DRINK AND DRUGS NEWS ISSN 1755-6236 DECEMBER 2016

DDN

STAR-CROSSED YEAR

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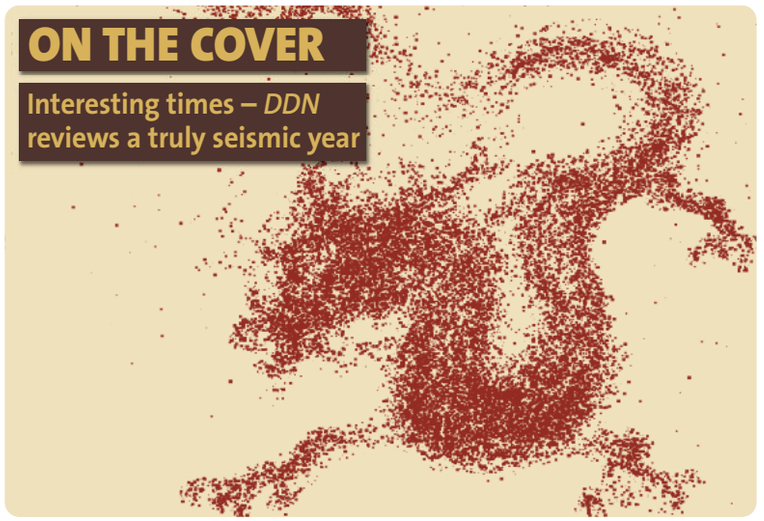

EDITOR'S LETTER

'It's our duty to do more... what are we doing with these statistics?'

This year has held more political turbulence than most of us can stomach. Alongside that, the ongoing onslaught on budgets and growing demands on the sector have ramped up the pressure with no easy way forward.

But we mustn't be lost for words. At the recent Hit Hot Topics conference (coverage next issue) American neuroscientist Professor Carl Hart said 'When there is injustice we need to take risks. When Obama was in office, we went to sleep and claimed victories for things that weren't victories... You know the score with Trump. It's better to know the score than to hear pretty lies. Go to work.'

Dr Judith Yates' article (page 8) demonstrates why it's our duty to do more. Heroin-related deaths have doubled – yet what are we doing with these statistics? The work of DRD inquiry groups is being stifled by financial cuts, but we know that the vast majority of drug related deaths are of people who are not engaged in treatment – and more than half of them have never been in services.

Simple inexpensive actions, says Dr Yates, can make all the difference, and this is echoed in many moving stories at the Addaction conference (page 12). But as Stephen Molloy warned, talking about essential service user activism, 'We've become the deserving versus the undeserving... if we don't challenge, governments will carry on doing what they're doing.'

I hope this festive season brings you comfort and joy – and that 2017 brings many more chances to make a difference.

Claire Brown, editor

Our next issue of DDN is out on Monday 6 February. Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

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LEGAL CANNABIS TAX COULD BE WORTH £1BN

A 'ROOT AND BRANCH' REFORM of UK cannabis policy is 'long overdue', says a new report from Volteface and free market think tank the Adam Smith Institute. A legal cannabis market in the UK could be worth £6.8bn a year and produce annual benefits to the government of up to around £1bn in tax revenue and reduced criminal justice costs, says *The tide effect: how the world is changing its mind on cannabis legalisation*.

Current policy is a 'messy patchwork', it says, with enforcement intermittent and dependent on each regional police force. The government 'must acknowledge' that legalisation is the only workable solution, the document states.

The report, which has the backing of cross-party MPs including Caroline Lucas, Nick Clegg, Paul Flynn, Peter Lilley and Michael Fabricant, comes after four more US states, including California, have voted to legalise the sale and consumption of recreational cannabis (see story this page). A regulation model is 'substantially more desirable' than either decriminalisation or unregulated legalisation as it is the only way to ensure that the product meets acceptable standards of quality and purity, it says, as well as removing criminal gangs from the equation 'as far as possible', raising revenue for the Treasury through point-of-sale taxation and protecting public health.

The document also echoes previous calls for the responsibility for cannabis policy to be moved to the Department of Health, with the Home Office's role changing from 'enforcement of prohibition to enforcement of regulation and licensing'. Jailing people for cannabis-related offences in England and Wales costs around £50m per year, the document adds.

'The global movement towards legalisation, regulation and taxation of cannabis is now inexorable,' said Volteface's director, Steve Moore.

'Today in the UK there is capricious policing of cannabis and no regulation of its sales and distribution. This quasi-decriminalisation of cannabis leaves criminals running a multi-billion dollar racket and exposes teenage kids to criminality. The evidence is now clear that regulated markets for cannabis cut crime and protect vulnerable children. The government's current policy vacuum is untenable in the face of this evidence.'

Report available at www.adamsmith.org

The report has the backing of cross-party MPs including Caroline Lucas, Nick Clegg, Paul Flynn, Peter Lilley (above) and Michael Fabricant.

RISK MANAGEMENT

HIV LEVELS IN THE UK REMAIN LOW but there are continuing risks among people who inject drugs and 'outbreaks still occur', according to PHE's updated ***Shooting up: infections among people who injected drugs in the UK*** **report. Diagnostic testing for HIV should be offered to all those at risk, it says, while 'new patterns of injecting drug use among some groups of MSM' is also a concern. Only 1 per cent of people who inject drugs in the UK are infected, although 17 per cent reported sharing injecting equipment and around half have been infected with hepatitis C, often without being aware. Bacterial infections also remain common, it states, some of which can lead to severe illnesses.**

Report at www.gov.uk

UNAPPEALING DEVELOPMENTS

THE SCOTCH WHISKY ASSOCIATION (SWA) has said it intends to appeal the Scottish Court of Session's ruling on minimum unit pricing (MUP) (*DDN*, November, page 5). The decision to appeal to the UK Supreme Court – and so extend the seemingly endless MUP saga – is not one the organisation has 'taken lightly', said its acting chief executive, Julie Hesketh-Laird. 'It comes after wide consultation with our member companies and other parties to the case to see whether there is an alternative way forward. However, given our strong view that minimum pricing is incompatible with EU law and likely to be ineffective, we now hope that our appeal can be heard quickly in the UK Supreme Court.' SHAAP director Eric Carlin said the decision 'beggared belief', while Alcohol Focus Scotland chief executive Alison Douglas called it 'truly shocking and saddening news' and accused SWA members of putting shareholder profits 'above the public interest'.

WORRYING PREDICTIONS

ALCOHOL IS EXPECTED TO CAUSE AROUND 135,000 CANCER DEATHS over the next 20 years, costing the NHS an estimated £2bn, according to a new Sheffield University report. Oesophageal cancer is expected to see the largest increase, followed by bowel cancer, mouth and throat cancer and liver cancer. 'These new figures reveal the devastating impact alcohol will have over the coming years,' said Cancer Research UK's director of prevention, Alison Cox. 'That's why it's hugely important the public are aware of the link between alcohol and cancer.' *Alcohol and cancer trends: intervention scenarios at www.cancerresearchuk.org*

'It is time to highlight the benefits of well-designed... drug policies.'
RUTH DREIFUSS

HIGH VOTER TURNOUT

LAST MONTH'S US PRESIDENTIAL ELECTIONS also saw citizens vote on commercial models of recreational cannabis supply in five more states. Maine, Massachusetts, Nevada and, significantly, California – which has a population of nearly 40m – all voted in favour of legalising the sale and consumption of recreational cannabis, while Arizona voted against. Meanwhile, a new report from the Global Commission on Drug Policy calls for UN member states to explore regulatory models for illicit drugs and end all penalties for possession for personal use. 'It is time to highlight the benefits of well-designed and well-implemented people-centred drug policies,' said commission chair Ruth Dreifuss.

Advancing drug policy reform available at www.globalcommissionondrugs.org

GOVERNMENT SEEKS TO ADDRESS PRISONS CRISIS WITH EXTRA STAFF

'Prisons should be places where offenders get off drugs and get the education and skills they need to find work and turn their back on crime for good.'

ELIZABETH TRUSS

JUSTICE SECRETARY ELIZABETH TRUSS HAS ANNOUNCED FUNDING TO RECRUIT 2,500 MORE PRISON OFFICES as part of the government's new prison safety and reform white paper. There will also be new measures to test offenders on entry and exit from prison 'to show how well jails are performing' in getting them off drugs and giving them basic education and employment skills.

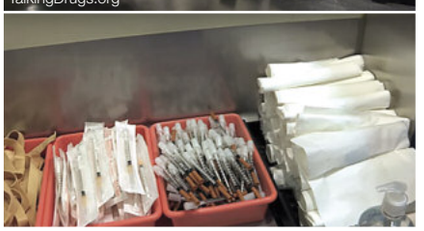
The white paper also includes measures to introduce no-fly zones over prisons to stop drones being used to drop drugs inside the prison walls, as well as extra sniffer dogs. Prisons should be 'places where offenders get off drugs and get the education and skills they need to find work and turn their back on crime for good', said Truss.

Deaths in custody rose by 30 per cent in the year to June 2016, while suicides and assaults on staff rose by 28 per cent and 40 cent respectively (*DDN*, September, page 4). A recent report by the Prison and Probation Ombudsman said that prison authorities must to do more to tackle the role of NPS and associated debts in the rising and 'unacceptable' levels of violence in the prison estate (*DDN*, October, page 4).

RAPt CEO Mike Trace – whose organisation recorded a seven-fold increase in reports of NPS use in prisons last year – said that while it was vital to undermine the prison drug market, more also needed to be done to reduce demand. 'More than half of new arrivals in prison are daily users of drugs, or dependent on alcohol,' he said. 'Most seek to continue using inside and, if a way isn't found to turn them away from the dealer and towards treatment and recovery, their demand fuels the profits of the gangs, which itself is behind most of the violence, disorder, and health emergencies in prison today. We call on the new secretary of state for justice to tackle the issue by prioritising effective drug treatment in the criminal justice system.'

The call for more investment in treatment was echoed by CGL executive director Mike Pattinson, who also stressed the need for better education, training and employment support, as well as provision of safe accommodation on release. 'Disappointingly there remains a complete absence in thinking and action about some of the other fundamental concerns that impact upon the prison population and therefore the safety of those being detained, namely sentencing reform and a sensible debate about the role of prisons in a modern society and who should be incarcerated,' he added.

White paper at www.gov.uk



EASY DECISION

FRANCE HAS OPENED ITS SECOND CONSUMPTION ROOM, less than a month after the country piloted its first project in Paris (*DDN*, November, page 4). Councillors in the city of Strasbourg voted 90 per cent in favour of the facility, which has a capacity for up to 150 visits a day. A third facility, in Bordeaux, is set to open soon.

URGENT UPSCALE

THERE IS AN URGENT NEED TO SCALE UP NEEDLE AND SYRINGE PROGRAMMES (NSP) and opioid substitution therapy (OST) to keep pace with growing need, according to HRI's latest *Global state of harm reduction* report. Out of more than 150 countries where injecting drug use is reported, nearly 70 still do not provide NSP – with no new countries establishing it since 2014 – while just 80 implement OST. 'The 2011 UN target to halve HIV among people who inject drugs by 2015 was missed by 80 per cent,' said report author Katie Stone. 'Now people who inject drugs are being left ever further behind.'

Report at idpc.net

SKEWED SYSTEM

BLACK AND ASIAN MEN are about 1.4 times more likely to receive a custodial sentence for drugs offences than white men, according to the interim report from David Lammy MP's review of race and the criminal justice system. For every 100 white women handed custodial sentences at crown courts for drugs offences, meanwhile, 227 black women are sentenced to custody. The review, which was commissioned by David Cameron, is due to publish its full report next year. 'These emerging findings raise difficult questions about whether ethnic minority communities are getting a fair deal in our justice system,' said Lammy.

Black, Asian and minority ethnic disproportionality in the criminal justice system in England and Wales at www.gov.uk

Are ethnic minority communities are getting a fair deal in our justice system?

DAVID LAMMY

DESPERATE MEASURES

NEW GUIDELINES for the management of coexisting severe mental illness and substance use – 'dual diagnosis' – have been published by NICE. Aimed at commissioners, providers, frontline staff, families, carers and others, they cover issues like referral, care plans and improving service delivery. The guidelines were 'desperately needed' said chair of the guideline committee, Professor Alan Maryon Davis. There needs to be 'much wider recognition that this group of people, despite their complexities, have as much right to dedicated care and support as anyone else,' he stated. 'They should not be turned away or left to flounder. Every effort should be made to help them benefit from the services they so badly need. Crucial to this is a non-judgmental, empathetic approach and the building up of mutual respect and trust.'

Available at www.nice.org.uk

Guidelines 'desperately needed'

ALAN MARYON DAVIS

REVIEW OF THE YEAR

INTERESTING

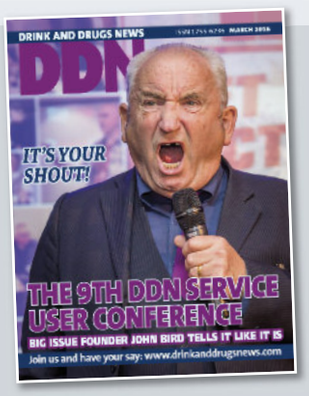
As the old Chinese curse has it, 'may you live in interesting times'… A truly seismic year for world events saw the triumph of populist policies, and politicians, across the globe – including one head of state elected after a campaign promise to eradicate drug users

JANUARY

As people are getting over their festive hangovers, the chief medical officer starts 2016 by revising the UK's alcohol guidelines. The official recommendation is now that men should drink no more than 14 units per week, bringing the level in line with that for women and making the UK's recommended consumption levels among the lowest in the world. An early day motion on the government's Psychoactive Substances Bill, meanwhile, brands the document 'evidence-free and prejudice-rich'.

FEBRUARY

The ninth annual service user conference in Birmingham sees powerful presentations, heated debate and a rousing closing speech from *Big Issue* founder John Bird. 'The skills you used to score and beg – use them.' he told delegates. 'Don't let anyone tell you that you don't have valuable skills!' As austerity policies continue to bite, a survey of directors of public health finds that 70 per cent of them expect drug and alcohol services in their area to face cuts.

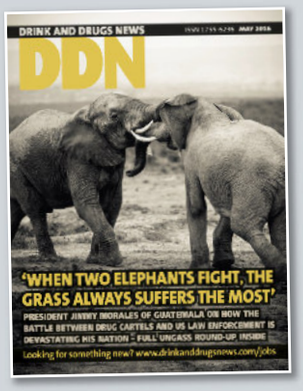


MARCH

The bleak news continues as a report by the Recovery Partnership finds that nearly 60 per cent of residential services have reported a decrease in funding, along with almost 40 per cent of community services. The government, meanwhile, delays its beleaguered Psychoactive Substances Act.

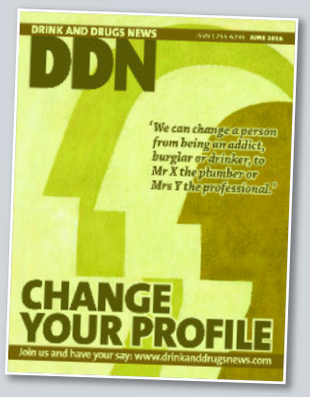
APRIL

The UN convenes its first special session of the General Assembly (UNGASS) on drugs since 1998, with UNODC executive director Yury Fedotov telling the session that the world needs drug policies that 'put people first'. The event's outcome document, however, receives a decidedly lukewarm response – despite some welcome language on human rights and harm reduction, the need for consensus renders it 'watered down' and 'generally a huge disappointment', Transform's Steve Rolles tells *DDN*. The seemingly unstoppable flow of new psychoactive substances continues in Europe, with EMCDDA now monitoring almost 600 of them – a sixth of which were reported for the first time in 2015.



MAY

In one of the grimmest developments yet in the 'war on drugs', Rodrigo Duterte is elected president of the Philippines, vowing to eradicate crime in the country in six months – a plan, he says, that would see him 'fatten the fishes' in Manila bay on the bodies of dead criminals, drug dealers and drug users. Closer to home, the Queen's Speech contains major reforms to the UK's struggling prison system – 'the biggest shake-up' since the Victorian era, says the government – although the Prison Bill's chief architect, justice secretary Michael Gove, will be sacked the following month. MDMA, meanwhile, is once again European young people's 'stimulant drug of choice', according to EMCDDA, with figures showing increased levels of use in nine out of 12 countries, along with stronger pills. The Psychoactive Substances Act, meanwhile, finally limps into UK law.



JUNE

As the UK's Brexit vote sends shockwaves through the world, consensus on the country's drug legislation continues to shift as a report by the two major public health bodies calls for personal possession of all illegal substances to be decriminalised. A *Times* editorial on the document goes further, stating that full legalisation should 'still be the ultimate goal'. Alcohol-related hospital admissions continue their upward curve, and the idea that problems in the prison service are 'all down to NPS and overcrowding' is naïve, former governor of Brixton and Belmarsh, John Podmore, tells *DDN*. 'It's looking for a quick fix, and there is no quick fix in this.'

TIMES

JULY

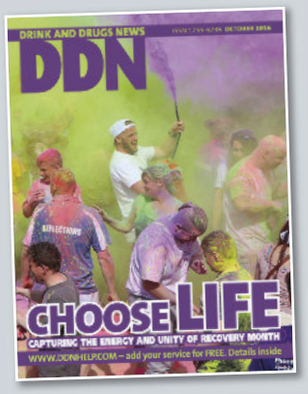
'The chances of political time and energy being focused on addressing alcohol and drug treatment are negligible,' Collective Voice head Paul Hayes writes in *DDN* as he considers Brexit's implications for the sector. While this may be useful in preventing 'renewed ideological attacks' in the short term, he says, the sector needs to come together to 'find a new narrative, as persuasive to local authorities as previous harm reduction and crime-led narratives have been to central government'.

AUGUST

Another bleak milestone for Scotland as the country records its highest ever level of drug-related deaths for the third year in a row. With over 700 fatalities in 2015 – nearly two per day, and more than double the figure from a decade ago – the statistics are 'a national tragedy' and 'the ultimate indicators' of the country's entrenched health inequalities, says Scottish Drugs Forum chief David Liddell. More than 300 NGOs sign an open letter to the UN's drug control bodies urging them to call for an immediate stop to the extrajudicial killings of suspected drug offenders in the Philippines by president Duterte.

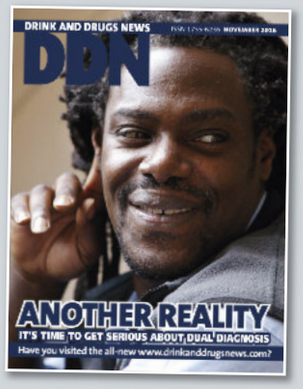
SEPTEMBER

Hot on the heels of last month's grim figures from Scotland, the ONS reveals that the number of heroin-related deaths in England and Wales has doubled in the space of four years, to more than 1,200. The highest number of deaths, for the third year running, are in the North East, while in the Philippines more than 3,000 people are now thought to have fallen victim to Duterte's 'war on drugs'.



OCTOBER

The Glasgow City Joint Integration Board approves the development of a business case for the UK's first consumption room, along with provision of heroin-assisted treatment, generating predictably outraged headlines in some newspapers. Meanwhile, France opens its first consumption room in Paris, with another to follow in Strasbourg.



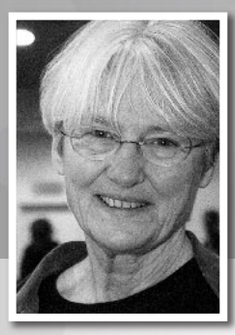
NOVEMBER

As the world digests the news that Donald Trump is to become the 45th US president, another set of American voting results see recreational cannabis legalised in four more states, including California.

DECEMBER

A year that many people will be keen to see the back of draws to a close, and still no sign of the *2016 Drug Strategy*. However, preparations are well under way for *DDN's* milestone tenth annual service user conference. With drug-related deaths continuing to rise and resources diminishing, the need for strong, targeted, effective service user involvement has never been stronger. Join us in Birmingham and let's make a difference!

A NAME NOT A NUMBER



Behind every drug-related death statistic is a life that could have been saved. It's our duty to do more, says **Dr Judith Yates**

I first met David in the 1980s when, as a small child, his mother kept him away from school all too often. She struggled to cope with life. By the end of the 1990s, in his early twenties, David was a regular attendee at my surgery, prescribed methadone and supported by my drug worker.

One night he banged on the back door of the surgery after 7pm when we were supposed to be closed and trying to pack up and go home. Our gentle-hearted nurse Angela opened the door to ask what he needed and stepped back as he staggered in, fell to the floor, stopped breathing and turned rapidly blue. My quick-witted partner ran to the emergency cupboard and dug out our newly acquired naloxone kit. Naloxone is the antidote to opiate overdose and David was breathing again, although still groggy when the ambulance arrived.

When he returned to my surgery for his routine appointment the following Tuesday he was surprised to be met joyfully by the reception staff who had thought he might have died. On waking in the hospital he had no idea how he got there, how close he had been to death, nor the role played by the surgery team. His was the first life I had known to be saved by naloxone.

It was therefore a shock two weeks ago to see David's name in the stark 'drug-related death' summary I was reading on a clear sunny day in Birmingham. I had trodden a familiar path to our local coroner's office to review the thick ring-bind folder containing reports of all inquests held in the city during 2016, as part of the preparation for our newly re-formed drug-related death (DRD) local inquiry group.

It seems that David had no longer been in treatment at the time of his death, as only heroin had been found on toxicology. I suppose there was nobody around to administer naloxone on this occasion.

This reviewing of the inquest reports is a miserable job, not only because beneath the terse language of the certificates lie the shocking stories leading to these sudden and unexpected deaths, but also because having been a GP in the area for over 30 years, I have known many of the people who have now come to the end of their lives in ways which might have been avoidable. It is always especially upsetting to find that one of my old patients has died in this way.

Last week, standing at the podium to address the audience at the 21st RCGP/SMMGP *Managing drug and alcohol problems in primary care* conference, I felt the warm glow of a room full of people who have been working together for all of the 21 years and more, but my subject matter – a review of drug-related deaths in Birmingham – replaced this with an icy chill and a feeling that we must be missing something. I thought of David and the other people I have known who have died suddenly and unexpectedly in this way.

We have all read the headlines telling us that heroin-related deaths have more

'David was only in his late thirties when he died, an increasingly common age for people to suffer accidental overdose. He was of course more at risk because of his age and history, because he had fallen out of treatment, and because he had a history of non-lethal overdose in the past. His death almost certainly could have been avoided.'

than doubled in England and Wales between 2012 and 2015 (*DDN*, October, page 4). Prof David Nutt, speaking at the same conference, asked the question 'Why are we collecting all these statistics if we aren't doing anything about them?' It is only by looking behind the statistics that we can have a chance of understanding what may be the causes and, more importantly, what solutions can be found.

It is shocking that in many parts of the country, as in my city, drug-related death inquiry groups fell victim to the financial cuts in services, and often no longer meet at all. As a result, nobody has been investigating the deaths of people not actually engaged with treatment services at the time of their death. The latest analysis by PHE shows that more than half of people who die in this way have never been involved with drug treatment services, at least since NDTMS records began seven years ago, and more than 70 per cent were not engaged with treatment services at the time when they died (http://bit.ly/2c3k2H6).

We need to learn from each of these tragedies and add to the frequently simple and usually not even expensive actions, which we already know from international evidence contribute to reducing future deaths. These include: low-threshold prescribing (and welcoming rapid re-engagement for those who drop out), supervised consumption facilities offering cups of tea, conversation and a safe hygienic place to inject for the most vulnerable who are not ready or able to come into treatment, and wide access to take-home naloxone wherever it might be used to save a life.

David was only in his late thirties when he died, an increasingly common age for people to suffer accidental overdose. He was of course more at risk because of his age and history, because he had fallen out of treatment, and because he had a history of non-lethal overdose in the past. His death almost certainly could have been avoided.

We have powerful examples of effective analysis and action, for example from the airline industry, the maternal deaths confidential inquiry groups, and the investigations into every road traffic accident death, all of which have found ways to prevent avoidable deaths.

In 2009 airline pilot Captain Sullenberger astonished the world when he made an emergency landing of his plane on the Hudson River, saving every life on board. When asked how he knew what to do, he said, 'Everything we know in aviation, every rule in the rulebook, every procedure we have, we know because someone somewhere died. We cannot have the moral failure of forgetting these lessons and have to relearn them.' (Quoted in *Black Box Thinking* by Matthew Syed, 2015.)

Local inquiry groups are needed now more than ever to look at every fatality and ideally at the near misses as well, to inform our treatment efforts and perhaps even more powerfully to inform people who use drugs how to keep themselves alive and safe into the future.

Dr Judith Yates is writing a guest 'Post-it' on behalf of SMMGP, www.smmgp.org.uk

CONFERENCE REPORT

A PARTICIPANT'S VIEW

Lee Collingham **shares his highlights from the GPs' conference on managing drug and alcohol problems**

'For me, the highlight of the day was the news from Professor Graham Foster that there is a pot of £70m available for the treatment of hepatitis C.'

DR STEPHEN WILLOTT, clinical lead for alcohol and drug misuse at NHS Nottingham City and conference chair, introduced the event's theme as addressing drug-related deaths, which not only continue to rise in England but are twice the European average.

It was a shock to learn alcohol-related deaths aren't recorded as DRDs, and Dr Willott appealed for a fresh approach moving forward. The average age of deaths had also risen from 35 in 1995 to 41 in 2016, with evidence proving opiate substitute therapy (OST) was highly effective in helping people get their life back on track. It was also noted that England's localised agenda is a barrier to not only the widespread provision of naloxone, but also to it being provided to prisoners on release .

Prof David Nutt, former advisor to the ACMD, then talked about how opiate and cocaine-related deaths were at their highest ever, and that there was a need to push for allowing cannabis for medical use in England, as it was in 18 other countries around the world.

He mentioned how alcohol and tobacco, though both legal, were responsible for the majority of deaths, with 80,000 a year dying from tobacco related illnesses and 25,000 from alcohol – compared to opiates being responsible for around 2,000 deaths a year. He also thought the recovery agenda had been the main cause for the rise in drug-related deaths.

Next, Dr Cathy Stannard, a consultant in pain management, questioned the use of opiate-based painkillers as the most effective solution for the long-term management of pain. She talked about the importance of getting it right or facing a public health disaster and mentioned that pain was strongly affected by mood, with those affected by anxiety and stress responding less well to the medication.

The morning finished with a choice of sessions on subjects ranging from the future of drug treatment to end of life care. Posters on display included 'seasonal influenza immunisation', 'opiate analgesic dependence' and ' the difference between buprenorphine prescribing and methadone for injecting opiate users'. This year's poster award went to Kathryn Chadwick and Zoe Black from Sheffield Social Care Trust, on leg ulcer management for the problematic user.

Interesting presentations in the afternoon included Professor Ken Wilson from the Cheshire and Wirral Partnership Trust around 'brains, booze and hospitals'. He explained how brain injury is the biggest concern for problematic drinkers, causing the frontal lobe to shut down and leading to problems with memory.

For me, the highlight of the day was the news from Professor Graham Foster, professor of hepatology at Queen Mary University Hospital London, that there is a pot of £70m available for the treatment of hepatitis C. He explained that, from January, there'll no longer be the need for combination therapy, with the release of a new licensed drug that will not only allow patients to take just one pill a day, but actually cure hep C.

Lee Collingham is a volunteer user involvement worker and advocate

LETTERS AND COMMENT

DDN WELCOMES YOUR LETTERS

Please email the editor, claire@cjwellings.com, or post them to DDN, CJ Wellings Ltd, 57 High Street, Ashford, Kent TN24 8SG. Letters may be edited for space or clarity.

'What we need to do is rage against cuts to services, and advocate for innovative community based solutions that have a passion to serve the needs of people coming to them.'

VITAL CHALLENGE

Kaleidoscope was one of the original drug services in England, and a pioneer of harm reduction services, campaigning against long waiting lists by providing rapid access to treatment. Over time local authorities improved the services to their own drug using population and the need for our services was reduced. At the same time, however, I saw many small drug services struggling to survive, losing their community based, charitable services to the large corporate drug services. The campaigning voice was beginning to get quieter as services recognised that responding to the demands of the commissioners was more important than meeting the needs of the service user.

So 13 years ago we were offered a route out of England to establish drug services in Newport, South Wales. There were significant problems in Wales with access to treatment and poor treatment outcomes. At the same time there seemed to be a real commitment to tackle the issues of drug and alcohol use that came from government and the local communities, which was incredibly refreshing. In Wales there was a communitarian approach with the concept of co-production key before the term itself was even invented. Recovery was an important element to any treatment service, but so was harm reduction.

Recently ARCH Initiative joined the Kaleidoscope family and I find myself back in England, saddened to see the decline of good service provision across the border as massive cuts to provision take hold. I was however pleasantly surprised to hear of Collective Voice and attended its meeting. Having reflected on this brief experience, I feel deeply troubled.

In Wales we provide services, at some level, to all the 22 counties. In our work there is not a single example where we do it alone we work in partnership. In England I do not get this sense of genuine partnership working and certainly not from Collective Voice. How do I have common cause with any agency that puts commercial prosperity over the needs of service users? How do I work with people who used to be passionate advocates of harm reduction, but because the political winds have changed have tried to emerge as recovery champions?

I see huge cuts to services in England, where the solution has been to make contracts ever bigger, which of course can only be delivered by the McDonalds/Burger King-like services offering cheap, off the hook solutions at the cost of more localised and specialist services. What we need to do is rage against cuts to services, and advocate for innovative community-based solutions that have a passion to serve the needs of people coming to them.

I hope that a new voice can be heard, made up of smaller organisations coming together, offering cost effective service delivery while maintaining their commitment to their values – campaigning services that are able to support government policy when it is right, but to work with the service user community when it is wrong.

Martin Blakebrough, group chief executive, Kaleidoscope Project and ARCH Initiatives

NORTHERN STARS

When will we south of the border in England follow the successful trail-blazing example set by our Scottish neighbours, with their pioneering and successful approach to the national, and in fact worldwide, drink and drug problems?

In 2011 Scotland introduced naloxone on prison release and it has been massively successful, and we now see an application being made for the UK's first safe consumption room in Scotland.

It is unbelievable to even contemplate a system where part of the pack you would leave prison with would not include naloxone. Tolerance levels are low so it's risky to use, and the natural thing to do following release is to stay with old friends, possibly using ones, and to have a hit to celebrate freedom.

The stats and figures citing the harms on society overall from alcohol speak for themselves these days, and we live in a society where alcohol is readily available 24 hours a day on virtually every street corner in the land. It is more affordable than ever, and we are seeing the consequences. It would therefore make a lot of sense to try and manage this risk by introducing sensible price restrictions – as Scotland is attempting to do with minimising unit pricing – as a form of harm minimisation.

In my opinion Scotland's approach to drink and drug problems is to be commended – it is a liberal and refreshing one. We need to move away from the moral, financial and target-based approach and instead move forward with a harm reduction based, compassionate approach aimed at longer lasting success, rather than a short-term commissioner and government pleasing approach.

Karl Newton, peer mentor

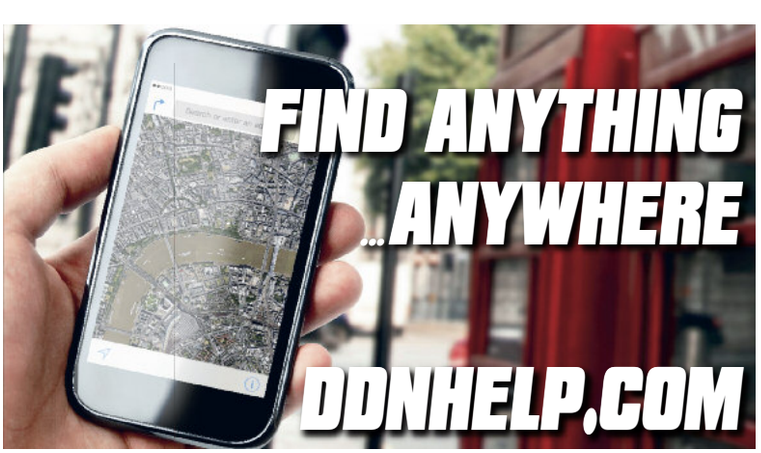
BREAKING BARRIERS

Here in Hastings we read with interest Claire's comments in the dual diagnosis editorial (*DDN*, November, page 3). Fulfilling Lives is a Big Lottery funded project set up in 12 areas across the country where it is acknowledged that a higher percentage of people with multiple and complex needs and a dual diagnosis are likely to call home.

Agencies here are aware that there is a need to re-engage with the issues that historically act as barriers to access, diagnosis, treatment and recovery for people with a dual diagnosis, particularly when you add homelessness into the mix. It is early days, but the membership of the recently set up dual diagnosis meeting grows, interest is sparked and those involved are keen to examine their part in the process from a solution-based perspective.

Progress is made and alliances formed. Will this result in systems change and more people receiving appropriate treatment? Yes, we believe so!

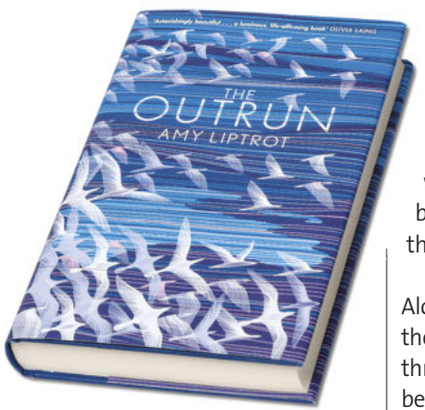
Gary French, area lead, BHT Fulfilling Lives



Lots more views and reviews at:
www.drinkanddrugsnews.com

BOOKSHELF

Recommended reading – from the drug and alcohol sector…



THE OUTRUN

by Amy Liptrot,
published by Canongate.
ISBN: 9781782115489, £14.99
Review by Mark Reid.

The dingy confinements of Amy Liptrot's addiction contrast utterly with the irenic spaces of her recovery. *The Outrun* refers to the furthest-flung coastline of the family sheep farm on Orkney, where she grew up and where she returns. Once oblivious to its beauty, Amy, like most teenagers , wherever they are, wanted out – to London – only to find no amount of big city bright lights can match the natural luminosity of the islands. Few alcoholics and addicts have anything like as much recovery capital to revert to, as Amy does, 800 miles north. Being fortunate does not prevent addiction.

Of course, when Amy first lived in 'fantasy' London she loved being the 'wild girl' spending 'enchanted summer days in the park with beautiful people' and then 'Soho nightclubs I'd read about in magazines'. But it's unsustainable. Soon Amy is making excuses to leave friends in bars 'to drink faster, alone'. Jobs are lost, as are places to live.

Looking for another new flat, 'I mumbled my story, they chose someone else'. So Amy finds a small room in a Victorian terrace in Clapton. 'I saw the sash window next to the bed, I knew I'd be able to drink and smoke freely there. I moved in'.

Amy's recovery is indebted to Alcoholics Anonymous. She accepts there can never be a first drink. She thrives in the trust and bond of being 'in church halls with misfits drinking tea from chipped mugs, listening to tales of people shitting the bed, laughing our heads off'. Amy strives to embrace the 12-step programme: 'I need to do more than just not drink'.

> Amy Liptrot 's coming home radiates how 'recovery is making use of something once thought worthless'

Amy does a lot more than just not drink. When *The Outrun* came out in paperback, the publisher quite rightly pitched it as 'a nature memoir', a very fashionable genre. Amy recaptures, and this time truly cherishes, 'childhood memories of chasing oystercatcher chicks, feeling their soft, hotly beating bodies in our hands, before letting them go'. It's an idyllic setting for recovery. Once so impatient to leave, Amy Liptrot 's coming home radiates how 'recovery is making use of something once thought worthless'.

Mark Reid is peer worker at Path To Recovery (P2R), Bedfordshire

LEGAL EYE

Joanna Sharr of Ridouts answers your legal questions

'As part of the data monitoring process for our CQC inspection we provided detail of commissioners, local authorities, and other organisations making referrals to our service. Since we did this our personal relationship with a senior individual in one of these organisations has gone sour, and we believe this has adversely affected our rating. How can we challenge this, while avoiding a public argument with the individual involved?'

JOANNA ANSWERS: **The Provider Information Return** ('PIR') is the information submitted by providers to CQC before CQC's inspections and is viewed by CQC as an important part of the inspection process. The information provided by services as part of the PIR is used by CQC to help plan inspections and will be considered alongside all other sources of evidence to develop CQC's inspection report.

Whilst negative comments can adversely affect inspection reports, CQC should not accept such comments and criticisms at face value without seeking to corroborate such evidence before it makes a judgement about a service. Judgements and ratings made by CQC in inspection reports should also be proportionate to the evidence before it and CQC should follow its own guidance in this respect. It is our firm's experience that CQC can fail to follow its own policies and guidance, which makes it all the more important for providers to challenge CQC's draft inspection reports through the factual accuracy process.

It would be perfectly reasonable for a provider to challenge comments made by a third party if those comments were unreasonable or were not supported by evidence; both CQC and the individual in question should be accountable for statements that are used to form judgements. The provider could challenge the evidence by requesting copies of the inspection notes, by checking that that the comments are backed up by other evidence in the draft report, or by assessing whether the comments could be countered by other evidence. The provider has five days from publication of the CQC report to seek a ratings review. CQC states that the only grounds for requesting a review are that the inspector did not follow the process for making and aggregating ratings decisions; the review does not offer providers a further forum to challenge the facts or judgements.

In light of the service's concerns about the deteriorating relationship with one of its commissioners, it would be advisable for the service to focus on maintaining and developing its relationships with its commissioning bodies and third party stakeholders. Ways that relationships with commissioners could be fostered include, for example, holding an open day to address any concerns that commissioners may have or by writing to stakeholders to seek their views. Not only would this encourage an open dialogue but it could also be used as evidence at CQC's next inspection that the service was driving improvement by seeking feedback. We recommend that this service is prepared for the next inspection by addressing any concerns that CQC made in its last reporting, and ensure that it is compliant in all respects. We would encourage all services to challenge CQC's findings through the factual accuracy process if CQC's draft inspection reports do not stand up to scrutiny.

Joanna Sharr is a solicitor at Ridouts LLP. Visit www.ridout-law.com

Send your legal queries to legal@drinkanddrugsnews.com

Addaction's two-day conference addressed emotional wellbeing while celebrating the value of shared experience, as *DDN* reports

A place to

'Learn, share, connect and celebrate,' urged David Badcock, Addaction's head of events, opening the charity's two-day conference on addiction and mental health.

The need to connect soon became a strong theme. 'I always felt so different from everyone else at school,' said mental health campaigner Jonny Benjamin – the first speaker to start the conversation about the feelings of isolation that pushed him to the brink of suicide. In his case, the eventual diagnosis was schizoaffective disorder – a combination of schizophrenia and bipolar – but it was not the hospitalisation or the medication that made him want to live. Standing on a bridge in London, contemplating the worst, he was approached by a man who said 'I'm not going to let you jump'.

'A few things that he said changed everything,' said Benjamin. 'The real turning point for me was him saying to me "look mate, I think you'll get better". No one had ever said that to me before.

'When you're in that phase, you have no faith left in yourself. So for someone else to put their faith in you – that was what changed my mind... here was a guy willing to listen to me and not judge, and be patient and show compassion. I had hope where I'd never had hope before.'

> 'We need to invite and involve people who use drugs into services... It's got to be meaningful engagement.'

He explained how he began talking about his mental health without embarrassment. Working with the charity Rethink, he began going into schools, prisons, hospitals and businesses to try to break the stigma – 'that shame and that silence' around mental health.

'I was in a cycle – either drunk, or hungover or both,' said Sarah Fitzpatrick, describing the painful lead-up to realising she needed to connect. Still drinking and in a violent relationship when she became pregnant, it was the mother she didn't get on with who phoned social services.

'When social services took my daughter away, I was very, very angry,' she said. 'I thought, "what's the point?" I'd lost my daughter, my house, everything.'

Connecting with Addaction completely changed her life. 'I remember my first session – I fell off the chair. After about six weeks I sobered up and was listening more. Joyce, my keyworker, is like my mam. She said "we're telling you what you need to do, but it's you who needs to do it.""

Gethin Jones described his route to disengagement when a troubled and troublesome schoolboy, with his 'life aged zero to 35 in one big social services filing cabinet'.

'Never once did a teacher ask me why I acted the way I did. They would say, "Gethin, why are you so disruptive? Gethin, you're never going to amount to anything." Those words stuck with me and I started to think, "I don't want your school. I don't need your education. I don't need to be around people like you.'

Sentenced to a detention centre, the frightened 14-year-old child was 'curled up in a prison bed, in a cell, the blanket over my head, crying into my pillow. I wanted someone to take me away, I wanted to feel safe. Nobody came.' The belief system that grew within him for the next 20 years was that he didn't need to have anything to do with anyone – a 'journey of self-destruction' that ended in a four-year custodial sentence.

While in prison, he met people who wanted to help him and 'sowed the seeds that rehabilitation was possible'. But it was a member of the prison outreach team, he says, that 'connected with me as a human being. Jo never judged or condemned me – she would always be consistent, ask how she could help. She was inspirational to my journey and started to take me through into other services, so they could help and support me.'

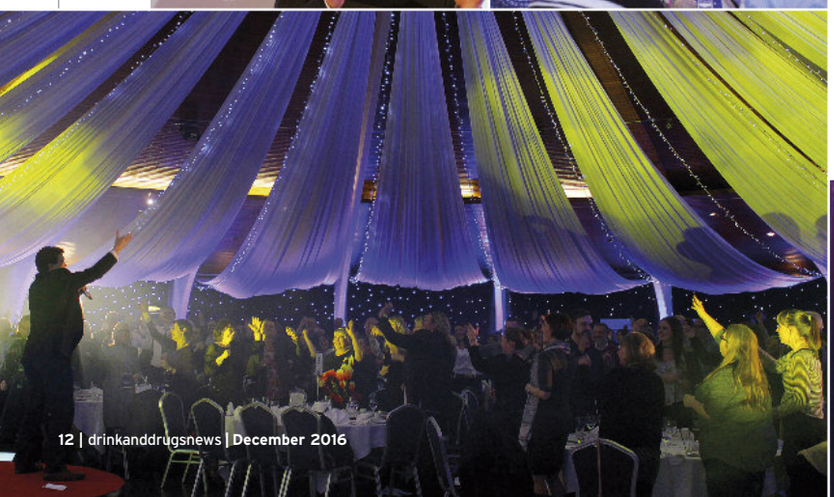
With no education, no employment record and 'no social skills whatsoever', Jo put him on the path to qualifications and found him a volunteering role.

'So her support and integrated way of working enabled me to move forward in my life quite quickly. From somebody who felt that they could never amount to anything, I went from two hours a week volunteering to becoming a service manager overseeing a staff team of 40.

'I've heard so many people wondering what they're going to do about the broken system and lack of support,' Jones told the audience. 'But the solution is in this room. All of you have ideas and can think what you can do to make the system better for the people that we support. The next stage is to talk about it, share it – with your peers, your manager, people of influence. Then the most important part is the action – get on and do it.'








CONNECT

Through chairing a panel session, Anna Whitton, Addaction's executive director of services, wanted to look more closely at why the system wasn't working for everyone.

'A young person said to me, "I have nothing to offer the system and the system has nothing to offer me", she said. 'It made me think, how do we empower people? How do we integrate and co-design services for the most vulnerable in society? What is it that's not working?'

'The system is very much broken, as we're missing multiple opportunities to intervene,' said Isabelle Goldie, director of the Mental Health Foundation. This was the case from perinatal services, to teachers missing chances to intervene in class, to

> 'People's lives aren't straightforward. People don't work in silos, but systems often do.'

adulthood, where one in three GP appointments related to mental health problems.

'Instead of demonising people, we need to ask what's gone wrong,' she said. 'There's not enough research about what would make a difference.'

'People's lives aren't straightforward,' said Paul Farmer, CEO of Mind. 'People don't work in silos, but systems often do. Most people don't "just" have a mental health problem.'

Campaigns such as Time to Change (www.time-to-change.org.uk) gave people a chance to talk about their experiences with mental health and could be a 'real powerhouse' in shifting the narrative, he said.

This narrative also needed to acknowledge the differences between treating women and men, said Katharine Sacks-Jones, director of Agenda, the alliance for women and girls at risk.

'Women don't really feature in the conversation about substance misuse and can find that services are designed as default services for men,' she said. 'They are a minority in services and often policymakers aren't thinking about them. But we need to treat them as individuals, and need to understand what shapes their lives... women are sick of telling their story again and again. We need to design services so they don't have to.'

Sunny Dhadley, director of the Recovery Foundation, brought the essential service user perspective – from both personal and professional experiences.

'The criminal justice system is seen as a necessary intervention, but this has to change,' he said. Service users had an 'absolutely crucial' role in shaping the system, but he was concerned about shrinking budgets, and the parts of services that could be 'left to one side', as well as the detrimental effect on the previously 'massive service user involvement in the drug and alcohol field'.

Bringing the first day's programme to a close, was 'A walk through Addaction', where the conference was turned into 'conversation café' and the round tables in the hall were themed by 16 different projects from all over the country. Delegates 'speed-dated' their way around the tables and had the opportunity to discuss projects with presenters, taking up David Badcock's initial invitation to 'learn, share and connect'.

Among the final day's diverse presentations, the theme of service user involvement was resumed by Stephen Molloy, director of the International Network of People who Use Drugs (INPUD).

'We need to invite and involve people who use drugs into services,' he told the conference. 'It's got to be meaningful engagement of people who use drugs – and not about when they're two years clean, but about where they're at.'

Key to this was developing community advisory boards, just as there were for many other medical conditions.

'People who use drugs don't have that voice anymore in the UK,' he said. 'We used to have it, but those organisations don't exist anymore. We have to see drug user activism and whether you're a drug user or not, you have to be part of that community.

'We've become the deserving versus the undeserving and drug-related deaths are rocketing... If we don't challenge, governments will carry on doing what they're doing.'

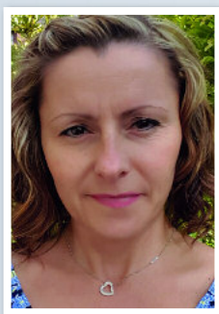
In the closing session, Welsh rugby legend Scott Quinnell brought together the themes and turned them into a rallying cry.

'It doesn't matter what you struggle with,' he said, talking about the dyslexia that gave him the impression he was 'thick, stupid and lazy' in school. 'When you're told by people you trust, that's what you become', with a disastrous effect on self-esteem.

'So tell people "you can do anything you want in life. Believe in yourself",' he said. He had turned around his prospects because he had asked for help – 'but more importantly, someone asked him 'how can I help you?'

And that is why you're so important,' he told delegates. 'Put a smile on their face – help them. You are the people making a difference.' **DDN**

THE POWER OF THE POSITIVE



Can positive psychology help to treat dual diagnosis? **Katalin Ujhelyi**, **Jerome Carson** and **Ioanna Melidou** share results of a new study

People with dual diagnosis – co-occurring substance misuse and mental health issues – have complex needs. The duality of their disorders gives augmented symptoms, leaving clients particularly vulnerable and with poorer treatment outcomes. They require the most support, but in fact receive the least, according to Turning Point's recent *Dual dilemma* report.

The unmet need of those with coexisting problems was the reason for developing a new treatment programme, within the scope of a PhD research project conducted at the University of Bolton, in collaboration with Lifeline Project. The project involved a group of participants with dual diagnosis issues who attended the Bolton Integrated Drugs and Alcohol Service (BIDAS).

Traditionally, psychology has been preoccupied with what is wrong with us and concentrated on trying to repair it. Positive psychology, on the other hand, is the science of positive aspects of human life and looks for what is right with people. It explores positive experience, positive individual traits, and positive institutions (Seligman & Csikszentmihalyi, 2000).

The field is not intended to replace traditional approaches, but to draw on the findings and methodologies of psychology in general and make it more representative of the human experience (Seligman et al, 2005). According to Seligman's PERMA Model of positive psychology, wellbeing or flourishing stands on five pillars: positive emotions, engagement, relationships, meaning, and accomplishment (Seligman, 2011; http://bit.ly/2gD2Vwl).

P	Positive emotions	feeling good
E	Engagement	finding flow
R	Relationships	authentic connections
M	Meaning	purposeful existence
A	Achievement	sense of accomplishment

Figure 1: Seligman's PERMA Model of Flourishing.

Positive psychology has been successfully applied in addiction recovery, as well as in the treatment of mental illnesses. However, there is a lack of research relating to dual diagnosis.

Applied to addiction, it can be seen in three areas associated with 'the pleasant life' (positive emotions about the past, present, and future); 'the engaged life' (having positive traits that are necessary for full engagement, such as hope); and 'the meaningful life' (service to, and membership of, positive entities such as family, workplace, Alcoholics Anonymous).

Positive interventions aim to increase positive feelings, behaviours, and cognitions rather than working on pathology and maladaptive thoughts and behaviours (Sin & Lyubomirsky, 2009). According to positive psychology, a lack of mental illness does not automatically mean you have a happy life. While the aim of traditional psychology is to treat mental illness, positive psychology gives a hand to this traditional approach but in addition helps people move beyond survival to achieve their full potential and flourish.

The new programme – developed by the University of Bolton and Lifeline Project, within the scope of a PhD research project – is providing dual diagnosis clients with an opportunity to increase their wellbeing. It has been shown that individuals with dual diagnosis are less hopeful about their future, struggle more to cope with whatever life throws at them, and therefore experience lower levels of wellbeing (Ujhelyi et al, 2016). The aim of the current intervention is to increase levels of hope, resilience and mental wellbeing through a positive psychology approach.

In a group, participants were introduced to several different positive psychology concepts and learned how these can be integrated into their lives to make them more resilient, more hopeful and happier. In collaboration with the Psychosocial Interventions Service (PSI) at Lifeline Project, participants already engaging in treatment were identified as having a mental health diagnosis and a relative level of stability in regard to substance misuse. The PSI service provided the group with a space and equipment to deliver the sessions, and a member of staff attended to observe and provide support if necessary.

Positive psychology does not equate with a 'smiley face' – it is much more than that. It considers concepts that are deep-rooted in different cultures all around the world, but may have been forgotten in terms of benefit to our everyday lives. It also seeks to provide robust empirical evidence as to how these aspects can benefit our wellbeing.

The new positive psychology Intervention consists of 12 two-hour sessions run on a weekly basis, delivered using a psycho-educational approach. Participants are

Photos taken by one of the group participants which, she states, show using her psychological resources, such as gratitude – a deeper appreciation of everyday things in life, savouring through photography, and being mindful of the experience.

Figure 2: A simple graphic of the aim of positive psychology.

encouraged to engage in group exercises and work in between sessions, acquiring skills and psychological resources that will help them with their recovery.

For people with addictions the work must begin by restoring character strengths. Taking the VIA strengths test – available to anyone at www.viastrengths.org – enables them to discover their top five signature strengths to follow specific objectives. A goal-oriented mindset can then be facilitated through increasing people's willpower or motivation, as well as their 'waypower' – their ability to set and achieve realistic goals while being able to deal with challenges.

What is needed is a radical change in the attitude people have towards life, taking responsibility to find the right solutions to whatever comes up. People need empowerment through increasing their resilience to take control over their own lives, and be given the freedom to accept or reject the opportunities life presents.

Finding what makes life worth living through the deeper appreciation of gratitude, learning about how generating positive emotions in one's life can build an upward spiral, and recognising the importance of compassion towards oneself and others, are all psychological resources that can provide us with tremendous support during hardship.

Focusing intentionally on our immediate experience and becoming grounded in the present moment through the formal and informal practices of mindfulness will help with the integration of the aforementioned aspects into our lives. And last but not least, we can use mindfulness to put basic nutrition into action to keep ourselves healthy. The end product of learned skills and acquired resources is resilience – the ability to cope with adversity by replacing maladaptive coping strategies.

Although it is too early to draw conclusions, the results of the first pilot study are promising. People's lives in the group have changed significantly. Based on participants' feedback, nothing had made them think as much as this intervention before. One participant said: 'I feel like I have just woken up! I see life in a totally different light!' Another said: 'This intervention has changed my way of thinking about myself. I think I shall give myself a little more credit from now on.' They also felt that the intervention taught them to rely more on themselves: 'I don't want to go to the recovery services for the rest of my life,' and were empowered by the skills and resources they acquired.

The main themes arising from the feedback were 'I can do this!' 'I am capable', and 'life is worth living'. Based on the results of the study questionnaires, participants have become more mindful, their dependence on substances has decreased, their wellbeing has increased and they feel more resilient and more hopeful. They have become less anxious and less depressed, and finally, they have more positive emotions and positive experiences.

We intend to start a second pilot study in January 2017, which will test an improved version of the intervention.

The authors would like to thank the clients who participated in the programme and Lifeline Project Bolton for their cooperation, and Alcohol Research UK for funding the pilot study. This project would not have been possible without their support.

Katalin Ujhelyi is a PhD student at the University of Bolton, Jerome Carson is professor of psychology at the University of Bolton, and Ioanna Melidou is psychosocial interventions team manager for Lifeline Project.

For further details of this work contact: K.Ujhelyi@bolton.ac.uk

Full references online at www.drinkanddrugsnews.com

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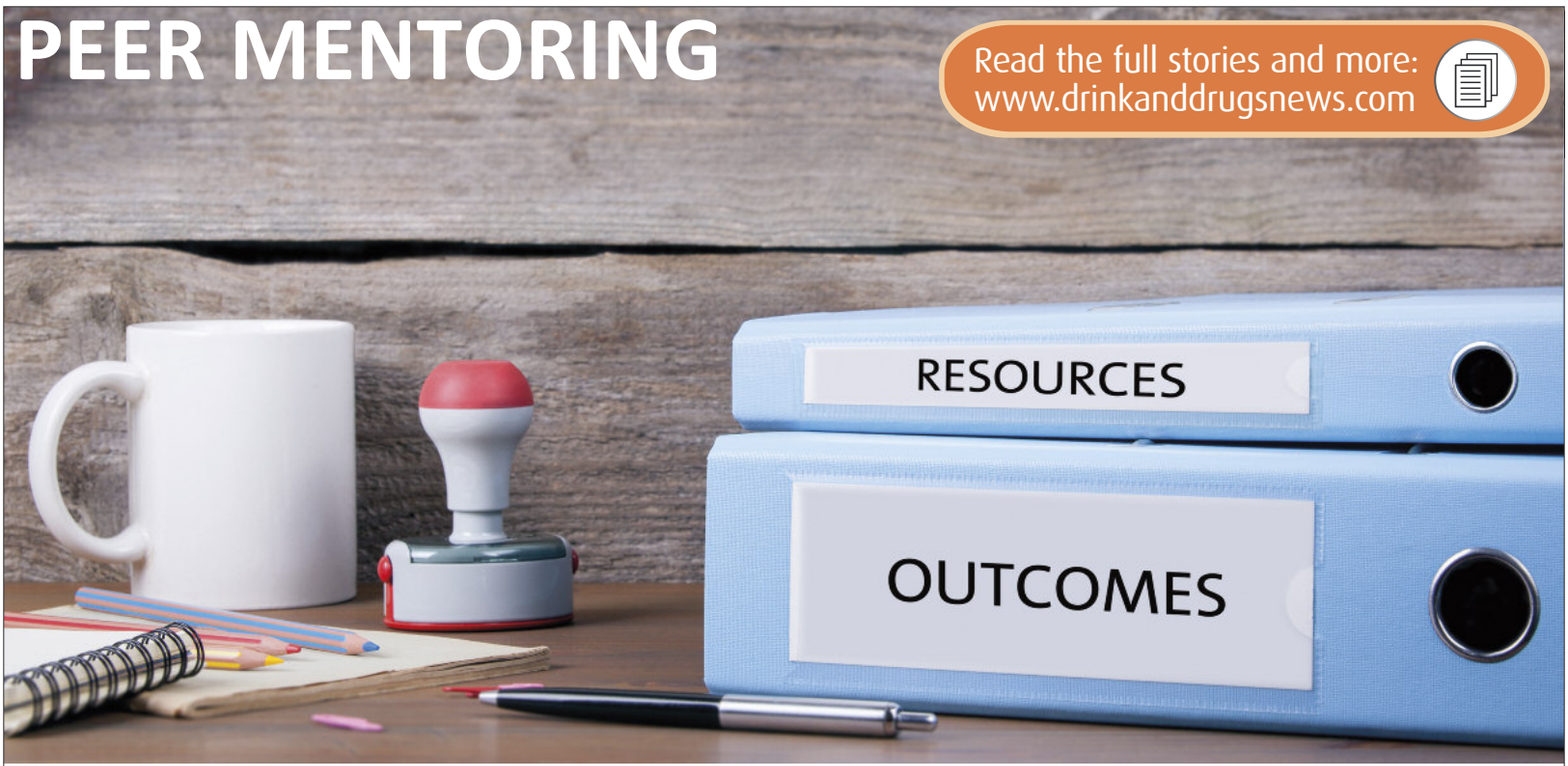


LIES, DAMNED LIES, AND STATISTICS

Harnessing service user activism is the key to stopping drug and alcohol services sliding further down the list of 'targeted outcomes', says **Martyn Cheesman**

The world of substance misuse is changing – it's a case of ever-decreasing circles. The government drug strategy of 2010 outlined the need for a recovery-focused model of treatment and services have been trying to adapt ever since. Don't get me wrong, the need for a focus on recovery was long overdue; but how can we accurately measure outcomes in an environment that demands instant gratification on dwindling budgets? The big issue is that no single model of recovery is definitive and many of the models that currently exist are no more than a remould of those that have come before them.

So let's talk about the elephant in the room. Treatment providers are regularly delivering ineffective services that are designed predominately to achieve targeted outcomes, as opposed to supporting the individual needs of service users. The concept of a person-centred approach has unfortunately become more of an ideal than an actual reality, and while there are great managers and service providers delivering creative and innovative projects and programmes out there, ultimately when it comes to commissioned services their hands are tied with the shackles of statistical outcomes.

It is also fair to point out that there is little gain in pointing the finger of blame here. Commissioners have limited resources to employ services and service providers can only present models based on the resources on offer. The sad truth is that social care is woefully underfunded and substance misuse is at the bottom of the pile.

There is a temptation here to concede defeat to the problems that the substance misuse field currently faces. However, if we remain in the mindset of solution focus, austerity can provide an opportunity for positive change. The sticking point is the current trend of risk aversion that dampens creativity and hinders development. The one thing I have learnt in my 11 years working in the field is that risk can be assessed and to a reasonable level calculated.

I have been fortunate over the past year to have a service manager that believes that taking well-calculated risks to further develop creative interventions can breed favourable outcomes, both statistically and tangibly for service users. It takes bravery and a pioneering spirit, but genuine outcomes that benefit communities and individuals are achievable while satisfying the statisticians.

What is required is a collective focus on improving interventions to meet the needs of individuals, by genuinely consulting service users – not just as a supplement to designing services but actually involving them in the fabric of the design process. Not all interventions require financial resources, in fact sometimes quite the opposite. I frequently find in my day-to-day working environment that such incentives often hinder progress or limit interventions under the banner of what an organisation is paid to deliver.

Over the past year I have been coordinating volunteers and peer mentors in the Medway towns for Turning Point. Medway has a significant percentage of its population involved with substance misusing behaviour and, it is fair to say, we are a very busy service. The team of volunteers I manage contribute countless hours, selflessly supporting our service users to access treatment, and have been extremely successful in doing so. What drives them is the passion to see others succeed, promoting recovery and mutual aid to benefit their own community, without the need of a pay cheque at the end of it all.

I am continually amazed and buoyed by their efforts and I believe they set an example that is so often overlooked; a sense of community wellbeing. Over the coming year we will be working with this team of volunteers to secure independence from substance misuse services, supporting them to set up a recovery community in the Medway towns that can survive the inevitable commissioned contract changes and the invariable reinvention of the wheel.

There is a quote attributed to British prime minster Benjamin Disraeli that states 'there are three kinds of lies: lies, damned lies, and statistics'. If we continue to 'let the cart lead the horse', we are only going continue to dilute our ability to achieve genuine outcomes. There are two key elements fundamental to supporting successful recovery that many modern substance misuse services currently lack – empathy and compassion. It's not that structured services are not important; however, investing in volunteer programmes as part of service provision would go a long way to bringing some balance back to services that are currently on offer, and one step closer to better outcomes for all.

Martyn Cheesman is peer mentor and volunteer coordinator at Medway Active Recovery Service

FOUNDATION66

part of the Phoenix Futures Group

Experts in recovery for more than 45 years

At **FOUNDATION66** everything they are and everything they do is channelled into helping people affected by drug and alcohol problems to make positive changes in their lives. **Grace House** is **FOUNDATION66**'s female-only residential service providing drug and alcohol free support for women with substance misuse problems and complex needs, including domestic violence, offending behaviour, sexual exploitation, homelessness and eating disorders. Amy's story is typical of the opportunities offerered at **Grace House**

LIFE CHANCE

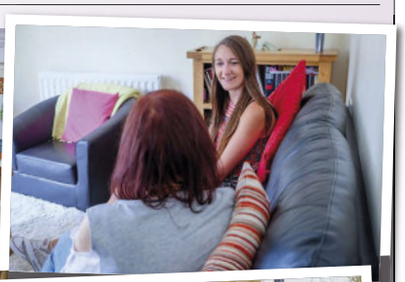
'It has been life-changing. I have been given the chance to build the future I deserve'

These are the words of Amy Munford, 27, after she spent nine months at Grace House, Foundation66's all-female rehab in Camden, North London.

Amy had been a heavy drinker and had suffered from an eating disorder since her teenage years, which became progressively worse through her time at university and into employment. Getting into an abusive relationship and surrounding herself with people who aided her addiction made matters worse and it wasn't long before Amy had deteriorated to the point where she was just surviving on drinking all day – her friends had deserted her and her family had no idea what more they could do.

With her health suffering to the point where she was unable to walk, Amy was referred by Westminster Drug and Alcohol Project to Grace House, where an all-female team provides friendly support to women with substance misuse problems and complex needs, including domestic violence, offending behaviour, sexual exploitation, homelessness and eating disorders.

Amy moved into the house, where she was assessed and given a personalised treatment and counselling programme that gradually helped her turn her life around. Looking back on her time there, Amy reflects: 'It was a wonderful community to recover in. I had enough freedom to grow and rebuild as a person and was able to input into my own recovery. Thanks to Grace House, I now have my health back, have been able to re-connect with my family and have built lasting friendships.'



'Amy's story shows how the philosophy behind Grace House really works.'

BEA WHEELER, LOCALITY MANAGER

Since leaving Grace House, Amy now has her own flat, at 'Amy's Place' (provided through the Amy Winehouse Foundation), is attending college and continues to have treatment for her eating disorder. She is now looking positively to the future, with plans to study further, move in to her own property and start a new career.

'Amy's story shows how the philosophy behind Grace House really works.' says Bea Wheeler, Foundation66's Locality Manager, 'A stable home is the basis for a successful and sustained recovery and Grace House provides women, like Amy, with the time, space and support to address their substance misuse and complex needs, to help them take the next step to a brighter future.'

If you would like further details on the **Grace House** service, either to refer, or self-refer, then please call on **020 7916 5013** or email **GraceHouse.Referrals@foundation66.org.uk**

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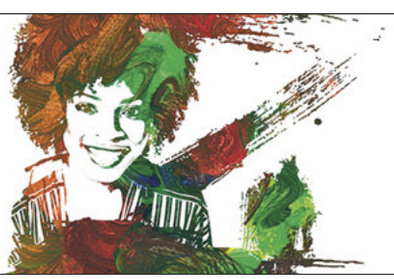

"I was wishing my life away at work. Now I'm helping people rediscover theirs."

At Turning Point, we support people across England with substance misuse issues. As a part of our team, you'll make a real difference to their lives as you go above and beyond to help them with their daily needs. Passionate about people, you'll enjoy the scope and support to enhance your own life and career too, as you gain the experience and training you need to progress in your career.

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You can also contact: Carla.Gorman@turning-point.co.uk

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Lifeline Project

MY RECOVERY Tameside
Together We Can Recover

TENDER FOR INCLUSION ON A STANDING LIST OF PROVIDERS OFFERING INPATIENT DETOX AND RESIDENTIAL REHAB SERVICES

Lifeline Project and its partners are seeking expressions of interest from organisations who wish to join a standing list of Providers offering a range of specialist and non specialist Tier 4 Inpatient Alcohol and/or Drugs Detox provision (Lot 1) and a range of abstinence-based Primary and Secondary Residential Rehabilitation Treatment services (Lot 2) to be accessible to residents of Tameside and Glossop which will offer flexible treatment packages suitable for the differing level of Service User need and complexity. Interested organisations are reminded that this tender is for inclusion on a standing list only and once approved, all placements will be subject to a panel process.

We are committed to reducing substance misuse related harm in Tameside and Glossop by supporting people who misuse drugs and alcohol to change so that these substances no longer have a detrimental effect on their lives or those of their families and friends. We commission a range of services that work together across the spectrum of prevention to recovery delivering a range of interventions that enable Service users to become free from alcohol and drug harm.

LOT 1 – INPATIENT DETOX

The aim of the Service is to provide short episodes of Tier 4 inpatient alcohol and/or drug detoxification with 24 hour medical cover and multidisciplinary team support, as described below. The service exists to provide both stabilisation and crisis management, depending on the individual needs of the Service User.

The objectives of the service are to:

- *provide a period of drug-free recovery as appropriate ;*
- *provide supervised medication to prevent withdrawal symptoms from alcohol dependency alongside the clinical management of related and other medical conditions;*
- *provide effective psychological interventions, such as cognitive behavioural therapy and relapse prevention therapy;*
- *reduce the use of illicit or non-prescribed and other drugs;*
- *facilitate, support and maximise the opportunities for abstinence from alcohol and drugs;*
- *improve overall personal, social and family functioning.*

LOT 2 – RESIDENTIAL REHABILITATION

The aim of the abstinence-based Primary and Secondary Residential Rehabilitation Treatment service is to provide:

- *a supportive and therapeutic environment as a key component of the recovery ethos of the service provision;*
- *a care planned structured rehabilitation programme designed around the health, social and psychological needs of an individual Service User;*
- *specialist support to provide a route out of dependency on drugs and/or alcohol and re-integration into the community.*

The objectives of the service are to:

- *sustain alcohol and/or drug-free abstinence in particular to follow on from detoxification;*
- *provide effective psychological interventions, such as cognitive behavioural therapy and relapse prevention therapy to understand and deal with addiction;*
- *develop a plan for psychological support to help a Service User address any underlying trauma;*
- *provide strategies to move away from the use of illicit or non-prescribed and other drugs and to overcome dependency on alcohol;*
- *facilitate, support and maximise the opportunities for abstinence from alcohol and drugs as part of a re-integration strategy;*
- *improve overall personal, social and family functioning;*
- *encourage mutual support as a means for sustaining abstinence;*
- *deliver a realistic re-integration plan to allow a Service User to re-enter their local community. This may involve plans for re-settlement.*

Providers interested in applying to be placed on the standing list for the above services should complete an Organisational Questionnaire (OQ) and a Tender Submission Questionnaire. All OQ and Tender Submission Questionnaire documentation must be completed and submitted electronically by using Pro Contract via the email lifelineprocurement@lifeline.org.uk by the due date of *6th January 2016*

Documents are available by emailing *lifelineprocurement@lifeline.org.uk*

If you are interested in submitting for inclusion on the Approved List but are unsure about the electronic tendering process, please contact by email *lifelineprocurement@lifeline.org.uk*

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