COUNTDOWN TO CONFERENCE – HAVE YOU BOOKED?

DDN
Drink and Drugs N
www.drinkanddrugsnews.com
ISSN 1755-6236 January 2012

'As burnout will tend to come on gradually from recurring and prolonged stress, there will be many warning signs. If you can recognise the onset, then it can usually be prevented.'

STRESS – A BALANCING ACT?

WHY PRACTITIONERS SHOULD ALSO LOOK AFTER THEMSELVES

Want to be more effective with service users and increase their motivation?

Play to strengths!

Train in the Resource Based Approach

BPS Learning Centre APPROVED

Approved by the British Psychological Society Learning Centre for the purposes of Continuing Professional Development

Small group intensive workshops. Post-course assessment & Certificate of Assessed Academic Competence

SDS 20 Years

Certificate In **Resource Based Therapies**

This course, consisting of 4 modules, brings together three separate approaches that all share an underlying assumption regarding the client's intrinsic pre-existing resources and psychological strengths. These include **Brief Solution Focused Therapy, Positive Psychology & Motivational Interviewing**

Positive Psychology (Module 1)

LONDON
7 DECEMBER 2011

MANCHESTER
20 FEBRUARY 2012

LONDON
12 JUNE 2012

Brief Solution Focused Therapy (Module 3)

MANCHESTER
25 JANUARY 2012

LONDON
15 MAY 2012

MANCHESTER
18 SEPTEMBER 2012

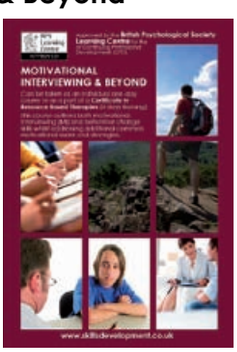
Motivational Interviewing & Beyond (Module 2)

LONDON
13 JUNE 2012

MANCHESTER
17 SEPTEMBER 2012

BIRMINGHAM
20 SEPTEMBER 2012

LONDON
9 OCTOBER 2012



BSFT with Difficult & Complex Clients (Module 4)

MANCHESTER
26 JANUARY 2012

LONDON
16 MAY 2012

MANCHESTER
19 SEPTEMBER 2012

The Certificate in Resource Based Therapies (RBT) Course consists of 4 training days that can be booked together or separately. The order, in which delegates attend the courses, is flexible.
Prices from £115 + vat per module. **Discount on booking 4 modules together. Online savings.**

The most demanded topic for in-house training. Call now!

You can book open courses or in-house training for the whole Certificate or for individual modules.
For further details visit: www.skillsdevelopment.co.uk or call 0870 241 7294

DDN Drink and Drugs News

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ

Editor: Claire Brown
t: 020 7463 2164
e: claire@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Advertising Manager:
Ian Ralph
t: 020 7463 2081
e: ian@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Publishing Assistant:
Kayleigh Hutchins
t: 020 7463 2205
e: kayleigh@cjwellings.com

Subscriptions:
t: 020 7463 2085
e: subs@cjwellings.com

Website:
www.drinkanddrugsnews.com
Website maintained by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: MHJ – iStockphoto

Editorial – Claire Brown

Treatment first

Why prison should always be the last resort

The difficulties of accessing appropriate treatment are acknowledged in NOMS' recent review of Drug Rehabilitation Requirements (DRRs), as Ros Weetman discusses on page 12. Over the page, Kelly Overton and Frankie Owens illustrate the need for the right treatment at the right time – Kelly as a young mother trying her hardest to kick addiction and Frankie, whose family life and career were jeopardised by a crippling mental health problem, and who didn't break the cycle of prison and crime until he was sectioned under the Mental Health Act. NOMS' acknowledgement that service user involvement should help to inform treatment is a welcome step, coupled with support to gain skills and qualifications and clearer referral pathways to essential wraparound services, such as housing and help with tackling debts.

If you're feeling a little stressed as we hurtle into the new year, take a long slow breath, shake your arms and legs, and read our cover story by psychotherapist Ben Gatty (page 8). Taking time to look after yourself might sound like common sense, but how many of us learn to recognise the signs of stress before they threaten to overtake us? For a morale boost and some energising team spirit, join us for our *Together we stand* conference in Birmingham on 16 February. (See details on our website.) It'll be a day well spent!

This issue

FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: JOBS, COURSES, CONFERENCES AND TENDERS

News in Brief

RELEASE ME

Sebastian Saville has stepped down as executive director of Release after eight years at the organisation. 'Sebastian leaves Release in a position that is not even comparable to the one he found it in – the services have grown, our campaigns have had international reach and every year we help thousands of people,' says the charity. 'This is Sebastian's legacy to Release and we wish him every success for the future.' Former head of legal services and deputy director Niamh Eastwood has taken over as executive director from this month.

AMPHETAMINE ACTION

A new report on the production and distribution of amphetamine in Europe has been launched by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Amphetamine is very much a 'European drug', says *Amphetamine: a European Union perspective in a global context*, with the continent the world's number one producer and a major consumer market. Although methamphetamine is more widely used globally, amphetamine is the most widely consumed stimulant in Europe after cocaine, and in many countries the second most widely used illicit drug after cannabis. Amphetamine should not be treated as a 'secondary issue', stresses the report, despite its lower profile in media and policy circles than other drugs. 'A better understanding of the amphetamines market – production, trafficking and use – seems crucial for a more effective and intelligent policy response', said EU commissioner for home affairs, Cecilia Malmström.

Available at www.emcdda.europa.eu

DISC MAN

Mark Weeding has been appointed chief executive of northern charity DISC (Developing Initiatives Supporting Communities) following the retirement of Steve Johnson after 26 years. DISC operates from more than 30 sites in the north of England including Tyne and Wear, County Durham, West Yorkshire, Lancashire, Greater Manchester and Hull. 'If we can deliver outcomes such as reduced offending, tenancy retention, keeping children out of the looked-after system or recovering from drug dependency then we will have a secure future,' said Mr Weeding. 'These outcomes save money elsewhere in public services and as such will always be a priority.'

'Poor understanding' prompts call for alcohol guideline revision

The government's sensible drinking guidelines should be reviewed, according to a report from the cross-party House of Commons Science and Technology Committee. Public understanding of how to use the guidelines and what constitutes a unit is 'poor', says *Alcohol guidelines – Science and Technology Committee*.

The 'sensible limits' of 21 units a week for men and 14 for women were revised after evidence suggested that alcohol consumption could reduce the risk of coronary heart disease, prompting the government to recommend that the guidelines be defined in daily terms – three to four units a day for men or two to three for women. The committee, however, said it found 'a lack of expert consensus over the health benefits of alcohol' and expressed itself sceptical about 'using the purported health benefits of alcohol as a basis for daily guidelines for the adult population, particularly as it is clear that any protective effects would only apply to men over 40 years and post-menopausal women'.

The evidence needs to be reviewed by an expert group, says the report, to include scientific and medical experts – it also wants to see an online resource where people can obtain 'individualised' advice that takes into account factors like age, weight, ethnicity and any family history of alcohol problems.

'Alcohol guidelines are a crucial tool for government in its effort to combat excessive and problematic drinking,' said committee chair Andrew Miller MP. 'It is vital that they are up to date and that people know how to use them. While we urge the UK health departments to re-evaluate the guidelines more thoroughly, the evidence we received suggests that the guidelines should not be increased and that people should be advised to take at least two drink-free days a week.'

The committee also warns that sensible drinking messages could 'conflict with the business objectives of drinks companies' in the context of the controversial public health responsibility deal between government, industry, retail and voluntary sectors (*DDN*, April 2011, page 4), urging the government to 'exercise proper scrutiny and oversight'.

Alcohol Concern welcomed the recommendation that the guidelines should not be relaxed, but added that 'those who benefit commercially from alcoholic drinks' should play a major role in making sure health messages are as effective as possible. 'We welcome the attention the committee has paid to widespread concern about the inherent inconsistency of making business whose role is to increase profits from the sale of alcohol responsible for messages about moderate drinking,' said chief executive Eric Appleby.

Report available at www.parliament.uk

Three quarters of young people 'successfully completing' drug treatment

Seventy-five per cent of under-18s leaving drug and alcohol treatment services in 2010 did so because they no longer needed specialist interventions, compared to 48 per cent five years ago, according to a report from the NTA.

The figures provide evidence that young people are 'increasingly responding to specialist treatment before problematic drug and alcohol habits became entrenched', says the agency.

The vast majority accessed treatment for problems with cannabis or alcohol, says *Substance misuse among young people: the data for 2010-11*, with the 'small number' receiving treatment for class A drugs more than halving in five years, to less than 800. However, the number seeking treatment for amphetamines – including mephedrone – more than doubled from 256 to 639.

The overall number of young people accessing services seems to have peaked, claims the NTA, with numbers falling for two consecutive years to less than 22,000, and waiting times remaining low. However, figures also show that most young people seeking help for substance issues have other emotional and social problems, such as offending or self-harming, with the report stressing that drug and alcohol misuse among teenagers is 'usually a symptom rather than a cause of their vulnerability'.

'Surveys show that fewer young people are using drugs, but services are getting better for those who do have problems, and outcomes are improving,' said the NTA's director of delivery, Rosanna O'Connor. 'It is also encouraging that the number needing help for class A drugs, particularly heroin, continues to fall. The advent of new substances like mephedrone shows that services need to be ready to respond to changing needs, but fortunately the numbers needing specialist interventions remain low.'

DrugScope, however, warned against complacency in the light of the scaling back of many young people's services and school-based prevention work. Continued investment was vital to respond to changing patterns of drug use, stressed chief executive Martin Barnes. 'The latest figures – for the year ending March 2011 – do not convey the whole picture for what is happening now,' he said. 'Although government funding for young people's treatment has been maintained in cash terms, there is evidence of significant cuts in local funding for young people's treatment, prevention and education services in some areas. The risk is that fewer young people are referred to, or can access treatment services early enough to prevent problems increasing later on.'

Meanwhile, researchers at the University of Manchester have been awarded £1m to investigate the effectiveness of the eight payment by results (PbR) pilots. The three-year study will look at whether the schemes represent good value for money and the impact on provider behaviour, among other issues.

Report available at www.nta.nhs.uk

Government promises action on 'country's most troubled families'

The government says it is making £450m available to 'turn around the lives of 120,000 of some of the country's most troubled families' – defined as those that have 'serious problems and cause serious problems' – by the end of the current Parliament.

It will offer up to 40 per cent of the cost to local authorities of dealing with the families, but on a payment-by-results basis with success measured on criteria such as reductions in criminal and anti-social behaviour, children returning to school and parents 'on the road back to work'. Troubled families cost the taxpayer around £9bn per year, the government says.

A troubled families team has been set up within the Department for Communities and Local Government, headed by former 'homelessness czar' Louise Casey, and the government will also fund a network of 'trouble shooters' to be appointed by local authorities to oversee work in their area and make sure that families receive the right help. 'This immense task will take new ways of thinking, committed local action, flexibility and perseverance,' said prime minister David Cameron.

Adfam welcomed the announcement but noted that while the government would provide 40 per cent of the money, councils would have to find the remainder themselves at a time when many are facing severe cuts. 'There are legitimate concerns over where this extra funding will come from, and what may have to be sacrificed in the short-term,' the charity stated. 'Given the whole range of services needed to support troubled families, it would be perverse to fund the programme through cuts to services which already support vulnerable people.'

Chief executive Vivienne Evans added that drugs and alcohol were also 'conspicuous by their absence' from the programme's goals. 'Substance use is a key concern for many "troubled families", whether services are currently aware of it or not, and without working to solve this other outcomes could be difficult to achieve,' she said.

DrugScope echoed Adfam's concerns over funding and stressed that stigma would also need to be properly addressed to make sure that families experiencing substance problems were not further marginalised.

'The intense stigma faced by people who have problems with drugs and alcohol can be a real barrier both to recovery and accessing services and support,' said chief executive Martin Barnes. 'People are often afraid to access treatment, especially parents who may fear losing children to the care system. While people should take responsibility for their own recovery, two thirds of employers state, for example, that they would not employ someone with a past history of heroin or crack cocaine use, even if they were otherwise suitable for the job.'

Consider heroin prescription in another anthrax outbreak, urges report

Consideration should be given to prescribing an alternative to street heroin in the event of another anthrax outbreak, says a report on behalf of the National Anthrax Outbreak Control Team (NAOCT) that handled the outbreak of two years ago (*DDN*, 18 January 2010, page 4).

Discussions should be held between health protection services and government departments on the best ways to engage treatment services during outbreak situations, says *An outbreak of anthrax among drug users in Scotland, December 2009 to December 2010* – adding that the extent to which emergency outbreak control considerations should 'influence clinical decisions about the prescribing of a controlled drug such as diamorphine could usefully be clarified', in order to give guidance to outbreak control teams and treatment services.

The outbreak of 2009-10 saw 47 confirmed anthrax cases in Scotland – including 13 confirmed deaths – with a further 72 classed as either 'probable or possible' cases. At the start of the outbreak, drugs organisations including Transform, The Alliance, Harm Reduction International (HRI) and Release wrote to the Scottish Government calling for a comprehensive public health response, including the prescription of alternatives to street heroin. The government, however, rejected the call and this week stated its position would not change should another outbreak occur.

See news focus, page 6. Report at www.hps.scot.nhs.uk

Opium production in South East Asia shows sharp increase

Levels of opium poppy cultivation in South East Asia have 'significantly' increased, according to a report from the United Nations Office on Drugs and Crime (UNODC).

High prices for opium in the Lao People's Democratic Republic (Lao PDR), Thailand and Myanmar are making production increasingly attractive to farmers, says UNODC's *2011 South East Asia opium survey*.

Cultivation in the region increased by 16 per cent between 2010 and 2011 and has doubled since 2006, says the document, with Myanmar – the world's second largest opium producer after Afghanistan – increasing its levels of cultivation for five years in a row. Although Myanmar accounts for more than 90 per cent of the region's cultivation, Lao PDR – which accounts for 9 per cent – saw a 38 per cent increase between 2010 and 2011.

As with other parts of the world, there is a strong link between insecurity and opium poppy cultivation, says the document, with around 35 per cent of households in Myanmar struggling to feed themselves. The international community needs to increase investment to support alternative development in the region, the report stresses.

Programmes should take into account 'issues of poverty reduction, environmental protection, food security and improved social and economic conditions as key objectives' according to UNODC executive director Yury Fedotov. 'Indeed, these projects are a necessity because reductions in illicit crop cultivation and opium production can bring tangible benefits to the lives of ordinary people,' he said.

Available at www.unodc.org

News in Brief

LEVESON LOBBY

The Leveson Inquiry into the ethics and practices of the press should look at how coverage of drugs issues can 'undermine political commitment to evidence-based drug policy', says the UK Drug Policy Commission (UKDPC). In its submission to the inquiry, the UKDPC warns that media treatment of drugs can create unnecessary pressure on policymakers to take rash decisions – citing the 2010 ban on mephedrone – as well as fuel stigma against people with drug dependency problems. 'On a few occasions the press has built up so much pressure on politicians that there has been little chance to think about the possible negative consequences of new policies,' said chief executive Roger Howard.

BOTTLING IT UP

Thousands of children who live with parents with a drink problem are at risk of mental health issues like depression and anxiety, according to a report from Turning Point. Early screening and identification of families is vital to tackle the 'inter-generational cycle' of alcohol misuse, says *Bottling it up: the next generation*. 'Early intervention is key in preventing a new generation of children at risk of experiencing poor mental health, drug and alcohol addictions, truancy and worse,' said Turning Point's director of substance misuse services, John Mallalieu. 'Where resources for action are scarce, it makes economic sense to integrate family and parenting specialists into existing treatment services to protect future generations from harm.' *Available at www.turning-point.co.uk*

A MATTER OF LEARNING

Making Every Adult Matter (MEAM) – the charity coalition made up of DrugScope, Homeless Link, Clinks and Mind – is holding a series of free learning events across the country. The days will look at how to develop locally coordinated approaches to support individuals with multiple needs and exclusions, and take place in York (23 Jan), Manchester (24 Jan), Birmingham (30 Jan), Crawley (31 Jan) and Cambridge (1 Feb). *To attend, contact Jesse Donaldson at events@mean.org.uk*

SHOULD DIAMORPHINE BE PRESCRIBED IN ANOTHER ANTHRAX OUTBREAK?

A report into the Scottish anthrax outbreak of 2009-10 has recommended 'further discussion' about prescribing alternatives to street heroin should there be a similar event. ***DDN*** reports

At the end of 2009, cases of serious soft tissue infection among drug users in Glasgow were confirmed as *Bacillus anthracis*, the organism that causes anthrax infection. Health Protection Scotland quickly issued a warning that contaminated heroin or a contaminated cutting agent could be responsible, and by early 2010 there had been 14 confirmed cases, half of them fatal (*DDN*, 18 January 2010, page 4).

It was the first anthrax outbreak to be associated with heroin use anywhere in the world, and went on to become the UK's largest single 'common source' outbreak in humans in more than 50 years. By the end of January the outbreak had spread across Scotland, with 17 confirmed cases and eight deaths, and Health Protection Scotland advised drug users to 'stop using heroin immediately and contact local drug services for help in stopping'.

Drugs organisations including Harm Reduction International (HRI), Release, Transform and the Alliance, however, branded the advice 'reckless' in the light of lengthy waiting times and wrote to health secretary Nicola Sturgeon calling for an emergency public health plan to include the prescription of alternatives to street heroin – such as synthetic opiate dihydrocodeine – by GPs (*DDN*, 1 February 2010, page 4). Failure to do so would mean the Scottish government was failing its citizens, the letter stated.

By March the number of Scottish cases was 26 – ten of them fatal – and the outbreak had spread to England; by July, there had been 47 confirmed cases in Scotland, with 13 deaths. The outbreak was not declared officially over until a year after it began, by which time 119 people were classed as anthrax cases – 35 'probable' and 37 'possible' in addition to the confirmed 47.

The National Anthrax Outbreak Control Team (NAOCT) has now published its report, setting out the lessons learned and warning that pathogen-contaminated heroin could be imported into the UK 'at any time'.

So if that did happen, should doctors be able to prescribe dihydrocodeine – or indeed diamorphine – as a risk control measure? The report states that while 'some external parties proposed that approved non-street (prescribed) heroin should be made available to drug users during the outbreak' NAOCT determined that advising on the subject was beyond its remit and therefore 'did not express an opinion'. Among the report's recommendations, however, is that further discussion could be useful on 'the extent, if any, to which emergency outbreak control considerations should influence clinical decisions about the prescribing of a controlled drug such as diamorphine could usefully be clarified, with the aim of providing guidance to future OCTs and addiction services'.

So does the Scottish Government think the accusation of recklessness regarding advising people to simply stop using drugs and enter treatment a fair one? 'Well, the situation has moved on so far in terms of drug and alcohol treatment waiting times that we wouldn't be in the same boat,' a spokesperson tells *DDN*. 'Waiting times are now at record lows.'

'We plan to write to the Scottish Government to have an emergency plan for infection outbreaks among drug users which is revisited every two to three years to ensure that it is still fit for purpose.'

Looking back, how does the government think the outbreak was handled overall? 'This was a complex and challenging outbreak which was very well managed by first NHS Greater Glasgow and Clyde and then Health Protection Scotland. As with all outbreaks and public health incidents it is essential that we capture the experience and learn lessons from it. We will consider the recommendations contained within this report and respond accordingly.'

Does that extend to considering prescribing diamorphine? 'We have no plans to do that – that's one thing I can be clear on,' says the spokesperson. 'It would never be a case of doctors prescribing illegal drugs, or allowing the temporary prescription of illegal drugs.'

The Scottish Drugs Forum, however, takes a different line. 'We have long argued for the introduction of heroin prescribing as part of range of approaches for reducing drugs harm,' director David Liddell tells *DDN*, but adds that there 'was no point discussing this as part of the outbreak response' as it could not have been implemented within the time-scale. 'One of the recommendations of the OCT is that a detailed economic appraisal should be under-taken as to the cost of the outbreak. Our hope would be that taking a look at the introduction of heroin prescribing could be part of that analysis. In the long term, it could be a cost-effective measure when compared to the cost of such outbreaks which, if history is anything to go by, will occur again.'

The outbreak was a huge and complex challenge, he stresses. 'We were unclear at the start of the outbreak of the relative risks of different routes of administration – therefore providing definitive information on routes of safer administration was not possible. The key information which had to be provided, therefore, was that if people got help early with their anthrax infection, they could be treated and cured.'

Seeking treatment was in fact a feasible option in most areas, he says, although 'there were areas with substantial waiting times where advice to seek help and get on substitute medication was of no help'. If there was one positive outcome it was 'to increase the pressure on some areas to improve service access', he points out.

And what about the lessons learned? 'The report highlights the key challenges – and particularly the difficulty – for government agencies to respond swiftly when dealing with a vulnerable marginalised group who are not easy to communicate with,' he says. 'From SDF's point of view, we were able to respond swiftly but had limited resources at our disposal to get the key messages to heroin users.'

The vital lesson is to plan for an outbreak 'on a regular basis', he warns. 'We plan to write to the Scottish Government to have an emergency plan for infection outbreaks among drug users which is revisited every two to three years to ensure that it is still fit for purpose. What was evident during the outbreak was that some people were getting access to wound care much more readily than would have normally been the case. But it should not take outbreaks of this magnitude to ensure people receive the care and attention they need.'

An outbreak of anthrax among drug users in Scotland, December 2009 to December 2010

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

There is a chasm between everyday life and official policy when it comes to drinking. Despite appearances, 'drinking by numbers' – or unit counting – represents an irrational and unsavoury approach to booze. It betrays an unhealthy neuroticism about normal and reasonable adult behaviour... Reconceptualising booze through the prism of units individualises and hence pathologises drinking, ripping it out of its social context.
Sarah Boyes, *The Independent*, 19 December

You don't have to be a stumbling drunk for a daily tipple to pose a risk to health. It's an easy habit that can cause the sort of liver disease most people think only afflicts serious alcoholics. Supermarket discounts mean booze is cheaper than ever, so it's not hard to have a well-stocked fridge.
Sun editorial, 10 January

The threat to young people's health from cheap booze is too great. If the government will not act, the supermarkets must be shamed into doing so. Anyone for a boycott of Tesco?
Jeremy Laurance, *The Independent*, 6 December

We are still bombarded in this country in ways that have been outlawed elsewhere in the world – you can't go to a sporting event, order from Amazon, turn on the TV or go to the cinema without being confronted with the lies that drinking alcohol is a pre-requisite to having a good time, that it's refreshing, that it makes you more sexy or that you need more.
Julia Manning, *Daily Mail,* 14 December

Bloated before it starts, Public Health England is one overweight nanny the country can do without. David Cameron's worst mistake on taking office was his decision to ring fence the NHS from the cuts. He must be regretting it.
Kathy Gyngell, *Daily Mail*, 22 December

Chancellor George Osborne must resist the soft-touch brigade such as the Lib Dems and the bishops who will be trying to water down his tough but fair plans... Making the scroungers work has one great advantage: they'll be too tired to breed like rabbits.
Daily Express editorial, 9 January

Recent seizures of ecstasy suggest that, following years of low levels of MDMA found in the drug, purity is rising to levels last found at the height of the rave music scene in the Nineties. But few, if any, of the teenagers, students and clubbers who boast of the so-called love drug's ability to bring people together, will realise that their thrill-seeking antics are destroying the rainforests. More alarmingly, 'popping' these new pills — or 'dabbing' the MDMA powder on their gums — means they're gambling with their lives.
Steve Bird, *Daily Mail*, 5 December

LEGAL LINE

THEY'RE CHANGING MY INCAPACITY BENEFIT – WILL I LOSE OUT?

Release solicitor Kirstie Douse answers your legal questions in her regular column

Reader's question:
I'm currently on incapacity benefit and have received a letter from the DWP saying I'm going to be moved onto employment and support allowance. Why is this, and is it different from incapacity benefit? I'm really worried that the money I get will be reduced – I barely have enough as it is and don't know how I'll cope if it's cut.

Kirstie says:
Try not to worry as all incapacity benefit (IB) claimants are being transferred onto employment and support allowance (ESA). Some people get confused because the benefit they receive is income support, but any payment they get for a medical condition is managed by IB. The transfer applies equally to these claimants. You should be transferred over automatically with no break in payment. However, ESA works slightly different to IB.

ESA is separated into two different groups – work-related activity and support. Basically, those in the work-related activity category are assessed as being incapable of working but able to undertake tasks to help them back into work. If you are in this group you will be required to meet regularly with a personal adviser and attend work-focused interviews to discuss moving towards returning to work. People in the support group are not required to attend meetings or interviews as they are considered to be incapable of working and undertaking work-related activity. Those in the support group also get paid a slightly higher amount of benefit to reflect the severity of their incapacity. The majority of people will fall into the work-related activity category.

As someone being transferred onto ESA from IB, your claim will be reviewed and you will then be told which group you have been assigned to. If you disagree with the group allocated, you can request a review and/or appeal of that decision.

You may be required to attend a medical assessment after you have been transferred to ESA. This is to evaluate your continued eligibility for benefit. Medical assessments may be repeated annually, or less often. Again, if you disagree with any decision made following the appointment, you can request a review and/or appeal of that decision.

In relation to the money you receive, you will not get any less than you do currently. If your IB payment is higher than the ESA rate (currently up to £94.25 for a single person over the age of 25 in the work-related activity group) then you will receive a top-up. If the amount you are currently paid is less than the ESA rate, you will get paid more than you are now and your money will increase as soon as you move to ESA.

Email your legal questions to claire@cjwellings.com.
We will pass them to Kirstie to answer in a future issue of DDN.
For more information about benefits and incapacity to work through substance misuse please contact the Release legal helpline on 0845 4500 215.

Keeping your ba

Practitioners need to look after themselves as well as the people they care for. **Ben Gatty** shares tips on dealing with stress, developed for a staff training day at Westminster Drug Project (WDP)

Repeat the word 'stress' a few times and notice your reaction. Now do the same with the word 'care'. Commonly, people notice physical tension and negative emotions coming into their mind when they think of the word stress. The word care tends to bring up warmer, more receptive responses.

It is striking how simply thinking of different words can make us feel so markedly different. In a recent training session, we looked at how we can reduce the negative impact of stress through some simple strategies.

In the worst case scenarios, people 'burn out'. How possible is it to reduce the likelihood of this, while enhancing wellbeing in the workplace? We recognised the limits of what we could explore in just one day, so chose not to focus on economic and organisational factors that may contribute to stress. This was not to deny the impact these can have, but to keep a clear focus on what the individual could readily shift in their day-to-day experience.

It is worth noting that stress is not intrinsically harmful. Clinical psychology makes the distinction between distress, which feels overbearing, and eustress, which is a helpful energising of our biological system. The prefix eu- comes from the Greek word for 'well'. Being too laidback in a job interview, or on a first date, could well mean that we are not in the right state of mind – we need eustress to ready us for challenges that we face. But clearly, distress is unpleasant and potentially corrosive.

A starting point for developing the training with my colleague, Katie Noorian, was recognising the detrimental impact that stress has had on us in the past. We recognised that it was too easy to allow pressure to build up, so when we did need to address it, it was that much harder. So our first point was awareness.

A way to think about distress is proposed by the psychotherapist Babette Rothschild, author of the book *Helping the Helper*. She suggests that we are like a Coke bottle: if we get shaken up too much, then pressure builds internally. The best approach is to release the pressure slowly and carefully – open the top slowly, quickly close again once it starts to fizz up, wait until it dies down, open again, and so on.

But to avoid things getting messy, I need to know that the pressure is building up. If I don't know that the cola bottle has been shaken around and I come into the room and open it, it will spill everywhere. It's the same with ourselves; awareness is foundational – once we know how we are being affected, we are more able to make choices to improve the situation.

To enhance participants' awareness during the training, we interspersed a number of 'mindfulness' exercises throughout the day – an approach that stems from Eastern meditation practices. Evidence shows that such approaches heighten our awareness of living in the present moment, and our capacity to choose where to orientate our mind. A range of psychotherapy and counselling approaches have incorporated understanding of this sort – Gestalt and other humanistic therapies from the 1960s on, and more recently the 'third wave' of cognitive behavioural therapy.

We started with very simple exercises, adapted from the work of psychiatrist Daniel Siegal, which focused on noticing our responses to simple words, and shifting our attention to different areas in the room. We built on this to run some of the classic mindfulness exercises, such as awareness of our breath.

When we are distressed we tend to breathe faster and in a more shallow way. So by becoming more conscious of our breath, we give ourselves the option of changing our state of mind by altering our breathing pattern.

A further type of mindfulness exercise – the Loving Kindness (Metta Bhavana) meditation – asks that we direct benevolent thoughts towards ourselves and a range of other people. Many participants were struck by how such a basic shift of intention and attention could significantly alter how they felt – the majority reported feeling a marked sense of wellbeing after this brief exercise. When applied to challenging work situations, this exercise suggests that we can orientate ourselves differently toward a client or colleague, and perhaps create a different type of interaction between us.

A wealth of recent research indicates that regular practice of mindfulness exercises can have a range of benefits, from reducing impulsive behaviour to increasing positive mood and enhancing energy levels. At the end of the workshop we asked participants to commit to applying some of what they had experienced in the following week. Could they, for instance, give themselves small 'mindful' breaks during the day, and by so doing put the brakes on the build-up of distress?

'We are like a Coke bottle: if we get shaken up too much, then pressure builds internally. The best approach is to release the pressure slowly and carefully.'

Mindfulness can help us to self-regulate when a situation triggers a negative emotion. The heightened awareness allows us to address the problem directly, rather than allowing our dissatisfaction to unwittingly feed into further problems.

Burnout is perhaps an over-used term in the social care field. In this context we used the term in a more clinical way, referring to a marked state of mental and physical collapse – a serious condition that frequently involves symptoms of depression, alienation, dissociation and isolation (Freudenger and North 2006). What is important is to recognise the more minor symptoms (see box) before

lance

they develop. As burnout will tend to come on gradually from recurring and prolonged stress, there will be many warning signs. If you can recognise the onset, then it can usually be prevented.

We asked practitioners to look at the day-to-day stressors in their lives, and to look at what enhances their resilience. We then asked them to create an action plan. What would they limit, what would they do more of, or start doing? How would they make this happen? What support would they need?

By working on this material with peers during the session, we modelled the principle of taking up support from friends, partners and colleagues. Clearly the support of others helps in a wide range of ways. Recent research points to the value of making a public commitment to a particular change, to ensure that our intentions are acted on and that we stay committed.

Clinical supervision is a form of social, practical and emotional support that WDP offers staff, but some people are quite sceptical about its value. So we explored how practitioners can make clinical supervision work for them, by creating a 'safer' environment in which to engage.

We ran an exercise where we asked people to imagine that the person they were paired with was a difficult client or colleague and practised extending our range of responses. For instance, if I feel that I can't say 'no' to my boss, I may allow myself to take on an excessive workload. If I can say when something feels too much, then there is the possibility of working together to address that.

Worrying about work after hours can reduce our ability to recharge our batteries. One technique is to shake your body when you get home – shake your arms, legs and whole body, as if shaking off water – and imagine shaking off your worries so that they are away from you until you are next at work. An alternative is to put work thoughts into an imaginary box and file it away at the end of the working day.

Feedback from participants suggests the simple methods practised on the course can be replicated at work. One person reported, 'All of our team now recognise the importance of mindfulness in relation to self care; we meditate for five or ten minutes at every check-in and check-out, and really feel the benefits of it.' Another said she had been inspired to seek help with her work/life balance. Others reported taking more regular breaks.

Longer term benefits for practitioners and clients were also reported. One participant said, 'I am able to stay more organised and focused, and be more assertive with colleagues so that work is distributed more evenly. For the client, it means they get a more focused session where I am not distracted by other work tasks or worries.'

Another participant had started a regular staff yoga class, with members already reporting the health benefits, and all round, staff reported feeling less pressure than before.

Ben Gatty is WDP's volunteer development manager and a psychotherapist.

The next stress management workshop is on 9 April. Places are £75 – contact Westminster Drug Project at training@wdp-drugs.org.uk or call 020 7421 3138.

NOTICING THE SYMPTOMS

- Exhaustion and fatigue
- Depression
- Helplessness and hopelessness
- Sleep difficulties
- Headaches
- Gastrointestinal disturbances
- Compassion fatigue
- Feelings of isolation
- Anger and aggression
- Loss of meaning and purpose
- Guilt
- Substance use – self-medication
- Anxiety
- Irritability

POSSIBLE WORK SPECIFIC SYMPTOMS

- Poor work performance
- Disengagement
- Absenteeism
- Lateness
- Misuse of break times
- Inability to concentrate with clients
- Withdrawal from clients and co-workers
- Dehumanising client
- Intellectualising clients
- Leaving job

YOU MAY BE ON THE ROAD TO BURN OUT IF...

- Every day is a bad day.
- Caring about work or home life seems like a total waste of energy
- You're exhausted all the time.
- The majority of your day is spent on tasks you find either mind-numbingly dull or overwhelming.
- You feel like nothing you do makes a difference or is appreciated.

TOP TIPS OUTSIDE WORK

- Healthy/regular eating
- Sufficient sleep
- Address health issues
- Make time to relax
- Make time for fun
- Exercise
- Therapy
- Be with friends/family
- Time for nature
- Take holidays
- Time for self reflection
- Make time to laugh
- Make time to cry
- Meditate/pray
- Listen/dance to music
- Live life!

TOP TIPS INSIDE WORK

- Take breaks
- Utilise available support
- De-brief with colleagues
- Practise mindfulness
- Eat and drink sufficiently
- Ask for help when needed
- Keep communication open with managers and colleagues
- Get enough sleep in between shifts
- Manage time effectively
- Use annual leave
- Limit amount of overtime
- Reinforce boundaries
- 'De-role' at the end of the day
- Use self care action plans!
- Leave work at work!

LETTERS

'We hold a responsibility to make sure that freedom of expression is underpinned by the required evidence in order to create a meaningful debate'

WE NEED TO TALK ABOUT KEVIN

I read with a degree of disappointment Kevin Flemen's 'Soapbox' article (*DDN*, December 2011, page 24).

On the one hand I was rather astonished by the fact that such an ill-informed piece of work has been published in your journal. I am very much up to the challenges of well-informed and evidence-based controversies in psychiatry and other aspects of life, however structuring a column based on a variety of personal opinions without any solid evidence behind them is something that makes me unsettled. As vectors of information, to patients and the public in general, we hold a responsibility to make sure that freedom of expression is underpinned by the required evidence in order to create a meaningful debate. The credibility of scientific journals or among the media, newspapers/magazines or radio/tv programmes, rests on this principle.

It is my impression that the distinction between an unfounded set of personal speculations and a thoughtful argument has suffered.

My second concern is related to the work that has been done towards naloxone projects and the impact that such an inaccurate narrative can have in those approaching the subject with a curious eye. I have been involved in naloxone programmes for several years, and rather contrary to what Mr. Flemen believes, issues of consent and capacity as well as legal, medical, and pharmaceutical aspects of naloxone projects have been carefully and widely explored among those involved, and conveyed during the training sessions.

The seed of fear or uncertainty is not a productive one when it is rooted in speculative arguments. I would invite Mr. Flemen to visit our website *take-homenaloxone.org* and perhaps inform himself of the various aspects of the projects as well as the extensive literature that underlines this piece of work, before entering a discussion on this subject. If there have been gaps in service provision within the programmes this is something to address, although I would politely suggest that in future columns, references are attached to the differing arguments to establish the source and credibility of the information being raised.

Dr Romina Lopez Gaston, consultant psychiatrist, substance misuse team, Dudley and Walsall MHPT

HIGH ANXIETY

Kevin has significant experience in the field and has made notable contributions to promote best practice and increase the welfare of people who use drugs. With this in mind I wonder why he has used *DDN*'s Soapbox to largely amplify previously-held negative views on naloxone distribution that bear little, if any, relation to developing practice and current experiences. His writing is unhelpful, unnecessarily contentious and serves only to raise anxiety rather than inform debate around how naloxone can be made more available and effective.

I'm surprised that Kevin states it's heretical to raise questions about naloxone – the considerations and challenges have been, and continue to be, extensive and ongoing. Indeed evaluation, monitoring and review typify naloxone distribution programmes and continue to update and contribute to improving practice.

Comments to support his arguments are deceptive. True, at Sydney's medically supervised injecting centre, they learnt they had the resources to support rescue breathing without automatically referring to naloxone – but this was by trained medical and social care staff in a clinical setting and isn't representative to other settings such as hostels and certainly not in the community where most overdoses occur.

I've certainly never seen any evidence to support the assertion of 'naloxone happiness' in any settings. Practitioners are trained to use naloxone in a life saving situation only. One can't be 'naloxone happy' when confronted by someone who has overdosed and is unresponsive. Naloxone administration can of course, depending on dosing, be briefly distressing for the user, but part of training is recognition of naloxone-induced withdrawal agitation and how to manage this. It's certainly isn't a reason not to administer a life-saving intervention.

Kevin emphasises the potential for failures and omissions in responding to an overdose in a way that might fall below expected standards of practice. Correspondences with services that distribute naloxone suggest that these threats and concerns are simply not recognised. His points are unhelpfully reinforced with misleading references to the Welsh take-home naloxone evaluation. Certainly a proportion of those administering naloxone, contrary to training, didn't call for an ambulance, but it is important to clarify that these were service users in the community, not professionals as implied.

The thrust of the column is that distribution and access to naloxone was a given and its roll out 'very likely'. However, and shamefully, although we've known about the potential for the community use of naloxone for several decades it's availability is still limited. With some noted exceptions, in many areas across England at least, there's still significant resistance to support this simple, life-saving intervention for some of the most vulnerable people in our communities.

Had Kevin made himself more aware of the growing international body of evidence supporting take-home naloxone and developing UK practice he would have readily answered his own concerns.

We now know that naloxone is an affordable, proven and effective drug that not only saves lives but increasingly appears, as described by people who experience its impact, directly or indirectly, as a recipient or administrator, as promoting constructive change and meaningfully empowering. Now, more than ever, there is potential for those and their services to learn and benefit from the advances in best practice that are being seen across growing areas of the UK and apply them to their own communities.

Danny Morris, UK Harm Reduction Alliance, clinical lead for harm reduction, RCGP, SMAH

DON'T SENSATIONALISE

I write in response to Kevin Flemen's recent 'Soapbox' column. It is really unfortunate to see such an ill-informed and frankly unhelpful piece published in *DDN*. Firstly, it is not 'heretical' to raise questions about the expansion of naloxone distribution – any bold and innovative public health approach such as this deserves to be continually challenged and studied to ultimately achieve best practice. However, it is important to raise questions that legitimately challenge the approach both practically and empirically, not to sensationalise issues that are neither relevant nor evidence based.

The rationale behind naloxone distribution is that it will reach those most at risk of overdose, in situations where there is no professional help available, with peers or family members being the only way to provide help until the paramedics arrive. In addition, the mention of oxygen as providing 'a safe and less violent method' is equally baffling. Naloxone is one of the safest medications available, with no potential for abuse. To describe it as 'violent' is alarming in the extreme and based on no credible evidence. I hope Kevin is not suggesting we promote take-home oxygen for drug users as an explosive alternative?

An issue worth exploring through research is whether provision of

naloxone in non-healthcare settings, such as hostels, deters clients from using drugs on site. However, to use language such as 'naloxone-happy staff' with no credible evidence or explanation is disappointing and potentially harmful to the professional/client relationships in those settings.

The lengthy discussion on liability has some interesting points, however they are again lost amongst a number of claims of implications for staff being prosecuted for failing to fulfill their duty of care. It's true that not every overdose which is witnessed has the full suite of interventions applied (basic life support, ambulance called, naloxone administered).

However the number of overdoses encountered by staff is likely to be minimal, and the figures quoted on failure to call paramedics will be related to overdoses witnessed by peers/family, not by professionals. The law protects those who administer naloxone from prosecution, it doesn't punish those who fail to administer it.

Finally, I find it worrying that a pharmacist's first thought if a client reported they had unsuccessfully administered naloxone would be to call the police. There are many issues with this, not least patient confidentiality.

Perhaps Kevin should come to a naloxone training session here in Scotland and see these issues covered for himself. I'm sure he'll be made very welcome and will be better informed as a result.

Andrew McAuley, public health adviser (substance misuse), NHS Health Scotland

Editor's comment:
DDN – and 'Soapbox' in particular – is a forum for free comment. While Kevin Flemen's article has proved controversial, we did not find it to be ill informed. It is not our intention to censor the views of contributors.

PREMATURE EXAMINATION

For any select committee to attempt before October 2013 to examine the effectiveness of the government's 2010 Drugs Strategy is just about as futile as my trying to test my students' course progress before I have even prepared the lessons. Because the coalition's 2010 drugs strategy will not be fully launched until the end of 2013.

Drug strategy examinations prior to that will inevitably be a re-inspection of the ongoing but failed policies and practices of the last 60 years – which the coalition has rightly announced will be abandoned, because they fail to deliver lasting abstinence and demand reduction.

Seeking to change a 60-year-old entrenched policy and treatment system is like attempting to get a country's dictator to step down. This is a massive time and effort-consuming endeavour, and, when also naturally but covertly resisted by members of the deposed administration to preserve their positions, creates a mutinously delayed situation for the coalition's full strategy launch.

The three year delay in that full launch has been imposed firstly by the resistance of the NHS's failed 'experts' at the NTA to the new government's plans for the NTA's totally-deserved closure, and secondly by a simultaneous appeal from the psycho-pharmaceutical supporters of the failed strategies for time to 'pilot' the effects on the solvency of providers delivering 'Payment by Results'.

All of which is proving no more than an excuse for the 'treatment' providers of the last decade to buy time to try and develop a treatment-based rehabilitation system which can actually deliver the 2010 strategy goal of lasting abstinence.

But all this need for 'piloting' any new form of 'treatment' is an unnecessary and costly delay, because there already exists addiction recovery training programmes which, for up to 75 per cent of dependents using most addictive substances, deliver the lasting abstinence results the government demands.

However, a programme which does not require the services of psychiatrists, or daily supplies of pharmaceutical drugs, is I'm afraid unlikely even to be considered by the psycho-medicos running the 'pilots'.

Elisabeth Reichert, school head.

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity – please limit submissions to 350 words.

Post-its from Practice

Routes to recovery

The right support can give everyone a chance, says Dr Chris Ford

I was pleased to see Darren had made his appointment yesterday after failing to attend two in the preceding fortnight. But as soon as he entered the room, I knew something was wrong. He had lost his sparkle and his head was lowered in shame. His first words were 'I've blown everything and I know you'll hate me'. He told me he had relapsed on alcohol about three weeks ago and was now drinking about a half bottle of vodka a day, taking some heroin and crack, particularly post-drinking, and that he had breached his probation.

'I started with the positives – he had come to ask for help, he had achieved abstinence previously and the drug-and-alcohol free hostel he was in had not thrown him out...'

I started with the positives – he had come to ask for help, he had achieved abstinence previously and the drug-and-alcohol-free hostel he was in had not thrown him out, but had insisted he got help.

Darren is now 34 years old. He had first come to see me about 16 years ago when he developed an alcohol and heroin problem. Over that time he had always remained a patient and he had experienced the full range of treatment – counselling, inpatient detox, methadone maintenance and detox, and fellowship meetings of every type. Darren had also had two previous attempts at rehabilitation – the first, ten years ago, lasted a week and the second, two years ago, lasted two weeks.

After the last attempt he knew that he needed to change but that it was difficult. He could not do it alone, so he suggested his two-year plan. He would work on his drinking, stop bingeing and attend AA. I would prescribe a good dose methadone maintenance, and he would stop all illicit drugs. He would build bridges with his family, sort out his housing and attend his probation. Then, when he was ready and we had searched out funding, he would do an inpatient detoxification, go straight to rehabilitation and stay the course.

When he went off to detox in August last year, he wanted abstinence for himself rather than to please other people. He completed his three months and returned looking well. Our only concern was he thought 'that's it', however much we said 'now the real work starts'. He soon started to drop off his relapse prevention sessions and, unable to find a sponsor, he stopped going to meetings. It doesn't need much imagination for what happened next.

I began his reassessment with what he had learnt from rehab, and 'can't do it alone' was top of the list. Right now I'm off to a meeting about recovery pathways where we will discuss a nice uncomplicated flow chart starting with a particular drug or alcohol problem, going through several steps and reaching treatment complete. Nowhere does it say what happens when people take a more higgledy-piggledy route or if they relapse soon after completing.

People are all different, but with support they find their own way, and I feel confident that Darren will use this lapse to strengthen his recovery. I'm glad that GPs, as yet, are not yet measured by 'payment by results' in its current form, because I wouldn't be earning much for Darren.

Dr Chris Ford is a GP at Lonsdale Medical Centre, clinical director for IDHDP and a member of the board of SMMGP, www.smmgp.org.uk

People who enter treatment through the criminal justice system should have the same access as anyone else to the right treatment at the right time, says **Ros Weetman**

GETTING IT RIGHT

The report from the National Drug Rehabilitation Requirement (DRR) Review has recently been published and contains useful information for anyone involved in delivering treatment for DRRs.

The review was carried out in two phases in 2010 – a questionnaire was sent to all probation trusts to get a factual picture of DRR provision in each location, followed by interviews with 370 stakeholders across England and Wales. These included commissioners, DRR staff in both probation and treatment agencies, people responsible for court sentencing and offenders who had been subject to DRRs. Their views were sought on topics including the accuracy of assessment of treatment needs, the quality of treatment offered and whether the DRR reduced drug use and re-offending.

The findings indicated both good practice and room for improvement. We found a variation in treatment delivery across all areas, which is perhaps unsurprising given the nature of local commissioning structures.

However, one of the main concerns was the narrowing of the treatment offered to offenders subject to DRRs, in that even where local treatment provision was sufficient to meet the widest needs of the general community, drug users subject to DRRs were often not offered the opportunity to access this treatment.

In some cases this was because of local service level agreements or communication protocols not being set up between probation and treatment agencies, so that only a minimum number of agencies were seen as 'DRR friendly'. In others, a narrow view of what DRR treatment should contain had resulted in the commissioning of a similarly narrow treatment path, while some treatment agencies appeared to be in competition with each another, possibly through needing to meet individual retention targets or competing for business, and resulting in service users being kept in a service when their needs would have been better met via an alternative.

Service user perspectives drove many of the recommendations of the review, and these were accessed through interviewing current offenders individually or in groups and accessing people who had previously been subject to DRRs and were now in custodial establishments. We took the view that the experiences of service users who had not completed treatment through their DRR were at least as useful as those who had.

An interesting and unexpected alignment emerged between the views of service users and court sentencers, who shared the same perspective on both the usefulness of drug testing and their expectations of the key outcomes of a successful DRR (to be drug-free). These were in contrast to many of the professionals working with DRRs – both in probation and treatment settings – whose views often demonstrated low expectations of service users in relation to treatment outcomes.

Drug testing was seen as an important element of the DRR, but we found evidence that results were not used consistently by workers to develop motivation or hold offenders to account for their drug-using behaviour, and some service users interpreted this as a lack of care or concern about their continued drug use. As one said, 'it's alright to use drugs but not alright to be late for an appointment'. We were therefore concerned about the messages that service users were getting from their workers about the purpose of the DRR.

We were also concerned to find that a large percentage of service users felt they had no involvement in their sentence plan or care plan, which led to a lack of knowledge of the DRR objectives, and potential disengagement. However, service users were in full agreement that where they had been successful, a supportive worker who 'went the extra mile' had been a key factor – we saw many examples of workers whose enthusiasm shone out during discussions about their work and the role they played.

The review also draws together themes relating to three areas – the unintended consequences of targets, the need for clearer governance in commissioning to support DRRs, and the impact of organisational culture and climate. It makes a number of recommendations including that service user perspectives should be integrated into the treatment offered in order to address the 'poverty of ambition' observed during interviews with treatment professionals.

Provision should include: an increased focus on recovery and abstinence support programmes; the opportunity to attend a structured group work programme; the opportunity to gain skills and qualifications and to take part in voluntary work; peer support, and clear referral pathways for 'wraparound' services such as accommodation, employment advice and debt counselling

Work has already begun on implementing this recommendation, with a new round of best practice projects looking at a variety of ways to improve local provision. DRRs should have the combined focus of addressing drug use and reducing re-offending, and this review, together with other research on developing recovery pathways, seeks to ensure that offenders who access treatment through community criminal justice routes have the same opportunity as other service users to the right treatment at the right time to meet their needs.

At the moment the report has only been published internally, but interested commissioners or treatment agencies should contact their local probation trust to access the full report. Ros Weetman is substance misuse policy and development manager at NOMS.

ros.weetman@noms.gsi.gov.uk

'For women in my situation, jail should be the very last resort,' says **Kelly Overton**, who speaks out on behalf of women in prison for drug-related offences

CASE FOR TREATMENT

I was asked by Jo-Anne the manager of the Oasis project if I would like to attend a conference in London with her, about women in prison. We were asked if we would read out some of the questions on behalf of prisoners.

Firstly I was grateful to be asked to go, and then to be asked to read out a question for one of the prisoners – but then the nerves kicked in because really I didn't know what to expect. There would be a panel there, but I didn't know how many people would turn up. But I looked forward to the day, wondering what would be said – and if I would have the courage to say or ask anything.

I was really surprised by the turnout. The people that attended obviously cared about what was going on in our criminal justice system and the fact that there were women in jail, and that maybe most them shouldn't be.

The lady who had organised the conference came over and gave me a little slip of paper with a question on it that she would like me to read out for one of the prisoners. She also explained that the whole conference was being recorded for a BBC programme, and I tried not to panic.

The question was to panellist Eoin McLennon-Murray. It said: 'Why does probation constantly over populate our prisons for breeching? If circumstances were taken into consideration, sometimes the reasons should be valid and recognised. After all it costs over £53,000 to the tax player to put/keep someone in prison for a year.'

He replied that he agreed probation held too much power when it came to breeching, and some of the reasons for women landing in jail should be explored a little deeper.

After listening to the other panel replies and hearing one of the girls speak out about her life experience and working with the Oasis project, I suddenly had a burst of confidence. So as soon as the responses were done, I put my hand straight back up and started reeling off my life story about my experience of being a heroin addict on and off for 12 years.

I talked about the lack of support, which I really needed at the time, and the kids being placed with my mum because of one stupid mistake I made. I remembered the criminal situations I had been in – within a year I had been up before a judge four times, all for shoplifting, three of them resulting in fines and the other in an electronic tag for three months. Why they did that no one knows, not even my solicitor, because my crimes were committed in the day and the tag curfew was for the evening.

'Not once through my criminal proceedings did anyone mention a DRR – it was a friend that told me about it... so I asked for one while hardly knowing what it was.'

No mental health help was offered, nor any help for my drug addiction. The only thing the tag did was add fuel to fire and make me worse. Not once through my criminal proceedings did anyone mention a DRR – it was a friend that told me about it when I was arrested again and put before the judge, so I asked for one while hardly knowing what it was.

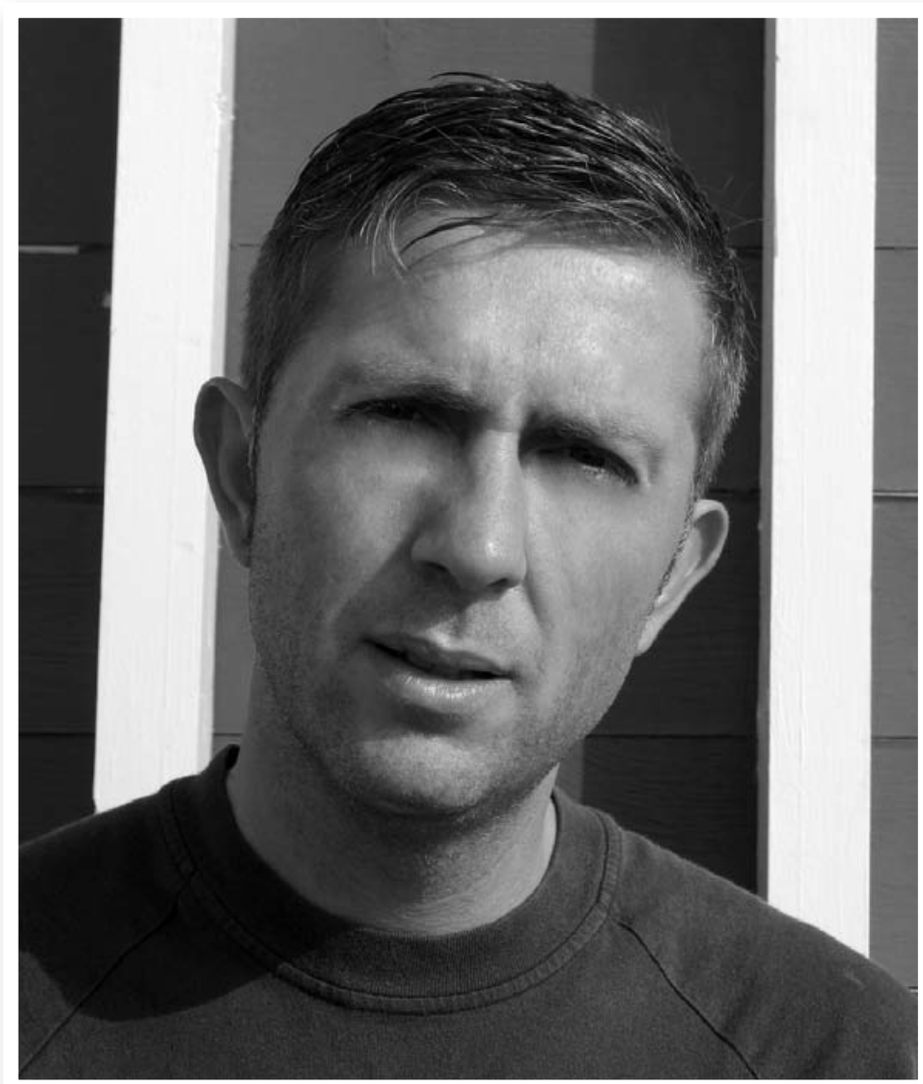
The point I wanted to get across to the conference was that these needed to be talked about more. It won't solve the problem but it will stop women with first time offences going to jail.

There were cases raised at the conference of women being sent to jail for first offences, to teach them a lesson. One of the panellists recalled a story of a young woman who went to prison and ended up committing suicide. A high number of female inmates self-harm while in jail – a situation that could be prevented if the government put a little more time and money into making sure jail is the very last resort.

I learnt a great deal at the conference and would jump at the chance of going again. At the end we were given a little book of poems, written by female prisoners who were self-harmers, and the contents were heartbreaking. Some women in jail just don't deserve to be there.

Jail should be the very, very last resort and circumstances should always be taken into consideration. I'm a mum of two wonderful, intelligent children, and I have had a drug problem ever since I understood something that happened to me when I was eight years old. I have made some mistakes and some very bad choices, but right now I'm trying my hardest to kick my addiction. This is the hardest thing I've ever done, but I hope whatever situation I found myself in, a judge wouldn't just throw me in jail, but would try everything going first.

I do know that one day I will kick this addiction and it will be for good, so I will be good enough to get my kids back. Because when I'm good with my kids, I'm good.



PRISO

Frankie Owens' life seemed destined to revolve around the criminal justice system until he finally got the right treatment in prison for his mental health problems. He tells his story

'Some people never go crazy. What truly horrible lives they must lead,' the writer Charles Bukowski once said. I carry a yellow card that says mental health survivor – and I'm exactly that.

I was diagnosed with hypermania in 1994, and I was medicated for nine months, during which time I refused to accept I had a mental illness. I was just doing what the doctors told me and what my family wanted me to do. My response to this was to prove everybody wrong and become a success. I progressed through university to a career in hospitality and then facilities management. This led to working within senior management in the education sector and completing a master's degree, along with a big house, beautiful wife and growing family of three girls.

However I continued to have manic episodes, which I thought were binges, over the next 15 years. But they were spaced out and not too self-destructive. After all, I had built a solid upward career and income with senior management responsibility – how could I have a mental illness? By mid-2009 I had realised that my binges were appearing more and more and the self-destruction was increasing. I attempted medication through my GP, 'trial and error' style, but I would not commit to any, and when on a binge would misuse the medication.

It was clear I was ill, but the only explanation was that I was an alcoholic and a drug addict. Why else was I bingeing, and my behaviour so completely different from the real Frankie? My wife bought me a book, *The End of My Addiction*, and I was

ONER OF THE MIND

introduced to baclofen which, according to the book, was a wonder drug that would stop the root cause of addiction. I took the book to my GP and explained that it was a prescribed medication, available in the UK. He agreed to trial it with me, as baclofen is not on licence in the UK for treating addiction according to the British Medical Council.

The book explained that most addictions derive from anxiety, from some point in your life that makes you take a substance to excess. Baclofen is prescribed as a muscle relaxant primarily, but secondarily it takes that anxiety away. I believe now that it worked for me, but not when I was suffering manic episodes, which it would feed along with drink and cocaine. It's an anti-psychotic, so became dangerous when I was manic. Could it have got any worse? I was trying to stop binges, but without knowing I was making them chronic.

As the episodes became more frequent, the binges were lasting for days on end. I had moved out of the marital home and lost my third job in three years. I was capable of drinking 30 units and taking 3 to 5 grams of cocaine in one sitting – I cringe now at the state I was in and how it scared the life out of my loved ones. I also felt like a lost soul, and with no duty of care for my wife and children and no job, I was nose-diving into chaos.

I was arrested 30 times in four months; my charge sheets were full of nonsensical actions and severely out of character behaviour, and the solicitor's file was full to bursting. When the desk sergeant and the jailers see you every other week, you're close to getting invited to the Christmas party. One of the charges was serious however, and magistrates' court became crown. In the blink of an eye I was on remand and in prison.

As a first-time offender I had no idea how the system or a prison worked. I was clueless to it all, and it was hard for me going in and frightening for the family and loved ones I left behind. I began writing *The Little Book of Prison: A Beginner's Guide* as a self-help book to save my sanity. I could not believe I was in prison; I had to try and make sense of it, and writing down the process was a saving grace – I thought 'well I'm here now, let's do something constructive'. It felt good to be writing something that I thought would help others, and in doing so I helped myself. I had brought baclofen into prison and used it for about eight weeks until it ran out and the head of healthcare refused to prescribe me any more.

I always relish a challenge and I like new life experiences, but prison was extreme. I kept my ears open and my mouth shut. Nothing prepared me for prison and it felt like a nerve-wracking and dangerous learning curve. The baclofen definitely helped with the anxiety of my new home in the first few months, and I put a 'couldn't give a toss' front on, which I was sure everyone could see through. I had to stay mentally strong and writing the book helped me to stay focused and away from the hooch and drugs – I knew they were a big part of the reason I was inside. The mania had gone away temporarily as it had done in the past, which again confused me and made me believe drink and drugs were the cause.

I read a lot of books about people in prison, people that were in far worse places than I was, and on far longer sentences. This gave me a lot of comfort, but I was most interested in the prison not the person. I liked the fact that I was writing a book that would help new inmates, their friends and families know what to expect from the system.

I was released on home detention curfew (HDC) – a very fetching ankle bracelet – and swore that I would never go back to prison. I also swore to never drink or take drugs again, as I thought this was the cause of my behaviour. When released I submitted the book to a handful of publishers who worked with ex-offenders and felt like I was putting my life back together. My wife was giving me a second chance and I was gaining confidence and staying clean.

I was nearly a month into this when another episode hit me. I could not control it, and it was as if I was possessed. I broke my curfew for days on end and went back to prison for another four weeks, which I believe drove me into prolonged hypermania. Inmates and officers could not recognise me from the person who had left them a month before. I wrote a diary, which I typed out much later and which was a completely different document from *The Little Book of Prison*. I didn't recognise the person writing it – frightening, but it also made me question the cause. I hadn't touched any drink or drugs during the return visit, but my behaviour was hideous. This was later to be my enlightenment, as the penny finally dropped about being manic.

However I still didn't acknowledge it – when in the throes of it you can't – and within eight days of the second release, I was sectioned under the Mental Health Act. Finally the authorities recognised that I was mentally unwell and within the 28 days so did I. Then – hallelujah! While in hospital I received an email from Bryan Gibson, director of Waterside Press, who was interested in publishing the book. In the worst place came the greatest news.

'I had built a solid upward career and income with senior management responsibility – how could I have a mental illness?'

If this wasn't enough I had entered the book for a competition while in prison and was contacted by The Koestler Awards to be told that I had won the platinum award for non-fiction, judged by the author Will Self. The book has had amazing support, from Jeffery Archer and Howard Marks to the Prison Education Trust and Nacro, the largest organisation for ex-offenders in the UK.

So I can finally say I have a complete handle on following my dream as a writer. I have the full knowledge of the cause of my binges, the medication to remove the manic episodes and the professional support to maintain my good health. I am convinced that everything good I have ever built in my life has come from hard work, self-belief, and self-discipline – and I now have the right combination and the winning formula.

At the age of 37 I have finally made sense of my life and the chaos of the last 18 months, assured that this is all behind me and that I can finally have a healthy, happy and stable future. Through the biggest challenges come the biggest rewards. I am now an award-winning published writer – something that makes me grin from ear to ear.

The Little Book of Prison – A Beginner's Guide is published by Waterside Press on 20 February. www.watersidepress.co.uk

Follow Frankie Owens on Twitter – @FrankieOwensJnr

'I started to work in Russia in the mid 90s when there were 700 people infected with HIV in the entire country... Now there might be more than 2m injecting drug users, and if you look at the policies hardly anything has changed. I've heard people talking about a lost generation, an entire generation that's dying.'

'When I walk around now I feel like an archaeologist in my own city,' says Harm Reduction International (HRI) chair John-Peter Kools of the once-notorious Zeedijk in the centre of Amsterdam. 'It's remarkable – it's changed into one of the tourist hotspots – and all because of sound, simple and effective policies.'

He's been involved in harm reduction since 1983, before the term even existed in the Netherlands – 'it was just a matter of helping people who needed help' – and when Amsterdam was regarded as the 'drugs Mecca' of Europe. 'There were thousands of people dealing in the street, day in, day out. There were regular overdoses, poisoned heroin, injecting on each and every corner in the centre of town. It was a terrible mess.'

His route into drugs work was through the squatting movement, and witnessing the treatment meted out to drug-using friends by the police. 'I'd studied political science and was an activist in the early '80s, and in the building where I lived there were quite a number of people who'd started using heroin,' he says. 'I saw how they were arrested and beaten up and didn't receive any methadone in the police stations, and thought that was an unbelievable injustice.'

An illegal squatters' broadcasting station offered the opportunity to raise awareness. 'I thought this inhumane and unjust treatment of people we lived with, and who were our friends, would make a good subject, so I made contact with a couple of drugs organisations and interest groups.' It was a decisive moment, he says. 'That was when I thought "this is somewhere I can do something with my competencies", and it suited my desire to change things.'

Official drug policy at the time was completely ineffective, he points out, and it was left to NGO initiatives, a drug users' union, religious groups and neighbourhood organisations to slowly come together to develop 'pragmatic,

A DUTCH MASTER

Harm Reduction International chair John-Peter Kools has been at the forefront of harm reduction work for almost 30 years, operating across Europe and beyond. He talks to **David Gilliver**

simple, lower-than-low-threshold services'.

An early initiative was the first needle exchange programme, after the main pharmacy in the Zeedijk area had to stop distributing syringes because it was overwhelmed by the demand. It was actually a user activist who suggested the idea of an exchange, he points out. 'We'd thought of handing them out or selling them, but a drug user at one of our meetings said, "why don't we exchange them, so they don't end up in the playgrounds?" It was one of the finest examples of collaboration between activists and users – it was the users who thought of the interests of the wider community.'

What might seem extraordinary to people outside the Netherlands is that the idea met with no community opposition whatsoever. 'In other countries you get resistance from neighbourhoods and religious communities – here it was the other way round,' he says.

The boxes of new syringes and buckets of used ones were originally transported by bicycle, and although the municipal health authorities weren't against the scheme, it was not originally seen as enough of a priority for them to fully get behind it. That, however, was before HIV.

'We didn't know anything about HIV at that time – it was about hepatitis B,' he says. 'But after about half a year the same guy we'd spoken to at the municipal health service called me and said, "Have you seen the newspapers? There's a new disease in the US. Would you like to make your request again?" Then it soon became part of municipal health policy, part of the mainstream.'

Wanting to develop more HIV-focussed help, he established the Mainline organisation, which published a magazine and carried out community-based outreach work, and remained there for 17 years. He set up similar programmes elsewhere – especially Eastern Europe and Russia – based on outreach and dissemination of practical information, but while NGOs did invaluable work, the problem was often the intransigence of the governments they dealt with.

'I started to work in Russia in the mid 90s when there were 700 people infected with HIV in the entire country,' he says. 'I remember drug users in the streets of Moscow talking about HIV as a disease of "Americans, negroes and Jews". Now there might be more than 2m injecting drug users, and if you look at the policies hardly anything has changed. I've heard people talking about a lost generation, an entire generation that's dying. There is a huge task to make the Russian government face this dire reality, and the international community should continue its efforts to support with that enormous challenge.'

The rest of Europe should guard against resting on its laurels, however, with a recent HRI civil society audit finding enormous gaps in coverage for syringes, methadone, overdose prevention, hepatitis treatment and user involvement. There are also the challenges of changing markets and new generations of drugs and drug users, he stresses.

'After 30 years, harm reduction isn't as controversial as it once was. It's written into documents as rights-based, effective European health policy, but I do see a tendency in many countries – especially the guiding countries of the previous decade – towards complacency, together with the setting of different agendas. I see that in my country, Germany, the UK, Switzerland. We have to work hard to keep pragmatic services for people who use drugs on the agenda, and it won't be easy. Among all the debates around austerity and people taking care of themselves, it's a huge job to show that our types of policies do fit with modern social policy.'

Indeed, as the economic outlook continues to worsen, so views appear to be hardening, with a Scottish social attitudes survey showing a double-figure drop in the number of people supporting harm reduction measures in the space of a year (*DDN*, 7 June 2010, page 5). With resources scarce, the risk is that drug users are seen as an even more 'undeserving' group. 'There's a general tendency when times are tough to blame "the other one" – whether that's Greece, or China, or drug users,' he says. 'Drug use, problematic use as well as recreational use, is now seen in the Netherlands as a non-issue, something from the last century', which itself can be 'fertile ground for changes of policy – cuts, the closing of consumption rooms, and so on', he says.

In addition to his HRI work, he is involved in the newly formed European Harm Reduction Network (EuroHRN), and has recently completed research for Dutch development agencies on the impact of drug use in sub-Saharan Africa. 'One thing that's clear is that African economies like Kenya and Nigeria are developing fast, and globalisation doesn't stop with a cellphone,' he says. 'Trading and use of consumables – including illicit drugs – is part of that, especially for disenfranchised young people. In countries that I visited, like Zambia and South Africa, injecting and non-injecting drug use is becoming a well-known phenomenon, and people have no idea how to protect themselves.

'The cruel thing is that we know what to do – what kind of public health measures are effective in terms of prevention and treatment,' he continues. 'We just have to put the money where it's needed.' A major blow has been the Global Fund's cancelling of new programming until 2014 – 'a huge disaster for communities in dire need,' he says.

In terms of challenges to harm reduction, much has been made – not least in *DDN*'s letters pages – of the tensions with the burgeoning recovery movement. Does he see it in those terms, or is he confident the two can work together?

'I think the recovery debate is very important,' he says. 'The recovery movement is gaining ground in Europe – it's not as big as in the UK – but harm reduction and recovery are two sides of the same coin. Drug policy should be about choices and providing alternatives. If people want to quit then they should be supported to quit, but you can't base an entire policy on that single option. The same goes if people don't want harm reduction. It's a matter of comprehensiveness.' **DDN**

GET REAL

James Attwood and **Alistair Sinclair** report on the regional work going on to translate recovery theory into action

Drug treatment is attempting to navigate its way across a new recovery landscape. We believe that treatment needs to connect more with those who are 'doing' and 'sustaining' recovery within the community, and support them in the generation of new diverse and inclusive recovery networks. We also believe that these new networks will have a vital role in supporting drug services in becoming recovery oriented.

Translating recovery rhetoric into reality within treatment services is not just a practical challenge; we believe it requires a conceptual transformation. As Mark Gilman (the NTA's strategic recovery lead) noted recently at DrugScope's national conference, 'Recovery is a long-term endeavour, it's communal in its nature and we have never been here before'. If recovery really is a paradigm shift, as we believe, then services need to move beyond rebranding exercises, slogans and banners and embrace a fundamental community-led shift in thinking and practice.

NORCAS, a charity in the East of England, is working with the UKRF and Re-Up (UKRF's training arm) to develop a quality assurance framework for recovery. This will support them in the delivery of recovery-oriented services and help them to embed recovery networks in their communities. Through a very dynamic and participatory process, a new recovery framework is emerging, which will support a necessary and dramatic process of transformation.

The framework has been named RODA – Recovery-Orientated Dynamic Assurance – and is being driven by a small team made up of local people in recovery, NORCAS frontline workers and UKRF members. This team has also been helping to map the community 'assets' that will play an essential role in the development of recovery-oriented services and strong local recovery networks. Central to the work has been the belief that treatment services and peer-based community support need to establish stronger relationships and work in a dynamic and mutually supportive way to support long-term recovery.

The UKRF and NORCAS have used community work methods to reflect the 'nothing about us without us' ethic. This approach centres very much on strengths, relationships and the co-production of learning and support. The thoughts, feelings, passions and concerns of those in recovery and their allies are central to developing and sustaining the RODA framework. Re-Up has brought some practical and theoretical knowledge to support this learning process.

By working in a participatory way, rather than being expert-led, a form of 'praxis' has been generated, drawing on the theories and practice of Larry Davidson, William White and John McKnight, among others. This informs relationships within the NORCAS team and supports our evolving understanding of 'recovery'. While the recovery movement in the US provides much guidance, learning and inspiration, it is clear that the UK recovery community – and we use this term in its widest sense – needs to explore and decide its own future, focusing on 'lived experience'.

The RODA framework is intended as a tool for those in recovery. It includes principles generated by the team and markers that enable the development and measurement of recovery orientation. For example, a key principle is 'recognise and support the process of recovery'. This principle has a number of markers, which break it down into key elements such as 'individuals will define their own recovery and their own journey'.

These markers are then understood in terms of what they mean to the service and, crucially, to service users, and the RODA framework sets out how they can be measured and reviewed. It seeks to define the concepts that underpin recovery and establish how services can support it.

with recovery!

This continual dynamic process encourages learning and reflection between staff and those in recovery, and the practical development of recovery plans becomes an ongoing process rather than an imposition of something drafted by a few people in a back office somewhere.

The NORCAS team wanted to ensure that the framework did not develop in isolation from other stakeholders and the wider community, so Re-Up facilitated

'Recovery is a long-term endeavour, it's communal in its nature and we have never been here before.'

a development day in November to give the staff team and service users a chance for reflection and input. Meanwhile the UKRF has been supported by NORCAS in its support of recovery networks in Norfolk – an example of a service making its support of community-led recovery 'real'.

Following its conference in Cardiff in September, the UKRF has focused on the rollout of recovery seminars. The first took place in Scotland and drew activists from all round the UK, and subsequent seminars were held in North Lancashire, Greater Manchester and Norwich during December. Further seminars will take place all round the UK this year, and we will be reporting on progress within *DDN*. Through bringing people together, the UKRF will support new friendships and provide a platform for new 'voices' of recovery.

We also hope to support recovery activists in identifying shared passions and values. Community members and professionals will be able to engage in supportive discussion, reflection and shared learning and we will begin to identify strengths and develop 'recovery capital' within communities.

The seminars will explore the role of recovery networks and establish what it is to be a recovery community organiser. Drawing inspiration from lessons learned within Asset Based Community Development (ABCD) we believe that these organisers will be the bedrock on which recovery networks are developed and sustained.

In a recent 'Recovery Uncovered' *Druglink* issue (Oct/Nov 2011), Harry Shapiro said that it was time people moved on from inspirational speeches and hugs and made recovery real. We believe that the establishment of value-driven recovery-oriented standards within services will make their supporting role clear and real.

Recovery lies within individuals, families and communities – they are the main players. However we believe there is an important supporting role for the emerging recovery networks. Those of us who wish to support recovery in the community are in it together.

James Attwood is director at Re-Up CIC; Alistair Sinclair is director of the UK Recovery Federation (UKRF) and Re-Up CIC

ENTERPRISE CORNER

INNOVATION THROUGH ENTERPRISE

In his first regular column, **Amar Lodhia**, chief executive of the Small Business Consultancy, introduces TSBC's work in turning marginalised individuals into entrepreneurs and urges you to get involved

WE ARE THRILLED to have been asked to write a regular column for *DDN*. So what can you expect from our offering each month?

The Small Business Consultancy (TSBC) has been inspired by the vision of a society in which anyone can succeed and achieve their life goals. We support underprivileged men and women, as well as those from offending, substance misuse and unemployed backgrounds, and those at risk of exclusion from mainstream education. We help them to become more socially mobile and survive in a global economy, by incentivising them to take positive steps while participating in our programmes.

Our participants are encouraged either to create their own opportunities by setting up their own business – particularly suited to those facing high barriers to employment because of substance addiction – or to find a positive purpose through adopting the core principles of entrepreneurship. These skills of leadership, communication, calculated risk-taking and opportunism support their transition into employment, education or training.

As the UK teeters on an economic precipice, it's only right that we look at alternative solutions to creating sustainable social change. We do however view the future positively, and for this we thank our participants, supporters and commissioners who provide inspiration in designing innovative solutions to societal problems.

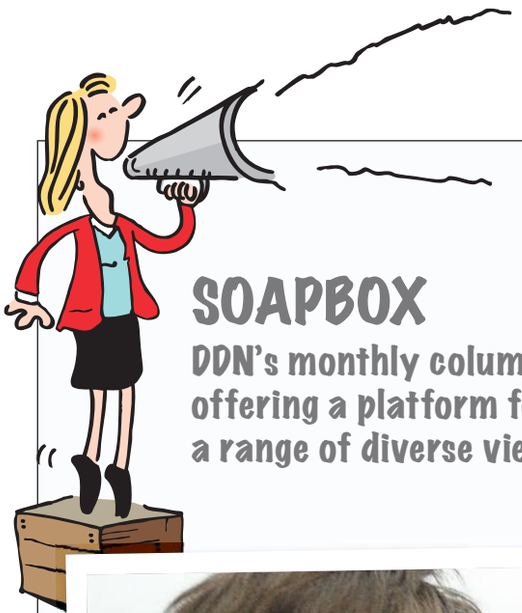
In keeping with our theme for 2012 – The Year of Innovation – this column will explore innovative solutions to our society's problems. We will also be responding to and generating debate around government policy, while developing creative and enterprising methods of service delivery design. We will offer opinions and solutions from members of TSBC leadership team, and hear from influential entrepreneurs, commissioners and peers within your field. We hope the issues and ideas raised in this column generate a conversation in which you want to take part.

Since being founded in 2009, we have worked with local authorities in ten London boroughs, as well as on a social investment project with the Ministry of Justice, and have also set up an office in Leicestershire.

We also have a voice at national level. Last December, TSBC's board of directors and I met with the prime minister's advisers and proposed a pilot scheme which, with government backing, could support up to 200 people to take part in paid eight-week placements in SMEs [small and medium-sized enterprises] this year. The focus would be on those who are currently furthest removed from the labour market. TSBC's role would be to train employers how to recruit, work with and get the best from taking on enterprising but marginalised individuals. Every firm who retains the new recruit after the placement would be given a cash incentive and a year-long National Insurance holiday, providing they use a percentage of the savings for training and development with the new employee.

We'd love to hear your views on the government's plans for tackling unemployment, repeat offending and substance misuse and increasing social mobility. Join in by emailing ddn@tsbccic.org.uk and follow us on Twitter @TSBCLondon using the #tag DDNews.

TSBC's website is at tsbccic.org.uk



SOAPBOX

DDN's monthly column offering a platform for a range of diverse views.

CALL TIME ON ALCOHOL POLICY!

Now is the time for change says **Jonathan Bradley**, who witnessed ADS's recent public debate

ADS (Addiction Dependency Solutions) recently held its fourth national annual debate at Manchester Town Hall. The title this year was 'Britain's drinking culture: do we have the bottle for change?' – a subject chosen because ADS had become frustrated by the lack of thinking around alcohol policy and wanted to kickstart the debate about a new approach. As ADS director of communications Sarah Chilton said, 'We wanted a really lively debate on an issue that affects every single person in the UK.'

An audience of more than 200 guests braved a cold, damp Tuesday evening in November to attend. Among the high profile panel members were Mark Baird, head of industry affairs and alcohol policy at Diageo; Eric Appleby, interim chief executive at Alcohol Concern; and Noreen Oliver MBE, who founded the Burton Addiction Centre. Also on the panel were assistant chief constable of Greater Manchester Police, Terry Sweeney; Lee Le Clercq, regional secretary of the British Beer and Pub Association; Fay Selvan, chair of Trafford Health Care Trust and CEO of the Big Life Group; Sarah Smith, assistant director of corporate communications and PR at North West Ambulance NHS Service Trust; and Lady Rhona Bradley, chief executive at ADS.

The debate kicked off with a hard-hitting video showing distressing images of city centres during weekend nights out, coupled with shocking facts on the alcohol problem in the UK. TV presenter Rob McLoughlin, chairing the debate, asked the panel what could be done to tackle these issues.

'ADS have taken the decision to kick start a national debate on drinking habits and to look at how we bring about fundamental change to alcohol policy,' said Lady Rhona Bradley. 'We do not have all the answers, but dialogue and collaboration with organisations that are directly involved in the field are imperative and the government needs to listen.'

All panel members acknowledged the need for change, demonstrated by the massive drain on resources, and the enormous toll on people's health, lives and communities across the UK. Terry Sweeney and Sarah Smith both commented on the burden that alcohol problems place on the police and ambulance services.

Sarah Smith, with over 20 years experience in the NHS, said: 'There is demand on services going up every year, with a real pattern on late Friday and Saturday nights of alcohol-related callouts going up 50 per cent. It's the same demographic, with resources been pushed towards city centres.'

Fay Selvan spoke about the problem of young people's drinking habits and felt that there was a need to encourage more dialogue around alcohol between parents and children. Noreen Oliver moved the debate on to dependent drinking, bringing her experience of running treatment centres in Staffordshire. Noreen believed that not enough was being done early enough to treat people with alcohol dependency problems. She called for recovery champions to share their experiences in primary and secondary schools, paving the way for a much wider discussion on the need to introduce comprehensive education programmes on alcohol as part of an early intervention programme.

Debate became heated around the availability and licensing of alcohol in the UK, with Lady Bradley highlighting that in 2001 the cost to the NHS of alcohol harm was £1.5bn, rising to £2.7bn by 2010. This came down to availability and a relaxation of licensing laws, she said, but Mark Baird replied that the drinks industry had the strongest industry regulation of any business when it came to availability and advertising. Eric Appleby rejected this point, saying that the drinks industry had started to take advantage of advertising options away from the traditional mechanisms regulated by the Advertising Standards Agency (ASA). He cited Diageo's recent deal to advertise on Facebook, which was not regulated by the ASA and was a targeted approach to advertise alcohol to younger drinkers.

An audience member questioned the panel about what they thought of promotional offers in clubs for very cheap alcoholic drinks. Lee Le Clercq said that if any nightclub grossly abused their licence in any way it would be against the law and a matter of police enforcement. Mark Baird made the point that this was not a reflection of the drinks industry as whole, but acknowledged that there was 'an awful lot that still needs to happen'. Lady Bradley summed up the mood of the debate by stating: 'A new plan is needed and it's about time we acted. Minimum pricing is not the only answer and the more we focus on this as the only policy available, nothing will change.'

What was immensely clear was that for any change to come about for alcohol policy in the UK, strong leadership is required. If the audience at Manchester Town Hall is anything to go by, the public does want a new and strong alcohol policy from this coalition government. Now is the time for change and the third sector has a critical and vital role to play.

Jonathan Bradley is ADS communications officer. Hear the debate online at www.adsolutions.org.uk

RECOVER AT PCP

PCP are a CQC-registered, established, quasi-residential treatment centre that offers clients the best possible treatment at affordable rates. We have been established for seven years in Luton and three years in Chelmsford, with other centres due to open in 2012.

PCP facilitates detox and takes clients through the abstinence-based, 12-step program of recovery in a twelve week period we call primary care. Our secondary care, which is a further twelve week program, offers our clients integration into society through education, charity work, re-entering the family home, rehousing and additional therapy. After clients graduate from PCP they will have a year's aftercare package free of charge available to them. PCP also meets the needs of family members through monthly workshops and therapy sessions. Our prices start from £450 per week.

PCP
a new beginning

Please feel free to contact Darren, James or Jo for an initial assessment on 08000 380 480 or email us at darren@pcpluton.com

Action on Addiction

UNIVERSITY OF BATH

THE CENTRE FOR ADDICTION TREATMENT STUDIES

Addictions Counselling Foundation Degree, 2012-13

The Centre for Addiction Treatment Studies, in partnership with the University of Bath, is offering their highly successful Foundation Degree in Addictions Counselling, available full-time or part-time.

Full-time delivery (2 years): for individuals interested in embarking upon a career as an Addictions Counsellor

Part-time delivery (usually 4 years, credit for prior learning may be available): for practitioners already working in the field requiring enhanced and up-to-date skills.

The Foundation Degree is accredited by FDAP, and provides all the required training hours for their counsellor accreditation, leading to eligibility for UKRCP registration.

Accommodation during teaching blocks is available. Our facilities include a specialist library and IT suite.

APPLICATIONS ARE CURRENTLY BEING RECEIVED.

*For further information see our website at **www.actiononaddiction.org.uk** (Training and Education) or contact us on **01985 843780** or at **training@actiononaddiction.org.uk***

Registered Company No. 05947481 INVESTOR IN PEOPLE *Registered Charity No. 1117988*

east coast recovery
releasing your potential

A NEW YEAR A NEW YOU!

East Coast Recovery specialises in the treatment of drug and alcohol addiction through our Suffolk based residential centre.

- *12 Step Programme*
- *CBT*
- *NLP – Creative Workshops/Psycho – Drama*
- *Community Cafe and Work Placements*
- *Sober Coaching and Personal Development*
- *Interventions*
- *Family Workshops*
- *Pathways to Education and Employment*
- *Developing and Supporting Recovering Communities*
- *Continuous Aftercare*

We offer 4, 6 and 12 week primary care along with secondary and after care packages. We are able to include a full community based detoxification.

Residential rehabilitation tailored to each individual's needs

www.eastcoastrecovery.co.uk
Tel: +44 (0)1502 587269

CQC Registered EATA fdap

BRIGHTON OASIS PROJECT

WOMEN ON THE EDGE

Brighton Oasis Project

29th May 2012

Audrey Emerton Building, Brighton

Women In Recovery ● Working with Women Offenders 'Troubled Families' ● Supporting the 'Hidden' Children

Brighton Oasis Project provides a unique portfolio of services for women with drug and alcohol problems and children affected by substance misuse.

This, our 3rd Annual conference will bring together a range of speakers from academia, medicine, nursing and social care to address issues facing this client group. Themes to be covered in both plenary sessions and workshops include:

- *Addressing Entrenched Neglect*
- *Recovery in Primary Care*
- *Meeting the sexual health needs of women substance misusers*
- *Working with "troubled families"*
- *Services for young women*
- *Patterns of Drug Use in women*
- *Personality disorders and women*
- *Domestic violence and substance misuse*

Baroness Massey of the National Treatment Agency will be opening the conference

Delegate rate: £130 per person including lunch and refreshments.
For more information please email info@brightonoasisproject.co.uk or call 01273 696970 or look at our website:

www.oasisproject.org.uk

East Sussex Drug and Alcohol Action Team
WORKING IN PARTNERSHIP TO TACKLE SUBSTANCE MISUSE

NHS Sussex

TENDER FOR THE PROVISION OF
SUBSTANCE MISUSE SERVICES AT HMP LEWES
IN EAST SUSSEX – NHSSUS/11/087

Notice calling for expressions of interest

Expressions of interest are invited from suitably qualified and experienced healthcare provider organisations or consortia interested in being invited to tender for the provision of recovery focused substance misuse services at HMP Lewes. HMP Lewes is a Category B Local prison serving Sussex courts.

The contract is expected to be awarded by the end of June 2012, with an effective start date of 1 October 2012. Duration of contract is 36 months. The value of the contract will be in the region of £3.3 million over the three years of the contract.

NHS East Sussex Downs and Weald is operating an electronic procurement process. Interested parties wishing to participate must register their details on the NHS Commercial Solutions website to gain access to further information (Memorandum of Information), and obtain the documents to be completed and returned for consideration (Prequalification Questionnaire) by no later than **17:00 hours on Friday 2nd March 2012**. All correspondence will be dealt with through this website.

Please visit the NHS Commercial Solutions website current opportunities for further information and how to register.
https://commercialsolutions.bravosolution.co.uk/web/login.shtml

Procurement contact for this project is Chris McCarthy (tel 01273 403717)

KINESIS LOCUM
Specialist Recruitment

- Total Recruitment for the Drug and Alcohol field. (DAAT, Nurses, Commissioning. NHS. Criminal Justice...and more)
- The Trusted Drug and Alcohol Professionals.

You call Kinesis, we do the rest!

www.kinesislocum.com

0207 637 1039

Substance Misuse Personnel

Permanent • Temporary • Consultancy

Supplying experienced, trained staff:

- Commissioning
- Service Reviews
- DIP Management
- DAT Co-ordination
- Needs Assessments
- Project Management
- Group & 1-1 drug workers
- Prison & Community drug workers
- Nurses (detox, therapeutic, managers)
- many more roles...

SAM

Call today: 020 8987 6061

Register online:
www.SamRecruitment.org.uk

Solutions Action Management
Still No.1 for Recruitment and Consultancy

INVITATION
to a market place event
TUESDAY MARCH 13TH 2012

Wiltshire Assembly Community Safety Partnership

PSYCHOSOCIAL SERVICES AT HMP ERLESTOKE

The **Wiltshire Community Safety Partnership** would like to offer potential providers an exciting opportunity to be involved in the commissioning of psychosocial services in HMP Erlestoke: CARATs and 12 Step Programmes.

A market place afternoon will be held on Tuesday March 13th 2012 for interested parties to participate in the commissioning process, details of which will be made available after the deadline below. Any acceptance received in response to this invitation will be registered as an expression of interest in any tender(s) which may result.

Registration to attend must be submitted in writing or by e-mail to: Sandra Jones, Drug and Alcohol Team, Wiltshire District Council, County Hall, Trowbridge, Wiltshire, BA14 8LE by 08.03.12
email: Sandra.Jones@wiltshire.gov.uk

pipmasonconsultancy

Training for alcohol and drug workers

Short courses, all mapped to DANOS
now run in Birmingham
Trainer Pip Mason

BOOK NOW:

New course in April 2012
COUNSELLING FOR RECOVERY (5 days)

Also booking now for
MOTIVATIONAL INTERVIEWING
at introductory, intermediate and advanced levels and Cognitive-behavioural approaches.

Full details including dates, costs and online booking form at
www.pipmason.com
or contact Sue Chamberlain on 0121 426 1537
or at bookings@pipmason.com

ADDICTION SUPPORT AND CARE AGENCY

COUNSELLING MANAGER

£19,200 pa • Surbiton, Surrey • Part time over three days

ASCA is a small local charity based in the boroughs of Richmond and Kingston. We are dedicated to providing counselling and support to those with a substance misuse problem and to their carers and family members.

We are looking for an experienced, suitably qualified and accredited Counselling Manager. You will need to demonstrate knowledge, innovation and the capability needed to manage a counselling service and a team of volunteer counsellors.

In addition you will need to:

- be familiar with the practices and principles of abstinence and harm reduction based treatment
- have experience of facilitating groups
- be flexible, and able to work with very little supervision.

For a recruitment pack email ***info@addictionsupport.co.uk*** or contact us at 233 Lower Mortlake Road, Richmond, TW9 2LL or telephone ***020 8940 1160***

Closing date: **Tuesday 31st January 2012**
Interview date: **Wednesday 8th February 2012**

Charity number: 1036555

DDN Drink and Drugs News

fdap

DDN/FDAP WORKSHOPS

We are pleased to offer the following workshop:

Be Prepared – CQC compliance

14 March 2012, Central London

CQC have recently changed the way they inspect residential and community-based services. Following a pilot scheme, they are initially intending to focus on a small number of outcomes in their inspections, but will be doing so in more depth. Their new method of inspecting means that they will be spending more time speaking with or observing service users and their care and treatment. They will also be making all inspections unannounced!

So how can you be prepared for your next inspection? The course will show you how to look in depth at specific outcomes yourself; and how to ensure that you have the right evidence available to demonstrate your service's compliance to CQC. The course will also look at what to expect and how to respond on the day of the inspection.

For substance misuse services this will be the first inspection under the new registration criteria, and for many newly-registered services their first experience of being regulated. For this reason it is especially important to be well prepared.

David Finney is an independent social care consultant with a specialist interest in the regulation of substance misuse services. He has facilitated training events around the country. He was a senior manager with CSCI where he was the national lead for substance misuse services.

15% discount to FDAP members.

The course runs from 10.00 am – 4pm in central London, and includes lunch and refreshments. For more details about these workshops email Kayleigh@cjwellings.com or call 020 7384 1477. Or visit www.drinkanddrugsnews.com

DDN training is run as a partnership between DDN magazine and independent training providers. DDN offers trainers promotion, advertising and marketing resources, a central London venue, and admin support. If you are a trainer working in the drug and alcohol field and would like to discuss partnering with DDN on a training course, please contact us.

looking for new opportunities?

Bristol Drugs Project is an experienced, energetic and resourceful service delivering effective harm reduction and treatment services to over 3,200 individuals a year.

bdp Bristol Drugs Project

SHARED CARE WORKER

(Permanent – either full time or part time) Ref: DDN SCW

Bristol's successful Shared Care scheme provides treatment to over 1,600 drug users. Based in GP surgeries in the heart of communities you will assess opiate users, provide advice to GPs, monitor prescriptions and deliver recovery plans. If you are assertive and diplomatic, with excellent organisational skills and are able to work well within pressurised primary care settings, this is for you.

For an informal discussion contact Maggie Telfer (0117) 987 6006

Closing date: Midday, Friday 3rd February 2012
Interview date: Friday 17th February 2012

Please contact Angelo Curtis, quoting the job reference, for an application pack: BDP, 11 Brunswick Square, Bristol BS2 8PE. Tel: (0117) 987 6004, E-mail: recruitment@bdp.org.uk

Safer Bristol

Funded by Safer Bristol – Bristol Community Safety & Drugs Partnership. We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation. No CV's agencies or publications.

Registered Charity No: 291714 Company Limited by Guarantee: 1902326

BLENHEIM CDP
THE LONDON DRUG AGENCY

Data Analyst

£28,403 - £31,527 pa **London, SE5**

35 hours per week

Following a reconfiguration of DIP services in Southwark, Blenheim CDP is now recruiting a Data Analyst.

You will be responsible for day-to-day data management of the service which includes inputting client information onto a database, cross-referencing information from multiple sources and producing performance reports. You should have a good working knowledge of DIP and substance misuse sector information management systems and strong IT skills, specifically MS Office. Knowledge of leading sector databases would be highly desirable.

REF: BCDP/22/DDN.

To request an application pack, please email: blenheim@peterlockyer.co.uk or telephone our response handling line on 01206 570706 quoting the reference number. Alternatively, you can download an application pack from our website www.blenheimcdp.org.uk

The closing date for the receipt of completed applications is midday, Monday 30th January 2012. We regret that late applications cannot be accepted.

Please note that interviews for this post will be held on Friday 3rd February 2012.

www.blenheimcdp.org.uk

We value diversity in our workforce and welcome applications from all sections of the community.

Blenheim CDP: Registered Charity No. 293959.


LAST YEAR
Charlie left it too late
DDN
Drink and Drugs News
The Alliance
Taking treatment forward
DON'T BE A CHARLIE!
book now
TOGETHER WE STAND
the fifth national service user conference - 16 February - Birmingham NEC
www.drinkanddrugsnews.com - www.facebook.com/DDNMagazine - 020 7463 2081