DDN

Drink and Drugs News
October 2023
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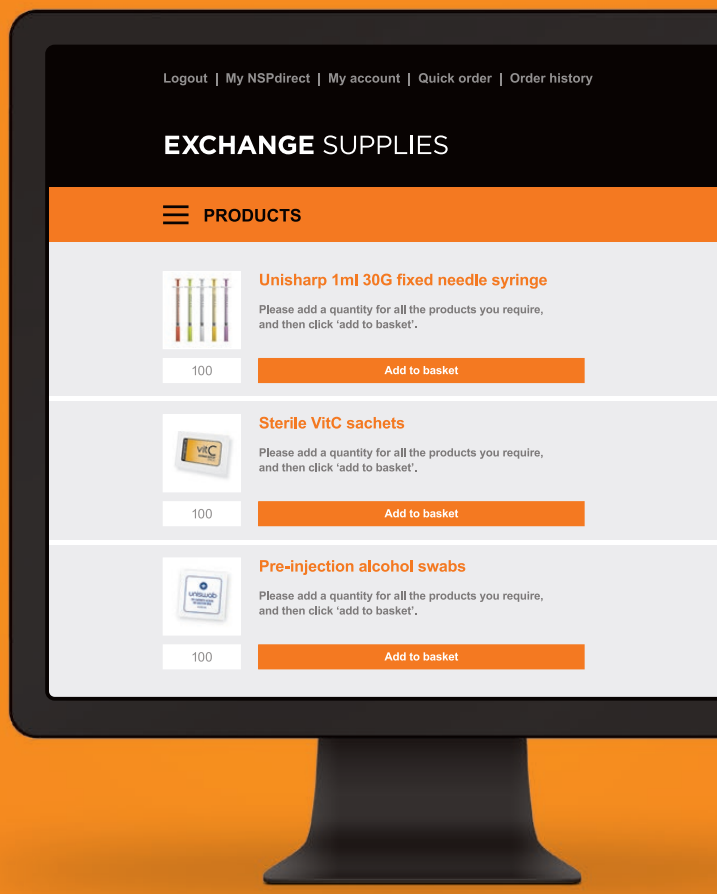

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STAYING STRONG IN PARTNERSHIP

'Let's remove the stigma... we want to shout at the top of our lungs that we're people.'

Alice, SDAS peer mentor – see our partner updates, **www.drinkanddrugsnews.com**

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The more we understand, the better we can help

With Mental Health Awareness Day this month, we're looking at some key areas of support. Our cover story explores moral injury (p6) – an area we haven't talked about directly before, but which traces a clear path from combat-related experiences to escaping trauma through substances. Veterans make up a significant part of our *DDN* community and we hope that this will open up more dialogue with Combat Stress and the other support charities who are ready with highly skilled interventions.

Meanwhile, the more we understand the reasons for young people's substance use, the better equipped we are to help them cope with the effects of adversity, abuse and exploitation and can aim for the essential 'whole school' approach (p12).

We're keen to help sustain momentum of your Recovery Month activities, so are sharing forward-looking ideas on recovery protection (p16). And have you heard about Recoverist Month (p10)? The founder began his journey in a homelessness hostel but is now working with inspiring visual artists who hope to be regulars on the cultural calendar.

For further inspiration, travel 20 years with Kaleidoscope (p20), trailblazing harm reduction in the community.

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

Go-ahead for UK's first official consumption room

The UK's first official consumption room has been approved by Glasgow's Integration Joint Board. The pilot facility will be based in a clinic on Hunter Street in the city's east end.

Last month Scotland's chief law officer – the lord advocate, Dorothy Bain KC – said she would be prepared to publish a prosecution policy stating that 'it would not be in the public interest to prosecute drug users for simple possession offences committed within a pilot safer drugs consumption facility' *(www.drinkanddrugsnews.com/not-in-the-public-interest-to-prosecute-users-of-consumption-rooms-says-scotlands-lord-advocate/)*, providing a legal basis for the establishment of a consumption room pilot.

The Scottish secretary, Alister Jack, subsequently confirmed that the UK government would not block the plans.

The lord advocate's prosecution policy would not cover any offences other than possession, Bain stated: 'It does not amount to an exclusion zone whereby a range of criminality is tolerated. Police Scotland have operational independence and it has been of the utmost importance to me to ensure that Police Scotland retain the ability to effectively police the facility and ensure that the wider community, those operating the site, and those using the facility can be kept safe.'

While the pilot consumption room facility will 'still be limited to some extent, due to the reserved Misuse of Drugs Act', the Scottish Government was confident that it will save lives, drugs minister Elena Whitham stated at the time of the lord advocate's announcement.

'This is not a silver bullet,' she said. 'But we know from evidence from more than 100 facilities worldwide that safer drug consumption facilities work. It is now time to see this approach piloted in Scotland.'

'This is not a silver bullet... but we know from evidence from more than 100 facilities worldwide that safer drug consumption facilities work.'
ELENA WHITHAM

www.gov.scot

Although the last set of official Scottish drug death figures showed a 21 per cent reduction on the previous year (*DDN*, September, page 5) the latest provisional figures from Police Scotland pointed to a 7 per cent increase in the first six months of this year compared to the same period in 2022. Scotland's drug rate remains the highest of any country in Europe.

Aid money spent on 'punitive' drug control

ALMOST $1BN FROM INTERNATIONAL AID BUDGETS intended to help end poverty was spent on the global 'war on drugs' over the last decade, according to a report by HRI.

Beneficiaries of the donor funding included police and prosecutors' offices and projects that increased surveillance and arrests, says *Aid for the war on drugs*, with at least $70m of overseas development aid going to countries that retain the death penalty for drugs. More than 90 developing countries were recipients of aid funding for drug control, the report states, with Colombia receiving $109m and Afghanistan $37m.

HRI analysed reports of donor spending that are submitted to the OECD each year and found that more than half of the funding for drug control since 2012 has come from the US, at $550m, followed by EU institutions ($282m), Japan ($78m) and the UK ($22m).

The report is calling for governments and donors to divest from 'punitive and prohibitionist drug control regimes' and instead invest in evidence-based programmes such as harm reduction. 'International aid is supposed to help end poverty and support development, not fuel human rights violations,' said HRI executive director Naomi Burke-Shyne. 'Using aid budgets for drug control doesn't help meet development goals.'

Document at https://hri.global/publications/aid-for-the-war-on-drugs/

Worrying shift in Afghan drug market

THERE IS ALREADY A 'SIGNIFICANT SHIFT' IN AFGHANISTAN'S DRUG MARKET, with 'surging' levels of methamphetamine production, according to a UNODC report. Methamphetamine trafficking saw a 'drastic' twelvefold increase in the five years to 2021, it says, from 2.5 tons to just under 30 tons.

UNODC found that heroin trafficking had continued, but at a lower rate, since the Taliban returned to power in 2021 and introduced its opium ban a year later. Many people fear that the opium ban – if sustained and successful – will see heroin replaced by far more potent fentanyls and nitazenes in the drug market, with significantly higher risks of overdose.

There have already been several reports of nitazenes entering the UK's drug supply, with agencies warning that increasing levels of synthetic opioids in the UK market could lead to an escalating overdose crisis that mirrors the situation in the US. The levels of methamphetamine trafficking in Afghanistan detected since the opium ban indicate a 'possible reshaping of illicit drug markets long dominated by Afghan opiates', says UNODC.

Understanding illegal methamphetamine manufacture in Afghanistan at https://www.unodc.org/unodc/en/press/releases/

Scotland consults on 65p minimum unit price

The Scottish Government has launched a consultation on raising the minimum unit price of alcohol to 65p. 'Views are being sought on whether to continue minimum unit pricing (MUP) legislation beyond the current term which ends next April, and the level at which it should be set,' the government states.

MUP legislation is subject to a 'sunset clause', meaning that it will expire in April 2024 unless the Scottish Parliament votes for it to continue. The level has been set at 50p per unit since MUP was implemented in 2018, with campaigners arguing that the rate has failed to keep pace with inflation. There were 1,276 alcohol specific deaths in Scotland last year, the highest number since 2008 (*DDN*, September, page 5).

A new report from the Sheffield Alcohol Research Group states that 'even under the most optimistic assumptions' about how quickly alcohol consumption among the heaviest drinkers is likely to return to pre-pandemic levels – if at all – there is likely to be a 'marked increase' in alcohol harms. High inflation has also 'eroded the real-terms value' of the 50p MUP level it adds.

'The recent rise in alcohol-specific deaths highlights the need for more to be done to tackle alcohol-related harm,' said drug and alcohol policy minister Elena Whitham. 'We believe the proposals set out in this consultation strike a reasonable balance between public health benefits and any effects on the alcoholic drinks market and subsequent impact on consumers, but we want to hear from all sides and urge everyone to take the time to respond.'

The minimum unit price should be increased to 65p to 'match inflation and ensure that this continues to be an effective measure in tackling our nation's complex relationship with alcohol,' said policy lead at With You, Graeme Callander. 'But minimum unit pricing cannot be delivered in isolation. The Scottish Government also needs to commit to the provision of well-funded and readily available support and treatment services for people with alcohol dependence.'

Alcohol – minimum unit pricing – continuation and future pricing: consultation at https://www.gov.scot/publications/

'Minimum unit pricing cannot be delivered in isolation. The Scottish Government also needs to commit to the provision of well-funded and readily available support and treatment services.'
GRAEME CALLANDER

Oxfordshire and Slough achieve micro-elimination of hepatitis C

TWO TURNING POINT SERVICES – Oxfordshire Roads to Recovery and Slough Treatment, Advice & Recovery Team (START) – have achieved 'micro-elimination' of hepatitis C.

To achieve micro-elimination status, the services had to meet three criteria set out by the NHS – every person accessing the services had to have been offered a hepatitis C test; 90 per cent of those had to be tested within the last 12 months; and of those diagnosed with hep C, 90 per cent had to have started treatment. NHS England has set targets for micro-elimination as part of its goal to eliminate hep C as a major public health threat in the UK by 2025 – five years ahead of the World Health Organization's global target of 2030.

'We are incredibly proud to achieve hep C micro-elimination in Oxfordshire,' said senior operations manager at Oxfordshire Roads to Recovery service, Andy Symons. 'Our wonderful collaboration with the John Radcliffe Hepatology Department and the Hepatitis C Trust has successfully treated over 250 people within drug treatment services, enabling life extending treatment, saving lives and protecting communities in Oxfordshire.'

Local News

TAKE FIFE
The NHS Fife health board has been chosen to manage the UK-wide Reducing Drug Deaths Innovation Challenge (*DDN*, September, page 4), and will now co-ordinate the £5m project. The initiative is a 'unique opportunity' for health and social care to work together with universities and industry to make a difference, said clinical lead Professor Alex Baldacchino.

CHANGING SCENES
An increase in the use of benzodiazepines and gabapentinoids are among the findings of the second GM TRENDS report on substance use in Greater Manchester. There has also been an increase in the availability of crystal meth – associated with the 'chemsex' scene – along with 'a reduction in price and a change in demographics of users', it says. *https://gmtrends.mmu.ac.uk/*

BEST FOOT FORWARD
Former Leeds United star Jermaine Beckford was among 100 people celebrating recovery at the 2023 Forward Leeds recovery graduation ceremony. 'Events like this remind us what success looks like, which will inspire others to undertake that journey,' said professor of addiction and recovery, David Best.

GROUND SUPPORT

There is increasing recognition of the impact of moral injury – the psychological harm caused by experiences that violate someone's moral or ethical code. Those affected by it need appropriate and effective treatment, say **Amanda Bonson**, **Gavin Campbell** and **Dominic Murphy**

The concept of PTSD arising from traumatic experiences is widely understood. Accidents, conflict exposure, and violence can, for some, result in lingering psychological difficulties. But what about those experiences which don't impact a person's sense of safety, but instead threaten their deeply held moral beliefs about themselves and the world? For those people, we talk not of PTSD, but of moral injury.

While the exact definition and application of moral injury is still being discussed by researchers and healthcare professionals, the central features of lasting feelings of guilt, shame and anger differentiate moral injury from the classic symptoms of PTSD. Crucially, moral injury results in a breakdown in the relationship the morally injured person has with themselves, their loved ones and the world around them. This contrasts with those with PTSD who often describe a loss of feeling safe as central to their difficulties.

Military veterans in the UK and around the world have described exposure to morally injurious events during their military service, and experiencing mental health difficulties as a result. These potentially morally injurious events may include situations where a veteran is unable to prevent harm, may bring harm to others or feel deeply betrayed by a trusted authority. For example, a soldier may be unable to intervene when a child is suffering or harmed due to their rules of engagement, a drone operator may take the lives of innocent civilians when dropping a bomb to take out an insurgent, or a medic treating casualties may be left with insufficient information or equipment to treat gravely injured patients safely or effectively.

MENTAL HEALTH

The impact of exposure to these events on the lives of veterans is significant. They are more likely to experience other mental health disorders such as PTSD and depression, have strained relationships with others and experience suicidal thoughts – they are also more likely to behave in a way that is self-destructive or self-sabotaging. These veterans also tend to have poorer treatment outcomes when accessing therapy services and often feel undeserving of support or recovery, preventing them from accessing support in the first place.

Increasingly, research is also finding that it isn't just military veterans who are at risk of moral injury. Journalists, firefighters, police, and veterinarians have also described similar struggles with their mental health following exposure to potentially morally injurious events. In particular, the COVID-19 pandemic shone a light on moral injury among healthcare workers. Frontline workers across roles and specialisms demonstrated being particularly susceptible to moral injury when faced with the death of vulnerable people and when they felt unsupported and unprepared for the moral load of the work they were undertaking.

Currently there isn't a specialist treatment approach that therapists can draw on to target moral injury symptoms. Instead, clinicians have told us that they rely on combining a number of different approaches in an attempt to best meet

Troy GB images / Alamy

> Crucially, moral injury results in a breakdown in the relationship the morally injured person has with themselves, their loved ones and the world around them. This contrasts with those with PTSD who often describe a loss of feeling safe as central to their difficulties.

the needs of their patients. Clear clinical guidance on best treatment approaches and how to ensure confidence in what is being provided is also currently lacking. As previously mentioned, research has demonstrated that existing treatments may not fully address the needs of those with moral injury and the barrier to positive changes that such strong feelings of guilt and shame can create. With a significant numbers of people reporting being exposed to potentially morally injurious events, there is a clear need for effective treatments to be developed.

NEW TREATMENT

Alongside our colleagues at King's College London, the research department at Combat Stress – the UK's leading veterans' mental health charity – have developed a new treatment for moral injury to meet this need. We've collaborated with leading clinical, pastoral and research professionals across the globe to better understand the needs of those with moral injury, and the most effective treatment approaches. From this we have developed a moral injury treatment plan which was then refined in partnership with veterans who had experienced moral injury or exposure to morally injurious events.

These veterans provided a valuable insight into their experiences of moral injury and how to improve upon the treatments currently provided. From this we developed Restore and Rebuild (R&R), a novel treatment for moral injury. This 20-session treatment was piloted at Combat Stress between 2021 and 2022, with 20 military veterans struggling with conflict-related moral injury. The one-to-one treatment with a therapist aims to provide veterans with an opportunity to share their morally injurious experiences, with a specific focus on understanding and overcoming guilt and shame-based thought patterns and beliefs. R&R also supports veterans in overcoming some barriers and problems in relationships with others following their moral injury, and helps them shape future goals and directions that are meaningful to them.

EARLY ASSESSMENT

The results of the early assessment of this R&R treatment are promising. Veterans demonstrated a significant reduction in symptoms of moral injury related distress, as well as associated symptoms of PTSD, depression and alcohol misuse. There were no drop-outs in treatment, which can often be a particular difficulty when working with veterans who've experienced military trauma. When interviewed, veterans who received the treatment described a 'light bulb' moment when moral injury was explained to them, finally having a name for the difficulties with which they had been battling. They reflected on improved self-care and relationships with others, as well as being more in touch with the personal values of importance to them. Veterans described an improved quality of life as a result of treatment and, despite the pain of talking through such distressing events, the treatment was seen to be well tolerated.

JOHN'S STORY

'I joined the Royal Engineers in 1984 when I was 16 and straight out of school. I served in Germany, Northern Ireland, Canada and served in the first Gulf War.

'I left the army after 14 years as I felt I'd reached the end of my time – I'd done and seen everything I needed to, been to war, got the T shirt and wore medals. I got a civilian job working as a development analyst for an airline and had a successful career in project management, but I knew inside I was an angry man. I didn't realise I had mental health issues, although I guess everyone me around soon realised.

'I had no patience and it wouldn't take me long to go from calm to taking the world on – it didn't matter what the consequences would be, in my mind it wasn't me who had the issue, everyone else had the problem.

'By 2015 everything was going wrong around me and my relationships were rubbish, I was alienating people who cared about me. In my mind I had a deep, dark secret stemming from my time in the army and I thought if people knew what it was, they wouldn't like me. I hated myself so how could anyone like me, let alone love me? So, I did all I could to make people dislike me first, no matter who it was – parents, partners, whoever.

'I finally went to the doctor in 2016 on the 'advice' of my family – it was get help or get out. The doctor suggested I needed help. He had a friend who had served and who had suffered, so I called Combat Stress and within 90 minutes I was talking to a nurse.'

So what next? While these results are encouraging, our R&R treatment still needs further rigorous assessment before it can be rolled out to other clinical settings and populations. The next stage of this assessment process is a stringent randomised control trial, which will again be running at Combat Stress starting in 2023 for three years. In this stage, R&R will be compared with the standard combination treatments currently provided to veterans with moral injury, and we hope to be able to report on the findings in 2026.

NEW TERM, OLD TRAUMA

Moral injury is a novel term to many people, and it is still finding its place in academia, diagnostic tools and clinical settings. Although research into the field has grown exponentially in recent years, this isn't a novel experience or type of trauma. It is increasingly clear that there are a significant number of people who struggle with symptoms of moral injury as a result of often impossible moral situations encountered as part of their profession, including professions centred around protecting, caring for and serving those most in need. We hope that R&R offers a treatment option that meets the needs of this population, in a way which current treatments may not. In doing so, we aim to provide effective relief from the heavy weight of moral injury which encourages compassion, understanding and hope for the future.

Amanda Bonson is a research therapist, Gavin Campbell is a research assistant and Dominic Murphy is head of research at Combat Stress

A SOBERING THOUGHT

Fibroscans offer an easy and effective way to help reduce alcohol-related harm, says **Gill Campbell**

A fibroscan which provides concrete evidence of liver damage can sometimes be a catalyst for people who have been drinking at harmful levels for a long time but who were previously reluctant or scared to seek help. This is why Turning Point made the decision to ensure we are able to fibroscan clients in all our services and why we are calling for widespread availability of free liver checks for anyone worried about their drinking.

It's one of the recommendations made in our report, *A sobering thought: the scale of alcohol harm and what we can do about it*, published last month, that urges the government to make alcohol harm a priority to avoid further damage to people's health and reduce the burden of alcohol-related harm on the NHS, the criminal justice system and the economy. Our analysis indicates alcohol-related admissions cost the NHS £1.16bn between 2021 and 2022.

Official figures show 9,641 people in the UK died in 2021 from causes specifically related to alcohol, the highest number on record and 7.4 per cent higher than in 2020. Deaths from liver disease alone have increased by 400 per cent since the 1970s, and account for most alcohol-related deaths.

Professor Sir Ian Gilmore, chair of the Alcohol Health Alliance, has said the recommendations featured in this report would make a 'real, tangible improvement to people's everyday lives. As liver health is a known indicator for wider health issues, the report rightly highlights how the broader commissioning of fibroscan could help reach people who are at higher risk of harm but not yet engaged in treatment,' he stated.

Turning Point supports more than 14,000 people each year for alcohol-related problems and we're seeing increasing numbers of referrals for those who have end-stage liver disease. Alcohol-related liver disease is a largely hidden epidemic because the warning signs such as yellowing skin take years to develop. Many people are unaware alcohol is affecting their health until they develop advanced cirrhosis.

Fibroscan tests are quick and painless health checks that can detect liver disease before any physical symptoms develop. Turning Point's service in Leicester was initially involved in an eight-month fibroscan trial, which was funded by Leicester City Council.

The scans were offered to two cohorts – clients on Turning Point's alcohol dependent treatment pathway and to registered patients within a pilot primary care GP site (Saffron Group Health) – who were identified to have potential alcohol dependence but were ambivalent/reluctant to engage in treatment.

A total of 178 clients were offered a fibroscan, of which 44 were referred to hepatology with 39 showing liver stiffness. A further ten client scans indicated advanced fibrosis, and another 17 showed cirrhosis of the liver.

Fibroscans are now routinely offered at our Leicester service. Steven Geary, who was drinking heavily for 14 years, said having a fibroscan done at the Leicester service was a 'massive' wake-up call. 'When you're in active addiction, all you think of is the drink, but with the fibroscan I could see the damage I was causing myself,' he said. 'I just thought "God this is horrendous" after I had the fibroscan. I went through detox and a rehab programme at Turning Point. I've been abstinent for five months.'

Fibroscan equipment is small and portable and can be delivered in outreach settings, reaching people who have not previously engaged in treatment but who are at higher risk. Wider availability of fibroscan would ultimately reduce the burden on acute and primary healthcare services.

The earlier we can identify and stage liver disease, the earlier we can support individuals to reduce their intake. Fibroscan offered alongside psychosocial intervention can support positive behaviour change.

Our ambition is to offer fibroscan to all new alcohol treatment presentations and to existing service users within the next 12 months. Our national alcohol pathway has been updated to include the offer of a fibroscan exam at the earliest opportunity.

Turning Point.co.uk

Fibroscan equipment is small and portable and can be delivered in outreach settings.

Other recommendations in *A sobering thought* include a national alcohol strategy incorporating the introduction of MUP in England and named alcohol leads in every integrated care system; proper funding of alcohol screening within primary care and A&E, in line with NICE guidance; and a new evidence based digital self-help tool which is free, available to anyone and publicised as part of an ongoing national public health campaign targeted at harmful and hazardous drinkers.

Gill Campbell is head of nursing at Turning Point

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BLANK CANVAS

From director of an art gallery to living in a homelessness hostel, Portraits of Recovery founder **Mark Prest**'s own lived experience led him to launch Greater Manchester's first Recoverist Month

It was December 2007, almost Christmas, and I was in my dream job. A northern working-class boy had shaken up the status quo and risen from exhibitions officer to director of the City Gallery in Leicester. Until my world came crashing down.

The launch of the Annual Open, our most popular show of the year – more than 100 guests including arts professionals and local government – were invited to view works by amateur and professional artists from across the region. It was a big night. And the gallery director, man of the moment, was inebriated, slurring his way around the show, making barbed comments.

When squeamishly reading the incident report, my crashing into an exhibiting artist's sculpture leapt off the page. Thankfully no damage was done – the damage was all to my reputation. I ended up suspended, narrowly avoiding dismissal for gross misconduct.

By that point, I had been struggling with alcohol use for seven years. The doctor's response? Simply 'don't drink'. I eventually engaged with drug and alcohol services, but nothing stuck. I was in denial. Time off work meant more drinking time, and things got worse.

CROSSING THE LINE

I can pinpoint exactly when I crossed the line from social to problematic drinker. It was after a night out on ecstasy with friends whilst on holiday in South Africa in 2000. I suffered a panic attack. A friend suggested a glass of wine to calm my nerves. It worked. From then on, I self-medicated my acute anxiety issues with alcohol.

The period between Christmas 2007 and April 2008 was a blur. My drinking was out of control, and I rarely went out unless it was for further supplies. Just before Easter, the telephone rang, and I answered – a rare occurrence at this point, as I neither opened the curtains or the mail.

It was a friend from home, and he said he was coming to fetch me. An intervention I now know, as he hadn't heard from me in ages and feared the worst. I've no recollection of him arriving or the 120-mile drive to Oldham, my hometown. I was – I was later told – deposited, a stinking, shaking wreck, at my mother's house. What I do remember is waking up the next day without booze, suffering two withdrawal seizures, being hospitalised, and having psychosis.

After a spell in rehab, during which I lost my job, I left and quickly relapsed. Worse was to follow.

My poor old mum was due to go into hospital for a long-awaited hip replacement. I was drinking again, and she was rightly fearful of leaving me in the house. So, she called my brother for help.

He arranged for me to stay at a homelessness hostel. I remember waking up the next morning with no clue where I was or how I had got there. I had hit rock bottom. Somehow, I got sober. All that I had learned fell into place, and after getting myself back to AA, I started working a programme.

ARTS IN RECOVERY

During my time in rehab, I had begun to think about the value and role of the arts within recovery. Undoubtedly the arts were in my blood. Prior to gallery work, I studied for a degree in contemporary glass. From 1991-95 I set up my own studio, selling my work internationally, including to Liberty in London.

The only exposure I had to creativity in rehab was some time-filling, pedestrian colouring in. The arts were only seen as diversionary activity rather than a parallel tool for recovery itself. A seed of thought, planted by a therapist, started my musing on how exploring self through self-portraiture might help socially reintegrate recovering people by redefining their relationship with themselves and their place within the world.

Out of rehab, feeling more stable, and having permanently relocated to Oldham, an opportunity presented itself. I approached the director of Gallery Oldham with a proposal. He was an arts colleague who I knew very well. I was honest about what had happened and explained that if he gave me desk space, I would deliver two arts recovery projects.

DELIVERED OVER MANCHESTER PRIDE WEEKEND, artist Harold Offeh set up a vintage radio show-themed art installation in city's the gay village to explore conversations on chemsex. A packed-out panel discussion featuring high profile figures from Manchester's queer community followed at Manchester Art Gallery

Coronation Street actor Sue Devaney's premiere of *Didn't You Used to be Somebody?* sold out at HOME arts centre and music producer Quieting recorded thoughts and stories on recovery and homelessness for a musical sound experience at The Stoller Hall.

Melanie Manchot's first feature film, *Stephen* (2023), blurs the lines between fact and fiction to examine addiction and recovery. The preview sold out quickly and was moved to a larger screen.

Finally, To the Sun, Moon and Stars saw textile artist Lois Blackburn deliver a series of arts and recovery workshops at Gallery Oldham (back where it all started), commissioned by Oldham Council's substance misuse team.

Main picture, opposite: A group of recoverists on their way to see Melanie Manchot's film* Stephen. *Portraits of Recovery's Mark Prest is crouching front centre, with artist and film maker Melanie Manchot to his right.

To my amazement, he agreed, getting on board with a series of artist-led self-portraiture workshops by painter David Hancock alongside an exhibition of artworks for and by people in recovery. Called Portraits of Recovery, the title later became the name of the arts organisation I now run.

My second proposal was for an R&D project called Addict, with artist Melanie Manchot. The central premise was an art dialogue in recovery exploring descents into and out of addiction, and for mapping journeys of recovery. This took some six years to realise, later becoming the multi-channel video installation Twelve, which toured nationally.

LIVED EXPERIENCE

The Portraits of Recovery pilot was a success. Participant outcomes included enrolment on local arts courses and increased confidence for volunteering. Local drug and alcohol services' ears pricked up and gallery audiences responded positively to the authenticity of the works on show. What I also realised was that new life opportunities had opened up for me through combining my cultural assets with my lived experience. If it could work for me then why not for others?

In 2011, I founded the visual arts charity Portraits of Recovery (PORe) - an organisation that works with contemporary art, artists and people and communities in recovery to create inspirational art for reimagining the world we live in. It was a slog working from home with little funding. PORe was just me, but I had done it. A raft of projects followed, in a range of art forms, and working with multiple partners. A 2015 project called Typecast saw people in recovery work with clay, to create an exhibition at Manchester School of Art. In 2017, young Asian men in recovery took part in workshops with artist Sutapa Biswas. The work resulted in a bold, neon artwork at Rochdale bus station, now in the permanent collection of Touchstones Rochdale.

In late 2022, I had some incredible news. After a lengthy process, PORe had secured Arts Council England's National Portfolio Organisation (NPO) status. Alongside securing three years' regular funding, it also meant national recognition for changing the conversation around addiction and recovery through art. We were now able to run regular programmes throughout the year.

A long-time ambition was to mark International Recovery Month, and PORe's Recoverist Month launched this year – an annual programme of cultural events for celebrating the aspirational hopes, fears, and dreams of Greater Manchester's recovery communities. In case you're not familiar with the term, recoverist = recovery + activist. The programme's aim is to put recovery communities centre stage by increased visibility and directly supporting the voice of lived experience.

FLAGSHIP EVENT

PORe's aim is to establish Recoverist Month as a yearly flagship cultural event, as a parallel to Black History Month and Pride. As the UK's only contemporary visual arts organisation working in recovery, we take our mission seriously.

PORe's aim is to establish Recoverist Month as a yearly flagship cultural event, as a parallel to Black History Month and Pride. As [a] visual arts organisation working in recovery we take our mission seriously.

This November, we host a post-Recoverist Month stakeholders' event at The Whitworth gallery with speakers including mayor of Greater Manchester, Andy Burnham. Sharing our success, we hope to garner support from decision makers for embedding Recoverist Month within Greater Manchester's annual cultural calendar. No mean feat but after that, who knows: the world is our oyster!

Mark Prest is the founder and director of Portraits of Recovery

EARLY INTERVENTION

Properly addressing co-morbidity in child and adolescent substance misuse treatment can have extraordinary results, says **Stuart Croft**

Despite what tabloid headline writers may think, the majority of young people in the UK are not perpetual or problematic users of alcohol and illegal drugs – although a significant proportion have tried alcohol or drugs during their lifetime. However, for those who find themselves in difficulties, whether as a result of experimenting with risk-taking behaviours (part of growing up) or something more sinister – such as exploitation at the hands of county lines gangs – the support available needs to be joined-up, effective and well resourced.

Those young people for whom alcohol or drugs become a serious problem are likely to have been exposed to risk factors such as abuse and neglect, parental substance use, chaotic environments, social exclusion or poor mental health. The single strongest predictor of the severity of a young person's substance misuse problems is the age at which they start using substances. According to Lankelly Chase's *Women and girls at risk* report, responses to adversity, including abuse, tend to be different according to gender. Boys are more likely to externalise problems and to act out anger and distress through antisocial behaviour, and girls to internalise their responses in the form of depression and self-harm. Substance misuse services for young people may need to consider these gender issues.

THE TOLL OF TRAUMA

The impact of such adverse experiences can be profound. According to an article in the *Lancet*, four per cent of 10 to 19-year-olds experience an emergency admission to hospital due to an injury that is self-inflicted, drug or alcohol-related or due to violence. Of these, 7.3 per 1,000 girls and 15.6 per 1,000 boys died within ten years of their first such hospital admission, with suicide, drug- or alcohol-related deaths, and homicides accounting for 64 per cent of these fatalities. The toll that childhood trauma is taking on young people's lives is shocking.

The public health response, quite rightly, has a focus on prevention and early intervention. At a universal level, evidence suggests that prevention approaches that set out to reduce risk and increase resilience are most effective. These approaches focus on such factors as family stability, improving educational attainment, training and employment, and promoting positive health and wellbeing, positive relationships and meaningful extra-curricular activities. Opportunities presented through personal, social, health and economic education (PSHE) and relationships and sex education (RSE) allow for a 'whole-school' approach that includes engagement with parents and families. This approach aims to equip young people with the skills and resilience they need to make healthy choices.

Intervening with addiction

Halfpoint / iStock

CONNECTING TO FLOURISH

At Gladstones Clinic, a residential detoxification and rehabilitation service in Gloucestershire, where we work with 16- and 17-year-olds alongside the adult cohort, we've seen a predominance of ketamine use with all of its associated and very painful health issues. We've also seen a proliferation of young people with very problematic relationships with food. We see, as you would expect, a range of co-morbid mental health conditions, care leavers, those who've been victims of sexual exploitation and those who are not in education, employment or training (NEET).

Young people we've worked with have been neurodiverse, have had a history of self-harm and suicidal thoughts, have had difficult parental relationships and low self-esteem. Some have a history of offending. We place a great emphasis on addressing behavioural factors and understanding that a pain management personality has developed, and the young person needs support in developing new strategies.

We've also, thankfully, seen some outstanding outcomes and many young people have gone on to build very successful recovery for themselves. Often, they leave rehab to go into well-selected housing where they become connected to a recovery community and begin to flourish. We find that working with them alongside the adult cohort produces some fantastic intergenerational interactions and far from being a problem, it's a real positive.

at an early stage can help keep a young person out of the criminal justice system and minimise the harm that more long-term drug and alcohol misuse causes to health, social functioning, family life, work prospects and overall quality of life.

In addition, though, as eloquently pointed out by Westminster City Council in their *Children and young people drugs strategy 2023-2026*, 'We need to challenge the acceptability and glamourisation of drugs and the "lifestyle" of being involved with dealing drugs'. In 2020 alone, referrals of children suspected to be victims of county lines increased by 31 per cent – not a lifestyle choice that is desirable, and one that's often made through coercion and that exposes young people to high levels of risk.

ESSENTIAL CAPACITY

The complex nature of mental health presentations means that specialist young people's services must have the capacity to work hand in glove with children and adolescent mental health services, as well as with troubled family teams, social workers and sexual health services. They also need to have the knowledge to understand, identify and respond to child sexual exploitation and abuse, because of the links to the use of alcohol and drugs.

There were 11,013 young people in contact with tier 2 and 3 (non-residential) alcohol and drug services between April 2020 and March 2021. Cannabis remains the most common substance (89 per cent) for which young people seek treatment.

Around four in ten young people in treatment said they had problems with alcohol. Meanwhile, among 17-year-olds in the UK, one in 10 will have used harder drugs such as ketamine and cocaine, according to University College London research.

FUNDAMENTAL DETERMINANTS

Wider determinants of health – such as housing, education and employment opportunities, social support, and personal resilience – are likely to have a fundamental effect on both the risk of drug misuse and the effectiveness of interventions to prevent drug misuse.

The Royal College of Psychiatrists reported that the impact of the COVID pandemic, together with 'drastic' historical funding cuts, had prevented young people from accessing the drug and alcohol treatment they need. It said spending on youth addiction services in England had been cut by 41 per cent in real terms since 2013-14, a fact that Dame Carol Black acknowledged in her independent review. There has been a 55 per cent reduction of the numbers of young people in treatment since the peak in 2008-09. However, the government's ten-year drug strategy brings with it the prospect of extensive reinvestment in drug and alcohol treatment, and promises early intervention for young people and families at the greatest risk, including through the Supporting Families Programme.

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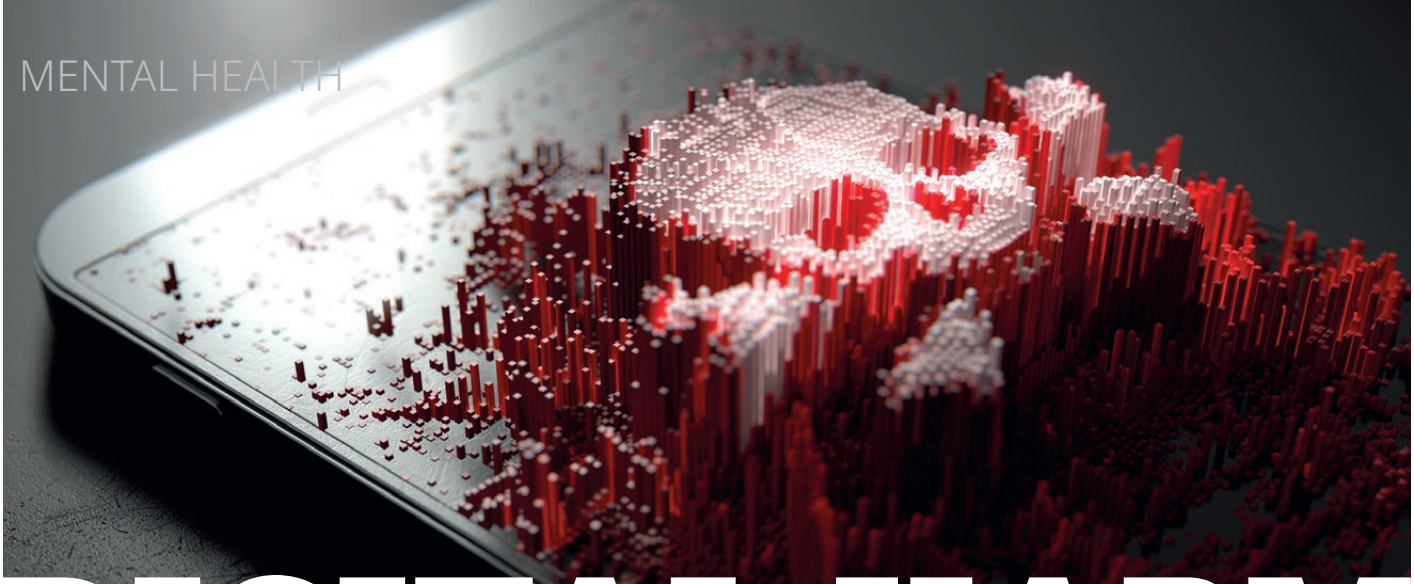
It sets a target of delivering 5,000 additional treatment places for young people. The government's mental health recovery plan earmarks funding for children's mental health services with the aim that an additional 345,000 children and young people in England will have access to mental health services each year by 2023-24. In addition, The Youth Investment Fund will be targeted at areas most in need and will provide investment in new safe spaces for young people, so they can access support from youth workers, and enjoy beneficial activities including sports and culture.

Working with younger alcohol and substance users, whether it be in preventative or specialist services can be challenging but extremely rewarding and, as the figures show, there is no shortage of young people out there needing our help. There is no better feeling than seeing a young person successfully complete treatment and go on to flourish in recovery, with the prospect of building an amazing life for themselves.

Stuart Croft is manager of Gladstones Clinic



DIGITAL HARM

Are we asking enough questions about the internet's impact on self-harm and suicide risk, asks **Fran Edmans**

This September saw the Online Safety Bill pass through parliament, ready to become law. With it comes new obligations for platforms to moderate harmful suicide and self-harm content that's currently easily accessible online.

However, for people over 18, much of their safety online will still be left in their own hands. Platforms will be required to provide adults with 'user-empowerment tools' to help them manage what they see – but ultimately how they use these tools will be for individuals to decide.

Harmful suicide and self-harm online content can have a devastating effect on people. Recent research Samaritans did with Swansea University found that three quarters of survey respondents harmed themselves more severely after viewing online self-harm content. A further 83 per cent of social media users surveyed were recommended self-harm content on their personalised feeds without searching for it.

It's crucial that we continue to support people to make safe and positive decisions about what they do online. Practitioners are in a unique position to provide this support, yet many don't ask about online activity around suicide and self-harm. A recent survey from Samaritans Lived Experience Panel found that 94 per cent of respondents had never been asked about their online experiences by a service provider, but 60 per cent agreed that this would be useful.

To address this, Samaritans has developed internet safety training around suicide and self-harm for practitioners. It's free to access and relevant for anyone who provides ongoing support around these issues.

The training provides practical advice on how to start open and non-judgmental conversations about people's online experiences. This includes how to bring the topic up, what questions you should ask, and advice and prompts you can give to help people decide what they want to see and do online.

To develop the training, Samaritans engaged with people with lived experience and over 200 practitioners from across the UK. We explored the barriers that stop service providers from asking people about their internet use, and what good support would look like for people engaging with this content online.

Many practitioners explained that they often feel nervous talking about online activity. They feel overwhelmed by the size of the internet and the speed of change, and worry that they don't know enough about online technologies.

They also worried that they don't have the right language to use. They were concerned that questions about internet activity would be seen as invasive, or that they may prompt people to look for dangerous material that they may not otherwise be viewing. One practitioner told Samaritans, 'Sometimes you feel like you're walking on eggshells; you have to be careful with your words when you're talking about online activity.'

Yet, asking about online activity is critical: it can help practitioners better understand someone's self-harm and suicide risk, as well as their wider care needs.

Service users are clear that this is an area that they want practitioners to address. One person explained, 'If they didn't ask me, I would never talk about my online use. By asking, it would stop me feeling so embarrassed.'

Often people themselves find it hard to understand the impact of their online activity. It can change over time, so that something that was helpful at one point can become part of a negative pattern of behaviour later. As such, it is helpful to have a safe space where they can reflect on their online experiences and better understand the impact it has on them. As one person explained, 'I don't feel anybody has a grasp on self-harm conversations online, so to understand it requires a good relationship between practitioner and patient.'

Samaritans' internet safety training gives practitioners a wider understanding of the risks and benefits of online activity and the way the internet is used by people looking for support around suicide and self-harm.

So far, the training has been accessed by over 11,000 practitioners from across the UK, and the majority of learners feel that it has directly helped them with specific elements of their work.

While a further evaluation into the impact of this training is currently underway, Samaritans is encouraging more practitioners to take a look at their resources, to help equip them to better support those negatively affected by the internet.

Fran Edmans is digital products manager at Samaritans. The training is at: www.samaritans.org/internet-safety-practitioners

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PROMOTING PROTECTION

The concept of recovery protection could empower clients by giving them a new and positive, perspective, says **Lisa Ogilvie**

Addiction recovery is considered by many to be a long-term undertaking, starting when an individual decides to address their addiction, followed by them making the changes needed to realise this, and then if successful, ending with them maintaining the changes. The transtheoretical model is often used to explain this process, as it categorises the stages a person goes through in reaching recovery, from pre-contemplation when they have yet to appreciate their problem, through to recognising how their life is failing, toward preparing for and taking action to address it, and ending with maintenance.

In the maintenance stage of the model, the changes made are upheld through measures that prevent a return to ways of thinking and behaving that could jeopardise recovery. For example, isolating, bottling up emotions or minimising consequences. Relapse prevention becomes a way of viewing life, when someone 'stands guard' over their recovery so they may recognise red flags that could indicate they're entering a process of relapse, at which point they take action to avert it – the fear of not doing so provides motivation for avoiding the suffering that this life brings. As a way of explaining recovery this is self-limiting, however, as maintenance is concerned with preventative adaptation, not progressive change.

LOOKING BACK

Looking back toward what is unwanted perhaps also explains why support is often considered in terms of reversing the decline in life quality caused by the symptomology of addiction and then preventing it from returning. For example, 12-step programmes suggest keeping a moral inventory and making amends for wrongdoings, and SMART recovery delivers interventions that counteract problematic thought processes. Approaches such as these not only look to fix what is broken, but also prevent a return to ways that increase the likelihood of relapse.

This does not coalesce with the definition of recovery as expressed through the recovery model however, which – following an extensive consultation with mental health professionals – was agreed as 'a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential'. More recently, the extended transformational model has corrected this, asserting that both change and growth are necessary components if recovery is to be forward looking, where new opportunities are appreciated, and satisfaction in life continues to grow. The difference in the two perspectives is that one looks forward to what is desirable, and the other looks back to what is not.

LOOKING FORWARD

This renewed perspective on looking forward to the positive champions addiction recovery to be an efficacious lifestyle choice, where an improved future is both envisioned and realised – a future that is worthy of continual and affirming action to protect the advantages it brings. To relay this message of foreseen optimism – as opposed to one of maintenance and prevention – is more empowering, especially for people who are new to recovery, as it could help them break down psychological barriers to engaging with support and propel them toward making an assured and valued choice. Moreover, it could help alleviate some of the anxieties people have over how life can continue without drink or drugs, also helping to counter the inherent

Jellypics

> To relay this message of foreseen optimism – as opposed to one of maintenance and prevention – is more empowering, especially for people who are new to recovery.

negativity that is associated with addiction and what can be expected from those with a history of substance misuse.

To build momentum in this forward-looking perspective, interventions that support recovery could be referred to as recovery protection instead of relapse prevention, and future work could draw on knowledge from positive psychology, the recovery model and the study of wellbeing, to demonstrate addiction recovery is something that is to be valued in life.

For professionals working in addiction services, embracing this affirming and valuing terminology is a simple change to make in support of empowering service users to safeguard their recovery because they recognise the value it affords. This would see services move from a relapse prevention perspective, to one of recovery protection.

Acorn Recovery Projects is a drug and alcohol rehabilitation service that helps a diverse demographic of client, often with complex mental health needs and a history of trauma. A shared characteristic of all is the despair they feel because of addiction – clients will likely have tried and failed many times to control their substance use, whether that be independently, in the community, or through previous rehabilitation attempts. They commonly have a low opinion of themselves, have fallen victim to the stigmatised views of society, and experienced the often numerous and severe consequences of addiction, the combined effect of which leads them to feel they are in a hopeless situation.

A caring staff team with experienced counsellors helps clients to re-establish a valued relationship with themselves so they may recognise their own worth. As they progress, clients are highly respected and supported to think reflectively, become more self-aware, and appreciate how life satisfaction and quality of life improve with their own progressive change and positive actions. In the early stages of treatment, focus is on their life to date and how addiction has affected the way they see and interact with the world around them. This aligns with the first part of the aforementioned recovery statement, where clients enter a process of change that improves their health and wellness. It is here that clients reach a level of acceptance where they can envision their recovery.

HOPE AND EMPOWERMENT

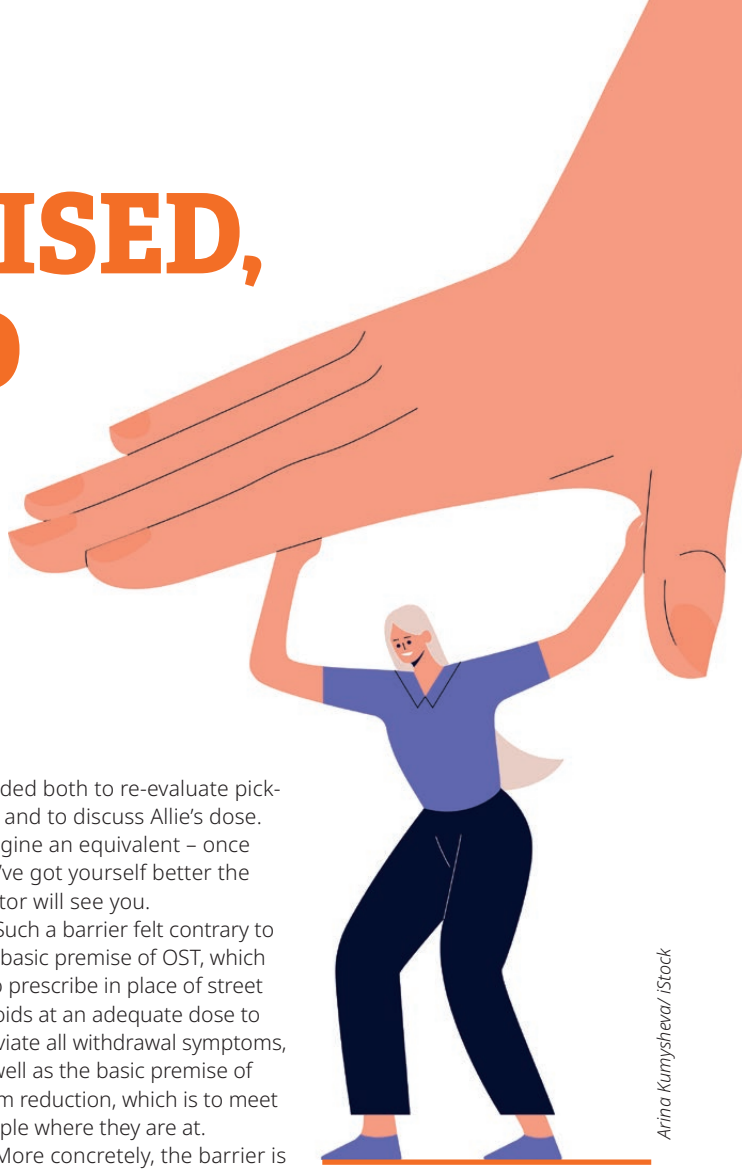
From this improved position, clients are then supported to look forward to their life in recovery through positive interventions aimed at further improving wellbeing, building recovery capital, and creating a foundation to flourish. The objective is to support clients to establish an optimistic basis for recovery, to instil hope and empower them to successfully live a life of their choosing. An important part of this is advocating addiction recovery to be a valued life choice that is not to be feared through risk of relapse, but instead experienced and enjoyed as the positive outcome of an effective period of personal growth.

This aligns treatment with the complete recovery statement – seeing clients using their own self-direction to strive to reach their full potential. When a client completes their treatment with Acorn, they leave carrying the message that recovery is valuable and worthy of protection, a positive opportunity that they have been afforded that would not have been possible if it had not been for addiction.

Lisa Ogilvie is a counsellor at Acorn Recovery Projects, and a doctoral student at the University of Bolton specialising in addiction recovery and wellbeing

OVER-SUPERVISED, UNDER-DOSED

In our latest column from Release, **Fenella Sentance** details the case of a woman facing a brick wall in her attempts to move from daily to weekly OST pick-ups



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This is the second column from the drugs team at Release, where every other month we are putting forward a new case study from our advocacy work to share with others in the sector. Our hope is to spotlight some of the difficulties people face in treatment and shine a light on how people might advocate, both for each other and themselves.

This time we are writing with Allie, a patient who reached out to Release for support with her pick-ups and under-dosing. Allie has been on the same dose of OST for about ten months. However, her current dose doesn't hold her, with severe effects from the under-dosing – daily insomnia, trembling, sickness, headaches, anxiety, diarrhoea, nervousness, and dizziness. In short, Allie has a textbook list of withdrawal symptoms, which she could reel off to any doctor if they asked.

Because of the withdrawal symptoms, Allie was buying heroin to manage. This was neither what Allie wanted to be doing nor was it financially sustainable. To make matters worse, drug alerts for nitazenes, as well as confirmed reports of xylazine in Allie's local area, meant her heroin was coming from an increasingly unsafe supply.

So, Allie approached her service to discuss a possible increase to her medication. Release supported Allie in the subsequent review. Though she is formidable at self-advocating in her own right, she feels more confident with an advocate there.

For a number of reasons, Allie was put onto daily pick-up of her medication during the review, having previously been on a weekly script. During Allie's appointment, we advocated for a timely review of the pick-up situation, stating clearly that continual daily pick-up would not be feasible in the context of her health and disabilities.

Regular pharmacy attendance, for some patients, increases their risk of harm rather than reduces it – these patients shoulder the financial and physical burden of attendance, and the practice reinforces stigma and a feeling of being untrustworthy. Allie has several disabilities, which make going outside regularly very difficult, whether it is to get food, go to the GP, or see loved ones. When on daily pick-up, what energy Allie does have is expended on pharmacy attendance.

Still, Allie negotiated and met the service in the middle, agreeing to supervision on the promise that it wouldn't become over-supervision, meaning without purpose and with no end-date in sight. We asked for a timely medical review for Allie, but what Allie got was new barriers. The service told Allie that she would need to present 'clean' urine screens before any medical review, which was needed both to re-evaluate pick-ups and to discuss Allie's dose. Imagine an equivalent – once you've got yourself better the doctor will see you.

Such a barrier felt contrary to the basic premise of OST, which is to prescribe in place of street opioids at an adequate dose to alleviate all withdrawal symptoms, as well as the basic premise of harm reduction, which is to meet people where they are at.

More concretely, the barrier is also contrary to the guidance of the 'orange book', which advises in chapter 4 that, for patients on OST who are having to buy street opioids, prescribers could 'increase dose, if inadequate' – something that can only be arranged in a medical review.

What Allie was thus left revolving in was a chicken-and-egg situation. She couldn't reduce her heroin use without an optimised OST dose, but she couldn't get that optimised OST dose without reducing her heroin use.

Over the last few weeks, Allie did reduce her heroin use to nothing, without any support and in a way that she fears is not sustainable. She is struggling and very sick, but her need for her pick-ups to be reviewed and reduced is so great that she is simply pushing through. Allie cannot pay for regular travel, has caring responsibilities, and does not have the energy to walk every day. She is hoping for a medical review soon. But it doesn't change the fact that she is being asked to do things in the wrong order – sort things out before getting support.

> Regular pharmacy attendance, for some patients, increases their risk of harm rather than reduces it.

In Allie's words, which put it best, 'I always think after these decisions, have I done something wrong? Am I doing something wrong? Is there something I should be doing that I'm not? Maybe I'm approaching the service wrong. But I feel like I'm always pleasant to them – I'm not rude. It's just that the more honest I am, the more I feel I get punished.'

Fenella Sentance is a drugs adviser and advocate at Release

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A PROUD TRADITION

Kaleidoscope established itself in Wales in 2003. **Martin Blakebrough** looks back on 20 years of innovation in substance use services

Founded in 1968 by my father Rev Eric Blakebrough, Kaleidoscope's name comes from the idea of making beautiful patterns from a diversity of people. Kaleidoscope grew from the acorn of a nightclub in the late 1960s that was used as a vehicle for community outreach – the club responded to the needs of those who came through its doors, including around drug use and, in particular, heroin. From the outset Kaleidoscope's focus was very much about harm reduction and it pioneered needle and syringe exchange and substitute medication.

Kaleidoscope's innovative approaches led Newport City Council, the police and the health board to ask Kaleidoscope to set up a service in the city, supporting residents throughout Gwent. The offer was made with no buildings or staff, and with the key stipulation that Kaleidoscope would treat 100 people in the first three months.

When Newport made their proposal, it was clear that Kaleidoscope could not simply be a London organisation providing services in Wales – there was a need to become Welsh. So in 2003, following a five-year apprenticeship with my sister Adele, who ran the organisation after our father's retirement in 1993 – I relocated the head office to Wales.

THE TEAM

The first tasks, documented by the BBC, were recruiting a team to establish services in Newport and securing a building. Kaleidoscope set up the services in St Pauls Church, Newport – the congregation and church were incredibly supportive of our work. Some of those initially recruited are still with Kaleidoscope today, including Veronica Snowball, Paul Perry and Sian Chicken.

The need for our help was clear and many who came through our doors had waited for years to get into treatment. What was particularly special was how grateful people were – it was amazing how service users were towards staff, with real patience shown to us.

The support of other local agencies helping people with drug and alcohol issues was great including from Drugaid (now Barod) and GAP (Gwent Alcohol Project). The collaborative approach had been missing in England, and it was inspiring to see how agencies worked together. This partnership approach led to us establishing Drug and Alcohol Charities Wales (DACW), now renamed Developing a Caring Wales. Critically, services were no longer in competition with one another.

SUBSTITUTE DRUGS

Kaleidoscope soon ran out of space and after a few years of working with King's Church in Newport we took over their building, an old primary school called Powells Place. This building is still the largest dispenser of substitute drugs in Wales. Need then drew us to expand into the Salvation Army Citadel in Tredegar. Initially there was real community hostility, but once they understood what we were doing – notably helping people in their own families and communities – we found we'd moved to an amazingly supportive environment.

> Kaleidoscope's name comes from the idea of making beautiful patterns from a diversity of people.

There were difficult days. We initially had a problematic relationship with the statutory NHS service but through partnership working the relationship has gone from strength to strength. Then,






Pictured from top left: Early days for the Kaleidoscope team, founded in 1968; working with the teams across Wales; celebrating the charity's anniversary of 20 years in Wales; and the Blakebrough family, including Rev Eric Blakebrough, who founded Kaleidoscope.

and after five years of success, a tender process was put in place and despite exceeding all our targets we lost our Gwent contract. Newport City Council didn't accept the decision and decided to leave the Gwent consortia, contracting all its services to Kaleidoscope. We only survived because of some real champions and the initial shock turned out to be a blessing as we became contracted to not only treat people medically, but to support care planning.

We continued to recruit amazing staff and won a wide range of contracts across Wales. The Powys and North Wales services are run in partnership with CAIS (now Adferiad) and, together with Barod, they're our two most important partners in Wales. Powys is the most complete service as it is both treatment and social support – an innovative and dynamic community service, as well as a criminal justice service. In North Wales we are linked with the North Wales police and crime commissioners, which has been vital in making sure those in the criminal justice system are properly supported.

CRIMINAL JUSTICE

In Kaleidoscope's early days we existed despite the police. We avoided criminal justice contracts but were approached in 2005 to set up a DTTO and prescribe to people in the criminal justice system. This was a very difficult decision to make, as we were rooted in community services where people chose to use us. Nevertheless, we were persuaded to work in this strange environment, and by doing so we have come across many inspiring people who have been the biggest champions of change.

We've worked together in Wales with third sector agencies with a focus on making real change for some very vulnerable people – most notably, in South Wales through Dyfodol and in Gwent, where we work with G4S and Barod.

POSITIVE FUTURES

Kaleidoscope's belief is that supporting people with drug and alcohol issues must be about positive futures, not just treatment. The establishment of our peer 'out of work' service allowed us to do this. Today this is funded by the Welsh Government, but for most of its 15-year existence it was funded by the EU. The service helps people to gain confidence, training and experience, creating pathways to employment.

As Kaleidoscope plans the next chapter co-production is a cornerstone of our plans. The Kaleidoscope board has committed £100,000 per year from investments to develop a team with lived experience to ensure we not only listen to people who take drugs, but that they are shaping our services. We want to amplify the voices of people who use drugs, and this investment is the next step in our co-production journey. This fresh focus will also see the creation of a shadow board comprising peers.

We always seek to work on an evidenced-based approach, and this drives our innovations. Thus, we've always gathered evidence to inform policy. The Senedd Cross-Party Group on Substance Use and Addiction, chaired by Peredur Owen-Griffiths MS, drives an ongoing debate on policy which we facilitate, while the Welsh Council (WCAD) – led by Professor Wulf Livingston and supported by Kaleidoscope – is another way of ensuring research continues to guide the future in Wales.

Martin Blakebrough is CEO of Kaleidoscope

SafePoint, a supervised injection facility in Surrey, part of the larger Vancouver area, Canada. Credit: Xinhua/Alamy

Scotland clearly has a very significant problem with 'deaths of despair'

BLAME GAME

So Scotland have finally got the go-ahead on their consumption room. I'm very much in favour of these facilities being established – north and south of the border – and I genuinely hope more will follow, and that they'll make a difference. But as Nick Goldstein pointed out in these very pages (*The right fix – DDN*, November 2018, page 11), once you get beyond the 'unquestioned orthodoxies' around the subject, there are a number of significant potential problems – not least that very large numbers of drug users have absolutely no interest in using them.

It's also curious that as soon as soon as the lord advocate effectively gave her green light by saying that she'd be prepared to issue a policy stating that it wasn't in the public interest to prosecute anyone for possession when using a consumption room, the Scottish Government immediately started in with the expectation management. 'This is not a silver bullet,' said their drugs minister. Well, no. But since they've spent any number of years blaming Westminster for their own country's shameful drug death statistics, the sanctioning of consumption room pilots effectively gives them one less thing to hide behind.

Scotland clearly has a very significant problem with 'deaths of despair' such as alcohol and drug-related fatalities – and we can all endlessly debate the reasons for that. But its government also halved budgets for drug and alcohol services between 2007 and 2019, alongside centralising service provision. When the terrible numbers keep rolling in, as I fear they will, just who's going to be left for them to blame?

Ross Hardie, by email

PARTNERSHIP PRACTICE

I wanted to congratulate you on your ongoing series of articles looking at different aspects of commissioning. I have found the articles extremely informative and your focus on best practice and examples of services and commissioners working in partnership with people with lived experience has provided a real sense of positivity around what can be achieved.

While having genuine input from community groups and lived experience recovery organisations (LEROs) is essential if you want to create services that meet the needs of the population, it is not always straightforward to achieve this. There is a balance that has to be struck between avoiding 'box ticking' exercises or asking too much of local groups. Your articles have provided some great examples of how some areas have achieved this and provided a real insight to smaller groups into the process they must undertake to be commissioned in their area. I believe one of the articles was called we are all 'On the same team'.

The Commissioning Quality Standard (alcohol and drug and recovery guidance) August 2022 provides a clear framework for commissioners to work in and the articles in *DDN* help to put 'flesh on the bones' by providing real life examples of partnerships in practice.

Colin West, by email

Thanks for your feedback! See the next issue for our spotlight on commissioning related to housing. Editor

MEASURE FOR MEASURE

I was delighted when I saw the news that Scotland's chief law officer stated that it would not be in the public interest to prosecute for possession within a safer injecting pilot, paving the way for the first facility to open in Glasgow. This evidence-based intervention has been proven across the world to tackle drug-related harms and help prevent drug-related deaths.

Given this, I was extremely disappointed to hear some representatives of the abstinence-based recovery movement voicing their dismay over what they saw as funding of harm reduction measures ahead of recovery and their belief that they were somehow being overlooked.

The Scottish Government has acknowledged DCRs are not a 'silver bullet' but must be part of a comprehensive package that includes harm reduction measures and recovery. Surely now, more than ever, is not the time for creating division but for recovery and harm reduction organisations to work together to provide this support. As the old saying goes – 'you can't recover if you're dead!'

Ellie Tobin, by email

SOCIAL CIRCLE

Thanks for the social work series and to the people who have been describing their jobs. It's opened up some interesting discussion at work around our responses to trauma and made us actively strengthen our relationship with the social work team, which has given us a lot more scope for responding effectively to our clients. In turn, we have been able to offer a lot of knowledge on all kinds of health issues, particularly around stabilising through the right medication. It also reminded me that there are a lot of people involved in healthcare who should be talking to each other as well as the client!

Sue Baines, by email

For more on professional training, development and career opportunities visit addictionprofessionals.org.uk. Editor

PATHWAYS FROM PRISON

I am a life sentence prisoner on recall and had a drinking problem before I was recalled to prison. I am engaged in work with my prison's drug and alcohol recovery services team and am growing in confidence. I am though, always on the lookout for more help and/or support.

Before my release in February 2017 I had served just shy of 22 years imprisonment. The main reason I am on recall is because I missed prison and the comforting security and strict routine that comes with it. To some this may sound very strange, but I am guessing that you understand exactly what I mean.

My mum mentioned to me something called 'Pathways from prison to community'. I was wondering if you could tell me more about this group and how it works, and if I would be eligible for such support?

Name and prison address supplied

If anyone can offer advice or information, please get in touch and I will forward your message. Editor

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.

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THE BEAUTIFUL GAME

Woody Albrow shares how a football tournament brought staff and service users together during Recovery Month

At one of our monthly national Connecting Communities forums it was suggested that Change Grow Live services, alongside our partners Bounce Back, should organise a national five-a-side football tournament. This idea was spawned from a successful South East regional tournament in 2022, and we decided that it would fit in with our Recovery Month celebrations.

We wanted to offer people of all genders and abilities who use our services, as well as our staff and volunteers, the opportunity to be part of a team sport. We wanted to make it inclusive and fun for all.

TURNING UP THE HEAT

We split the country into three regions – the South, the Midlands, and the North – to host regional heats. We partnered with Powerleague, a national football organisation, to host a five-a-side tournament.

We had a fantastic turnout for the heats in August, with more than 600 people attending in total. Thirty-six services registered an interest, and out of those, we created 42 teams – which was well over what we ever expected. Around 300 people attended the southern heats, 180 in the Midlands and 150 in the northern heats. It was a great day and there was some fierce competition, but overall a lot of fun was had. One service user said, 'It's the first time since I can remember that I've felt like a normal person and fitted in.'

The labels were left aside, and it was a day of connection and of coming together of different people from different backgrounds, enjoying a team sport. 'You don't know who anyone is, no judgements, everyone's just a bod playing a game and having fun,' said another player.

THE FINALS

On Friday 22 September, the 12 teams who qualified from the three regions arrived in Birmingham to compete to be Change Grow Live's first National Recovery Month football champions.

Teams travelled from as far as Sunderland and Croydon. We had a great turn out of around 250 people, with each service bringing about 20 individuals. The 12 teams battled it out until the grand final between the Birmingham and Gloucester services.

It was a tough final match at the end of a very competitive day. The final score was 1-4 and Gloucester were crowned as our well-earned Recovery Month national football champions.

> 'It's been so good to be part of it, I can't compliment it enough. Twenty-five years of drug taking and now, thanks to CGL, life is the best it's been.'

The presentations and trophies followed with an outpouring of joy. Even though there were a few disappointments, overwhelmingly there was a sense of elation and camaraderie between everyone.

The tournament promoted our values of fun and inclusion, and participants experienced these through the connections they made. We enjoyed so much positivity on the day and people were already talking about how they were looking forward to next year's event.

Dave, a service user from Manchester said, 'Fifty-five days ago, I was sitting in a full bath holding a kettle – I didn't want to live. Thanks to CGL and things like this football tournament, I am now living my best life.'

Our vision is to grow the event year-on-year and explore how we can open our door to other services and local community groups. We will pursue our desire to partner our services with local football clubs and grow those that already have connections.

Football is a powerful tool which can enable someone to fit in and engage where other attempts and methods have failed. One player said of their experience, 'When I play football, it makes me feel so good, I get into the zone and can forget my worries. This tournament has helped me to be with others.'

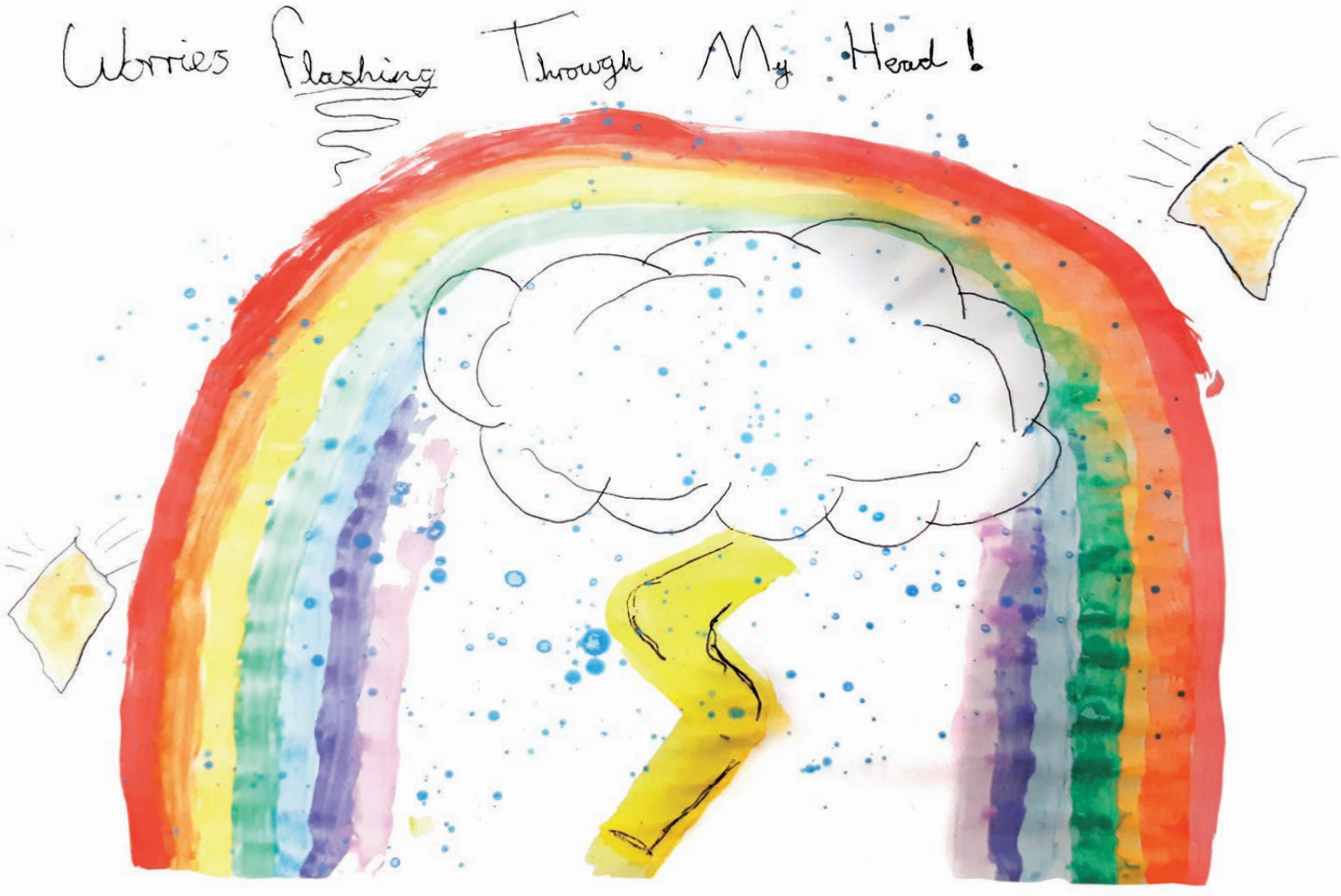
We envisage this event to be a key part of Change Grow Live's annual Recovery Month celebration.

Sean from Birmingham summed up the day: 'This tournament has given me a lot of confidence, I've enjoyed the camaraderie so much. It's been so good to be part of it, I can't compliment it enough. Twenty-five years of drug taking and now, thanks to CGL, life is the best it's been.'

We'd like to give special thanks to coordinators Sabbir, Lydia, Marco and Bernie, our partners Bounce Back, our hosts Powerleague, all of our football captains and, of course, the players and supporters.

Woody Albrow is national connecting communities lead at Change Grow Live.

Pictured: Team Gloucester, Recovery Month Football Champions



FAMILY FOCUS

Embedding a whole-family approach is the best way to keep children safe and improve outcomes for their parents, says **Rebecca Pettifor**

I sit writing this article in a full circle moment. My first experience of social work was as a service user in my early 20s – I found myself feeling frustrated at the lack of action after years of failed opportunities for professionals to keep myself and my brother safe. It wasn't one defining moment that resulted in me changing my career goal completely, it was a series of events that sparked curiosity and a drive to make a difference.

The senior social worker role is complex and, as it develops, I have found there is scope to be creative, which I love. A fundamental part of my role is to lead the service in making a difference to families impacted by substance misuse. What motivates me is knowing our offer is trauma-informed, nurturing, and understanding of to the complexities of family life. I pride myself on putting children and families at the heart of my practice and I can see the impact this is having in Kirklees.

I am proud of the offer we've developed and confident there is an evidenced impact, such as with the early support offer and Moving Children and Parents Together Programme (M-PACT). As a social work team, we are empowering children who are hidden and parents who are embroiled in feelings of guilt and shame. We are creating safe spaces for families to be open about how substance use has impacted them, and inspiring change.

WHAT ADDICTION LOOKS LIKE

The rainbow artwork above was completed by an 11-year-old – it reflects what addiction looks like to them. The rainbow is Grandma, she is her safe place. The thunder reflects her worries about parents' substance use and the rain is uncertainty. The lights represent when she was happy at home, and how she wishes they are always on.

When I think about what keeps me going at work it must be my social work practice and values. I enjoy developing others

CASE STUDY:

Client A entered treatment for alcohol support and was with a worker in the alcohol team. Once the family recovery element was fully established client A was offered the option to move to a family recovery coordinator (RC).

A trauma-informed approach was implemented, and the RC quickly began unpicking client A's lived experiences. Client A began talking about her family dynamics and what life was like for her child. The RC sought support from myself, and it transpired there was an element of domestic abuse in the family home.

Together we developed a robust plan and worked alongside client A, children's services, the police, and the domestic abuse service to ensure information was shared effectively and the risks to client A or her child were not exacerbated.

My role within this was to provide the RC and team leader with advice and direction as well as provide a space for reflection and empowered decision making.

and supporting practitioners to reach their potential. I enjoy being part of complex decision making and helping to bring about social justice and advocacy for service users. I feel fulfilled knowing my practice has inspired change, prevention, and contributed towards families feeling empowered.

As a social worker I am naturally curious and a bit of an information gatherer which allows me to understand context and build a picture to make safe and balanced decisions. I am confident with professional challenges, and I carry restorative approaches which are embedded within the family project. As I lead with these practices, I can see a shared confidence growing and as a result I am hearing feedback from services users and professionals that reflects collaboration and trust in the service. 'The social worker really listened to me and took the time to understand me.' In another instance a young person shared, 'My dad told me he loved me last week for the first time, I think that's because of M-PACT.'

I am extremely proud of the social workers I supervise, who continue to advocate, challenge, and deliver best practices. They work alongside me each day, striving for a gold standard service user journey.

I hope to continue developing the family offer in Kirklees and build on the collaborative approach with the young people's service to inspire change for future generations.

WHO AM I NOW?

I appreciate the poem may bring about different feelings, whether you reflect on a personal experience or someone you are supporting within your current role. The reason I decided to share this was to remind us all how important it is to recognise children within our interventions. You may not directly work with the child, but your role will have an impact.

By embedding whole-family working we can contribute towards keeping these children safe and allowing families to move through trauma, stay together and have better outcomes.

I stand here today, a full circle moment. I look forward to working alongside you all to make positive changes to practice and improve outcomes for the families in Kirklees.

Rebecca Pettifor is senior social worker/family project manager at Change Grow Live

WHO AM I NOW?

Laughter, love, warmth and smiles
new-born in your arms, in the photograph piles.
I flick through them all with pain in my soul,
I was small just crawling and starting to roll.

In a frame we look so calm and content
behind the camera lens our lives were hell bent.
You missed my first steps, my first day at school
You were so wrapped up in a narcotics pool.

My sister tells tales of darkness and despair.
Despite it all, she was always there.
she loved me so dearly; she made sure I ate
because you would always get out of bed late.

You lived in a state of pure delirium
You left me alone; you abandoned your son.
My sister, my friend, my one spec of hope
My protector, when you fell down a slippery slope.

All I've seen is you take back the drugs,
I'm lacking the love, the kisses, the hugs.
Such a young boy, so fresh and naive,
Scared to turn my back in fear that you'll leave.

I want you to care so sometimes I cry,
Instead of wiping my tears, you hit and chastise.
You shout and say 'they're coming for us'
'No mum' I cry, 'stop taking the drugs'

That dark turn for you, means a dark turn for me
Stuck in this world makes it hard for me to breathe,
Hiding the bruises so no one will know,
I'm scared for you mum; I don't want you to go.

At school I try hard to carry on learning,
Unable to focus beyond the love I am yearning.
I walk out of that place, as that's what you've taught me,
To give up at the first sign of struggle and be free.

You tell me to puff, to a faraway place,
I reluctantly suck back; my eyes start to glaze.
Cannabis becomes some sort of release,
But soon leads to trouble with the local police.

I'm hungry, I'm tired, I need care, not neglect,
I'm angry at you but you shout for respect.
The house is cold, and the cupboards are bare
They laugh at me at school, they taunt, and they stare.

My shoes are scuffed, my trousers too short,
Spending money on drugs, to you, is a sport.
I have nothing to call my own
all that I have is this shell of a home.

They came as a pair, with blouses and skirts
'How do you feel? Are you scared? Are you hurt?'
They pry and the question me, again and again
writing down what I say as I try to hide pain

I don't want them to take me away from you, mum
I'm confused by these questions after all, I'm your son
I want to protect you, but you don't keep me safe
exposed to your madness, and your psychotic ways.

A distant memory, my innocence is gone,
I just wanted you to live up to the role as my mom.
You took away my childhood, my friends, and my toys
who am I now? I am a lost boy