DDN

Drink and Drugs News
December 2022 – January 2023
ISSN 1755-6236

IT'S UP TO US
Let's eradicate stigma together

FESTIVE FEARS
Extra support for prisoners at Christmas

SHARE THE LOVE

SOLIDARITY AND PEER-LED OUTREACH AT HIT HOT TOPICS

Season's GREETINGS

Personal safer sniffing tubes

Attractive and comfortable colour-coded personal tubes made for sniffing powders. Made from durable and washable aluminium alloy.

Added to our catalogue to reduce the risk of cuts and bleeding, and transmission of viral infections including COVID-19.

Availability of sniffing tubes at drug services is a novel and useful harm reduction tool that can promote useful discussions about non-injecting routes of drug administration.

Exchange Supplies product code: M105

EXCHANGE SUPPLIES

TOOLS FOR HARM REDUCTION

DDN

Drink and Drugs News is published by **CJ Wellings Ltd**, Romney House, School Road, Ashford, Kent TN27 0LT
t: 0845 299 3429

Editor: Claire Brown
e: claire@cjwellings.com

Advertising manager: Ian Ralph
e: ian@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

website:
www.drinkanddrugsnews.com

Website support by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover by: nigelbrunsdon.com

IN THIS ISSUE

6

ON THE COVER – HIT Hot Topics

INSIDE

10

Trauma-informed treatment systems

18

Dismantling stigma

12

Support for prisoners at Christmas

STAYING STRONG IN PARTNERSHIP

Ziggy B Designs

Festive greetings from DDN to all our readers, partners and advertisers. We couldn't do it without you!

Visit our partner updates at
www.drinkanddrugsnews.com

DDN is a self-funded independent publication. Our bespoke partnership packages provide an opportunity to work closely with the magazine. Please get in touch to find out more.

Thank you for sharing your amazing work!

Speakers at Hit Hot Topics talked of dilemmas, frustrations and being on the wrong side of the law (p6). But what shone from their talks was the bravery, resilience, determination and clear purpose in making life (a lot) better for their peers. Some of them made uneasy choices and compromised their own safety. Others are struggling through the disappointments and setbacks of funding cuts that make no sense when held against the evidence. We have to hope that cost-effectiveness will be weighed up in human terms.

Our review of the year (p17) reminds us of the struggles at home and abroad, and the pressures we all face. One big positive that seems to have come out of it all is a renewed appetite to work in partnership – particularly the culture of more informed commissioning (p14 and p21) and a harnessing of the collective energy to tackle stigma (p18). We're also fully involved in helping to skill up the workforce, so please keep participating in our careers series, which focuses on counselling and therapy this month (p22).

I hope you enjoy the festive season and get some time to relax. We'll be here online and back in print on 6 February. And as the year draws to a close, thank you for sharing your amazing work with us and being part of the *DDN* community. Take this hug and pass it on!

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

Two in five deaths of homeless people drug-related

Almost two in five deaths of homeless people last year were related to drug poisoning, according to the latest figures from the Office for National Statistics (ONS). The high proportion remains consistent with previous years (www.drinkanddrugsnews.com/two-in-five-homeless-deaths-now-drug-related).

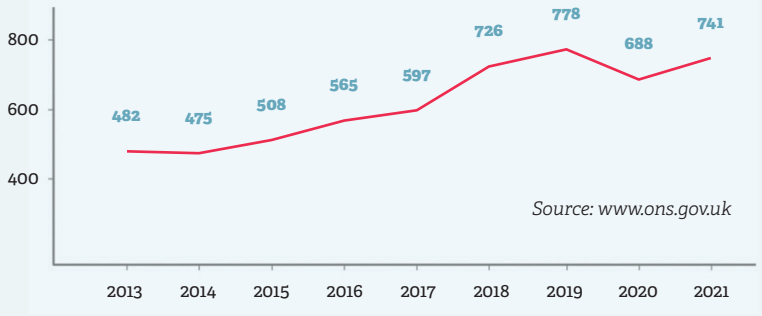
There were almost 750 deaths of homeless people in England and Wales registered in 2021, says ONS, which also included more than 70 alcohol-specific deaths and almost 100 suicide deaths. By comparison, the number of deaths involving COVID was 26, although this was twice the figure for the previous year. The ONS data defines someone as homeless if they had been sleeping rough or using emergency or temporary accommodation at or around the time of death. Almost 90 per cent of the overall deaths were among men – again, consistent with previous years – and the highest number was recorded in the 45-49 age group. Most deaths were registered in London – at more than 150 – and the North West, but death registration delays mean that some of the deaths will have occurred in previous years, ONS points out. The number of deaths among homeless people has increased by more than 50 per cent since the ONS data time series began a decade ago.

'The deaths of 741 homeless people in England and Wales registered in 2021 represents an increase of 7.7 per cent (or 53 deaths) from 2020,' said James Tucker of the ONS social care and health division. 'The latest figure is more in line with pre-pandemic levels following a notable fall in 2020, although it's too early to say whether this is a resumption of an upward trend in homeless deaths. Any death in these circumstances is a tragedy and our estimates are designed to help inform the work of everyone seeking to protect this highly vulnerable section of our community.'

'Each one these people was someone's child, sister or brother – all with their own hopes and dreams,' said St Mungo's chief executive Emma Haddad. 'Health and homelessness are inextricably linked and it is an awful reality that sleeping rough causes chronic illness and can lead to premature death, with the average age of death for someone living on the streets being around 30 years earlier than the general population. The government's recently published rough sleeping strategy has a strong focus on prevention and tackling the root cause of homelessness. Today's data shows yet again why it is so important we implement this to prevent people from ending up on our streets in the first place, especially as winter approaches, the current cost of living crisis worsens, and more people are facing losing their homes.'

Deaths of homeless people in England and Wales: 2021 registrations at www.ons.gov.uk

The estimated number of deaths among homeless people has increased by 53.7% since 2013



APPG: Make tobacco firms pay

THE GOVERNMENT should introduce an immediate windfall tax on tobacco companies along with an additional 'polluter pays' levy, says the All Party Parliamentary Group (APPG) on Smoking and Health – the additional levy would work to limit profits to the average 10 per cent margin for businesses.

The windfall tax could raise £74m a year and the levy ten times that, says the APPG, which could help pay for the 'shortfall in funding for tobacco control and public health'. Reducing smoking rates would also help to ease the annual £17bn cost to the NHS, social care and the UK economy, it says, as well as help families during the cost-of-living crisis.

The average smoker pays around £2,000 a year 'to fund an addiction which for most starts in childhood', it states, with lung cancer now the cause of one in five of all UK cancer deaths.

'Banks and energy companies have been made subject to windfall taxes, so why not the tobacco manufacturers, who make eye wateringly high profits from products which kill two out of three lifelong customers?' said APPG chair Bob Blackman MP.

> The windfall tax could raise £74m a year and the levy ten times that...which could help pay for the 'shortfall in funding for tobacco control and public health'.

Unacceptable risk

MORE THAN 90 PER CENT of ambulance staff in the North East of England surveyed by Balance say that dealing with intoxicated patients is wasting valuable capacity and resources, with 40 per cent saying they've received threats of physical violence on at least six occasions.

Just one in ten said they'd never been threatened by an intoxicated patient or member of the public while on duty.

'The increased risky drinking we saw on the back of the pandemic is likely to lead to thousands of extra cases of disease and premature death,' said Balance's head of alcohol policy Susan Taylor. 'And for 999 crews it has created additional pressure on already stretched services.' The North East continues to have the highest rates of alcohol-specific deaths in England.

Scottish alcohol sales down three per cent since MUP

Minimum unit pricing (MUP) led to a 3 per cent net reduction in alcohol sales in Scotland in the three years after its implementation, according to a report from Public Health Scotland (PHS) and Glasgow University. The reduction was to off-trade sales, the report states, with 'no observed impact' on sales in pubs and restaurants.

The report follows PHS research that found the average price of alcohol in Scottish supermarkets rose by nearly 18 per cent after MUP was introduced in 2018, bringing it in line with the traditionally higher prices of convenience stores and hitting sales of own-brand spirits, strong ciders and multi-packs (www.drinkanddrugsnews.com/supermarket-alcohol-prices-in-scotland-rose-by-18-per-cent-after-mup). Alcohol-related deaths in Scotland, however, are at their highest level for more than a decade (www.drinkanddrugsnews.com/scottish-alcohol-deaths-at-highest-level-for-13-years), with a PHS report from earlier in the year finding that MUP was having little effect on dependent drinkers, some of whom were choosing to spend less on food and utilities and more on alcohol (www.drinkanddrugsnews.com/mup-having-little-effect-on-dependent-and-harmful-drinkers).

The MUP level of 50p is currently under review, and the Scottish Government is also consulting on increasing the restrictions around alcohol marketing in order to 'reduce the appeal of alcohol to our young people' – among the proposals are phasing out sponsorship deals, banning alcohol advertising in outdoor public spaces, and reducing in-store promotions (www.drinkanddrugsnews.com/scots-consult-on-alcohol-marketing-curbs)

'The latest data shows a reduction in per-adult sales of pure alcohol in Scotland at the same time as an increase in England and Wales was observed,' said PHS public health intelligence principal Lucie Giles. 'We found net reductions in per-adult sales of cider, perry, spirits and beer, and net increases in per-adult sales of fortified wine and wine. Taken together, the overall impact of MUP on total per-adult alcohol sales in Scotland was a 3 per cent net reduction, driven by a reduction in off-trade sales.'

Minimum unit pricing had been 'effective', added public health minister Maree Todd, a conclusion that took into account factors such as the impact of the pandemic, seasonal variations, household income and comparisons with England and Wales.

'Minimum unit pricing is achieving what it set out to do – a reduction in sales overall with a focus on the cheap high-strength alcohol, which is often drunk by people drinking at harmful levels,' she said. 'Further studies on MUP, including a final evaluation report, which is due next year, will examine how MUP has impacted on alcohol harms.'

'Minimum unit pricing is achieving what it set out to do.'
MAREE TODD

Evaluating the impact of minimum unit pricing (MUP) on sales-based alcohol consumption in Scotland at three years post-implementation at www.publichealthscotland.scot

Drug-checker Loop gets charity status

THE LOOP drug-checking service has been granted charity status by the Charity Commission, the organisation has announced. Earlier this year its new, regular drug-checking service in Bristol became the first of its kind to be licensed by the Home Office (*DDN*, June, page 4).

The commission undertook a comprehensive review of the organisation's activities and 'determined drug checking as a legal and charitable activity in the UK', the Loop states. This will help the organisation to further develop its services and reach more people and communities, it says, as well as improving opportunities to secure further funding. The Loop has also appointed a new CEO, Kay Porter, and full-time administrator Ursh Skeet.

'It's an amazing time to join The Loop; all the continued energy and commitment of so many over the past ten years has enabled us to get to this next stage in our development,' said Porter. 'The recognition and registration as a charity will mean that our health services and the important information we generate through drug checking will now reach more people in more places across the UK, and greatly assist in reducing drug-related harm.'

'It's an amazing time to join The Loop...'
KAY PORTER

Local News

INSIDE HELP
A new treatment service for alcohol, drugs and gambling has been launched in HMP Birmingham by Cranstoun, in partnership with Birmingham and Solihull Mental Health Foundation Trust. 'We want to continue to improve care for people and support them away from the criminal justice system to rebuild their lives in our communities,' said Cranstoun's assistant director for criminal justice, Arron Owen.

RESPONSIVE RECOVERY
The Calderdale Recovery Steps service, which is led by Humankind, has been rated 'outstanding' by CQC, particularly in the categories of being 'caring and responsive'. The service finds 'innovative ways of delivering more joined-up care to clients, particularly those with complex needs', CQC states. The rating reflected the 'dedication and hard work of our staff' said Humankind regional director Emily Todd.

LEAP AHEAD
Edinburgh-based LEAP has been able to add an additional eight residential rehab places and four detox places after being granted almost £3.3m in Scottish Government funding. 'LEAP is a perfect example of good practice in this area, with their three-month holistic programme of therapeutic care,' said drugs minister Angela Constance.

SHARING THE LOVE

HIT Hot Topics came back stronger than ever with a message of solidarity on peer-led outreach and a call to redouble action on drug-related deaths and ill health. **DDN** reports, photography by **nigelbrunsdon.com**

The stage was set for the first Hit Hot Topics conference for three years – and the tenth anniversary event. Pat O'Hare held up a 'chill out' leaflet from 30 years ago and recalled how HIT's advice on taking ecstasy 'caused a lot of fuss'. Times had changed but the challenges around harm reduction were no less significant. Coming together as a community was so important, said chair Niamh Eastwood of Release, because 'it provides us with resilience'.

Colleen Daniels, public health lead at Harm Reduction International (HRI), set the scene by drawing on the *Global state of harm reduction* report. The last two years had seen a slight increase in uptake of harm reduction interventions, she said. There had been a decrease in injecting but more people taking drugs overall, and both the COVID pandemic and the Ukraine war had had a significant impact on harm reduction services – their availability, accessibility and quality.

People of colour, women, LGBTQI+, migrants and refugees faced additional barriers and it had become obvious that the 'war on drugs has worked as a means of racial control'.

'MASSIVE GAPS'

There were also 'massive gaps' in prison harm reduction, and barriers to effective therapies such as hepatitis C medication, which was 'extraordinarily expensive' in some countries. Naloxone, 'one of the most cost-effective interventions in public health', was still not enough of a priority in tackling the 'massive issue' of overdose.

The data on mortality and morbidity showed that funding for harm reduction was only 5 per cent of what was needed in low- and middle-income countries. It was a situation affected by an 'antiquated colonial top-down approach', she said.

'We have to look back to look forward,' said Peter Furlong from Change Grow Live, who spoke from long-standing personal experience of pioneering harm reduction. 'The new drug strategy says we'll have world class treatment system – but what's happened to the evidence?' he asked. We'd lost the balance of harm reduction, treatment and recovery and the sharp increase in drug-related deaths 'comes back to abandoning harm reduction'.

The purity of drugs had increased, cocaine-related deaths had risen significantly, and Dame Carol Black's review showed that 'money alone will not fix this'. 'We have to redesign services to make them more attractive, involving people who use drugs,' he said. 'We need to make treatment easier to access.'

TACKLING EXCLUSION

The need to tackle exclusion became clearer as the day went on. Jesse Bernard, a writer, DJ, researcher and filmmaker talked about three events that had shaped his own experience – being excluded from school, censorship of his music (drill, a subgenre of rap), and policing related to drugs.

He learned the hard way that people of colour were treated differently when he was suspended from school, but 'nothing happened to the other [white] kid'. There were 'school to prison pipelines – if you're kicked out of school, you're more likely to end up in prison'.

Censorship of black music and criminalisation of artists had 'always been there', from jazz in the 1910s onwards. Musicians had endured all kinds of suppression including broadcasting bans, shows being cancelled and being forbidden to record. Artists had evaded censorship by inventing new words and slang, which were shared rapidly online.

Mackayla Forde, a poet and academic known as Red Medusa, took up the narrative. Black people had been subjected to violence,

'We have to look back to look forward... What's happened to the evidence?'

PETER FURLONG

lies – and to disproportionate stop and search.

Did people who made global drug policy consider race? A search of key words in 41 documents suggested they didn't. Words and terms such as race, racism, racist, and racial injustice didn't feature. 'Our story has not been included in the literature,' she said.

Dynamic peer networks were helping to rewrite the narrative. Phoenix – aka Mohawk, a 'rebel educationist' – travelled to parties around California with information and a 'pharmacopeia to help hydrate people and help them think about harm reduction'. From being a 'raver, engaged in a lot of drug use, getting whatever I could to enhance my experiences', Mohawk rose to the challenge of outwitting the NYPD to distribute water, evading arrest, and – with the aid of a borrowed spectrometer – running a drug-checking lab from an apartment living room, 'Ubering samples back and forth from a party to give people the information.'

The need for this intervention was acute, particularly with such high risks from a tiny amount of fentanyl. 'I feel I have to work outside of an institutional context,' said Mohawk. 'There are a lot of people like me, low income, people of colour, at very great risk.'

SHARING INFORMATION

Karin Silenzi de Stagni had had similar experience of needing to find people and intervene at the right time. As part of a small volunteer-run charity called Psycare UK, she shared information – at parties, schools, music events, festivals – wherever people might come into contact with recreational drugs. 'Young people taking drugs is part of human nature – it's a natural thing to do, to discover, to know,' she said. 'So we try to take the stigma out and create bridges with health services. And because we are peers and not in uniform, we are approachable.'

'I feel I have to work outside of an institutional context. There are a lot of people like me, low income, people of colour, at very great risk.'

MOHAWK

Prohibition led to lack of information and all kinds of risks – adulteration and misidentification of drugs, dosing errors, adverse interactions from polydrug use, and effects of pre-existing medical conditions. Added to festival conditions – lack of sleep, sensory stimulation, lots of people, bad weather – psychedelic drugs could magnify the mindset and setting and lead to symptoms that appeared to be common with psychiatric illnesses. Psycare took 'a non-conventional approach without medication and without burden on the NHS' to help the person understand and integrate their experience, and tried to work with them afterwards. 'We're non-judgemental and listening is key,' she said. 'We allow the process to unfold and let them acknowledge their capacity to treat themselves. It's a mutual learning experience.'

SELF ESTEEM AND RESPECT

Using drugs for 42 years, 18 of them injecting, had informed Lee Hertel's decision to create Lee's Rig Hub in Minneapolis, 'a space to drop in and hang out', with access to syringes, HIV testing, information and the internet. Until then, 'services were delivered in a very stigmatised setting, with people expected to stand outside in all weathers and temperatures,' he said. His hub was a place for camaraderie, which made a 'great difference to self-esteem and self-respect'. It also acknowledged that 'people want to get high' and got on with 'meeting and educating more and more people'.

Haven Wheelock met her challenge while living and working in Portland, Oregon – 'founded as a white supremacist state, with some of the highest rates of substance use and misuse in the country, where drug laws always disproportionately affect black people'. Her work at Outside In, helping to link marginalised and homeless people with health and wraparound services, made her realise the desperate need to increase care for people who use drugs.



> ‘Gone are the days when you could only get treated in treatment centres. We’re rocking up in car parks and at people’s doors’ to make sure of not losing people.’
>
> TRACEY KEMP

With support from the Drug Policy Alliance, she became chief petitioner for decriminalising small amounts of all drugs. It resulted in a transfer of millions of dollars in tax from the legalised cannabis market to create a harm reduction programme across the state from naloxone rollout to distributing crack pipes. A peer-led council (‘over half of people on it have been incarcerated and there are no cops’) was deciding where the money goes and there had already been ‘great progress’ in distributing naloxone and crack pipes. The council’s work was not easy, as it was ‘a messy process – messy and passionate’ with untrained people, she says. ‘But we have a lot of passion and the potential is amazing’.

Distributing crack pipes was also a hot topic in the UK, as Dr Magdalena Harris of the London School of Hygiene and Tropical Medicine explained. The safe inhalation pipe provision (SIPP) project had been driven by the significant rise in crack use alongside neglect of the relevant harm reduction. There was ‘little incentive for people who use crack to go through the door of services’, she said.

Prohibition of crack pipes had led to an increase in pipe sharing and crack injecting, which were both associated with ‘a lot of health harms’. People were also resorting to making their own pipes, which might not be heat resistant, have sharp edges and result in vapour inhalation being overly hot – all significant issues ‘in relation to a vulnerable population’.

The project was working to try and change the law and had police and crime commissioner support, but she was feeling frustrated at the hurdles to get it off the ground. ‘Efforts have stalled – people are not certain about the legality,’ she said. ‘We have to demonstrate that it won’t cause harm, but we can’t do it as it’s against the law.’ The Ethics Committee was concerned it would cause undue harms to a vulnerable population, but as a qualitative researcher she was excited at being able to address people’s needs and urged anyone interested to get involved in the collaborative project.

HEP C ELIMINATION

As a project with the full weight of UK government – and World Health Organization – support behind it, the goal of hepatitis C elimination by 2025 seemed to be within reach. But as Tracey Kemp, Change Grow Live’s harm reduction lead explained, much of the significant progress was down to working with invaluable Hepatitis C Trust peers, ‘a force to be reckoned with’ and part of ‘an army of us working together’ to test and treat.

Harm reduction pathways were ‘the golden thread’ in making testing and treatment accessible to all, and this meant ‘meeting people where they’re at,’ she said. ‘Gone are the days when you could only get treated in treatment centres. We’re rocking up in car parks and at people’s doors’ to make sure of not losing people who were not in structured treatment. Sustaining elimination would depend on having adequate harm reduction, including syringe provision, and collaboration and partnerships – including working with other providers to engage people in treatment.

UNCOMFORTABLE QUESTIONS

With a clear evidence base for effectiveness, the project was meeting clearly defined goals. So hearing about Danny Ahmed’s experience with the diamorphine assisted treatment (DAT) programme in Middlesborough raised many uncomfortable questions. The programme, also known as heroin assisted treatment (HAT), had been celebrated as a highly successful intervention, but was being discontinued through lack of funding from the local authority.

As the programme’s clinical lead at Foundations, Ahmed had seen ‘huge levels of engagement – 97 per cent’ from the people involved. Middlesborough had the highest number of people using heroin in the country and with half of its wards deprived, there was ‘no better place to look at alternatives to traditional treatment models,’ he said. Patients were relatively young (an average age of 38-40) and had ‘medieval levels of life expectancy’ as well as being likely to have mental health issues and be impacted by early trauma. ‘It was obvious we needed to do something,’ he said.

Starting in October 2019 the programme operated for three years, using two rooms with injecting booths and offering wraparound support (*DDN*, November 2019, p5 and *DDN* November 2020, online news). Many individuals became completely abstinent from street heroin, and many reduced their use of alcohol and street tablets. Furthermore, he says, ‘the biggest outcomes were the connections, not related to drugs... there were vast increases in physical health, mental health and wellbeing. Staggering changes... people were able to get their own housing.’ There was also a 60 per cent reduction in crime.

At £16.50 per person per day, he was told that DAT was too expensive. But on what terms? Of those who didn’t take part in the programme, six died and 43 had custodial sentences. ‘We heard that the programme has failed,’ said Ahmed. ‘But it hasn’t. Commissioning has failed, the drug strategy has failed and people who use drugs have been failed.’

‘We hear that there’s no demand from treatment services for this treatment,’ added Niamh Eastwood. ‘We need to tell OHID that there is. Fifty per cent of people who are dying aren’t in treatment.’

Hearing throughout the day about such dynamic work to scale seemingly insurmountable challenges certainly demonstrated a harm reduction community ready to fight for its lives. **DDN**





A question of TRUST

A genuinely trauma-informed approach is vital to any effective treatment system, say **Andrew Tye** and **Kimberley Ward**

In the field of substance use, working with distress associated with early trauma is a regular feature of helping clients to understand and gain control of their dependence. One of the leading causes of developing substance dependence later in adult life is childhood trauma. A study of individuals being treated for substance use disorder and PTSD found that 77 per cent of the sample had experienced at least one trauma as a child (Farrugia, et all, 2011).

However, what constitutes 'trauma' is subjective and varies from one person to the next. It isn't necessarily a specific experience, but more to do with how the individual perceives and experiences the event. Trauma results from an event or multiple events that an individual experiences as emotionally or physically harmful. These experiences can have lasting effects on wellbeing, and some of the most common experiences of childhood trauma include neglect, sexual, physical and psychological abuse, loss of a parent or other close family member, witnessing domestic violence, medical traumas or having a parent that used drugs or was mentally ill.

UNPROCESSED TRAUMA

How these traumas manifest, and how they affect the individual differs from person to person. As adults we can deal with trauma more effectively, but as children we may lack the frame of reference that we use later in life, which makes it much harder for children to process trauma. As a result, such experiences are more likely to have long-lasting effects. Unprocessed trauma is stored in the subconscious, where it can have huge effects on how our lives are shaped as we grow older.

As a child, we depend on those around us for protection and support. When that fundamental need is met with the polar-opposite, it often has irrevocable effects that can last for an individual's entire life. Self-medication with substances offers relief or respite from pain and memories associated with these experiences, so substance use may develop as a coping response that can be effective but also problematic in terms of the consequences of substance dependency.

PeopleImages / iStock

DELPHI AND ACORN offer substance misuse services within prisons in Manchester and Lancashire, detox, residential rehab and community-based services in Blackpool and Blackburn with Darwen, including ADDER.

According to Clark (2022), there are just under 80,000 prisoners in the UK. A study of Welsh prisoners by Ford et al (2020) found more than 80 per cent of male prisoners have suffered at least one ACE, while approximately 45 per cent have suffered four or more ACEs. This demonstrates how many of our clients in prison services might have experienced ACEs, so our understanding of them is vital to adopting a holistic, person-centred approach when supporting them through psychosocial interventions and OST treatments. Staff need to be mindful of the possibility of re-traumatisation and develop close working relationships with the prison mental health services to ensure the clients' mental health and wellbeing is supported.

Research into the impact of childhood abuse has demonstrated a correlation with impacts such as on establishing safety in relationships, hypervigilance, deteriorated self-esteem and increased possibility of developing a range of mental health issues...

ACEs (adverse childhood experiences) research and training has increased awareness of the impact of early trauma on health outcomes. Research into the impact of childhood abuse has demonstrated a correlation with impacts such as on establishing safety in relationships, hypervigilance, deteriorated self-esteem and increased possibility of developing a range of mental health issues, including anxiety, depression and psychosis.

NEGATIVE CONSEQUENCES

The 2010 drug strategy with its focus on recovery and abstinence, a period of reduced funding and an outcome-based focus – such as payment by results – had many negative consequences, including record levels of drug-related deaths. The value of therapeutic support diminished with a perception that engaging clients in dialogue to discuss difficult experiences was slowing down the process toward 'successful discharges', on which services were measured for effectiveness.

Unfortunately, a focus on abstinence without the opportunity to provide a means to address the issues to which substance use had developed as a coping response is likely to lead to increased risks – either of relapse, development of alternative maladaptive coping responses such as self-harm, or ultimately, of course, of an increase in drug-related deaths.

In England, no area has been affected more by drug-related deaths than Blackpool. Thankfully there is a well-informed and dedicated leadership within Delphi, as the lead substance misuse service provider, as well as local commissioners with passion to drive forward harm-reduction initiatives and the compassion of staff with a wealth of knowledge and determination. This has provided the foundation for an effective, innovative and meaningful way of addressing the issues that can result from experiences of early trauma.

At Acorn, the residential rehabilitation programme is based around attachment theory and working with ACEs. The former refers to the type of emotional bond formed between an infant and a caregiver – those who are at increased risk of substance misuse as such insecure attachments can influence psychological, physical, and behavioural wellbeing later in life.

Substance use may be seen as a dysfunctional way of compensating for feelings of insecurity. These feelings make it difficult to form meaningful and healthy relationships, with the substance a replacement for secure relationships. The substance is predictable, unlike the caregivers of the past. In this sense, the relationship with substances can be an attempt to replace the lack of safety and security as an infant. The substance user is looking for a solution 'out there' to make up for the lack 'in there'.

Many in recovery will attest to this theory, having had a history of trauma or abuse, neglect and inconsistent care-giving when they were children. However, a common view in society is that people who suffer from substance dependency have made a choice to become dependent or have some kind of moral failing.

To be effective, treatment focuses on the inner deficit, the lack of a sense of security and the feelings of inner pain. Compassion and understanding are required to fully assist the person to heal from their inner pain, and treatment may require longer-term therapeutic support with a focus on repairing the pain from the past. The emphasis is to develop a 'secure base' using a trauma-informed model of: no blame, no shame, empathic curiosity and that the behaviour is not the problem but the answer to the problem.

TRAUMA-INFORMED

In each of our services, a trauma-informed approach (TIA) is applied to the way services are delivered, how professionals relate to the people who use services and how staff are supported. TIA is becoming evident in every aspect of our work, from the ways in which prescriptions are managed to how we consider our policies and how we create our environments to promote safety, choice and trust.

Assessments are designed, and trusting relationships are formed, to appreciate the possibility of adverse experiences and improve awareness of early trauma. We are developing our services to be psychologically informed, reducing the possibility of triggers of vulnerability (re-traumatisation) and use a 'trauma lens' to understand clients' behaviour, including considering why a person may have disengaged from services or responded with aggression – fight/flight responses to vulnerability often associated with early childhood experiences.

We are also mindful of the possibility of 'vicarious trauma', experienced by staff when working with those who have experienced early trauma, on a regular basis. Safe spaces, in the form of weekly talking circles, are available to ensure wellbeing and develop supportive relationships as well as opportunities for discussion. All of this is already having a positive effect on the ways that we engage with service users and support our staff.

However, further work is needed and we realise that our work is situated in a wider context. Hopefully, as other services also address their approach to appreciate the prevalence and impacts of early trauma, this will lead to provision of suitable and safe housing, opportunities to develop safe and trusted relationship within the community, and timely provision of trauma-specific interventions, to support the undoubted progress that is being made.

With acknowledgement to all of the wonderful and determined staff and clients.

Dr Andrew Tye is clinical psychologist and Kimberley Ward is recovery nurse at Delphi Medical

People in prison often need extra support at this time of year, says **Pam Hassett**

FESTIVE FEARS

Christmas is almost upon us, and it can be an especially hard time for people in custody. With the Christmas period seemingly starting earlier and earlier each year, the impact it can have on the people that we support cannot be underestimated.

We hear people talking openly about the stress this causes them, not only because they know they will not be with their families over the Christmas period and won't be there to see the joy on their children's faces when they open their presents, but also their feeling of guilt and shame that they feel for not being there.

This time of year tends to be a time of reflection for the people that we support, not just on the year gone by but on where they find themselves now and the circumstances which led them here. I would say this is not necessarily a negative thing, as it's a chance to explore these feelings, sometimes for the first time. It can also bring back memories from their own childhood Christmases, and feelings about how they want their children's Christmases to be from now on. This can bring them motivation to address the reasons why they are where they are right now.

With all of this in mind there is the added pressure of the availability of substances. There is the temptation of wanting to block out these feelings and fall back on old ways of thinking – to 'have a day off' and get out of their own head, something which is explored on a one-to-one basis and in groups. It is still amazing to me how honest the people that we support are in expressing their feelings. It feels like 'we're all in the same boat together'. We encourage people to support each other over this time, to get together and talk about how they're feeling.

In the run up to Christmas from 1 November the team get together and discuss Christmas and how we can best support people at what can be their most vulnerable time. Every year, in the two weeks leading up to Christmas we attend reception daily and see everyone who is being released. We talk to them about harm reduction and how to keep themselves safe if they do end up using drugs or alcohol. We also hold a daily drop-in service on wings, which gives people a chance to come and have a chat to us in a safe confidential space.

We hold a feedback forum for people to have their say on how they would like to be supported over this period, and what they want that support to look like. The top feedback we have received every year has been to just simply sit down, share their feelings and to have a listening ear.

In the run up to Christmas we also hold support groups with no specific topic to be addressed. It's simply to talk about what's going on for people right now, and to share their feelings with their peers and gain support. This is where they tend to realise that they all share the same feelings of guilt and remorse at where they find themselves at Christmas. This leads to bonds being formed and a feeling that they can support each other over this time. Distraction packs are also available for anyone who needs them – these take the

'Prisoners tend to realise that they all share the same feelings of guilt and remorse at where they find themselves at Christmas. This leads to bonds being formed and a feeling that they can support each other over this time.'

Jellypics

form of crosswords, Sudoku and colouring books.

We also can't forget about the families who are impacted by their loved ones being in custody. We arrange a family day, which means that families can have an extended half-day visit, and we also arrange for food to be provided and activities for the children and dads to do together. The hall is decorated, and families get the opportunity to spend more time with their loved ones. Pictures are taken of families as a memento of the day, and judging by the feedback received these are always greatly appreciated by everyone.

Apart from family days, by far the most popular activity is Christmas card-making, especially for their children. The people that we support take great pride in their creations, and it gives them a feeling of accomplishment in doing something personal for their children. Quizzes and bingo are always a big hit, especially when the prize is extra PIN credit to enable them to have extra contact with loved ones.

In the lead up to Christmas we also have a harm reduction campaign, which is a great opportunity to reach everyone in the establishment and spread the harm reduction message. In addition to this everyone is given harm reduction advice during one-to-one meetings, and we utilise our peer supporters to spread the message across the prison as they have access to people outside of our 9-5 working day.

Our peer support programme is now well established after COVID and it can be invaluable in offering support when we are not here. Peer supporters have an open-door policy so anyone can pop in and see them when they are struggling. They are easily recognisable in their Phoenix Futures t-shirts and the peer supporter sign outside their cell door.

This Christmas will no doubt be a very busy time. However, our focus will be to support people through it and maybe spread a little festive cheer along the way.

Pam Hassett is Phoenix Futures service manager at HMP Wayland

VITAL KNOWLEDGE

Thank you for giving such helpful information on a sensitive topic last month ('Game changer, *DDN*, Nov, p15). I have recently learned about the effects of menopause that might affect women's drug use but I knew nothing about the possible link between opioids and a dramatic drop in testosterone. Can I encourage my fellow professionals to read this article and arm themselves with information that could make someone's life a lot happier. And particular thanks to the author for sharing a personal story.

E Challenor, by email

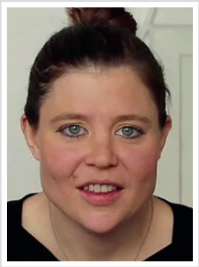
'Can I encourage my fellow professionals to read this article and arm themselves with information that could make someone's life a lot happier.'

OPENING OPTIONS

Thank you for the careers series, which I'm finding very helpful. As a student I'm keeping my options open during my training but it's giving me ideas on where to head for. I came in contact with *DDN* through my university careers service and have learnt so much from it. I'll write you an article when I qualify!

Amy Reeve, by email

WRITE TO YOUR MP!



'IF YOU WANT DRUG POLICY TO CHANGE, you need to write to your MP,' said Jane Slater of Transform, who also led the Anyone's Child campaign. She was talking at a lunchtime session at HIT HOT Topics and brainstorming the most effective ways to bring about policy reform.

'Lots of MPs haven't thought about these issues – you are the experts,' she said. 'They think these issues don't work for their voters. Meet your MPs, do your research, find the common ground through rational conversations.'

'A slow, slow hammer approach' worked, she said. From just one MP supporting Anyone's Child, the campaign now had 50. Attend MPs' Friday surgeries, she urged. 'Prepare for the meeting, think about the tone, have an ask. Get your MP to sponsor a meeting – they don't have to give their views, but it will bring people together to exchange views.' An MP's involvement would also bring stakeholders, including police, and 'if an MP says something progressive, others follow and discuss.'

There was plenty to discuss, including diversion schemes, overdose prevention centres and heroin-assisted treatment – and the reasons to keep these life-saving initiatives going. Find the evidence and bring in respected sources like the Royal Society of Public Health journal and the Royal College of Nursing, she said, and 'let's build bridges'.

DDN welcomes all your comments. Please email the editor, **claire@cjwellings.com**, join any of the conversations on our Facebook page, 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.

/ddnmagazine @ddnmagazine
www.drinkanddrugsnews.com

FACING THE

In the third part of our commissioning series we look at what's needed to get the sector in the right place to deliver a world-class treatment system

In the first of this three-part series we surveyed the commissioning landscape after a decade of shrinking budgets (*DDN*, October, page 12) and in part two we looked at how local areas go about making sure that people with lived experience are part of their partnership structures – in a meaningful way (*DDN*, November, page 12). In this final part we focus on where we go from here, and what's ultimately needed for better commissioning.

Two of the words people most often use when it comes to effective commissioning are honesty and trust. Joint commissioning manager at Cornwall Council, Kim Hager, explains that her relationship with provider With You has always been an 'entirely joint approach' – one that's made far stronger by a willingness to be frank on both sides. When the council's supplier management team carried out an appraisal of the relationship, what came through was 'high challenge, high support', she says. 'We both said, "we'll take that". It's very robust, very challenging, but they know it's for the right reasons.'

MUTUAL UNDERSTANDING

The mutual understanding is that both organisations are constantly learning together, she points out – something she feels is vital. 'I've noticed in some other areas that they devolve so many things to their provider – the case management system, the engagement, everything – but we don't do that. It's been dialogue all along – dialogue, challenge, support, and they know we'll fight their corner when required.'

Meanwhile, trust obviously needs to be an 'essential component of a strong and positive working relationship with commissioners', says executive director of services at WDP, Craig Middleton. 'The commissioners I work with are quite progressive in terms of finding new and exciting ways to solve a problem – that's genuinely the case. It's about having conversations with people and saying "this is what's

Ponomariova_Maria / iStock

FUTURE

'We're in a position where those who want to can seize the ground and make a good job of it.'
KIM HAGER

happening" or "this is what we need" and working together, a co-production of solutions.' From there, all parties work can work together on a mutually agreed plan – key to delivery of which will be maintaining that trust, he says.

BUILDING TRUST

'I think commissioners are doing that' agrees executive director of new business at With You, Sarah Allen. 'As a provider we really invest in building trust with commissioners. I think the more open and transparent we are as an organisation the better.' The additional funding coming into the sector has led to some 'really collaborative conversations' with commissioners, she says, and 'being really open around saying, "These are areas we've not been able to focus on, we want to drive this forward – how do we do that together?" It can also be about making sure the right partnerships are in place outside of these relationships, she stresses, if that's what's necessary to meet the needs of service users. 'No one provider can do everything on their own – we need that collaboration locally. Commissioners are open for that innovation and working with us to do that, and I think that's really exciting.'

However, while commissioners have been supportive with innovation, up to now providers may sometimes have had to go external sources to fund that innovation.

'Commissioners and providers need to be pragmatic in the context of current challenges, but also remain ambitious about improving the quality of treatment.'
ROSANNA O'CONNOR

'The benefit we have now is that additional money is coming into commissioning teams to be able to work side-by-side with us and see that through,' Allen says, 'rather than us hoping that we can secure funding through grants or trusts or additional funding streams to support it. If anything it's going to help us plan to be more innovative and creative and think longer term, because those other funding streams would normally be one or two years. So I think there's enormous potential to really grow and embed that innovation across different services.'

The government is making 'a record investment in drug and alcohol treatment and recovery of £532m over three years, as our part of the bold ten-year drug strategy,' director of the Addiction and Inclusion Directorate at the Office for Health Improvement and Disparities' (OHID), Rosanna O'Connor, tells *DDN*. 'This is to improve the capacity and also the quality of drug treatment to reduce harm and help people initiate and sustain recovery.'

There is new investment totalling almost £900m over three years, with £780m to improve treatment and recovery – of which £532m will be invested to improve local authority drug and alcohol treatment and ensure more collaborative invigorated partnerships, she says. 'We want to see high-quality services that meet local need and allow for innovation. As part of this, we are supporting partnerships to foster and support recovery communities and lived experience recovery organisations.'

ROBUST FRAMEWORK

For commissioning to truly deliver it also needs a robust framework, and the government's wide-ranging overview of what good commissioning should look like – the Commissioning Quality Standard (CQS) – was published in the summer in response to one of the key recommendations of the Carol Black review. 'What substance misuse has lacked over the time I've been in it – which is a decade – is central leadership on procurement, so it's useful that commissioners know what they're working with,' says executive director of development at WDP, Graham Howard.

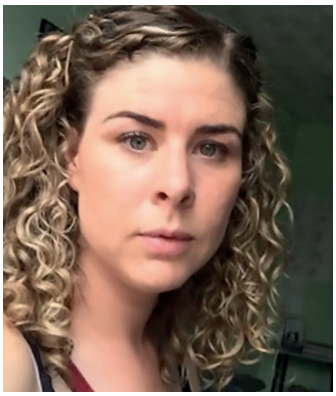
Local authority commissioners have traditionally faced a wide range of challenges, he points out. 'They have to look at what national best practice is, NHS

'We've got to bring in a whole new generation of practitioners to meet the expectations of the new investment.'
CRAIG MIDDLETON

procurement regulations, and their own local team who are across the procurement of all the services a council runs tendering processes for – that could include building contracts, cleaning, waste disposal, all kinds of things.'

CONSISTENT STANDARDS

These local teams will want to apply consistent standards across those contracts, so if the new standard allows commissioners and procurement teams to work together to tweak tendering methods for drug treatment contracts where needed it will be 'really useful', he states. 'For example, sometimes you get price/quality splits that are very highly in favour of price, which I don't think are very helpful when investment should be going to frontline delivery as much as possible.' Commissioners may have had to use that split because the local authority uses it across all its procurement, so 'more of a sense of central best practice' for local commissioners to use will be very helpful, he states.



'No one provider can do everything on their own – we need that collaboration locally.'
SARAH ALLEN

The CQS has been well received, says O'Connor, and 'aims to support partnerships to improve the consistency and quality of treatment and recovery systems in England. It has been welcomed by commissioners, providers and partners – in particular, feedback has praised how the CQS understands commissioning as a process of system leadership and development. We look forward to supporting local partnerships as they work towards meeting the standards over the course of the drug strategy.'

So are we genuinely entering a new era for commissioning, and the treatment field in general? 'Notwithstanding the backdrop that public finance and government policy are quite changeable at the moment, I've not seen anything like the Dame Carol Black report in the ten years I've been doing this,' says Howard, 'nor have I seen something that's actually translated into policy so quickly and with impact. It's quite difficult to get attention on our sector and that actually managed it, and I think the government investment has actually been very much in line with what the report says is needed.'

TIME AND INVESTMENT

'The investment is long overdue,' says Allen. 'It's extremely welcome and the recommendations in Dame Carol Black's report are absolutely vital to us as providers to be able to reinvigorate the sector and get back to where we need to be, and we hope that investment commitment to 2025 remains for that stability.' For the sector to be able to deliver on the strategy it will need that time and investment, she says – 'without that it will be really hard to achieve some of those commissioning standards.'

Although treatment funding escaped the knife in the chancellor's recent Autumn Statement, the great unknown remains what will happen to the new investment after the first three years.

'Hope for the best, prepare for the worst' might be a wise strategy, says Middleton. 'We're having conversations with commissioners trying to understand what the plans are for the next few years, because obviously there's a commitment up to a certain point but we need to understand what's going to happen after that as soon as we can. With the new money, the sector obviously has an opportunity to grow again, and we've got to bring in a whole new generation of practitioners to meet the expectations of the new investment.'

SERVICE IMPACT

If the funding is maintained, however, then 'we should absolutely be seeing its impact in services,' says Howard. 'Some of that will take a longer amount of time, because one of the problems Dame Carol Black identified was that certain professional and medical roles have been diminished, and those can't just be created out of thin air. We need to get people training for them and going through years of study, so even in a ten-year cycle we might potentially only start to see the dividends of that towards the end.'

So does that mean that people should possibly try to manage their expectations? 'Commissioners and providers need to be both pragmatic in the short term in the context of the current challenges, but also remain ambitious about improving the quality of treatment in the longer term,' says O'Connor.

'It's vital that we increase the skills mix of the workforce if we are to deliver high-quality treatment and recovery systems which reduce harm and help more people to initiate and sustain recovery. OHID has commissioned Health Education England to develop a ten-year workforce strategy that will set out a clear roadmap for the future, including the training of registered professions.'

The government has also commissioned a new drug and alcohol treatment and recovery capability framework, which is due to be published next summer, O'Connor points out. 'This will be a refreshed drugs and alcohol national occupational standards, reflecting the sector's current needs. Work will begin soon to scope and develop this framework with the sector.'

'Price/quality splits in favour of price are not helpful... investment should be going to frontline delivery.'
GRAHAM HOWARD

SUPPORT AND DEVELOPMENT

'I think we're in a position where those who want to can seize the ground and make a good job of it,' says Hager. 'It's what's behind the standard to support commissioners who aren't experienced, to understand what commissioning is – or could be – the evidence around it and approaches they can take. Those who've been around a while know how to navigate that, but we're a minority.

There needs to be support for commissioners to develop in their role. The standard's good for that, but it's about how much people buy into that – how do we develop the learning? In our joint commissioning group we discuss 'what do we mean by commissioning', because often what you encounter in local authorities is they just think it's shopping and procurement. It's strategic leadership and acting on behalf of the people we represent, making the best use of the resources available. We're that link. Transforming commissioning isn't just about transforming procurement – it's about a learning approach, not a top-down approach.'

SKILL SHARING

'It's a really interesting time,' says Allen, and retaining some of the hybrid models and approaches around staff training and development that developed during the pandemic will be important. 'That very virtually-based offer – we've got really skilled and experienced staff, and we need to make sure those new staff coming in have the opportunity to work alongside and be close to them, and have the combination of face-to-face and different training options.

'It's sharing those skills and best practice that's really going to allow the workforce to develop – a lot of people have worked in this sector for a long time, and we need to value that. We're going to be having staff coming in with less experience and we need to do as much as possible to wrap around them so they don't feel overwhelmed by this.

'I am optimistic and I'm going to remain optimistic,' she says. 'I think we also have a huge sense of responsibility. We want to show that this funding works and has impact, and if we want to make the argument for continued investment beyond 2025 we need to deliver on that. We can't waver on that passion, commitment and enthusiasm – we have to remain committed on that path.' **DDN**

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

We welcome your thoughts, feedback and experiences on commissioning and hope to take the conversation forwards from this series of three articles (Oct, Nov and Dec/Jan issues). Please email the editor.

ON THE ROAD TO RECOVERY

In a tumultuous year that saw three prime ministers and a war in Europe, the sector tries to get back on its feet after COVID and a decade of tightening budgets

JANUARY

With COVID still casting a shadow over the country, research by Newcastle University and NIHR finds that people already in the top fifth of heaviest drinking households were buying 17 times more alcohol during lockdown than those in the lower fifth, while a separate NHS Digital report says annual alcohol-specific hospital admissions have hit 280,000 – an 8 per cent increase in just three years.

FEBRUARY

The NHS opens two new gambling clinics to try to cope with 'record' demand, while the Royal College of Psychiatrists warns that thousands of young people struggling with substance issues are 'falling through the cracks' of treatment services as the pandemic compounds the problems caused by shrinking budgets.

MARCH

Despite the Scottish Government's commitment to spend £250m to repair its struggling treatment system, drug and alcohol data north of the border is still 'not good enough', the country's auditor general warns, with an ongoing lack of transparency about how money is being allocated and spent.

APRIL

The Committee for Advertising Practice announces a ban on gambling firms using content likely to appeal to young people – such as sports stars and social media influencers – in their ads, while the Biden administration's first drug strategy adopts a harm reduction approach in the face of record US overdose deaths.

MAY

The Home Office issues its first ever licence for a regular drug checking service, operated by The Loop in Bristol. In stark contrast, crime and policing minister Kit Malthouse pens an article in the *Telegraph* warning that 'middle-class cocaine users' risk losing their passports and driving licences, while the ACMD states that the UK's drug prevention system – especially 'fear-based' campaigns – is failing.

JUNE

'We wondered if it would ever happen – and then there we were'. *DDN* holds its first conference for three years, with a palpable sense of energy as delegates gather in Birmingham for *All Together Now*. UNODC says worldwide cocaine manufacture is at its highest level ever, while EMCDDA adds that the European drug market has rapidly 'bounced back' after COVID, with cocaine availability now surpassing pre-pandemic levels. In Ireland, meanwhile, the drug overtakes heroin as the main problem substance for people seeking treatment for the first time.

JULY

Scotland sees the first fall in its drug-related death total in almost a decade, although it's just 1 per cent. In its final report, the country's Drug Deaths Taskforce states that the issue has 'not been given the priority it deserves' and that many feel the healthcare system 'often sees only the drug problem and does not recognise the person', a perception that 'dissuades many from accessing services'.

AUGUST

Days after Scotland records its slight fall in drug deaths, England and Wales yet again register their highest ever drug poisoning death toll – a 6 per cent increase on the previous year, at 4,859. As always the death rate in the North East is 'statistically significantly higher' than elsewhere, says ONS. Meanwhile, a YouGov survey finds that two thirds of adults think government drug policy isn't working.

SEPTEMBER

In the heart of the North East's drug crisis, Middlesbrough's ground-breaking HAT programme is set to close as funding runs out, while global drug executions increase by more than 300 per cent in a year. Meanwhile, Entain Group – which runs Ladbrokes.com, coral.co.uk and foxybingo.com – is slapped with a record £17m fine. Even people subject to gambling restrictions were able to open multiple accounts with its other brands, the Gambling Commission finds, with one customer blocked by Coral able to immediately deposit £30,000 with Ladbrokes – in a single day.

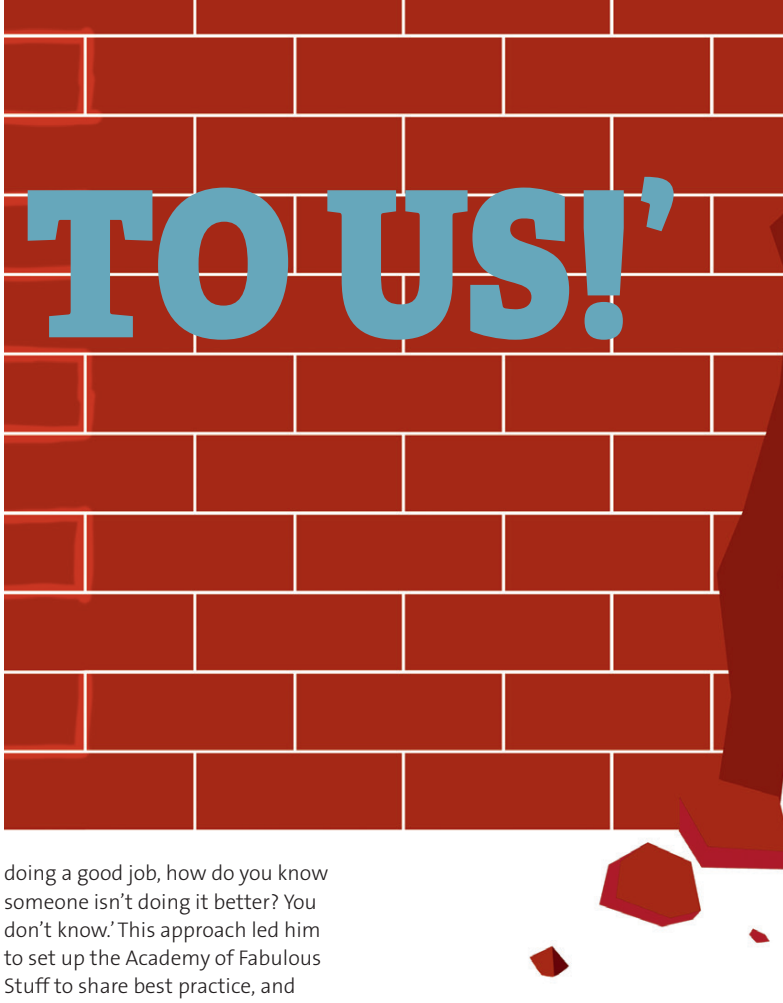
OCTOBER

While the money now flowing into the sector means that services finally have the funds for new staff, many are finding that a health and social care recruitment crisis means the candidates just aren't there, commissioners tell *DDN*. Offering more money also risks destabilising other parts of the system, warns ESUCG chair Chris 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' – something that 'doesn't help anybody because we need a workforce plan right across that multiple and complex needs sector.'

NOVEMBER

Fears that the sector's new funding might fall victim to cuts in the chancellor's Autumn Statement thankfully prove unfounded, while more than 50 organisations write to the prime minister calling for the alcohol equivalent of Dame Carol Black's *Independent review of drugs*. *DDN*, meanwhile, celebrates its 18th birthday – here's to the next 18! **DDN**

'IT'S UP TO US!'



Stigma may feel like a brick wall but we can work together to dismantle it, heard the NHS APA annual conference. **DDN** reports

Opening a conference about stigma, Roy Lilley began with a personal story. His dad was 'born illegitimate' as it was regarded back then. The status thwarted his chance to go to the Royal School of Music at the form-filling stage. He came back from WWII with shell shock and went to a mental health hospital where they gave him electric shock therapy. Later, struggling to make a living in post-war austerity Britain, he couldn't get a job in the grocery trade where he'd started, as he'd been in a mental institution.

'That's a story about stigma,' said Lilley. 'It happened a long time ago, but it has relevance. Stigma changes people's lives.' Whatever the context – and 'it doesn't matter if they're unfortunate enough to be dependent on a drug' – it was still stigma, and as prevalent now (he gave Twitter as an example) as when it impacted his father's life in the 1920s.

Thinking about three categories of stigma could help to tackle it, he said. Self-stigma was about internalising feelings of shame and lack of self-belief; social stigma involved taking on negative attitudes towards yourself and your family members, while structural stigma was built into the system.

So what could we do about any of this? 'It's up to us – up to people like you who work in the sector,' said Lilley. He offered a phrase from his earlier writing about stigma: 'Stigma is a burden borne by people with quite enough of a burden already. It's our job to lighten their load.'

A good approach started with curiousness. 'When you think you're doing a good job, how do you know someone isn't doing it better? You don't know.' This approach led him to set up the Academy of Fabulous Stuff to share best practice, and he urged people to 'pinch it with pride'. He believed that we wouldn't improve health services by league tables, inspections and embarrassing people. 'The only way to improve our services is by being curious, by opening our minds,' he said. 'Our minds are the parachutes – they're better when they're open.'

The next important factor was to improve skilfulness by training, aiming to 'improve everyone's skills base by one notch'. He appealed to budget holders to give time to people to improve their skills base, something that could be done in-house through dialogue, by talking to each other, if money for training was tight. We should aim to 'lighten the load by taking one brick at a time' and days like these [the online conference] were 'when people come together to lighten people's load'.

The other important strand was helpfulness, he said. 'Test everything you do – is this helpful?'

So how do we get rid of stigma? His response to this was that we don't. Stigma was 'part of prejudice, part of life, the ugly bit of humanity'. Rather, we needed 'to make people understand that no one sets out to take drugs and destroy their and their families' lives. We have to look beyond that' and attempt to understand it: 'If you were born when they were born, taught what they were taught, you would think like them.'

Everyone had a history, a back story, and were unlikely to have been born in a bundle of rags in a doorway, but 'most of us were lucky to take the right fork in the road'. He gave the example of a sportsman – breaking a leg would result in plenty of support, but the complete opposite if they had a substance misuse problem.

ANTI-STIGMA NETWORK

'Society's attitude towards people who use drugs, and people in addiction and recovery, hasn't significantly changed over time and we continually see examples of stigmatising language, depictions and policies across our media, health and social care and policy domains,' said Phoenix chief executive Karen Biggs, as she announced a new Anti-Stigma Network alongside Danny Hames of NHS APA. The network will be formally launched in early 2023.

'If we are to make real progress in helping people whose lives are devastated by addiction we need our governments, our media, our public servants and those in positions of influence to understand stigma, how it is created and the pernicious effect it has on so many people's lives,' she said. 'We need to all act against stigma and ensure our work doesn't inadvertently or purposefully perpetuate it.'

***DDN* is proud to be involved the Anti-Stigma Network – look out for our coverage in coming issues. Visit www.stigmakills.org.uk/ for resources and personal stories.**

Tawatdchai Muelae | Dreamstime.com

Moving on to a panel discussion, conference chair Danny Hames asked, 'how do we tackle stigma in the NHS?'

'The separation of drug users needs to be called out,' said Kate Hall, who had been involved in a 'See the person, hear their story' campaign. 'We need to lobby from the top. There needs to be a complete intolerance of how people with addiction issues have been treated over the years.' Despite the health focus of the Dame Carol Black review, the drug strategy had become very crime focused – a 'silo approach'. 'We need to work really collaboratively to make sure we're doing the best we can for people who are facing really marginalising behaviour,' she said. 'It wouldn't be tolerated in any other healthcare setting.'

Andy Ryan, head of services at Changing Lives, had experienced stigmatising treatment himself, with a hospital doctor telling him 'these beds are for people who are really sick, you know'. While acknowledging that stigma was 'an unfortunate offshoot of stresses and pressures of the system', he urged everyone to look at education and language. He also highlighted a 'systemic problem around teams' and called for transparency in tackling stigma together, including working with employers. We should also help people to understand the causes of addiction, especially the link with trauma, and to explore the potential of psychosocial interventions. 'Be curious not critical,' he said. 'That could really link us together.'

Howard King offered a perspective as MD of a large community trust that included mental health. While disappointed that the drug strategy focused on crime, it was also an opportunity to work with people when they were brought into the criminal justice system – to turn the stigma of being separated from society into a chance to connect them with services. We needed to resist the NHS culture of working in blocks, even though it was 'easier to push people off and refer them to someone else' and be curious about how we could help them.

'We can deal with all these stigmas but not in one go – it's a brick-by-brick approach,' concluded Lilley. 'As we say in the academy, start with the person and work backwards. It never fails.'

The Academy of Fabulous Stuff is at https://fabnhsstuff.net/

CHALLENGING IGNORANCE

'Get that druggie out of my hospital.' Tony Mullaney (now training and development coordinator at Hep C U Later) described the barriers that disclosing his hepatitis C status had put in front of his healthcare. A hospital had insisted on moving his operation to the end of the day so they could clean everything down. When he had an intravenous line in, nurses wouldn't take it out for him. A dentist wouldn't treat him at the mention of hepatitis C, even when he told the dentist he was antibody positive.

'Stigma isolates people, pushes them away, makes them feel they don't belong,' he said. Furthermore, it made people with hep C afraid to disclose their status. People in prison didn't want others to find out – 'hep C is whispered about... people won't share a cell.'

At home he felt stigmatised by his own family: 'My mum washed my clothes on a hot wash so no one else could catch it.' Even peers stigmatise each other, he said, as 'no one wants to catch it – there's ignorance on how it's spread'.

So what could we all do to combat hep C stigma? Louise Hansford, Hep C U Later coordinator, said we needed to 'demystify it, talk about it, make it OK for people to have hep C'.

Much of the stigma related to ignorance – she described how her friend was antibody positive, but the nurse appeared in full PPE and goggles when she had her baby. She had also had 'horrendous experiences' herself and believed it was 'not through vindictiveness'. In the past, recovery workers didn't talk about hep C, but now we needed to make it acceptable to have it.

Hep C treatment had transformed her, and to see that replicated in other service users was 'phenomenal'. 'No one sets out to be a drug user with hep C,' she said. 'We need to get back to our core values.'

REMEMBER THEM

The pervasive stigma around substance use makes it even more vital to commemorate those who've died, says **Martin Blakebrough**

On Friday 2 December Kaleidoscope observed 'Our Day for Remembering and Celebrating'.

The purpose of the day was for us to remember those people in our service who have died – often, those people who die who have used drugs and alcohol are not considered 'worthy' in the eyes of society, and not entitled to the same amount of respect and sympathy shown to others.

The focus isn't on people who have died from an overdose – International Overdose Awareness in August is the right moment to raise that issue more widely. Our day is a day to remember and celebrate all those lives that get forgotten or excluded. People who experience drug or alcohol problems continue to be blamed for their issues – the healthcare and criminal justice systems can view drug and alcohol use as a result of 'moral weakness' or 'flawed character'. This stigma is systemic and can lead to substandard care or rejection of requests for treatment.

Attending a funeral is vital for both celebrating and remembering a person's life. Sadly, because of the stigma around substance use, some families have excluded friends of their loved ones because of the fear of shame. For this community, not only is stigma present in life, it is also present in death.

Challenging stigma directed towards people who use drugs and alcohol is vital. People who use should be treated in the same way as everyone else with a health condition. They should receive support and help, not judgement. Problems with substance use are a health matter and should be treated as such. People need to experience humanity and dignity, not fear and stigma. Both in life and death.

The majority of people who take drugs do not die from overdose, and us linking remembrance with overdose could stigmatise people further. We know of people who have taken their own lives because the system has focussed on their drug use and not their mental health. We also know people whose health conditions get ignored and/or misdiagnosed, and that too can lead to early death. There are also those who die entirely of natural causes, but because of the stigma associated with their substance use, their friends may still not be allowed to their funeral.

This yearly observance will happen on the first Friday of every December. Staff, peers, volunteers and service users will observe this in their locations in different ways. Some will be planting trees in memory of those who have been lost, some will be writing memories on Christmas decorations, some will light candles. The focus is on reflecting, remembering and celebrating our memories of those people. It is vitally important that our community of people can remember their loved ones, friends and family. This is our day each year for ensuring that can happen.

Martin Blakebrough is CEO at Kaleidoscope

izzy71 / iStock

Tackling the silent addiction

Supporting people to share their stories will break down the stigma around gambling, hears **DDN**

A project to share personal stories of people affected aims to improve understanding of gambling addiction, Claire Wyllie, research director at Tackling Gambling Stigma explained at the NHS APA conference. The initiative was to improve understanding among members of the public and professionals of the reality of living with gambling harms.

Gambling harms were often hidden, she explained, and the lack of physical symptoms could make it harder to see that people had a problem. The lack of understanding of gambling addiction could lead to stigma, with neither friends or professionals understanding the seriousness of the problem and why the person wasn't able to 'just stop'.

While there were no physical symptoms, there were also no limits to the amount you could lose. The sense of shame of people who had gambled large sums of money could be very isolating and lead to suicide. Lack of visibility and awareness had reduced the estimates of the harm being caused, and this lack of evidence limited the opportunities to make a case for more regulation, she said.

Furthermore, gambling's position in society had shifted from being tolerated to being seen as an important contributor to economic growth. The gambling industry had been very effective at portraying it as harmless fun and marginalising people who developed a problem as being a small minority with a lack of self-control. In reality, modern online gambling sites used an incredibly sophisticated system of algorithms and artificial intelligence, much of it learned from the gaming industry, to encourage people to spend more money. This had led to a £5bn increase in revenue over the last ten years.

More openness and honesty about the scale of the problem would help make the case for tighter regulation of how the industry operated and marketed itself. 'We need to normalise the conversation with healthcare professionals and include asking about gambling as part of Making every contact count [a strategy by PHE, NHS England and Health Education England],' she said. Currently the majority of treatment options were outside the NHS and often funded via the gambling industry, and this needed to change.

By sharing stories and amplifying the voices of people with lived experience she hoped the initiative would help to break down the stigma around 'the silent addiction' and enable more people to get the help that they needed. **DDN**

https://tacklinggamblingstigma.com/

LET'S DO THIS TOGETHER

New ways of working with commissioners are vital to stop drug and alcohol related deaths of people sleeping rough, says **Ellie Grieg**

Not that many years ago, seeing a commissioner's name come up on my phone was inevitably followed by a deep breath to compose myself, an unconvincingly cheery greeting and mentally scanning through potential reasons for a cold call. Lately, I've more often been the one calling our commissioners, asking if they have time for a quick chat, cheery greeting 100 per cent organic.

In March, we began mobilising the RhEST team, a brand-new service that was commissioned as part of the new pan-London substance misuse rough sleeper pathway. Its remit is to engage with people who are or have been rough sleeping and require support from substance use services, with a view to supporting them into those services and, in particular, to help them access inpatient treatment. The vital importance of this is reinforced by the latest ONS figures, which show that two-in-five deaths of homeless people are drug-related (see news, page 4).

One exciting element of the specification for the service was the clear expectation that the service feed back to the commissioner around the experiences of the team and the people we work with when trying to access services. During our regular catch-ups and contract monitoring meetings we've had opportunities to discuss anecdotal examples of some of the work we get to see as a pan-London team, including common practices that pose a barrier to people accessing support as well as innovations that have opened services up to them.

These conversations don't feel like frustrated rants – they feel optimistic because there's a real drive from all involved to ensure the best possible outcomes for the people we work with, backed up with a strategic capacity/potential to actually enact/influence change on a city-wide scale, and that's a hugely motivating feeling.

For example, in our first few weeks we saw that many services would book appointments via text and mobile, and if the person didn't turn up their attempts to re-engage would again be limited to attempted phone contact, which if unsuccessful would often mean the case was discharged.

We know that owning, topping up and keeping a phone is extremely difficult for a lot of people who are rough sleeping, so we've begun speaking to partners internally and externally about how services which are already so stretched can develop joint-working plans with outreach teams to make contact with their rough sleeping clients to increase longer term engagement and reduce the amount of time spent texting and calling a number that's probably no longer in use.

We aim to collect and develop examples of smart approaches that services that are already so stretched can adopt to make sure they're as accessible to our cohort as possible.

As well as the general sense of collegiality in our partnership with our commissioner at City of London, some of the other things that have felt like game changers are incredibly simple. For example, having case studies form a part of our reporting has allowed us to have much more nuanced conversations around the work the service is doing for the people we work with on an individual basis, moving away from the sometimes dehumanising act of reducing performance to numbers, and also giving space for us to discuss some of the complexities we are responding to instead of purely using the space to prove performance. Anecdotal evidence around trends also allows us to use the meetings to inform joint strategies to target specific areas and issues, for example boroughs with low referral rates or under-represented demographic groups.

In our Essex service, this kind of relationship with their commissioners directly resulted in genuine system change. Phoenix's Changing Futures team raised concerns with their commissioners about a gap that was consistently identified in the delivery of all the projects – namely the fact that individuals with mental health needs who did not meet secondary mental health services criteria but were in need of lower-level interventions to support their wellbeing had no real options for the necessary support. Through continued discussions with commissioners Full Circle were able to bridge this gap with the mental health wellbeing team (MHWBT).

This service has been invaluable to the work Phoenix are delivering in the region, as the MHWBT are able to provide a range of swift interventions to stabilise and support clients, while in turn alleviating pressure on other agencies who don't have the necessary clinical expertise or capacity. Due to the positive outcomes of the work the MHWBT are completing alongside Phoenix, commissioners are exploring how this provision can continue to be funded and mainstreamed as part of their Essex drug and alcohol commissioning plan.

Not that many years ago, seeing a commissioner's name come up on my phone was inevitably followed by a deep breath to compose myself...

While we're still facing the same huge challenges – recruitment, increasing complexity, high demand – this way of working together with our commissioners, being able to share actions, reflect together, and strategise as one team with a common goal, as well as being held to account, feels essential if we hope to achieve our shared ambition to end drug related deaths in the rough sleeping population.

Ellie Grieg is Phoenix Futures regional housing manager south

Drawlab19 / Dreamstime

COUNSELLOR/ THERAPIST

Becoming a counsellor or therapist can open up opportunities to practise a range of specialised techniques. In the latest part of our careers series with Addiction Professionals we look at how to take this path

Some people choose to develop their skills in counselling to pursue a career in addictions. There are also counsellors who become interested in specialising in addictions as a result of coming into contact with people with addictions in their work role.

TRAINING REQUIREMENTS

Counselling is an unregulated profession in the UK and practitioners are not required to have a qualification in order to advertise counselling services, although the UK government encourages voluntary registration for counsellors/therapists/psychotherapists.

There are a number of voluntary registers in the UK, including Addiction Professionals, that practitioners can register with, and most voluntary registers require counsellors and psychotherapists to have completed a degree-level course with specified hours of supervised practice and learning.

FURTHER DEVELOPMENT

Addiction Professionals is the only regulatory body that provides accreditation for addictions counsellors. Some practitioners choose to study addictions at a masters level and/or to specialise in areas of interest, for example EMDR (eye movement desensitisation and reprocessing).

'Many people are surprised to hear that you do not need any qualifications to advertise as a counsellor,' explains Kate Halliday, Addiction Professionals executive director.

'That's why it's so important that people seeking counselling check to see that practitioners are voluntarily registered with a regulatory body which requires practitioners to sign up to a code of practice and ethical standards. These standards require practitioners to have a required level of training, to commit to ongoing professional development and supervision, and to maintain boundaries with clients to keep them safe. Ultimately if a practitioner breaches these standards the regulatory body can take action and sanction – and even remove – a practitioner from their membership, providing safety for the public and for the reputation of the profession.

'Addiction Professionals provides accreditation for counsellors working with addictions which emphasises ongoing experience and training in addictions – something that many counsellors do not have. We are committed to upholding and improving standards in the field to give the best possible service for the public.'

Email your Qs for our Careers Clinic to the DDN editor

'It's so important that people seeking counselling check to see that practitioners are voluntarily registered with a regulatory body which requires practitioners to sign up to a code of practice and ethical standards.'

KATE HALLIDAY

SeventyFour / iStock

MAKING A VITAL DIFFERENCE

Helping people make positive change is a satisfying vocation, says **Eileen Wellings**

I work as a private therapist specialising in hypnotherapy, while offering other related therapies. I have completed courses and have qualifications in advanced hypnotherapy, which I also train, neuro linguistic programming (NLP), emotional freedom technique (EFT – commonly known as tapping), eye movement desensitisation and reprocessing (EMDR) and cognitive behavioural therapy (CBT).

My work days are very varied, which is one of the things I love about my job. I spend two days a week working in private clinics as well as offering my services from a therapy room in my house. I have always offered online treatment and this has increased since COVID as people have become more comfortable with the technology.

What makes the job so rewarding is being able to see positive change in people and knowing you have made a difference. I see a wide range of people with very different backgrounds and a variety of reasons behind their addictions. I work with people to discover and treat the underlying cause of their problem and use EMDR and EFT extensively when working with past trauma.

I am pleased that therapy is discussed more openly now, and the stigma around it has lessened. It can still be seen as a joke and not taken seriously though, and this has to change. I would also like it to become the first resort for people in a lot of cases – before prescription medication.

If you're starting out along this path, make sure you get the right qualifications that are recognised by the NHS – there are a lot of low-value courses that need to be avoided, so do your research. But I would say that it can be the most rewarding career, knowing you are helping people make positive changes that will improve their and their families' lives.

Eileen Wellings GHR(reg), MASC,(NLP)(Ad P.Th), UKRAH(adv), Dip.Hyp is a psychotherapist at www.eileenwellings.co.uk

THAT 'LIGHTBULB MOMENT'

Julie Tantum enjoys the transformative side of her varied role

I am an accredited therapist with over ten years of experience in delivering treatment to individuals with drug and alcohol problems as well as a range of other mental health issues. I have a very eclectic role as I support the delivery of our intensive outpatient programme, both online and face to face, although I've worked in residential settings in the past. We find many people can't get to physical services for a number of reasons, so having an online programme really helps them. Furthermore, with an online programme in the mornings or evenings it is really handy for people that have work or childcare issues.

Much of my work is delivering group psychotherapy using a range of techniques such as CBT, DBT and art therapy, but I also see clients individually for one-to-one psychotherapy and offer conjoint sessions between them and their significant other, so there is some couples work involved. Part of my role is also about giving clients an introduction to the 12-step model of recovery and signposting them to meetings alongside the psychotherapy we give.

I work with a small team of other therapists to deliver the programme. If I'm doing a split shift then I would be working in tandem with my colleagues to deliver the face-to-face programme between 9am and 2pm, taking it in turns to deliver the groups from Monday to Friday. I may also have to see the client for their one-to-one after, as I see them once a week for this. Then I will be online later in the evening for a couple of hours from 6.15pm delivering the same group programme to our online clients but via Zoom, although we don't do art therapy groups online.

The client work is the most rewarding part of my job. Although I appreciate that the admin side is important, there's nothing like helping clients have that lightbulb moment or seeing them months later still abstinent and enjoying life. We also run a family programme (although I don't deliver this) and it's terrific to see how rewarding this is to those trying to support their loved ones in their recovery, as this is not easy and often family members get left out.

I think anyone deciding to specialise in addictions counselling should get some experience of working with this client group, especially in the community and doing groups, before deciding to make this a career choice. It is very rewarding but can be very challenging too, as unfortunately addiction is a chronic relapsing condition and many must have a go at treatment a few times before they understand the behaviour change side of things – but also accept that controlled drinking or recreational drug use is not something they can ever go back to.

> 'The client work is the most rewarding part of my job.. there's nothing like helping clients have that lightbulb moment or seeing them months later still abstinent and enjoying life.'

Julie Tantum is a registered counsellor CME NET CCSA BAPSA, an Addiction Professional and psychotherapist at Help Me Stop

WE NEED TO TALK ABOUT... SPIKING

Was the recent spate of scare stories around needle spiking driven by something other than concern for potential victims, asks **Nick Goldstein**

Spiking is a polysemous word, meaning it has several definitions ranging from impaling with something pointed, to a rapid rise in something, to being 'shot in the ass' – the last one is from the Urban Dictionary. The definition of 'spiked' that concerns us, though, is when someone puts alcohol or drugs into another person's body without their consent. Spiking has been around as long as people have been getting intoxicated. It's an old and far too common story that occurs for a variety reasons, ranging from revenge to a poor sense of humour to much darker motivations – spiking people or pets really isn't funny or cool.

In fact, spiking someone for any reason at all is immoral and a form of chemical assault. If people want to make the hopefully informed decision to get high that's fine with me (law enforcement may view it differently), but forcibly altering someone's consciousness is always morally wrong. The darkest variety is to incapacitate someone as a prelude to an assault, often of a sexual nature, and specifically the recently much-reported alleged use of a syringe to deliver the spiking.

The first alleged cases date back to 2019 and quickly became 'a new phenomenon' according to Jason Harwin, the National Police Chiefs Council's drugs lead. Incredibly the police received 1,382 reports of spiking with a needle in under six months – that's compared with 1,903 total spikings for the entire preceding year. Universities, nightclubs, bars, student unions *et al* warned anyone with a pulse, and the BBC carried a special warning on the news. So, a huge new danger stalks the land, right?

I'm not so sure, and I say that with some expertise on this subject. I might not have spiked anyone else, but I've spiked myself tens of thousands of times over decades. I wouldn't claim to be an expert on astrophysics or Balinese shadow puppetry, but I am an expert in the baleful art of injecting drugs and my initial problems with spiking with a needle are technical.

Once one gets beyond the emotions and headlines and examines the idea of needle spiking with cold logic it starts to fall to pieces. Let's take a look at the technical aspects. Firstly, you have to acquire a suitable drug. No point spiking someone with speed or LSD, you're looking for a sedative or soporific, and even with the internet you need to be able to access illegal drugs. You also need to be sure the drug can be prepared for injection and know how to prepare it without losing the active drug in a pool of gunk that will just set and jam your works. Then you need to access an appropriate syringe – I'd imagine a smaller works would be best, maybe a .5? Certainly anything above a 1ml would be useless. Do you know where to access works? Because most people don't.

Ok, we've got our drugs and works together. So, when are you going to prepare the drugs for use? I can't see prepping in a club or pub toilet being a good idea, but if you prep it at home how do you get the loaded syringe into a venue? You really don't want to carry a loaded syringe in your pocket because of the chance of accidentally depressing the plunger leaving you with an empty syringe and a wet pocket, but if you put the loaded syringe in a protective container it becomes more likely to be found by bouncers.

Anyway, let's say we've managed to get a loaded works into a venue and I spot someone I want to spike. How is this done without anyone noticing, bearing in mind you have to stick someone with the syringe and then depress the plunger? It is possible to use one hand for both tasks, but it's not easy. So we've managed to inject someone in an often poorly lit and packed room. What then? At best you've given an IM shot, which means it will come on slowly over 15-20 minutes. Do you follow the victim hoping she'll somehow fall into your clutches... really?

Technically this makes no sense. Maybe I'm just being cynical, but in this case something more than my cynicism appears to be happening because there have been precisely zero convictions for this offence. In fact, not one person has even been charged. To be clear, I'm not claiming spiking with a needle never happens. It's a large planet with a lot of people out there so most things will happen, but that doesn't mean there's some sort of epidemic of crazed perverts lurking in the bushes armed with a syringe and ill intent.

I believe what we are seeing in the media response to this subject is a good old-fashioned drug scare story. We're appear to be in crack baby/marijuana fiends territory, and I expect in time needle spiking will be debunked too. The problems come when the media attention turns the scare story into political action, and with stretched budgets the last thing any of us needs is for money to be pissed away on a myth. Coda, this shouldn't need saying again, but spiking with or without a needle is always wrong no matter the reason.

Nick Goldstein is a service user

nemke / iStock

'You are worthy. You are capable. You have purpose. You are not alone.'

FIRED UP

Cooking pizza saved **Tom Gozney** from oblivion, and gave him the impetus to turn his life around

I turned to alcohol and drugs when I was young, lost and struggling to understand myself and where I fitted in in the world. In my early years I was always a timid, sensitive kid and then when I started school I began to struggle. Unbeknownst to me, I had dyslexia. But it was at a time when dyslexia wasn't really recognised and I didn't understand why I found everything so difficult when other kids were doing so well. I began acting out through frustration – I adopted this persona of the clown and the naughty kid that really wasn't me, but it got me attention and made me popular.

When I was 13, I was introduced to a friendship group outside of school that were smoking and using drugs and it felt like a natural progression for this persona I had embraced. It felt good to be a part of something. For the first time I really felt comfortable in my own skin, part of a group of boys that felt, at the time, like brothers. Drugs and alcohol became intertwined in my perception of who I was and allowed me to switch my brain off, or at least slow it down for a bit. At that time, it all felt manageable and fun but it wasn't long before I was expelled from school for reckless behaviour.

By the time I was 16 it had got bad. My mum took me into a rehabilitation centre after overhearing a conversation and realising I had been using hard drugs. I just thought I was doing what all teenagers do and so I rejected it and refused help. The reality of my parents finding out and trying to help/protect me drove me out the house and to the escapism of drugs even more.

I finally realised I might have a problem was when I tried to stop and couldn't. I got into trouble with the police – the reality of going to a prison was sobering and I knew I wanted to change. This wasn't the person I wanted to be or who I felt I was deep down. But I couldn't stop and it turned my world into a horrible rollercoaster where my issues with drugs and alcohol got worse with inconsistent periods of sobriety and then intense relapses and benders.

One evening I was attacked by eight boys when leaving a club. I lost all my teeth, broke my eye socket and smashed my skull. As a result of my injuries after the attack, I was struggling to eat or drink and that triggered an insane escalation. In rehab they always say there needs to be a rock bottom but there was no moment until then. That was my rock bottom.

With the support of my mum and girlfriend I finally admitted I was ready to accept help.

We found a rehabilitation centre in South Africa that focused on addressing the deep-rooted causes of my issues and helping heal them. Even then I tried to sabotage it. I was petrified. But I think I knew deep down something had to change and that I was capable of so much more.

Rehab and my recovery journey was so hard but my life was instantly better for it. I was determined to prove everyone wrong and finally get sober. I was blessed with a councillor called Oliver who truly helped me flourish, helped me unearth the severity of my issues and accept the damage they had caused. He changed my perspective and allowed me to be vulnerable. He changed my life.

Leaving treatment and returning home at 21 and sober was really challenging. I threw myself into cooking, there was something in the ritual of it I could just lose myself in, and it became a beacon of light for me in a tough time. I started having my mates over for dinners and one night we made pizza. Unlike other dishes or dinners, everyone rolled up their sleeves and got involved. I witnessed this insane sense of community and connection and it felt special.

I was inspired and began building my own brick pizza oven by hand. Building the oven and the experience of hosting those pizza nights gave me a purpose and a safe space to reconnect with loved ones. I don't think anyone at the time really knew how much that oven meant to me. It saved my life and ultimately changed it for the better. All my mates started asking me to build them an oven and I became obsessed with the ritual, determined to build the best oven I could. I rediscovered my love for design and coupled with my drive for others to experience what I had. My company Gozney was born.

We've done some incredible things since, and I've built a business beyond my wildest dreams all with the aim of bringing that experience to as many people as possible. Today, the hardest thing for me in my life is maintaining balance, and it's something I know I'm going to have to continue to work on.

You are worthy. You are capable. You have purpose. You are not alone.

Tom Gozney is founder of Gozney. Sales of his Signature Edition Roccbox pizza oven will raise funds for With You's work across the UK.

Practice Plus Group

Have you ever thought about working in a secure environment?

We are seeking **Advanced Clinical/Nurse Practitioners** and **Registered Nurses** within primary care, mental health and substance misuse to join us at our prison healthcare services across England.

We can offer you a clear career path with various options to develop your skills by joining an experienced multidisciplinary team who share the same passion for quality care as you do.

We have over 50 services across England with positions available in Yorkshire, West and East Midlands, East of England, London, Thames Valley and the South East and West.

In order to find out more and apply visit **practiceplusgroup.com** or email **careers@practiceplusgroup.com**

EMERGINGFUTURES

We're hiring for a range of full time and part time roles across the country!

Are you passionate about making a difference?

Do you want to work for a growing organisation that invests in their staff and gives back to the community?

- Housing Support Workers
- Substance Misuse Group Workers
- Community Recovery Workers

We offer flexible hours, an extensive training package, support with personal and professional development, opportunities for those eligible for permitted work and enhanced family friendly policies.

www.emergingfutures.org.uk/join-us/
info@emergingfutures.org.uk

INVESTORS IN PEOPLE™ We invest in people Standard

NEEDED

SUBSTANCE MISUSE STAFF

ARCHER RESOURCING

RECOVERY WORKERS

NURSES

NON-MEDICAL PRESCRIBERS

01473 939670
WWW.ARCHERRESOURCING.CO.UK

Join WDP's IPS Into Work service in West London or Islington!

IPS Into Work is an intensive and personalised employment support service provided by an award-winning team who understand the ebbs and flows of recovery and believe that anyone that wants to work can work.

THE FOLLOWING ROLES ARE AVAILABLE:

- Team Leader
- Employment Specialist
- IAG Volunteering & Training Specialist

CLOSING DATE: 2 January 2023.

Find out more & apply for roles at wdp.ciphr-irecruit.com
Read about IPS Into Work at wdp.org.uk/employment-support

Contact Rebecca Odedra, Head of Reintegration
with any questions on rebecca.odedra@wdp.org.uk