesses, regulators, charities and health bodies to 'work to bring a lasting impact'.

The strategy will focus on prevention, education and support – delivering 'truly national' treatment that 'meets the needs of users' – while the commission has also pledged to take a 'firm' regulatory enforcement approach.

Gambling advertising has long been a controversial issue, with new standards to protect children from 'irresponsible' adverts published by the Committee of Advertising Practice (CAP) earlier this year (*DDN*, March, page 4). Finding help for problem gambling, meanwhile, is still seen largely as a postcode lottery – 'if you use substances you're far better off in terms of access to treatment', gambling harm consultant Owen Baily told this year's *DDN* conference (*DDN*, March, page 16). 'With gambling it very much depends on where you live.'

'The Gambling Commission's strategy reflects our clear expectation that the whole sector must come together to reduce problem gambling and the harm it does to people and their families,' said sport and civil society minister Mims Davies. 'Through increased research, education and treatment I want to see faster progress made in tackling this issue.'

'The whole sector must come together to reduce problem gambling and the harm it does to people and their families'

MIMS DAVIES

Public Health England will also conduct a review of evidence on the public health aspects of gambling to be published next spring, looking at the 'range and scale' of gambling harms and the impact on health and wellbeing. 'PHE welcomes the strategy's commitment to taking a public health approach to gambling related harms,' said the agency's director of alcohol, drugs and tobacco, Rosanna O'Connor.

Strategy at www.reducinggamblingharms.org

COUNTY CONCERNS

THE HOME OFFICE has produced a series of posters to help staff working in social housing identify potential victims of county lines activity and report their concerns. The number of potential modern slavery victims reported to the authorities has risen by more than 80 per cent in the last two years to just under 7,000, according to the National Crime Agency (NCA) (*DDN*, April, page 4). The numbers of British citizens and minors referred doubled between 2018 and 2019, both partly the result of exploitation of young people by county lines gangs.

FORENSIC FINDINGS

THERE ARE NO SPECIFIC UP-TO-DATE GUIDELINES for forensic toxicology investigations for drug-related deaths except for single substance groups such as fentanyl and its analogues, according to an EMCDDA report. This is the case at both the European and wider international levels, says the agency, despite between 7,000 and 9,000 drug-related fatalities being reported in Europe every year for the past decade. Screening for NPS in post-mortem specimens, for example, requires up-to-date technical equipment and is therefore 'generally limited to specialised laboratories'. *An analysis of post-mortem toxicology practices in drug-related death cases in Europe at www.emcdda.europa.eu*

'Psychedelics are set to have a major impact on neuroscience and psychiatry...'

DR ROBIN CARHART-HARRIS

PSYCHEDELIC CENTRE

THE WORLD'S FIRST FORMAL CENTRE FOR PSYCHEDELIC RESEARCH has been launched at Imperial College London. The £3m centre will focus on the use of psychedelics in mental health care and as 'tools to probe the brain's basis of consciousness'. The centre's opening represents a 'watershed moment for psychedelic science, symbolic of its now mainstream recognition,' said its head, Dr Robin Carhart-Harris. 'Psychedelics are set to have a major impact on neuroscience and psychiatry in the coming years.'

DEADLY SERIOUS

ALMOST 100 EXECUTIONS FOR DRUG-RELATED OFFENCES are known to have been carried out in 2018, according to Amnesty International. While this represents 14 per cent of the total number of global executions, it is down from 28 per cent in 2017. Overall, almost 700 executions in 20 countries were recorded by the agency last year, a decrease of more than 30 per cent compared to 2017.

A QUESTION

Existentialism can give us a fresh angle on addressing the debilitating void that follows addiction, suggests **Lana Durjava**

Through years of interactions with compulsive drug users in a variety of different settings, I have noticed the recurring pattern of lack of direction and meaning. This has appeared to be a significant factor in both predisposing and perpetuating addictive behaviour, and is something that is not automatically eliminated when a person stops using drugs.

Purpose deficit, so to speak, frequently persists through time, and it sometimes becomes even more pronounced once drug-free life is achieved. To help people attain long-term and personally fulfilling recovery, it is advisable for practitioners to be mindful of this shortfall, to understand how it relates to excessive drug use and to possess enough practical knowledge to be able to confidently deliver effective interventions. In order to do that, useful insights can be drawn from a field that is not necessarily the first go-to within substance use treatment – that of existential philosophy.

OF WHY

Existentialism is a philosophy that is concerned with finding self and the meaning of life through free will, choice, and personal accountability. Its basic premise is that there is no inherent purpose in life and that each individual is responsible for finding their own meaning, making autonomous choices and aspiring towards freedom and authenticity. The topics that it focuses on are directly relevant to the symptomatology of addiction, and because of its emphasis on understanding people as free agents who are fully accountable for their lives, it can offer a fresh angle that complements biopsychosocial theories and treatment of substance use.

Clients with substance use problems often present under the illusion that they are working against their will when they are using drugs. The existential perspective suggests otherwise. It argues that drug use is not random but serves a specific purpose; underlying drug use is a particular need and people are acting in accordance with their will, which aims for this need to be met. As a part of effective addiction treatment, this need has to be identified, fully explored and addressed in an alternative way.

However, that is not enough. We shouldn't just focus on why the drugs, we must also inquire into why anything else. What motivates a person at a specific time to change their behaviour? What could carry more significance than drugs? What can provide solid ground and a sense of direction? What has the potential to offer some value to life?

Drug use is essentially a needs-driven behaviour, and underlying every addiction there is a certain lack, an emptiness, a gap that needs to be filled. This gap might have been, to varying degrees of success, replete when the person was using drugs. However, when drug use stops and once the initial post-detox honeymoon phase comes to an end, the person is faced with the original void that played a material role in setting off compulsive drug use in the first place.

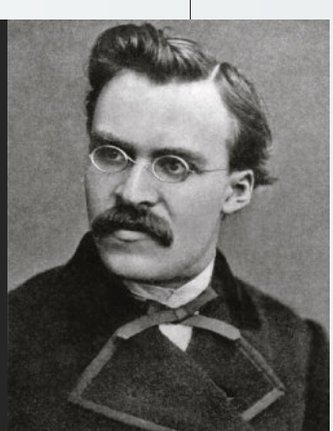
Jean Cocteau once wrote down reflections on his opium using days and treatment, and I have encountered the same message, expressed with different words, on multiple occasions during my work with people with substance use problems: 'After the cure. The worst moment, the worst danger. Health with this void and immense sadness. The doctors honestly hand you over to suicide.'

Every person is unique, and people use drugs for a variety of different reasons, but among those who progress from recreational to dependent drug use, certain patterns keep emerging. There is a recurring motif of disconnection from the world; an acute sense of feeling out of place. Reality is experienced as unsafe and unreliable to lean on, relationships are perceived as overwhelming and bewildering, and self is interpreted as overly sensitive and ill-equipped to navigate through life on its own resources.

Among other things, drugs bring relief, freedom, joy, relaxation, company, safety, focus, comfort and solace. Because they serve to compensate for the deficits in other areas in life, the relationship with them develops the structure and dynamic of a volatile love story, and practitioners need to be aware of the meaning clients attribute to drugs and the amount of hope they invest into this relationship. Meaning and hope, in combination with extreme attachment to the drug, is what makes the transition away from compulsive drug use a complicated process.

Change can, of course, be initiated by applying pressure or removing an obstacle, and recovery often begins in the context of a crisis of sufficient magnitude that it temporarily overwhelms the person's deep-rooted aversion to stopping using drugs. However, what triggers the commencement of recovery is not necessarily sufficient for its maintenance. To keep drugs out of the equation on a consistent and long-term basis, something else will need to start to matter more than them because a satisfying life can simply not be built around emptiness.

'If we have our own why in life, we shall get along with almost any how.' Friedrich Nietzsche



But just as there is no one-size-fits-all in addiction treatment, the new meaning is not universal. Every person needs to find what gives their life a direction, fulfilment and purpose, and the practitioner's role is to support this journey of discovery, not endorse a particular model of living. Clients primarily need to be encouraged to consider their life experience in light of their implications, purpose and consequences, and leading the way in the process of reflection and change must be the client's own narrative, not the practitioner's theoretical model or personal biases.

Addiction tends to be accompanied by a dissatisfied world view and thrives in an atmosphere of unhappiness, mistrust and isolation. It is also closely associated with a general feeling of disorientation and discomfort with existing in the world. However, while it is overall a rather unsatisfying condition, it does come hand in hand with the longing for something more, with an itch to live a different life – a life that matters.

This is a natural human condition that addiction doesn't eradicate. It might temporarily mask it, but it doesn't put an end to it because people have an intrinsic orientation towards a personally meaningful life. After all, human beings are just meaning-making animals. This inclination towards purpose is important to be acknowledged and utilised as a solid foundation for the process of change, self-discovery and development of a value-driven life.

Once people feel safe within their own psychological resources, once they have a better understanding of their authentic self, and once they discover things that are of personal significance to them, they will find it substantially easier to move on from drugs and invest their time and energy in activities and relationships that are purposeful, fulfilling and sustainable on a long-term basis. And while an important part of recovery consists of learning new skills and adopting alternative patterns of thinking, feeling and relating to the world, people also need a rationale for making these changes, direction as to where they want to go, and the belief that a drug-free life is worth the effort.

Essentially, when the going gets tough, people need a reason not to give up. Or to put it in words of Friedrich Nietzsche, a philosopher whose work has been fundamental to the existentialist movement: 'If we have our own why in life, we shall get along with almost any how.'

Lana Durjava has a background in forensic psychology and works in the probation service

FINDING THE RIGHT BALANCE

As deputy drug czar for the Blair government, **Mike Trace** oversaw the expansion of today's drug and alcohol treatment system. In the fifth of his series of articles he gives his personal view of the successes and failures of the past 20 years, and the challenges the sector now faces.

In last month's article, I looked at what the sector needs to do to achieve better results with fewer resources – focusing on reducing bureaucracy and redirecting activity towards the most effective interventions. I also said that we need to do less of some things and, controversial as it may be, one of the things we need to reduce expenditure on is the clinical component of drug treatment – the cost of prescribing, purchasing and dispensing medicines.

This is not a simplistic call to prioritise abstinence and recovery. Amazingly, after 40 years of debating it, too many people in the sector still see the abstinence/harm reduction issue in binary terms – choose your side and criticise the other side. An effective system has to have a full menu of services.

Good healthcare provision for drug users is important, and the delivery of harm reduction interventions to people at risk should be at the core of any local treatment service. Substitution treatment in particular is proven effective in attracting opiate users to services, helping them to stabilise their lifestyles and reducing overdose and infection risk.

But, looked at from the perspective of changing needs and tightening finances, our focus of resources on the healthcare aspect of treatment presents two problems. The first is a mismatch between presenting needs and allocation of resources. Our treatment system has been built around the needs of daily heroin and/or cocaine users. As this cohort has aged, there are new generations presenting to services with similar patterns of use, but many more whose problems are with cannabis, novel psychoactive substances (NPS) like spice, prescription drugs, or alcohol.

In recent years, only a small proportion of people presenting to treatment are primary heroin/opiate users (in 2017/18, around 30 per cent), but substitute prescribing is the service most commonly provided (to around 50 per cent of all clients recorded on the National Drug Treatment Monitoring System that year). Of course, substitution treatment is also relevant to those using opiates as a secondary drug, but there will also be hundreds of thousands of people struggling with the use of non-opiate drugs who do not present to treatment services because they do not find what is on offer attractive.

The second problem is that of spiralling costs. The days when substitute prescribing was seen as the cheap option seem long gone. The rise in supervised consumption, the costs of the drugs themselves, the shortage of suitably qualified doctors and nurses (allied with exorbitant agency fees), and the raising of standards on governance and dispensing by the Care Quality Commission (CQC) and the National Institute for Health and Care Excellence (NICE) have led to a multi-headed inflation of costs that stretches provider resources and commissioner budgets. In some of the Forward Trust contracts (prison and community based), the cost of delivering medicines safely to clients takes up over 40 per cent of the entire service budget. I am prepared to consider that other providers are more efficient than us but, looking at the financial profiles of contracts run by others, the general picture is the same.

So, while it is important to maintain good clinical components of any local treatment system, we do have the problem that too high a proportion of the available budget is spent on them, and we have to remember that these services are not relevant to an increasing proportion of potential clients. Meanwhile, this concentration of resources pushes out any possibility of investment in other areas of provision – including other harm reduction measures – or quality improvement.

It's not clear what we do about this, as any reduction in coverage or quality of clinical services is quickly met with challenges from CQC or commissioners, which can lead to loss of contracts. However, the sector needs to find a way out of this dilemma. We know that good quality healthcare provision attracts people into services, and can provide a good foundation for behaviour and lifestyle change, but it is not enough on its own.

Amazingly, after 40 years of debating it, too many people in the sector still see the abstinence/harm reduction issue in binary terms – choose your side and criticise the other side. An effective system has to have a full menu of services.

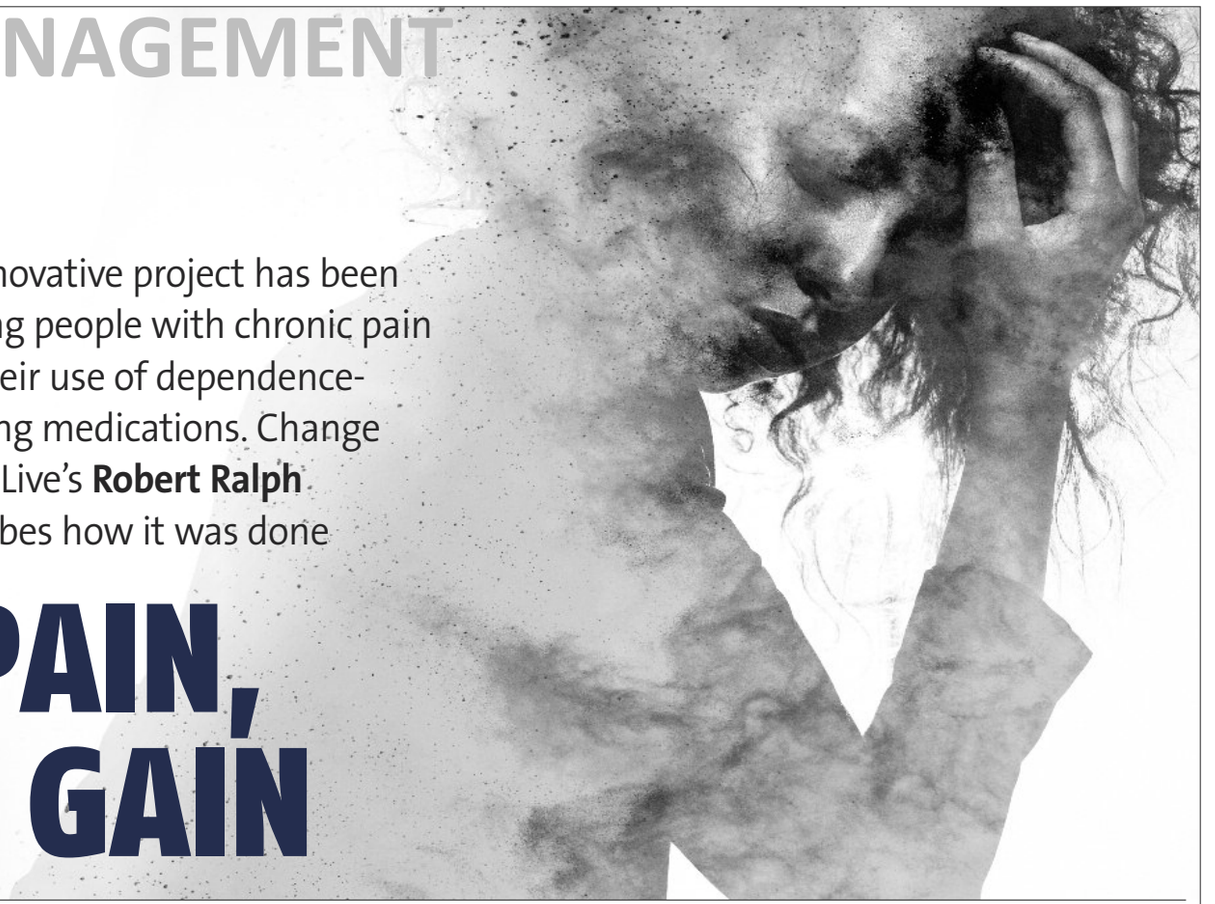
All the research on substitution treatment emphasises the need for it to be allied with psychosocial/therapeutic work to be effective, and the recovery programmes and pathways that move people towards independence and reduce the burden on clinical services are still not sufficiently widespread or well funded in our system. We need to have a mutually reinforcing balance between healthcare provision and recovery pathways, but the sector does not have that balance at the moment. This inhibits our impact.

There are indeed many challenges facing the sector, but not without possible solutions. In my next piece I will try to lay out my vision of how we can create a new period of positive achievement.

Mike Trace is CEO of Forward Trust

An innovative project has been helping people with chronic pain cut their use of dependence-forming medications. Change Grow Live's **Robert Ralph** describes how it was done

LESS PAIN, MORE GAIN



Opiate medications don't work for chronic pain – in fact they often make it worse. In a recent pilot scheme in Hastings run jointly by Change Grow Live's East Sussex drug and alcohol recovery service (STAR) with local GP surgeries, 235 patients were assessed and supported to manage their pain and wean them from opiate medications. Sixty were fully weaned and a further 57 reduced to a safe and sustainable level.

The results were startling. Patients who weaned from opiates reported an average 19 per cent improvement in their quality of life, significant reductions in anxiety levels, improved sleep, less constipation – and no increase in pain. Early indications also suggest a further reduction in GP appointments following weaning of as much as 20 per cent – a huge cost saving, especially when added to the £31,000 per annum saved in medications.

In addition a group work programme was developed that supported patients with a range of self-management techniques for pain. The isolation caused by chronic pain leads to a wide range of problems, and the group found it useful to spend time together connecting with others who truly understood their issues. In fact, the core of the group has continued to meet and, with support from Change Grow Live (CGL), is setting up a community-based peer support group for chronic pain sufferers.

Moderate to severe chronic pain – that is, pain that continues for more than 12 weeks – is thought to affect around 18 per cent of the UK population. GPs have traditionally prescribed opiate medications such as morphine, fentanyl, buprenorphine and oxycodone, as it was thought that – provided they did not over-sedate, cause overdose or other severe reactions – it was safe and there was little else that could be done for these patients.

A broad definition of dependence-forming medications encompasses GABAergic medicines, benzodiazepines and Z-drugs such as zopiclone, and the prescribing of these has been increasing (with the exception of benzodiazepines). In 2000, 6 per cent of the UK population were prescribed at least one of these types of medicines, but by 2015 this had risen to 9 per cent.

Hastings and Rother CCG looked at GP surgeries locally and were able to identify those with the highest rates of opiate prescribing. CGL were then contracted to provide a pilot scheme alongside The Station Practice in Hastings for one year from February 2018.

The pilot worked in two phases, with the first half of the year a multi-disciplinary team (MDT) approach, and the second half CGL-led with limited GP support and expansion into a second practice. The MDT approach showed the greatest results, but also used the most resource. The CGL worker engaged patients with an above 120mg morphine daily equivalent, as well as patients prescribed polypharmacy opiates or other DFMs.

Engagement was key – someone listening to patients' stories was an incredibly powerful experience for them, as most clinical staff are usually unable to take the time to do this. Motivational interviewing was used to support movement towards change, both with lifestyle and medication, and mindfulness, TENS machines, sleep hygiene, and referral to other agencies were also key in fully engaging patients.

Once a week for half a day a dedicated GP was available and MDT practice appointments were run alongside the CGL worker – these were 20-minute slots that allowed time for holistic interventions for a wide range of health issues. Patients were provided with a 'Hastings pain toolkit' to assist with self-management of pain and lifestyle, which included links to other useful resources. A surgery pharmacist was also involved to provide follow-up support and discuss medication with patients by telephone. The MDT team has been nominated for this year's *BMJ* awards in general practice, and has reached the final five.

During the second half of the year the CGL worker was spread across two GP surgeries, carrying out the same interventions without the MDT clinic. This approach was less resource intensive, yet still wielded some promising results.

> Long-term prescription of opiates can lead to a faulty pain system, with the medications starting to 'drive' the pain.

Future plans – provided appropriate funding can be secured – centre around whole-surgery approaches, with all GPs supporting the programme, referring to a DFM worker for assessment, and most psychosocial and self-management of pain support taking place in a group setting. A similar trial is due to begin soon in Worthing, supported by CGL.

This is an often-neglected cohort of patients, who suffer daily and are often left 'parked' on large doses of opiates that have devastating long-term effects on their life, affecting their memory and digestion, accelerating osteoporosis, and potentially damaging their immune systems or causing fatal overdose.

Long-term prescription of opiates can also lead to a faulty pain system, with the medications starting to 'drive' the pain. But these effects can be reduced or negated through a combination of psychosocial support, a change in pain management techniques and judicious use of pain relief medications. After all, who wouldn't want an 18-20 per cent improvement in their overall quality of life?

Robert Ralph is dependence forming medications lead at Change Grow Live (CGL)

SYSTEM FAILURE

Huge numbers of people accessing drug or alcohol treatment have experienced childhood sexual abuse, yet most services remain ill equipped to offer them the support they need. **DDN** reports

'I credit alcohol as the coping mechanism that saved my life,' says Claire, one of the people quoted in the One in Four charity's stark new report *Numbing the pain: survivors' voices of childhood sexual abuse and addiction* (*DDN*, April, page 5). 'The feelings of shame, self-disgust, dirtiness, worthlessness lead to a deep pain that only medication with alcohol can pacify,' says Elizabeth.

Although disturbingly common, the link between childhood sexual abuse as an underlying trauma and adult substance misuse remains poorly understood, says the report. The ongoing adverse childhood experiences (ACE) study, which began 20 years ago, has identified that people who experienced four or more types of ACE – which includes sexual abuse as well as emotional and physical neglect and exposure to domestic violence – are ten times more likely to be involved in injecting drug use, seven times more likely to be alcohol-dependent and 12 times more likely to have attempted suicide. Anecdotal estimates by One in Four put the proportion of people in substance treatment who have experienced childhood sexual abuse at anything up to 70 per cent.

One significant problem, however, is that this data is not routinely collected in the UK, and the document calls for all treatment services to record anonymous adult disclosure of abuse, which could then be collated via the National Drug Treatment Monitoring System (NDTMS). Services also need to make sure that workers are trained to respond to disclosure, and that appropriate processes to support survivors are in place.

While some organisations have taken measures to equip their staff with the necessary skills to respond appropriately (*DDN*, 19 October 2009, page 6), they remain far from the norm. But what services really need to do be doing, the report stresses, is properly 'making the link' between the underlying trauma of childhood sexual abuse and adult substance issues.

The report is not the first to highlight the need for better understanding and cooperation – just over two years ago, a

Christiane Sanderson is project consultant for the One in Four report and senior lecturer at the University of Roehampton.

Chip Somers is addiction consultant to the study.

PHE-commissioned report on young people's specialist substance misuse services by the Children's Society called for better joined up working with child sexual exploitation and abuse support services, with PHE's director of alcohol, drugs and tobacco, Rosanna O'Connor, stating that it was important to remember that young people did not 'develop substance problems in isolation' (*DDN*, February 2017, page 4).

One significant problem is that this data is not routinely collected in the UK. The document calls for all treatment services to record anonymous adult disclosure of abuse.

Many survivors of childhood sexual abuse self-medicate with drugs and alcohol to 'numb the emotional pain of this trauma', says project consultant for the One in Four report and senior lecturer at the University of Roehampton, Christiane Sanderson. 'We are encouraging addiction services to make the link between addiction and the underlying childhood trauma and signpost clients to specialist support, following recovery, so they can achieve post-traumatic growth in their lives.'

The document comprises 14 powerful and harrowing first-person testimonies from people who have experienced childhood sexual abuse. Their ages range from 20s to 60s, and common to them all is the use of substances. This can be to 'feel euphoria or fill the void', says the charity, with drugs or alcohol often providing 'a mask to bury the secret' of abuse, the 'corrosive feelings of shame and self-hate associated with it, and to keep negative mental health and suicidal thoughts at bay'. The testimonies describe journeys through addiction and recovery – often after hitting 'rock bottom' – as well as PTSD, anxiety, depression, self-harm and repeated failures by professionals to offer appropriate help.

Many of the survivors also painfully detail the impact on their emotional lives and ability to relate to others, with fear and mistrust of intimacy leading to loneliness and isolation, and substances often becoming a substitute for relationships. Drugs and alcohol can be 'life saving', says the report, as for some, emotions can be so 'unbearable and overwhelming that they are unable to manage them, or they shut down to the extent that they don't feel anything at all'.

One in Four has developed a National Lottery-funded film for treatment services to promote awareness of the links between childhood trauma and addiction, which urges services to build links to specialist support so that when clients are 'stable following recovery, their underlying trauma can be addressed'. A guidebook for drug and alcohol workers, GPs and others, *Numbing the pain: a pocket guide for professionals supporting survivors of childhood sexual abuse and addiction* will also be launched in the summer.

While the organisation acknowledges that funding remains a challenge for many services, they still need to move beyond the 'medical model of dealing with addiction and begin to provide support for survivors holistically' as in far too many cases they are still treating the 'symptoms rather than the cause', it states. Without identifying the trauma of childhood sexual abuse, it is not possible to 'begin the process of managing the trauma symptoms'.

Childhood sexual abuse is still 'dealt with poorly across addiction services', says addiction consultant to the study, Chip Somers, with services under-resourced and residential rehabs 'out of the reach' of most people.

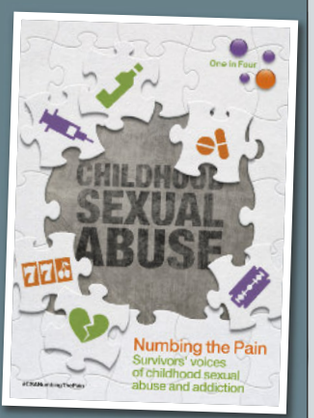
'We all know the numbers are immense, yet this is an issue which still gets side-lined,' he said at the report's launch. 'I don't blame the workers – I blame the system. The workers don't have the opportunity to engage in proper sit-down time and talk with service users. The work is not being done because people don't have the time. And I can see those resources disappearing year-on-year.'

At the start of his 30 years in the substance field there was a 'general attitude that you should never go near trauma and child sexual abuse in any way,' he stated. 'What we are saying today is the opposite – if you don't do that work a lot of the other recovery work we are doing can easily be wasted, because we are not getting people to a place of good stability and they are much more likely to fall back into bad ways.'

It was vital to make sure that people felt safe and properly supported, he said, and it was 'really so easy' to make a referral. 'If you work in a service that deals with drug and alcohol addiction, then it is your responsibility to find what's available in your local area.' **DDN**

View a 20-minute film for recovery services at http://bit.ly/oneinfoursurvivors

SURVIVORS' VOICES



'MY STORY IS DIFFICULT TO HEAR. I don't want to hear it myself. I don't want it to be about me. I don't want it to be true. Better to have no story at all than to have mine. It has taken me over 60 years to find the courage to face the truth about my childhood. Sixty years during which I have defended against the pain of that knowledge in the only way I knew how, by dissociating so completely I wasn't really there.'

Thomas

'I WAS DRINKING TO NUMB MYSELF and block it all out. The blackouts became frequent, landing me in some dangerous situations. It's as if I had no care for myself left anymore. I felt like I died during the abuse and had nothing left to live for. I went past the point of controlling my drink and I could no longer predict where I would end up if I picked up the bottle. It was like a game of Russian roulette.'

Claire

'WHEN I WENT TO DRUG COUNSELLING WE TALKED ABOUT TRIGGERS, cutting down, substituting, creating healthy habits. By that time, the reason why I used had pretty much been forgotten. I used because I used. That was just my thing, my problem. I tried to talk about the sexual abuse a few times. But I could not face it. I would go to a session and yammer about my dad, anything to change the subject from how I was, the deep fear and hurt that I carried.'

Eve

'EVEN IN MY EARLY 20S WHEN I WENT TO MY GP WITH DEPRESSION and told him about the CSA [child sexual abuse] he only prescribed anti-depressants, which I used in a suicide attempt. Even then in A&E they didn't ask why I had attempted suicide and didn't offer me help. I asked to be hospitalised, and although they didn't want to section me, I was not referred for help.'

Elizabeth

'TO OTHERS WITH THE SAME SEXUAL ABUSE HISTORY, I want to say you are not alone. Seek some help. Be kind to yourself. There is a future. You are worth fighting for. Let go and live.' *Aishya*

Report at www.oneinfour.org.uk

THE TRAGIC LOSS OF CITY ROADS

Why is a life-saving service forced to close its doors in an era of rising drug-related deaths, asks **Dr Carole Sharma**

I'M SO SAD TO HEAR THE NEWS OF CITY ROADS CLOSING after so many years of life-saving service to the drug and alcohol users of London.

I had the great privilege of working there as the ops manager and registered person in charge from 1997 to 2001.

Like many others I had previously worked there as a relief nurse when I first came to London in the 1980s and like so many others I learnt so much by working there, so I was delighted when I became the ops manager in a service that I loved.

During my time there we focused on the crisis intervention work, although we did offer limited detox facilities for some boroughs. The crisis service was available to all London boroughs and was commissioned by all.

My abiding memories are of the sterling and gifted staff team who were mixed between those with lived experience and those who were nurses, doctors and social workers plus wonderful housekeeping and catering staff. We also had complementary therapy practitioners. This team worked miracles with residents who were in so much trouble and needed so much help in all aspects of their life. They gave excellent physical care, psychological care and support.

I would meet people coming into the service on a Friday afternoon who, by Monday morning, looked so much better that I wouldn't recognise them.

Much of what happened was pretty basic, sorting out immediate health needs, a rapid detox, a referral on if you wanted it – but all of this in a safe supportive environment with good food, as many hot baths as you wanted, lavender oil on your pillow to help you sleep and a staff team that really knew how to get you through and would sit up all night with you if that's what it took.

We took in the worst cases on the day, that's how the crisis service worked. We took people in day and night, 365 days a year.

We did not limit the number of times people came to the service and some were frequent flyers but got there in the end.

So in these days of rising drug-related deaths it is tragic that a lifesaving service is forced to close for lack of funding.

City Roads provided another vital service as well. We had a number of volunteers and this was a route into working with drug users. Many of the sector staff, especially around my age (63), worked at some time in City Roads. It taught us so much and brought a greater understanding of the individuals we serve.

So my last memory of City Roads was when I was a relief nurse back in the 80s – in the kitchen with some of the residents cooking Sunday dinner and dancing to *Little Creatures* by Talking Heads, we were playing it loud.

The founders of City Roads knew that drug users needed to be cared for in an environment that understood them. Where are those specialised beds now?

FINDING THE WORDS

Michelle Graham is training to be a peer mentor at Inspiring Recovery Wakefield. Here she explains how writing poetry has played a huge part in her recovery journey

I'VE HAD A DIFFICULT PAST and I have mental health issues. I hear voices.

I have been sober for over a year now and since moving to Wakefield I have had support from Turning Point at Inspiring Recovery Wakefield. As part of my recovery I started writing poetry and discovered that I could use poetry to get my feelings and emotions about the past out of my head on to paper.

Recently, I've even started doing open mic nights where I stand up and read my poetry. I also attend two creative writing groups and have started writing short stories. I've just finished one called 'Christmas through the eyes of an alcoholic'. By attending these groups I have rebuilt my self-confidence. In the future I hope to publish a poetry book on mental health and addictions.

I've never been a social person but as part of my recovery journey I've learnt to live again, and what has got me through it and made me stronger is my poetry. Here is one of my poems:

RECOVERY

The power of control in the hands of me, all emotions coming to the surface, no more poison to push them down to the toes in my feet, having to learn how to deal with them.

Getting up in mornings with no drink in hand, fighting off the demon poisons, shaky but wise, like a flow of water brushing past the rocks, learning to live all over again.

The pain I caused mainly to myself, unloving, uncaring, mixed up mind of confusion, a life not worth living, out of control disappointments.

Trying to escape the

Abuse of every kind,

Torment in my brain,

Physical pain from being thrown around,

Voices that haunt and control,

The uncontrolled thoughts of dying,

The numbness in the head,

The bottle with words of hate,

The harm to self constant.

The recovery journey, uphill and strained but amazing, like climbing the highest of mountains, but left so childlike, learning the skills of life.

Stepping stones hoping not to fall in, sink into old ways, been a year, a year of learning about me, allowing myself to let people in, who am I, feeling like road runner running off the cliff.

Downside mental health spiralled, voices over take, but for once in my life I have friends that understand me and that side of me, the group's so important, even for me the oddness about so many people or men in general, but that's getting a bit better, but panic inside so real.

Floating on clouds of marshmallow, the journey I'm taking of inspiration and creativity is just the best feeling of all, without that poison inside me.

LET'S CONNECT!

Extracts from DDN's social media. Have your say by commenting on our website, Facebook page or tweeting us

Naloxone is 'failing to reach those who most need it' – a new report by Release shows that local authorities are not providing sufficient naloxone

SW Dunlevy responds:
I'm constantly running into IV heroin users who know OF naloxone but don't know much else. I've handed out dozens of yellow boxes (opened so a couple of pins could be added) and need more.

It's so simple and so effective. I've had 6 people go over on me and 3 I kept going without naloxone and it was HARD. 45 minutes of jabbing them to keep them breathing. With naloxone it's a whole different story. People recover in seconds. For the price this is the best HR aid currently available.

We need to normalise naloxone. Even if you don't know an opioid user, you may be in that place at that time and then you can save a life. What sickens me is that there are potent, euphoric opioids that do not cause respiratory depression but the same old poisons (brown & fentanyl) are the market norm.

For my post-grad I tested some levorphanol analogues and one in particular was some x180 M in potency but its LD50 was a full x50 that of H, M or fentanyl. Nobody has gone for it because it means investment... and being what it is, people buy whatever opioid they can get that day.

Government announces drugs and violence review – Prof Dame Carol Black to look at how 'drugs are fuelling serious violence'

Sally Howels responds:
If they aren't considering legalisation there is little point to this. If drug users need to have some kind of treatment plan in order to claim benefits then this will lead to more crime and more homeless!

Better to legalise so crime does not need to be committed. Without running around, raising money to score, then running around to score, drug users will have more time on their hands to actually work – saving money on benefits.

Without committing crime, even just the crime of being in possession, they won't have a criminal record so will have more chance of employment.

Once employed, many will be too busy to want to use drugs all day. Money saved from the judicial system – police, courts, prison, probation – could be used better. Police could catch real criminals!

Some of the money saved could be spent on helping those who want to stop using, educating and training so they can work. The crime rate would fall. Less alcohol would be drunk.

Legalisation is the only way to go – without that even being discussed this is an 'empty job', paying an undeserved salary. Probably employing secretaries, advisers etc – just more pointless jobs all so the government can say they are doing something.

People will always use, no matter what punishment is handed out.

So what? The damage is done by making them criminals. By making moral judgements over something that isn't really anyone else's business.

Until total legalisation happens the crime rate will continue to go up. Drugs don't ruin as many lives as the antiquated drug laws.

So upset to hear City Roads is closing – it was where I started in 1983 as a drugs worker 36 years ago. I have never really recovered. Time moves on and my life passes into the history books. Still City Roads has a right to celebrate its amazing history. @JohnJolly64

Really sad news, we lose another amazing resource and place. @johnbransfield

Sad to hear City Roads is closing, I have met a few lovely professionals there throughout my career starting with CDP, SLAM, BEHMT and NELFT to mention a few. Strong memories of referrals and follow ups. How sad. @Wabharm

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MEDIA SAVVY

The news, and the skews, in the national media

WITHIN THE FIELD OF MENTAL HEALTH, substance misuse represents a microcosm of mental disorders: environment interacts with genetics, stigma hinders treatment, and untreated disorders create a downward spiral of more mental ill-health, economic hardship, and poor familial support or even increased risk of experiencing domestic violence. Addiction services, in other words, should not be regarded as just another psychiatric specialty... At a time when substance misuse is increasing globally, cuts to addiction services cannot be justified, either morally or economically, yet they occur.
***Lancet* editorial, 30 April**

IF WE ARE TO TACKLE THE PROBLEMS SURROUNDING THE MISUSE OF DRUGS effectively we have to open our minds to a more liberal evidence-based approach. Too many lives have been blighted by drugs, by their misuse and the needless criminalisation that interferes with people's education and careers. Nobody would argue that the misuse of drugs doesn't have deadly effects. However, billions of pounds continue to be channelled through organised crime every year as young people are pushed towards dealers, and dangerous, unregulated backstreet drugs. If we are to avoid another generation being faced with the same problems we have to change.
Christine Jardine, *Independent*, 21 April

MORE THAN ONE IN TEN MALE PRISONERS report developing their drug problem while in prison, drug addictions fuel almost half of all acquisitive crime, and the prison service is losing officers at an alarming rate. It is time to tackle the understaffing and to value the role of 'prison officer' as the driver of personal transformation. It's also vital to grip the problem of drugs in prison. That means body scanners for prisoners, visitors, and staff – and it also means protecting officers from being corrupted, and rooting out the tiny minority who are. Crucially though, it will require those in Westminster with control of the purse strings to loosen them, and it will require sustained political and organisational leadership to turn things around
Rory Geoghegan, *Spectator*, 29 April

THE NATIONAL POLICE CHIEFS' COUNCIL has recommended that instead of arresting, cautioning, warning or charging cannabis users, the police should suggest they seek treatment. This is a decision that undermines the law...The police are merely reflecting a consensus promulgated by the intellectual, political and cultural establishment. This consensus comprises, among other things, unquestioning faith in the benefits of drug liberalisation, the looming catastrophe of man-made global warming, as well as identity politics and the grievance culture. It repudiates reason and evidence, prioritises feelings over facts, and roots itself in the breakdown of social and moral norms.
Melanie Phillips, *Times*, 23 April

FACTS

As CQC rolls out its new factual accuracy process, **Laura Paton** explains the main changes for service providers

My colleagues have written in previous issues of *DDN* about the importance of submitting comprehensive factual accuracy comments (FACs) to your CQC inspection report if you consider that the report and/or rating is not a true reflection of your service. Most recently, one of my colleagues set out some of the changes proposed by the CQC to the factual accuracy process which had been put out to consultation among providers (*DDN*, March, page 13).

In April 2019, following the end of this consultation, CQC finalised and rolled out its new factual accuracy process and has updated the provider handbooks to incorporate the changes. Substance misuse providers should ensure that they are familiar with the most recent version of CQC's guidance, and the new FAC process and forms.

The consultation had proposed a number of amendments to the FAC process including a reduction in time – from ten to five working days – for providers to submit FACs, prohibitive word count restrictions and draconian restrictions on requesting further evidence or inspection notes from CQC. Fortunately, not all of these proposals have been taken forward. The main changes set out in CQC's guidance for providers and FAC guidance are as follows:

NEW FAC FORMS

A new FAC form has been introduced and a link to this will be emailed to the appropriate registered person, along with the draft report. The provider then has ten working days from the date of the email to submit their factual accuracy comments on the new form.

The new FAC guidance states that all providers must use this form and CQC says that it will only permit providers to depart from this 'in exceptional circumstances'. It should be noted that there is no statutory basis for CQC to impose a requirement to use this prescribed form and CQC should not refuse to accept other forms of comments unreasonably. However, the mechanism to challenge an unreasonable refusal would be by judicial review, which would be time consuming and expensive for a provider. Providers should therefore endeavour to use the form wherever possible and, if there are any reasons why they cannot, ensure to advise CQC of this in good time, and in writing, setting out the exceptional circumstances that mean the form cannot be used.

The new form seems more complex and less user-friendly than its predecessor, especially when it comes to providing evidence to support the FAC submissions. There is a reference to 'evidence tables' being given to some types of providers to respond to, in addition to their draft report, but no detail of who specifically will receive these tables or what they will contain.

PRESCRIPTIVE PROCESS

The new form is exceptionally prescriptive, and seems designed to make life easier for the regulator and more difficult for a provider that needs to challenge a report

More on CQC inspections at:
www.drinkanddrugsnews.com

‘Providers should in no way be discouraged from submitting robust factual accuracy comments with evidence when these are required. CQC appears to forget how damaging and stigmatising an incorrect rating can be..’

OF LIFE

to avoid having inaccurate or damaging information about its service put in the public domain.

Providers are told that for each point they must specify exactly where CQC can find the information that supports the correction or the information but that they cannot hyperlink or embed it into the form. It appears that there is no reason why this information cannot be sent separately by email, as long as the relevant parts are clear and specifically referred to in the FAC form. CQC’s website states that if documentation is provided in support of a point, you must specify the page and paragraph number and highlight the relevant part of the document that relates to the point you are making.

We would always encourage providers to be clear and specific when it comes to referring to evidence, but often these matters are not straightforward. Under the new system providers will also have to work within the newly imposed character restrictions on each point they wish to make in the FAC.

In the new FAC table each row is limited to a maximum of 975 characters (about 150 words). That said, the guidance also states that ‘if you cannot make your point using one row, continue in the one below’. The point of the word limit, therefore, remains unclear, and it may be the case that all CQC will achieve here is making response forms disjointed and cumbersome for both inspectors and providers to manage.

DEADLINE FOR RESPONSE

The new guidance suggests CQC will take a strict approach to the deadline for submitting FACs. The non-statutory deadline of ten working days has been in place for some time, and while the consultation had suggested this time would be shortened this proposed change was not welcomed by providers. As such, the ten working-day deadline has not been amended. However, CQC now states that it will not extend that ten-day deadline unless there are ‘exceptional circumstances’. Providers must let CQC know of any such circumstances ‘immediately in writing’ – at the moment there is no further information setting out what would be considered to be ‘exceptional’ circumstances, and therefore providers should be very careful to submit their FACs in good time and let CQC know in writing with as much notice and information as possible if they are not going to be able to meet the ten working-day deadline.

REQUESTING INSPECTION NOTES

The consultation had suggested that CQC was going to attempt to implement a blanket refusal to release inspection notes as part of the factual accuracy process. We are pleased to see that the new guidance takes a more measured approach to this, stating that, while CQC will not release the inspector’s full notes from an inspection, it ‘will consider requests for extracts of notes about a specific issue where this is reasonably necessary to enable you to understand the basis for a statement in the draft report that you believe is factually inaccurate (that is, if the basis of our statement is not clear from the draft report)’.

It is absolutely correct that a provider should be able to request further information to clarify parts of a draft report that are unclear, to allow them to be able to provide an appropriate response. CQC now explicitly requests that if providers do ask CQC for information as part of the factual accuracy checking process, their request should be short, specific and should clearly justify why they need the information to raise a point of factual inaccuracy. We would always encourage providers to be specific about why sight of inspection notes or further information from CQC to enable them to respond to the report is necessary. Providers should not be discouraged from making such requests – after all the notes contain the underlying evidence upon which judgments and ratings are based.

It remains to be seen whether the changes to the FAC process will really make it more efficient. At first glance, the changes appear to be geared to making the process easier for CQC but not necessarily for the provider.

Providers should in no way be discouraged from submitting robust factual accuracy comments with evidence when these are required. CQC appears to forget how damaging and stigmatising an incorrect rating can be for a provider. In a climate where resources are decreasing, reports are becoming shorter and less detailed, and inspection timeframes are increasing, it is all the more important that providers seize their opportunity to ensure the information about their service that is placed in the public domain is correct.

The new guidance and FAC tables can be downloaded at: https://www.cqc.org.uk/guidance-providers/how-we-inspect-regulate/factual-accuracy-check-how-respond

Laura Paton is an associate solicitor at Ridouts

DON'T SELL YOURSELF SHORT

Getting back into the world of work can intimidating, especially when it comes to job interviews. **Kay France** shares some tips in BoB's latest newsletter on how to make the best impression on potential employers

FIRSTLY, IT MAY SOUND OBVIOUS but make sure you know the exact date, time and address of your interview, and the name of the person you're going to see. Allow plenty of time for travelling to ensure you arrive at least ten minutes early, and dress appropriately. A conservative approach is recommended, and be sure to research the company's policy on workwear.

IT'S VITAL THAT YOU DON'T CRITICISE YOUR PREVIOUS OR PRESENT EMPLOYER! Try to show that you're looking for new challenges and career advancement, and take a positive approach by saying what you've gained from your previous/present job by way of relevant experience, and that you hope to put it to good use in the post you're applying for. Make a list of your transferable skills.

IT'S INEVITABLE THAT YOU'LL BE ASKED WHY YOU WANT TO WORK FOR THE COMPANY/ORGANISATION AND DO THIS PARTICULAR JOB. This question gives you the opportunity to show that you've done some research into what the company/organisation does, and you can pick out an area that particularly interests you and tell the interviewer why. You'll also be asked exactly what you do or did in your present or previous job. Explain briefly what you do now, be prepared to follow up in more detail, and be positive. Point out any training you received both on and off the job, if any, and explain how what you've done in the past is of relevance to the post, backing it up with examples. Mention any promotion or upgrading if applicable.

YOU'LL ALSO BE ASKED ABOUT YOUR MAIN STRENGTHS AND WEAKNESSES. It's important to avoid confusion here. Answer in respect of your strengths first, then weaknesses – weaknesses are areas for improvements.

Be prepared to substantiate your answers and provide evidence, and try to give three main strengths, such as 'technically strong, good interpersonal skills, hard working' Back these up with specific examples, and stick to just one weakness, unless prompted.

OTHER QUESTIONS TO CONSIDER ARE:

- *'What do/did you enjoy/dislike about your present/last job or role (ie volunteering)?'*
- *'What do you see as your main achievements to date?'*
- *'What skills or attributes do you have to offer for the job you're applying for?'*
- *'How do you handle pressure?'*
- *'What are your medium/long-term goals, or where do you see yourself in two, three or four years' time?'*
- *'Can you describe a difficult situation you've had to handle?'*
- *'Think of a time when you had a difference of opinion with your manager/one of your team. How did you resolve the situation?'*

AN INTERVIEW ISN'T JUST ABOUT YOU BEING ASKED QUESTIONS – YOU SHOULD THINK CAREFULLY ABOUT THE QUESTIONS YOU'RE GOING TO ASK. This is another opportunity to show that you've given serious thought to the job and the company/organisation. These questions can help you stand out from the rest of the applicants, for example:

- *'What training will be offered?'*
- *'What are the prospects for promotion or advancement?'*
- *'What are the company/organisation's future plans?'*

You can also use this as an invitation to mention anything else relevant to your application that the interviewer hasn't asked you about.

REMEMBER TO DO YOURSELF JUSTICE! Be as well prepared for the interview as possible, listen carefully to questions and speak clearly when you answer.

Try to make the conversation flow freely to establish rapport. Just answering 'yes' or 'no' to questions doesn't tell the interviewer anything about you and won't help you make a good impression, so expand on your answers.

FINALLY, SHOW A GENUINE INTEREST IN THE ORGANISATION AND AT THE END THANK THE INTERVIEWER FOR SEEING YOU AND MAKE SURE HE/SHE KNOWS YOU ARE INTERESTED IN THE JOB! If you don't get the job, it's always a good idea to ask for some feedback. The interviewer's advice can be invaluable, and they may notice things about your approach that you don't realise. It can help you to prepare for your next interview and make sure you do better next time.

IN CONCLUSION, THINK OF IT THIS WAY – interviews are the type of conversation where you need to learn the rules in order to come across in the best way. The more you learn about what they expect, the more you are able to adapt your approach. If you've had a few interviews without being successful, it's important to remain positive. If you persevere you will get there in the end! You could also ask for expert advice from a career advisor from your local jobcentre to help fine tune your interview technique. Good luck!

The original version of this article can be found in Build on Belief's Spring 2019 *BoB Newsletter* at buildonbelief.org.uk

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