From Darkness to Light, from Harm to Hope

Journeys of addiction

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH FOR WIRRAL 2024/2025

Contents

Foreword

Every year, Directors of Public Health in local authorities fulfil a statutory duty to write an independent report on the health of their population.

The Public Health Annual Report (PHAR) highlights key health and wellbeing challenges facing our local communities and provides information and evidence on key issues that partners should prioritise in the forthcoming year. This year, I have chosen to focus the Annual Public Health Report on the important public health issue of addiction in Wirral, including substance use (smoking, drugs and alcohol) and gambling. This supplements our State of the Borough report, which sets out Wirral's wider health and wellbeing needs. This is available on our Wirral Health and Wellbeing Knowledge Hub.

While many reports focus on a single addiction, in reality many people who experience addiction often struggle with multiple forms, and we recognise that these addictions often share underlying causes and have similar impacts on families, friends and society. By addressing addiction as a unified issue, we aim to amplify our response, ensuring we allocate resources to address multiple forms of addiction simultaneously and support the development of integrated programmes of work that focus on prevention, treatment and recovery.

Throughout this report we will share data and insights that shed light on the historic and current landscape of addiction, including the deeply moving stories of our Wirral residents. Addiction is complex; people do not choose to be addicted. They are influenced by various interrelated factors, but sadly, the impacts and stigma surrounding addiction have profound negative effects on so many.

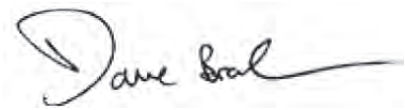
This report is timely. Both our Health and Wellbeing Strategy (2022-2027) and the Council's Wirral Working Together Plan (2023-2027) set out our commitment to addressing addiction in partnership. We have experienced significant investment over the last few years especially for tobacco control and for drugs and alcohol. We are already reaping the benefits of these investments in improving the experiences and outcomes of people with addiction while reducing the harmful or negative consequences. The Wirral Working Together Plan highlights the priority of keeping residents well and tackling the significant health inequalities that exist across Wirral. It references the development of various plans, many focusing on addiction including the Wirral's Combatting Drugs Strategy, the Substance Misuse Treatment and Recovery Programme, a Local Tobacco Control Plan, and a Gambling Harm Strategy. Much work is already in place and this report highlights and celebrates some of the amazing work, achievements, and outcomes while emphasising there is much more to do.

We all know, that addressing addiction is not solely the responsibility of public health services; it requires a whole-system approach that involves cooperation across various sectors, including education, wider local authority services, the NHS, the voluntary, community, faith and social enterprise sector (VCFSE), and law enforcement. This report, therefore, serves to inform us about the pressing need to continue to develop collaborative strategies that embrace evidence-based practices and create effective support systems for those suffering from addiction or its impacts. By working collaboratively and drawing upon the strengths of individuals and communities, we can aspire for every resident to live a fulfilling, addiction-free life.

Consequently, I would like to call on all of us to focus more on those actions that prevent and address the harms from addiction. As we navigate these challenges together, it is crucial to remember that recovery is not only possible but a reality for many people. Individuals who have triumphed over addiction serve as powerful reminders of resilience and hope. Their stories inspire us to continue our work, reinforcing our belief in the potential for change.

Additionally, I wish to acknowledge the contribution and hard work of the team and partners who worked with me to develop this report, who gave their time and expertise, and provided healthy challenges. I especially want to thank those men and women who shared their stories, dreams and hopes. These shed light on the human side of addiction; their challenges, triumphs, and ongoing battles that define their journeys.

Finally, I also want to thank you for reading this report and for your continued dedication and support in tackling this important public health issue.



Dave Bradburn
Director of Public Health, Wirral

Addiction: Why the focus?

Addiction represents a significant public health issue due to its widespread harmful effects on individuals, families and communities, affecting millions globally. The health impacts of addiction are profound, contributing to a range of severe health issues including chronic diseases, mental health disorders and increased mortality rates. The economic burden on healthcare systems and social costs are substantial. By focusing on addiction, we aim to understand its root causes, the factors that make individuals vulnerable and the most effective prevention, treatment and recovery strategies.

Understanding addiction

Chapter one describes the personal struggles of addiction through the untold stories of individuals who have faced the harsh realities of addiction. Through their candid narratives, we uncover the profound impact addiction has on their lives, families and communities. These case studies offer a raw and unfiltered look at the challenges, triumphs and ongoing battles that define their journeys. At the same time, it should be remembered that these stories belong to these individuals, and do not represent the story of everyone who has had an issue with addiction. Everybody's story is different, everyone has their own story. For Chapter one case studies, participants' names are pseudonyms (not their real names).

Chapter two describes the history of addiction. All addictions can be traced back to ancient civilisation but their journey through time reveals not only the persistent nature of addiction, but also humanity's unwavering determination to overcome it. We set out how addiction has unfolded over the years and explain that understanding its history is vital, as it provides insight into how societal attitudes and patterns of addiction, as well as prevention, treatment, and recovery systems, have evolved. The prevention, treatment and recovery strategies we see today are significantly informed by this context. Finally, we use an image board to explore the history of addiction illustrating the timelines for key societal changes, policy and regulatory frameworks and service responses.

Chapter three explains what addiction is, why some people become addicted while others do not, and explores the factors that increase susceptibility. We identify numerous influences, including environmental factors, life experiences such as trauma, physical predispositions for addiction, and personal or cultural factors. We outline the serious and wide-ranging harms that affect the health and wellbeing of individuals, families, and communities. Each addiction is explored individually, offering data and insights into their presence and impact in Wirral.

We discuss how health inequalities are exacerbated by alcohol, smoking, drugs, and gambling, highlighting their unequal distribution within our communities. Addictions are not mutually exclusive; the environmental and genetic factors that increase

the risk of addiction are often common across different forms of addiction, with many individuals experiencing multiple addictions throughout their lives. These addictions can occur simultaneously or sequentially.

We recognise that addiction during youth can have lifelong impacts. Adverse Childhood Experiences (ACEs) are well understood to have a detrimental effect on the wellbeing of children, adolescents, and onwards throughout the life journey of many who have had these experiences. Alongside other environmental and genetic factors, ACEs can increase the risk of addiction in young people.

Prevention, treatment and recovery

Chapter four explores the evolving landscape of prevention, treatment and recovery in Wirral, which demands a comprehensive system response due to the nature and complexity of addiction. Wirral's approach is robust, built on firm foundations established in the late 1980s and early 1990s, initially in response to drug issues. This has led to an established network of partners working collaboratively to design and deliver services for adults, young people, children, their families and communities.
This systemic network approach has also been applied to developing services for smoking cessation and reducing tobacco harms. More recently, it is supporting the development of a stronger response to gambling addiction and the related harms.

Wirral's model fosters partnerships across the entire system, including Health, Social Care, Community Safety, Criminal Justice, Housing and the Community, Voluntary, Faith, and Social Enterprise sectors. This supports a holistic response that addresses the needs of individuals caught up in addictive behaviours. Services support users along a treatment and recovery continuum, allowing them to progress at their own pace and choose to pause their journey as they see fit.

Chapter five investigates the journey of addiction, recovery and employment using Photovoice, a Participatory Action Research method based on the simple idea of using self-selected photographs in research interviews. We hear Katy's self-titled Photovoice case study, where she describes her "greatest hits" – six images that best represent her personal journey from the "darkness" of 30 years of drug dependency into the "light" of recovery and the opportunities of employment.

Katy's story is a reminder of resilience and hope, helping us understand why many others with lived experience dedicate their lives to working with people like them and inspiring countless others to begin their journey.

Looking ahead, overcoming the challenges

Chapter six sets out our challenges. Addiction in Wirral presents multiple challenges and is influenced by demographic, social and economic factors. Social determinants such as poverty, unemployment and social isolation significantly contribute to addiction, and conversely, addictive behaviours often reinforce poverty, unemployment and social isolation, making it essential to address these issues holistically.

We have an ageing cohort of long-term substance users that require more specialised and integrated care, while economic instability and housing insecurity can hinder recovery efforts. Marginalised communities experience higher addiction rates, necessitating targeted interventions. Additionally, changing substance use patterns and the hidden nature of addiction, especially home drinking and online gambling, complicates identification and treatment.

Effective policy and regulation are crucial for controlling addictive substances and behaviours, but inconsistent regulations and emerging products like e-cigarettes and online gambling pose ongoing challenges. Mental health and addiction are intricately linked, requiring integrated care approaches. Industry tactics, including sophisticated marketing and online access, undermine public health efforts, highlighting the need for stricter regulations and transparency.

Ensuring equitable access to treatment and support services and fostering community-based initiatives are vital for improving recovery outcomes. Collaboration across public health systems, statutory providers, and community organisations is essential to develop cohesive, compassionate, and evidence-based strategies to tackle addiction effectively.

Chapter seven highlights how addiction, explored uniquely in this joined up way, has enabled us to think differently about our work in the future. We set out how we can amplify our efforts by creating a stronger, more integrated and effective system response, across all of types of addictive behaviours, that makes best use of resources. There are six themes to this work:

- Placing a greater focus on addressing gambling-related harms.
- Building a positive culture to reduce addiction-related harm through our partnerships.
- Addressing the wider determinants of health.
- The impact of online forms of addiction need far more exploration.
- Developing integrated prevention and treatment models and community-based support.
- Maintaining sufficient level of investment.

Introduction

This year's public health annual report (2024/2025) focuses on addiction, exploring addictive behaviours of both substance use (smoking, drugs, and alcohol) and gambling. Addiction is a complex issue characterised by compulsive substance use or behaviour despite harmful consequences, and it is not uncommon to struggle with more than one addiction.

Whilst the nature, extent, and acceptability of different addictions have varied significantly across cultures and time, sometimes their underlying causes are shared, and the impacts felt across family, friends and communities are often similar. Whilst most people associate addiction with gambling, drugs, alcohol and smoking, it is possible to develop an addiction to anything, including gaming, shopping, sex, solvents, internet use, or even work.

A further consideration, and complication, is that for several of these behaviours, many people will indulge occasionally, and in a controlled way, and not become "addicted". Only a minority will experience the more damaging outcomes set out in this report.

Why is addiction a public health issue?

Addiction poses significant challenges to public health systems globally and in Wirral. The health implications of addiction are profound. Smoking is the leading cause of preventable deaths worldwide resulting in over 8 million deaths every year, including 1.2 million deaths as a result of non-smokers being exposed to second-hand smoke.[1] Alcohol consumption contributes to 2.6 million deaths each year, 4.7% of all deaths globally, and psychoactive drugs accounted for nearly 600,000 deaths.[2] Psychoactive substance use also results in negative social and economic consequences for communities.[2] Globally, among adults, 8·7% (6·6–11·3%) were classified as engaging in harmful gambling, and 1·41% (1·06–1·84%) were engaging in problematic gambling.[3]

Addiction has substantial socio-economic impacts. In the UK, estimates show that the social and economic costs of alcohol-related harm amount to £21.5 billion, while harm from illicit drug use costs £10.7 billion annually.[4] The combined economic and social costs of gambling are estimated to be between £1.05 billion - £1.77 billion in the UK, including an estimated £119.5 million of direct health harms.[5]

Over 80% of the 1.3 billion tobacco users worldwide live in low- and middle-income countries, where the burden of tobacco-related illness and death is heaviest.[1] Tobacco use contributes to poverty by diverting household spending from basic needs, such as food and shelter, to tobacco.[1]

There are significant wider society impacts of addiction. For example, drug-related crime costs are both financial and human: victims of county lines gangs are as young as seven; vulnerable people's homes are "cuckooed" by gangs to deal, store or take drugs; and business owners are often targeted by acquisitive criminals shoplifting to fund addiction. Crime harms are more acute in the most deprived areas.[6]

These challenges require a public health approach to addressing addiction that involves prevention, treatment and recovery strategies to reduce these harms and improve overall community wellbeing. Collaboration and partnerships are critical to this work.

The purpose of this report

The purpose of this report is to highlight and understand the disorder of addiction (smoking, drugs, alcohol and gambling) and how our system can best respond to the challenges we face. By recognising addiction as a unified issue, we aim to enhance our response by simultaneously addressing various forms of addiction. We will develop integrated programmes and promote shared messages focused on prevention, treatment, and recovery.

We will explore not only the current statistics and trends related to addiction but also the historical context. We will highlight the range of services that support people locally and set out our future challenges. We hope that the stories of lived experiences add depth and breadth to our understanding of addiction.

Chapter 1

The Realities of Addiction

Stories from local people

Addiction is a complex and deeply personal struggle that affects individuals in every part of society. In this chapter, we delve into the untold stories of local people who have faced the harsh realities of addiction.

Through their candid narratives, we uncover the profound impact addiction has on their lives, families, and communities. These case studies offer a raw and unfiltered look at the challenges, triumphs, and ongoing battles that define their journeys. By sharing these stories, we aim to shed light on the human side of addiction and foster understanding, empathy, and hope for those who are still fighting their own battle.

Alcohol Addiction

Drug Addiction

Gambling Addiction

Smoking Addiction

Case Study 1

Alcohol Addiction

Dr Mike's Story

Dr Mike is a 58-year-old Wirral resident who lives alone. Dr Mike dealt with an alcohol addiction throughout his professional career.

He moved to the Wirral in 2001 for a career change, where he has lived and worked for the past two decades until his retirement in 2017. He struggled with alcoholism most of his adult life. There is no history of alcoholism in his family, his mother never drank, and his father went to the pub about once a week. He started drinking at 18 years old and he says, "I've not had a sober week since the age of 18." He drank to deal with what he described as a 'busy head', "so, I have a busy head, which is full of nastiness, judgment, criticism, and it leads to me not liking myself very much." He spent most of his adult life having a "bottle of gin every other night". He drank alone as well as occasionally with friends. Buying the alcohol was a point of shame for him. He would always try to not get recognised when he was buying his gin. In certain moments he had to lie and say that he was hosting a party, "It's always a party at my house."

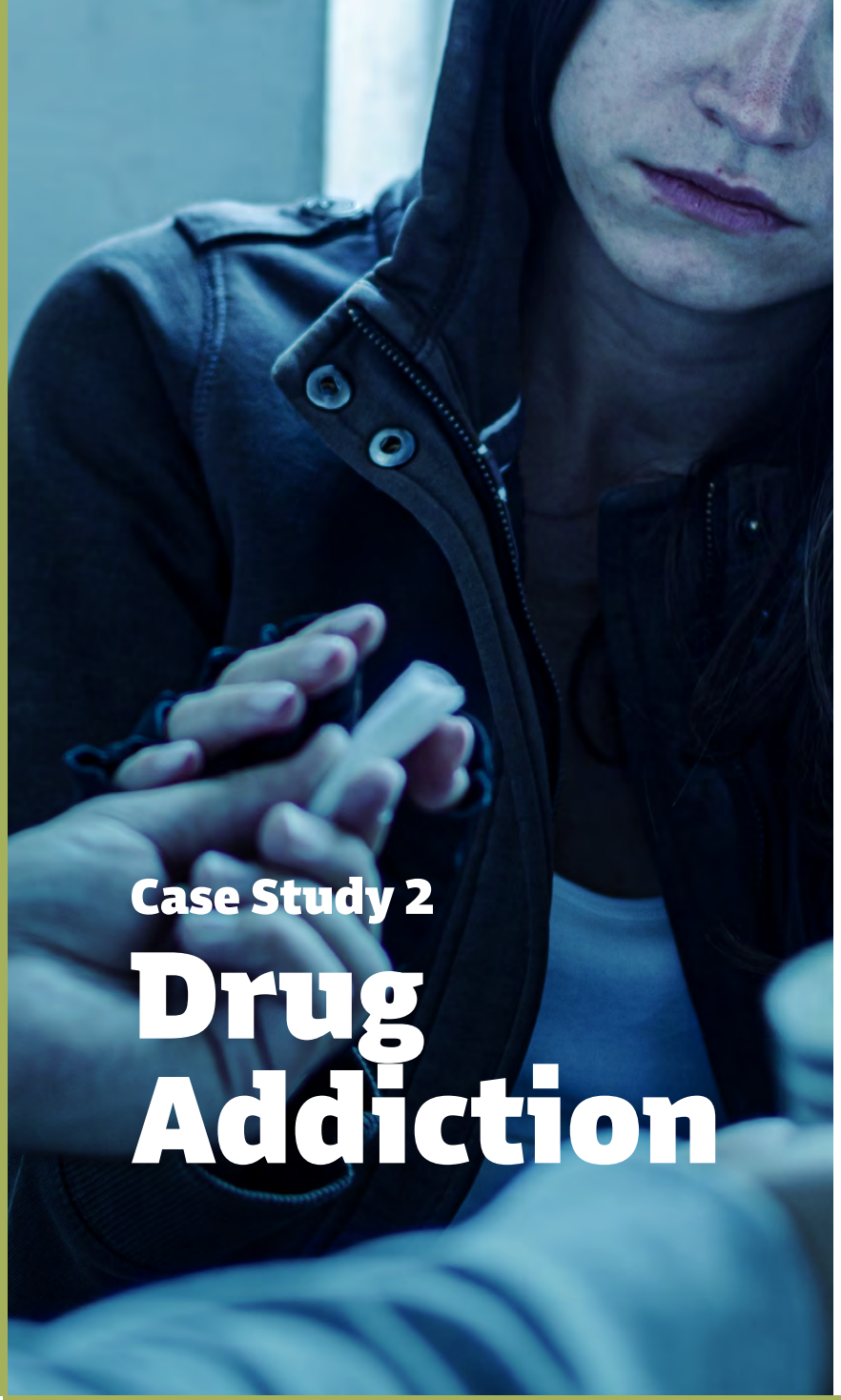
For more than two decades Dr Mike didn't think that he had a problem. He didn't consider himself an addict, "I did not identify with being an alcoholic because I felt in control. I was holding down a job. I was being promoted. I had great appraisals at work." In fact, he spoke about how he used to sit with patients and explain to them the damage they were doing to themselves by drinking alcohol. In 2004 he had a drink driving offence, and this experience made him 'creative' in his drinking. He describes how he started living with an alcohol meter and driving while "on the fence" of permitted amounts. He also started "pulling sickies" at work to manage his drinking.

Dr Mike's recovery journey was influenced mainly by his best friend. The gradual encouragement and support culminated into what Dr Mike described as being "cornered" into recovery. The first person he saw at the start of his recovery journey was his GP. They were trying to navigate getting him into services in the local area while considering that people knew him in the community and that he had worked with them. Ultimately, he got into a six-week programme meant for NHS practitioners that offered the 12 steps of recovery approach. The first few weeks were horrible because he was still in denial of his addiction. He also started smoking again, a habit he had given up 6 years earlier in 2011 but has since stopped again. After a few weeks he started feeling the benefits of stopping drinking, "In the past I could stop alcohol. But I couldn't stay stopped. Any time I stopped I never had enough time to recover any of my faculties."

After leaving the recovery facility, Dr Mike moved in with his brother in a different borough. He found himself withdrawing from everyone. His head was starting to get busy again. He didn't have the 12 steps anymore and the structure offered by the facility. Furthermore, in the borough where his brother lives there was only one AA meeting a week that was far away. He moved back to Wirral because there were many meetings available. He returned with the goal of attending 90 meetings in 90 days. Eventually he attended 90 meetings in 40 days. At first, he didn't find them helpful, but gradually he found them very helpful and now he leads three meetings weekly online and is sponsoring others.

He speaks on the importance of person-centred care on the journey to recovery. He described his relationship with his sponsor as "It's like a 24/7 envelope of care and dare I say, love!" He also reflects on how important a support system was in his recovery. "My experience was that I needed a concentrated period of a no chance of alcohol and very intense support. So just getting someone off the drink is not enough." He hopes that more people join AA because he has seen so much value in the meetings and advocates for person-centred care on the journey of recovery.

His story represents a significant demographic of professionals who slip through the cracks because, on the surface, they look like they have their lives together. They also have jobs that give them the wages to support their addiction without raising eyebrows. This highlights that sometimes addiction can be missed if it is not manifesting in the ways in which people stigmatise 'addicts'.



Case Study 2

Drug Addiction

Mary's story

Mary is a 61-year-old Wirral resident who dealt with a drug addiction for most of her adult life. Mary's addiction journey is with heroin, temazepam and methadone.

Her doctor prescribed her temazepam (to treat sleeping problems) and methadone for 10 days to help her with her heroin addiction. However, this then started 27 years of addiction to these substances on top of her heroin addiction. Mary says she is from a "dysfunctional family" and has a brother and sister who also had heroin addictions. She grew up on an estate on the Wirral and, at some point in her childhood, she lived in a children's home. It was during this time of her life that Mary got involved with drugs to deal with the challenges she was going through. She says, "I was a mum at 17. I've been in a children's home, there'd been sexual abuse and stuff in the family. I'm not saying that's why I used drugs though, because I know a lot of people who that happened to them and not turned to drugs. It was a choice. I found that when I took drugs, it changed the way I feel, and it gave me false confidence. I felt different. I felt like I could be myself when I had something inside me. But I never realised the consequences that that was going to have."

Mary became a mother at 17. She spoke about how she had hoped that having children would rescue her from the lifestyle she was living. Unfortunately, it didn't happen as she expected, and she struggled with addiction through motherhood. This actually became a barrier to her recovery as she explained how she was concerned about going to see a GP about her heroin addiction because they "would involve social services straight away." There was a worry that if she opened up about her heroin addiction, that her children would get taken away.

Her struggle with heroin addiction affected other aspects of her life as she got involved in anti-social and criminal behaviour, such as serial shoplifting, to finance her addiction. Mary explained how she would enter a cycle over a number of years: “And then it just went on for years. The same old like, shoplifting, getting caught, going to court, coming out, going into detox, coming out and using. I had two more children, each time thinking if I have a child, it’ll save me.” As a result of all that was going on in her life, Mary ultimately became homeless for nine years. This vulnerable position also led her to have a few abusive relationships. She shared her experience of being in a “violent relationship” with an ex-partner. She explained how she would rather tolerate being in this relationship than being on her own and out in the streets.

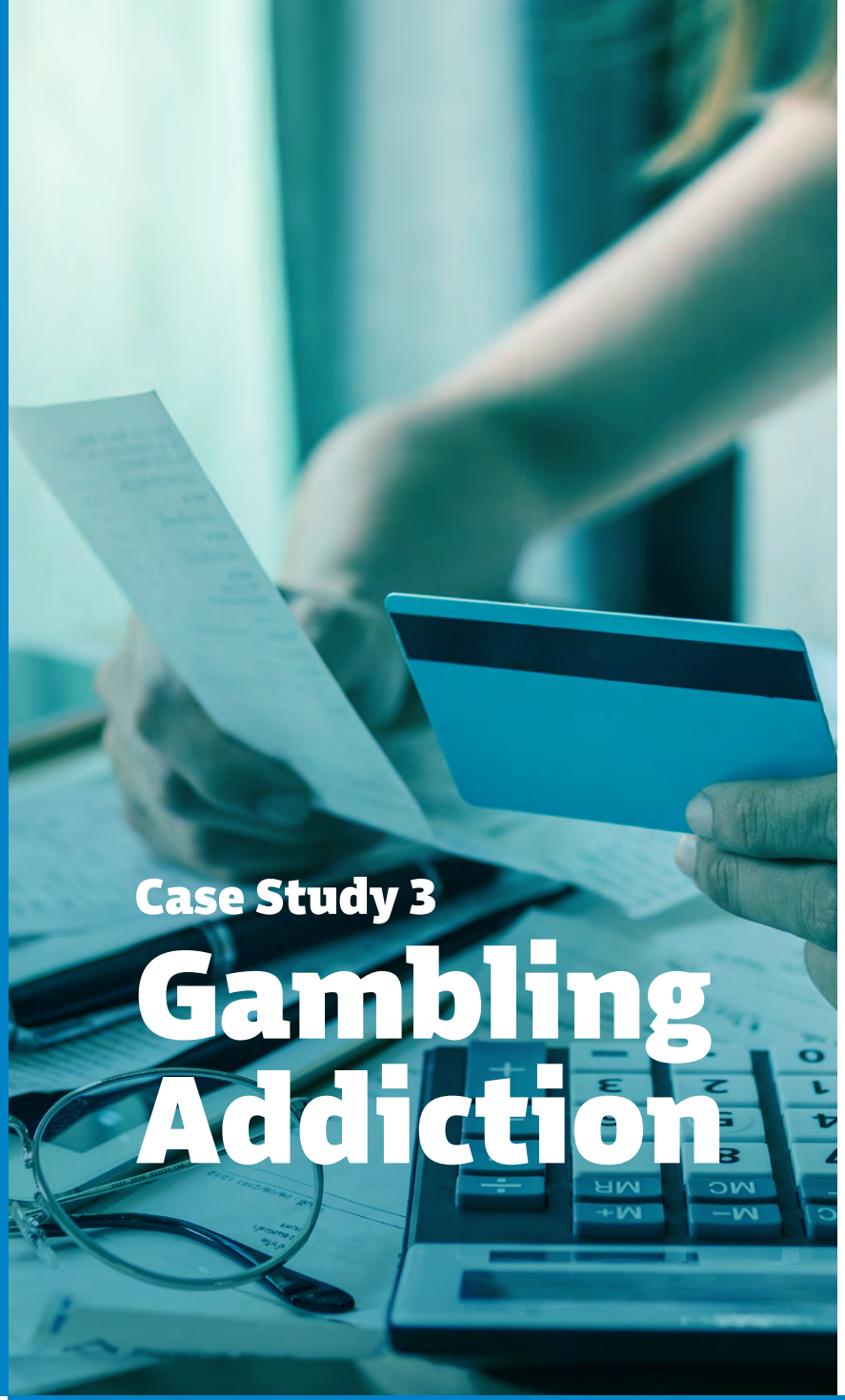
Her addiction also affected her children’s lives. She spoke about how her children were also susceptible to bullying and name calling at school because other children found out that their mum was using drugs: “I have heard horror stories like my older children were, like, they would argue with their friends and they’d say, ‘Your mom’s a smackhead’ in the playground and stuff like that. Imagine having to grow up with that.”

Mary’s struggles went beyond her addiction. She also had other health problems. She spoke about how she was “in and out of hospital” regularly and when she was in hospital aged 47, she had a brain haemorrhage and aneurism. She explained that she felt that “I was that done at the time that I thought, this is my way out”, but that even though she left hospital knowing how drugs were impacting on her health, she continued to go out and use drugs. It was only when she was found almost at the brink of death in the street and was immediately admitted into a service that her recovery journey began.

After she started her recovery journey, she also began attending Narcotics Anonymous (NA). This came about when she met people that she “grew up with and used with”, while visiting a soup kitchen at the Salvation Army, who had begun recovery through NA. It was at this point she realised, while attending an NA session, where she saw the people that she knew not feeling isolated or lonely, that there was an alternative “way out”. She explains that NA is a self-supporting organisation, and she now helps to sponsor and guide others who have had similar lived experiences with drugs.

Mary discussed how provision for drug treatment and services has changed over the years. She has found there to be more acceptance, and people can use their voice to speak up about their experiences with drugs, that people can be heard, and that there is “always room for change”.

Mary’s passion is largely for mums and children. Her own journey showed her that recovery from drugs can be harder for mums and their children. Mums can find it difficult to admit addiction as there is a fear that social services or police could get involved and take their children away from them. Mary’s story also shows that stigma can be experienced by the families of addicts and have lasting impacts on children. The key message that she would give to anyone who is dependent on drugs is to “talk to someone”.



Case Study 3

Gambling Addiction

Liz's story

Liz is a 35-year-old Wirral resident who has lived in Wirral all her life. Liz started gambling in her late childhood and her gambling addiction was active for ten years.

Liz's addiction started as a fun hobby and source of entertainment. In her late teens/early 20's she would have a "flutter" on the football or attend the bingo in Birkenhead with her friends at work. She found later (mid-20s) that her addiction progressed through the proliferation of online/smartphone apps, "I would never have started gambling, if it weren't for the smartphone apps." She found out that the bingo app and other gambling apps would offer free bets. Liz was able to 'gamble' via her phone contract at first, where the fees and 'services' were transferred to her contract bill. This felt almost invisible and unseen to her, like free money. One day, from a single 50p bet, Liz won a £150-£200 prize, which she said was a "significant win" for her and "a trigger that got me into gambling". The idea of winning significant amounts of money from such a low stake was appealing to Liz. She also suffered domestic abuse with an ex-partner who had a gambling addiction and feels that this proximity probably worsened her addiction.

Liz would spend all of her money from her wages on gambling as soon as she was paid. She spoke about how over time her gambling addiction "spiralled out of control". It became part of every moment of her life. She recounts moments where she would be gambling until the early hours of the morning: "I would be lying in bed at night next to my husband, with my phone on silent mode. I would be gambling until 4am [...] The only reason I would stop was because I ran out of money, which to be honest, was actually always a relief." She started spending more and more large sums of money: "At one point in my addiction I could put £2,000 on a spin and was able to do that every

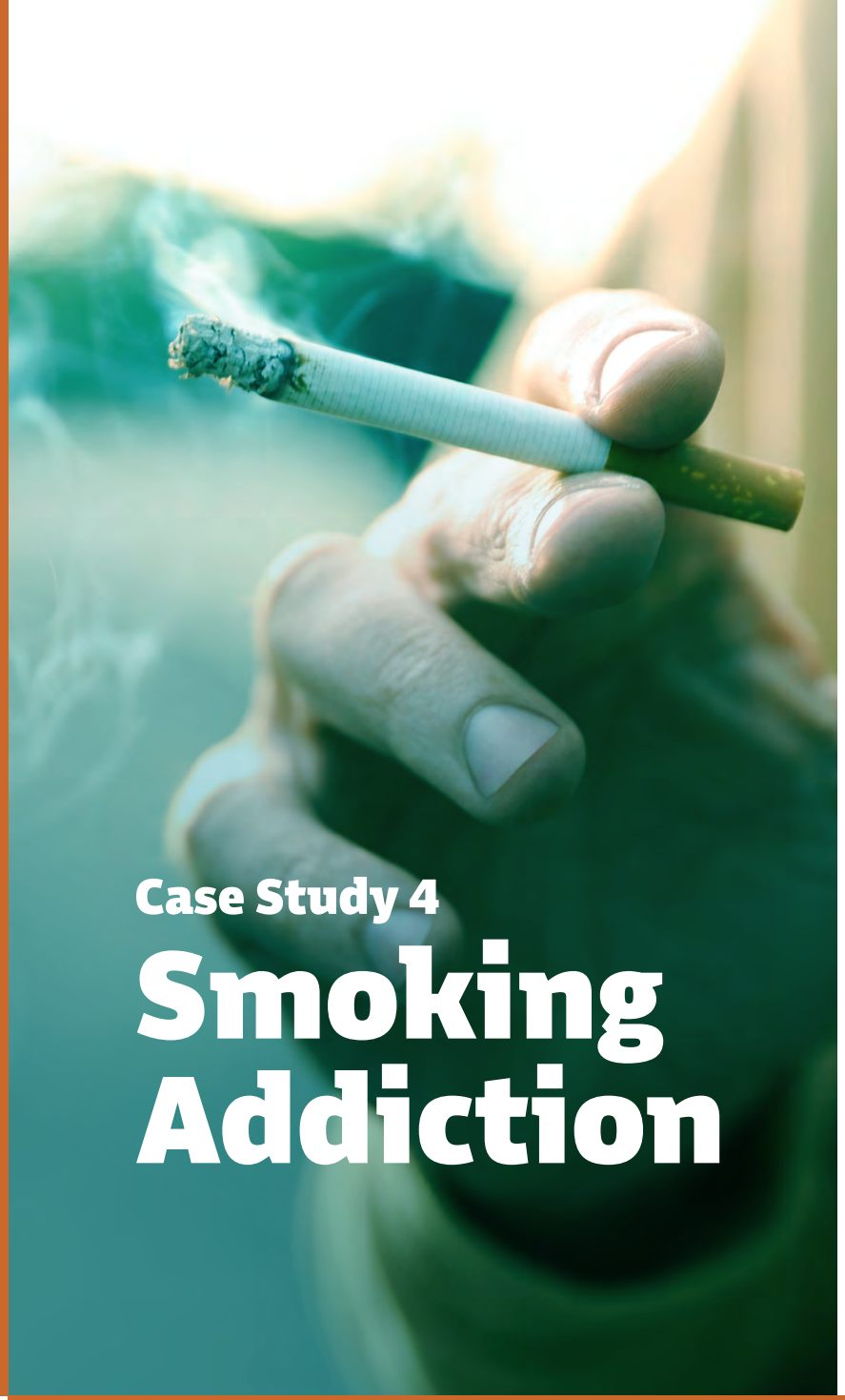
20 seconds." The situation progressed further: "I got myself into a real mess with money [...] and would be taking out payday loans to fund my addiction."

Now Liz's passion is for the regulation of online gambling. She recounts how she tried to quit several times on her own, and in 2015, she managed to stay abstinent for one week. However "They [the gambling sites/apps] emailed me to say, 'we miss you' and credited my account with £500, whilst I was trying to get away from gambling. They gave me free credit to try and get me back...I was a VIP member, so I would get all these offers for free bets, offers to take me to the races and things like that, because I was spending so much money [...] They never once asked – 'you're a finance manager, how have you got all this money?'" This is a particular concern for Liz because she believes that this is something that the gambling industry is able to get away with in a way that wouldn't be possible for other industries. She remarks, "You wouldn't see a pub landlord knocking on a drunk's door – 'we've missed you at the pub, come and have a free pint', you just wouldn't."

As her addiction grew, Liz got involved in criminal activity to finance her gambling. She stole £323,000 from her former workplace. She explains that she stole with the intention of paying it back: "In my head I thought I will make all this money back; I will make everything okay." She was arrested, charged and went to court, receiving a custodial sentence of two and a half years for stealing money. She went to prison in 2018/19, where she served one year of the sentence. While in prison she gave birth to her son who is now six years old. It was then that she realised that she had to get her life back on track. She started working with a trust while she was still in prison which supported her to get a degree. After she left the prison Liz started working with a service that supports people who are dealing with gambling addictions.

While her recovery journey is progressing well, Liz is still struggling with effects of the decisions she made during this period of her life, particularly with regards to finances. At the peak of her addiction, Liz fabricated false stories to persuade family members to take out loans for her in their names; these loans totalled nearly £30,000. When Liz later went to prison, her husband and family continued to pay these loans using their own money. Liz cannot declare bankruptcy against these loans, as technically, they do not sit on her personal credit report. She has been concerned about the possibility of debt companies seeking to recover debt from her family members directly at times when she cannot afford to make the agreed payments towards the loans.

Liz believes that unless online gambling is regulated and the providers are held accountable, addiction to gambling will continue to increase. She holds that, "advertising is a challenge, prevention services and legal interventions need to focus on social media, in particular to prevent grooming into gambling, i.e. 'FIFA Packs' and 'Call of Duty micro-transactions' etc." Emails and 'free spins' are problematic in Liz's opinion, and there needs to be more limits and caps imposed on gambling. Gambling experiences could be more regulated and individualised to prevent harm, relevant to people's individual financial circumstances, and monitored by banks. Liz also believes that the tax income incentive for the government is problematic as it prevents and slows action on gambling. She thinks that gambling sites need to be more transparent in their advertising and explanations of services so that people understand the risks.



Case Study 4

Smoking Addiction

Nick's story

Nick is a 37-year-old Wirral resident who has lived in the borough for the past seven years. Nick is from Northeast England. He moved to Wirral in 2017 to access drugs detox treatment.

He started smoking tobacco aged 14. He stole one of his dad's cigarettes. Smoking tobacco then became routine for him. He became addicted straight away. He continued smoking rolling tobacco throughout his teens, 20s and 30s. His addiction peaked at 40-50 cigarettes a day. Nick explained that it was easy to buy tobacco in a small town as a small boy, and no one questioned his age. Nick explained that party culture in Northeast England was intense, and he'd go out Thursday to Sunday drinking and taking drugs. He was exposed to 'uppers' like cocaine and ecstasy, which then led him to rely on heroin to bring him back down.

When asked if there is history of addiction in his family he said no, but then he later reflected on how his dad was a smoker. This is interesting because he didn't initially associate addiction with tobacco, and he reflected on the normalisation of smoking: "Not in my family" ... "I suppose my dad smoked, that's addiction in the family I suppose, isn't it?" Similarly, he said he'd never sat and thought about his addiction to tobacco, but he had thought about what led him to drugs and alcohol: "I've never really sat and thought about it (tobacco addiction). I've sat and thought about addiction to drugs, but I suppose tobacco is a drug, isn't it?"

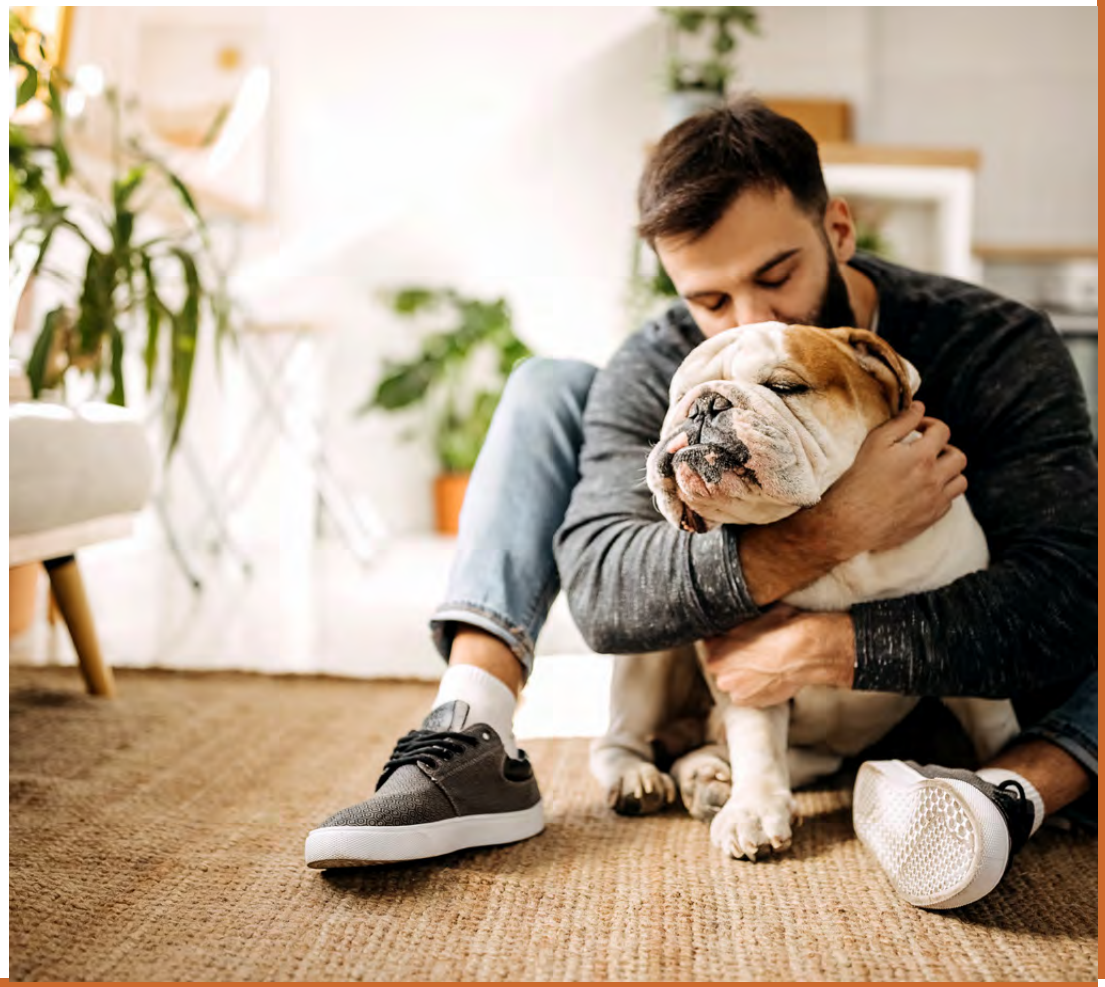
Nick explained that smoking tobacco became part of his daily routine, and that he'd smoke excessively while gaming. "Things turn to a routine, don't they?"

Nick reflected on how addiction is often associated with family history of addiction or low income, which was not his personal experience: “I’m the black sheep. I know addiction follows patterns, but there’s none really in my family… My family is well educated, wealthy, ‘normal citizens’ and I just f***ed up didn’t I. Just went on an absolute rampage.”

Nick also believes he has an addictive personality, and his addiction started with tobacco and developed to alcohol and other drugs. “I’ve got a really, like, addictive personality. So, I started smoking cannabis at probably 15, then moved onto ecstasy, amphetamines. This is going to sound really bad, but this is the way it was. Amphetamines, and then I went to hallucinogens and then I was on heroin and got onto a methadone script… Smoking goes hand in hand with drugs. It’s just the way it is, isn’t it?”

Nick tried a lot of times to quit by himself. “I’ve tried to quit a lot of times.” Nick first tried to quit smoking tobacco aged around 30. He did this alone, by finding things that work for him, such as dog walking and chewing cocktail sticks. “I just quit.” Nick wanted to quit smoking to improve his health. “I’ve got health conditions going on. I’ve got fibromyalgia, I suffer from chronic migraines, so yeah, my health’s poor at the minute. That’s why I wanted to stop smoking.” Nick also wanted to stop smoking out of concern for his dog’s health. He was feeling guilty smoking in the house with the dog.

Nick first realised that he needed professional help with quitting when he was getting out of breath walking his dog. During the walk he googled smoking cessation services, and a service came up and he rang the number. Nick has used the service 3 times. The first time he called, he didn’t know how they’d help, he just rang the number. This was five years ago and the first time he worked with them he quit for 6 months using nicotine patches. “First time I accessed the service I quit for 6 months. That was with patches and something else.” He found these 6 months surprisingly easy. But he didn’t put 100% effort into quitting.



Nick says he started smoking again to manage the stress of his health conditions. He said it was also hard for him to maintain quitting when he has smoked from age 14. About a year and a half after first accessing the service, Nick returned to the service for a second time. He was offered vapes, but he didn't like them or find them effective for quitting. The vapes were leaking, they didn't taste right and didn't have enough nicotine hit. "The last time I tried to quit, they started sending me vapes out, and I didn't really like them. I was smoking vapes with cigarettes, which is not good. I did try them though." He started smoking again.

Nick got a phone call from the service out of the blue a few months ago. They were checking in to see how he was. He felt this call came at a good time because he was in the right state of mind to quit properly this time. He has been off tobacco now for a few months. He feels that he's ready to quit now at his age of 37. He doesn't use drugs, alcohol or tobacco anymore. Nick has also found his own coping mechanisms for staying off tobacco. He uses running and swimming, but he feels bad for people who can't do this. He also walks the dog or chews on gum or cocktail sticks if he feels the need for a cigarette. He also used his relapse prevention techniques that he learned during drugs therapy, such as looking out for his triggers.

Reflecting on his recovery journey, Nick has seen so many benefits from stopping smoking, "I've saved a load of money, I'm not waking up coughing up loads of crap as well, which is good. My lung capacity has doubled, I've got a lot more stamina. I used to smoke in the house and blow it around the dog and that. It's not good for the poor dog. And the smell on your clothes and fingers, just absolutely rancid."

He spoke highly of drug treatment and rehabilitation services in Wirral compared to other services he has used before, "I went to one [a rehabilitation centre] in [Northeast England]. How different were they? This one in Wirral is a peer-to-peer programme, the staff don't get involved and you kind of police yourself. You have therapy groups; you do relapse prevention where you point out each other's behaviours. You do a lot of cleaning there, you can do gardening. So, a lot more therapy. The one in [Northeast England] is a 12-step one, which is completely different. The therapeutic based one in Wirral worked best for me. Obviously, I'm clean now."

Nick doesn't want his life to be defined by his past addictions. Addiction is just part of his story, but he'd like people to know he's had a good life: "I sound like my life's been dim. It hasn't really. I've had a really good life. I'm just mentioning addiction... I'm talking about going into rehab and being on heroin. Yes, it was bad, but I've worked all my life. I've done some cool stuff, It's not all bad."

Chapter 2

Tides of change

The historical journey of addiction

The early journey of addiction

Addiction is complex and whilst it has evolved over the ages, it has always maintained its core characteristic: a compulsive engagement in rewarding stimuli, despite the negative consequences.

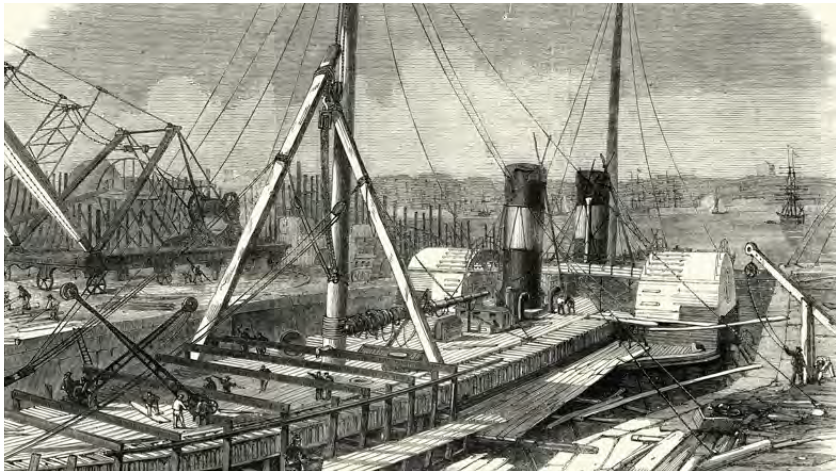
Understanding the historical context of addiction is essential as by piecing this together, we see how each era has contributed to its developing picture today. All addictions can be traced back to ancient civilisation[7] but their journey through time reveals not only the persistent nature of addiction but also humanity's unwavering determination to overcome it.

In ancient times, we find writings of civilisations cultivating opium poppies (referred to as joy plants), alcohol was plentiful, and intoxicating substances were often viewed through a spiritual lens where substances were believed to have the power to connect individuals with the divine, enhance spiritual experiences, or facilitate communication with gods and spirits.[7]

Through the Middle Ages and the Renaissance period, societal attitudes began to shift, and early medical theories emerged. Physicians began to recognise that habitual drunkenness might be more than what society considered to be a 'moral failing'. A small but significant step. It was around this time, that a Swiss physician created a specific tincture of opium called laudanum in his medical practice and this would go on to play a significant role in both medicine and addiction for centuries to come.[7]

The Industrial Revolution marked a new era of increased substance availability, through the industrialisation of distilleries and breweries and the convenience of buying opiates and coca products from chemists without restriction.[8] These developments contributed to the emergence of modern addiction.

During the 19th century, Wirral was shaped heavily by its maritime and industrial legacy and rose as a significant population hub. This era brought a wave of social change, with many labourers settling in the area due to opportunities in the docks and shipbuilding industries.



The rapid urbanisation and challenging working conditions often led to increased levels of stress and economic uncertainty, and drugs, alcohol, tobacco and, to a lesser extent, gambling, provided mechanisms to cope. As industries expanded, so did the prevalence of addiction. Public houses flourished, becoming social centres, yet also leading to patterns of excessive drinking. These establishments were also hosts for gambling activities such as horse betting and pub lotteries as forms of entertainment.

During the 19th and early 20th centuries, various temperance movements aimed at combating excessive drinking began to shift societal attitudes towards addiction. While alcohol remained a staple of social life, the increasing awareness of health risks associated with alcohol and smoking began to reshape public behaviour, which were further highlighted through new public health campaigns.

In 1924, following concerns about the treatment of drug addicts by doctors, the Ministry of Health established a Departmental Committee on Morphine and Heroin Addiction under the Chairmanship of Sir Humphry Rolleston. The committee published a report that recommended that the gradual reduction in the amounts of drugs consumed was the best method of treating those addicted to heroin and morphine. It also recommended that there should be no restrictions on the doctors allowed to prescribe morphine or heroin.

This became known as the “British system” and it allowed those who could not be “cured” to be maintained. They said that addiction was a middle-class phenomenon, so criminal sanctions were unnecessary, as there were few “criminal or lower class addicts”. The Rolleston Committee report was followed by what was seen to be a period of nearly 40 years of tranquillity with respect to drug addiction, known as the “Rolleston Era”.

By the late 20th century there was also a growing awareness of substance use, particularly regarding illicit drugs. The rise of the counterculture movement in the 1960s and 70s saw an increased public interest in drug experimentation, which quickly transitioned into complicated narratives of addiction and a move away from the British Model of the Rolleston Era.

In Wirral, as in other areas, heroin and crack cocaine use emerged as increasingly significant issues in the 1980s, exacerbated by economic hardships, unemployment and a lack of support services. The perceived glamour of the drug culture clashed with harsh realities, resulting in social stigma that affected those seeking help.

Wirral was one of the first areas in the country to experience the dramatic growth in heroin use at this time. This led to higher rates of opiate and crack cocaine use compared to the national picture, and this continues up to today. In a report published in the mid 1980's it was estimated that there were about 5000 heroin users in the Wirral out of a total population of about 300,000.[9]

This increase in heroin use, mostly among a younger population, also led to a new era of harm reduction approaches, with engagement and treatment approaches being introduced that focused first on reducing the harms rather than, as had become the case, trying to reduce the substance use itself.
The first of its kind, the 1980s Mersey Harm Reduction Model[10] was established in response to the growing heroin epidemic. It was given great impetus by the emergence of HIV and the government's recognition of the danger of the spread of HIV infection from using contaminated injection equipment. It became imperative to reduce this kind of risk behaviour.

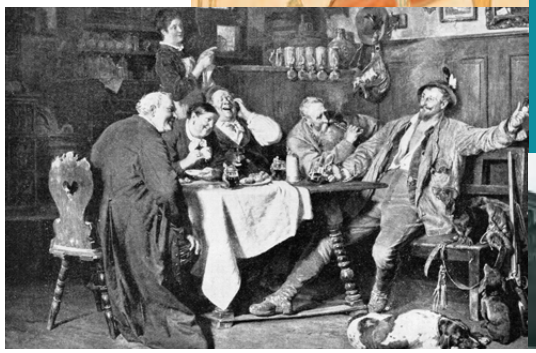
The new harm reduction approach advocated for the provision of ample supplies of clean needles and syringes, along with safe disposal sharps bins, and prescribing optimal doses of methadone. This included injectable preparations, and in a small percentage of cases, heroin. The approach made strong use of outreach workers going into the community to make contact and help people where they lived, and to attract them into services. The police played a key role.

As a consequence of these measures, service uptake was rapid and included many who had never had previous contact with services. These harm reduction approaches now feature in the service responses we see today and terminologies such as "reducing gambling-related harm" and "tobacco harm reduction responses" are familiar modern concepts used widely.

In recent years, the digital age and the impact of the internet have dramatically transformed the addiction landscape, increasing the accessibility to substances and online betting platforms. We are yet to fully understand the impact, but this raises new concerns as younger people, familiar with technology, find it easy to engage in risky behaviours. Parallels can be drawn between the advocacy for the use of methadone to respond to heroin addiction, and the case made for the value of vapes in reducing the harms caused by smoking tobacco.

Timeline of addiction

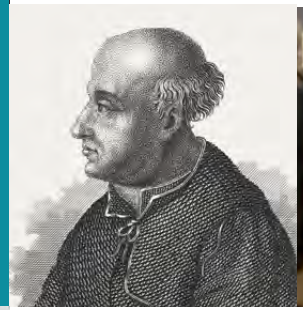
3100 B.C to 30 B.C – **An ancient Egyptian hieroglyphic carving** showing the goddess Isis in a red dress and holding two jars of wine together with sacred ankhs.



Early History

Built circa 1622 – Wirral's oldest surviving pub. **The Wheatsheaf Inn, Raby**

16th Century – the alchemist **Paracelsus** created laudanum by mixing alcohol with opium.



Late 17th Century – **Gin production was encouraged in Britain** resulting in the 'gin craze' associated to widespread drunkenness, poverty, child neglect and economic decline.

19th Century – laudanum became widely available from pubs, grocers, barber shops etc. The drug was often cheaper than alcohol, making it affordable to all levels of society.

In 1924 the Ministry of Health established a Departmental Committee on Morphine and Heroin Addiction under the Chairmanship of Sir Humphry Rolleston. A report recommended the gradual reduction in the amounts of drugs consumed and became known as "The British System".

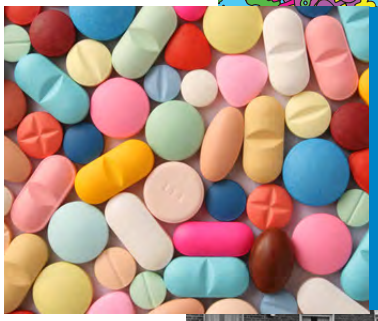
1865 – **The Birkenhead brewery** was established through the amalgam of two family run businesses.

Timeline of addiction

1960 – **Betting and Gaming Act supported by working-class communities**, the bookmakers were providing entertainment and employment. Bingo and private casinos are legitimised.

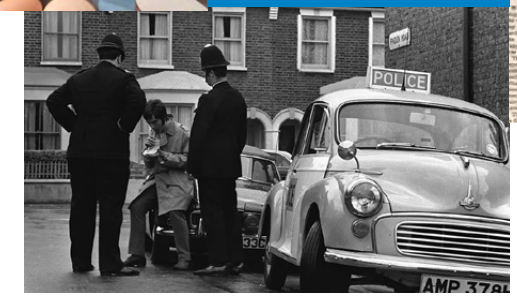
1960s – **Recreational use of LSD emerges** and becomes popularised, amongst other drugs, through musicians, including The Beatles.[11]

1967 – **Dangerous Drugs Act** requires doctors to notify the Home Office of addicted patients and limits the prescription of heroin and cocaine to licensed doctors in newly established clinics called drug dependent units (DDUs).



1960s

1967– **Road Safety Act** introduces the offence of operating a vehicle with a blood concentration of over 80mg of alcohol per 100ml of blood.



1964 – **US Surgeon General's Report on Smoking and Health** suggests a link between smoking and lung cancer.[12]

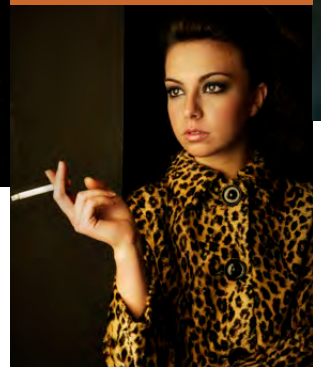
Timeline of addiction

1970s – A new heroin supply route opens in Britain from Iran, increasing the availability and affordability of heroin on the black market.[13]

1970s – Virginia Slim campaign targeting women portrays smoking as ladylike and glamorous.

1971 – US President Nixon declares drug abuse as 'public enemy number one', beginning a period which became known as the 'war on drugs', marked by increased incarceration for drug crimes and targeting drug smuggling into the US.

1970s



1971 – Misuse of Drugs Act. Introduces classification of A, B, C drugs according to their perceived harmfulness. Creates offence of 'intent to supply' and set harsher penalties for trafficking and supply. Establishes The Advisory Council on the Misuse of Drugs.

Timeline of addiction

1980's – The Heroin Epidemic. The first wave of the heroin epidemic hits Wirral, spreading through 'micro-diffusion' amongst the most deprived communities. Wirral Council at the forefront in responding and commissions Merseyside Drug Council to provide drug services, with a complementing NHS offer being provided through Wirral Drug service soon after.[14]

1984 – The Mersey Model of Harm Reduction responds to the increased risk of HIV infection among drug users - needle exchanges are established in Wirral. This marks the beginning of the harm reduction movement that is rolled out globally.

1980s

1985 – UK publishes first ever national drug strategy, Tackling Drug Misuse, which links treatment, education and supply.

1988 – Licensing Act extends opening hours for public houses from 11am to 11pm.

1987 – Royal College of Physicians produces alcohol consumption recommendations on 'sensible drinking' limits, including limiting consumption to no more than 21 units per week for men, 14 units for women.[16]

1986 – Tobacco advertising in cinemas is banned in the UK and the Protection of Children (Tobacco) Act makes it an offence to sell tobacco products to under 16s.[15]

1986 – Estimated rates of HIV infection amongst drug injectors.

Edinburgh	70%
New York	60%
London	10%
Mersey model areas	0.1%

Timeline of addiction

1991 – **Criminal Justice Act Schedule 1A6** makes provision for probation orders to attach the condition of attending drug treatment.

1994 – **The National Lottery** is set up by the government.

1995 – **Online Gambling begins** with the launch of the first internet casino software.[17]

1996 – **Trainspotting film explores heroin addiction** and poverty in Edinburgh.

1990s

1999/2000 – **NHS Stop Smoking Services** are initially launched in Health Action Zones, to be rolled out to all English Health Authorities within a decade.

1999 – **Saving Lives: Our Healthier Nation** The White Paper states smoking is 'the single biggest preventable cause of poor health'.

1998 – **The government publishes 'Smoking Kills'**, the first strategy to tackle smoking and its harmful effects.

1998 – **Tackling Drugs to Build a Better Britain** set out the Government's Ten-Year Strategy for tackling drugs.

Timeline of addiction

2002 – **European Union Directive** on tobacco products is adopted, requiring 'Smoking Kills' warnings to be included on tobacco product packaging.

2008 – **Photographic warnings** are placed on tobacco product packaging. [15]

2007 – **The British Gambling Prevalence Survey** conducted by the UK Gambling Commission, finds approximately 0.6 percent of the adult population had problem gambling issues.[19]

2007 – **Smoking Ban.** In the three months following the smoking ban there was a 6.3% drop in the volume of cigarettes sold in England. The legal age of tobacco sale is raised from 16 to 18.[15]

2000s

2003 – **Tobacco Advertising and Promotion Act** bans advertising of tobacco products to the public, online and in print media.

2003 – **Talk to Frank** campaign is launched and the National Drugs Helpline is rebranded.

2003 – **The first e-cigarette** is invented by Chinese pharmacist, Hon Lik.[18]

2006 – Amy Winehouse releases Rehab.

2004 – **National Alcohol Harm Reduction Strategy for England** - the government publishes its first strategy to address the harms of alcohol.

Timeline of addiction

2010 – **Annual tax escalator** put on all tobacco products, meaning prices would rise ahead of inflation.

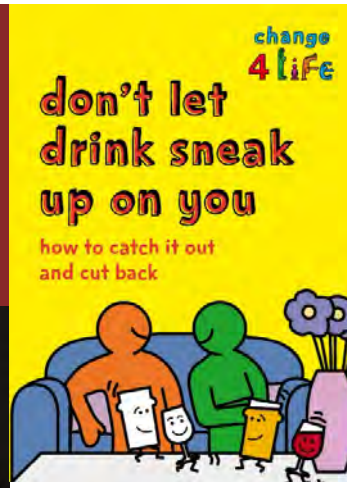
2011 – **Public Health Responsibility Deal** encourages businesses to take action to improve public health, including clear labelling of alcohol units and tackling under-age alcohol sales.

2012 – **The Government's Alcohol Strategy** commits to tackle the availability of cheap alcohol and promotes shared responsibility for alcohol misuse with the industry.

2020 – **Menthol cigarettes** are banned in UK.

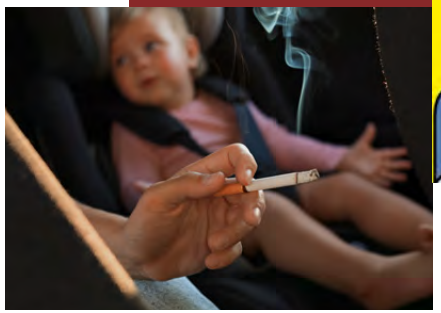
2019 – **Dame Carol Black** is appointed to lead an independent review of drugs, including prevention, treatment and recovery.[21]

2010s



2012 – **Change4Life** launches its first nationwide alcohol public health campaign to raise awareness of long-term impacts of drinking alcohol above recommended lower-risk levels.

2018 – **Wirral PH annual report** focuses on gambling-related harms



2015 – **Children and Families Act** makes smoking in cars with children an offence.

2016 – **Psychoactive Substances Act** restricts the production, sale and supply of a new class of psychoactive substances often referred to as 'legal highs'.

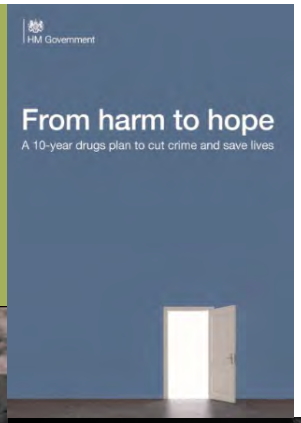
2016 – **Chief Medical Officer's** updates guidelines stating that lower-risk alcohol consumption is no more than 14 units a week for both men and women.[20]

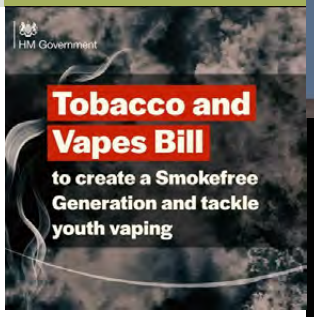
2016 – **Wirral ABL Health** continues the delivery of a specialist stop smoking service.

Timeline of addiction

Dec 2021 – **From harm to hope.** Significant national drug policy and investment (Supplementary Substance Misuse Treatment and Recovery (SSMTR) Grant and the development of Wirral Drugs Strategy (2023-2027).

2020s





Coming soon (2025)

Tobacco and Vapes Bill 24/25 is progressing through parliament. **The biggest public health intervention in a generation**. Creates the first smoke free generation so children turning 15 this year or younger can never legally be sold tobacco, extends the indoor smoking ban to specific outdoor spaces and will ban the advertising and sponsorship of vapes and nicotine products.

Chapter 3

Unmasking Addiction

Exploring addiction and its impact

What is addiction?

Addiction is a complex disorder and is defined as "not having control over doing, taking, or using something to the point where it could be harmful to you." [22]

While addiction is often linked to gambling, drugs, alcohol and smoking, it is possible to develop an addiction to anything including gaming, shopping, sex, solvents, internet use or even work.

Substances like drugs, alcohol, and nicotine (the addictive substance in tobacco) alter your physical and mental state, often creating pleasurable sensations that lead to a strong desire to use them again. Gambling can produce a similar mental 'high' after a win, prompting a strong urge to try and replicate that feeling. This can develop into a habit which is difficult to stop.

Addiction occurs when the use or behaviour becomes compulsive and uncontrollable. Addiction is linked to two brain reward pathways: liking and wanting. 'Liking' is the immediate pleasure, like enjoying a chocolate biscuit, while 'wanting' is the desire to have it when you see it in the shop. 'Wanting' drives us to seek and repeat behaviours. Addiction can be seen as a rewiring of these reward systems where the 'liking' and 'wanting' become disconnected, where the 'wanting' remains constant, but the 'liking' diminishes. This leads to needing more of the behaviour or substance to achieve the same level of pleasure.

Why do some people get addicted and others do not?

So why do some people start doing, taking, or using something and others do not, and why do some people continue to use, do, or take something whilst others do not? Unfortunately, there is no simple answer. There are many influences including environmental factors, life experiences such as trauma, a physical predisposition for addiction, as well as other personal and cultural factors. In Table 1, we highlight some of the protective and risk factors that may increase or reduce a person's risk of becoming addicted, most of these factors relate to more than one addiction.

Risk factors	Protective factors
Aggressive behaviour in childhood [23,24,25]	Self-efficacy (belief in self-control) [26]
Lack of parental supervision [24,27]	Parental monitoring and support [25,27-29]
Low peer refusal skills [23,24,28,29]	Positive relationships [28,30]
Drug experimentation [27,31,32]	Academic achievement [24,28,33]
Availability of drugs at school [32,34]	Effective school based drug policies [28]
Community poverty [35,36]	Neighbourhood resources [37]

Table 1: Risk and protective factors of addiction

The harms of addiction

Addiction is a source of potentially serious and wide-ranging harms which affect not only the health and wellbeing of the individual, but also that of their families, communities, and wider society. Tables 2 - 4 set out the harms of addiction.

The physical and mental harms of addiction

	Smoking [38,39]	Drugs [40, 41]	Alcohol [42]	Gambling [43]
The impact on the physical and mental health of individuals	Tobacco use, specifically cigarette smoking, continues to be the single largest preventable cause of ill-health, death and disability. Half of all smokers die prematurely. Cigarettes contain over 5000 chemicals and gases designed to uniquely deliver nicotine to the brain which causes an increase in the release of dopamine. It is the tar, carbon monoxide and other chemicals and carcinogens found in cigarette smoke that are responsible for these negative health effects. Smoking causes at least 15 different cancers and is responsible for 22% of all cancer-related deaths. Smoking increases the risk of hypertension and clogged arteries, and eventually causes heart attacks and strokes, often in relatively young middle-aged adults. Smoking is linked to diseases of the respiratory system and is responsible for 36% of all deaths from them. In addition to lung cancer, tobacco causes other breathing-related diseases such as emphysema and chronic bronchitis. Smoking creates fertility problems for men and women and complications during pregnancy and childbirth.	Chronic respiratory diseases, liver cirrhosis, and infectious diseases linked to intravenous drug use. Mental health struggles, including anxiety, depression, and suicide thinking, are frequently comorbid with addiction. Drug use can also increase the risk of contracting infections. HIV and hepatitis C (a serious liver disease) can occur from sharing injection equipment or from unsafe practices such as condom-less sex. Infection of the heart and its valves (endocarditis) and skin infection (cellulitis) can occur after exposure to bacteria by injection drug use.	Persistent alcohol misuse increases your risk of serious health conditions, including heart disease, stroke, liver disease, liver cancer, bowel cancer, mouth cancer, breast cancer, pancreatitis, damage to the brain, which can lead to problems with thinking and memory. A dependent drinker usually experiences physical and psychological withdrawal symptoms if they suddenly cut down or stop drinking, including hand tremors (the shakes), sweating, seeing things that are not real (visual hallucinations), depression, anxiety, difficulty sleeping (insomnia). This often leads to “relief drinking” to avoid withdrawal symptoms.	People with gambling disorder have an increased risk of dying from any cause, in a given time period, relative to the general population, in particular in gamblers aged between 20 and 49. Deaths from suicide are significantly higher among adults with gambling disorder. Gamblers are more likely to experience anxiety and depression, could be consequential or causal. Feelings of guilt, shame, loss of self-esteem, loneliness and sleep problems, self-neglect. In qualitative studies, gamblers reported co-occurring alcohol and drug-related problems, both of which were risk factors.

Table 2: The physical and mental harms of addiction

The impact on family and social networks

	Smoking [38,39,44]	Drugs [40, 41]	Alcohol [42]	Gambling [43]
The impact on family and social networks	During foetal development, smoking can increase rates of stillbirth and selected congenital malformations. In infancy, it can cause sudden infant death syndrome. In childhood and adolescence, smoking can cause disability from respiratory diseases. People who breathe in second-hand smoke regularly are more likely to get the same diseases as smokers, including lung cancer and heart disease. Children who live in a smoky house are at higher risk of breathing problems, asthma and allergies.	Drugs can have a negative impact on friends and family including emotional distress, financial strain, and social isolation. The dynamics within families can shift dramatically. Parental drug use can have a detrimental effect on the health and wellbeing of children. Links to increased likelihood of the children partaking in risk-taking behaviours, reduced educational attainment and earlier uptake of drugs or alcohol.	Like, drugs, alcohol can have a negative impact on friends and family. One in five adults had been harmed by the drinking of another person in the previous 12 months. It can lead to social problems such as divorce, domestic abuse and homelessness. Alcohol during pregnancy also creates a risk of Foetal Alcohol Spectrum Disorders (FASD), causing neurodevelopmental problems that impact on the life chances of those affected.	Problem gamblers may take out loans in other people's names, steal from friends and family and are more likely to commit fraud. It is estimated that for every person experiencing gambling-related harms, a further six to ten people (for example family members, friends, or colleagues) are also directly affected. Children of gamblers also noted difficulties at school because of the chaotic home life associated with a gambling parent.

Table 3: The impacts of addiction on family and social networks

The wider impact on communities and wider society

	Smoking [45]	Drugs [6]	Alcohol [46,47]	Gambling [43,48]
The impact on communities and wider societies	Smoking contributes to poverty by diverting household spending from basic needs, such as food and shelter, to tobacco. This spending behaviour is difficult to curb because tobacco is addictive. It also causes premature death and disability of productive age adults in households, thus leading to reduced household income and increased healthcare costs. Smoking is estimated to cost the UK economy £28.7 billion a year, through lost earnings, unemployment, early deaths and reduced Gross Value Added due to expenditure on tobacco. A further £1.89 billion is estimated to be the combined cost of hospital admissions and primary care services in the UK. For the Wirral, this is estimated as £118 million and £10 million, respectively. An estimated £66.8 million is spent by consumers on purchasing (legal and illicit) tobacco per year in Wirral. The illicit trade involves a range of tobacco products that are sold illegally, often to underaged users, without paying taxes (VAT and excise duty). It provides a cheap and unregulated supply of tobacco to those who might otherwise be deterred by cost. Illicit tobacco trade undercuts law-abiding businesses. It funds other organised crime with its proceeds and increases the burden on honest taxpayers.	There are substantial social and economic costs related to illicit drug use: • £19.3 billion total costs of harms related to illicit drug use for 2017-18 • Drug-related crime was the main driver of total costs - £9.3 billion • Drug-related deaths and homicides make up the next largest cost at £6.3 billion • Drug treatment and prevention make up a small fraction of the total cost at £553 million People with drug problems can struggle to hold down a job, which is particularly acute for people who use opiates and/or crack cocaine. A significant proportion of the costs associated with drug use are indirect costs related to lost outputs from the labour market (£4.03 billion). Drug-related crime costs are both financial and human: organised crime has a major impact on some communities and victims of county lines gangs are sometimes as young as seven; vulnerable people's homes are cuckooed by gangs to deal, store or take drugs; and business owners are often targeted by acquisitive criminals shoplifting to fund addiction. Crime harms are more acute in the most deprived areas.	Alcohol consumption differs from many other risk factors, as attributable health burden is not restricted to the drinker alone but also extends to others, including those who have abstained from alcohol during their lifetime (e.g. via drunk driving or maternal alcohol consumption). Harm attributable to alcohol is not restricted to health but comprises many other aspects of life and sustainable development, such as criminal behaviour and loss of economic productivity. Our recent calculations estimate that alcohol costs society in England £27.4 billion, which is equivalent to £485 per head of population.	Cultural harms refer to the tensions between gambling and cultural practices and beliefs, and normalisation (where an activity and the associated harms become thought of as normal). Studies showed that gambling-related harm is influenced by cultural norms, so some gamblers and their close associates experience additional harm like shame and isolation. Gambling is normalised in society so harms can be passed on to the next generation. Government estimates for the combined economic and social costs of gambling in the UK is between £1.05 billion - £1.77 billion, including an estimated £119.5 million of direct health harms.

Table 4: The impacts of addiction on communities and wider society

Addiction and health inequalities

There are well-documented inequalities in health, with people in our most socioeconomically disadvantaged communities more likely to die earlier and spend more of their lives living in poor health.[49, 50] These inequalities in health are exacerbated by alcohol, smoking, drugs, with the harms disproportionately affecting some communities es explained below.

Smoking remains the leading cause of preventable illness and is responsible for up to half the difference in life expectancy between the highest and lowest socioeconomic group.[51] Smoking rates are more than three times higher in the most disadvantaged communities in England compared to the least and people in the most disadvantaged areas are more than twice as likely to die from smoking-related causes.[51]

Deaths caused by alcohol are also more than twice as high in the most disadvantaged areas of England than in the least disadvantaged areas.[52] Even when more disadvantaged groups consume the same number of, or fewer, alcoholic units than the less disadvantaged, they still experience worse harms in what is known as the alcohol-harm paradox.[53]

There is emerging evidence that the same is true in gambling, with more disadvantaged groups experiencing more gambling-related harm even when gambling less. To some extent, this follows, because the financial impact of gambling losses may be more severe for those with fewer resources.[54]

The links between drug-related harm and social/economic disadvantage are well documented, with individuals from the most deprived areas being significantly more likely to experience drug-related harm. In the UK, almost two thirds (62.5%) of people sleeping rough have a problem with substance use, with this being both cause and consequence.[55]

Addiction and young people

Adverse Childhood Experiences (ACEs) are well understood to have a detrimental impact on the wellbeing of children and adolescents, and throughout the life journey of many people who have had these experiences.[56] Like adults, in conjunction with other environmental and genetic factors, ACEs can lead to young people being at increased risk of addiction (Diagram 2).

ACEs increase individuals' risks of developing self-harming behaviours

Compared with people with no ACEs, those with 4+ ACEs are:

4 x more likely	to be a high-risk drinker
6 x more likely	to have had or caused unintended teenage pregnancy
6 x more likely	to smoke e-cigarettes or tobacco
6 x more likely	to have had sex under the age of 16
11 x more likely	to have smoked cannabis
14 x more likely	to have been a victim of violence over the last 12 months
15 x more likely	to have commited violence against another person
16 x more likely	to have used crack cocaine or heroine
20 x more likely	to have been incarcerated at any point in their lifetime

Preventing ACEs in future generations could reduce levels of:

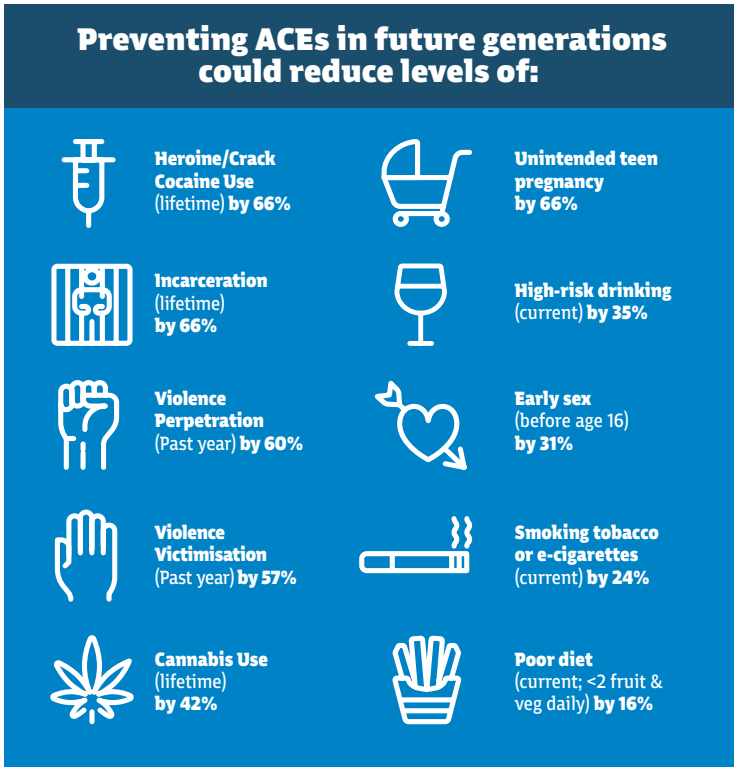


Diagram 2: The impact of Adverse Childhood Experiences (ACEs) and their impact on health harming behaviour (Public Health Wales, Welsh Adverse Childhood Experiences, 2016)

Addiction during youth can have lifelong impacts. Most adult smokers have had their first cigarette or were already addicted to nicotine by age 18 and 90% of lifetime smoking is initiated between 10-20 years old in the UK.[57] Those who drink alcohol regularly from an early age are more likely to develop problems with alcohol later[58] and, compared with children who have not gambled, those who have spent their own money on gambling are more likely to have consumed alcohol, taken drugs, or smoked.

However, the nature of addiction for young people can be different than that of adults. Cannabis is still prevalent in over-18s but there has been a significant increase in Ketamine use among this group, causing, in some cases, life changing harm. The involvement of young people with illicit drug use exposes them to other risks. Organised crime gangs are known to recruit younger people to be part of their delivery chain, and even in Wirral there are cases of modern slavery and sexual exploitation arising from a young person's involvement in drug use. The proportion of young people who smoke cigarettes is far lower than in adults, however it is acknowledged that the proportion of young people who smoke e-cigarettes seems to have markedly increased in recent years.[57] Alcohol use by 15-year-olds is also understood to have fallen significantly compared to a couple of decades ago.[58]

- **9% of 11-15 year olds vape. Of pupils who have ever tried vaping, 89% have never regularly smoked tobacco cigarettes.**
- **37% of pupils aged 11-15 said they had ever had an alcoholic drink.**
- **13% of pupils aged 11-15 years old reported they had ever taken drugs.**
- **18% of pupils felt that they often had no-one to talk to.**

Survey of Smoking, Drinking and Drug Use among Young People in England, 2023 National statistics, Accredited official statistics, published 17th October 2024 [59]

The challenges of multiple addictions

Addictions are not mutually exclusive; the environmental and genetic factors that lead people to be at greater risk in one area of addiction are common across other forms of addiction. This is evidenced in recent studies that have shown certain genes are more prevalent across addiction disorders, regardless of the substance involved.[60] Also, some people experience multiple addictions throughout their life, which can often be in conjunction with another addiction, but sometimes sequential.

Substance use can act as a catalyst for other addictions. For example, there is a clear association between increased alcohol consumption and gambling at all levels of harm.[43] Furthermore, smoking has been found to be highly prevalent among people in treatment for substance use disorders.[61] In some cases, this will be due to the environment that individuals experience, or the lowering of inhibitions caused by some substances. However, there is emerging evidence that "cross-addiction" can cause new-onset addiction.[62]

Multiple co-occurring or sequential addictions can increase the risk of health harms associated with addiction. For example, smoking and crack cocaine use can compound respiratory system damage, leading to significant life-limiting conditions.

Addictions and mental health

People experiencing problems of addiction and mental health are very common. Research has shown that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment.[63, 64] Gambling is also associated with mental health problems, including anxiety and depression.[43]

Smoking rates among adults with a common mental disorder, such as depression and anxiety, are almost twice as high compared to adults who are mentally well, and three times higher for those with schizophrenia or bipolar disorder. People with substance use disorders, with or without co-morbid mental health problems, have the highest rates of smoking. In every area of mental health, smoking rates are disproportionately high.[61, 65]

High prevalence of co-occurring conditions has been found among the following populations:

- people in prison and those in the criminal justice system.[66]
- children, young people and adults in alcohol and drug treatment.[62, 63, 67]
- individuals presenting to hospital emergency departments in mental health crisis.[68]
- people experiencing severe and multiple disadvantage.[69]

Individuals often face difficulties accessing the necessary care from both mental health and addiction services, with those in mental health crisis sometimes struggling to receive care due to intoxication.[70]

What we know about addiction in Wirral

59%

of opiate clients in Wirral are aged over 50 compared to 30% nationwide and this is increasing

3.7%

of adults (11,981) in Wirral are estimated to consume 7 or more alcoholic drinks on average per day

10.9%

of adults approximately in the borough smoke. This is 28.1% in adults in routine and manual occupations and 22.8% in adults with a mental health condition

3,346

people are in treatment services at Change, Grow, Live (CGL) with drugs and alcohol problems

4,038

In 23/24 there were 4,038 referrals to the stop smoking service. Of these 2,453 came from the most 20% deprived areas in Wirral (60.7%)

210

On average 210 people die from lung cancer each year in Wirral and this number is increasing. Rates of lung cancer mortality in Wirral are significantly higher than the national average

115

On average 115 people die each year directly due to drugs or alcohol and this number is increasing. Rates in Wirral are significantly higher than the national average

76%

of children/youths aged 13 to 19 years who took part in the response survey and said they used drugs said that cannabis was their primary drug

1,104

clients in treatment at CGL are parents with 53% having children living with them

48%

of adults gambled in the last 4 weeks

77%

of opiate clients live in the most deprived areas of Wirral

7 X higher

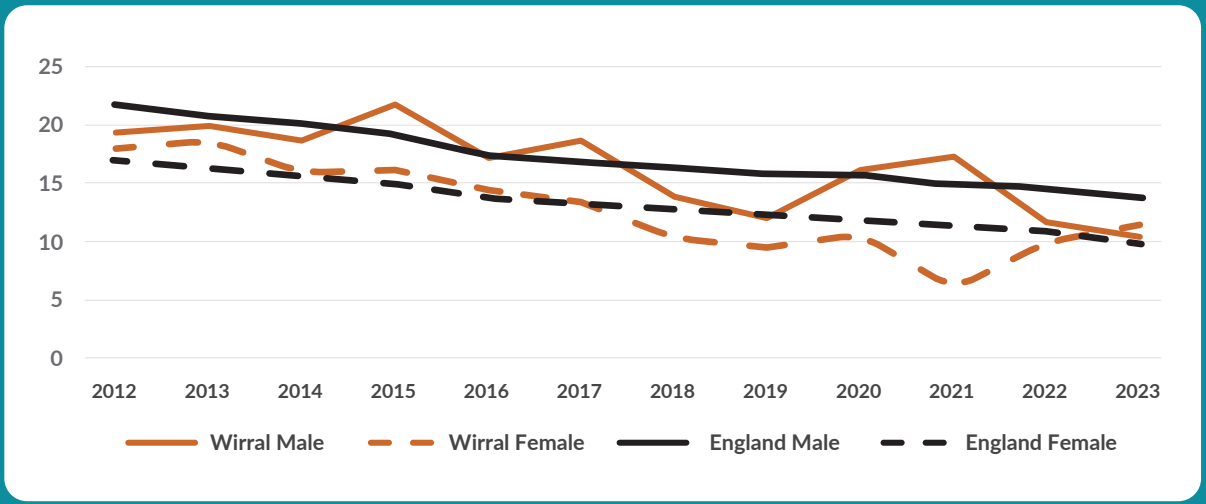
The prevalence rate of Chronic Obstructive Airways Disease (COPD) for opiate clients aged 45 plus is 7 times higher than that of the overall Wirral population

Source: locally sourced JSNA data, accessed November 2024

The local picture of smoking

Approximately 10.9% of adults in the borough smoke (27,500 people), a figure that is statistically similar to the national average of 11.6%.[71] The overall rate is decreasing in men but has increased in woman since 2021 (Graph 1). An estimated £10 million annually is spent in Wirral on healthcare costs on smoking-related conditions, and £212 million taking into account productivity, social care and fire costs.[72]

ONS Smoking prevalence estimates 2012 - 2023



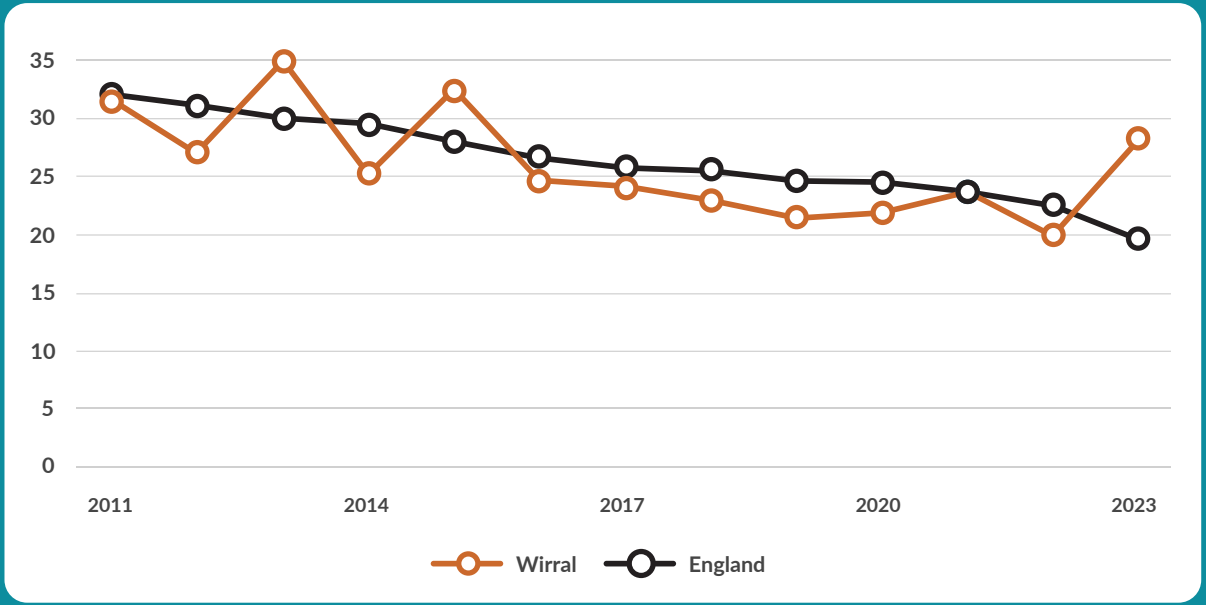
Graph1: Wirral smoking prevalence estimates (2012-2023). Source: Annual Population Survey (APS), Office for National Statistics (ONS).

Smoking is also the leading cause of health inequalities and accounts for half of the difference in life expectancy between the most and least affluent communities in Wirral.[73] The Annual Population Survey (APS) uses data (which has been weighted to improve representativeness) but is based on a sample of the population and, as such, are not true counts. This means the estimated figure may be imprecise, and future data points may be required to understand longer term trends in Graph 1 and 2.

In 1948, 52% of the UK population smoked. In 2023, 11.6% of the UK population smoked.

Source: NHS Information Centre: smok-eng-2011-tab.xls & fingertips smoking profile data (accessed 28.11.24)

Smoking prevalence in adults in routine and manual occupations (aged 18 to 64) current smokers (APS) for Wirral



Graph 2: Wirral Smoking Prevalence in Adults in routine or manual occupations (2011-2023). Source: Fingertips, accessed 28.11.24

Smoking prevalence in adults in routine and manual operations (aged 16-24) has been significantly higher than the general population. In 2011 rates of smoking were 31.5%, by 2019 this had reduced to 19.9%, however rose to 28.1% in 2023. As this graph also uses APS survey data the same cautions as described on the previous page apply.

The proportion of the population who currently vape nationally is 11%, the highest rate ever. More than half of ex-smokers who quit in the last five years say they used a vape in their last quit attempt, of whom around two thirds are still vaping, while around a third have quit vaping as well. Around 1.6% of never smokers are current vapers, amounting to 8.0% of vapers.

An average smoker spends £2,451 a year on smoking

ASH -Smoking and poverty, December 2022 [73]

The local picture of gambling

There is little real time data about the prevalence of gambling in Wirral, and only estimated prevalence data exists. These are indicative estimates that use the Problem Gambling Severity Index (PGSI) to measure levels of gambling behaviour which may cause harm to an individual.[74] The PGSI consists of levels including low risk (PGSI 1-2), moderate risk (PGSI 3-7) and problem gambling (PGSI 8+). Table 5 shows the levels of risk in Wirral.

Approximately, 1 in 8 people in Wirral have a PGSI score of above 1, meaning 1 in 8 may experience some potential harm or negative consequence from their gambling. This is 13% of the population in Wirral compared to 13.4% in the UK. However, 1 in 37 people are estimated to have a PGSI score of above 8, meaning 2.7% of people have some form of problem gambling. This is slightly lower than nationally.

Level of risk	Wirral estimated rate (%)	UK estimated rate
Low (1-2)	7.0	7.5
Medium (3-7)	3.3	3.0
Problem gambling (8+)	2.7	2.9

Table 5: Levels of risk in Wirral. Source: Gambling Commission (Gambling Severity Index Estimates)[74]

Wirral shows lower numbers of people with a PGSI score of 3+ accessing treatment, support or advice (26.0%) compared with 32.1% across the UK, although more would like access to treatment and support, especially at lower risk levels.[74] A notably higher proportion of people with a PGSI score of 8+ are currently accessing treatment (Table 6). In Wirral, the estimated annual cost of problem gambling (PGSI 8+) is over £6 million and includes crime related, health, housing and welfare costs.[74]

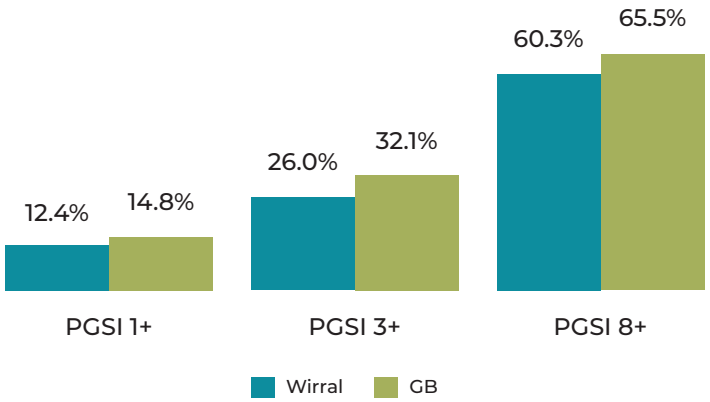


Table 6: People accessing treatment, support or advice by PGSI score. Source: Gambling Commission - Gambling Severity Index Estimates[74]

"I would never have started gambling, if it weren't for the smartphone apps"

Liz, recovering gambler

11.4% of those who have a score of PGSI 1+ would like treatment, support or advice to deal with their gambling

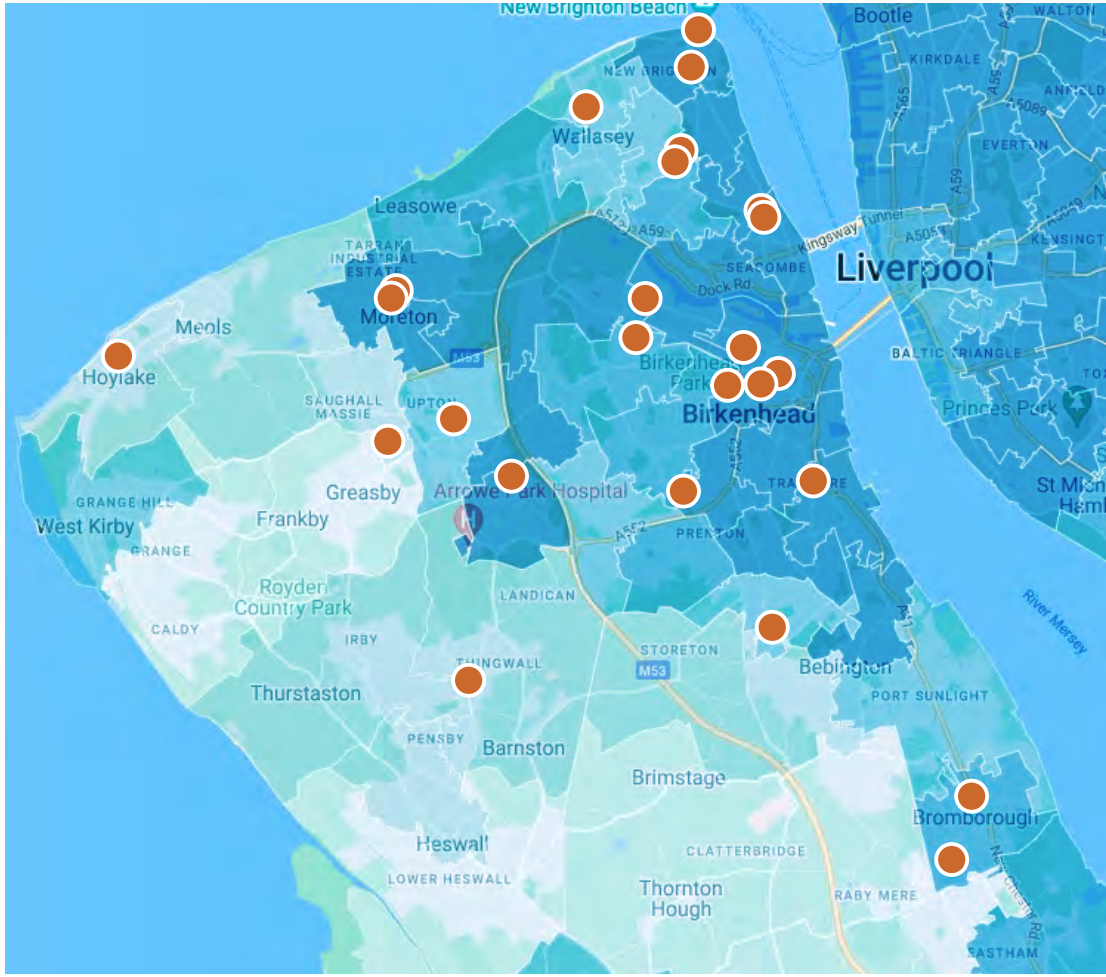
This rises to 55% among those with PGSI 8+ in the Wirral

Source: Gambling Commission - Gambling Severity Index Estimates[74]

Some groups are more at risk from problem gambling (PGSI 8+). This includes younger age groups, people from Black, Asian, and other minority ethnic backgrounds, the unemployed, and full-time students (possibly linked to higher rates in younger age groups).[74] Despite being an illegal activity in those aged under 18 years, in 2024, almost one in three children (27%) aged 11–17 years in the UK said they had spent money on gambling activities in the previous year.[75]

Map 1 shows the location of licensing betting premises by electoral ward in Wirral, compared with the Index of Multiple Deprivation (IMD) Score. IMD scores are a widely used measure in the UK to classify the relative deprivation of areas. In this graphic, the darker the shade of a ward, the more relatively deprived it is. It is notable that there is often a strong correlation between the deprivation of an area, and the number of betting premises located within that area.

The number of licensed betting premises has reduced from 61 in 2018 to 27 as of 2024, reflecting the industry shift to online forms of gambling. In 2018, 3 of these premises were in the 20% least deprived areas of Wirral, in 2024 this has reduced to 0. In comparison, in 2018, 57% of all betting premises in Wirral were in the 20% most deprived areas and in 2024, this reduced slightly to 56%.



Map 1: Off track betting premises (Bookies) overlaid on IMD 2019 deprivation score

The local picture of alcohol use

The Chief Medical Officer low risk guidelines [20] state to keep risks from alcohol low, it is safest not to drink more than 14 units of alcohol a week on a regular basis, that is on average, no more than two drinks per day. One unit of drink is equivalent to 1/2 pint(s) of beer/larger/cider or a single measure of spirit, for example, gin. In Wirral, it is estimated that 32.7% of the population (105,090 people) drink on average above 3 alcoholic drinks per day, with 3.7% (11,981) drinking 7 or more alcoholic drinks per day, over 49 drinks per week as per Table 7.[76]

The Covid-19 pandemic also had a huge impact on drinking behaviours in the UK, with those who drank more, drinking even more, and those who drank less, drinking even less. Alcohol is the 6th biggest risk factor that drives death and disability combined in the North West.[77] Wirral's total burden of alcohol annually is estimated to be £166.4m, equating to £519 per head of population. The distribution of drinking varies across the borough, with higher levels of drinking (7+ or more per day) being associated with higher levels of deprivation (Map 2).

Alcoholic drinks per day (percentage of Wirral population)

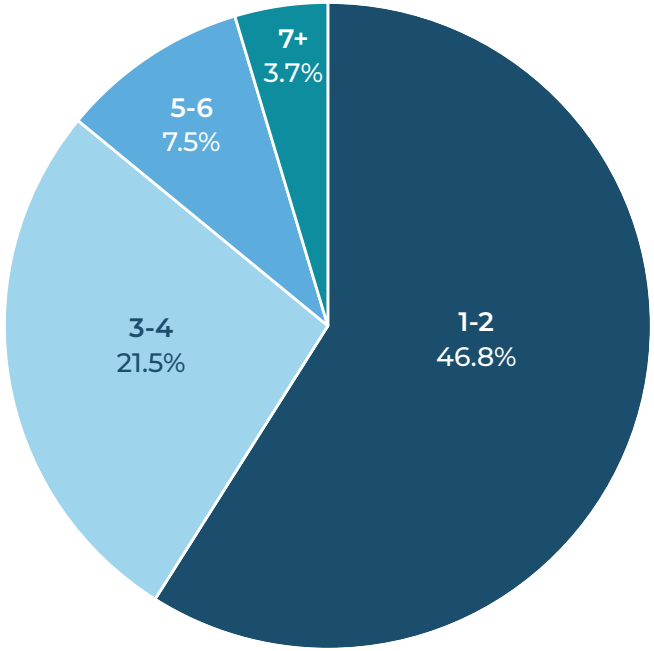
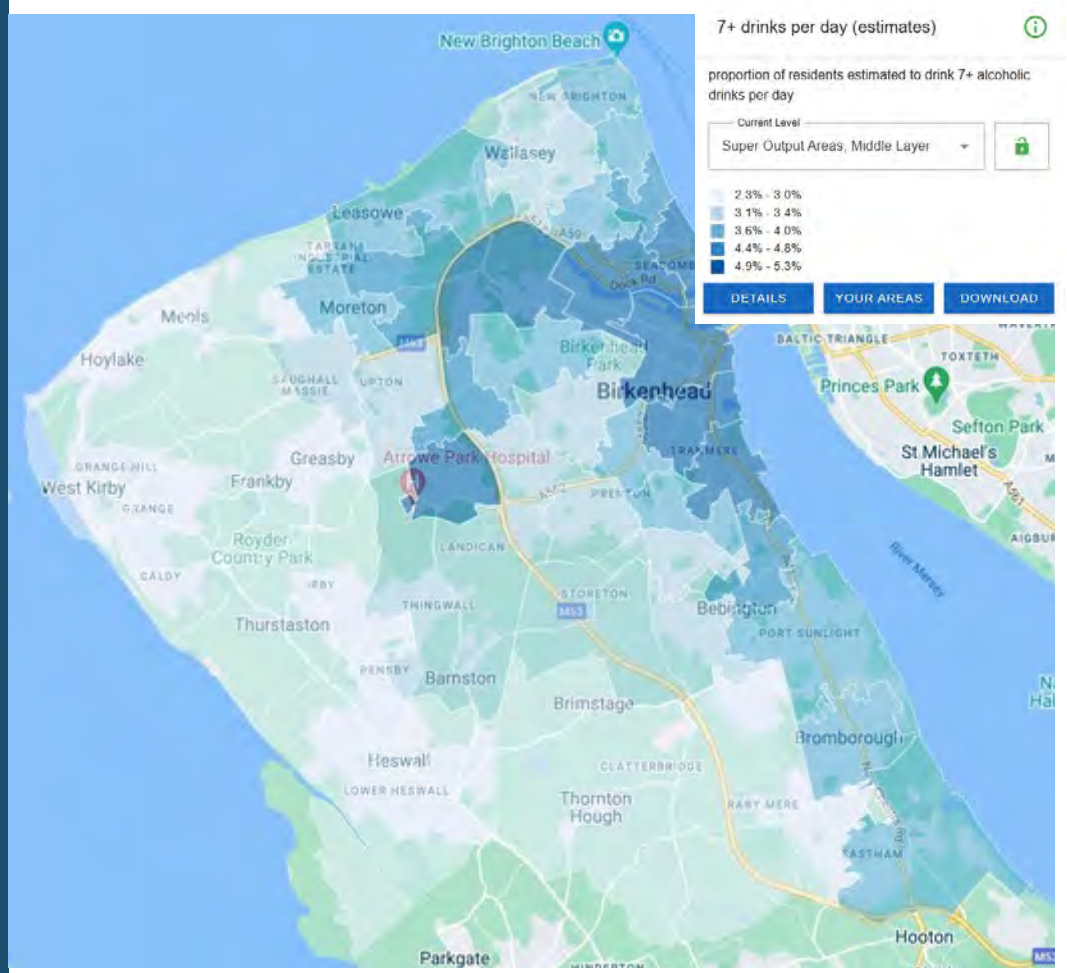


Table 7: Drinking behaviours: alcoholic drinks per day.[76]



Map 2: Drinking behaviours: alcoholic drinks per day within each ward (unpublished data, 2024)

The evidence is that some people are more vulnerable to drinking and this includes males (although alcohol-related harms are increasing at a faster rate among females in Wirral), deprived populations, people from Irish, Polish and certain other Eastern European backgrounds, children in need of social care services, people coming out of military service and people with mental health problems.[76]

Table 8 shows the rates of off licenses and on licenses (allowing consumption of alcohol on the premises) per ward. The 5 highest rates of off licences per 1,000 people aged 18 plus are in the 5 most deprived wards in Wirral (Birkenhead and Tranmere, Liscard, Rock Ferry, Seacombe and Bidston and St James).

Rates of on licences per 1,000 people aged 18 plus are more varied however the highest rate of 4.0 in the most deprived ward of Birkenhead and Tranmere; more affluent wards in Wirral, such as Heswall and Hoylake and Meols, also have high rates due to having a large number of bars and restaurants in the area. Research has shown a link between alcohol availability and alcohol harms, as well as links between alcohol and health inequalities. Alcohol has been implicated as both a determinant and an outcome of socioeconomic inequality.[2]

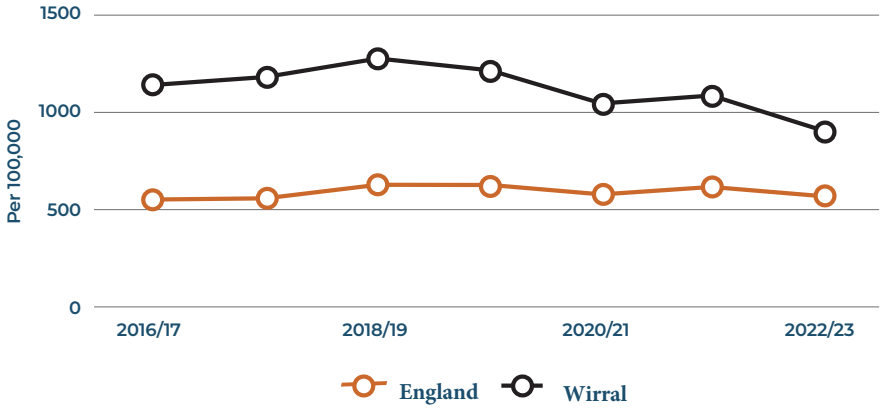
	Population Aged 18+	Off Licences		On Licences	
		Number	Rate per 1,000 Aged 18+	Number	Rate per 1,000 Aged 18+
Bebington	12,257	12	1.0	12	1.0
Bidston and St James	11,819	23	1.9	11	0.9
Birkenhead and Tranmere	12,652	32	2.5	51	4.0
Bromborough	13,075	20	1.5	32	2.4
Clatterbridge	11,417	8	0.7	19	1.7
Claughton	11,957	12	1.0	6	0.5
Eastham	11,404	11	1.0	15	1.3
Greasby, Frankby and Irby	11,697	14	1.2	20	1.7
Heswall	11,171	10	0.9	31	2.8
Hoylake and Meols	10,727	14	1.3	42	3.9
Leasowe and Moreton East	11,493	12	1.0	5	0.4
Liscard	12,355	28	2.3	34	2.8
Moreton West and Saughall Massie	11,353	12	1.1	16	1.4
New Brighton	12,122	12	1.0	36	3.0
Oxton	11,300	10	0.9	15	1.3
Pensby and Thingwall	10,624	9	0.8	6	0.6
Prenton	11,578	12	1.0	17	1.5
Rock Ferry	11,626	25	2.2	12	1.0
Seacombe	11,278	26	2.3	10	0.9
Upton (Wirral)	12,981	13	1.0	9	0.7
Wallasey	11,857	15	1.3	7	0.6
West Kirby and Thurstaston	10,070	4	0.4	15	1.5
Total		**334**	**1.3**	**421**	**1.6**

Table 8: Location of Licensed Premises by Index of Multiple Deprivation (IMD) Score3

Addiction-related harms have been described earlier in the chapter. Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. To understand how Wirral is affected by alcohol consumption, an age-standardised rate per 100,000 population is applied, as otherwise two populations with the same age-specific rates for a particular measure will have different overall rates if the age distributions of their populations are different.

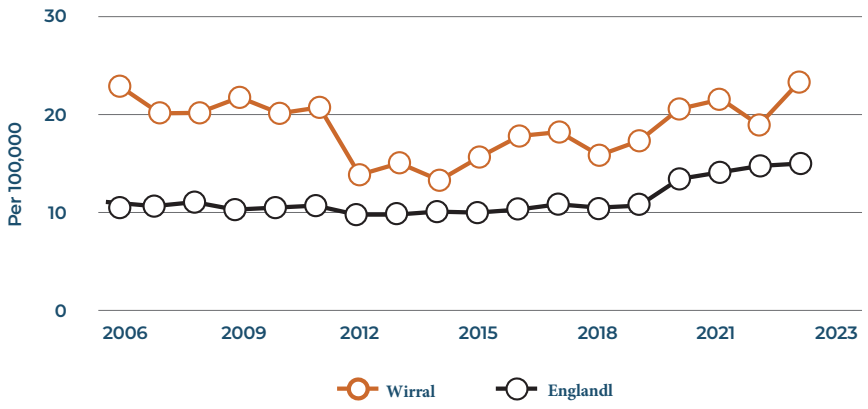
Wirral's age-standardised rate of alcohol-specific admissions to hospital for conditions such as these has been statistically significantly higher than England for the past 7 years (Graph 3). In some years, the rate locally was over double the national average. More recently, this rate has improved, and the number of people admitted to hospital for these reasons is decreasing, but Wirral continues to be statistically significantly higher than the national average. Sadly, the high rate of admissions to hospital over this period is accompanied by a high rate of alcohol-specific mortality in the area (Graph 4).

Admission episodes for alcohol-specific conditions



Graph 3: Alcohol-specific admissions to hospital – Wirral compared with England.
Source: Fingertips (accessed 28th November 2024).

Alcohol-specific mortality



Graph 4: Alcohol-specific mortality – Wirral compared with England
Source: Fingertips (accessed 23rd January 2024)

"I have been a GP for more than twenty years, and in all of that time, in all my medical career, I had no idea what alcoholism really was. I thought it was a moral choice"

"I did not identify with being an alcoholic because I felt in control. I was holding down a job. I was being promoted. I had great appraisals at work"

Dr Mike

The local picture of drug use

Wirral (along with Liverpool) was one of the first areas in the country to experience the dramatic growth in heroin use in the early to mid-1980s. This has left a legacy of higher rates of opiate and crack cocaine use in Wirral compared to national figures. Increasingly, this generation of people born in the 1960s and 1970s are now dying from chronic ill-health and drug poisoning. Long-term consequences are being seen in Wirral ahead of most other areas and include an older drug-using population with more complex health and social needs and, arising from this, higher rates of drug-related deaths. The difference in mortality rates between the most and the least deprived quintile is most pronounced in these age groups, with mortality rates being 10 times higher for people aged in their mid-40s.

In 2022, there were 44 deaths due to drug poisoning in Wirral, an increase from 35 deaths in 2018; this is slightly higher than in the UK. 66% of drug-related deaths were males, and the largest proportion of deaths were in those aged 40-49 (32%) and 50-59 (34%), reflecting the history above. The average age of drug-related deaths in Wirral among males was 48 years and 53 years for females, both substantially lower than the average age of death in Wirral (from any cause) for both males (76 years) and females (80 years). Morphine, cocaine and alcohol were the three most commonly found drugs in the body at time of death (42%, 40% and 33% respectively). There were 15 deaths due to prescription only drugs and the average numbers of drugs at

postmortem was 4.4, ranging from 1 to 14 drugs. 65% of those in drug treatment were from most deprived neighbourhoods.[78] Death rates are significantly less in Wirral's ethnically diverse population but higher in those who are unemployed, long term sick or retired, or living alone. 80% deaths were in people who were single, separated or divorced.

Since the increased investment in treatment services through the Substance Misuse Treatment and Recovery (SSMTR) grant, there has been an overall increase of in the number of people actively engaging with treatment with an additional 434 people currently accessing services. In June 2024, there were 3414 people in treatment, a growth of 15%.

The Wirral Drugs Joint Strategic Needs Assessment (JSNA) has recently been refreshed and is available for further information.[78]

Myth Busters: Dispelling myths about addiction

Myth: Addiction is a personal choice; people can just stop if they wanted to.

No one chooses to become addicted, any more than they would choose to get cancer. There are genetic, social, environmental and psychological risk factors that can put some people at greater risk.

Myth: You'd know if someone close to you was addicted.

Many people see a stereotypical version of an addict, the one that society perpetuates. However, many addicts do function in regular life and may even lead successful lives. High-functioning addicts are skilled at covering their tracks so that their addiction goes unnoticed. Sometimes those with addiction don't even realise, or acknowledge, to themselves they are addicted. However, the consequences of the addictive behaviour almost always eventually impacts.

Myth: Willpower is all you need to beat addiction.

Addiction can lead to profound changes in the brain. These changes alter the natural "reward pathway" of the brain. When addiction takes hold, these changes in the brain erode a person's self control and ability to make good decisions, while sending highly intense impulses to take more substance/or do more of the behaviour. It is not as simple as a matter of willpower.

Myth: Prescription drugs are not addictive because they come from a doctor.

Addiction to prescription medications, such as painkillers, sedatives and stimulants, is a growing and serious issue affecting people of all ages. These substances can be very addictive and lead to significant harm. Even when prescribed by a doctor, they can still carry risks. In Wirral, 15 out of 44 drug poisoning deaths during 2022 were linked to prescription-only medicines.

Myth: Some addictions are worse than others.

As we have seen in chapter 2, societal attitudes and perceptions, the legal status of substance/behaviour etc. can all influence the acceptability of an addiction and normalise that some are less bad than others. For example, millions partake in drinking as a social activity, and this social aspect creates the impression that it is less dangerous than drugs like heroin or cocaine. In fact, the harms arising from drug use, alcohol use, smoking and gambling can all be serious.

Chapter 4

Hope and Healing

Overcoming addiction - Prevention, treatment and recovery

Introduction

In her seminal report on her "Review of Drug Treatment, 2020" Dame Carol Black wrote:

"Treatment services have been curtailed by Local Government funding cuts. The total cost to society of illegal drugs is around £20 billion per year, but only £600 million is spent on treatment and prevention. So the amount of unmet need is growing, some treatment services are disappearing and the treatment workforce is declining in number and quality. Ultimately, we need to transform our approach to treatment, investing in it but also innovating so that treatment services are able to respond to today's drugs market and future developments."

Wirral's approach to "treatment" has been to deliver this work through a strong "system" rather than a more limited view of delivery through "services". In line with Dame Carol's findings on the drug treatment services nationally, Wirral saw significant reductions in funding in drug and alcohol treatment in the 10 years up to 2020. Similarly, smoking cessation services saw widespread disinvestments nationally and locally and gambling harm failed to attract significant public service funding.

For drug and alcohol treatment, this resulted in a reduction in the capability and capacity of the core addiction services, and the wider system of partners, although services still succeeded in maintaining some level of quality and expertise. This is evidenced by Wirral Ways Community drug and alcohol services securing an "outstanding" CQC assessment in 2019.

Since 2020, Wirral has seen significant national investment initially through Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery) funding and then, from 2023/24 onwards, through the Supplementary Substance Misuse Treatment and Recovery (SSMTR) grant. Project ADDER piloted a whole-system response to combatting drug misuse in the 13 hardest hit areas across England and Wales, Wirral being one of these areas. This was part of the UK government's initiative to test out innovative new approaches to drug-related harms before the publication of the government's 10 year drug strategy. Wirral has been at the forefront of this innovation and continues to lead the development of recovery services to this day. We use our learning to drive improvements in other areas of addiction.

Project ADDER focused on enhancing local capacity to improve treatment quality and accessibility and reduce drug-related deaths and crime. The programme included various components such as inpatient detoxification, employment support, and enhanced outreach services and was overseen by our local Combatting Drugs Partnership.

The SSMTR funding aims to build on the successes of the ADDER programme, with an expanded remit that includes support for children and young people and addresses both drug and alcohol misuse. This funding continues to support the core drug treatment and recovery systems, improving the quality and capacity of services.

Similarly, in 2023, the government announced plans to invest an additional £70 million per year to support local authority led stop smoking services and support. This doubled the current spending nationally from £68 million per year to £138 million with an ambition to support around 360,000 people to quit smoking. The extra stop smoking grant funding is ringfenced for local authority led stop smoking services and support and enhances current service provision. In July 2024, Wirral received an allocation of £90,182 (total for 3 years).

This investment was made in response to the 2022 Khan review, [79] which assessed whether the government would achieve its ambition to make England smokefree by 2030. This review presented an opportunity to review local priorities and processes, and build on the work achieved across the borough, with a focus on all factors required to control tobacco.

Our addictions system

Wirral has a successful model for creating partnerships that work across the whole system of health and social care, criminal justice, housing and community and voluntary sectors. This supports a whole person response to support people caught up in addictive behaviours.

The approach in Wirral is strong, based on firm foundations laid down in the late 1980's and early 1990's. The focus at that time was primarily on drug services, and then a little later, extended to alcohol services. There is an established network of partners that work collaboratively to design and deliver services for adults, young people and children, their families and communities.

This systemic network approach has also been applied to developing services to deliver smoking cessation to reduce tobacco harms and will shortly be used to drive a stronger response to addressing gambling addiction and gambling harms.

Wirral Public Health commission, mindfully and purposefully, the co-production of services with people who have lived experience as an important, essential component of service development and delivery. For example, between 35% and 40% of Wirral Ways workforce have lived experience, and this is integral to how the service understands the needs of its service users, and how it tailors its service delivery accordingly.

There is a close and open connection between the commissioners and the service providers and also with the service users. Contact is frequent, often face-to-face, and occurs in structured and unstructured forms. Some of this engagement is in organised meetings and workshops, but much of it is in casual encounters and conversations that allow frequent and informal feedback and learning, which is used to better understand local need, and identify what is working and working best. This informs the local systems ability to be most effective and to make a difference.

"It's almost like we have the services of a city, but it's set within a town, so the accessibility and the sense of working together towards something is intensified."

Professional, addiction support service

Our strategic alignment

Strategically aligning work across systems to address addiction is crucial because it ensures a comprehensive and coordinated approach to tackling this complex issue (Diagram 3). Addiction affects multiple facets of an individual's life, including health, social relationships and economic stability. By aligning our strategic efforts, we maximise opportunities to create a more effective support network that addresses the root causes of addiction, provides quality care and reduces the risk of relapse. This holistic approach not only improves outcomes for individuals struggling with addiction but also enhances the overall well-being of communities by reducing the social and economic burdens associated with addictive behaviours.

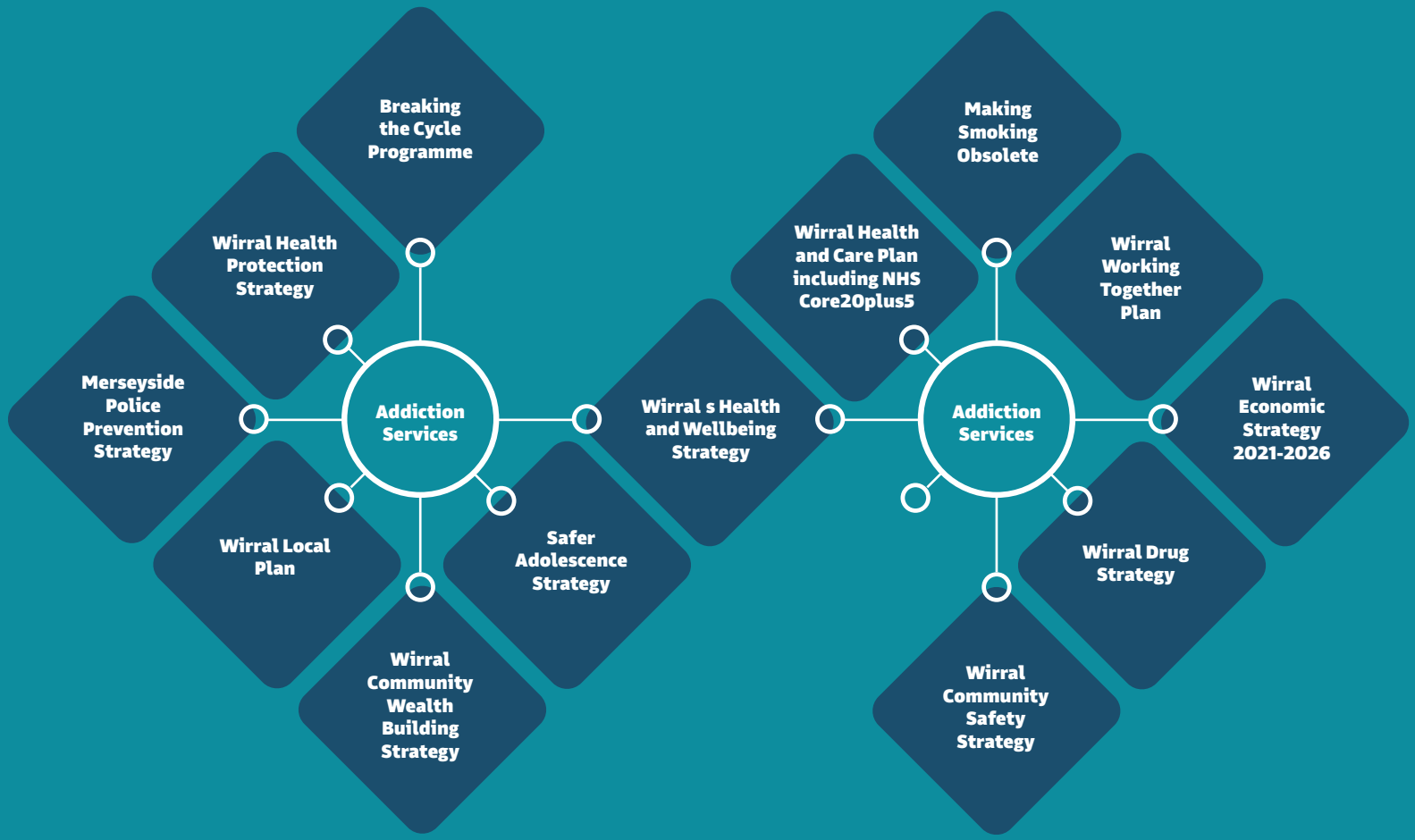


Diagram 3: Strategic alignment of addiction services in Wirral

Our partnership

Our partnerships are key because they bring together diverse resources, expertise and perspectives to address addiction. By collaborating, we create a unified strategy that addresses the multifaceted nature of addiction. This collective effort ensures that individuals receive comprehensive support, from prevention and treatment to recovery and reintegration into society. Our partnerships innovate, share best practices, reduce duplication of efforts and maximise the impact of available resources. Diagram 4 sets out our system partners.

"The recovery network in Wirral is massive in comparison to what I've experienced in other areas. There's just so much available here. Everybody wants to work together, and the big thing that stands out to me is its (recovery services) aren't hidden."

Professional, addiction support service

Diagram 4: Our system partners

Our approach to prevention, treatment and recovery

In Chapter 3, we reported that the causes and impacts of addiction are wide and complex. This means that people from diverse social and ethnic backgrounds, with a wide range of causality factors, present to services. This, in turn, requires services to provide a similarly wide range of responses and be adaptable to the varied needs of those presenting. In Wirral, we see services supporting service users along a continuum. Service users can travel at their own pace and can choose to hold the journey where they determine (Diagram 5). There is a focus on an Asset-Based Approach, working with people to enable them to identify and work with their own strengths, determine their own goals, and define their own recovery.

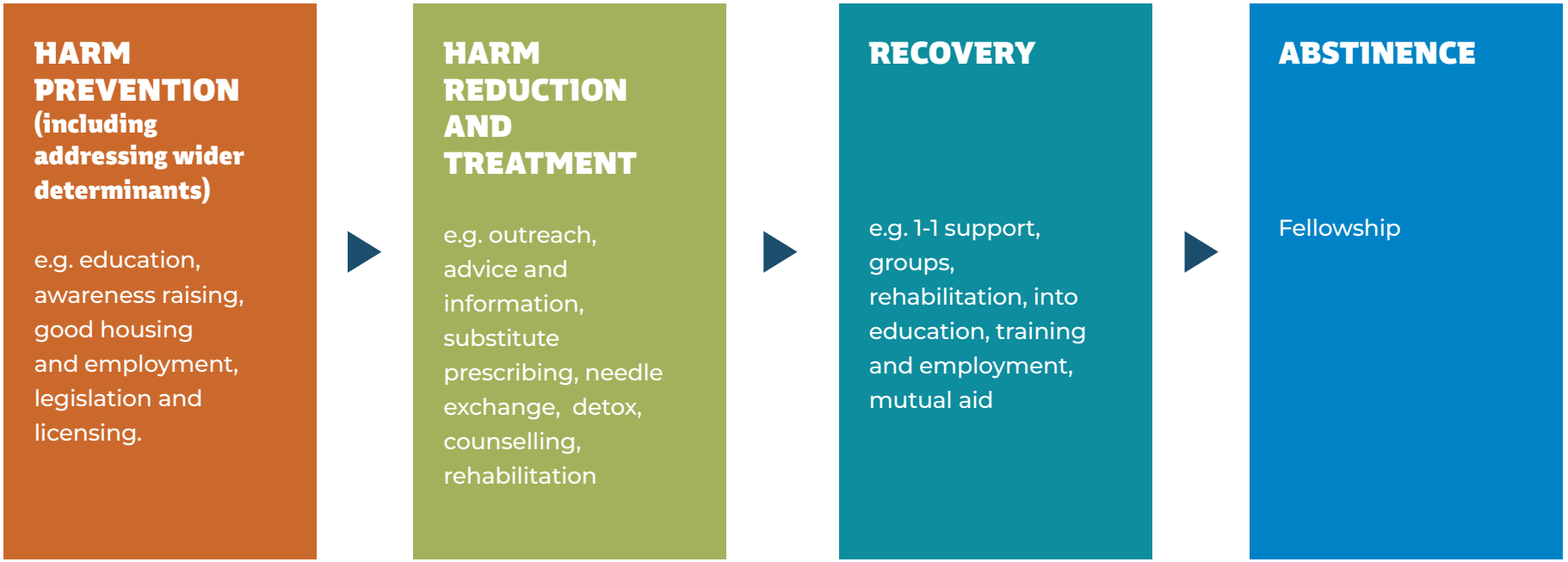


Diagram 5: The continuum of support and services

There are a key set of principles that guide our addiction treatment offers. These are:

- Treatment is a partnership between service user and service.
- Treatment is a journey, from active addiction to the person's chosen level of recovery.
- Recovery does not have to mean abstinence from the addictive behaviour, it can mean achieving a better balance of control.
- Treatment should work with someone's strengths, adopting an Asset Based Recovery approach.
- Engaging with treatment should involve choices as to what will best support their recovery journey. They should be encouraged to try different options to see what works best for them.
- Treatment should be holistic in its approach and involve family and important others.

"Not many businesses, like holistic therapy or hairdressers, will touch our clients. So, the fact that people want to come and support us is really good for the reintegration of our service users. And it shows that they are worthy, and they are valued."

Professional, Addiction support service

Augmenting a strong recovery system

We augment our recovery system to ensure it is fit for the future to address the needs of those with addictive behaviours, this is achieved through a number of mechanisms.

Expand	Expand to ensure we have enough capacity in our treatment system.
Increase	Increase the quality of our treatment services.
Focus on	Focus on stronger prevention and early intervention offer.
Strengthen	Strengthen our existing system-wide support, involving and investing in key partners, including housing, education, employment and training.
Integrate	Integrate our service offers makng them relevant to the needs of our population
Provide	Provide ongoing support for people in recovery – e.g. health, housing, training. Better integrate our recovery and wider communities
Harness	Harness the positive impact of recovery in our communities.

Building a positive culture to reduce addiction-related harms

Building a positive culture to reduce addiction-related harm involves fostering an environment where support, understanding, and proactive measures are prioritised. This culture emphasises the importance of education, open communication and community involvement to address the stigma associated with addiction.

Enhance the voice of people with lived experience.

Combat the stigma faced by people with lived experience of addiction.

Adopt trauma-informed practice

Run culturally adaptive and inclusive services.

Build positive messages about treatment and recovery across addiction services.

Upskill our wider system to support people actively using substances, or in recovery.

Myth Busters: Dispelling myths about addiction

Myth: You must apply "tough love" if you want people with addiction to change.

Tough love can lead to feelings of rejection and hopelessness. Compassionate, kind, empathetic approaches are more effective and can make family, friends and the person addicted feel better.

Myth: People have to hit "rock bottom" before they can get well.

This is not true and is potentially even dangerous. There can be deadly consequences to waiting. People who seek and accept help early in the process have more resources to draw upon, such as a supportive family or a job. The sooner someone gets help, the better.

Myth: Treatment will resolve the addiction

Treatment is often the first step, but it's mostly just the very beginning. Most people need more than one treatment visit to get well and staying well requires a long-term commitment to new coping skills and seeking the necessary support.

Myth: If someone relapses, they're a lost cause.

Addiction is a chronic, relapsing condition, and as with other chronic illnesses such as type II diabetes or high blood pressure, this often means lifelong management. Relapse can occur with any chronic disease, and this includes addiction. We should not be discouraged by a relapse, which is a recurrence of symptoms.

Myth: There is a one-size-fits-all treatment

Whatever the addiction, there is nothing that can magically cure it. People respond to treatment very differently, even if it is the same substance being used or behaviour being undertaken. A successful treatment should be tailored to the individual and their specific needs.

Chapter 5

From Darkness to Light

A journey from addiction, through recovery and into employment

'Photovoice' is a Participatory Action Research method based on the simple idea of using photographs in research interviews - BUT the participant is in control of the camera.

By involving participants in the design of the research, the method aims to empower communities and understand their experiences through their eyes.

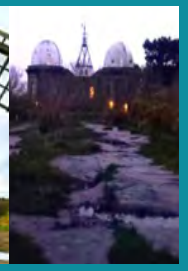
In Katy's self-titled photovoice case study "From Darkness to Light", she has chosen her "greatest hits" - six images that best represent her personal journey from the "darkness" of 30 years of drug dependency into the "light" of recovery and the opportunities of employment. This is Katy's story.

Name: **Katy Goodwin.**
Age: **51 Years.**
Occupation: **Group Facilitator and Recovery Coordinator (Change, Grow, Live).**

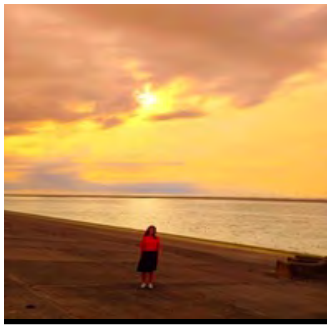
Katy's timeline "From Darkness to Light"

Addiction began 1992	**Abstinence** 2018 – present	**Volunteering** 2019 – 2021	**Employment** 2021 – present






Just for today



Sunset at Moreton Beach, Wirral.

"The sun symbolises a lot for me, it sets and rises – we have a saying in Fellowship 'Just for today', keeping everything in the day, one day at a time, which is how we approach abstinence and recovery, the days mount into months, the months into years [...] and like the phases of the sun, recovery is all about growth, change and transformation. I tried to detox before, 2-3 weeks clean and I was back using again. But this time, so far so good, because I've surrendered and I know, that deep within me I don't want to be that person anymore."
"There's a peace about me when I go to Moreton, out of everywhere, it's so peaceful."

For Katy, the sun's many phases represent 'change'. Like the first of the 12-steps of recovery - "surrender"- abstinence and recovery are brought about by 'surrendering' to the idea of change, in this case "a life without substances".

You learn what you like

Stargazing at Bidston Windmill and Observatory.

"In recovery, you learn what you like." "When I got clean, I struggled with it at first, but my mind just started opening to the fact that there's more to it, I love the planets, astronomy, astrology, the sun, the moon and the stars. Now, everybody knows it's my thing. In addiction, you don't know what you like. All I knew was taking drugs. You feel stupid, I didn't know how to send an email, use a laptop, mobile phone, I didn't know what WhatsApp was. It's like you're born again, like a child, you have to show humility, ask for help and people don't always understand it."

Katy's early experience with addiction in her teenage years meant that she grew into adulthood without knowing herself fully; what she liked, her hobbies, interests and ambitions. She finds this to be a strange concept at 51 years old, finally understanding herself as a person beyond a life of dependency. For her, finding herself and her connection with spirituality represented a new kind of freedom, but one that came with feelings of embarrassment, confusion and challenge.

Employee of the year

Katy during her time volunteering and working at Birchwood.

"I got clean 1 year after my partner's death, by attending Birchwood Treatment centre."
"When I got clean, I wanted to give back and wanted to give back to Birchwood."
"I went to Birchwood because I wanted to work on the front lines of drug dependency, so I was really intrigued by the detox centre [...] They were very proud of me and I was proud to volunteer and to work there, I loved my job at Birchwood, I really, really did. They were very good to me [...] The staff there helped me so much, with learning to use computers, and now I can use my own laptop - I think it shows the possibility of how far you can come [...] I now consider myself to be a productive member of society."

Volunteering at Birchwood and gaining the award for 'employee of the year' signified a big step in her recovery journey. For Katy, volunteering was a key stepping stone into employment and helping other people with addiction. Katy describes "being given a chance" as a contributing factor to her success. Having a workplace ran by other people in recovery, she was free from the fear of judgment and able to gain key skills that laid the foundation for her readiness for full-time employment.

Full circle

Nightingales Recovery Café, Birkenhead.

"Us lot are gifted, put us to work in the community and we shine."
"We have done terrible harm to our family, the community around us, our loved ones and ourselves, but you put us to work in the drugs services, detox centres, homeless shelters, and we shine from within, employment gives us people in recovery a chance."
"We understand how people in recovery feel, no self-worth, no confidence, you're judged all your life, the stigma, but in recovery we come into our own."

Katy engaged with Nightingales café when she first entered recovery. From attending the café and making connections on the ground floor, she now works as a Group Facilitator and Recovery Coordinator at Change, Grow, Live (CGL). Katy told us that full-time employment at CGL gave her a sense of purpose and routine, enabled her to pay bills and feel like a contributing member of society. This parallel represents the 'levels of recovery' Katy has passed through, coming full circle in her recovery journey.

Passport to a new life

New experiences travelling abroad. Sunrise at the Temple of Poseidon, Athens.

"I love my job, it gives me purpose, routine and pride."
"I want to be a responsible part of society in the best way I can be."
"I earn my own money, I pay my own bills, life is great now."
"I couldn't believe it... at 46 getting a passport, something other people take for granted."
"I'm 51 now, I've probably got 20 years of good life left, I have to make the most of this now."

Katy's recovery and subsequent employment have enabled her to do activities she "never thought possible in addiction". In 2019, Katy bought a passport for the first time in her life. For her, this marks coming a long way, after never thinking she'd be able to travel, she tells us "recovery and employment opened that door for me. A door that had previously been closed due to addiction - the document means more than a travel pass for Katy, but signifies a passport to freedom and possibility.

Experiencing the sunrise abroad brings her "a feeling of peace", "a sense of connection to something bigger", and the start of a new and hopeful chapter in her life.

Chapter 6

What Lies Ahead

Emerging challenges in tackling addiction

This chapter explores the challenges that Wirral is facing in responding to the changing face of addiction. We explore these through a series of common themes.

Demographic, social and economic factors

- Addressing social determinants like poverty, unemployment, and social isolation is essential as they increase addiction risk and hinder recovery. Focused efforts are needed.
- Prevention must consider issues like deprivation, trauma, poor mental health, peer pressure, and adverse childhood experiences.
- Providing realistic hope for a better future, making the move from addiction to sustained recovery seem believable, desirable, and attainable.
- Addressing complex needs of ageing long-term substance users in Wirral is a pressing challenge.
- Changing substance use patterns, such as drinking at home or online gambling, make addiction more hidden and harder to identify.

Licensing, regulation and enforcement

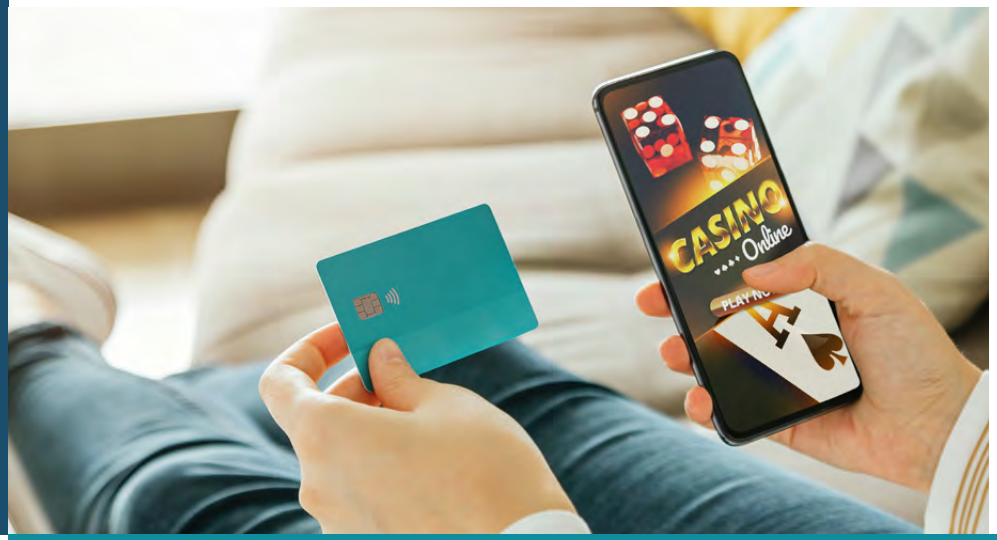
- Effective policy and regulation are vital. Future challenges include keeping pace with emerging products and technologies like e-cigarettes/vapes, online gambling, or buying drugs online.
- Inconsistent regulations and policies regarding the diverse range of substances complicates prevention and treatment efforts. Adaptation of policies is necessary.
- Increasing recognition of the prevalence of “drug driving” alongside “drink driving” and the risks this presents.
- Strengthening partnership work with Licensing and Trading Standards colleagues to better manage availability and accessibility of alcohol through retail outlets and reduce illegal sales of other products.

Mental health and addiction

- The relationship between mental health and addiction is complex. Providers need to work closely together to integrate service provision.
- Individuals with co-occurring disorders face institutional barriers in accessing treatment, often exacerbated by stigma. Efforts must focus on reducing stigma, removing barriers, and improving access.
- Remove the acceptance of front line health and care staff having a smoke with patients.
- The COVID-19 pandemic intensified mental health struggles, leading to increased substance use. Future strategies must prioritise integrated care approaches addressing both mental health and addiction.

Industry tactics

- Tobacco, alcohol, and gambling industries employ sophisticated marketing strategies that undermine public health efforts. For instance, the gambling industry associates gambling with popular sports, normalising addiction among younger age groups. Similarly, the tobacco industry targets younger populations with vape promotions.
- The rise of online access and an industry push to switch to online removes the physical constraints and barriers to marketing. For example, betting on the internet or home delivery makes it easier for increased and underage access. This is particularly true for gambling but it is also becoming an increasingly significant issue for drug use.



Managing demand and supply

- Greater access, availability and affordability of substances/ behaviours make them easy to access and harder to police.
- New products create new demands and changing behaviours. For example, synthetic and potent drugs regularly emerge and this increases overdose and death risks. Young people are more commonly using snus (oral tobacco pouch) and nicotine pouches and the gambling industry regularly develop “new products” to attract more people to gamble more. Younger users are often drawn in with little understanding of the risks.
- Involvement of organised crime in drug supply and the recruitment of young people to support this business causes damaging impacts on communities, including intimidation and violence, mostly in socially deprived areas.
- Addressing illegal activities will provide ongoing challenges e.g. under age sales for tobacco and addressing the potential increase in illicit trade once disposable vapes are banned in 2025. Additionally, drug use drives up types of acquisitive crime to fund the habit, causing damage to communities and businesses.

Access to quality treatment and support services

- Ensuring our services are able to address the changing needs of the population especially the complex health needs of ageing long-term substance users with multiple co-morbidities.
- Ensuring more people engage with treatment across all addiction services is necessary.
- Developing addiction services so that they have an identity, profile and a varied offer that is attractive to and engages with the many profiles of people who will need to access support and services. For example, developing offers relevant to users of drugs other than opiate/crack cocaine, such as Ketamine and Spice.
- Reducing pressures on the health and care system, including the number of presentations to A&E due to drug and alcohol poisonings and the impact on adult social care.
- The non-linear path to recovery, with potential relapses, can be discouraging and challenging.
- Ensuring messages are widely understood and recognising that recovery is a personal journey with self-determined aims and goals that everyone could make if they chose to accept the support, but recognising not everybody will.
- Training healthcare providers to recognise and address addiction is crucial for integrating care into primary healthcare and other settings.
- Increasing the focus on gambling addiction.

Public awareness, education and lobbying

- Raising public awareness and addressing conflicting messages about addiction risks, and harms, remain ongoing challenges.
- Securing a better understanding of other addictions and their harms, including addiction to social media and gaming.
- Future public health campaigns must leverage digital platforms and social media to reach younger audiences.
- Integrating education about addiction into school programs so children are equipped with essential knowledge. Also maximising opportunities for positive peer influence.
- Education and supportive policies aimed at reducing stigma are integral to fostering a society where those affected can seek help without fear.
- Driving increased uptake of the “Lower My Drinking” app to promote healthier alcohol consumption.

Partnerships, collaboration and funding

- Short-term investments create uncertainty over funding, potentially compromising progress and improvements.
- No direct investment for addressing gambling harms.
- Public health systems must continue to collaborate with statutory providers, voluntary, community, faith, and social enterprise (VCFSE) sector organisations, and wider system partners to develop cohesive strategies, despite system-wide financial pressures.

Chapter 7

Moving Forward

Where do we go from here?

So far, by examining various forms of addiction together, rather than in isolation, we have a better understanding of the shared underlying causes and impacts on individuals, family and communities and see how addictions can co exist, not only with other addictions, but also with other morbidities.

We also observe how the system has evolved in response to the challenges and how new issues continuously emerge. This report now offers a unique opportunity to set out key priorities that will enable the system to amplify its work by creating a stronger, integrated and effective system response, across all of types of addictive behaviours, that makes best use of resources.

What can we do differently or better?

Theme 1:
Placing a greater focus on addressing gambling-related harms.

To level up our response to gambling harms, Wirral system partners need to integrate comprehensive strategies similar to those used for other addictions. This includes increasing public awareness, providing accessible support services, and implementing robust prevention and intervention programmes.

By addressing gambling harms with the same urgency and resources as other addiction issues, we can create a more balanced, proportionate, and effective approach to minimise this often hidden but growing problem.

Key first steps may involve Wirral system partners collectively signing up to the Gambling Workforce Charter and championing local action to reduce gambling-related harm.

Theme 2:
Building a positive culture to reduce addiction-related harm through our partnerships.

Wirral already has strong partnerships in place but may benefit from creating closer collaboration with an extended range of partners to address the wider breadth of addiction. One mechanism may be extending the remit of the Combatting Drug Partnership to cover all addictions, allowing for better integration, governance, and oversight of addiction in Wirral. The partnership will then be best placed to address future challenges, including protecting the next generation from addiction-related harm. For example, by actively working to reduce stigma across all addictions, we can create a more inclusive society where individuals feel empowered to seek help and support.

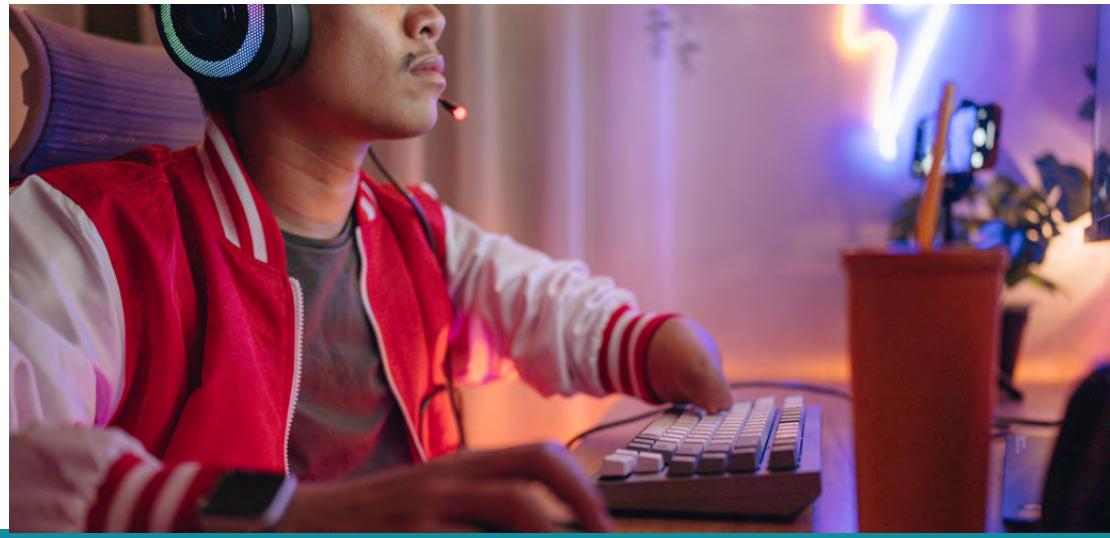
Theme 3:
Addressing the wider determinants of health.

It is essential to broaden our focus beyond treatment services to include the wider determinants of health. Factors such as education, employment, social support networks, and physical environment significantly influence outcomes, acting as protective factors or, in their absence, risk factors for addiction. Investing in initiatives that address these underlying causes, such as improving access to education and awareness programmes about the risk of addiction, enhancing job opportunities, and fostering supportive and safe environments that discourage substance use is key. This, in addition to advocating for policies that regulate the availability and marketing of addictive substances, including restrictions on advertising and sales, will not only enhance individual health but also build resilient communities capable of sustaining improvements over time, enabling them to live free from addiction-related harm.

As a starter, directorates within Wirral Council will work together to identify opportunities to strengthen approaches to reducing addiction-related harm; role modelling new ways of workng.

Theme 4:
The impact of online forms of addiction need far more exploration.

Addictions are increasingly becoming hidden in the online world. The anonymity and accessibility of the internet make it easier for individuals to engage in addictive behaviours without immediate detection. This includes not only online gambling but also new areas of concern such as addiction to gaming and social media use. We need to better understand these emerging issues and design effective interventions, informed by evidence. For example, Australia has recently passed a groundbreaking law banning social media use for children under 16. This legislation, which is the first of its kind globally, prohibits platforms like TikTok, Facebook, Snapchat, Reddit, Instagram and X from allowing users under 16 to hold accounts.



Theme 5:
Developing integrated prevention and treatment models and community-based support.

A unified approach to addiction requires the development of integrated prevention, treatment and recovery models that are able to make connections and address multiple addictive behaviours simultaneously. Our systems have already moved away from operating in silos, but more can be done. By fostering greater collaboration among our providers, we can create comprehensive care pathways that consider the complexities of co-occurring addictions. It will be particularly important to include areas such as Mental Health, Primary Care Networks and colleagues from other Council teams (e.g. Licensing and Trading Standards colleagues).

Equally, prevention is a critical component of addressing addiction. Educational initiatives will need to better inform communities about the risks associated with various addictions and promote healthy coping mechanisms. By targeting at risk populations, particularly youths, we can reduce the incidence of addiction before it starts.

Theme 6:
Maintaining sufficient level of investment.

We have previously seen the impact that new and greater investment has on the ability of services and systems to effectively meet the needs of those affected by addiction. As referenced in the report, the Heroin epidemic and the fear of HIV produced a strong new investment in drug services in the early 1990's, and this resulted in enabling an effective response to be made to the issues being presented. This saw the spread of HIV being contained, drug related crime significantly reduced, increasing numbers of drug (and alcohol) users being supported out of their addiction and onto their recovery, and eventually the numbers of new heroin users tailing off. We have also seen some of these trends reverse and a lot of these gains lost, over the years from 2010 to 2020. Advocacy at policy level to secure funding and resources for addiction services will remain important. Coordinating efforts across wider footprints to lobby for better policies/funding will be key.

Addressing addiction as a unified public health issue requires multifaceted approaches. By working collaboratively across sectors, we can create a more effective system that not only prevents and responds to addiction but also fosters resilience and recovery within our communities. The time to act is now and together we can reduce the number of people who become addicted and illuminate the path from addiction to recovery, from darkness to light, for those affected by addiction.

Where to get help?

Local help and support

ABL
Wirral's stop smoking service, providing free personalised support to stop smoking through a 12-week quit programme run by expert advisors and free nicotine replacement therapy.
www.smokefreewirral.co.uk | 0151 541 5656

Alcoholics Anonymous
Multiple Wirral sites – The purpose of AA meetings is to stay sober and support others who are trying to get sober following a 12-step programme.
www.alcoholics-anonymous.org.uk | 0800 9177 650

Beacon Counselling Trust
A North West based education, treatment and support charity, providing free counselling for anyone affected by gambling harms and a suicide bereavement programme.
www.beaconcounsellingtrust.co.uk/get-support/
0151 226 0696

Citizens Advice Wirral
Telephone, online and face to face help with a range of subjects that include the management of debt, problems with housing and rent, relationship issues and consumer rights.
www.citizensadvicewirral.org.uk | 0808 2787848

Drug Talk
Accessible drug and alcohol harm-reduction information for people from ethnic backgrounds living in Wirral. Available in over 100 languages.
www.drugtalk.co.uk

Gamblers Anonymous
Provides a safe space to share experiences, strength and hope with each other to solve gambling addiction and to help each other overcome similar problems.
www.gamblersanonymous.org.uk

Narcotics Anonymous
Meetings are where members learn from one another how to live drug-free and recover from the effects of addiction in their lives.
www.mana-ukna.co.uk

Response
A confidential service for young people aged 13 to 19 years old offering a wide range of support for young people who are struggling with substances, alcohol, or their mental health.
www.zillowirral.co.uk/response | 0151 666 4123

Let's Talk
Wirral's NHS risk and resilience service works closely with young people to develop their knowledge, skills, and confidence to make informed decisions about their health and wellbeing.
www.wchc.nhs.uk/services/letstalk/ | 0151 514 0219

Wirral Info Bank
Wirral's directory of community groups, services, and activities that can support your health and wellbeing.
www.wirralinfobank.co.uk

Wirral Ways – CGL
A free and confidential drug and alcohol service which provides a non-judgemental service, with qualified, experienced staff and volunteers who offer support in health and wellbeing and substance misuse. They offer information, treatment and support to help an individual reduce their substance misuse or become abstinent.
www.changegrowlive.org/wirral-ways | 0151 556 1335

National help and support

Adfam
The leading charity in England for all the millions of people affected by someone else's drinking, drug use or gambling.
www.adfam.org.uk

National Gambling Helping
Run by GamCare – call 0808 8020 133 for free 24 hours a day, 7 days a week for free information, support and counselling.
www.gamcare.org.uk

Samaritans
Provides 24 hour support and advice
www.samaritans.org | 116 123

Talk to Frank
Honest information about drugs and confidential advice via text, email or phone for yourself or someone you know. Find local and national services in England that provide confidential information, advice and support.
www.talktofrank.com | 0300 1236600

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