DRINK AND DRUGS NEWS

DDN

ISSN 1755-6236 **OCTOBER 2018**

THE BIG CHALLENGE

LET'S WORK TOGETHER TO ERADICATE HEPATITIS C

PLUS: Our eight-page hep C supplement inside

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"When using alcohol I isolated myself. Now that I am part of a Therapeutic Community we work together." – Willie

Service users reported a 94% improvement outcome scores for alcohol misuse on completion of programme.

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EDITOR'S LETTER

'We're in danger of under-valuing vital healthcare'

Personal stories are the essence of DDN. They speak volumes about good (and bad) practice and they also serve to inspire; and that's vitally important in the land of diminishing resources.

Many of the people we speak to about their experience of treatment have a debt of gratitude that inspires them to share their story. Wayne (page 16) and Tony Adams the footballer (page 20) both fought a dangerous battle with alcohol. It's unlikely they would be around to tell the tale if they hadn't experienced the right intervention at that pivotal moment.

Sharon's story (page 22) demonstrates what can happen when chances are missed – an all-too-likely scenario when services do not stretch around complex needs. If we're serious about getting the best for our patients and service users, every stakeholder needs to be around the table. We're turning a blind eye to processes that don't work (page 10) and are in danger of undervaluing vital healthcare in our haste to run services to one 'cost-effective' template (see the letter on shared care, page 12).

Any straightforward opportunity to save lives should be an obvious move (page 6), and we hope that our hepatitis C supplement will contribute to this important public health initiative – visit our website to share the pdf and order free printed copies. Let's all do our bit to make hep C elimination a reality.

Claire Brown, editor

Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

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ENGLAND SEES 'SHARP DECLINE' IN YOUTH DRINKING

THE LAST 15 YEARS HAVE SEEN A 'SHARP DECLINE' in drinking levels among young people in England, according to a new report from the University of Sheffield's Alcohol Research Group. Young people are now 'less likely to drink and, if they do drink, they start doing so later, drink less often and consume smaller amounts', it says.

The study – which was funded by the Wellcome Trust – looked at age groups from 8-24 and found a 'consistent pattern' of reduced participation in drinking and consumption levels, and 'less positive attitudes' towards alcohol. The proportion of 11-15 year-olds who had consumed a full alcoholic drink fell from 61 to 44 per cent between 2002 and 2016, while the proportion of 8-12 year-olds fell from 25 to 4 per cent. The proportion of 16-17 year-olds who had drunk over the previous year also fell from 88 to 65 per cent between 2001 and 2016, and among 16-24 year-olds the proportion fell from 90 to 78 per cent.

Young people who do drink are also drinking less, and less often, says the document, with the proportion of 16-24 year-olds who had drunk in the last week falling from 76 to 60 per cent between 2002 and 2016, with a fall from 35 to 9 per cent among 11-15 year-olds.

'It may be that increases in internet use and online gaming are changing the way young people spend their leisure time,' said lead author Dr Melissa Oldham. 'Economic factors may also play a role – concern about increasing university tuition fees and the cost of housing means young people feel they have less disposable income to spend on alcohol.'

The decline in youth drinking raises 'important questions about the direction of future alcohol policy', says the report. 'For example, will future youth drinking be spread across society or concentrated in specific high-risk groups, do the policy platforms of public, private and third sector organisations require updating and are new interventions needed to reinforce and perpetuate the positive trends? To date, there has been little public debate on these questions.'

Meanwhile the Welsh Government has launched a consultation on its proposed minimum unit price of 50p. The Public Health (Minimum Price for Alcohol) (Wales) Act 2018 was passed by the country's National Assembly in June, received Royal Assent in August (*DDN*, September, page 5), and is set to come into force next summer.

'Are new interventions needed to reinforce and perpetuate positive trends?'

The aim of the law was to protect the health of 'hazardous and harmful drinkers' who consume larger quantities of low-cost, high-strength products, said health secretary Vaughan Gething. 'The higher the level of MUP that is chosen, the greater the proportion of purchased alcohol that is captured and the greater the estimated impact on alcohol-related harms. However, there is a trade-off, as there is also a greater impact on moderate drinkers, particularly moderate drinkers in the more deprived groups.'

Youth drinking in decline at www.sheffield.ac.uk

Consultation at beta.gov.wales/setting-minimum-unit-price-alcohol

DUTY CALLS

INCREASING ALCOHOL DUTIES by just 1 per cent would raise around £100m a year to invest in treatment services, according to a briefing paper from Alcohol Concern/Alcohol Research UK. While this would equate to an extra 3p on a pint of beer or 5p on an average bottle of wine, it could increase alcohol treatment budgets in England by 50 per cent, says *The alcohol treatment levy*. More than two thirds of local authorities cut their alcohol treatment budgets between 2016 and 2018, says the document, with 17 making cuts of more than 50 per cent. 'While every year the alcohol industry generates around £8bn from the 4 per cent of the population who drink most heavily, cuts to alcohol treatment services are having a devastating effect across the UK,' said the charity's director of research and policy development, Dr James Nicholls. 'This is out of balance.' *Document at www.alcoholconcern.org.uk*

BUMPER CROP

THE AREA UNDER COCA CULTIVATION in Colombia has reached its highest ever level, at more than 170,000 hectares, according to UNODC. It marks an increase of 17 per cent between 2016 and 2017, and puts the value of potential cocaine production at $2.7bn, says *Coca cultivation survey report for Colombia*. *Document at www.unodc.org*

CONTINENTAL CONSUMPTION

EUROPEANS SMOKE AND DRINK MORE than anyone else, according to WHO's *European health report 2018*. While alcohol use is declining overall, adult consumption in Europe is still the highest in the world, it says, with per capita consumption levels ranging from one to 15 litres per year. One in three Europeans aged 15 and over smoke, making the continent's tobacco consumption rate also the world's highest. While life expectancy is increasing overall, smoking, alcohol and obesity are 'hindering progress in some countries' the report states. *Document at www.who.int*

COUNTY COORDINATION

THE GOVERNMENTS £3.6M NATIONAL COUNTY LINES COORDINATION CENTRE (*DDN*, May, page 4) is now fully operational, the Home Office has announced. While there are already 200 active county lines investigations underway, the new multi-agency centre will allow the police to 'intensify their operations', the government says. 'Using vulnerable young people to travel across the country to sell drugs is an appalling crime and we are cracking down on the gangs and networks responsible for these deplorable acts,' said crime minister Victoria Atkins. 'The National County Lines Coordination Centre will strengthen the law enforcement response to this issue and enable police forces to work together to tackle a crime that crosses regions and demands a multi-agency approach.' However, a report from St Giles Trust found that county lines intelligence was 'not, or not easily, shared across police force boundaries', with many local authorities also unaware of vulnerable children in their areas. *County lines scoping report at www.stgilestrust.org.uk*

'We are cracking down on the gangs and networks responsible'

VICTORIA ATKINS

ONE IN 20 GLOBAL DEATHS CAUSED BY ALCOHOL, SAYS WHO

MORE THAN 3M PEOPLE DIED AS A RESULT OF HARMFUL ALCOHOL USE in 2016, according to the World Health Organization (WHO), representing one in 20 deaths worldwide. More than three quarters of those who died were men, with alcohol now responsible for more than 5 per cent of the global disease burden.

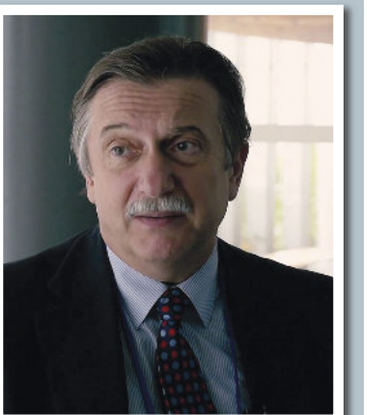
Despite some 'positive global trends', the overall burden of disease and injuries caused by alcohol is 'unacceptably high', particularly in Europe and the Americas, says *Global status report on alcohol and health 2018*. Of all the deaths attributable to alcohol, 28 per cent were the result of injuries – including traffic accidents and violence – while 21 per cent were due to digestive disorders, 19 per cent to cardiovascular diseases and the remainder the result of cancers, infectious diseases, mental health disorders and other health conditions.

Globally, an estimated 2.3bn people are current drinkers, with 237m men and 46m women suffering from alcohol use disorders. These are most common in high-income countries, with prevalence rates of 14.8 and 3.5 per cent for men and women respectively in the European region and 11.5 and 5.1 per cent in the region of the Americas. Although drinking levels in Europe have been falling since the start of the decade, the region still has the highest per capita consumption in the world.

Worldwide, 45 per cent of total recorded alcohol consumption is in the form of spirits, 34 per cent beer and 12 per cent wine, with the average consumption among those who drink standing at 33 grams of pure alcohol per day, the equivalent of two 150ml glasses of wine.

'All countries can do much more to reduce the health and social costs of the harmful use of alcohol,' said coordinator of WHO's management of substance abuse unit, Dr Vladimir Poznyak. 'Proven, cost-effective actions include increasing taxes on alcoholic drinks, bans or restrictions on alcohol advertising, and restricting the physical availability of alcohol.'

Meanwhile, a new study by the Alcohol Health Alliance (AHA) claims that fewer than 10 per cent of alcohol labels in the UK carry the government's current 14 units per week guidelines. A review of 320 labels in 12 locations across the country found that most products displayed out of date guidelines and carried no health warnings. 'Once again we see that the alcohol industry cannot be trusted to provide the public with health information,' said AHA chair Professor Sir Ian Gilmore. 'We all have the right to know what we are drinking and the fact that alcohol increases our risk of seven types of cancer, liver disease, heart disease and stroke. Few of us know or understand these risks or are aware of the CMO's advice.'



'All countries can do much more to reduce the health and social costs.'

DR VLADIMIR POZNYAK

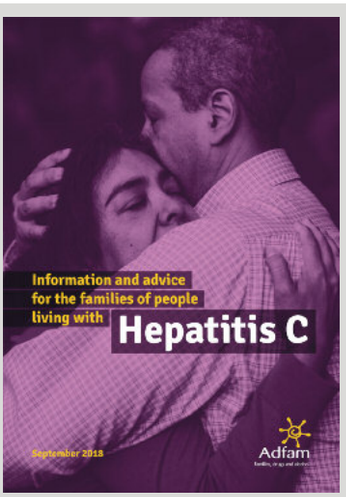
Global status report on alcohol and health 2018 at www.who.int

Our right to know at ahauk.org

C SUPPORT

A NEW RESOURCE providing practical and emotional support to the loved ones of people living with – or at risk of – hepatitis C has been launched by Adfam. 'Managed well, hepatitis C needn't interfere too much with family life,' says *Information and advice for the families of people living with hepatitis C*.

Available at adfam.org.uk. See centre pages of this issue for our pull-out hepatitis C supplement.



HALF MEASURES

PORTUGAL'S 'HUGELY INFLUENTIAL' DECRIMINALISATION MODEL does not represent 'full decriminalisation', according to an INPUD report. While discussion of the Portuguese model tends to focus on HIV and drug-related deaths, it rarely includes the 'lived experiences, perspectives, and rights of the drug-using community', the document says. 'Interactions with the state and the police, and issues of violence, social exclusion, stigmatisation and discrimination are often entirely omitted from discussion and analysis of decriminalisation in Portugal', it states, with people who use drugs still 'stopped, searched, and harassed by the police'. *Is decriminalisation enough? Drug user community voices from Portugal at www.inpud.net*

TAKE ACTION

APPLICATIONS TO STUDY Action on Addiction's September 2019 foundation degree in addictions counselling at the University of Bath are now open. The FDAP-accredited course provides students with the vocational skills necessary to become a practitioner in the treatment field. *More information at www.actiononaddiction.org.uk/study-with-us.*

PROBLEM PLEDGE

US PRESIDENT DONALD TRUMP told a UN event, the 'Global call to action on the world drug problem', that he aimed to 'deliver a drug-free future for all of our children' by working together with delegate countries to reduce demand, block the illegal drug supply, expand treatment and strengthen international cooperation. Meanwhile a new report from the Global Commission on Drug Policy looks at how governments could 'take control of currently illegal drug markets through responsible regulation', and calls for reform of the 'prohibition-based international drug control system'. *Regulation: the responsible control of drugs at www.globalcommissionondrugs.org*

SEEING THE LIGHT

THERE ARE 1M FEWER SMOKERS in England than four years ago, according to PHE, with almost 400,000 giving up the habit last year. 'Millions of people are living healthier lives as a result of our efforts to reduce smoking rates,' said public health minister Steve Brine. 'Quitting altogether is the single best thing a smoker can do for their health.' *Statistics at www.smokinginengland.info*

GILMORE GONE

THE CO-CHAIR OF PHE'S ALCOHOL LEADERSHIP BOARD has resigned over the agency's partnership with industry-funded Drinkaware for its 'Drink Free Days' campaign. Professor Sir Ian Gilmore had previously expressed objections to the partnership, citing a 'clear conflict of interest' between the drinks industry's objectives and public health goals. The campaign marks the first time that PHE has joined forces with an industry-funded organisation, with a joint letter to the *Times* from Professor Gilmore and Professor John Britton, director of the UK Centre for Tobacco and Alcohol Studies, stating that the partnership demonstrated 'a failure at senior level' to learn the lessons of how voluntary agreements had been used by the alcohol and tobacco industries to 'undermine, water down or otherwise neutralise' policies to cut consumption.

Fighting for a

A once-in-a-lifetime opportunity to finally eliminate hepatitis C is within our grasp, says Professor **Ashley Brown**

When I first graduated in medicine, hepatitis C didn't even have a name, let alone a cure. The clinical condition characterised by low-level inflammation leading to liver fibrosis, and in some cases to cirrhosis, liver failure and liver cancer, was known as 'non-A-non-B hepatitis'. Once the virus had finally been isolated and identified in the late 1980s, it acquired a catchier name, joining the alphabet of viral hepatitides as hepatitis C (HCV). In the 30 years since I began practising, the shift from this earlier era of ignorance to the current possibility for elimination has been unprecedented in the history of medicine.

Hepatitis C is a blood-borne virus, meaning that it is transmitted through blood-to-blood contact, such as getting a tattoo with an unclean needle or receiving treatment in a country or environment where inadequately sterilised medical or dental equipment is reused. An estimated 4,000 haemophiliacs in the UK were infected with HCV when they received contaminated blood products prior to the initiation of screening blood donations in 1991. But the most common method of transmission in the UK today is through the sharing of needles and other drug paraphernalia.

It has been estimated that around half of all people who inject drugs (PWIDs) have been exposed to the virus at some point. Because of the social stigma and legal issues surrounding drug use, hepatitis C brings with it a raft of shame, ignorance, and fear. Many people resist testing because they don't want to be 'in the system', while others experience no symptoms so feel there is no hurry to test. Sadly a stigma exists that rivals HIV in the 1980s, which we need to dispel so that people are less fearful about finding out their HCV status.

In the early years of attempting to treat this virus, clinicians believed that by boosting the immune system with very high doses of interferon – a substance produced naturally in response to viral infections – HCV infection could be overcome. This early treatment was successful in beating the virus in between 30 and 60 per cent of cases, but this limited success came at a high price. The flu-like side effects were deeply unpleasant and often intolerable, and the treatment could also trigger depression and exacerbate other mental health issues. Worse still, the drug had to be injected, a major deterrent for many recovering drug users. This meant that many people at risk refused even to test for HCV, let alone contemplate treatment.

Thankfully we have moved on from the dark days of interferon-based treatments to an era where cure is not just possible but highly probable. A pharmaceutical revolution has resulted in the development of a whole range of highly effective drugs called direct-acting antivirals (DAAs) that target the virus directly, with minimal side effects, and can cure it in more than 95 per cent of cases.

These incredible medicines provide us with an opportunity to eliminate HCV as a public health concern. The challenge has already been laid down by NHS England, which announced earlier this year that it was aiming to make England the first country in the world to eliminate hepatitis C by 2025 – a full five years ahead of the World Health Organization (WHO) global target.

However, two major obstacles remain in our way. Firstly, since the majority of people living with HCV are unaware of their infection we need to ensure that all those who may be at risk are given appropriate information and offered testing and pathways into treatment. Secondly, there are many who have been diagnosed but due to lifestyle, stigma or ignorance of advances in treatment have disengaged from treatment services.

To overcome the first obstacle we need to understand that hepatitis C is a disease of vulnerable people who might lead chaotic lifestyles, which means testing and treatment must be available where these groups access care – not only in hospitals and GP surgeries but homeless shelters, needle exchanges, sexual health clinics, pharmacies and amongst the prison population.

We know from peer-to-peer conversations that out-of-date misinformation about diagnosis and treatment persists, dissuading those who would benefit from treatment from coming forward to receive it. All healthcare professionals therefore need to make it clear that the days of the brutal interferon treatments are over, and that simple, short, well-tolerated oral drug combinations are available to all.

In order to overcome the second we need to radically reconfigure existing HCV treatment services. Commissioners need to be asking about HCV treatment delivery in their area, and we have to accept that many who need treatment will simply not conform to classical care pathways. New treatments are

More on hepatitis C at www.drinkanddrugsnews.com

C change

The most common method of transmission in the UK today is through the sharing of needles and other drug paraphernalia.

straightforward to take and can be delivered effectively in the community, and those who have adapted are already seeing the benefits in terms of increased treatment numbers and patient satisfaction.

Here in West London I am fortunate to work with a team people who are proactive and committed, and prepared to go beyond the normal call of duty. My specialist nurses already offer counselling, testing and treatment in a whole range of locations including drug and alcohol services, sexual health clinics, homeless hostels, needle/syringe exchanges and mental health facilities. One consultant colleague is offering clinics in a GP surgery that caters to marginalised communities and another is piloting a scheme for point-of-care testing in community pharmacies.

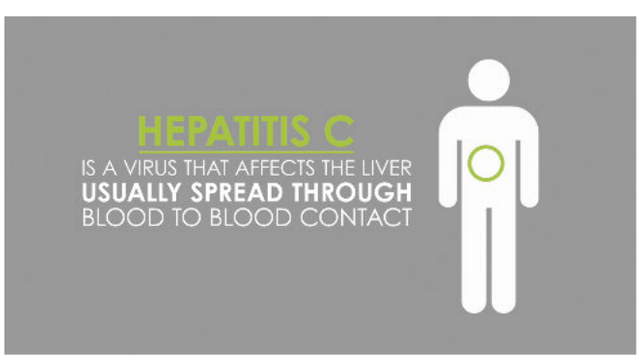
Along with my PhD fellow I have established an in-reach service at the local prison, HMP Wormwood Scrubs, and while it has taken some time to navigate the prison bureaucracy the service is already paying dividends with increasing numbers of prisoners accessing treatment. Additionally, I am working hard to reconnect with patients who have fallen out of contact with services.

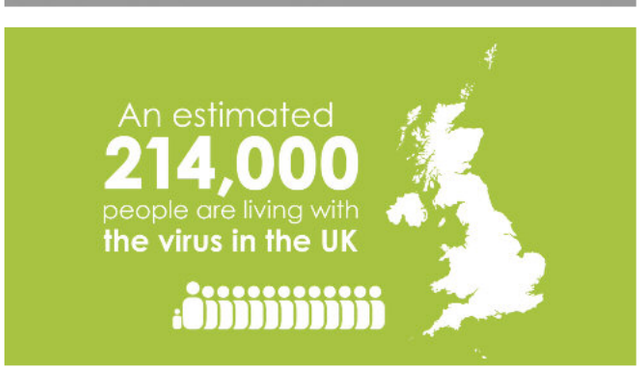
While NHS England and Public Health England quite rightly focus on the statistics – already we have seen a significant decrease in the demand for liver transplant for HCV and hospital admissions due to HCV-related liver failure – what drives those of us who work on the ground is the individual human benefit that each and every patient derives from treatment. The physical and psychological benefit of clearing a virus that can potentially lead to cancer or premature death is immeasurable, as are the benefits to society of a healthier, happier workforce. The walls of our clinics are covered with 'Thank You' cards from grateful patients – one that brought a tear to my eye was from a young girl who simply said 'Thank you for giving me my Grandpa back.'

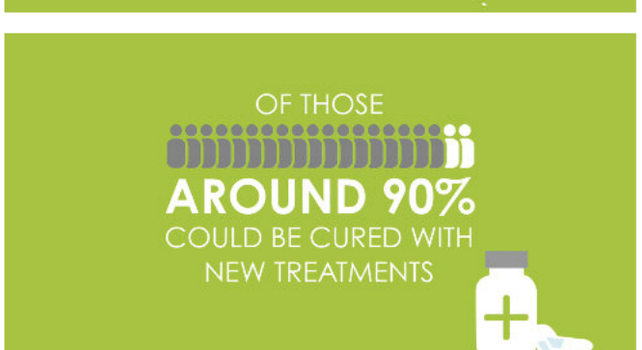
The transformation of HCV from an unknown virus to potential global elimination within a single career lifetime is truly a one-off event, and the possibility for a genuine public health success story remains within our grasp. But this will only be achieved by education of public and professionals alike, and a willingness from all parties to adapt. With your help, I hope we can put this 'silent killer' to bed before I collect my pension.

Prof Ashley Brown is vice chair of the Hepatitis C Coalition and hepatitis C lead for North West London

Turn to the centre section for our pull-out-and-keep hepatitis C supplement







VALUING THE FUTURE

POST-ITS FROM PRACTICE

Guiding people towards hepatitis C treatment can be a matter of self-esteem, says **Dr Steve Brinksman**

ONE OF THE SERVICES I WORK WITH has been looking at setting up a hepatitis C treatment programme in conjunction with the local hospital trust, based in the prescribing centre. This is obviously a good idea and is a model of treatment that needs to be replicated across the country if we are to make serious in roads into eliminating hepatitis C – which given the efficacy of modern treatment, could be achievable.

Speaking to the hospital consultant, it transpired they have the provision to treat far more people than are currently on their waiting list. And as they struggle with engaging active service users, due to high drop-out rates, it is envisaged that more readily accessible treatment will help reduce this.

This prompted me to think about why people in drug treatment who know they have hepatitis C don't engage with a treatment that is highly effective and, these days, relatively low in severe side effects? I couldn't imagine not having treatment, if it was me who was affected.

I spoke to Andy – a patient at my practice who has had hepatitis C treatment and who is now virus free – about my puzzlement. He told me that he put off treatment for a long time because although aware there were significant health consequences to having hepatitis C, something that might harm him in ten to 20 years didn't seem a big issue when he knew he risked overdose every time he injected, had nowhere stable to live, and was being regularly arrested.

He also knew treatment was expensive – and quite frankly, he didn't think he was worth it. It was only some time into treatment for his drug use, and after he began attending a peer support group and started to develop self-esteem, that he felt

> 'It is a simple mistake to think that others think as we do and place value on the same things we do.'

he could make a commitment to his long-term health and other health issues.

It is a simple mistake to think that others think as we do and place value on the same things we do. If we continue with that paradigm, I fear large numbers of people will remain with untreated hepatitis C and we will keep scratching our heads and wondering why.

I fully support the enhanced provision of hepatitis treatment and welcome the move to provide it in a geographically accessible way to service users. However, I think we also need to realise that difficulty getting to a treatment centre isn't the sole reason people don't engage in anti-viral treatment.

Alongside making treatment accessible, we need to work at improving our services to develop our service users' self-esteem, ensuring that they value themselves and their future in the way we might value our own.

Steve Brinksman is a GP in Birmingham, clinical lead for SMMGP and RCGP regional lead in substance misuse for the West Midlands

MEDIA SAVVY

The news, and the skews, in the national media

SCOTLAND IS A SMALL COUNTRY with some big problems. For too long we've accepted drug and alcohol problems as part of our society and culture. If we can look beyond these shores we will see brave people who have found creative solutions to their unique circumstances. It is time for us to be brave.
Andrew Horne, *Herald*, 4 September

IN WALES AND SCOTLAND minimum unit pricing is on the table or enacted. The government's failure in England to act on price seems to disregard the weight of expert and empirical evidence. Such is the reality of having a tax funded, politically accountable NHS while public policy relating to wider determinants of health rests with other government departments, Treasury included. ...My concern is that however switched on our health service and public health leaders may be, the funding and the wider social policy to make their ambitions a reality rely on ministers, government communications teams, and Treasury officials. These parties are late to the party.
David Oliver, *BMJ*, 11 September

WE CAN'T SIMPLY TELL YOUNG PEOPLE to 'say no to drugs' at festivals. It hasn't worked for half a century and it won't work now. Instead, we need a mitigating factor – and that's what pill testing is. It's not a silver bullet. But it is backed by international evidence.
Shelley Smith, *Guardian*, 17 September

TO THE RELIEF OF ANYONE who for medical or cultural reasons isn't getting sloshed and doesn't feel like constantly explaining why, the stigma of not drinking may be wearing off. Personally, I've got no intention of going on the wagon. But a world where people are neither slut-shamed out of drinking, nor bullied into it? I'll raise a glass to that.
Gaby Hinsliff, *Guardian*, 27 September

THE CULTURAL PULL OF TOBACCO, its hardiness in the face of hostility, may be weaker than it once was – those who would have smoked until they dropped are mostly now fogged in clouds of vape – but its survival instincts are those of a cockroach in the aftermath of an atomic strike. Eleven years ago, I watched as pubs erected smoking shelters for the incoming smoking ban; I don't see them pulling them down in the near future.
Stuart Evers, *Guardian*, 24 September

REOFFENDING RATES ARE FAR TOO HIGH, few alternatives to custodial sentences are pursued – because of populist political pressure – and the result is more recidivism, more violence, more burglary, more crime generally and more emotional and financial costs loaded onto peaceful citizens when offenders are released. It is a classic example of a false economy.
***Independent* editorial, 20 September**

After running for 25 years in Glasgow, Phoenix Futures' Scottish residential service has moved to a new home within the city

OPENING NEW DOORS

'Our Scottish residential service holds a very dear place in our hearts', says Phoenix Futures' chief executive Karen Biggs. 'For thousands of people it's where their recovery began.' But the changing needs of service users and a desire to create a fully accessible building meant it was time to move to new premises.

The service houses one of the only therapeutic communities in Scotland. It operates on a peer-led model, with members taking ownership of the whole community's recovery plans. The staff at the house try not to interfere, but have a structure in place that works well to ensure a harmonious environment.

The community's inclusive model runs right through all aspects of day-to-day life, with members taking charge of cooking, cleaning, and tending the garden. Residents have also been involved in designing the house, right down to choosing the wallpaper and colour schemes – 'which has made sure the service has a personality that reflects the people who will use it,' says Biggs.

Offering both three- and six-month programmes, the service works with community members through three distinct stages. The first stage in the welcome house is about establishing a commitment to the programme and a desire for long-term recovery. After this, residents move to the main house for the primary stage, which involves members telling their stories.

'This is a big part of the programme,' says head of house, David Brockett. People are more often than not revealing traumatic experiences that have had a direct impact on their lives and their using. This process is a chance for people to begin to develop self-acceptance and, through peer-support, 'start to feel a bit of love', he says.

When they are ready, residents move on to a senior stage that gradually reintroduces them to life in the wider community. They take part in in-house courses, while also being expected to commit to at least 16 hours a week attending college or volunteering projects outside of the house. It's a very gradual process, with the emphasis on staying safe and moving towards employment and independent living, at the right pace for them.

Once residents have completed the programme they can either return home – or as many of the members are from Glasgow, they go on to rebuild their lives within the city. The service works closely with local housing associations, some of whom have property in areas needing regeneration.

Many of these see graduates of the service as very desirable tenants. 'They like abstinent guys who want to be involved in the community, and get involved in local volunteering projects and groups,' says Brockett. Around the city, mini Phoenix projects are sprouting up where former residents are able to make positive changes in the wider community.

Having the new premises has meant the service has been able to help even more people and since it opened in the spring, referrals have increased. 'It's a funny feeling, but sometimes I would be angry that the old building was holding us back,' says Brockett. 'This new building allows us to offer services to people we couldn't reach before.'

> The community's inclusive model runs right through all aspects of day-to-day life

Time

A couple of years ago, addressing an audience at The King's Fund, Lord Victor Adebowale commented, 'There should be no wrong door and every service should reverse the Inverse Care Law, which simply states those people in need of health and social care the most get them the least.' Since then, this conversation has grown louder. As the threat of disinvestment has become reality and more of the smaller treatment agencies are forced to close their doors, we find ourselves looking at escalating mortality figures relating to drugs and alcohol and wondering why this is allowed to happen.

If, as Lord Victor suggests, we are drifting towards the opposite of community-based care, what should we do about it? Can we overturn the mentality of 'survivalism' we've been forced to adapt to and harness an appetite for revolution? Are our systems and processes wrong – and what specifically isn't working?

According to Annette Dale-Perera, an international consultant who has spent many years working in UK drug policy, we have lost much of the perspective that comes with being a comparatively rich country. 'We are seen as a high investor, but our systems aren't comparable to some other countries,' she says. 'We get criticism around the world for focusing on getting people out of treatment.'

We need a switch in focus to 'really work together, providers and commissioners' and reach a consensus to 'not go below the line, or treatment will suffer', she says. By going 'below the line', she means cut-price tendering – and the frequent recommissioning ('bloody waste of money'), 'political yo-yo-ing' and 'bean counting' that has helped to deprioritise investment in addiction services.

What we're left with is a state of growing inequality and what she describes as the 'really shit life' syndrome. 'We've got to ask ourselves why we've got people living in worse situations than in war zones,' she says. 'Maybe it's our systems and processes that are wrong. Have we built processes that don't work? There are structural inequalities and our benefits system is shocking.'

Furthermore, she believes we are missing the public health and human rights approach to drug use, which UNGASS (the United Nations General Assembly Special Session on Drugs) brought to global policy in 2016. At this latest session, 193 member states agreed the need to move from a criminal justice to a public health approach, and supported the concept that people can recover through evidence-based treatment and social support.

'There have been calls for solutions that dovetail with the mainstream – long-term recovery and support,' says Dale-Perera, and these should include strong elements of harm reduction – community OST, more needle exchanges, and better coverage with naloxone.

Mike Dixon, chief executive of Addaction, believes we need to 'change the feel of services' – a strong message from one of the larger treatment agencies. 'Many services operate from a room that local authorities don't want to use for other stuff,' he says.

Changing the welcome to clients is part of changing something much bigger, he adds. 'We need to reach out to a lot more people, particularly for alcohol and non-opiates. We divide people by substances [to treat them]

to talk

When the going gets tough, is it time to get round the table, asks **DDN**

but have no idea who's using other substances and how many people are using problematically.

'We don't think about the chance people have as they walk through the door. We have been conditioned to think about completion rates.'

If addiction services are losing profile and suffering from disinvestment, what should – and could – happen at a political level? Jonathan Ashworth, shadow health and social care secretary, says that in power, Labour would 'give addiction services the profile they need'. He acknowledges that we're 'facing an addiction crisis' and that despite high demand, 'people receiving treatment have fallen to their lowest levels'.

'Overall it's a bleak picture, with more cuts to come,' he told the National Substance Misuse Conference in September, pledging to expand treatment services if he became health secretary. Labour would reverse cuts, spend an extra £7.7m on prevention, and address gaps in the workforce, he said. He talked about how the loss of addiction psychiatrists meant that we were unable to provide services for complex dual diagnosis early in the treatment cycle, and wanted to improve links between mental health and addiction services. Another priority he had learned from talking to the sector was the need to address patchy naloxone provision across the country.

'Drug education in schools is terrible – we need to be honest about the harms and benefits...'

'The UK has the largest number of dark net sales in Europe.'

'I don't believe we can go on cutting drug and alcohol services – we need to completely change the landscape,' he said. 'If I become health secretary I will put in a proper strategy for care, support and rehabilitation, backed up by the resources needed.'

The political pledge from the shadows is one thing; working with the ramifications of complex and illogical drug laws is another. Dr Prun Bijral talks from experience as CGL's medical director and draws a direct line between 'the prohibitive situation' and more potent forms of drugs finding their way into the mainstream.

'Drugs become more potent because there is more profit from stronger drugs,' he says. You don't have to look too far to buy these drugs online, he points out – 'the UK has the largest number of dark net sales in Europe. We also know the impact of fentanyl and the increase in drug-related deaths from it.'

Katy MacLeod has expertise from her work in training and development at the Scottish Drugs Forum (SDF) and also as director of Chill Welfare, a social enterprise created in response to drug-related deaths at music events. She, too, is concerned about 'super-strong' versions of drugs, and comes across ecstasy tablets on the festival circuit that are 'three times the strength they were' – a particular issue for people returning to ecstasy at festivals. Many of the people she comes in contact with have undiagnosed mental health issues. She knows of prisoners who aimed to become drug free but who are now on synthetic cannabinoids – just because these drugs are such a regular part of prison life.

'If it was any other public health issue we were talking about there would be an outcry,' she says, and believes that drug services are hard to reach: 'We have to do something about that. If we do what we always did, we'll get what we always got.'

So how do we go about doing things differently? Many deep-rooted problems stem from lack of investment or outdated legislation. But there is an argument for grabbing the things we can influence by the scruff of the neck.

Many believe that education is of primary importance, in every context and to every audience. 'Drug education in schools is terrible – we need to be honest about the harms and benefits,' says Dr Prun Bijral, while Mike Dixon suggests that 'small conversations at home' with parents normalising information about drugs, could make a big difference. On a wider scale, those of us working in the sector can audit our language and practice to make sure we are challenging stigma at every opportunity. 'Until I worked internationally I didn't realise my language was stigmatising,' says Annette Dale-Perera. 'International colleagues do not accept the term drug users – it has to be people who use drugs.'

'We really need to up the ante and become more dynamic' in response to the loss of infrastructure and expertise, suggests Danny Hames, chair of the NHS Substance Misuse Providers Alliance (NHSSMPA). 'One of the things we could be doing better is finding allies and forming alliances. We need to up the game on how we improve influence in local authorities, where decisions are being made.'

A positive sign is the willingness of police and crime and commissioners (PCCs) to join the conversation. A recent meeting of the Drugs, Alcohol and Criminal Justice Cross-Party Parliamentary Group heard from four PCCs keen to declare that 'our approach to drugs is failing' and find an effective, evidence-based way forward. (*DDN*, April, page 6). 'By joining up with different groups, we can make positive steps in the right direction,' said Derbyshire PCC, Hardyal Dhindsa.

Vital to the debate are those who use services, and Hames is among many who see the value of a 'strong and equipped service user voice'. 'We need to create a strong service user movement in this country,' he says. 'If we lock in this powerful movement, we have a chance of fighting cuts.'

With less time and fewer resources, it can be difficult to make time for debate. A comment at the National Substance Misuse conference, from a worker at a homeless service, could serve as a reminder that a little action can go a long way: 'We had a grown man cry because we gave him underwear,' he said.

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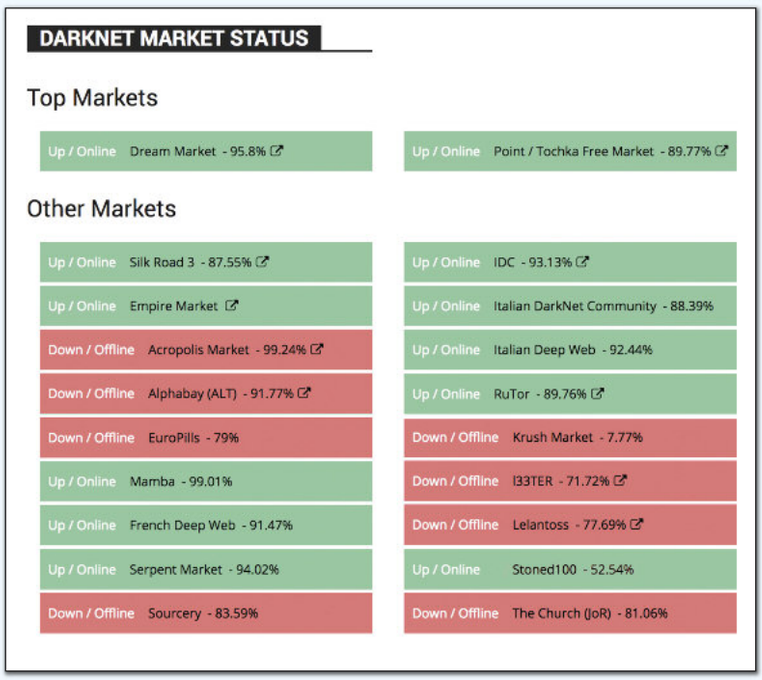
LETTERS AND COMMENT

DDN WELCOMES YOUR LETTERS

Please email the editor, claire@cjwellings.com, or post them to DDN, CJ Wellings Ltd, Romney House, School Road, Ashford, Kent TN27 0LT. Letters may be edited for space or clarity.



'Although online drug markets have massively opened up "consumer choice" for drugs and lead to higher purity and lower prices, they are much safer for users to access compared to buying more dangerous and expensive "street drugs".'

INSIDE VIEW

I am 20 years old, serving a five-and-a-half-year sentence for importation of MDMA and ketamine, and possession with intent to supply for the same, including LSD. I have reasonable experience as a casual user of most traditional illicit drugs, including opiates.

I mostly used the 'dark net' and have significant experience with this as a buyer and minor experience as a 'vendor'. I no longer have any intentions to sell drugs when released on any level, and will be focusing on building a legitimate career and pursuing education.

With regards to addiction, overdoses, violence and crime associated with illicit drug use, I cannot see how we would ever come close to managing these until we move drug policy from the Ministry of Justice to the Department of Health, and this should be the very first step – just getting government policy in the correct regulatory framework would lay the foundations for far superior solutions to these chronic problems.

Until all drug use is decriminalised and we begin to legalise and regulate certain drugs for (at least) medicinal use, we won't even scratch the surface with solving the problems drug markets and drug use create.

As a former 'drug trader/supplier' myself, I can say with confidence that no current and active drug supplier would want drug law reform in the form of legislation, as it would wipe out a lot of their profits and they would lose most of their market share to the legal supply chains.

There seem to be so many areas that would benefit from a regulated drugs market. But specifically for prisons, surely we would completely solve overcrowding by not sending non-violent drug users to prison, opting instead for rehab centres *etc*.

The only negative effect of more liberal drug policies would be some increase in drug use. But please distinguish from casual drug use and compulsive drug use; they are very different animals.

One point on the dark net – although these online drug markets have massively opened up 'consumer choice' for drugs and lead to higher purity and lower prices, they are much safer for users to access compared to buying more dangerous and expensive 'street drugs'. The dark web markets are utterly unstoppable, in the same way that street markets will never be stopped unless there are radical changes in policy aimed at removing the profit incentives that drove people like me to sell drugs.

I reiterate my urge for you to focus all efforts on fighting against the concept of prohibition of drugs and argue for a more rational, humane approach – rather than demonising all illegal drugs as 'bad'. No solution will ever be a panacea, but this pragmatic case is the best.

When released, I will be working (in my spare time) to combat the irrational laws on prohibition until every last battle against the 'war on drugs' has been won.

Lewis Rawlinson, HMP Portland

WRONG PRESCRIPTION

Dr Simone Yule's interesting article on painkiller addiction (*DDN*, September, page 9) starts to reveal the far greater problem of prescription-fuelled addiction, initiated by the Carnegie Institute and John D Rockefeller when, in the early 1900s, they jointly took over and eventually re-directed worldwide doctor training overwhelmingly towards palliative symptom medicating.

In addition to the approximately 1m illicit drug users and the similar number of patients addicted to painkillers, the UK has some 200,000 people on prescribed methadone or buprenorphine *etc*, and approaching 3m more prescription addicts on benzodiazepines, 'C' drugs and 'Z' drugs, a major proportion being in care, nursing or rest homes.

These were previously mainly diagnosed with depression, anxiety or some other form of psychosis, but today are now suffering solely from addictive drug usage 'side-effects' as well as severe 'cold turkey' trauma if they try to escape their addiction.

The near 4m prescription addicts – in dosage supplies alone – cost the NHS some £12,000,000 each day (that's £4.38bn a year), 70 to 75 per cent of whom could be cured in six to nine months with BNF-recommended 'small-dose step-down withdrawal management'. But the pharmaceutical industry has largely decided against offering,

manufacturing or stocking the short range of 'small-doses' essential to withdrawing their clients from addiction.

Furthermore, with the full total costs of OST hidden by their being spread across several government departments, the National Audit Office reports an annual cost of £9.4bn to maintain and support former illicit addicts on methadone or buprenorphine, *etc.* But we know that 13 weeks of proven addiction recovery training technology would cure 70 to 75 per cent of them.

Cures taking 13 weeks and six to nine months may not be 'quick fixes', but, in less than a year, we would start significantly reducing the number of addicts from 5.2m to 1.56m, whilst at the same time saving £9.65bn every year for the next 20+ years.

E. Kenneth Eckersley, C.E.O. Addiction Recovery Training Services (ARTS)

SHARED CARE PLEA

In 2018, how can a person die at age 49, a son and father, and it be somehow acceptable, expected? There may be a review, but due to his lifestyle it will not really be questioned. In fact he may not be the only one this week, but still it won't sound any major alarm bells. And yet we live in one of the best cities to live in the UK – just not if you struggle with substance misuse.

At 49, his death was not unexpected. In the drug and alcohol service we like to think we tried hard to prevent it, with frequent appointments and letter writing to the other services involved. We wanted to apply for inpatient detox funding from our limited, rationed budget. We needed mental health to support this as he had a dual diagnosis and was prescribed antipsychotics – largely unmonitored – for years.

He was given the familiar message, and to live with constant voices in your head and be told you can't access help until you stop drinking is a hard position to find yourself in. How do you even start this process when you know alcohol is the one thing to quieten them? There is no longer a link mental health worker who would pick up people struggling like this, no single point of contact for patients with the most complex needs.

He was clearly ill, he knew it, we all knew it. He didn't access his GP – perhaps he may have if we still had access to the more specialist GP service set up for those with housing issues or substance misuse, but that closed some years ago. It's still fondly remembered by patients and the staff still working in the sector, but shared care stopped so there is no 'specialist ' at the GP service.

Logically, he could have spoken to the doctors and nurses at the substance misuse service, but they can only address his drug and alcohol problems – although on a different day and in a different location they could help with these other problems and refer him for help rather than ask others to do it. Why have we become so sectorised? We can't even communicate electronically, as our systems don't talk to each other.

He will not be the only one dying needlessly. The case will be discussed and the usual topics will come up – mental health services, primary care support, access to detox funding, but there is no money and no joined-up thinking. He has been failed by a system content to fail, to let down some of the most vulnerable in society with increasingly complex mental and physical health problems. In any other population, young adults dying at such frequency would cause an outcry. Here, well, 'it was expected'.

Name and address supplied

LET'S CONNECT!

Have your say by commenting on our website, Facebook page and tweeting us

In response to our Facebook story '140 lives "saved" during first months of safe injecting room trial in Melbourne'

Alexandra Georgina Harrison
To the opposition saying it sends the wrong message to kids, what about bars and pubs? People kill themselves slowly on a regular basis with alcohol and no one bats an eye.

Gary Wicker
Sadly this is a little skewed as one working in the drug and substance field for 15 years. What they don't share is the related drug or substance deaths from increased drug use as many will be logged as natural causes and not related to drug-related death... it only works for a few and will not help the majority become substance free, but only as I have witnessed create a stable crutch of use for those using. I have tried both models and my own personal feeling is this is a model filled with many pitfalls and cannot be sustained due to huge cost, and nobody is willing to pick up these immense staffing and substance costs. Having said that I am willing to give it a go if it saves just one life and a family from a life destroyed by drug misuse.

Larry Barnett
Brushing it under the rug doesn't help. Provide support. No matter what. Safer for everybody... People use, for whatever reason, and sometimes the back story associated with the use is harrowing. Sometimes 'everyday' people in 'everyday' walks of life use. Supporting clean use makes absolute sense. Demonising, punishing, persecuting, ostracising is ridiculous. Make it safe, clean, accepting, supportive, helpful, love.

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Civil injunctions and criminal behaviour orders can be a treatment opportunity, says **Mike Ward**

CORRECT MOVE

IN MY PREVIOUS TWO ARTICLES in *DDN* (June, page 23 and September page 12), I discussed various legal powers which can be used to help people with chronic alcohol problems, including the Mental Health Act and the Mental Capacity Act – both of which are challenging to apply in practice.

A third group of legal powers that can be used are Civil Injunctions (CIs) and Criminal Behaviour Orders (CBOs). Unlike the other two powers, government guidance has clearly specified that they should be used for people with alcohol problems. The challenge is how to turn that into a reality.

These powers were introduced in 2014 and replaced the much better known ASBOs (anti-social behaviour orders).[1] The new orders are similar to ASBOs; they allow courts to ban behaviours (such as visiting a specified location, carrying an open drink container), but they also allow positive requirements, which encourage lifestyle changes that can prevent future anti-social behaviour.

The two powers are essentially the same, but CBOs are usually sought as part of an existing prosecution – whereas CIs require a separate legal process. The police are most likely to initiate an application for a CBO; the CIs are more likely to be used by local authorities and housing associations. Of the two, the CBO is by far more commonly used.

Most importantly, the guidance supporting the legislation states that these orders are appropriate for people whose anti-social behaviour is due to alcohol problems and that the positive requirements can include mainstream alcohol interventions, such as to receive support and counselling or attend alcohol awareness classes. This could equally apply to drug interventions.

In some ways, these orders are similar to Alcohol Treatment Requirements (ATRs) or Drug Rehabilitation Requirements (*ie* probation orders with a treatment condition). However, whereas the ATRs are usually offered as a choice instead of a prison sentence, the CBOs and CIs can be imposed without client consent. That does not mean that someone can be 'forced to have treatment', but if they repeatedly do not comply with their order, this could lead to a prison sentence of five years.

Some people dislike this approach because of the danger of increasing someone's involvement in the criminal justice system. However, if all other strategies to protect the public from a person's anti-social behaviour have failed, then CBOs and CIs are an option which may ultimately protect someone from the most serious consequences of their behaviour.

*****

OVER THE LAST YEAR, an Alcohol Research UK-funded project has been running to help community safety and alcohol treatment staff develop alcohol-focused positive requirements. More than 100 staff from local authorities across England and Wales have contributed, alongside three over-subscribed regional workshops. This project has been well received and there is real local interest in how these orders can best be used.

This article comes out of a more detailed report on this topic, which is available on the Alcohol Concern website.[2] This research evidence shows a positive impact from these orders for many clients. However, the key finding from the research is that further work is required to enable alcohol and drug treatment services to support these orders. For example, at times people have been given requirements to engage with services, without any consultation with the services expected to deliver the interventions. Therefore, more needs to be done to engage and include alcohol treatment services from the beginning of any CBO or CI process.

Anti-social behaviour is a serious concern, which causes alarm and distress to communities, often to the most vulnerable. We believe that senior police officers, police and crime commissioners and community safety managers should work with public health commissioners to design service specifications and contracts that support treatment service involvement in positive requirements.

> 'CBOs and CIs can be imposed without client consent.'

The CBOs and CIs are not the only powers in the 2014 Act that can be used to help people with long-term substance misuse. Other powers include closure orders and the community trigger. For details on these interventions, see the guidance on the government's website.[1]

To learn more about this research and for training opportunities, email mward@alcoholconcern.org.uk

[1] *Home Office (2017). Anti-social Behaviour, Crime and Policing Act 2014: Anti-social behaviour powers. Statutory guidance for frontline professionals. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332839/StatutoryGuidanceFrontline.pdf, pp.1-67.*

[2] *Alcohol Concern and Alcohol Research UK (2018). Tackling alcohol-related anti-social behaviour through Civil Injunctions and Criminal Behaviour Orders: A missed opportunity? Available at: https://www.alcoholconcern.org.uk/tackling-alcohol-related-anti-social-behaviour-through-civil-injunctions-and-criminal-behaviour-orders, pp.1-19.*

Why are we sending people miles away to rehab instead of supporting them to survive in their own community, asks **Mark Gilman**

ADIOS RECOVERY RIVIERA?

In his 2017 book *Poverty Safari*, Darren McGarvey explains how stress is often the engine room that fuels addictions and mental health issues: 'For those living in poor social conditions, stress is all consuming; it's the soup everyone is swimming in all the time.'[1]

So, why is it a bad thing to be sent 300 miles away from home for a mental health issue, but a good thing for someone with a substance use disorder?[2]

People with a substance use disorder (addiction) are still sent out of area to residential rehabilitation. I had never heard about residential rehabilitation until 1984 when I was interviewing young heroin users in the North of England. I knew a lot about drugs and had been using them myself since my first encounter with benzodiazepines in 1969 at the age of 12. Until 1995, I had known many people who had died from drugs (barbiturates and opioids) but I had never seen anyone 'recover' from 'addiction'.

In September 1985, I was employed by Lifeline as the manager of one of the first community drugs teams in Trafford, Greater Manchester. I never understood the fixation on sending people away to residential rehabilitation. Some of the rationale included getting the 'client' away from 'triggers' in the places where their problems had originated. I didn't get this because by then I had started to develop my own alcohol problem. As I sat watching TV during one of my countless DIY detoxes, I had to sit through alcohol adverts.

I had to walk past pubs, shivering and knowing that I had the money to go in and order a large brandy and port and a pint of stout (my favourite morning tipple). I could never understand why 'addicts' had to be sent away, out of area, to residential rehabilitation while 'alcoholics' like me (I never admitted this till 1995) were sent to the local psychiatric hospital for a detox and then sent home.

My perspective has been tainted by the fact that I have always lived in Bury (apart from a brief exile in Bradford and now in Burnley) and mix with people I grew up with on an almost daily basis. When I first sought help for my own alcohol problem it never even occurred to me to go anywhere other than 12-step mutual aid. I knew some real alcoholics (who I had drunk with) who had stopped drinking by going to Alcoholics Anonymous (AA). Residential rehabilitation, if discussed at all, was dismissed as a bizarre joke, but AA was treated with a degree of respect because people had seen the change in people like 'Terry from Bury'.

> 'Residential rehabilitation, if discussed at all, was dismissed as a bizarre joke, but AA was treated with a degree of respect.'

Fast forward to 7 September 2018 and I am sat in the audience at the recovery conference and I hear David Best talking about building recovery communities by connecting people to hope. He seems to say, or I choose to hear him say, that sending people out of area to residential treatment is harmful because it doesn't add to the local therapeutic landscape. I get excited and start to tweet. In my haste to tell the world that one of our leading, bone fide academics on recovery is presenting evidence that says 'keep it local' I fear I may have over egged the pudding. If I have, I want to publicly apologise to David Best for misquoting him.

However, I do want to state, for the record, that I certainly think that if people do need residential detoxification and residential rehabilitation they should stay as near to home as they can. We do recover and we can get well where we got sick. When we are 'recovered' or 'in recovery' and walk through our local shopping centres, people who know us, who drank and used with us but are stuck in the madness see us and they can connect to hope. They can't do this if they are recovering 300 miles away on the Recovery Riviera.

Finally, I want to dedicate this rant to 'Terry from Bury' who planted a seed of hope in me that grew roots and 23 years later sprouted, and gave me a life beyond my wildest dreams.

Mark Gilman is managing director of Discovering Health, www.discoveringhealth.co.uk

1 Darren McGarvey, Poverty Safari: Understanding the Anger of Britain's Underclass. Picador 2018. Page 61.

2 https://www.theguardian.com/society/2018/sep/17/mental-health-patients-sent-300-miles-from-home-due-to-lack-of-beds?CMP=share_btn_fb

The space to GROW

Far away from the usual distractions, Kenward's residents are given the chance of a new start. **DDN** reports

Turning away from the traffic of Maidstone, you take the narrowest and windiest of lanes and the longest and stoniest of drives until a vast Georgian mansion appears before you. This is the sight that confronted Wayne Smythe as he arrived at Kenward – just 30-odd miles but a whole other world away from his home in Plumstead, south London.

Fresh out of detox in November 2017, he was given three options by the drug and alcohol team who sorted out his funding – the first on the list was Kenward. 'I said, I'm going there. It's right in the middle of nowhere – you've got a long walk to the shops. You've got a long time to think what you're doing,' he says.

Wayne's struggle was with alcohol, and he had 'died from it twice'. A year earlier, in the run-up to Christmas, 'they gave me five days to live,' he says. 'It was my last chance. Basically, I can't pick up another drink, and if I do I'm six foot under.'

After '32 years of the drink' (he's nearly 42 now), he had to learn to walk again, to speak properly, and to write. 'I was writing like a four-year-old,' he says, 'so I've had to rebuild myself.'

Still wobbly – he had been walking with a zimmer frame until three weeks before – he arrived at Kenward, finally realising he needed help. 'I tried to do it my way and couldn't,' he says. 'When I arrived, I wanted to get back out drinking again, but I forced myself to stay there – and I'm glad I did.'

The first week was all about survival – 'I was just taking five minutes at a time.' After a week, he felt like he had stabilised a little bit, 'I was still falling asleep in every group – I just couldn't stay awake. I was still listening, but I was drifting off. They were very tolerant and helped me through that.'

He was grateful that Kenward 'took me at my own pace'. 'Sometimes I wanted to be on my own, but it was nice to interact with other people on the same sort of level,' he says. 'It was very difficult at first, because I didn't know what to do or what normal life was like.'

One-to-one sessions were mixed with therapy in a group with people at different stages of their recovery. In the early stages, he needed help with every move, 'because I was incapable of making my own decisions'. But as he settled into his three-month programme, he began to explore his surroundings and his options for activities.

Kenward's residents have the opportunity to work in a social enterprise three days a week, maintaining the beautiful gardens, tending the animals – including a very friendly group of alpacas – making arts and crafts in the workshop, restoring furniture or working in the onsite Sage and Time Café.

'I knew skills – I was a builder – and when I started to come round and get my brain into action, I was helping out with the enterprise,' says Wayne. The talking and the recovery continued alongside his work. 'They were inspiring me to open up a bit more than I was used to,' he says. 'They were encouraging me to do that.' His knowledge and skills were perfect for contributing to the vast Georgian house's refurbishment, and gave him much-needed confidence. 'You start to rebuild your life,' he says.

Since February Wayne has been living in a 'dry house' – a part of Kenward's move-on accommodation – where he is doing the garden and some paintwork, while preparing for stage three. When the year's up next February, he will move across the road and be supported for another two years in his transition back to the wider community. In the move-on house, 'you're mainly left to your own devices' but have the support of other residents and can attend regular groups. There's also professional support on hand 'if ever you need it'.

Looking back, Wayne cannot believe how far he has come and is filled with gratitude to those who helped him. 'What I was like last year, to what I am now, is complete change,' he says. 'When I look back at pictures of me in hospital... I hope my story helps someone else out.'

Find more on recovery at
www.drinkanddrugsnews.com

'They gave me five days to live, It was my last chance. I tried to do it my way and couldn't... When I arrived, I wanted to get back out drinking again, but I forced myself to stay there – and I'm glad I did.'

WAYNE SMYTHE

'We're all part of the enterprise'

'We've been a therapeutic community since May,' says Penny Williams, Kenward's chief executive, who only came to the role in May. Before that she was the charity's director of marketing and communications, so when she began her new job she was excited about developing the social enterprise.

'Residents become part of the enterprise, developing their confidence, expressing themselves and learning skills,' she says. For Kenward it means an opportunity to harness talent, to help the organisation to thrive.

Creating Kenward Enterprises Ltd as a separate company has given scope to run a business, using all the assets of a beautiful location. They run the café and are expanding their events programme. They have the perfect backdrop for exclusive events and hope to become a dry wedding venue in the near future.

'We want to develop more activities – classic car rallies, zip wires, woodland walks – and get more animals such as donkeys,' she says, stretching her arm towards the grounds beyond the alpaca enclosure. She is excited about the business opportunities, which go hand in hand with plans to develop accommodation at the house.

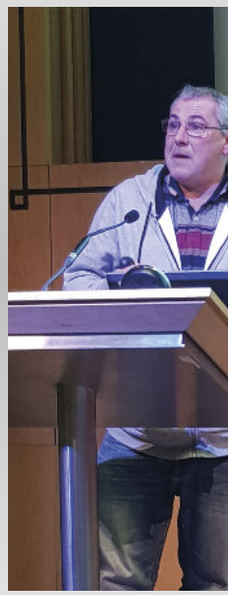
As well as a female move-on house, she talks about a homeless project using onsite accommodation and partnering with an organisation in Maidstone, where these clients would receive support. Alongside this she is 'starting to do partnerships with business' and is excited about the future.

She has had her own journey – coming to Kenward was her 'starting point' in recovering from cancer. Now, just as so many of her residents are, she feels full of possibilities. 'There are so many opportunities here,' she says, as she takes her leave to investigate the next.

'We want to develop more activities – classic car rallies, zip wires, woodland walks – and get more animals'

PENNY WILLIAMS

Giving the



This year's NHSSMPA conference was dedicated to creating lasting behaviour change, as **DDN** reports

'How can we give the best chance of long-term behavioural change?' This was the question 13 NHS trusts gathered to discuss at the NHS Substance Misuse Providers Association (NHSSMPA) conference in London.

The context for this debate was not easy, said NHSSMPA chair Danny Hames. There were many challenges – loss of expertise, disinvestment and diminishing resources, and increasing needs from all areas of the population.

'As a sector we really need to think about how we do stuff and the quality of what we do,' he said. While the sector had 'held up pretty well' against recession, we should not be measuring success by successful completions.

We needed to address the critical loss of expertise right the way through the workforce – from addiction psychiatrists, to recovery workers, to commissioners. Add to this the loss of many small valuable organisations and it gave a 'bleak picture' and many separate challenges. 'We need to up the ante and be more dynamic,' he said. We had lost 'vital capital' so we needed to understand how to use investment to the best effect.

'One of the things we could be doing better is finding allies and forming alliances,' he suggested. We needed to think about how we worked with commissioners, improved influence in local authorities, and sought out meaningful partnerships with service users. Our culture should focus on being transparent – making the effort to understand where risk is, focusing on evidence and 'sharing what works more openly'.

Cutting the numbers of specialists was a backward step, agreed Dr Luke Mitcheson, a consultant clinical psychologist at South Maudsley NHS Foundation Trust, who said that the loss of clinical psychologists was one of the biggest challenges faced by the sector.

Psychosocial interventions (PSI) contributed significantly to positive treatment outcomes, but delivering them effectively depended on highly trained staff and good governance, he said. Cutting down on the level of supervision and on skills such as motivational interviewing undermined our capacity to use PSI effectively.

Many clients had experienced trauma and abuse – in fact 'we should start from the premise that clients have trauma,' he suggested. The skills to deal with this had to go hand in hand with a flexible approach – the capacity to do different things at different times and 'step things up or down'.

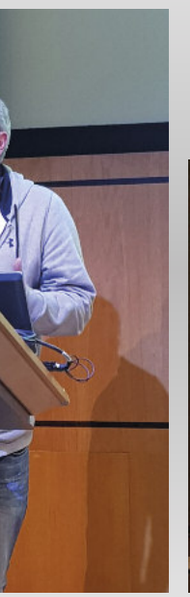
It was important to keep the perspective of delivering PSI as part of an integrated service that included opioid substitution treatment (OST) and other harm reduction initiatives, said Mitcheson. 'Some recovery services don't understand harm reduction, and that's a problem.'

Another major challenge was the ever-changing drugs market – how was the sector meant to keep abreast of new information? Since 2009 there had been 803 new substances identified by the UN, said Dr Dima Abdulrahim, of the Central and North West London NHS Foundation Trust. She was the main author of guidance for NEPTUNE – the Novel Psychoactive Treatment UK Network – which had been developed to improve knowledge around club drugs and NPS and was funded by the Health Foundation.

Many clinicians lacked confidence in dealing with the rapid growth in new substances, she explained. A panel of experts, including experts by experience, had developed a system to simplify guidance to new drugs by categorising them into stimulants, depressants, hallucinogens and synthetic cannabinoids. This framework had proved effective in helping clinicians to orientate themselves when they came across a drug they were not familiar with.

More than 70,000 downloads over the past two years had confirmed the need for

best chance



this information, leading to an e-learning course evaluated by the Royal College of Psychiatrists, to disseminate the information more widely. As well as increasing their knowledge, participants had reported improvements in their confidence and morale through being able to identify NPS.

Another area of the sector where information and support were needed urgently was for problematic gambling, and Dr Henrietta Bowden-Jones shared her expertise as a doctor, neuroscience researcher and founder/director of the National Problem Gambling Clinic. With half a million problem gamblers and 2m people at risk, there were 'many organic reasons why people gamble,' she said. 'It's not all about the bookmaker around the corner.

'Gambling was something I came across by chance in my research on alcohol dependency and I became obsessed with understanding the illness,' she explained. People used to wait years to come forward, but it was now becoming recognised as a condition to be treated.

'Most people will walk away from a table when they are losing,' she said, describing the pattern of behaviour that could become a preoccupation from first thing in the morning and escalate into lies and deceit.

Cognitive Behavioural Therapy (CBT) was being used to treat gambling – very successfully in many cases. For those who didn't respond to CBT, naltrexone (as used to reduce cravings for alcohol) had been trialled successfully. Bowden-Jones had written guidelines on naltrexone and found that it 'gives an opportunity' if CBT had been ineffective.

The National Problem Gambling Clinic was the only multidisciplinary treatment centre in the UK for problem gambling and had been inundated with referrals since opening ten years ago. With a gambling culture that was rife – including in prisons, where inmates could inherit a bunk with debts – NHS England really needed to take the problem on board, she said.

Another extremely valuable – and under-used resource – was families, according to Vivienne Evans OBE, chief executive of the national support service Adfam. There was still a culture of seeing family members as part of a patient's problems, but in fact they could be agents for change, she explained.

Commissioning family support should also be viewed as an investment, rather than an 'add on' to recovery services. The effects of substance misuse were a high factor in incidents of domestic violence, family break-up and divorce so it made sense to commission strategically: 'They should be seen as more than supporting an individual's recovery and receive the support they deserve in their own right,' she said.

Another major challenge is the ever-changing drugs market – how is the sector meant to keep abreast of new information? Since 2009 there have been 803 new substances identified by the UN

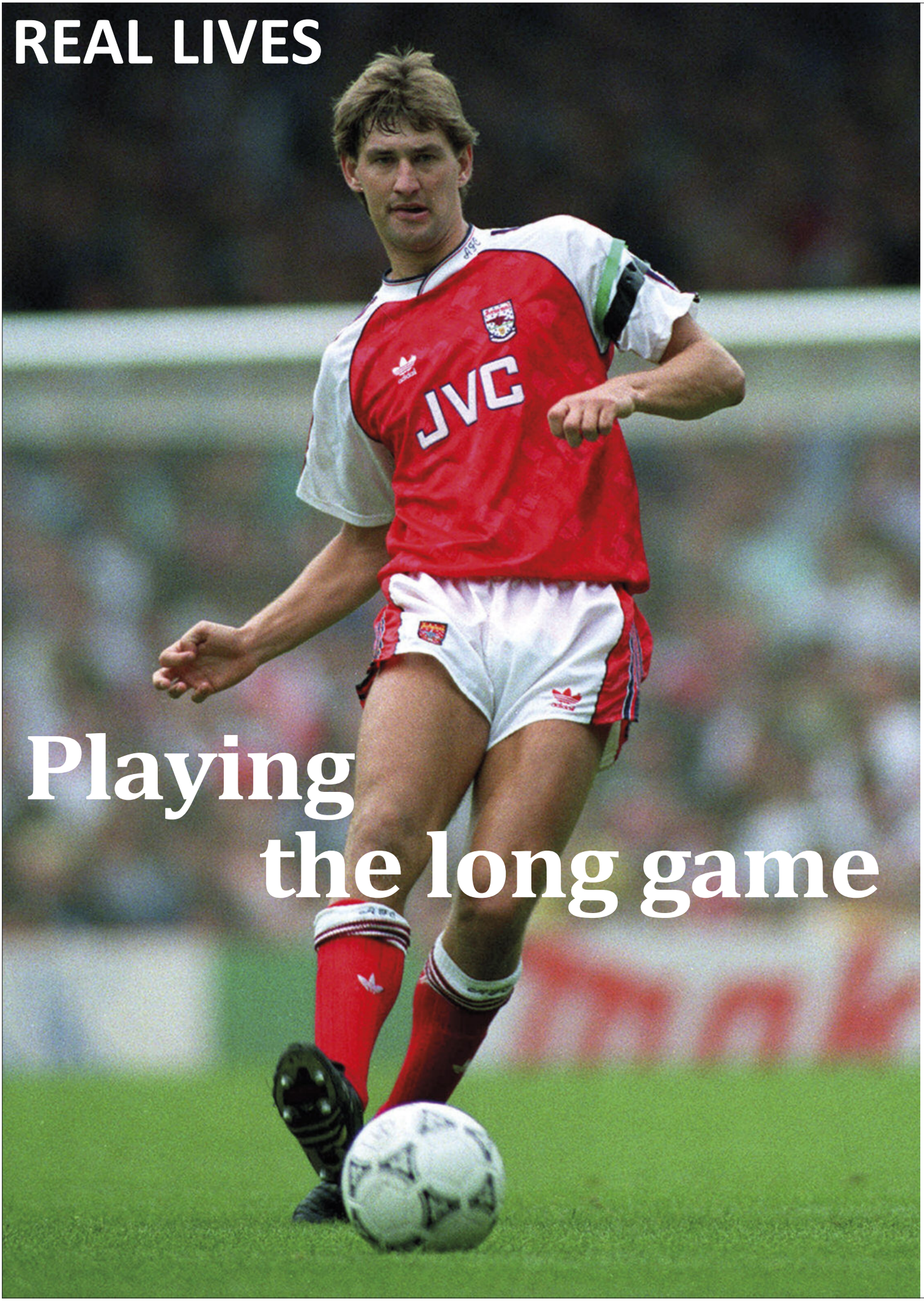
Throughout the conference there had been frequent mention of the need to harness the power of service user involvement – in his opening speech Danny Hames talked about the value of a 'strong and equipped service user voice'.

In the final session Rob Eyres, founder of the Telford After Care Team (TACT), demonstrated what that could mean. Caught up in a destructive cycle of drug dealing and addiction, he served time in young offenders' units and then prison. He carried on using drugs and drink after he was released, right through his relationship and break-up of his family, until a new key-worker confronted him with the responsibility of changing his attitude to his addiction, telling him 'it's your addiction – I'm here to support you'.

Committing himself to treatment (which involved a subutex script) Eyers discovered the support of SMART Recovery meetings, then decided to begin his own support group. He rented a room in a leisure centre and for 12 weeks no one came – 'the cleaner used to hoover around me'. Then people started to join him and when the group began to become more established, they began a gardening project, alongside regular meetings.

Seven years on, their blossoming project had its own premises and works on four NHS projects, running social enterprises that include a café, a landscape gardening company and a printing business. With 28 full-time staff and more than 40 volunteers, they had around 100 people accessing their services each day.

The peer support was an essential element; staff all formerly had problematic substance use and now worked with people at all stages of recovery. 'If people turn up and are intoxicated, we will talk to them and get them to come tomorrow and try again,' said Eyres. 'We don't turn people away – it's a recovery centre, not a recovered centre.'



Playing the long game

Allstar / Alamy

More recovery stories at www.drinkanddrugsnews.com

Tony Adams' glittering football career could not mask deep-seated problems that needed to be tackled. He shared his story at the NHSSMPA conference

'You don't suddenly become an addict – there's a path, a journey,' Tony Adams told the NHSSMPA conference. Adams' 19-year football career had included 669 matches for Arsenal and 66 for England since his debut in 1983, but over much of that time he had become increasingly addicted to alcohol.

'I was very shy as a kid, full of fear. I had the worst attendance at the school – I just couldn't do it. The book would be going round the class and I'd be having a panic attack. When I got the book I was such a mess, I couldn't say the words.

'My family would say "how was school today?" and I would just shove it in a box, bury it as deep as I could. Football was my escape, psychologically, emotionally. I was as free as a bird out there, kicking the ball. I did that instead of facing the fear and going to school. I couldn't do real life, I couldn't do interaction, I couldn't do school. I couldn't do thoughts and feelings. So I'd pick up the ball. On the football pitch I was comfortable in my own skin.

'When I was 17 I broke the metatarsal in my foot and I couldn't go to football to escape those thoughts and feelings. But I found that alcohol did exactly the same thing for me. It took me away from all that stuff – everything.

'When I first picked up alcohol, I didn't like the taste. So I had to work on it because I loved that feeling of numbness, that escape. I'd wet the bed and it became normal – I'd just roll to the other side. It got to the stage where I'd do that and then sleep on the floor – no personal hygiene, no dignity, no self-respect.

'My football career and my using career went side by side. Every time I didn't have football, I needed something else to numb all those thoughts and feelings in life.

'I was spending a lot of time in pubs and clubs and I married a barmaid. She's part of my story, and I'm part of hers. Her drug of choice at the time was crack cocaine. I knew she took a little bit but over the six years we were together it developed. It was a very volatile relationship – we were soulmates in sickness really. I'd think, "at least I'm not like her – she's the druggie." So I'm out there sleeping with other women, pissing myself, going to prison – but thinking, "at least I'm not as bad as you because you do crack and I do booze."

'I was trapped in denial. If you'd have told me I had a problem with alcohol I'd have told you to get lost. The consequences then started to happen and the pain became unbearable.

'I put my wife into treatment at Clouds House to sort her life out – "cos it's her fault" – and I saw the 12-step programme on the wall. I thought, what the hell's that? I sat down with two counsellors and they looked at me as if they could see straight through me. I said "I haven't got a problem – sort her out and we'll be ok. She's got to stay in here for a couple of months and I've got three kids at home I'm looking after. Sort her out."

'So the wife's gone. Then I got injured and couldn't play. As long I was on the pitch I was getting rid of all that anger – and getting paid for it!

'I took the kids out one Sunday to an Indian restaurant and got absolutely smashed. I brought them home and passed out. The next thing I know, my mother-in-law's slapping me round the face – and she took the kids away. My first thought was "holiday!" Then the consequences became more and more painful: "Wife's gone, football's gone, kids have gone."

'It was starting to dawn on me. My mother-in-law gave me the name of a therapist. It was the first time in my 12 years of drinking that I didn't want to drink again – yet I was still getting drunk. I had crossed the line and I couldn't get back. I had completely lost all control over it and it frightened the hell out of me.

'I tried to do it with willpower – "I'm not going to drink again." But with no tools and no idea how to stay stopped, I continued to use. There was the big tournament in '96, the European Championships, and I white-knuckled it – football had always worked for me. I locked myself in my room on the 15th floor of the hotel, with my life falling to bits. I said to the lads, "when we win it I'll go and have a drink with you, we'll celebrate," but until then I was scared – I didn't know how to drink. As soon as the last game of that competition was kicked and Gareth missed that penalty, I went back into the bar in the corner of the dressing rooms and I was off.

'I had my moment of clarity, my surrender moment at 29 years of age. I started to cry. "I don't want to drink, I'm still getting drunk. All this behaviour I'm doing, I don't want to do." My life was a complete and utter mess.

'But as soon as I surrendered, as soon as I gave in, it was a release. Somewhere inside of me I had a moment of clarity, something shifted within me that let a shaft of light in and the therapy got me well.

'The best thing about recovery is that you get your thoughts and feelings back – and the worst thing about recovery is that you get your thoughts and feelings back!

'My life is fantastic today. I get angry, but I express that anger appropriately. I've had to learn absolutely everything from people who are down the journey a little bit further.

'I've had many "surrenders" and emotional "bottoms" – things that took me to a very dark place. But I got through it with different tools, including talking about it. We don't know what the triggers are for other people – all we can do is to lay out the tools in front of them, whether it's a treatment centre, a counsellor, a friend, or a coffee with someone.

'If one programme doesn't work for you, try everything. And as professionals, put everything in front of people and they might pick up one of the tools. It's the pain that gets them usually. The consequences of your life become so unbearable, you've got no other choice.'

Tony Adam's book *Sober* was published in August by Simon & Schuster, ISBN 9781471156755. He has used the proceeds of his books to set up Sporting Chance Clinic to support current and former professional sportspeople, www.sportingchanceclinic.com

'The best thing about recovery is that you get your thoughts and feelings back – and the worst thing about recovery is that you get your thoughts and feelings back! I've had to learn absolutely everything from people who are down the journey a little bit further.'

Lone journey

The right support from her early years onwards could have made a vast difference to Sharon's life. She shares her story

When I was born, in 1958, I weighed just 1kg (2.2lb) and was 47.5cm (19ins) long. I was placed in an incubator for three months, because I was too small to survive on my own. While in the incubator I was given too much oxygen and developed a condition called retrolental fibroplasia, which damaged my eyes and left me with visual impairment. At 18 days old I developed pneumonia, after being handled by a nurse who had a cold, and was quickly christened as it was thought I would not survive. I was later christened a second time.

When I was a year old my mum was approached by the authorities who wanted her to enrol me into a Sunshine Home for the blind. My mum refused, as she felt it was cruel and didn't agree that a visually impaired child should stay away from her parents and only come home at the end of term.

They wouldn't accept me at an ordinary school, so at the age of four, I went to a day nursery for visually impaired children. I had good days and bad days like any other child. I was mischievous and ran around playing with friends.

When I was five years old I had to go to boarding school – firstly to one where I was only allowed to come home during holidays, and then to another where I could come home at weekends. Some of the kids were very mean and, because I had a weak bladder, I was bullied and beaten up quite a lot.

I had a relatively normal childhood spending time playing with my brother. However, I can remember one evening wanting to watch *Daktari* – my brother was allowed to stay up for an extra half an hour, but not me. My parents grabbed hold of me, slapped me round the face and pulled my hair really hard until I screamed in pain. I got to my room, lay on my bed and cried my eyes out. My mum came in, grabbed me and banged my head on the wall. I screamed so loud and wanted to get out of the house. I also had cold water thrown over me that night. Every time I said something out of line, I was smacked by my parents.

Like most teenagers, I rebelled and did not want to take my exams, but I came away with a handful of CSEs. At 13 I began dating a guy called Ron but my parents pulled us apart and I was forbidden to talk to boys. I joined the local youth club and made friends, however I was unable to go anywhere unless I was supervised. I began to play loud music to curb my anger.

At 16 I enrolled at an ordinary school – a grammar school – and went on to take 'O' levels. I was a lot happier here, as I was treated as a normal person. I went out with the girls and was told off by the teachers.

As I grew older I realised that my brother had it easier than me. He was allowed to stay on his own and be with his friends while I was looked after by my gran, like a child, which I hated. I didn't feel I had my full freedom like a normal teenager and missed out on lots of things.

I went to college and trained as a masseuse on a health farm, but then struggled to find employment – I was rejected every time because of my visual impairment. After three years I did finally manage to get a job offer in Malta – however, my parents, including gran, wouldn't let me go. My gran had a tendency to interfere in my life and tell me what to do.

When I was 21 I heard job prospects were better in Holland, so I went to live there, staying with a friend called Monique. I managed to get voluntary work in a health food place, preparing vegetables in the kitchen, and another job in a nightclub called the Milky Way, washing pots in the evenings.

By this time, however, I was addicted to drugs. I was on heroin, opium, cocaine, speed, marijuana and LSD. I was also eating space cake – I could eat three pieces, as big as the palm of my hand, in one night. I got to the stage where I would wake up in a morning and have a joint, another one in the middle of the morning, one after lunch, one in the afternoon, one after tea and one before I went out.

I was in the Milky Way five days a week, from 7.30 in the evening until 3.30 the next morning and made lots of friends, including several boyfriends, and we all shared joints with each other.

Then I fell in love with Jaap, who was addicted to heroin – but, unlike me, he used needles. My friends told me to be wary as he could be vicious at times, but with me he was completely different. He knew I had a visual impairment but he fell in love with me. He would do anything for me and even stopped using needles because I begged him to. I was having the time of my life.

Then at the age of 22, I returned to England as my money had run out. I didn't want to but I had no choice. I continued to take drugs for a month, but they weren't as easy to find as

‘I have been told there are others with the same conditions as me, but I haven't met them yet. I am unsure how they cope with the pain, but can only assume they crave the drugs as I still do... I don’t want people to get into the same situation as me.’

in the Milky Way. There was no club to go to and I was on my own.

My parents forced me to go ‘cold turkey’ and my withdrawal symptoms were horrendous. I was dizzy, sick, and had severe pain throughout my body. I shook violently and had terrible mood swings – one minute depression, the next minute anger. I become paranoid and frightened of everything around me – even the furniture and Smokey our cat. When I tried to tell my parents how I felt, they said it was my own fault for taking drugs.

I saw two drug specialists and was given tablets for a week to stop me shaking and craving. I then attended day treatment at a psychiatric hospital, where I was given tablets to stop my heart racing, as it was over 240 beats per minute.

It took me two years to recover properly because my body was still detoxing and support was extremely limited. During this time I became friends with an ex-user, Edwin, who I met through *Trend*, a magazine for the visually impaired. My parents hated him because of his drug-using past, but he gave me a lot of support. I could ring him and tell him how I felt.

I moved in with Edwin and we lived on the 11th floor of a tower block. One day I fell and sprained my left knee, pulling all the ligaments, which was worse than a break. Edwin had to help me as I was having difficulty walking, but he needed to go to work so I was often left alone. I was getting to the stage where I needed a frame to move around. Then after eight months, I needed a wheelchair because I had developed sciatica and my heart would have been under too much strain without it. Edwin and I parted because of the stressful situation. I left the flat and went into a care home until I could be rehoused.

Ten years after my drug use, I nearly died from septicaemia which damaged my kidneys, and led to me having a kidney transplant. I also developed osteoporosis caused by polyrheumatoid arthritis.

People don’t realise what long-term damage drugs can do. I’ve had friends who have been left brain damaged, leaving them unable to communicate. I have been told there are others with the same conditions as me, but I haven't met them yet. I am unsure how they cope with the pain, but can only assume they crave the drugs as I still do.

I wrote this article because I don’t want people to get into the same situation as me.

More legal advice at:
www.drinkanddrugsnews.com

Forewarned is forearmed

Joanna Shah gives an essential guide to navigating the CQC inspection process

Inspections are at the core of CQC's regulatory model in assessing the quality of care provided by health and social care services in England. CQC now has powers to rate independent standalone substance misuse services and has started its wave of comprehensive inspections to enable it to establish an initial baseline rating for these providers.

Preparation before an inspection is a key element to ensuring your organisation does itself justice through the inspection process. One of the starting points in ensuring your service is ready for an inspection is to be mindful of the following:

- Ensure that the information CQC holds about your service (contained in CQC's Insight model), is accurate and fair.
- CQC will normally ask for you to submit a Provider Information Request (PIR) before they come to inspect your service. It is likely that an inspection will take place within three months of completing and returning the PIR. The PIR is your chance to get your case across to CQC by highlighting any evidence of innovation, improvement and sustainability.
- As part of your own quality assurance checks, challenge your own systems to check for weaknesses against CQC's Key Lines of Enquiry and Core Service Guidance.
- You could invite an external consultant to assess your service's compliance with the Fundamental Standards. At Ridouts we have access to experienced consultants who could support you through the planning phase.
- Audit documentation across your service: care plans, risk assessments and daily records should be 'joined up' and demonstrate the delivery of safe and effective care and treatment.
- It is worthwhile briefing your staff on what to expect in a written summary of the CQC inspection process. Reassure your staff that inspections are not something to fear but an opportunity to demonstrate how your service works.

No matter how well prepared you are, the inspection can be a stressful experience for staff, and surprises can occur. It is worthwhile to prepare staff for all contingencies on inspection day:

- Assist CQC to ensure a smooth inspection by asking questions and offering assistance where it is appropriate. Request feedback throughout the inspection to avoid surprises.
- Address any immediate compliance issues that arise during the inspection and confirm that you have taken any necessary action.
- CQC may require additional information; ensure there is clarity about the documents CQC requires and provide those documents promptly to CQC.
- CQC will conduct a feedback session at the end of its inspection. This session is an opportunity to head off any issues that have arisen during the inspection or identify matters to take up with CQC after the inspection. Ensure that you take notes, ask questions and request evidence to support allegations where it has not been provided already, and if possible, present evidence to counter any findings.

The inspection process does not end on inspection day. It is important to respond to any further queries from CQC promptly and comprehensively:

- If you have concerns about the manner in which CQC has gathered its evidence, or other aspects of the inspection, consider requesting copies of CQC's inspection notes.

'Preparation is the key element'

- Consider lodging a complaint to CQC if there are issues about the professionalism and conduct of particular inspectors.
- You have ten days to submit a factual accuracy response to CQC'S draft report. Be prepared for the draft report and respond in detail when it arrives. If you do not submit factual accuracy comments, the report will become a record of fact.
- When you prepare your factual accuracy comments, bear in mind that you can challenge findings (opinions) and judgements as part of the process. In particular, consider the following:
  - challenge negative or imprecise wording and any connotations in the draft report;
  - assess whether CQC has provided evidence to support any allegations of breaches of regulations; and
  - assess whether CQC has taken a measured and proportionate approach to rating your service.
- Remember to display your ratings in your service and on your website – it is an offence not to do so.

While it is important to cooperate with CQC and address compliance issues effectively, it is also important to ensure that CQC is held to account where it gets things wrong. Like any organisation, CQC is not above reproach. Timely legal advice should be sought during the inspection process on areas in dispute, particularly where enforcement action is threatened or inadequate ratings might arise.

Joanna Shah is a solicitor at Ridouts, a specialist law firm that has a core expertise in health and social care law, www.ridout-law.com

More recovery stories at www.drinkanddrugsnews.com

RECOVERY IN ACTION

A beautiful bank holiday campout confirmed that recovery is bursting with life in Lancashire, says **James Williamson**

On a beautiful August bank holiday weekend, more than 150 people from Lancashire's flourishing recovery movement celebrated their seventh annual campout at LUFStock18. Salus Withnell Hall, one of the north west's leading drug and alcohol detox and rehab centres, provided the perfect venue. Set in 14 acres of beautiful grounds and woodlands, the centre is run in partnership with CAIS, the leading voluntary sector provider of personal support services in Wales.

Campers enjoyed plenty of fun activities in the grounds, including football coaching, games, songs and storytelling around the campfire. A particular highlight was a special performance from the Fallen Angels Dance Theatre.

Qualified football coach, barbecue chef and CAIS director of residential services Leon Marsh said the team at Salus were thrilled to host the event alongside partners from the Lancashire User Forum and Red Rose Recovery: 'We were really pleased to play a small part in such a big statement of the power of recovery, right here in our own grounds,' he said. 'Everyone involved in the organisation of this fantastic event, and everyone who attended, shared the common goal of celebrating and enjoying recovery – and that's what made the weekend so special.

'It's often the simple things which make the biggest difference,' he added. 'It was great to hear the buzz and excitement of children toasting marshmallows around the campfire. And it's been wonderful to have such great feedback from many of those who attended.'

Campers were also offered free blood-borne virus testing, naloxone training, and naloxone kits to take away, thanks to the support of local teams from CGL Inspire.

The annual campout is a grassroots event, and offers an inclusive space for people in the recovery community, their families, and others interested in or affected by addiction to connect.

Peter Yarwood from Red Rose Recovery said the weekend's events were a prime example of effective co-production. 'It was really refreshing to work with an organisation which looks at what it can give rather than what it can take from the service user community,' he said. 'Both in the lead-up to the weekend, and during, all our peers found that the team from Salus wanted to bring something to the party. That set the scene for us to create an event where everyone had a great time.'

The event wasn't about titles or authority, he added. 'Everyone was on the same level, everyone had the opportunity to be part of the activities, and everyone had something to contribute. That means a lot in a community which is often stigmatised and marginalised. This was a fine example of co-production in action – it really was a beautiful thing.'

Leon said the team at Salus Withnell Hall would continue to forge mutually beneficial relationships with the recovery community. 'It really was a privilege to be part of the weekend,' he said. 'This was true co-production – combining people with experience of substance misuse, their families and loved ones, recovery services, harm reduction, public health, and the third sector in visible and infectious recovery. We're looking forward to continuing to work with the Lancashire User Forum, Red Rose Recovery and other partners in the weeks, months and years ahead.'

James Williamson works at CAIS

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