

DDN

Drink and Drugs News
November 2026
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THINK DIFFERENTLY

FINDING NEW WAYS TO GET RESULTS

PRIORITISING WELLBEING
More than a 'nice to have'

COMPLEX COMBINATIONS
The age of hidden dependence

BREATHING SPACE
Natural healing

Exchange Supplies

Harm reduction innovation

by the field, for the field



PUBLICATIONS

FREE NICE APPROVED E-LEARNING

INNOVATION

EMPLOYMENT OF PEOPLE WHO USE DRUGS

EXCHANGE SUPPLIES

TOOLS FOR HARM REDUCTION

DDN

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IN THIS ISSUE



INSIDE

4 **NEWS** Alcohol deaths fall in Scotland; government rough sleeping pledge
10 **WELLBEING** Space for women
11 **MENOPAUSE** Simple actions to help
12 **ADVOCACY** Hidden dependence
18 **WOMEN** Facing impossible choices
19 **EQUALITY** Wellbeing for all
24 **APPG** Strategy with Dame Carol Black
25 **LETTERS & COMMENT** Your say









'A personal journey of healing and growth... It goes beyond quitting a substance, it's about building a life I could enjoy.'

Ste, volunteer at Acorn, from our DDN partner updates at **drinkanddrugsnews.com**

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How many chances do we give to engage?

A perspective from Ireland gives us fresh insight into diverting people away from the criminal justice system (page 6). What are the practicalities of implementing a health-led approach? How many 'chances' do we give people to engage with health services? How quickly can we join up people with screening and interventions? How can we make sure resources aren't pulled away from others who need them? And how can we judge these schemes on the broader definition of success – including engagement with the wider range of support services including housing – rather than just the referral numbers? These questions preoccupy us up and down the country – so why are we so cautious about keeping health and wellbeing at the centre of drug policy, justice policy, rehabilitation policy?

One thing we can be sure of – keeping respect, empathy and kindness at the forefront of services brings culture change from the grassroots. So while we wait for a stronger steer from Westminster, let's keep sharing what works well.

Claire Brown, editor
www.drinkanddrugsnews.com and @DDNmagazine



Scotland sees 3 per cent fall in alcohol-specific deaths

The number of deaths wholly attributable to alcohol fell by 3 per cent in Scotland last year, according to the latest figures from National Records of Scotland (NRS). There were 1,152 alcohol-specific deaths registered in 2025, with a slight increase in the number of deaths among females. However, the death rate among men is still twice that among women, NRS points out. While the alcohol-specific death rate in the most deprived communities has also fallen, it remains nearly five times higher than in the least deprived.

Scotland and Northern Ireland continue to have the highest rates of alcohol-specific deaths in the UK, while the latest set of Scottish drug-related death figures showed an 11 per cent increase on 2024. 'The number of deaths this year is the lowest from 2020 onwards and well below the peak of 2006,' said NRS head of vital events statistics Phillipa Haxton. 'However, the rate of deaths is around 1.7 times as high as 1994 when records for this series began.'

Despite the small decrease the number of deaths 'remains far too high,' said alcohol minister Maree Todd. 'The Scottish Government and its partners are making progress in tackling alcohol harms, but we must do more. That's why we are providing record levels of funding of over £160m this year for alcohol and drugs programmes, widening access to treatment and residential services, and improving pathways through detox, crisis care and stabilisation.' A new alcohol harm prevention plan would be published soon, she added.

While the fall was good news, the Scottish Government had 'rightly' described the situation as a public health emergency, said Alcohol Focus Scotland chief executive Carolyn Lochhead. 'We're yet to see a response matching the scale and urgency required. The recent alcohol and drug strategy commits to improving treatment and services, which is vital. But to make real change, we need to give equal priority to preventing people from needing these services in the first place. We want to see that happen as part of a comprehensive prevention plan, with action to keep controlling alcohol prices, restrict advertising and reform the licensing system.'



alcohol-focus-scotland.org.uk

'We're yet to see a response matching the scale and urgency required.'
CAROLYN LOCHHEAD

Alcohol-specific deaths 2025 available at www.nrscotland.gov.uk

Tik Tok 'failing to address drug sales'

THE VAST MAJORITY OF TIKTOK ACCOUNTS identified as connecting their users to people selling drugs in the UK were still accessible two weeks after being reported, says a study led by researchers at the University of Bath.

The social media platform returned a finding of 'no violation' on 95 per cent of accounts reported for suspected breaches of rules on advertising illegal drugs, says *A prospective audit of TikTok's response to UK drug-selling accounts*.

The research team carried out what they believe to be the first independent real-time audit of how a major social media platform responds when users report accounts they believe to advertising drugs for sale. Between February and July researchers identified more than 450 UK-facing TikTok accounts that offered to supply drugs, with references to substances including spice, cocaine and controlled medicines – all displayed UK targeting, a 'drug-related cue', and an 'offer or route to supply'.

The researchers then used the in-app reporting function to notify TikTok. The platform returned an 'explicit "no violation" decision' for 95 per cent of reports, with 83 per cent of the accounts remaining publicly accessible after 14 days.

The report stresses that the findings 'should not be interpreted as evidence that all drug selling content escapes detection by TikTok', with the platform reporting the removal of large amounts of content through its own monitoring systems. The study, however, was examining 'what happens when a user directly reports an account' that appears to be involved in illegal drug supply.

'Platforms often publish impressive statistics showing how much content they proactively remove, but these tell us very little about whether a platform acts when a user directly reports apparent criminal activity,' said study lead Professor Chris Pudney. 'That gap should be tested, not assumed away.'



Iryna Shatilova / Dreamstime

Between February and July researchers identified more than 450 UK-facing TikTok accounts that offered to supply drugs.

Report available at www.sciencedirect.com

Government pledges extra £430m to end rough sleeping

The government has announced new funding of £432m to end rough sleeping, taking the total investment to £874m.
The prime minister had 'set out his confidence that everyone sleeping rough will be offered a route off the street or wider support before Christmas', the government states, with the extra £432m extending support to the end of this Parliament.

The government also held the first rough sleeping summit at Downing Street, attended by housing providers, businesses, charities and others. The National Housing Federation is working with housing associations and local councils to identify at least 2,000 potential homes and bedspaces, including empty homes for people moving off the streets, while the Salvation Army is also developing social housing and move-on options – 'including provision for people with complex needs for whom mainstream accommodation may not be suitable'.

According to the Museum of Homelessness, more than 1,700 people died while homeless last year – almost 7 per cent up on 2024 – with over 30 per cent of the deaths either on the streets or in rough sleepers' accommodation. More than half of the total number of fatalities were classed as 'deaths of despair' – the result of drugs, alcohol or suicide.

The doubling of funding was a 'vital step towards sustaining progress for years to come', said St Mungo's CEO Emma Haddad. However, the key would be 'to build trusted relationships with people facing the most complex barriers to ending their homelessness and rebuilding their lives. Whether that's poor physical or mental health, domestic abuse, or alcohol or substance use support needs, we know from our work that this takes time. Offers of a route off the streets will need to be person-centred and go hand in hand with patience and the right kinds of support.'

> More than 1,700 people died while homeless last year – almost 7 per cent up on 2024...

Over a third of Welsh prison leaver deaths 'are drug related'

THIRTY-SEVEN PER CENT OF DEATHS AMONG PRISON LEAVERS supervised in the community in Wales last year were the result of drug poisoning, according to a report from Cardiff University. The proportion is 'substantially higher' than for England and Wales as a whole, the researchers point out, where the figure stands at 21 per cent.

There was also an almost 25 per cent increase in prison leavers supervised by the Welsh probation services sleeping rough on the day of their release, to almost 700 people. Overall, there were nearly 420 drug poisoning deaths registered in Wales in 2024, 288 of which were drug misuse deaths – the highest number ever recorded.

'No one should lose their life to drug use whether inside or outside of prison,' said operations director for Kaleidoscope, Mike Vigar. 'Everyone should be able to access effective support, regardless of their gender, ethnicity, or experience of the prison and criminal justice system.'

Prisons, punishment and sentencing in Wales is available at www.cardiff.ac.uk

Tobacco industry 'exaggerating' size of illegal market to fight stricter legislation

TOBACCO COMPANIES are exaggerating the scale of the UK's illegal cigarette market to lobby against tobacco taxes and tougher smoking legislation, claims a report from ASH.

The number of illicit cigarettes smoked in the UK has fallen by almost 90 per cent since 2000, the charity states, despite cigarette prices more than tripling over the same period. While HMRC estimates that around 12 per cent of UK cigarettes are illicit, a KPMG report from June commissioned by Philip Morris International puts the figure at 45 per cent.

'Exaggerated claims' about the black market and legitimate concerns about organised crime involvement in the illicit tobacco trade are being used by the industry to undermine taxation and new legislation designed to create a 'smokefree generation', says ASH, with tobacco companies repeatedly warning that higher taxes and tougher laws will lead to a dramatic rise in illegal sales. Organised crime involvement in the illicit tobacco trade has led to violent turf wars in Australia and elsewhere. Claims from industry-funded reports have been 'widely reported' in the media as well as repeated in Parliament during debates on the Tobacco and Vapes Act, says ASH.

Beyond the headlines: the reality of illicit tobacco in the UK available at ash.org.uk.

Local News



FAMILIAR FACES
More than 220 people attended the annual Abbeycare recovery gathering in Gloucestershire, with contributions from clients, family members and staff. 'Seeing so many familiar faces come back through the door, looking healthy, happy and full of hope, is a powerful reminder of why we do what we do,' said Abbeycare Gloucester manager Tim Pope. (*See feature in DDN, October, page 24.*)

NHS
The Veterans Mental Health and Wellbeing Service
OpCOURAGE

OUT IN FORCE
Op COURAGE, a specialist mental health team for veterans in the South East, has developed a new pathway that includes peer support recovery groups led by lived experience practitioners. The team recently showcased its approach at the Royal College of Psychiatrists. *www.opcouragesoutheast.nhs.uk/treatments*

SURREY SUPPORT
A new app has been launched in Surrey for people sleeping rough or at risk of homelessness. Created by i-access, which is run by Via and Surrey and Borders Partnership NHS Foundation Trust, it offers treatment options, BBV testing, Citizens Advice Bureau support and more.



Ireland has recently introduced a Health Referral Scheme for people found in possession of drugs for their own use. **Tony Duffin** explains how Ireland got here, what the scheme does, and what questions are yet to be answered

CREATING A DIVERSION

Since the beginning of September, under Ireland's new Health Referral Scheme, an adult found by Gardaí (the Irish police) in possession of drugs for personal use for the first time may be referred to the Health Service Executive (HSE) rather than prosecuted.

This is not decriminalisation, however. Possession of controlled drugs for personal use remains a criminal offence under section 3 of the Misuse of Drugs Act 1977. So what's changed, and what hasn't?

Ireland's 2017–2025 national drugs strategy committed the government to a health-led approach. A working group set up under it reported in 2019, with diversion to health services one of the recommended options – people found in possession would be referred to the HSE for a screening and brief intervention known as SAOR (support, ask and assess, offer assistance, refer). The government decided to implement a health diversion approach and, separately in December 2020, the Gardaí's adult caution scheme was extended to possession of cannabis. Between December 2020 and February 2024, 5,139 people were cautioned for cannabis possession, while 17,125 were charged or summonsed.

Diversion

Diversion refers to non-punitive mechanisms that redirect individuals away from the criminal justice system and towards health or social interventions, such as assessment, counselling, treatment or social reintegration.

CITIZENS' ASSEMBLY

Meanwhile, the debate moved on. In 2023, a Citizens' Assembly on Drugs Use brought together 99 members of the public, randomly selected to reflect the population, with its report published in January 2024.

The assembly rejected the status quo, with just 13 per cent voting to keep the current legal approach to possession. Recommendation 17 called for a 'comprehensive health-led response to possession of drugs for personal use'. Under that model, possession would remain illegal, but people would be offered, first and foremost, extensive opportunities to engage voluntarily with health services.

A Garda would refer the person directly to an SAOR brief intervention. Depending on how it was legislated, the approach could minimise, or potentially completely remove,

AG News / Alamy



People listen to panelists at The Citizens' Assembly on Drugs Use at Dublin Castle in 2023. Panelists met over six weekends, from April to October, and heard from 130 speakers. Niall Carson / Alamy.

Two committees, formed under two different governments, have reached the same conclusion. But they can only recommend. Policy is set by government, through the national drugs strategy.

the possibility of a criminal conviction and prison sentence for simple possession. The assembly pointed to Portugal and Austria, and set out questions for the Oireachtas (Irish parliament) to consider in balancing three objectives – health diversion, dissuasion and decriminalisation. One such question was how many times a person should be diverted.

A citizens' assembly advises, however – it does not legislate. Its report went to a cross-party Joint Committee on Drugs Use, made up of TDs and senators, members of the Dáil and Seanad – Ireland's lower and upper houses. That committee's interim report, in October 2024, called for the decriminalisation of the person for possession of all substances for personal use, and recommended the repeal of section 3, the possession offence. It warned that mandatory health referrals risk perpetuating stigma and would likely draw limited resources away from those who need them most. No one found in possession, it said, should be criminalised for not availing of a supportive intervention.

DEPENALISATION

A general election followed and that committee lapsed. A new Joint Committee on Drugs Use was formed under the current government with its final report, published this summer, reaching the same conclusion. Recommendation 126 calls for the repeal of section 3 'in order to fully decriminalise the possession of drugs for personal use'.

The committee also addressed diversion directly – pending reform of section 3, it said any health diversion scheme should be voluntary, reflect the principles of depenalisation, impose no arbitrary limit on the number of referrals a person may receive, and be independently evaluated. It warned that HSE staffing levels were likely to be insufficient to meet demand.

So two committees, formed under two different governments, have reached the same conclusion. But like the citizens' assembly, they can only recommend. Policy is set by government, through the national drugs strategy. That new *National drugs strategy 2026–2030* was launched last month, and the Joint Committee's final report had asked that it

THE ROAD TO THE HEALTH REFERRAL SCHEME, 2015–2030

2015 An Oireachtas justice committee visits Portugal and recommends that possession of small amounts of drugs for personal use could be dealt with by a civil or administrative response, rather than through the criminal courts.

2017 In July, the then taoiseach (prime minister), Leo Varadkar, launches the national drugs strategy, *Reducing harm, supporting recovery 2017–2025*, at Dublin Castle. It commits to a health-led approach and to a working group on alternatives for possession.

2019 The working group reports and the government decides to implement a health diversion approach.

2020 In December, the Garda adult caution scheme is extended to possession of cannabis.

2021 Mid-term review of the 2017 strategy.

2023 From April to October, the Citizens' Assembly on Drugs Use meets over six weekends and hears from 130 speakers.

2024 In January, the assembly publishes 36 recommendations. The health-led option on cannabis beats legalisation and regulation by a single vote on the final count, 39 to 38. In October, the Joint Committee on Drugs Use publishes its interim report, calling for decriminalisation. The committee lapses with the general election.

2025 Independent evaluation of the 2017 strategy. The successor strategy is due by the end of the year. After the new committee's chair asks that it not be finalised before the committee reports, the minister agrees to take account of its recommendations.

2026 In February, a draft national drugs strategy is published for public consultation. On 24 June, the new Joint Committee on Drugs Use publishes its final report; Recommendation 126 calls for the repeal of section 3 of the Misuse of Drugs Act 1977. On 1 September, the Health Referral Scheme begins as a pilot. On 13 October, the *National Drugs Strategy 2026–2030* is launched, with a first two-year action plan of 33 actions.

2030 The *National Drugs Strategy 2026–2030* will conclude.

Depenalisation

Depenalisation means removing or ceasing to apply criminal penalties for low-level, personal possession and involves keeping the law in place but choosing not to enforce criminal punishments, or removing the penalty altogether, even though the behaviour technically remains prohibited in law.

To be offered a referral, a person must:

- be over 18
- be facing a first-time drug offence
- admit possession of what they believe to be a controlled drug
- be willing to take part
- be someone for whom Gardaí believe prosecution is not in the public interest.

The decision rests with a superintendent, or an inspector acting in that capacity. Previous convictions for other, non-drug offences do not automatically exclude someone, but a recent one – or more than one – points to unsuitability. Reasons for not offering the scheme must be recorded. Gardaí and members of the defence forces are excluded.

commit to diversion, dissuasion and decriminalisation. It does not commit to decriminalisation – instead, the government presents the Health Referral Scheme as its response to the assembly's call for a health-led approach to possession.

APPROVED PILOT

The police describe it as a pilot, approved by the director of public prosecutions under section 10 of the Policing, Security and Community Safety Act 2024. It applies to offences committed on or after 1 September 2026. Formally a separate scheme, it is closely modelled on the adult caution scheme, but extends to all drugs and offers a referral to the HSE in place of a caution. Garda policy says a second offence may be dealt with by an adult caution, but only for cannabis. For any other drug, a second offence can still lead to prosecution. The new national drugs strategy commits to reviewing whether other drugs should be included.

A person who accepts the referral is told how to self-refer, and must contact the HSE themselves to arrange an SAOR brief intervention. The case is then closed without prosecution; a person who declines faces prosecution or, for cannabis, possibly an adult caution.

QUESTIONS RAISED

So what questions remain? It's too early to judge the scheme, but its design raises questions the pilot will need to answer. Four stand out.

The first is reach. The scheme applies only to a first possession offence, and a referral is offered only once. The assembly envisaged extensive opportunities to engage; the committee's final report argued against arbitrary limits. Anyone found in possession a second time is outside the scheme, whatever their current health needs. Will the scheme reach those experiencing the greatest harm?

The second is admitting the offence – no admission, no referral. The adult caution for cannabis has the same requirement and, as noted above, has been used far less often than charges. The government says there's no sanction if a person doesn't attend the intervention. Garda policy says the referral will not count as a previous conviction or appear on vetting, but may be made known to a court in later proceedings if the judge asks. Will people understand this when deciding whether to admit possession, and will the evaluation examine whether admission is a barrier?

The third is discretion. Under the 2019 government decision, referral on a first occasion was to be mandatory. In February 2026, a Garda assistant commissioner told the Oireachtas committee that referral would be automatic for anyone who admitted possession and wished to take part. Garda policy now leaves the decision to a superintendent, applying a public interest test. Will it be applied consistently?

The fourth is access. The person must arrange the intervention, and the HSE says it can be delivered in person or online – however, online needs a phone or internet access, and in person means travelling. Both can present barriers, and in both cases the person has to make contact themselves and follow through. The joint committee warned that HSE staffing was likely to be insufficient; it is understood that nine full-time staff deliver the intervention nationally. Will people be able to access the screening and brief intervention, and how quickly?

BROAD CRITERIA

The Health Research Board will monitor the pilot through its first year, and it will then be independently evaluated. This echoes the 2019 Working Group, which recommended that any new approach have data collection, evaluation and scope for modification. The Oireachtas committee has asked that schemes like this be judged on a broad definition of success, including health, housing and engagement with services, not referral numbers alone.

The government says it has accepted the citizens' assembly recommendation for a comprehensive health-led response to possession. But accepting a recommendation is not the same as implementing it. The Health Referral Scheme is not the model the people on the Citizens' Assembly described, nor the decriminalisation the politicians on the two committees recommended. Whether it is fit for purpose, time will tell.



www.oireachtas.ie

In June 2026 the Oireachtas Joint Committee on Drugs Use published its final report in which Members recommend the repeal of section 3 of the Misuse of Drugs Act 1977 in order to fully decriminalise the possession of drugs for personal use.

Committee Cathaoirleach Deputy Gary Gannon said: 'The Committee has concluded that the personal possession of drugs for one's own use should cease to be treated as a criminal matter and should instead be met with a health-led approach. This is not a marginal adjustment. It is a recognition that criminalising people for their own drug use has not reduced harm, and that a different approach is both possible and overdue.'

Progressify

Tony Duffin leads Progressify, an independent social policy and public health consultancy, is an adjunct teaching fellow at Trinity College Dublin, and co-hosts *Dealing with drugs*, a Hot Press podcast. He was independent chair of Strategic Implementation Group 5 (Alternatives to Coercive Sanctions) under Ireland's *National Drugs Strategy* until it concluded its work at the end of 2024

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A show garden from the Chelsea Flower Show has found a permanent home at The Elms, soon to be the UK's first women-only detox centre. **Jane Simons** explains why outdoor space belongs in women's detox



ROOM TO BREATHE

Five months ago, a garden that had spent a week in the spotlight at the RHS Chelsea Flower Show arrived somewhere much quieter.

The Boodles Garden, designed by Catherine MacDonald and inspired by the gardens of historic royal palaces, was built around ideas of retreat and restoration. In late May, parts of it were replanted in the grounds of The Elms, in the countryside on the Gloucestershire/Worcestershire border. Its pavilion, a young tree, perennials in deep purples and reds, and a rill reworked as a planter now have a permanent home.

Our gardeners have looked after it all summer, and it's settling in well. By the time The Elms opens towards the end of 2027, it'll be established. That matters, because the garden isn't for visitors anymore. It's for the women who'll stay with us.

The Elms will be the UK's first women-only inpatient detox centre. It'll have 16 beds and support around 104 women a year, offering medically managed detox in a psychologically informed setting.

Many *DDN* readers will recognise the picture. One in two women engaging in treatment have experienced domestic abuse. Drug and alcohol-related deaths among women are rising. Caring responsibilities, fear of losing children, and stigma that lands harder on women stop many from asking for help at all.

For some women, a mixed residential setting is a barrier in itself. One woman told us that she 'wouldn't have had the courage to stay at a residential detox with men' while another said that 'being with other women, in a safe space where we can talk about our experiences and feel able to share, is so important. It can be really triggering being with men in a group, especially when men have harmed us in some way.'

When we ran focus groups with women with personal experience of detox and rehab, one thing stood out. Their expectations of what a detox should look like were low. They asked for things most of us take for granted – being able to shower whenever they needed to during withdrawal. An en-suite, for privacy when they felt unwell. A bed bigger than a single. A lamp, a shelf, a corkboard for photos. Light, fresh colours. No darkness.

> One in two women engaging in treatment have experienced domestic abuse. Drug and alcohol-related deaths among women are rising.

For some, those low expectations reflected how they'd come to see their own worth. So we set ourselves a different bar. We want indoor and outdoor spaces that tell every woman, from the day she arrives, that she's worth this care and attention.

Medically assisted withdrawal, or detox, can be exhausting – not only for the body but for the mind. As substances leave the body, feelings that have been held down for a long time can return quickly. We want to provide a space where women feel physically safe and are supported to make the changes they want. For the women we spoke to, the outdoors, space and fresh air made a real difference. For us, the garden isn't a treatment in itself. It's part of the setting that helps care feel safe.

The focus groups didn't stop at the front door. Women told us what they wanted outside, too. The garden gives women somewhere to be that doesn't feel clinical. Some will want quiet time on their own, while others will want to sit with women who understand what they're going through. It's a place to take a breath, and to feel that this space was made with them in mind. A seed packet is a small thing – but the women we spoke to liked the idea that someone staying with us might plant something that flowers for the women who come after her.

The Elms is due to open towards the end of 2027. Until then, the building will be refurbished into a warm, safe space, and the garden will keep growing. We're raising £500,000 to complete the refurbishment. If you know someone who might like to support it, we'd love to hear from you.

'Every woman who comes to The Elms will bring her own story, and many will have looked for help before,' says Anna Whitton, Via's CEO. 'We want this to be a place where she feels safe, heard and cared for, wherever she is on her journey. The garden is one way of showing her she's worth that.'

Jane Simons is clinical lead for The Elms. viaorg.uk/theelms

READING THE ROOM



Talking about the menopause can be tricky – for both service users and staff. But a few simple things can go a long way, says **Iniobong Udo**



Hanna Shvets/ iStock

A woman in one of my recovery groups was experiencing menopause, which made it difficult for her to maintain her concentration. To support her, I positioned her seat adjacent to the window and directed a fan towards her, even though the room was not particularly warm. It resonated with her. Every time she spoke, she apologised: 'Sorry, it's the menopause. It's stressing me out.'

I informed her that she had no reason to apologise. My intention was to create awareness – not make this woman feel alone – and at the same time make the conversation comfortable to members of the group, including the men.

No one appeared to be surprised or uncomfortable, of if they were, they didn't express it. I could detect a sense of relaxation in the room, shared by both men and women. Subsequently, she expressed her gratitude for my understanding and for uplifting her spirits. All it needed was a seat, a fan and a few sentences. None of it necessitated a health qualification, nor did it incur any expenses.

In my experience, many women in recovery have already been subjected to judgement, both by themselves and by others. Hot flushes, heavy periods, pain or poor sleep, which are not under their control, can be perceived as an additional source of shame.

Additionally, these symptoms are imperceptible. The dread that accompanies PMS, brain fog or cramps is invisible. So no one enquires and, in the interim, some indicators may be misinterpreted. Low motivation – or a warning sign for relapse – may be misrepresented as poor focus, low mood or irritability when the underlying cause is much simpler.

The silence is reciprocal. The staff may be concerned that it's not their responsibility, or they may have concerns about saying something inappropriate. It's not uncommon for male employees to believe that they're unable to discuss certain topics. Therefore, an issue that impacts half of the attendees remains unaddressed.

Services should include a single enquiry in routine check-ins or reviews and ensure that it's addressed to everyone, not just women: 'Is there anything about your physical state that is complicating this?' Asking everyone maintains a standard tone and gives people an opportunity to express their thoughts without having to raise the issue first.

It's much more difficult for an individual to admit that they had missed an appointment, or they had been in pain for months, if they're unable to say 'it's my menopause' without apologising. They may also find it easier to speak up about other topics in a group setting if there are brief moments of comfort.

I didn't perform any extraordinary actions in that room. I simply listened attentively, made a few adjustments, and publicly declared she'd committed no infractions. The same can be done by any frontline worker.

Iniobong Udo is a public health practitioner at Airedale Voluntary Alcohol and Drug Agency

THERE ARE SOME SIMPLE ACTIONS THAT YOU CAN TAKE

Easily implemented minor modifications. A brief respite, an open window (if needed), a fan and a cooler seat. Perform the task discreetly.

Tell her unequivocally that she's not required to apologise.

Address the entire audience to prevent her from being singled out, and use general terms.

Refer to it as 'normal' and 'human'. Sharing your personal experience can be beneficial, if you're at ease with it.

Enquire as to what would be beneficial. 'What would make you feel at ease in this environment?', and implement her recommendations.

THERE ARE ALSO SOME BEHAVIOURS THAT COULD PREVENT ACCESS

Ignoring it.

Poking fun at the situation to alleviate the tension, which could be perceived as ridicule.

Interpreting it as a lack of effort. Before concluding that someone isn't making an effort, it's important to evaluate whether there are any obstacles that may be impeding their progress.



The increasing availability of substances like nitazenes and xylazine in the drug supply is raising vital questions that extend way beyond any individual substance, says **Riley Johnson**



HIDDEN DEPENDENCE

The UK drug market is changing, and with it comes a challenge that many treatment services are only just beginning to experience. The emergence of substances such as xylazine, nitazenes and medetomidine as contaminants in the market has raised urgent questions for those providing treatment and OST. While often discussed in the context of overdose risk and drug-related deaths, the question of what happens when people become dependent on the contaminants has received far less attention.

Through the Release helpline, we supported an individual who suspected that they were dependent on nitazenes. They had been started on methadone and titrated up, but still experienced significant withdrawal symptoms. TH's drug service explained that they were not comfortable increasing the methadone past 90mg, and that TH's dose should be sufficient based on the amount of heroin they reported using. We supported TH in posting a sample of their heroin for drug testing, and it came up positive for nitazenes. After presenting these results to TH's drug service it was agreed that they would increase the dose but were eager to reduce it again as soon as TH was stable.

Current guidance offers a clear framework for managing opioid dependence. Methadone and buprenorphine remain highly effective treatments, but neither medication is designed to treat dependence on non-opioid adulterants. Nitazenes, which are opioids, can also add an extra layer of complexity. They can in principle be managed through OST, but their potency means that the reported amount of heroin use is often a poor indicator of what the person's tolerance really is.

> The reported amount of heroin use is often a poor indicator of what the person's tolerance really is.

As a result, services increasingly find themselves navigating a clinical territory for which there is little formal guidance. Xylazine is a veterinary sedative with effects that differ significantly from opioids and medetomidine, another veterinary sedative increasingly detected in illicit drug supplies, acts in a similar way. As neither substance is an opioid, neither is addressed by methadone or buprenorphine.

This creates a potentially confusing situation for clinicians and drug workers. Someone may start OST and still report severe anxiety, insomnia, agitation or distress. Historically, practitioners might interpret these symptoms as evidence that the opioid dose is too low or that treatment is not yet adequately stabilised, but what if the symptoms relate to withdrawal that cannot be managed through opioid treatment?

Where drug-checking is available, it can help to identify emerging adulterants which clients may be using, or dependent on. For frontline services, this information can help explain unexpected presentations, unusual withdrawal symptoms and difficulties stabilising on OST. Drug testing strips are becoming more available, often offered in drug services and NSPs, though medetomidine testing strips can be difficult to come by, depending on the area.

At present, evidence regarding dependence on xylazine and medetomidine is still emerging. Much of the available literature comes from North America, and there is no established UK protocol for managing people who are dependent on these substances alongside opioids.

A useful starting point may be to recognise that, while provision of OST remains essential, it may not always be enough. Services may need to ask new questions – do we have up-to-date data on the local drug trends? Are clients reporting longer periods of sedation or experiencing their drugs differently than they are used to? Are withdrawal symptoms presenting differently? Are multiple clients describing similar experiences?

Perhaps most importantly, services should take clients' reports seriously. Someone explaining that the methadone is helping but something still feels wrong, or that they are finding that their heroin is cooking up differently, or affecting them differently, should prompt further exploration rather than assumptions of non-compliance or 'treatment failure'.

While there is currently no consensus on the optimal management of dependence on xylazine or medetomidine, several principles seem likely to become increasingly important. The appearance of xylazine, nitazenes and medetomidine in the drug supply raises a question that extends beyond any individual substance. Increasingly, people may present to treatment dependent not just on the drug they sought to buy, but on a complex combination of compounds added along the supply chain.

People cannot be expected to fit neatly within existing guidance when the drug market itself no longer does. Our responsibility is not merely to treat the dependence we anticipate or that is described in guidance, but the dependence that is actually showing up in treatment services today.

Riley Johnson is drugs support advisor and NSP specialist at Release

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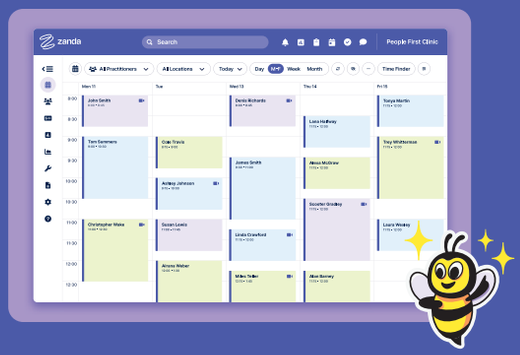
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Ahead of Remembrance Sunday, **DDN** hears about a pilot programme that's bringing a new approach to supporting veterans with substance and mental health issues

FORCE FOR CHANGE

'The armed forces community experiences a unique combination of pressures,' national armed forces lead for WithYou, Andy Craze, tells *DDN*. 'Operational stress, trauma exposure, sudden transition to civilian life, loss of identity, chronic pain – and sometimes fractured relationships.'

According to a study of almost 3,000 veterans by King's College London, while 'the majority' of UK armed forces personnel coped well with military service and its challenges, and successfully adapted to civilian life afterwards, rates of common mental disorders and alcohol misuse were nonetheless close to double that of the general population – a rate that may have been heightened by the fact that many of those in the study had served in Iraq or Afghanistan. However it was something that could not be explained by 'sociodemographic differences between veterans and the general population samples', the researchers pointed out, while a ten-year study in the US found more than a quarter of American veterans to be consuming alcohol 'at the at-risk-to-excessive level'.

Alongside combat-related PTSD and the associated hypervigilance and hyperarousal, veterans can also face difficulties fitting back into society and relating to people who haven't had similar experiences. They might also struggle with intense feelings of guilt, particularly if they've witnessed the deaths of friends or civilians.

SENSE OF PRIDE

And while a sense of stigma and shame remains one of the biggest deterrents to *anyone* seeking help for drug or alcohol problems, this is often far worse for veterans. There's a real sense of pride in the military, but with that comes the risk that the very act of seeking help could feel like a sign of weakness. According to Craze, this remains the 'biggest barrier' for most – 'the belief that asking for help is weakness. Many veterans have spent years in environments where vulnerability wasn't encouraged.'



> The biggest barrier for most is the belief that asking for help is weakness.
>
> ANDY CRAZE

WithYou has a long history of providing specialised support to veterans, and was the first drug and alcohol service provider to receive a gold award in the Ministry of Defence's employer recognition scheme. Its Rebuild Project was launched to provide specialist trauma-focused support for female veterans (*DDN*, March, page 6) and, building on the success of that, the charity is now launching a new trauma-focused treatment pilot for veterans in North Lincolnshire, Wigan and Leigh, North Somerset, and Bournemouth, Christchurch and Poole.

The specialist support on offer at these pilot programmes is taking a different approach to previous veteran support services by making specific trauma-focused therapies – such as EMDR (eye movement desensitisation and reprocessing), CBT and cognitive processing therapy – a key part of the treatment pathway. The idea is to make sure that people don't have to

Yevheniia Sednieva / Dreamstime

choose between 'addressing their substance use and addressing their trauma', putting mental health 'on an equal footing' with physical health.

PSYCHOLOGICAL TRAUMA

The four pilot areas were selected 'based on their existing psychological therapy provision', including counsellors, mental health and wellbeing practitioners, explains Dr Claire Wyatt, WithYou's national psychology lead. 'This enables us to offer specialist trauma-focused therapy alongside existing support, in line with our stepped care model. Three EMDR-trained clinicians provide this specialist therapy across the four services, helping us build on existing resources and develop a sustainable approach to psychological support.'

WithYou recognises that psychological trauma can 'have a significant impact on mental and physical wellbeing, relationships and substance use,' she continues. 'By offering evidence-based approaches including EMDR, trauma-focused CBT, cognitive processing therapy and compassion focused therapy, we can tailor treatment to individual needs rather than offering a one-size-fits-all approach.'

EMDR in particular can 'help people process traumatic experiences without necessarily having to describe them in detail', she explains, something that could be transformational for those who find talking about their experiences difficult or distressing. 'Our aim is to make specialist psychological support more accessible as part of a holistic approach to recovery', she states.



> EMDR in particular can 'help people process traumatic experiences without necessarily having to describe them in detail'.
>
> DR CLAIRE WYATT

BUILDING TRUST

Several studies have concluded that veteran-specific – rather than generic – services are far more likely to be successful for this treatment population, as it can take a long time to build up the necessary amount of trust. It can also help if the counsellors have military experience themselves. Although the WithYou staff operating the new pilots don't have military backgrounds, they 'do bring specialist expertise in trauma-focused therapy', Wyatt explains, including a counselling psychologist with extensive professional experience supporting veterans and serving personnel within a national armed forces charity. 'We understand the importance of building trust and establishing strong therapeutic relationships, and our clinicians are experienced in creating safe, compassionate environments where individuals feel understood, respected and supported.'

Is there also an element of family support? 'Absolutely,' she says. 'The pilot is open to the wider armed forces community, including veterans, serving military personnel and family members of those currently serving, or who have previously served. We recognise that the psychological impact of military service can extend beyond the individual to their families.'



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EARLY INTERVENTION

According to a 2025 finance and housing survey from the government's Office for Veterans' Affairs, around one in 400 veterans said they were homeless, rough sleeping or living in a refuge for domestic abuse, while nine in 400 were living long-term with family or friends. Liverpool charity Tom Harrison House says that over recent months it has seen more and more people engaging with its reducing veteran homelessness project (THH-RVH).

Early intervention – reaching someone before crisis point – is vital, the organisation stresses. 'Finding accommodation can be an important first step, but without addressing the underlying challenges that have contributed to homelessness or housing instability, it can be extremely difficult for someone to achieve lasting change,' it says, with housing instability existing alongside substance issues, trauma, poor mental health, relationship breakdown, social isolation, financial difficulties and the challenges associated with the transition from military to civilian life.

SUSTAINABLE MODEL

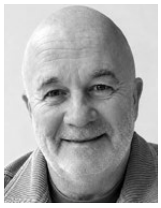
The Rebuild Project was funded by the Armed Forces Covenant Trust, and while the new pilots aren't, they have been 'made possible through the learning, research and positive outcomes generated by the Rebuild Project, alongside investment in EMDR training for three members of staff,' says Wyatt. 'This is an important step towards developing a sustainable model of trauma-focused psychological support for the armed forces community, embedded within our existing services – rather than dependent on short-term project funding.'

Is there a sense that some of the issues people are struggling with might already have become ingrained before the transition to civilian life? The forces have long had a really significant drinking culture, for example. 'Alcohol has historically been embedded in military culture and for some people it becomes a coping mechanism long after service ends,' says Craze. 'When you combine that with stigma around seeking support, you get a group of people who often present late, in crisis, or not at all. Specialist support helps break down those barriers.'

It's important that veteran provision 'recognises that military culture is different – and so is the way people seek help,' he adds. 'Veterans often avoid or delay asking for support, minimise their struggles, or feel they should "just get on with it." Our programme is designed to meet people where they are. Without judgement.' **DDN**

FROM THE GROUND UP







The new Beautiful Monsters manifesto maps a journey from lived and living experience to lasting system change. What would we build if we started again, ask **Mark Tudor** and **George Charlton**

What would drug and alcohol support look like if we designed it around people's lives today? Would we build the same boundaries between treatment, housing, healthcare and community support? Would we use the same measures of success? Would the people most affected have to wait for an invitation to influence the decisions?

These are the questions Beautiful Monsters wants to bring into the open. They ask us to examine arrangements that can become so familiar that we stop questioning them. A service can meet its contractual requirements while someone struggles to get the support they desperately need. Improving one part of that system may leave the gaps between its parts untouched.

Beautiful Monsters is a CIC and a peer-led system change movement helping people build beautiful futures. Our ambition is to change how problems are understood, how responses are developed and who has the power to shape them. Our manifesto sets out the journey from understanding what is happening to building something totally wonderful which communities can sustain. The manifesto launched on 30 October, opening a meaningful conversation about what needs to change and setting out a practical route for doing the work together.

THE RIGHT QUESTIONS

A missed appointment can become a judgement about motivation. A referral can be counted as progress before anyone knows whether support was received. Someone can be described as difficult to engage without asking how difficult the service is to access, and a positive urine sample can see you kicked off your script. Our starting point is that people are not the problem – systems can be.

That doesn't remove personal agency or dismiss the commitment of practitioners. It widens the questions we ask. What happened to this person? Which rules, relationships or barriers influenced the outcome? What could change in the way support is organised? Those questions take us beyond asking people to adapt to arrangements to informing us that the whole process itself may need redesigning.

We also want to challenge the assumption that involvement automatically means influence. If people accessing services can describe their experiences but cannot change priorities, decisions or delivery, then the balance of power remains much the same. Peer-led must mean meaningful responsibility and ownership, with the support and resources to exercise them.

Changing a system means examining the decisions that keep producing the same barriers: who sets the priorities, what gets funded, how organisations share responsibility and whose definition of success counts. A Beautiful Monsters local project can reveal where those arrangements need to change. We want its learning to travel into governance, commissioning and everyday practice, so that improvements become part of how support works rather than depending on a few individuals continually bridging the gaps.

ADDRESSING THE GAP

For Beautiful Monsters, innovation begins with understanding what people need, and being willing to question the usual response. It may involve a different partnership, a peer-led way of navigating support, a redesigned transition from prison or a community space



that connects help currently scattered across organisations. What makes it valuable is whether it addresses a real gap.

Our manifesto brings evidence and experience together. Research, data and professional knowledge matter. But people's experiences can reveal what the data misses, why a pathway fails or why an apparently sensible intervention is difficult to use. Innovation needs that understanding before a solution is chosen, and honest learning once it is tested.

Harm reduction provides the direction – keeping people alive, safer, connected and supported. Kindness shapes the design. How someone is welcomed, listened to and treated is part of how a system works. A response that looks efficient on paper can still fail if people feel judged or unsafe using it.

> Our starting point is that people are not the problem – systems can be.

ACROSS BOUNDARIES

This journey matters particularly where responsibilities become blurred – between prison and community, treatment and healthcare, housing and homelessness, or referral and appointment. We want to work across those boundaries with people experiencing the gaps and organisations able to help close them. Sometimes Beautiful Monsters will lead; sometimes we will partner or strengthen someone else's work. Collaboration over empire building is a deliberate choice. System change requires us to look beyond our own organisational interests.

Our Beautiful Monsters test brings the journey back to its purpose. Did people have meaningful power? Did support become easier to navigate? Were people safer? Did trust improve? Can the change last? Most importantly, did it make things better for people? Those questions apply to our work too. And yes, our planned national provider league table will take that challenge further – making peer influence and accountability visible and encouraging organisations to show how they improve.

We will challenge accepted practice with evidence, experience and kindness, and expect our own assumptions to be challenged. The manifesto invites people, families and partners into that work, with 'Monster Conversations' providing space for discussion. Bring a gap, a difficult question or an idea worth testing. Read the manifesto at beautifulmonsters.org and help shape what comes next.

Another meeting is not an outcome. Another strategy is not an outcome. Change is the outcome.

Mark Tudor and George Charlton are the founders of Beautiful Monsters CIC
www.beautifulmonsters.org

SEVEN-STEP MODEL

The manifesto's seven-step model shows how we intend to move from challenge into action. Its 'house' metaphor follows the building of something useful, welcoming and lasting. The foundations are knowledge and shared power; the finished home represents support shaped around local lives. The journey applies to services and wider systems as well as physical places.

First comes **peer-led research**. People closest to the issue help establish what matters, what works and where the gaps are. This includes paid community inquiry with our sister CIC, We are LUV, or Liberating User Voices, bringing experience together with existing research and data. We begin by understanding the problem before deciding what to build.

Second, **peer-led harm reduction steering groups** create the structures through which that knowledge can influence decisions. People help guide priorities, challenge assumptions and shape the work as it develops. This gives the journey direction and accountability – those most affected are front and centre and have a continuing role in deciding where it goes.

Third, **peer-led harm reduction projects** turn understanding into practical interventions. Ideas are tested, their effects evaluated and the approach adapted. This is where innovation becomes something people can use. The question moves from what we think might help to what happens when the response meets people's lives.

Fourth, **peer ambassadors take that learning into communities, services and decision-making spaces**. They help widen involvement and connect local experience with discussions about practice, commissioning and policy. The ambition is for useful learning to influence the conditions around a project, as well as the project itself.

Fifth, communities define what their home should look like. **Local needs, strengths and relationships shape the response**. A model can provide a method without imposing an identical service everywhere. People and families help determine what belongs in their local response and how the different parts should connect. The response must be shaped by the needs and aspirations of communities, rather than expecting communities to adapt to a predetermined model.

Sixth, we **make the house a home**. Plans become delivery, with attention to accessibility, culture, relationships and joined-up support. We call these places living rooms: places where people go to live, not die. Their value depends on whether people experience safety, practical help and a sense of belonging when they use them.

Seventh comes **sustainability**. Funding, workforce development, partnerships and community ownership must support what has been built. A promising project should create capacity that lasts beyond its initial funding. The strongest change should eventually belong to the community, with people able to guide its future.

WHAT CHOICE?





Many women seeking treatment face impossible choices. They shouldn't have to lose everything to get help, says **Rachel Clegg**

Every day, women are encouraged to ask for help, be honest and seek treatment. But for many, this can feel like a risk rather than a simple step towards recovery. A woman may fear losing her home, being judged as a parent, facing agency scrutiny or retaliation from an abusive partner. Treatment is often presented as an obvious choice; for many women, it's not.

The choice can feel false – recovery or your children, your relationship, or the life you've held together despite everything. The problem is not unwillingness to seek help, but systems that make help feel dangerous to access.

When a woman presents with substance use, the first question is often: Why is she using? An equally important question is asked far less often: What has happened to her? For many women, substance use exists alongside trauma, exploitation, domestic abuse and coercive control. Substance use may be a response to harm or part of it. An abusive partner may encourage use, create dependency, sabotage recovery or threaten disclosure, making substances another tool of control.

Maya's experience reflects this. Introduced to drugs by a trusted partner, she still struggles to understand how someone she loved became part of the harm. 'All I wanted was to settle down,' she says. 'Looking back, I still don't understand why someone who is supposed to care about you would do that?'

Here, substance use is not simply a health issue but part of a wider pattern of abuse. Yet services can treat the substance separately from the violence surrounding it. The addiction, crisis presentation, missed appointments or safeguarding concerns remain visible – the coercion, fear and violence shaping them often disappear from view.

A woman may be labelled chaotic when somebody else has made her life chaotic, or irresponsible while navigating impossible circumstances. She may be judged as an unfit mother while trying to protect her children from violence and control. This is clear in safeguarding and child removal. Domestic abuse is a significant factor in care proceedings, yet mothers can be held responsible for abuse perpetrated against them. They may be asked why they stayed, returned or could not protect their children, while the perpetrator's behaviour receives less focus.

Some mothers therefore believe seeking support could bring greater scrutiny rather than safety. Fear of judgement, blame and losing their children becomes a powerful barrier to asking for help.

For Nadia, everything changed after her baby was removed. After years of domestic abuse, she was left coping with overwhelming grief and trauma. 'People talk about my drug use like it's the cause of everything, but it wasn't,' she says. 'It was a way to cope.' Her experience shows how the response to trauma can become more visible than the trauma. Services can unintentionally reinforce an abuser's messages – that she is the problem, no one will believe her and she does not deserve support.

> The problem is not unwillingness to seek help, but systems that make help feel dangerous to access.

Women who use substances, particularly mothers, are often portrayed as irresponsible, neglectful or dangerous, and professionals – like everyone else – are influenced by cultural attitudes. Without trauma-informed approaches, assumptions about addiction, parenting and risk can shape how women are understood and supported.

Phoenix Futures' Women and Families Pathway provides specialist residential support for women affected by substance use, trauma, domestic abuse and family challenges. Its gender-specific, trauma-informed services offer the safety, stability and support needed to recover and rebuild. The pathway includes women-only Ophelia House and Sheffield Family Service, the country's only residential treatment service where women can access treatment alongside their children. Both recognise that recovery, parenting and safety are interconnected, not competing priorities.

Women need more than access to treatment. Support must feel safe enough to use, remain flexible enough for their lives and recognise the experiences that brought them there. Accessibility is more than an open door: it means enabling honesty without fear of judgement, punishment or losing everything that matters. For Maya, the women-only environment at Ophelia House made a difference. 'Everybody understands,' she says. 'People have been through similar things. You don't have to pretend.'

Women seek treatment because they want what everyone else wants – safety, stability, a home, healthy relationships and the chance to look forward rather than simply survive. Too many women face a false choice between recovery and what matters most, not because these goals must conflict, but because systems make them seem that way. The question is whether the help offered feels safe enough to reach for. She shouldn't have to lose everything to get help.

Rachael Clegg is head of residentials – women and families at Phoenix Futures

Overearth / iStock

ALL BEING WELL





For those experiencing multiple disadvantage, a sense of wellbeing is far more than a 'nice to have', says **Helen Munro**

Ask people what wellbeing looks like and they may describe a long weekend away, a lunchtime walk, or a busy mum finally getting an hour to herself. These are all perfectly good examples. But wellbeing should belong to everyone, and for some people it sits at the very bottom of a long list of priorities.

For people experiencing multiple disadvantage, especially those with complex co-occurring conditions including homelessness, mental health challenges and addiction, priorities are usually practical and clinical – solve the housing problem, treat the addiction. Wellbeing becomes a 'nice to have', something to consider once everything else is sorted.

Bridge the Gap (*DDN, April, page 12*) takes a different view. Practitioners put individuals at the heart of their care using the My Team Around Me model, offering a whole-person, trauma-informed approach that considers both current needs and past experiences.

Finding a home for someone who is homeless is essential. But in isolation it may do little for their sense of wellbeing. Providing housing for someone with other significant conditions does not, on its own, provide a long-term future. Bridge the Gap practitioners build relationships with clients, working with them to uncover the barriers to wellbeing and prioritising the factors that matter most to them. This might mean creating opportunities for their clients to become part of a community, or helping them navigate forms and attend appointments, helping to build a life which includes their new home, instead of solely 'being housed'.

These themes ran through Dame Carol Black's recent visit to Surrey, hosted by Guildford Action Against Homelessness, where she heard presentations from Voices Support CIC LERO and from Bridge the Gap practitioners and clients.

Focusing on addiction, Dame Carol compared treatment to care for diabetes. 'Clinicians would never say "when you recover from diabetes..."," she pointed out, adding that 'we should move away from the idea of completing treatment for addiction'. Addiction is a condition, and support must be wide-ranging and long-lasting, including helping people into work and finding them a good place to live. In closing, Dame Carol suggested councils ringfence money for recovery, so local organisations can spend it according to the needs of their local populations.

> One in two women engaging in treatment have experienced domestic abuse. Drug and alcohol-related deaths among women are rising.

Following the visit Dr Jack Bedeman, Surrey's director of public health said it was a 'real pleasure to welcome Dame Carol to Surrey. Her work has been instrumental in highlighting the challenges faced by people affected by drug and alcohol problems, and in demonstrating how systems can work more effectively together to improve outcomes. [Dame Carol] was impressed by the powerful insights shared by Voices Support CIC LERO members – and Bridge the Gap's support for people experiencing multiple disadvantage.'

The importance of prioritising wellbeing is illustrated through Sally's* story. Sally was referred to Bridge the Gap by the high intensity user lead at a local hospital, where she'd attended A&E 64 times in the previous year. Sally's history included addiction, epilepsy, domestic abuse and mental health challenges. Supported by two BTG practitioners, Sally's situation improved dramatically. They helped secure a neuropsychiatry consultation which helped identify and manage her epilepsy symptoms. Her A&E attendances reduced considerably, she has rebuilt some family relationships, engages with her local community and is being supported to apply for part-time work. 'I have never had so much care, empathy, compassion and understanding from a professional in my life,' she said. 'You make me feel like I'm worth something.'

Wellbeing is not a reward for getting everything else in order. For many people experiencing multiple disadvantage, it's what makes recovery and stability possible and sustainable. As Dame Carol's visit reminded us, that means long-term, joined-up support, and treating wellbeing as a priority for everyone.

**not her real name*

Helen Munro is marketing and communications lead at Bridge the Gap

Caramel/ iStock



MINDED TO





Are people being asked to get well before they can access help, ask **Lisa Ogilvie**, **Stephanie Ash** and **Bernard Shaw**

At the latest Greater Manchester Recovery Network (GMRN) Spotlight event people with lived experience joined services, LEROs and people from the local and recovery communities to explore the challenges people face when seeking support for both mental health and problems with drugs or alcohol – and what needs to change.

GMRN Spotlight provides a space where people affected by issues in addiction and recovery can come together and speak for themselves. This time the focus was on accessing mental health support while experiencing active addiction, and whether they're effectively being asked to get well before they can access help.

Participants divided into three groups to explore different parts of the problem. They looked at trying to get mental health support while using drugs or alcohol, what happens when mental health and drug and alcohol services don't join up, and what people would like to see change. What emerged was not a call for one service to solve everything. It was a call to recognise that people's lives cannot always be separated into neat categories.

THE FIRST THING THAT'S SEEN

The first group looked at what happens when somebody seeks mental health support while using drugs or alcohol. A recurring concern was that substance use can become the first thing services see, while the mental health difficulty behind or alongside it receives less attention. Participants spoke about the complexity of mental health and substance use and how difficult it can be to separate one from the other. For some, drugs or alcohol had become a way of coping with mental distress they did not yet understand. Others described experiences of drug-induced psychosis and serious thoughts or actions relating to ending their lives. Across these different experiences was a shared concern that substance use could affect whether, or how, mental health support was offered.

One participant described asking mental health services for help while experiencing drug-induced psychosis and being unable to access the support he felt he needed. His experience raised a difficult question – how unwell does somebody have to become before their substance use stops being seen as a reason not to help? Another participant reflected on recognising, only later, that she had been using substances to cope with mental distress she did not understand at the time and being told that support could not be offered until she was free from substances.



These experiences reflected a wider contradiction discussed by the group. If somebody is using drugs or alcohol as a way of coping with poor mental health, what happens when that same substance use becomes a barrier to accessing



Participants at the GMRN Spotlight event divided into three groups to explore different parts of the problem.

mental health support? Similar concerns arose around crisis support. Participants discussed experiences of attending A&E while intoxicated, experiencing severe mental distress or drug-induced psychosis, and feeling that the presence of drugs or alcohol could change how their mental health needs were understood or responded to.

The discussion was not simply one of services failing people. Positive experiences of mental health support were also shared, including crisis teams and early intervention teams providing intensive support at times of serious risk. The Samaritans was also identified as an important source of support, particularly because people could talk openly and feel listened to without judgement. People were not saying that good support does not exist – they were asking why access to it can feel so inconsistent.

Judgement and stigma featured strongly. Asking for help with mental health can already mean talking about experiences that are frightening, confusing or difficult to put into words. Anticipating judgement because of drug or alcohol use can make taking that step harder still.

There were practical barriers too. Where somebody lives and what is funded locally can affect what support is available. Participants spoke about a lack of information, difficulties getting beyond self-referral and uncertainty about where to go. Grassroots organisations and peer groups were identified as important sources of connection and support, particularly where people struggled to navigate formal services. The discussion ultimately came back to a deceptively simple point – look beyond what somebody is using and ask what might be happening underneath it.



OVERCOMING BARRIERS

The second group explored what happens when mental health and drug and alcohol services operate separately. The discussion quickly revealed the number of barriers people can face, from poor communication, waiting times and service thresholds to funding, postcode differences and a lack of collaboration between professionals. There were concerns about people being passed between services and receiving conflicting advice, and the discussion also highlighted how difficult it can be to separate mental health and addiction into a simple question of which came first.

Participants questioned whether services organised around a single problem are always equipped to understand this complexity, with wider concerns about whether professionals have sufficient understanding of the range and complexity of needs they encounter, with the discussion repeatedly returning to the need for more training. Medication was another area of concern. Participants spoke about the difficulties that can arise when different professionals or services are responsible for different parts of somebody's care. There was also discussion about the need to better understand the relationship between prescribed medication, substance use and self-medication.

Yet one of the strongest messages from the group was also one of the simplest. Better collaboration would help. Mental health professionals, drug and alcohol services, people with lived experience and the wider network around an individual each hold part of the picture. Problems arise when those parts remain separate.

> For some participants, drugs or alcohol had become a way of coping with mental distress they did not yet understand.

BETTER SUPPORT

The final group was asked what people would like to see change. Many of their suggestions were practical, such as easier access and fewer boundaries between services. They called for updated guidance within health services, greater education around addiction and more training. They wanted professionals to understand dual diagnosis and to recognise the relationship between mental health and substance use. But they also wanted something more fundamental. They wanted to feel heard and understood. One contribution captured this particularly well: 'See the person as a person, not a patient who takes drugs.'

They wanted better information about local services and stronger links between mental health, drug and alcohol support and other services. Some of this felt familiar – at the previous GMRN Spotlight (*DDN*, July/August, page 12), people leaving prison spoke about what happens when support is fragmented at precisely the point when different parts of somebody's life need to come together, and this discussion brought us back to many of the same issues. People leaving custody may be dealing simultaneously with mental health difficulties, substance use, accommodation, relationships, probation and the practical task of rebuilding a life. Addressing each of these separately risks missing how strongly they interact.

Lived experience was repeatedly seen as part of the solution. But the discussion went further than simply saying that services should listen to lived experience. It raised the possibility of lived experience being present within the places where people actually seek help. Participants considered what might be different if somebody arriving at A&E experiencing drug-induced psychosis, severe mental distress or suicidal



3

What We Would Like to See Change?

What would better mental health support for people using drugs or alcohol look like?

thoughts could speak with a person who understood both addiction and mental health through lived experience.

Someone arriving in that condition may be frightened, intoxicated, confused or unable to explain what has brought them there. A lived-experience practitioner would not replace clinical assessment or mental health and addiction professionals. Instead, participants saw the potential for such a role to provide connection, help somebody communicate what is happening, and support navigation between services that can otherwise feel disconnected.

The same thinking led to discussion about lived-experience dual-diagnosis roles more broadly. Rather than treating mental health and substance use separately, such roles could help explore how the two interact in a person's life. What is the substance use doing for that person? Is it helping them manage distress or experiences that preceded it? Has substance use itself contributed to deteriorating mental health? What other support might be needed if the substance is removed? These are not questions with simple answers, but participants felt that lived experience could bring an important perspective alongside professional expertise.

THE SAME MESSAGE

Across the three groups, the same message kept resurfacing. Mental health and addiction may be divided across different services, funding streams, professional roles and referral pathways. The person experiencing them is not. What people were asking for was greater understanding across services, better communication, clearer pathways and more opportunities for lived experience to work alongside professional expertise. They wanted fewer points at which somebody seeking help is told, in effect, 'deal with that problem first, then come back'.

Nobody was suggesting that every service should do everything. Specialist knowledge matters, and different services have different roles and responsibilities. But specialism should not become separation. Better joined-up working means finding ways to connect that expertise around the person, particularly when their needs cross more than one area.

When mental distress and substance use occur together, understanding how they interact may be more helpful than expecting one to be resolved before support for the other can begin. Perhaps the question is not whether somebody is ready for support. It's whether our systems are ready to support the person in front of them.

Dr Lisa Ogilvie is a psychologist for Acorn Recovery Projects and visiting senior lecturer at the University of Greater Manchester

Stephanie Ash is a CQC-registered manager and therapist at Acorn Recovery Projects.

Bernard Shaw founded Project Free, a LERO that supports adults affected by substance use across Greater Manchester.



GETTING THE PICTURE



Acorn's specialist work with people affected by ketamine use has reached a national audience through a BBC Three documentary, writes **Sarah Tattersall**

Filmed largely at Acorn Recovery Projects' Stockport and Burnley services, Down the K-Hole presented by Stacey Dooley explores ketamine addiction, treatment and recovery at a time when we're seeing increasing numbers of younger people experiencing problems linked to the drug.

As a LERO operating across Lancashire and Greater Manchester, we've been responding to ketamine use through peer-led support, changes to our residential rehabilitation provision and specialist interventions shaped around the experiences of the people using our services. This has grown to include dedicated pathways and a ketamine support service commissioned as part of the Lancashire substance misuse contract.

Participating in the documentary has given us an opportunity to make treatment and recovery part of the wider discussion about ketamine – we see first-hand the impact ketamine can have on people and their families. It's a particular challenge for treatment and recovery services, as established approaches to drug and alcohol use will not necessarily meet the needs of younger people experiencing difficulties with ketamine. Services need to understand why and how people are using the drug, the harms they are experiencing and what will make support feel relevant and accessible. We've developed ketamine-specific interventions rather than trying to fit people into existing generic models.

Illicit ketamine use has continued to rise, particularly among younger people, with the 18-24 age range recording the highest rates of use. The number entering treatment for ketamine use is now reported to be eight times higher than it was a decade ago. Frequent use can result in serious physical and psychological harm, including damage to the bladder and urinary tract, chronic abdominal pain, memory problems and dissociation. In some cases, the physical damage can be irreversible.

At Acorn we combine specialist knowledge with lived experience, putting peer support at the centre of our approach. People across our services have put so much into understanding and responding to ketamine use; I'm incredibly proud that their work, and the value lived experience brings to recovery, is being given this platform.

The documentary has helped bring a rapidly developing issue to a much larger audience. The next challenge for all of us is ensuring that people affected by ketamine can find support that understands their experiences and is designed around their needs.

Stacey Dooley: Down the K Hole is available to view on BBC iPlayer
Sarah Tattersall is head of operations at Acorn Recovery Projects.

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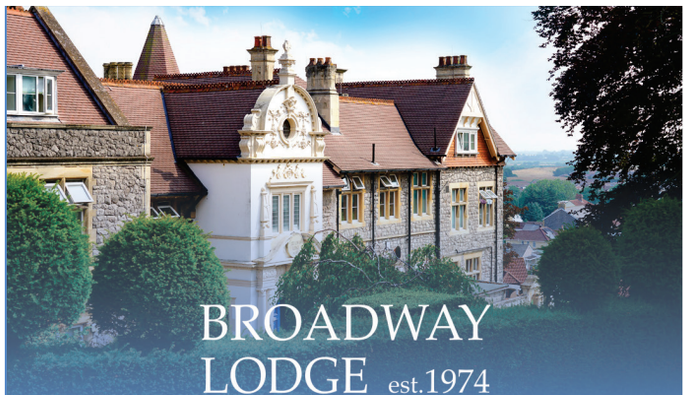


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Case for commitment

We need to build on progress to step up to the next set of challenges, Dame Carol Black told the APPG on Drugs, Alcohol and Justice. **DDN** reports

Nearly five years since the publication of From Harm to Hope, Dame Carol Black outlined progress under the government's ten-year drug strategy and explored the challenges of meeting increasingly complex treatment needs. Significant achievements included more people receiving treatment, an expanding workforce, and greater support for recovery communities, while Individual Placement and Support (IPS) was helping people into employment.

But the strategy was still facing fundamental challenges, including quality of treatment, response to drug dependency within the criminal justice system, and the need for sustained political leadership.

Increasing workforce numbers alone was not enough if services lacked the skilled practitioners needed to deliver effective psychosocial interventions, said Dame Carol. People's needs had become more complex, yet treatment was not always sufficiently tailored to individual circumstances. Drug dependency also continued to be stigmatised rather than recognised as a chronic health condition.

She called for a more personalised approach to treatment, matching it to individual circumstances, the same way that chronic conditions like diabetes are managed. Appropriate housing and access to residential rehabilitation were also an important part of the equation, and she questioned why local authorities were expected to fund long-acting buprenorphine – rather than the NHS funding it as a medicine, as they would for any other health condition.

Difficulties were particularly evident in prisons. Dame Carol's 2024 review had identified shortages of appropriately trained staff, burdensome administration, unclear accountability and commissioning arrangements that failed to reflect prisoners' needs. A subsequent National Audit Office report had highlighted difficulties measuring the cost and effectiveness of prison drug treatment, alongside a real-terms reduction in funding. Prison and community treatment were 'two sides of the same coin', she argued. Effective treatment in custody could support people's return to the community, while good community provision could help prevent imprisonment in the first place.

Sentencing reform and police-led diversion offered opportunities to reduce pressure on prisons, with research by the University of Sheffield demonstrating reductions in reoffending. Dame Carol highlighted the scale of the opportunity, noting that annual police custody detentions were around ten times the prison population. However, she warned that diversion must not overwhelm already stretched treatment services – those entering through diversion represented a different cohort from people seeking help independently, and without careful planning and sufficient capacity there was a risk of making services less effective for everyone.

Discussion in the group highlighted how practice often fell short of ambition. Kelly Grehan, policy manager at Revolving Doors, described how people sometimes concealed setbacks in recovery for fear of being recalled to prison. She also highlighted the poor conditions in some accommodation for people leaving custody, with some feeling safer sleeping in a park than staying in a hostel.

Vicky Fobel, programme director of the Better Justice coalition at User Voice, questioned why discussions about early prison release had barely mentioned drug treatment, while Mike Trace argued that preventing people returning to custody required effective treatment pathways, not simply arrangements for their release.

There were other serious gaps in support outside the criminal justice system. Judith Yates pointed to progress towards hepatitis C elimination through partnership working, but warned of the risks facing people injecting drugs in unsafe environments. Lydia Plant, CEO of Bristol Drugs Project, raised concerns about neglected low-threshold harm reduction services, including needle exchange.

Political leadership and focus were a major concern – tackling drugs had previously been recognised as central to delivering wider government priorities, with ministers given the drugs policy brief. Historic funding cuts had had a significant impact, despite services dealing with a wider range of substances and increasingly complex needs.

APPG chair Grahame Morris emphasised the importance of concrete action rather than another talking shop, with the forthcoming publication of the England and Wales drug death figures offering another opportunity to press the case. 'Keep banging on doors', urged Dame Carol, and remain a 'polite thorn in the flesh'. **DDN**

'It dawned on me that there were resources within myself that could be focused towards achieving the outcome that the treatment programme was designed to deliver.'

TAKING THE INITIATIVE

Given the chaos taking place in prisons, I am hoping to communicate the concept of self-rehabilitation as a vital complement to formal programmes for those who struggle within treatment settings for whatever reason.

The idea came to me while serving my final prison sentence in HMP Downview, where I was one of the early graduates of the Rehabilitation for Addicted Prisoners trust (RAPt) programme – nowadays the Forward Trust.

I had the advantage of occupying a single cell so was able to sit in meditation. This is how it dawned on me that there were resources within myself that could be focused towards achieving the outcome that the treatment programme was designed to deliver – abstinence-based recovery. The neuronally-sculpted pattern of recidivism I was in the grip of for so long could dismantle at an unconscious level, allowing a brand-new life-trajectory to establish itself even before custodial release.

At this stage the individual can use their inner resources to create a rehabilitative structure. For practitioners too, encouraging the person to further their self-rehabilitative initiative – rather than allowing them to continue to struggle with an authoritarian agenda – can encourage self-motivated individuals to achieve their own outcome by accepting responsibility. This offers a way to dismantle entrenched offending-behaviour patterns long before release, and gives staff a language to encourage genuine engagement.

For those still caught in the cycle of continuous relapse-and-return, whether in community-based treatment settings or custodial environments, self-rehabilitation is not grandiose theory but a simple means to self-rehabilitate by means of self-effort. It allows the body and mind to rebalance and reintegrate with society to build daily structure and the foundation of a new life.

Self-rehabilitation, once awakened, can carry a person far beyond the walls of any institution, as proved true for myself. I'm currently approaching completion of my 32nd year of abstinence-based recovery following approved school, borstal, a sequence of six prison sentences in the UK, a sentence in Germany and a period of time in the Central Prison Peshawar, in the Northwest Frontier Province – all for drug-related offences.

The pattern of recidivism fuelled by active addiction was ended by my decision to self-rehabilitate while drawing on the resources available in custody (the RAPt Programme and the Phoenix Prison Trust), from which my motivation for inner-resourced rehabilitation was fostered.

John Graham, by email

EMPIRE STATE OF MIND

I am not sure that treatment services are too narrowly focused (Aiming higher, *DDN*, October, p22). If anything, the opposite is probably more accurate. Treatment, the NHS – or now farmed out to big third sector – is about the process of acute harm reduction and supported substance behavioural change. Keeping folk and helping them get sobriety to start sorting shit out.

What has actually happened is addiction service empire-building, morphing into 'we change anything and everything' organisations as long as we have got funding to do so. But if we consider much substance use as a logical response to situations folk find themselves in and experience, which has developed into maladaptive use making things worse – then the behaviour change is beyond these services. Whether economic, educational, housing or social injustice-related, or deeper trauma-based, it seems the service or provision is better provided by others – including separate peer-led recovery, better-funded housing, basic universal income, counselling etc.

So perhaps less of a belief in the omnieffective 'addiction' service and hot potato referral to them by others – what we need is a sense in which the wider needs of alcohol and drug users are actually attended to by those better versed in the underlying considerations. We do not have omnieffective services for diabetes, those with life-changing injuries etc – but stigma towards alcohol and drug use means we feel a need to treat them differently. It just may be that the empire-building reinforces this, rather than challenges it.

Wulf Livingston, professor of alcohol studies, Wrexham University, via LinkedIn

BEST SECTOR

Thank you Richard Chapman for sharing a really important point – 'I get to meet some of the most interesting people in this world' (*DDN*, October, p21). I love this. We talk about how to get people through the system – how to treat them, medicate them and make sure they don't come back. But how often do we acknowledge that we work in the most interesting and rewarding – and dare I say the best! – sector? Having the opportunity to watch people grow and flourish is a privilege we should celebrate. Thanks for the motivation!

Sarah, by email

PITIFUL PROVISION

Maybe we need to stop mapping where NSP services are – and start mapping whether people can actually access them (News, *DDN*, October, p3).

A service can appear on a directory; a pharmacy can be listed as providing NSP; a contract can say provision exists. But what happens when someone actually walks through the door? The service has stopped providing NSP; the opening hours have changed; equipment isn't available; access is restricted; the person is directed somewhere else; the information online is six months out of date; there is technically a service – but practically, there isn't access. That's not simply a data problem. That's an accessibility problem.

The Hepatitis C Trust's latest research found significant gaps between recorded and actual provision – including less than half of pharmacies identified through existing intelligence actually providing NSP. The person who discovers that an NSP has closed doesn't need a quarterly report – they need accurate information now. This isn't about creating another database. It's about creating a living picture of harm reduction accessibility. We shouldn't just be measuring whether NSP exists. We should be measuring whether it is reachable.

Natalie-Louise, recovery navigator, via LinkedIn

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

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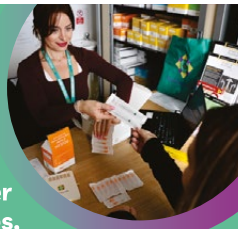
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