DDN

Drink and Drugs News
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TRANSFORMING STREET LIFE

ELECTRONIC PRESCRIBING
The future for OST?

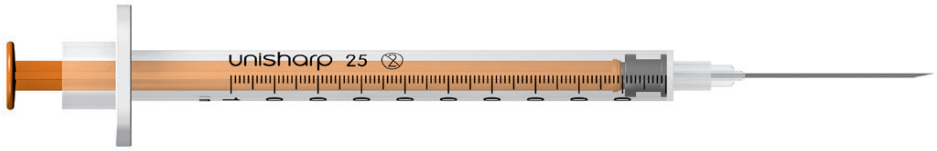
PERMANENT PAIN
Survivor's guilt in recovery

GETTING IT RIGHT
Commissioning challenge

BRINGING CHOICE AND DIGNITY TO PEOPLE SLEEPING ROUGH

NEW!

1mL 25G 25mm (1 inch) Fixed needle syringe!



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DDN

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IN THIS ISSUE

INSIDE

Creating conditions for recovery

Electronic prescribing, the OST experience

M-Pact, a whole-family approach

STAYING STRONG IN PARTNERSHIP

'Respond to government Qs to challenge drug criminalisation...'

Andre, Release, in our partner updates at **www.drinkanddrugsnews.com**

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We talk about stigma – let's also talk about empowerment

We talk about stigma a lot. We think about language and we want to be inclusive. But let's take the vision wider and talk about empowerment – and initiatives that go hand in hand with service user involvement and co-production. Dave Higham strongly believes we have to look at the environments we create in places of support, if we're to build recovery-orientated systems of care (p10). This is no more starkly illustrated than when tackling homelessness, and the co-founder of BillyChip (p6) shares a very clear vision – to spread kindness and compassion.

These values should underpin every strand of our sector, and at the planning stages they very often do. The vision for electronic prescriptions is about getting the meds out swiftly and safely (p8). Our in-depth look at commissioning (p12 and the first in a three-part series) highlights that we need to expand services to meet the needs of those who haven't been well served up to now, and create the right partnerships if we're to change people's lives for the better.

Meanwhile, our careers series turns the spotlight on nursing (p16) and offers a guide to the many and varied roles in this life-changing vocation. We also discover some highly effective initiatives that are already making a difference with M-PACT family support (p18) and action to help steroid users in Wales (p14).

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

Police need better training on child slavery and exploitation

More needs to be done to keep children involved in county lines activity away from the criminal gangs exploiting them, according to a report by criminal justice consultancy Crest Advisory. Agencies were frequently missing opportunities to respond to 'red flags' indicating that young people were at risk of child criminal exploitation (CCE), it says.

The report includes in-depth analysis of the cases of 13 boys, based on police records, local intelligence and interviews with staff at support agencies. Common features in the boys' lives included domestic abuse, drug misuse and periods where they'd gone missing, along with missed opportunities to stop them being drawn into gangs.

The document is calling for a new approach, including updated police training on child trafficking, modern slavery and spotting the signs of CCE. The Crown Prosecution Service (CPS) needs to work more closely with the police on suspected CCE cases, it says, while local authority children's services and other agencies also need to take more account of CCE in their adolescent risk strategies. 'Young people who spend longer periods missing from home are more likely to be involved in gangs or carry out crimes with adults,' it says, and should be considered at heightened risk. One of the case studies, 'John', had gone missing almost 100 times between the ages of 12 and 15. The report also calls for an end to the practice of 'exile', where young people are placed in care long distances from where they live, and states that the National Referral Mechanism (NRM) for supporting modern slavery victims is failing children.

Young people involved in county lines are increasingly being recognised as potential victims of exploitation rather than simply as gang members or drug dealers, the report acknowledges, but states that the response from authorities is often of 'poor quality' and leaves them vulnerable to further exploitation and harm. Some – known as 'alpha victims' by police – may go on to groom and exploit others, while most county lines cases are also characterised by absence of clear evidence or disclosures by the young people themselves through fear of reprisals.

Research last year by the University of Nottingham found that county lines activity involved increasing levels of extreme violence and sexual exploitation, including rape (*DDN*, July/August 2021, page 5).

'The criminal justice system is characterised by a binary approach to individuals as either victim or offender,' said former anti-slavery commissioner, Dame Sara Thornton, in her foreword to the report. 'The challenge of county lines drug dealing is that individuals may be found offending but are, in reality, victims. This report illustrates how difficult it can be to make that judgement and the absence of clear guidance for front line staff exacerbates that difficulty.'

The government recently announced extra funding to help young people escape from county lines gangs, as well as a specialist support service delivered by not-for-profit organisation Catch22.

Report at www.crestadvisory.com

nottingham.ac.uk

'The criminal justice system is characterised by a binary approach to individuals as either victim or offender.'
DAME SARA THORNTON

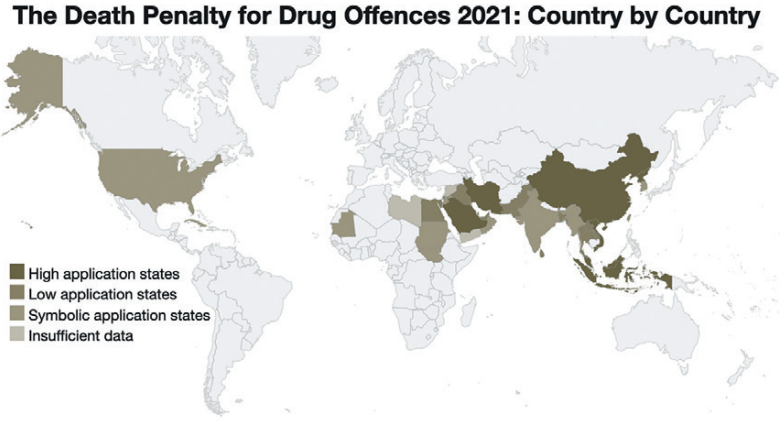
Global drug executions up by more than 300 per cent

MORE THAN 130 PEOPLE were executed for drug offences last year, an increase of 336 per cent on the figure for 2020, according to Harm Reduction International (HRI). However, censorship and severe lack of transparency mean it is 'imperative to note that this number is likely to represent only a fraction of all drug-related executions carried out globally', HRI states.

There were also almost 240 death sentences reported across 16 countries, an 11 per cent increase on the previous year, says *Death penalty for drug offences: global overview 2021*. Around a tenth of known death sentences for drug offences are handed to foreign nationals, which brings 'a host of fair trial and human rights concerns', says HRI.

'High application' states for imposing the death penalty for drugs offences include China, Indonesia, Iran, Malaysia, North Korea, Saudi Arabia, Singapore and Vietnam, although no one was executed in Singapore for the second year in a row and no one in Indonesia for the fifth in a row. Saudi Arabia also declared a moratorium on drug-related executions last year, meaning that none were carried out for the first time in a decade.

However, a 'sudden increase' in executions was noted in Iran.



China and Iran are among the 'most opaque' countries regarding the death penalty, the document states, with the information classified as a state secret in the former, as it is in Vietnam. Information regarding North Korea is 'virtually impossible to obtain', the report adds.

Document at www.hri.global/death-penalty-2021

More young people vaping while fewer taking drugs

The number of secondary school pupils who report taking drugs has fallen from 24 per cent to 18 per cent since 2018, according to the latest figures from NHS Digital. However, while the number of young people smoking has fallen to 3 per cent, 9 per cent now report vaping – compared to 6 per cent in 2018. *The smoking, drinking and drug use among young people in England 2021* report is based on a survey of more than 9,000 secondary school pupils aged 11-15 across almost 120 schools.

Cannabis remains the drug that pupils were most likely to have taken, with 6 per cent saying they'd taken it last year – a 2 per cent decrease from the 2018 figure.

The number who reported taking class A substances has remained consistently around 2-3 per cent since 2010, while the number who drank alcohol has remained at 6 per cent since the 2018 survey. The rate of current e-cigarette use among 15-year-old girls had more than doubled since 2018, however, to 21 per cent.

Of the young people who reported taking drugs more than once, just under 20 per cent said they'd done so alone on the most recent occasion, up from 11 per cent in 2018. Low levels of life satisfaction were reported by almost 60 per cent of the young people who had recently smoked, drank and taken drugs, compared to less than 20 per cent of those who hadn't. *Report at digital.nhs.uk*

Of the young people who reported taking drugs more than once, just under 20 per cent said they'd done so alone on the most recent occasion, up from 11 per cent in 2018.

isabella antonelli / iStock

Canadian cannabis

THE CANADIAN GOVERNMENT has launched a review of the country's move to legalise and regulate cannabis four years ago (*DDN*, November 2018, page 4). The review will evaluate the impact on young people, indigenous groups and others, as well as on criminal activity and the illegal cannabis market. The Cannabis Act also created a new criminal offence of selling the drug to minors, and toughened laws relating to drug-impaired driving.

The review will evaluate the impact [of legalisation] on young people, indigenous groups and others, as well as on criminal activity and the illegal cannabis market.

An independent panel will advise the government on progress towards achieving the act's objectives, and priority areas for improvement. 'The work of the expert panel will address the ongoing and emerging needs of Canadians while protecting their health and safety,' said health minister Jean-Yves Duclos. 'Through this useful, inclusive and evidence-driven review, we will strengthen the act so that it meets the needs of all Canadians while continuing to displace the illicit market.'

Betway fined

ONLINE GAMBLING COMPANY BETWAY LIMITED has been fined more than £400,000 for advertising on the children's pages of West Ham United FC's website. The operator's logo was displayed on a page that allowed children to print a teddy bear to colour in, while another logo with a link to the Betway website was featured on the 'Young Hammers at Home' webpage.

'Although there is no suggestion that the operator was deliberately targeting children, or that children had been allowed to gamble, we take the breach of any rules aimed at protecting children extremely seriously,' said Gambling Commission director of enforcement, Leanne Oxley. 'We note the remedial actions since taken by the licensee but advise all operators to learn from this case and ensure that they take responsibility and have the correct processes in place so that websites directed at children do not include advertisements for gambling.'

Local News

LIMITLESS COMMITMENT
Three services offered by Southampton charity No Limits have been shortlisted for the 2022 Children & Young People Now Awards, the 'gold standard' for work with children, young people and families. 'To be chosen from a large, national pool of charities is a true reflection of the energy, enthusiasm and commitment that our staff give to their work,' said CEO Natalie Webb. The winners will be announced on 24 November.

PROBATION PATHWAYS
Forward has launched new services offering recovery support to more than 8,000 people on probation in Humberside and London. The Dependency and Recovery Service will help to develop understanding of substance issues among probation teams as well as address gaps in the criminal justice pathway. *For more information contact sarah.cahalan@forwardtrust.org.uk.*

CANNABIS COUNT
Half of Londoners support decriminalising cannabis in the capital, according to research by YouGov, compared to 33 per cent who are opposed. Support for decriminalisation was highest among 25-49-year-olds and lowest among those aged over 65. *Complete findings at yougov.co.uk*

CHIPPING AWAY AT HOMELESSNESS

A safe and secure currency for people experiencing homelessness has been launched to help bring choice back to those on the streets. **Jon Hope** explains its purpose and how the scheme is being adopted across the UK

World Homeless Day always brings our work into sharp focus. Although the government provided temporary support for rough sleepers during the pandemic in many parts of the UK, the situation for those on the streets is now worse – especially with many people continuing to work from home and spending less time in town and city centres. This means there's less awareness of the problem, but according to the *Observer* 130,000 households were made homeless in 2020*, and this year the cost-of-living crisis and risk of a deep recession will only make things worse.

BillyChip was the idea of my late son, Billy Abernethy-Hope, who was an ambulance driver in Bristol. After helping support those on the streets himself – both personally and through his work – Billy was left disheartened at how little the general public gave to homeless people, for fear of the money being used for drugs or alcohol. Billy's ambition was to find a solution to this problem and the seeds of the BillyChip scheme were sown.

After losing Billy in a road accident in Thailand our family established The BillyChip Foundation in 2018 as part of our commitment to create a legacy for Billy. The BillyChip is the first currency platform for those who are homeless or sleeping rough, and helps remove stigma – allowing members of the public to overcome some of the barriers they might have when choosing whether to give. Although BillyChip is not the solution to homelessness, it can play a huge part in supporting those living rough.

HOW THE SCHEME WORKS

BillyChip is the first scheme of its type in the UK, and offers a safe and secure currency. People can buy a BillyChip token online or from participating food and drink outlets – most often, we see people adding a BillyChip to their own tea or coffee order at a café. The purchased

According to Shelter 274,000 people were registered homeless in 2021, and 70,000 households were under threat of becoming homeless.

BillyChip can then be passed on to rough sleepers and homeless people as an alternative to cash, which they can then redeem for food, drink or – in the future – other products.

Outlets joining the scheme receive a starter pack containing BillyChips and point-of-sale materials. Each month, they supply details of chips sold and redeemed and receive a payment to cover the costs of redeeming a BillyChip. Volunteers are helping spread the word too, encouraging their local cafés and outlets to get involved.

For those who want to give something to support someone on the streets, it removes any hesitancy about giving money to a rough sleeper. Instead of worrying that money will be used for drugs and alcohol, the BillyChip ensures that any exchange is only for food and drink. Using a BillyChip also promotes human interaction and conversation, without the worry that the person handing over the chip might be contributing to a habit.

BRINGING BACK CHOICE

BillyChip also means those on the streets can go into a café or restaurant to order and pay for a food or drink item of their choice – and it's this choice that's a vital part of the equation. It recognises that those who are homeless may have their own dietary issues, as well as particular likes and dislikes. Being able to order a coffee with a particular type of milk, or a gluten-free sandwich with a favourite filling is important too, especially for that individual's self-esteem given the particular challenges they are facing.

GROWING THE SCHEME ACROSS THE UK

After establishing ourselves in Bristol, BillyChip enjoyed some great local support – firstly with independent cafés, and then further afield. Some of our local emergency services started championing BillyChip too, with the police community support officers (PCSOs) in our local police force, Avon and Somerset Police, wearing interactive BillyChips on their uniforms to help raise awareness. The PCSOs use the chips as a reminder of the scheme and to create a talking point with the community as they go about their work.

As the scheme picked up pace and expanded across the South West we began working on a partnership with Greggs, who are currently trialling BillyChip in seven of their outlets across Bristol city centre. And we're also in the process of launching the scheme in London, through our partnership with Change Please and AMT Coffee.

SPREADING OUR REACH

Our work has seen us being able to offer BillyChip across a growing number of outlets in the UK, but we're determined to do more. The aim is to spread kindness and compassion to the homeless community and ensure that the BillyChip is available in every high street across the UK.

We also want the concept of a cashless currency to develop further to support the homeless community. As we expand, it's clear that BillyChip's potential can grow. For example, even some of the charities with retail outlets whose remit is to help the homeless don't offer them any concessions, making their retail offerings inaccessible to the very people they are intended to help. We're hoping that the BillyChip can overcome this and allow rough sleepers to buy clothes and other items from these shops.

There's a lot we can – and want to – do, and we've been encouraged by how our simple scheme has been so recognised and adopted in a fairly short space of time.

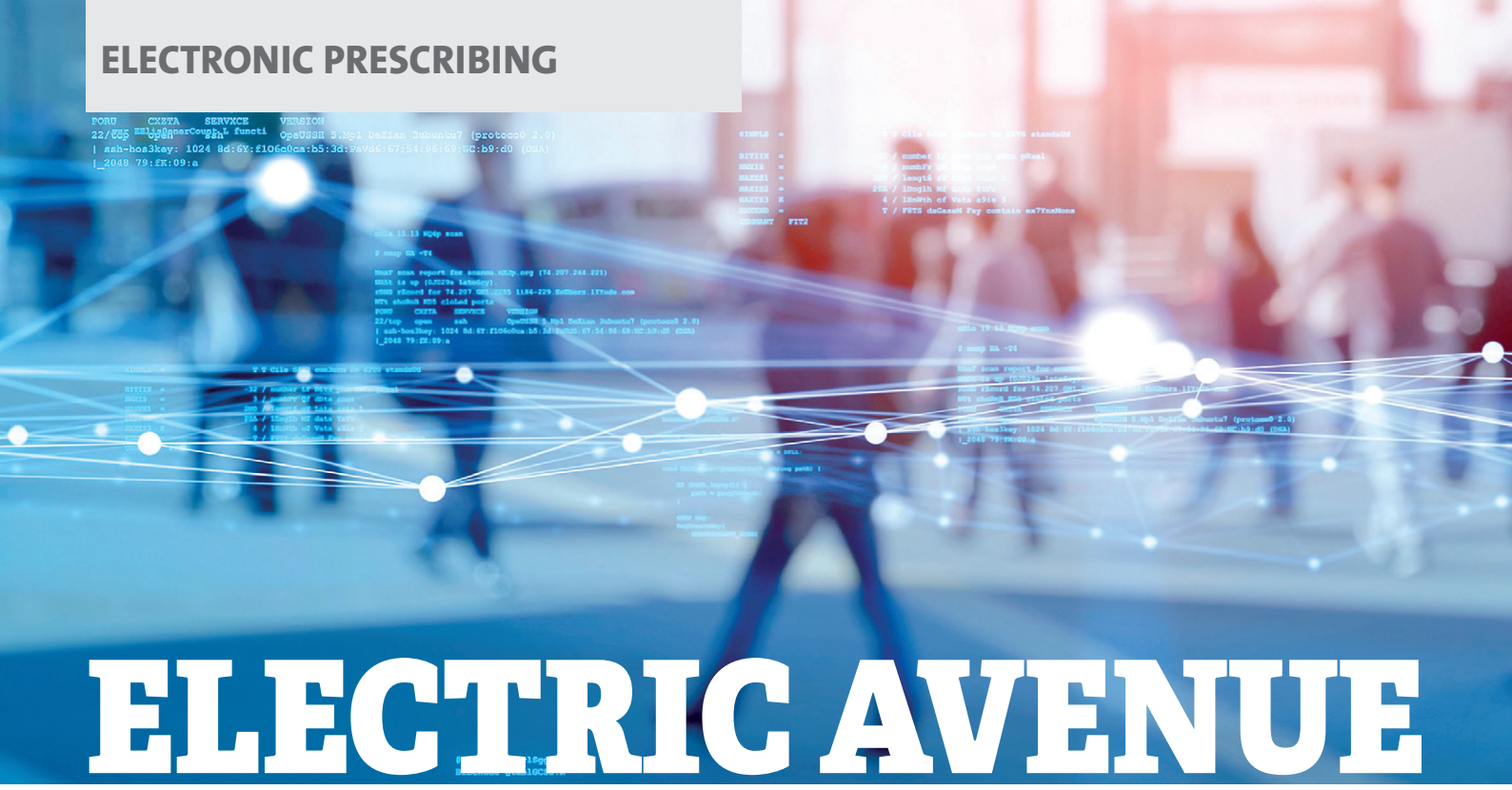
Find out more about our work at www.billychip.com

> ***'You're fabulous and don't you ever forget it!'***
>
> Billy's much-loved phrase is printed on every BillyChip. The words don't just mean a lot to his family – they send a clear message to the person buying or exchanging the chip too.

Top: After joining the BillyChip scheme members receive a starter pack containing BillyChips, stickers, cards, posters and decals.

Right: Meg Abernethy-Hope and John Hope outside a Greggs outlet. Greggs are currently trialling BillyChip in seven outlets across Bristol.

Left: Avon and Somerset PCSOs carry the tokens on their stab vests and guide homeless people to the nearest shop that accepts them.



ELECTRIC AVENUE

Are we a step closer to electronic prescriptions for substance misuse services in England? **Linda Geddes** and **Dr Georges Petitjean** reflect on their experience of prescribing OST electronically

HISTORY OF THE ELECTRONIC PRESCRIPTION SERVICE

The notion of digitalising the prescription service was first conceived in 2003 as part of the bigger National Programme for Information Technology (NPfIT). Although the initial project had a budget of £6.2bn, it failed to deliver changes and subsequently did not improve services or patient care as expected. The mantle to digitalise the service has gone through various iterations over the years – Connecting for Health, Health and Social Care Information Centre (HSCIC) and finally NHS Digital.

In July 2019 a new unit, NHSX, was created as a working collaboration between the Department of Health and Social Care (DHSC), NHS England, NHS Improvement and industry. NHSX is rolling out an electronic prescription service (EPS) via phased software releases.

The principle of an EPS system is that an electronic prescription is generated and is sent to the NHS spine (a secure NHS database) where it can be retrieved by the pharmacy team. One of the main benefits is that the electronic prescription can be tracked throughout the system and therefore cannot be lost.

According to the online version of the NHS long term plan, EPS has been successfully implemented across primary care and is now used in 93 per cent of England's 7,300 GP practices, with more than 67 per cent of their prescriptions delivered via EPS.

OUR EXPERIENCE OF EPS AT INCLUSION

In 2021 following collaboration with NHS digital and Cleo Systems (a subsidiary of IC24) the Midlands Partnership NHS Foundation Trust (MPFT) was chosen to be a 'first of type' pilot site for testing the EPS in secondary care. Inclusion approached the MPFT programme manager and sought approval to be included in the pilot. Our Telford substance misuse services (SMS) site was chosen for the Inclusion pilot as it was a small enough team to ensure that control mechanisms could be implemented and maintained. It was also the closest service to the trust, so support from the programme manager could be assured. Preliminary work started for the trust at the end of 2021 and initial testing began at the start of 2022.

We were aware from the outset that the platform would not enable us to electronically send prescriptions requiring instalment dispensing (FP10MDAs), packaged doses or supervised consumption. That limited our ability to use the system for the majority of our work. As this was a stand-alone system which did not interface with our current clinical system, we had to have an additional process to ensure the clinical system was updated. We identified a cohort of stable service users who were on weekly pick-up of their opioid substitution therapy (OST). To maintain control and to allow us to work collaboratively with pharmacy we limited our pilot to one main provider. Although service users are not always directly involved in how their prescription gets to the pharmacy we wanted to ensure they were asked if they wanted to be included in the pilot. The Cleo Solo EPS has the ability to send the service user an SMS message with the address of the pharmacy and a Google Maps link pinpointing its location. We wanted to test this functionality as it would be beneficial in the future if we had to send a prescription to an alternative pharmacy (such as what we're seeing with short-notice pharmacy closures).

As you would expect with any new system there were stops and re-starts as issues were identified and resolved by the system supplier. As we knew it would be difficult for us to react quickly should the pilot be halted we planned to start our prescribing at least one week after the other trust sites.

On 4 April 2022 we sent through seven electronic prescriptions to the nominated pharmacy. Unfortunately after a few hours a message came through from NHS Digital to tell us to stop. Their reason for this was based on safety – unlike the EPS system employed in primary care the Cleo Solo EPS did not have the functionality to post-date prescriptions. The EPS clinicians

metamorworks / iStock

felt that there was a risk that any prescription that had a post-dated instruction in the body of the text could get dispensed as the only date on the electronic prescription was the date generated. Although we fully appreciated the reason for us being pulled from the pilot it was still disappointing for the service and the service users who had agreed to participate.

DIGITAL SERVICES CAN SUPPORT THE NHS NET ZERO AGENDA

The NHS is now required by an amendment to the Health and Care Act 2022 to contribute towards compliance with the Climate Change Act 2008. The NHS must therefore support the UK net zero emissions target, and in response to this commitment NHS England have published *Delivering a 'net zero' National Health Service* in which digital transformation is a requirement.

WHAT HAPPENS NEXT?

For a digitalised service to replicate the current model we need a system that allows the pharmacy to dispense and be remunerated for instalments and to allow for post-dating. The ideal EPS system would also take into consideration part-filled prescriptions as well as letting treatment service providers know when an instalment has not been dispensed. Currently these features are not available.

According to the online version of the NHS long term plan, EPS has been successfully implemented across primary care and is now used in 93 per cent of England's 7,300 GP practices.

As substance misuse providers we all support the urgent need for an EPS for OST prescriptions. We can be assured that FP10MDA (instalment) prescriptions are on the digital road map, however there are a number of complexities which NHSX are looking to overcome in the coming years.

www.inclusion.org
The NHS Addictions Provider Alliance: www.nhsapa.org

Linda Geddes is the pharmacist lead and Dr Georges Petitjean is the substance misuse medical lead for Inclusion, part of Midlands Partnership NHS Foundation Trust

HOW AN EPS COULD BENEFIT SERVICES AND SERVICE USERS, AND SUPPORT THE NHS GREEN AGENDA

Having an electronic prescription enhances safety and quality:

- It reduces the likelihood of prescribing or dispensing errors
  - *The barcode on the prescription means it is read electronically, removing the need to interpret prescribers' handwriting. It also prevents fraudulent alterations.*
  - *It minimises the risk of there being duplicate prescriptions.*

- It simplifies the process thereby increasing efficiency
  - *Services can be more reactive to short-notice pharmacy closures, speeding up the process for the service user. They would not have to wait for a prescription to be printed, signed and sent to the pharmacy.*
  - *Prescribers sign the prescription electronically using their NHS 'smartcard', removing the requirement for a 'wet' signature as there is no paper prescription*
  - *It allows for remote working so a prescription could be generated by another prescriber working elsewhere in the organisation. This removes the need for 'runners' who currently drive miles around services to get a new prescription.*

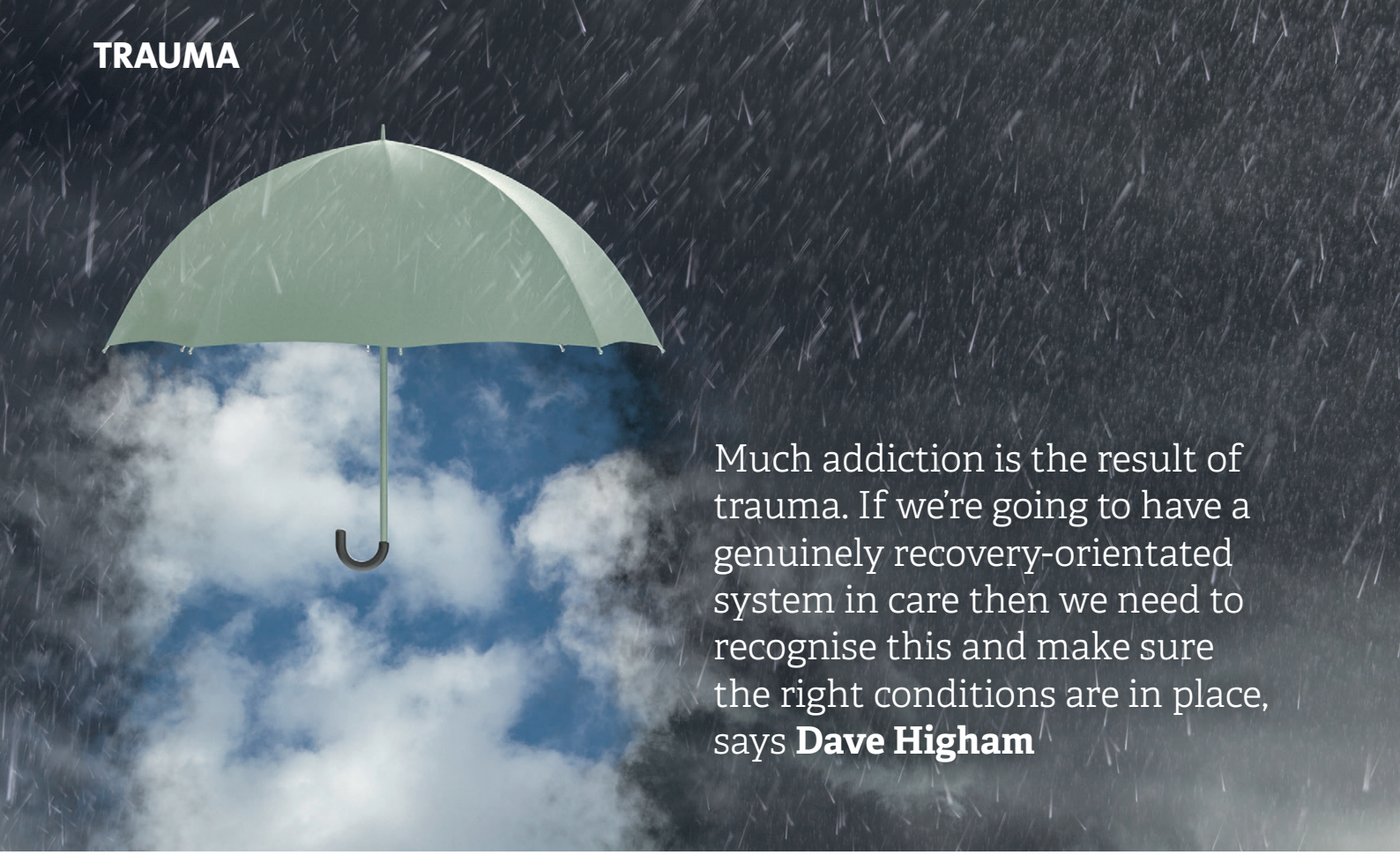
- It saves healthcare costs
  - *The online version of the NHS long term plan has already identified that EPS has saved the NHS £136m in three years (2013-2016)*
  - *Removing the need for paper prescriptions reduces the costs associated with:*
    - *Manufacturer: Paper production, printing, transportation and security.*
    - *Our services: Ordering, receipting and invoicing of controlled stationery; storage of bulky prescriptions forms and the requirement to store them securely and fully account for them; staff time conducting annual audits (as a minimum requirement) to ensure adequate security; hidden costs associated with printer ink, staff time for printing, transportation – postage, delivery.*
    - *When cancelling existing prescriptions consider the costs associated with shredding and disposal of confidential waste.*

- Prescriptions cannot be lost
  - *The electronic message is end-to-end encrypted*
  - *Authorised personnel can track prescriptions through the system. This removes the time spent ringing the pharmacy or vice versa.*

- Prescriptions can be sent for dispensing anywhere in England
  - *It is useful for holiday prescriptions where you have concerns about security of medicines*
  - *EPS prescriptions generated in England cannot be processed in Scotland or Wales*

- Prescriptions can be cancelled
  - *Up until they have been dispensed*

- Prescriptions in the system are automatically cancelled when the Personal Demographics Service is updated with notification of death



Much addiction is the result of trauma. If we're going to have a genuinely recovery-orientated system in care then we need to recognise this and make sure the right conditions are in place, says **Dave Higham**

FAVOURABLE CONDITIONS

When I look back on my own life and the lives of others who have been in addictions, I start to see patterns and similarities that we have all felt and experienced. I see the trauma we experienced both in childhood and the lifestyle – we can then begin to understand where the negative beliefs we have about ourselves began.

Our view of the world starts to change from it being safe to a scary and dangerous place to live. We start to distrust people around us – in some cases, our own family, as these family members who were meant to care for us were the very people that were hurting, neglecting and abusing us. From an early age, our mental health starts to deteriorate. We start to feel we are worthless, that we are unlovable, unliked or unwanted. In order to stay connected to our caregivers, we turn those feelings into self-hatred and assume there must be something wrong with us.

NEGATIVE PATTERN

At this point, our mental health can become unmanageable and it's not uncommon for us to adopt negative patterns of behaviour in order to cope with the internal reality we created. At the tender age of 12 I was offered drugs. Without hesitation, I took them and for the first time in as long as I could remember I got a reprieve from the all-consuming negative thoughts and feelings of low self-worth. At this point, the drugs worked. They took my pain and feelings away and I began to care less about anyone or anything, apart from drugs or drink.

> When we use lived experience... we end up with a system that is much greater than the sum of its parts... Lived experience, where respected and utilised, enables the development of new services that *really* meet the needs of people.

Unfortunately, and unbeknown to me at that time, my life was destined for a level of destruction that I never thought possible. Quickly, I began doing things that went against my values and beliefs, which led me to a place where death felt like the only option. In fact, I welcomed death as a relief from the mental torture I was living through on a daily basis.

LIVED EXPERIENCE

When we use lived experience, learning and insight symbiotically, we end up with a system that is much greater than the sum of its parts. I have never struggled to recognise the value that having lived experience can bring to the development and creation of new ways of working. It's a movement I've championed for nearly two decades. This concept became apparent to me during my last prison sentence more than 19 years ago. I strongly believe that lived experience perspectives, where respected and utilised, enable the development of new services that really meet the needs of the people we're aiming to help.

Initially, I became an expert of my own experience through ongoing recovery programmes

CarlosAndreSantos / iStock

– all methods of counselling, psychotherapy, endless reading, listening and studying. Alongside this, I began my career as a frontline worker in services, working my way up to regional manager. After seven years, I departed statutory services to form my own lived experience recovery organisation (LERO) called The Well.

ENVIRONMENTAL CONDITIONS

Propelled by what I had learned, seen and experienced, I came to believe that the majority of those who come into services are suffering from complex post-traumatic stress disorder (CPTSD) and that treatment and wellbeing services need a rethink about how to support people in a way that brings real change. I strongly believe that we have to look at the environments and conditions we are creating in our own places of support, and that the right conditions need to be realised for a genuinely recovery-orientated system of care. I say system because it's the responsibility of all services to get on board. When the right conditions are not in place, mental health can be further compounded by re-traumatisation, feelings of disconnection, hopelessness, and despair. This can lead to further relapse and a life devoid of opportunity and aspiration.

My book, *Rat Hell to Rat Park: The Core Conditions for Recovery* represents my life's work to date from childhood trauma, to using addict, to prison, to personal recovery, and my subsequent investment as a professional in the field of addiction and recovery. Of most importance is that this book finds anyone who is looking for a way out and inspires hope. It's also my intention that the hope, coupled with the reality of what can happen when we create the right conditions for people – as outlined in this book – provides a blueprint for services and professionals who are looking to be part of the change.

Dave Higham is founder and CEO of The Well Communities, author of *Rat Hell to Rat Park, The Core Conditions For Recovery* and co-author of *The Bigger Book of ACEs*

MAKING CONNECTIONS

An extract from *Rat Hell to Rat Park, The Core Conditions For Recovery*

> What if addiction was about your cage? What if it is an adaption to an environment? When we bond and connect with each other, we become free of addiction.

AT THE WELL we have housing, recovery support, and psychosocial interventions. At the heart of these interventions are the core conditions for recovery, which provide a wrap-around nurturing environment for healing to take place. It is our version of Rat Park – a place where people feel comforted and loved, where they are part of a community and feel a sense of belonging. The rats in Rat Park are basically in their form of heaven; they had lots of wheels to play on, lots to eat, lots of other rats to play with or breed with.

When those rats were exposed to water laced with heroin or cocaine, as per Bruce Alexander's experiment in the 1970s, they almost never used it, compared to the experiment using a single rat left alone, with no rat friends or activities, which drank the drugged water until it died. The lesson here was that rats living happy and connected lives just didn't use drugs. They didn't overdose. They didn't take it compulsively. Journalist Johann Hari (2015) gave a TED talk about this, and he summarised this experiment saying, what if addiction was about your cage? What if it is an adaption to an environment? When we bond and connect with each other, we become free of addiction, but if we're traumatised or alone in our cage, then this is the breeding ground for obtaining some sense of relief. That's human nature. That's what we want as human beings.

I have created the six core conditions based on my years of experience, both working in the addiction and psychology field and as a recovering addict and survivor of multiple adverse childhood traumas (ACTs). I believe these conditions are the pathway to supporting sustainable, life-long recovery from any addiction, trauma or mental illness because they create an environment where human beings can connect, share their experiences and create bonds that lead to a drug-free life. Together, these six conditions create a culture for people to heal themselves, to face whatever they need to face within a safe environment, and pave the way to stay better, and even go on to thrive.

The six core conditions, which are building blocks for healing and recovery, are outlined here:

1. LIVED EXPERIENCE

This is the key ingredient for creating the core conditions for recovery. People of lived experience (POLE), who work supporting our clients, enable people to identify with those who have walked the same path.

2. CONNECTION

I felt disconnected throughout my whole life. The saddest part was I did not even know I was disconnected from myself, my family and from my community. I did not feel I belonged. We need to rebuild these broken connections. It makes perfect sense if people take drink or drugs to escape the feelings of being alone, to then find the solution in positive connections with like-minded people in recovery.

3. MEANING AND PURPOSE

Through this new sense of connection and belonging, a pathway is created for our clients to find meaning and purpose in their lives. The impact on self-confidence and self-belief means they can finally go out into the world and live their best lives and reach their true potential.

4. COMMUNITY

Creating a community is important when building the right environment for people to recover. We support this by developing the conditions for people to connect to each other. We openly encourage people to engage with their peers, and to connect with other people with lived experience.

5. TRAUMA-SAFE ENVIRONMENT (TSE)

We consciously create a safe, trusting and non-judgmental environment, promoting a culture of mutual respect and unity. This is not just for the people we support. This also has to include the staff and the organisation as a whole.

6. HOPE

Sometimes I wonder if this is the most important condition of all. Without hope that people can rebuild their lives and live a better, kinder, more meaningful life, then change cannot happen.

For further information regarding the book email: book@thewell2.co.uk or info@thewell2.co.uk

LET'S GET THIS RIGHT

The new money in the wake of the drugs strategy provides an enormous opportunity for the sector to transform itself after years of disinvestment, but it's vital we get the basics right. In the first of a three-part commissioning series we ask whether commissioners are fully ready and hear about some of the immediate challenges they face

When Dame Carol Black surveyed the treatment landscape for the second part of her *Independent review of drugs* the findings were 'disturbing, even shocking', she said. Not only had funding cuts left services 'on their knees', but commissioning had become fragmented, with deteriorating partnerships between local authorities, health, housing and criminal justice agencies, and little accountability for outcomes.

The government did take notice, however, and since then we've had the drugs strategy and the significant amounts of money announced on the back of it. However, while the funding is clearly welcome – and desperately needed – a robust commissioning framework also needs to be in place to make sure it gets to all the places it needs to go and is used in the right way.

GOOD COMMISSIONING

The government has now provided a comprehensive view of what good commissioning should look like in the shape of the new Commissioning Quality Standard (CQS), which was published this summer in response to a key recommendation of the Carol Black review. The CQS aims to offer a framework to help ensure an accessible, effective person-centred treatment system, covering areas like partnership and governance, the commissioning cycle and integrated system approaches.

'I'm absolutely hopeful that it will help,' says public health specialist at Lancashire County Council, Chris Lee, who was part of the expert advisory group involved in developing the standard. 'There will always be people who do things a bit differently, but if you're newer into this space then I think it's a really good tool. It's one of those structural pieces that might help support the system, part of that landscape of improvement.'

And improvement is clearly something that's sorely needed. So was Carol Black's stark assessment of commissioning as a fragmented, almost broken, system accurate?

'I think it was, in most areas,' says drug and alcohol treatment commissioning consultant Tony Margetts, who was commissioner for the East Riding for 16 years. 'One thing is you had this relentless retendering of services, and every time there was less money in the system. When you retender you can get very slick presentations in effect colluding with commissioners seeking to deliver services as cheaply as possible. She brilliantly summarised where we were.'

RETURNING PRIDE

Part of building back a quality system will mean returning some of the pride that's been eroded over years of shrinking budgets and stretched workforces to the field – forging a real collective identity and creating a sector that people want to work in. 'For that it needs to have a bit of rigour and robustness to it, and I think the Commissioning Quality Standard could give us that,' says Lee.

The challenge, however, as many organisations are already finding, is it's one thing to finally have the money to recruit new staff, and quite another to actually find those staff. 'Everyone's after them,' says Margetts. 'There's thousands of vacancies in the NHS and even more in adult social care – there's a massive workforce issue across the board. I'm pretty sure the sector can get itself sorted out, it's just going to take a long time. You've got to get the people in who want to do this and are committed to it, and get them qualified. We need better salaries, but also really decent national training programmes. We're not alone in this.'

While the ongoing cost of living

Charlieaja | Dreamstime.com

Chris Lee is a public health specialist at Lancashire County Council and chair of ESUCG. He was part of the expert advisory group involved in developing the new Commissioning Quality Standard.

Tony Margetts is a drug and alcohol treatment commissioning consultant. He was commissioner for drug and alcohol services with East Riding of Yorkshire Council for 16 years, responsible for the range of drug and alcohol treatment services from harm reduction to community services.

> 'There's thousands of vacancies in the NHS and even more in adult social care – there's a massive workforce issue across the board.'
> TONY MARGETTS

crisis is leading to intense wage pressure across all sectors – often with industrial action to go with it – simply offering more money comes with risks of its own, warns Lee. 'If you can earn three grand a year more as a drug worker than in the homeless hostel down the road then you're going to do that – my fear is that we risk destabilising other bits of the system. That doesn't help anybody, because we need a workforce plan right across that multiple and complex needs sector. So that's a real concern.'

QUALITY TRAINING

Capacity issues aren't just limited to drug and alcohol workers themselves, however – there are very real challenges in the commissioning workforce itself. 'Lots of experienced commissioners went, and there isn't good training for commissioners,' says Margetts. 'You're tending to get people with no experience of drug and alcohol treatment, or people from drug treatment services who don't necessarily know how to crack on as commissioners and work their way around local authorities, which can be a tricky process.' While there are 'some fabulous people out there', adds Lee, 'a lot are choosing to work freelance or going off to do something else. If you start losing experienced commissioners because they're fed up of the pressure, then the whole thing will crumble – if commissioners don't get the money out then providers can't deliver the extra treatment places.'

CAPACITY ISSUES

So are commissioners fully ready for this new post drug strategy landscape? 'It's a mixed bag,' states Lee. 'That's not just based on the fact that there are those who are more experienced and therefore more ready, and those who are a little bit more new to the game and so maybe have less resilience. I know colleagues who are some of the most experienced who are effectively working on their own. You're trying to do so many other things in the treatment system from a commissioner side. I've got a reasonably sized team because we're a big local authority and we're struggling for capacity just to service the grant methodology and everything else.'

A commissioner's portfolio can be incredibly wide ranging and easily encompass sexual health, gambling, mental health, tobacco, digital health, complex needs accommodation and more alongside drugs and alcohol – with all the partnership working, meetings, admin and reviews that entails.

'You commission your treatment system contracts, but then you've got agendas like drug-related deaths,' says Lee. 'So you're managing all your public health grant funded stuff, and you've got all your agendas that sit on top of that, your organisational responses because you've got a transformation programme running, NHS reorganisation going on around you, and then you've got different OHID grants coming down. And that's if you're lucky, because it is great to be getting the money and we genuinely appreciate that it's flowing. But it's not like "here's some money, deliver some outcomes".'

His area is one of those receiving a housing grant, for example, but putting in the bid obviously takes time and effort. 'We're scrambling around over a massive county area in a tight window trying to get meetings with 12 district housing leads and different organisations on the ground, because it's not all about your treatment system. Over the geography we're working on it's a massive task.' And all of this, of course, could easily be disrupted by anything that happens in the 'day job'. 'If there's a death in a rough sleepers unit, for example, that might take half a week out', he says.

EXPANDING SERVICES

A key challenge, therefore, will be how the money ends up being woven into the system – not only getting the experienced and qualified staff, but also expanding services to meet the needs of different groups who perhaps haven't been particularly well served up to now, such as the growing cohort of people with cocaine issues, people using steroids, people experiencing problems with prescription drugs, or people with alcohol issues who aren't at the dependency level. 'It's nowhere near a comprehensive service,' says Margetts. 'We have got the money and it is an opportunity, but a lot of damage was done over a long period and it's going to take a long time to get it back. Just chucking money at it over a couple of years won't give you a magic fix.'

PRESSURE ON

'The pressure's on in the commissioning world,' states Lee. 'Everybody looks at it from the outside and goes, "It's great you've got all this money flowing in – it's the answer to all your dreams."

And it is. But I've had posts vacant in my team for 12 months. We had to prioritise doing the grant work so we haven't been able to do the recruitment work. Getting people into public health teams and commissioning teams is hard. There aren't necessarily the people who want to do it, or the skills sets out there. So it's going to take a little bit longer to get your teams together, get your training done, get your competencies up and then start getting more people through the door.'

But it's obviously vital not to let the challenges obscure the fact that this a hugely exciting moment – one with enormous potential. 'I think the overarching position is that this is brilliant,' says Lee. 'We've all been crying out for the money and we'll make sure we do the right thing and deliver as best we can. If we don't, the money's not going to keep flowing, is it? It's great that all the attention is coming and that there's going to be partnership structures in every area, and it's a real chance to change people's lives for the better. I don't think there's anyone in the commissioning landscape who questions any of that. The mechanics is where it gets difficult.' **DDN**

Commissioning Quality Standard at www.gov.uk/government/publications/commissioning-quality-standard-alcohol-and-drug-services/commissioning-quality-standard-alcohol-and-drug-treatment-and-recovery-guidance

See November's DDN for part two of the series, which will explore how we go about creating genuinely effective operating partnerships.

This series has been produced with support from an educational grant provided by Camurus, which has not influenced the content in any way.

PEER POWER

Kaleidoscope need people with lived experience to help create a dedicated steroid clinic

Over the past 20 years there has been a substantial increase in the number of people using steroids across Wales. Wider availability of anabolic steroids and growth hormone have contributed to this increase in use, combined with idealised media and social media depictions of the male physique and perceived pressure to use substances to achieve it. Kaleidoscope Powys has seen a rise in people attending its needle exchange scheme who are using steroids and is concerned about the number of young adults who are turning to steroids for performance or cosmetic enhancement.

There are several possible adverse reactions to anabolic steroid use, including acne, gynaecomastia, liver damage, harms to the cardiovascular system and impact on mood and behaviour. Anabolic steroids are taken both orally and by injection, but unlike many other drugs they must be injected intramuscularly rather than intravenously. Long needles with a wide bore are needed to inject viscous steroids into large muscles such as the gluteus maximus (buttocks) or vastus lateralis (thigh).

Sharing injecting equipment can result in the transmission of blood-borne viruses such as HIV, hepatitis B and hepatitis C. Studies with steroid users in Sydney and North East England reported that 5 per cent and 2.1 per cent respectively had shared injecting equipment, while one study conducted in South Wales found that 20 per cent of steroid users reported syringe sharing.

A recent study also found that 8.9 per cent of image and performance-enhancing drugs (IPED) users from NSPs in England and Wales had shared injecting equipment. Of particular concern is the fact that 1.5 per cent were HIV positive (similar to levels of HIV prevalence found amongst injectors of psychoactive drugs in the UK), 8.8 per cent had been infected with hepatitis B and 5.5 per cent with hepatitis C, highlighting that this particular group of IDUs is at risk of blood-borne virus infection.

Approaches adopted across the UK vary – there have been some innovative schemes set up including outreach in gyms and specific clinics for those using steroids and other IPEDs. But as most steroid users get their information – and possibly misinformation – from other steroid users, it's important that we give people the right information and involve people with lived experience.

Barry Eveleigh, service manager for Powys, says it's vital to ensure three things for individuals using IPEDs – that they are well informed and can access accurate information; that no one feels pressurised to use the drugs to look a certain way or improve performance; and that anyone using or considering using them can engage with health and other services to address concerns and make informed choices.

'For us to develop and deliver services that meet the needs of those using IPEDs in Powys, we want services to be informed and designed by people using IPEDs,' he said. 'So we are trying to establish a group of individuals who can share their experiences.

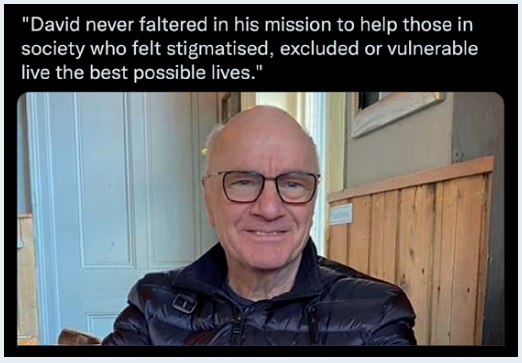
'Already in Powys we have launched a new scheme involving service users to work with their peers and the success of this so far has been phenomenal. Our colleagues in Newport have established a clinic – which opened in 2018 and was the first of its kind in Wales – only for steroid users and which offers blood tests and other tests to check users' health. Building on these successes we want to expand the scheme for both peer work and a dedicated steroid clinic in Powys.'

If you would like be involved in helping Kaleidoscope establish services across Powys, call 01686 616810 or email info@kaleidoscope68.org

'Already in Powys we have launched a new scheme involving service users to work with their peers and the success of this so far has been phenomenal.'
BARRY EVELEIGH

OUTSTANDING PROGRESS ON NALOXONE...

On 4-5 October Dyfed will see the final stage of a roll out of peer-to-peer naloxone training across Wales – the first country to achieve this nationwide coverage. The overdose reversal drug is being delivered to those at risk by people with lived experience of addiction. Funded by the Welsh Government, the initiative has delivered four times as many naloxone kits as anticipated and saved lives as a result. Kaleidoscope are proud of the staff and peers involved in this collaborative and outstanding work.



OBITUARY

Remembering David Biddle

We were deeply saddened to learn of the death of David Biddle, former chief executive of Change Grow Live, who had worked with the charity for 21 years before his retirement in 2017.

His enthusiasm was inspiring and he was quick to embrace the benefits of working in partnership with *DDN* to examine the challenges facing the sector.

Read a tribute by Mark Moody (current chief executive and former colleague) at *www.changegrowlive.org*

Do you work with parents who drink?

Provide free and confidential access to parent specific alcohol support with DrinkCoach.

Resources include:

- **Parent specific Alcohol Test**
- **Free downloadable Planning Tool**
- **Support and advice for partners**
- **Tips to make positive family memories**

All resources are available to anyone free of charge. Visit drinkcoach.org.uk or scan the QR code below.

Administered by Office for Health Improvement and Disparities (OHID), funded by the Department of Health and Social Care and the Department of Work and Pensions.

Haringey LONDON

CARING AND COMPASSIONATE

This month our careers series turns the spotlight on nursing

Hero Images Inc. / Alamy

Many people choose to qualify as a nurse so they can pursue a career in addictions. There are also nurses who become interested in specialising in addictions as a result of coming into contact with people with drug or alcohol issues in their working lives. To practise as a nurse in the UK you must be registered with the Nursing and Midwifery Council (NMC). Nurses are required to have a nursing degree or equivalent in order to register with the NMC – there is no externally recognised addictions accreditation.

Nursing gives the opportunity to work in a variety of roles within services including providing specialist interventions in physical and mental health, leading on harm reduction initiatives for bloodborne viruses, needle exchange, provision of naloxone, and support with detoxification from alcohol and/or other drugs. Some nurses choose to study at Masters level, including addictions courses, but these are open to a range of professionals and are not nurse-specific. There are a range of nurse-specific MSc courses – for example in leadership, or mental health – although there are none that focus solely on addictions.

Others study to become nurse independent/supplementary prescribers and play an important role prescribing medication to those with substance problems. To do this, nurses must have one year's post registration experience.

Email your Qs for our Careers Clinic to the DDN editor

HOW DO I BECOME A NON-MEDICAL PRESCRIBER?

Natalie Thompson explains the route to qualifying as an NMP

Non-medical prescribing was introduced in May 2006 to improve patients' access to treatment. It enables quicker access to medicines, delivers high quality, innovative clinical care, and offers choice for the individual. Only nurses and pharmacists that have been trained to prescribe can do so, and they can only prescribe within their area of expertise.

WHAT ARE THE DIFFERENT TYPES OF PRESCRIBERS?

Allied health professionals who have completed an accredited prescribing course and registered their qualification with their regulatory body are allowed to prescribe. The two main types of prescribers are independent prescribers (IPs) and community practitioner nurse prescribers (CPNPs). An IP is someone who has successfully completed a Nursing and Midwifery Council (NMC) independent nurse prescribing course (a v200 or v300) and who is registered with the NMC as an IP.

IPs can prescribe any medication provided it's in their competency to do so. This includes medicines and products listed in the British National Formulary as well as unlicensed medicines and all controlled drugs in schedule 2-5 (https://bnf.nice.org.uk/medicines-guidance/controlled-drugs-and-drug-dependence/).

A CPNP is a nurse who has successfully completed an NMC CPNP course (v100 or v150) and is registered as a CPNP with the NMC. Most nurses who have done this course are district nurses and public health nurses (previously known as health visitors), community nurses and school nurses. They are registered to prescribe from the Nurse Prescriber Formulary (NPF) (https://bnf.nice.org.uk/nurse-prescribers-formulary/) which includes appliances, dressings, and pharmacy.

HOW CAN YOU BECOME A PRESCRIBER?

To become an NMP, eligible practitioners will undertake an accredited programme, delivered by a higher education institution. Non-medical prescribing programmes provide the knowledge, skills, and training to prescribe safely and competently.

The Royal Pharmaceutical

Case study 1

CHALLENGING, BUT HIGHLY REWARDING

MY ROLE is to provide quick access to treatment for drug and alcohol clients. This includes prescribing opiate substitute medication like methadone and buprenorphine. I also facilitate alcohol assessments and detoxes. I am a qualified nurse prescriber and have been since November 2014. I qualified as a registered mental health nurse (RMN) in 2000. When I did my training to become a non-medical prescriber (NMP) you were expected to have practised in your area of expertise for at least three years at a senior level.

I work in prison and community settings – in both my role involves reviewing clients' treatment as well as supporting colleagues with their caseloads.

There are many aspects of my job that I like. One that stands out is when I make a decision that may have looked tough at the time but later a client is appreciative of the progress they've achieved. The gratitude of clients when you've assisted them in their journey is one of the things that keeps me going. It's a highly rewarding job that requires an interest in people as a prerequisite. The client group is challenging and the job itself can be character changing.

Kudzai Mutizhe, nurse prescriber

Case study 2

EVERY DAY IS DIFFERENT

AS AN NMP my role is to provide high quality clinical assessments to diagnose and prescribe opiate substitute treatment (OST) – the role also includes alcohol assessments to establish and diagnose dependency, supporting alcohol detox, and decision-making for either in-patient or community detox.

The role requires a nurse qualification and NMP course completion. A qualification in substance misuse is preferable and some experience is desirable, however the service is happy to develop nurses to fulfil this role and training and peer support is ongoing. A thorough induction is completed with support from our doctors and other nurses/NMPs to ensure that new staff feel confident and competent to carry out this varied role.

Every day is different – some are extremely busy, others are spent waiting for clients to attend. We see unexpected releases from prison and urgent referrals from GPs, and we cater for clients who often have a diverse range of complex needs. There are numerous other aspects to this role which include assessment of the liver via fibro scans and blood results, assessing the risk for IV drug users and putting a plan of care in place to minimise this risk. We raise awareness of blood-borne viruses, and provide a vaccination service for those at risk as well as onward referrals for hep C treatment.

The role also includes student mentorship, recovery worker support and liaising with other agencies such as GPs and mental health teams to deliver a person-centred approach. We have new initiatives, including piloting the buprenorphine injection/depot, Buvidal.

We aim to provide a service which we would all be happy for our family/loved ones to attend. The most rewarding part of the job is to see people making positive changes and maintaining these changes. I enjoy working with people who have previously been judged and have little self-esteem – to witness our clients gain confidence in themselves to turn their lives around is very satisfying and makes the work worthwhile. This is a very fulfilling role. If you are caring and want to make a difference, this is the role for you.

Sue McCutcheon, non-medical prescriber

Society has created a prescribing competency framework for all prescribers that has been designed to help maintain prescribing standards, inform education curricula, and provide a source of recognised guidance for those involved in NMP.

All prescribing roles build on registered professionals' ability to deliver full instalments of patient care. In turn this enhances patients' timely access to treatment with medicines and experience while reducing waiting times, hospital admissions and more effectively using members of the healthcare team.

WHAT QUALIFICATIONS AND EXPERIENCE ARE NEEDED?

- *Registration with the NMC as a first-level nurse or specialist community public health nurse for a minimum of one year prior to application for entry.*
- *Applicants are to be professionally practising in an environment where there is an identified need to regularly prescribe, and able to demonstrate support from their employer/sponsor, line manager, non-medical prescribing lead and practice supervisor and assessor.*
- *Applicants should be capable of safe and effective practice at a level of proficiency appropriate to the module/programme undertaken and their intended area of prescribing practice in the following areas: clinical health assessment, diagnostics/care management, planning, and evaluation of care.*
- *Applicants must be able to demonstrate ability to study at academic level 7.*
- *Applicants must have at least three years' experience as a practising nurse or specialist community public health nurse and be deemed competent by their employer to undertake the programme.*
- *Employment is subject to enhanced Disclosure and Barring Service (DBS) clearance.*

Your approved course will enable you to learn the skills and knowledge you need to qualify. You'll be able to develop your legal, ethical, and professional knowledge on topics relevant to pharmacology and therapeutics.

WHAT CAREER OPPORTUNITIES WILL THIS OPEN UP?

Once you've completed your course and registered with the NMC, you'll be able to prescribe independently and in partnership with a medical or dental prescriber and the patient.

Areas you can work in include mental health, substance misuse, travel medicine, HIV medicine, critical care, nutrition, and rheumatology.

You can also progress to higher level courses including advanced nursing practice or advanced clinical practice as well as becoming a prescribing supervisor.

If you're looking to develop your medical career, take on greater responsibilities and manage enhanced patient care, becoming a non-medical prescriber may be the right direction for you.

Natalie Thompson is at Archer Resourcing, www.archerresourcing.co.uk

MAKE AN M-PACT

The whole-family approach of Forward Trust's M-PACT programme is reaping dividends, says **Katherine Jenkins**

Attachment theory, the most important tenet of which is that young children need to develop a relationship with at least one primary caregiver for healthy social and emotional development, has remained a prominent concept across a wide range of disciplines over 50 years.

It's a foundational part of the learning for our Moving-Parents and Children Together (M-PACT) practitioner training programme. The M-PACT programme itself has been delivered to families for nearly 20 years and can be best described as an evidence based, group psychosocial intervention that takes a whole-family approach. Through recognising the overlooked voices and experiences of children and young people, we aim to improve the wellbeing of families affected by addiction.

However, the enduring nature of attachment theory means that we must be particularly conscious of its relevance in the context of modern-day relationships. We must be prepared to critique its application in order to ensure M-PACT continues to achieve positive outcomes and meet the diverse needs of the families it supports.

This was an important question raised to us by Addiction Professionals, when recently going through the accreditation process with them for our M-PACT practitioner training – a helpful challenge to ensure that what we were including in the course recognised some of the limitations of this theory and how we were able to respond.

The accreditation requires courses to provide an evidence-based approach to learning. As stated, attachment theory forms a central role within the M-PACT programme and it's so well established that it's often just accepted as evidence, including within the legal system. However, there have been a number of challenges over time which must be considered.

metamorworks / iStock

'WE ARE DELIGHTED to accredit this impressive course which supports practitioners to strengthen family relationships for those who have experienced addictions. The programme has been externally evaluated, is evidence based, and focuses on support for families and also for the practitioners who are involved in delivering this rewarding course. The focus on the voices of the children of parents with addictions, together with the emphasis on working with the whole family makes this programme a valuable asset for the field.'
Kate Halliday, executive director, Addiction Professionals

'LEARNING TO BE A PARENT AGAIN without addiction is tougher than being a parent for the first time. I know this first-hand. Not only do you forget how to be a parent, you struggle with two things... learning to be a parent again and learning to parent without your crutch. I wish this had been available for me and my boys. M-PACT could have helped me when I was struggling.'
Nicole Dyer, M-PACT/family lead coordinator

'I LOVE M-PACT. If I did not do M-PACT, I would not be how I am right now, to be honest. I would have bottled up all those emotions. I just would not be what I am today. M-PACT really made me happy... M-PACT also really helped me with knowing that I was not alone, because there were loads of other kids there who were going through the same thing as me. If I had not met those kids at M-PACT, I would have thought that I was alone, probably to this day, unless I found someone else who I could relate to.'
M-PACT participant, attended M-PACT at the age of ten with her mum

'OVER THE MANY YEARS of working on both the facilitation of M-PACT programmes to families and training others to do the same, I have seen repeatedly the incredible changes that families can make to improve their quality of life during and after attending the programme. M-PACT to me means connection, change and professional satisfaction. M-PACT can and does make a difference to individuals, families, and ultimately communities.'
Matt Serlin, M-PACT training coordinator

'Critics highlight some of the potential failures of attachment theory, including the lack of acknowledgment of different norms across nations, cultures and class, promoting stereotypical approaches to parenting that do not take into account the diverse environments in which children are raised today,' says executive director at Addiction Professionals, Kate Halliday. 'Despite this, the theory continues to hold great weight and has even been labelled one of the last surviving "grand theories" not to have been completely dismissed, replaced, or extensively reworked. It remains an important force across professional practice and as such, the Forward Trust were asked to acknowledge its strengths, whilst also providing a helpful critique for this ubiquitous approach.'

It's fair to say attachment theory has indeed evolved over the decades – moving beyond the child-parent relationship, it has expanded to address the attachments formed with others in our lives. This is a critical consideration in the M-PACT programme as, despite the name, we welcome attendees who have any care-giver relationship with the child or young person.

Attachment theory has evolved over the decades – moving beyond the child-parent relationship, it has expanded to address the attachments formed with others in our lives.

We must remember families function in their own way, influenced by many complex and diverse factors. It's important to resist the temptation to adopt an out-of-date view of what family should look like. Our aim in M-PACT is to establish what works for those attending, enabling their system to support all members in it to feel safe and cared for.

Standing still in an ever-changing environment will mean interventions run the risk of quickly becoming out of date, and it's up to us to ensure that we're able to identify where change and challenge is needed. The new relationship between M-PACT and Addiction Professionals will provide fresh opportunities for reflection and, most importantly, continuous improvement.

Katherine Jenkins is head of families and young people at the Forward Trust

THE MOVING PARENTS AND CHILDREN TOGETHER (M-PACT) programme was developed by Action on Addiction, now part of The Forward Trust, in response to the 2003 *Hidden harm* report. Each M-PACT programme brings together a small number of families over eight core group sessions. Each session combines work with all participants, work with adults and children/young people separately, and work with individual family units. There is also a family review session, and a reunion.

THROUGH INDEPENDENT EVALUATION M-PACT has been shown to improve global family functioning, coping efficacy and communication. It has been noted as an effective intervention in several government and academic publications. M-PACT is available to any eligible organisation through a licence arrangement, which includes practitioner training now accredited by Addiction Professionals. *For further information please contact m-pact@forwardtrust.org.uk*

THE ONES LEFT BEHIND

Survivor's guilt is a painful aspect of recovery that doesn't get the attention it deserves, says **Jamie Gratton**

One of the things they never prepare you for when entering into recovery is survivor's guilt – a condition of persistent mental and emotional stress experienced by someone who has survived an incident in which others died. The truth of the matter is if you decide to enter into recovery, you will most likely have friends and acquaintances who continue to use.

When you get sober, you'll make friends with other people in the recovery community, and the sad truth is that some of these amazing souls are likely to relapse, with tragic consequences.

I'll never forget the first time I felt survivor's guilt during my recovery. I was a few months into my recovery journey, and it was around that time that I experienced what many people feel when substances leave their bodies and their minds clear. I was starting to feel at ease in my new sober skin, and for the first time in a long time my entire body felt alive. The people and environment around me felt electric, and I felt like a child again – everything I was experiencing was like I was seeing life in colour for the first time. And in some ways, I was – so much of my life had been lost due to substances and mental health issues.

It was at this time that a great friend and peer mentor, Paul, who had been in recovery for about three years, lapsed due to life and family issues. He started to spiral out of control and very quickly we lost him. And the truth of the matter is, this is a very common story. This is when the survivor's guilt first hit me. Why did I not see the signs? I should have been there – it should have been me. And being truthful, I didn't handle these feelings of guilt very well.

Even after 25 years in recovery, I still haven't found a way to deal with this. Yes, I can cope and work through it, but every time it hits me. It brings doubts and raises questions like, 'Why me – why have I managed to get clean and someone else didn't? What makes my story different? Why do I deserve to live and they don't?'

Your thought process spirals and you can end up analysing everything. Could I have done anything different? Maybe if I hadn't walked away from them, I could have saved them. If only I'd tried harder to get them in recovery. Now logically, I know that no one can be in charge of someone else's recovery, and no matter how much you try to help someone, only they can take the steps needed. But the feelings of guilt, if not dealt with, could lead to lapsing on your own recovery journey, so it's really important to not only acknowledge these feelings but to do something about them.

This is where I have found focusing on my emotional recovery comes into play.

Emotional recovery often includes establishing a self-care habit. Moving your body on a regular basis, engaging in calming or relaxing activities, eating well, and getting enough rest are all staples of self-care routines. Having someone to lean on while dealing with survivor guilt is also very important. A person might feel more understood by talking to others who've been through the same thing – joining a support group, or seeing a trusted mentor.

Even finding a method to remember or celebrate the departed may be therapeutic for some people. All these things help me deal with that guilt I get when someone I know passes away due to addiction. Now I'm not sure if I'll get to the time in my life and recovery where I don't feel like this, but if I am truthful, it's one of the reasons behind what I do and why I'm passionate about recovery and shout about how recovery not only changes lives but saves lives.

So, I'll leave you with this – survivors' guilt is a part of recovery, but you can also learn to control how you react to it. Remember that we may lose people in our recovery journey, but you are worth your recovery, you deserve your recovery, and you have control over your recovery, no matter what.

Jamie Gratton is operations director at Staywell Derby CIC

Your thought process spirals and you can end up analysing everything. Could I have done anything different? Maybe if I hadn't walked away from them, I could have saved them. If only I'd tried harder...

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Rachel.Lockett@mpft.nhs.uk **www.inclusion.org/work-with-us/**

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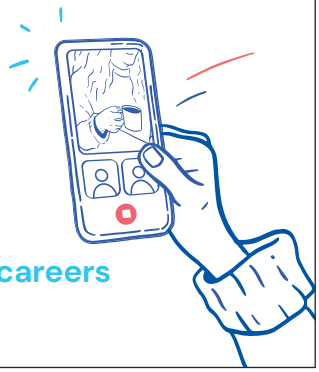

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