1 February 2010
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# DDN
## Drink and Drugs News

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Liverpool's round-the-clock supported housing project

**INJECTING IN PUBLIC**
Antisocial and chaotic or a response to poor services?

**'If we don't develop our drug interventions within a framework of harm reduction... people will die.'**

# HIGH STAKES
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**Editorial – Claire Brown**

# Lives first – always

## Public health's no follower of fashion

The language of recovery can be exciting. It enthuses, it galvanises, it stirs people into action. Most of all it can make us feel we're doing something very positive to counter the negative energy of addiction. But as the story on public injecting demonstrates (page 14), many of the challenges of drugs work are much less visible and no less vital for it. The recent anthrax outbreak among Scottish heroin users demonstrates these challenges at their most extreme (cover story, page 6). Why was the public health response so inadequate? Would it have been an entirely different scenario if the sufferers were in danger of infecting the public, rather than contained within the injecting drug user population? Why was the official advice to those at risk so impractical? Any drugs worker knows the impossibility of long-term heroin users being able to stop injecting immediately, let alone to push themselves forward for emergency treatment, so why was this patient group not supported through this crisis as intensely as society's most vulnerable?

Positive initiatives are great for the morale of this field but they should never introduce an either/or option to fundamental treatment rights. We know that – but do our politicians? Never has the tired old harm reduction versus abstinence debate seemed so hollow and we must insist on public health policy that learns from this tragedy. As Andy Stonard points out (page 8), now is the time to lobby from an informed perspective to make sure the politicians of each party understand the policies they are moulding around their voters. Public health is everyone's business and whichever way the political winds blow over the next few months, we should never forget we're talking about the right to life and not just how we choose to live it.

Talking of debate, there will be some very different views aired at our DDN/Alliance service users conference on Thursday 4 February (still time to book... just) – we hope we'll have the chance to meet you there!

# This issue


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### FEATURES



### REGULARS

## News in Brief

**Arresting behaviour**

Police in England and Wales arrested more than 7,500 people during a month-long crackdown on drink driving over Christmas, according to the Association of Chief Police Officers (ACPO). More than 223,000 people were breath tested between 1 December and 1 January, three per cent of whom were then arrested. 'Despite all the messages that drinking and driving is dangerous and illegal some people still do not get the point,' said ACPO lead for roads policing, chief constable Mick Giannasi. Meanwhile, the Home Office's Drugs Intervention Programme (DIP) has carried out its millionth drug test using Concateno's drug detection system. The test was carried out in Sheffield on a suspect arrested on suspicion of fraud, and was negative.

**Drug offences down**

Drug offences recorded by the police fell by four per cent during July-September last year compared with the same quarter in 2008, according to *Crime in England and Wales: quarterly update to September 2009*. 'These recorded crime statistics are heavily influenced by policing priorities and may reflect changes in the policing of drug crime more than real changes in its incidence' says the document. The previous period of increased recording of offences has been attributed to the use of police powers to issue cannabis warnings. www.homeoffice.gov.uk

**Nutt cash**

A hedge fund manager is providing £450,000 worth of financial backing to the Independent Council on Drug Harms, according to *The Times*. Toby Jackson will provide the money to the new body, set up by sacked ACMD chief Professor David Nutt (*DDN*, 18 January, page 4), over the next three years.

**Awarding recognition**

Voting is now open for the HubCAPP (Hub of Commissioned Alcohol Projects and Policies) awards, which aim to recognise people and organisations working to tackle alcohol-related harm in England. www.hubcapp.org.uk/awards

**Manifesting recovery**

EATA has launched its *Pathways to recovery* manifesto (*DDN*, 18 January, page 10) on how rehabilitation and reintegration can bring long-term cost savings to the NHS and benefits system. 'Some savings could be made almost immediately and other savings in wider social impacts will come over the next ten years,' said chief executive Peter Martin. Available at www.eata.org.uk/policy/completed-activities/

# Call for 'responsible' action as anthrax outbreak spreads

**The Scottish government has been called on to implement an 'emergency public health plan', including prescription of appropriate alternatives to street heroin, in response to the outbreak of anthrax cases among injecting drug users in Scotland (*DDN*, 18 January, page 4).**

A letter signed by leading drugs organisations including Release, the International Harm Reduction Association (IHRA), Transform and the Alliance has been sent to health secretary Nicola Sturgeon calling for action and branding Health Protection Scotland's advice to heroin users to stop using or seek treatment 'reckless' in light of long waiting times.

As *DDN* went to press, there were 17 confirmed cases of anthrax – including the first case in the Ayrshire and Arran NHS district – and eight deaths, with Health Protection Scotland warning that 'heroin users all across Scotland need to be aware of the risk that their supply may be contaminated.'

'We are calling upon the Scottish government to respond to this health crisis in a responsible manner with the aim of trying to prevent further deaths,' says the letter. This should include the prescribing of dihydrocodeine by GPs, it states.

'Failure to adopt such a policy would mean that the Scottish state would be failing in their duty to its citizens,' says the letter, adding that waiting times in Scotland for opiate substitute medication are the longest in the UK. 'Many of those accessing services are informed that it is a condition of their treatment to engage with the service for a minimum period of time before they will be entitled to a prescription offering an alternative substitute medication, usually methadone. In some areas of Scotland we have been informed that waiting times for (opiate substitute medication) can be up to 12 months.'

Meanwhile a briefing document for people working with heroin users – whether in treatment or other relevant services like mental health, criminal justice, family support or homelessness – has been produced by the Scottish Drugs Forum to help detect early signs of anthrax and ensure people receive medical help. An anthrax-related death in an injecting drug user in Germany has also now been reported.

*Anthrax and heroin users: what workers need to know* available at www.sdf.org.uk See feature, page 6.

# Report shows drug strategy 'lack of evidence'

**A Home Office report on value for money in drug strategy spending demonstrates the lack of evidence behind the strategy, according to Transform.**

The report, which was produced before the Home Office's public consultation on the ten-year drug strategy in 2007 (*DDN*, 30 July 2007, page 4), took two years for Transform to obtain under the Freedom of Information Act.

Keeping the report out of the public domain was 'purely political' says Transform, as it provides a 'stark contrast to the absurd rose-tinted picture painted by the 2007 consultation document'. The *Drugs value for money review: July 2007*, it says, demonstrates the lack of meaningful evaluation behind the existing strategy and shows that most of its associated costs – £2bn out of a total of £3bn in 2005/06 – are related to law enforcement.

The report, which is stamped 'this is not a statement of government policy', says 'Policies to reduce the availability of drugs produced the greatest analytical challenge. The absence of robust and recognised measures of success, combined with a limited base of research evidence makes it particularly difficult to draw conclusions about supply side policies.'

'The withholding of this report demonstrates yet again how the government is committed to the rhetoric and fantasy of success of the current strategy, whilst doing its damnedest to keep the truth out of sight of the public,' said Transform's head of policy and communications Danny Kushlick. 'Ultimately we are being duped into supporting a policy that is demonstrably failing to deliver anything even approximating to value for money.'

*Drugs value for money review: July 2007 available at www.homeoffice.gov.uk/about-us/freedom-of-information/released-information/foi-archive-crime/8908_Drug_value_money_report_07.html*

**Unseen damage:** The Department of Health has launched a new £6m campaign to alert people to the 'unseen health dangers' of drinking above NHS recommended limits. The TV, press and billboard campaign is backed by health charities including Cancer Research, the British Heart Foundation and the Stroke Association. 'Over a quarter of the population regularly drink above the government's recommended daily limits, with over two and half million adults regularly drinking above the higher-risk levels, putting their health at risk of serious diseases and conditions,' said chief medical officer Sir Liam Donaldson. 'It is important people realise the harm they, unknowingly, can cause to their health by regularly drinking more than the recommended daily limits.' www.nhs.uk/drinking

# Scots found to be drinking more but taking fewer drugs

**The number of people taking illegal drugs in Scotland is declining, according to figures from the Scottish government, while drinking rates continue to far exceed those of England or Wales.**

More than 10,000 people responded to the *Crime and justice survey 2008-09* on self-reported 'last month, last year and lifetime' use of drugs. Use of cannabis was declining, according to the survey, but cocaine use – after cannabis, the most commonly reported drug used in the month and year prior to the interview – had remained stable.

The survey also showed a lower proportion of 16 to 59-year-olds who had taken drugs at any point in their lives than in England or Wales. However, it has drawn press criticism for not including people more likely to have taken drugs, such as those living in hostels, the homeless and prisoners. The survey represented a 'small step in the right direction' said community safety minister Fergus Ewing, and the Scottish government has also launched a new cinema and online campaign aimed at 16 to 22-year-olds on the health risks associated with cocaine.

Meanwhile a report on Scottish drinking habits reveals that more than 50m litres of pure alcohol were sold in Scotland last year. Sales in the year to September 2009 averaged 12.2 litres of pure alcohol per person over the age of 18, around 25 per cent higher than in England and Wales. Sales of pure alcohol per head from supermarkets and shops were more than double those of pubs, clubs and restaurants, and it was now possible to exceed the weekly drinking guidelines for a man for less than £3.50, according to health secretary Nicola Sturgeon.

'Studies have indicated that around a million Scots are drinking above guideline levels, often in binges – with nearly a quarter of a million drinking more than twice the recommended limits,' she said. 'All the evidence tells us that the big rise in Scottish alcohol consumption in recent decades is closely linked with the 70 per cent drop in alcohol's relative cost. As a consequence, our country now faces an unprecedented burden from alcohol-related health problems, crime and lost economic productivity which runs into billions and which we are all paying for.' The Scottish government estimates the total cost of alcohol misuse to society at between £2.48bn and £4.64bn a year (*DDN*, 18 January, page 5).

*Results from the Scottish crime and justice survey 2008/09: drugs use module available at www.scotland.gov.uk/Publications/2010/01/22152358/0*

*Analysis of alcohol sales data 2005 – 2009 available at www.healthscotland.com*

# Shut Cambodian drug detention centres, says Human Rights Watch

**Human Rights Watch is calling on the Cambodian government to permanently close down its compulsory drug detention centres.**

Cambodian drug users are at risk of 'arbitrary detention' in centres where they are frequently tortured and raped, according to a new report based on extensive interviews with former detainees.

The official function of the centres is treatment and rehabilitation. However punishments documented in *Skin on the cable – the illegal arrest, arbitrary detention and torture of people who use drugs in Cambodia* include beatings, rapes, forced labour, electric shocks and being chained in the sun. Detainees also describe having to survive on rotten or insect-ridden food and being forced to donate blood. Many of the inmates are arrested without reasonable cause, often on the request of a relative or as part of a police round-up of 'undesirables', and have no access to a lawyer. The centres are also used to detain children and people with mental health issues.

Last year *DDN* reported from the International Harm Reduction Agency (IHRA) conference in Bangkok, where speakers described mass round-ups of drug users, sex workers and the homeless for detention at a former Khmer Rouge execution centre (*DDN*, 4 May 2009, page 9). 'The real motivations for Cambodia's drug detention centres appear to be a combination of social control, punishment for the perceived moral failure of drug use, and profit,' states the report.

'Individuals in these centres are not being treated or rehabilitated, they are being illegally detained and often tortured,' said director of Human Rights Watch's health and human rights division, Joseph Amon. 'These centres do not need to be revamped or modified. They need to be shut down. Drug dependency can be addressed through expanded voluntary, community-based, outpatient treatment that respects human rights and is consistent with international standards.'

A Beethoven concert by the European Doctors Orchestra is being held at Cadogan Hall in London on 9 February in support of the Medical Foundation for the Care of Victims of Torture. To buy tickets visit www.cadoganhall.com

*Skin on the cable available at www.hrw.org*

# Mandatory code on alcohol limps towards reality

**The government has set out the key conditions of its long-awaited mandatory code for alcohol retailers.**

They are banning irresponsible promotions, ensuring that smaller measures and free tap water are always available, ensuring an age verification policy is in place and banning 'dentist's chairs' where drink is poured directly into the mouths of customers. Tough action on pricing, labelling and advertising, however – long called for by health organisations – do not form part of the code.

Breach of the conditions could mean loss of licence or a maximum £20,000 fine and/or six months in prison. The proposed conditions will now go before Parliament for approval, with those relating to irresponsible promotions like 'women drink free' or 'all you can drink for £10', free tap water and the 'dentists chair' scheduled to be introduced on 6 April. The age verification and smaller measures conditions will be introduced in October to give retailers time to prepare. More than 7,000 people responded to the consultation on the code, says the Home Office.

New powers for local authorities have also come into effect to make it quicker and easier to call for a review to restrict or remove a licence without having to wait for the police or local residents to complain. 'Alcohol-related crime costs the UK billions of pounds every year and while the vast majority of retailers are responsible, a minority continue to run irresponsible promotions which fuel the excessive drinking that leads to alcohol-related crime and disorder,' said home secretary Alan Johnson.

The Royal College of Nursing said that minimum pricing and tighter regulations on labelling and advertising should have formed part of the code. 'Every day, frontline nurses see the devastating consequences of drinking on patients' physical and psychological health,' said chief executive Dr Peter Carter. Alcohol Concern also called for 'decisive action' on the issue of price. 'We need a minimum price per unit of alcohol to eradicate irresponsible sales in supermarkets as well as pubs and bars,' said chief executive Don Shenker. 'The country's alcohol misuse has reached a level the government should be ashamed of. Giving the alcohol industry the upper hand is a catastrophe for the nation's health.'

However, even in a watered down form the code has angered sections of the drinks trade, with the British Beer and Pub Association calling the measures 'pub-centric' and 'lopsided and unbalanced', as almost 70 per cent of alcohol is now sold through supermarkets. 'This is not the time for the Home Office to be burying business in yet more unnecessary red tape,' said chief executive Brigid Simmonds. 'All the powers needed to deal with problem premises already exist. The trouble is poor enforcement of current laws. Just adding to that pile is unhelpful.'

**'Heroin users not currently in drug treatment who decide they want to minimise their risks of infection also need to stop using street heroin altogether.'**

Between 16 December and 25 January eight people in Scotland have died from anthrax related, it is suspected, to contaminated heroin (see page four). To date there are a further nine confirmed and 50 possible additional cases. Drugs workers across Scotland have been checking all injectors who attend services for signs of anthrax. Leaflets have gone out to drug users. Information has been cascaded through NHS structures. But despite this and recent improvements co-ordinated by Health Protection Scotland (HPS) and the Scottish Drugs Forum, the initial response was slow. By the time there had been seven deaths there was little if any information available on any of the key drugs websites, and the only advice available to drug users was to stop using heroin immediately and get into treatment.

'Heroin users not currently in drug treatment who decide they want to minimise their risks of infection also need to stop using street heroin altogether, but they may need to talk first to their local treatment service about how to engage with the available drug treatment options (such as abstinence-oriented support or, at least for a period, prescribed opiate substitution treatment),' says the HPS factsheet for drugs workers.

And it is obvious isn't it? If you stop using street heroin you cut your risk of getting anthrax to zero. Smoking anthrax spores seems to be pretty much as dangerous as injecting them, so advising people to smoke is probably not much use. So what we need to do is get people to stop using heroin. Quickly. One wonders if 'abstinence-oriented support' is actually what is needed? Or if substitute prescribing – however much of a secondary option it may seem to the author of this advice – might actually be the way forward?

Currently in Scotland, waiting times to prescribed treatment – the point at which people can access medication – range from eight to 52 weeks. I was working with a group of drug users in Glasgow yesterday who, despite being committed to the recovery orientation of the Scottish Drug Strategy, also instinctively understood the need for Scotland to get better at providing basic healthcare, saying 'You could die in the time it takes to get a script here.'

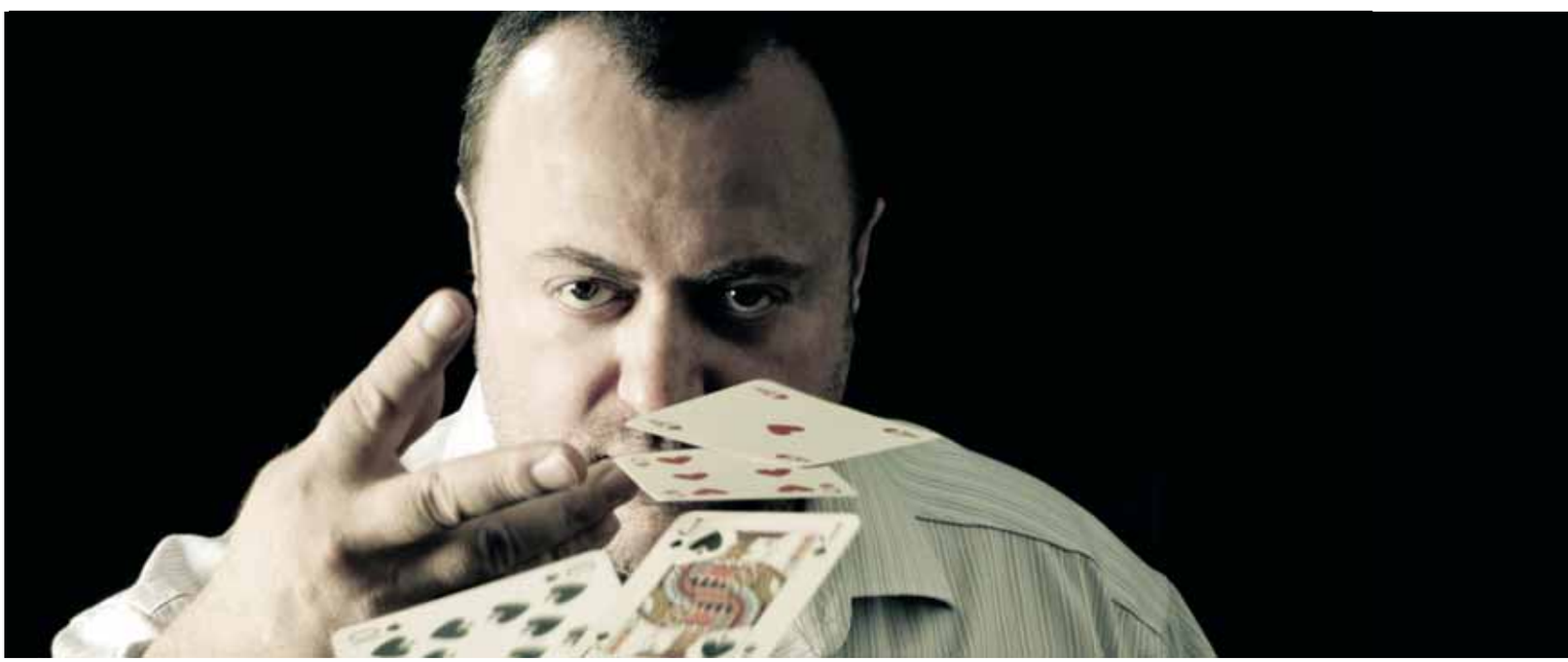
The Scottish government has recognised this variation is problematic and that delays getting into treatment impact on community and individual outcomes. They've set new targets for drug treatment waiting times, but this will be too late for some users making the choice between using potentially contaminated heroin and going into withdrawal, like this teenage drug user quoted in *The Paisley Daily Express*:

'It's scary but the problem is that folk like myself just can't break their addiction to heroin. I'm still taking the drug, even though I'm worried that the batch I'm using might be contaminated. I just can't help myself. I would rather put my life at risk than do without my heroin.'

When the threat of HIV transmission in this country was at its height in the late eighties, the government invested in an approach to drugs called harm reduction. The problem, it was argued, was so pressing and so dangerous that we would be morally irresponsible if we allowed infection to spread. We needed to find a way to stop people using heroin so dangerously. The approaches we knew would yield results – keeping people alive – were substitute prescribing and honest and frank advice about injecting and support for people at whatever stage in their drug-using career they came for help. And it worked. Drug deaths reduced and HIV transmission rates to new users dropped. Record numbers of drug users contacted services. Lives were saved. Not just those of people directly affected by drug use, but those of people in the general population who may have become infected.

Maybe this is where there is a big difference. HIV is infectious. Anthrax isn't. In the same press release where we are told that drug users should stop using heroin we are also reassured that anthrax will not be passed to the general population and that they are at no risk.

If we know that providing substitute prescribing can save the lives of drug users at risk of dying from contaminated heroin surely we are doing it? Well, kind of. It's no secret that waiting times for drug treatment are significantly higher in Scotland than in England. In part the successes around this in England are due to a longer-



standing focus on substitute prescribing as a cornerstone of drug strategy. This is not without its costs and problems. However research from Scotland last year clearly demonstrates that methadone cuts the number of heroin use incidents and so cuts the risk of infection. It is clear that substitute prescribing is an invaluable part of our drug treatment options – and must remain so. It helps people become stable, it helps people get their lives back together and it helps people recover. Most importantly, in the context of the current public health risk in Scotland it brings people into services, it enables them to access healthcare and it swiftly and safely reduces the risk, well, of dying.

Treatment for anthrax can be successful – people can make a full recovery – if it's caught early enough. Ideally in Scotland now we do need people to stop using street heroin – and we also need to be realistic about how this is going to happen. We need those that continue to take this risk to be aware – fully aware and informed – about the danger signs. We need drug users to be confident in accessing healthcare if they think they're in danger.

A straightforward co-ordinated approach between drug services and public health can achieve much in terms of making sure the right messages get out to the right people. It seems the cascade of information to people in treatment has been reasonably effective. But what about those who aren't? Although data is a bit ropey, a generous estimate would suggest that around 60 per cent of the people who need to get this information will not receive it directly. It will come to them by word of mouth, on the internet, or through the newspapers. If at all.

Most importantly, people need rapid access to substitute prescribing. This has the advantage of not just stopping people using street heroin, but cutting dead in its tracks what must be a very lively street market at the moment. It would bring vulnerable people into treatment – some maybe for the first time – and hopefully, hold them there until a slot is available in a specialist service. Having made no comment on this for the first month of the Anthrax crisis, finally on 20 January the Scottish Government suggested:

'In areas where there are waiting lists for access to drug treatment and in particular substitute medication contingency measures may be required to ensure that all those who wish to stop using heroin, in order to avoid being infected with anthrax, have the means to do so.'

Good advice and necessary, but does it go far enough? And what took them so long?

One Scottish commentator suggested that maybe the reason for this lack of real interventions was the increasing emphasis on recovery and abstinence in Scottish drug policy:

'I wonder if this terrible anthrax chapter could be the Banquo's ghost of recovery? There is an increasing recovery discourse that is being shaped by story telling and soft-focused personal recovery narratives. This new discourse does not sit well next to impersonal epidemiological modelling… health protection and drug policy people seem to operate on different planets.'

So here we are, it's 9am on a Thursday morning and you're a heroin user waking up in Scotland. It's cold and you need a hit. You can get yourself down to the community addictions team but you know you're going to be facing a significant wait until you finally get a script. Even at the most optimistic, if you're using twice a day and waiting two months that's a potential 120 chances between now and getting treatment that you could become infected with anthrax. You can try and buy some methadone or some buprenorphine on the burgeoning black market for substitute drugs. You can get together with some mates and see if you can get a car drive down into England and buy in bulk down there. Or you can go out, take a chance and buy street gear. And you can hope that this isn't going to be your time.

Let's be realistic — this is a small number of deaths. It's not infectious. It probably relates to one batch of heroin. Sooner or later it will run out or be tracked down and destroyed. It may be sad, and there may be more we can do, but its not huge – yet – is it?

Well maybe all that is true, and maybe anthrax is not the issue. But what about the 1,000 new cases of hepatitis C in IDUs that are predicted in Scotland this year? Does our reaction to the anthrax crisis not reveal something quite troubling about our ability – and inclination – to respond to public and individual health crises related to injecting drug use?

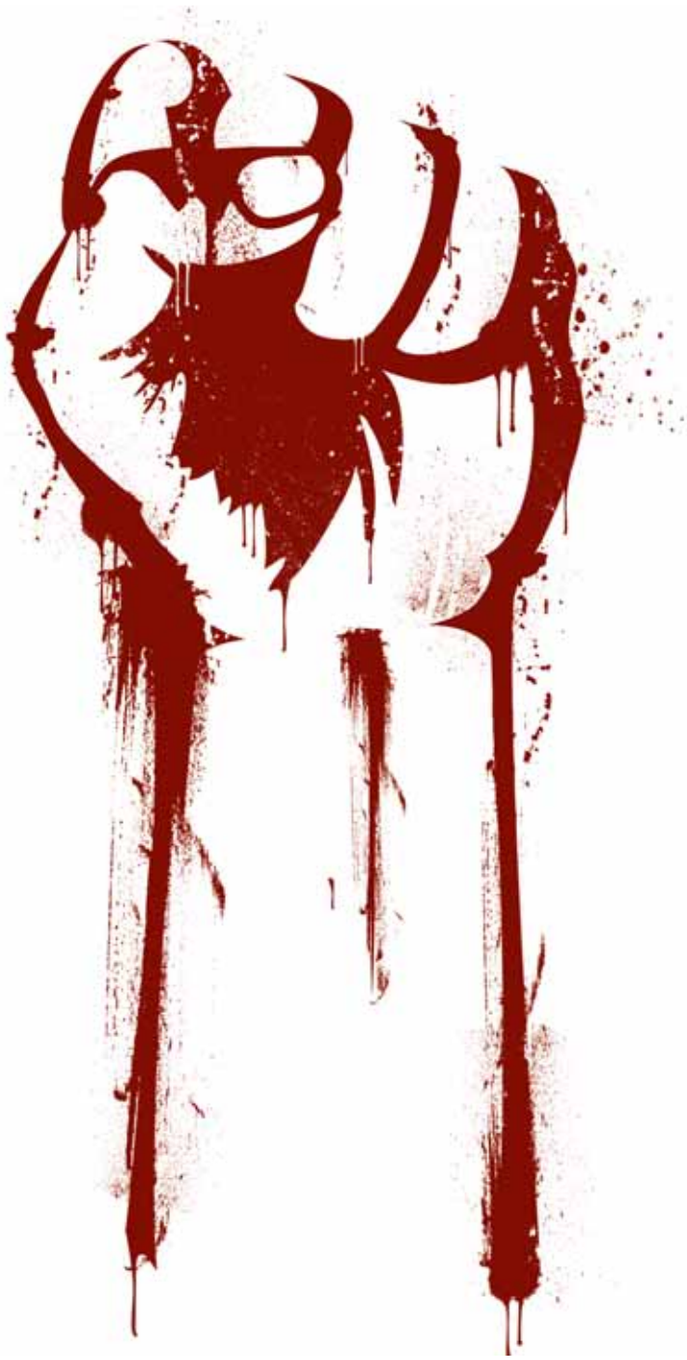
However much we may want to recast our drug policies as being about recovery or abstinence, however uncomfortable we may be with needle exchange and substitute prescribing, we need to be realistic. If we don't develop our drug interventions within a framework of harm reduction – dealing with the public and personal health issues related to drug use as they are, not as we wish they were – people will die. Harm reduction and recovery are not mutually exclusive. They can and do exist side by side. But no amount of recovery coaching, marching or witnessing, will, in the end deal with an issue like anthrax. For that we need harm reduction – and the courage and vision to implement life-saving policies.

*Sara McGrail is a freelance drug policy specialist. Her website is at www.saramcgrail.co.uk*

*The Scottish Drugs Forum have updated their website with new advice: visit www.sdf.org.uk*

# HIGH STAKES

**Scotland's recent anthrax outbreak from contaminated heroin has raised urgent questions about forfeiting essential public health measures, says** Sara McGrail



# FIGHT THE POWER

Rather than cosying up to political parties, those in the treatment field should be using the coming election as a vital opportunity to put candidates on the spot and demand some answers, says **Andy Stonard**

**OVER THE LAST THREE MONTHS** I have listened to, or heard about, numerous discussions and initiatives on the theme of who to cosy up to and brief in both main political parties for the forthcoming general election. It's not until the eve of an election campaign that you become aware that our field is littered with so many expert political analysts, or how brazen some individuals are in their willingness to ditch their beliefs – and those of their organisation – in case the other side wins.

Why has it come to this? I'd like you to consider the election from a different perspective, and think about what you could do rather than just vote or not. In the UK there are supposed to be some 2m people who attend AA and NA each year. There are, according to government estimates, 750,000 drug users who are in, have been in, or need, treatment. Most of those 2.75m people have families and partners who are affected by their problems. On top of that there are many millions who are told they are drinking hazardously or using drugs – up and down the classification list – that may be a problem. That adds up to an awful lot of people.

From my perspective alcohol and drugs are among the greatest blights affecting every corner of the UK – our homes, our streets, our neighbours. Yet despite all the rhetoric from our politicians and those who represent them through the civil service and national organisations, the problems just increase – alcohol and drug related ill health and crime, estates that become no go areas, alcohol related disorder, our social care systems, family breakdown, accidents and absenteeism at work, the risk to young people. It affects everyone.

So, are the Tories going to spend more than the current government? What is Labour going to do next? Are there any bright ideas from the Liberal Democrats and the others? Whose sound bite is going to sound the sternest, the toughest, or the most compassionate?

Who is going to put the politicians under pressure about drugs and alcohol? What a lobby the 2.75m people mentioned above would make, together with their families and friends, if they asked the following of their potential political candidates:

1. *Please give me your detailed analysis of the alcohol and drug situation in the UK.*
2. *Please send me your detailed strategy and commitment to how to tackle this over the next five years.*
3. *Please tell me what your spending commitment is going to be on alcohol and drugs.*
4. *What laws and statutes do you intend to present to Parliament in relation to alcohol and drugs?*
5. *And please do not flannel – we just want answers to the above, and our votes will depend on them.*

AA and NA are the most successful and impressive self-help groups in the world and changes to how alcohol and drugs are managed hold the key to the major issues of law and order, health and social care. If any party's major plank is going to be based on a minimum price per unit of alcohol, what does that mean to someone on a low income or someone who already has a significant problem? It means more spent on alcohol for the same quantity and less on food or the kids in my analysis. And how does that affect drug markets, especially for young people? My guess is that most of your candidates will not even have thought about that.

Is every DAT (or DAAT) gearing up with their stakeholders and user groups to book a large venue for their local candidates to present themselves and meet with their potential voters? There is a section in the annual plan for each DAT about effective partnerships. Organising high level consultancy days with political candidates – not just an hour or two but a whole day to properly look at the local issues – would tick that box for me and leave most of you in no doubt who to vote for.

We in the field may not agree on everything but we add up to a major potential political lobby. Whether we choose to use that power is down to all of us. But, in the middle of the next Parliament, if things aren't going well, just remind yourself what your contribution was during the election.

*Andy Stonard is an independent consultant and former chief executive of Rugby House*

## Statistical manipulations?

My heart goes out to Chris Ford in her perplexity at the situation of good specialist drug and alcohol services, effective at street level and run by caring and dedicated staff, suddenly closing down through lack of support and funding (*DDN*, 30 November, page 9).

Since my own service lost its funding in April 2009, for reasons which we have never been able to ascertain with certainty, I have taken more than a passing interest in the issue of treatment in its broadest sense, and where the funding supposedly to carry it out, goes. I have found that, in common with so many areas concerning the public pound, there is a mismatch between the reality on the street and the rhetoric of government and its agents in the treatment arena.

If I was contemplating further study, a research project entitled 'Where has all the money gone?' would reveal this brutal fact; that a very low proportion indeed actually filters down to street level. After all, the NTA for instance spends over £40m per annum and not one single penny is used to treat a single addict. I would urge your readers to get themselves a copy of November/December's *Addiction Today*, turn to pages 17 and 19 and be enlightened on the statistical manipulations of that useless quango or read their latest report on recovery (if you can penetrate the jargon), and weep.

Target-driven politicians are not the ideal drivers of drugs policy or conduits for its financing. Our clients deserve properly thought-out, properly financed long-term solutions delivered by a stable addictions/care sector workforce.

**Andy Holt, Papa Stour Project, Shetland**

## Obscuring the issue

Observers agree that the effective result of addiction treatment is recovery of the natural abstinence into which 99 per cent of our population is born. Yet conversely the main goal of the NTA is not a recovery outcome, but to increase of the number of problem drug users 'in effective treatment'. This is triumphantly claimed as 'achieved' in their invitation for tenders to redesign their website. However, nowhere is there mention of anybody leaving 'effective treatment' to rejoin society in a recovered condition.

NTA accurately claims 'we do not provide drug treatment ourselves, but work in partnership with national, regional and local agencies to ensure that effective evidence-based drug treatment is quickly available for all who need it'.

Nowhere do they identify or recommend organisations which regularly enable addicts to recover themselves from their addiction. Instead of supporting those operations which facilitate the attainment of long-term abstinence, the NTA dwells on what they call 'balanced treatment' and describe 'the basics' for their website as 'news about conferences, media releases, contact details and work programmes', plus 'a basic job of hosting news and publications in an electronic library' and the hosting of 'new communication tools.... including e-newsletters and ezines, podcasts and videos, discussion forums, blogs and social marketing techniques'.

In other words, the NTA's 'basic' communication requirements are those of any PR and lobbying organisation. Which is not their job. Their job is to get our society out of its drug-ridden stupor and they are just not doing it, which is why their website now needs re-jigging to obscure what they are not achieving.

But don't blame Paul Hayes. He wasn't there when they set up NTA targets.

**Kenneth Eckersley, CEO, addiction recovery training services**

**We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3.**

# Recipes for recovery

## EAT, SLEEP, RECOVER

**Understanding the relationship between food and sleep can be an important defence against relapse, says** Helen Sandwell

Adequate, quality sleep is hugely important for all of us, for maintaining good physical and mental health, yet most of us aren't getting enough of it. A poll in 2008 by the US National Sleep Foundation showed that 65 per cent of working adults experienced sleep problems at least a few nights a week and 44 per cent reported this occurring every night or almost every night.

Sleep problems among substance misusers are common, as highlighted in a recent study, but whether they are a cause or effect of substance misuse is not always clear. What is known is that sleep problems can be severe and persistent enough to reverse the success of drug and alcohol abstinence. One study has found that sleep disturbance is a statistically significant predictor of relapse, even when other factors such as depression and severity of dependence are controlled for. It is known that sleep disturbances associated with substance misuse can persist for quite some time after abstinence. For example, the sleep fragmentation and REM sleep disruption associated with alcohol misuse can persist for up to three years during abstinence, increasing the risk of related relapse over this period.

With this knowledge, it really does seem important that sleep management sits high up on the agenda of drug treatment and that client groups are encouraged to make the necessary lifestyle changes that support adequate uninterrupted sleep.

Unfortunately, relatively little research has been done on the effects of diet on sleep. However, there are some dietary factors that are known to contribute to poor sleep and these need to be given careful consideration by those working in drug treatment settings. Caffeine is probably the substance most studied and is well known to be a stimulant and disruptor of sleep. Yet copious amounts of caffeine are often still consumed by people abstaining from drugs and alcohol, and still relatively little positive action is taken by some treatment providers to discourage it.

Another major factor known to cause sleep disruption is sleep apnoea, which is often but not always associated with obesity. Why this should be a concern for those involved in drug treatment is because of the rapid and excessive weight gain often experienced by some individuals upon cessation of drug use, particularly if they are in settings where all their meals are prepared for them, such as prison and residential treatment.

Sleep apnoea is a breathing disorder characterised by brief interruptions of breathing during sleep, which is associated with increased fatigue and irritability, depressed mood, impaired concentration and a decreased interest in daily activities – not great for improving mental health or maintaining drug abstinence. Nor is apnoea good for physical health because the altered breathing results in abnormally low levels of oxygen in the blood, which are associated with increased blood pressure and heart rate. Sleep disruption is also associated with increased risk of type 2 diabetes.

Exercise is also known to promote good sleep and of course helps maintain a healthy weight and reduces blood pressure and risk of type 2 diabetes. A healthy balanced diet, plenty of exercise and a good night's sleep: it's what our bodies evolved to have and it's no wonder that in terms of both mental and physical wellbeing the three are proving to be inextricably linked.

*Helen Sandwell is a freelance nutritionist (her website is at www.goodfoodandhealth.co.uk), author of the DDN nutrition toolkit (email charlotte@cjwellings.com for details) and will be giving a nutrition workshop at the DDN/Alliance service user involvement conference on 4 February in Birmingham (visit www.drinkanddrugsnews.com for details and booking form).*

*Helen's next DDN nutrition workshop in on 24 February in London. See pages 17 and 18 for details.*


**The NTA's head of delivery (north), Mark Gillyon, tells** David Gilliver **about the thinking behind its new Commissioning for recovery guide**

# Personal services

**What was the impetus to publish the guide?**

We recognised that treatment systems over the past nine years have developed quite significantly and have mainly concentrated on improving the capacity and accessibility of treatment – getting more people in and more quickly. One of the things we wanted to do was help drugs partnerships re-focus on ensuring people get what they need while they're in treatment and are able to recover and reintegrate. A lot of guidance and information has been published but it wasn't really pulled together in any cohesive way that pointed partnerships towards a recovery-focused system. This provides partnerships and their commissioning staff with the standards we would expect them to meet, and commissioning competencies checklists so they can check themselves against what we'd expect in terms of best practice to support recovery.

**Recovery can be a controversial word – the guide describes it as clients achieving their goals for making positive changes, including work, housing, family relationships.**

The drug strategy set an overall direction in terms of seeing the point of treatment as helping people to overcome their drug – or drugs – of dependency, but it's about pulling in the additional things we want partnerships to do. We want them to have a vision about what treatment in their area should look like and be clear about their ambition and the range of options to help people reintegrate and exit the system effectively – whether through community options, abstinence services, residential rehabilitation.

**How important are mutual aid groups?**

Building the links between formal treatment systems and mutual aid is really important and some partnerships have done it really well. It's important to say that for some partnerships this is mostly about what they're already doing, but some haven't done it at all.

**So this is about helping them get up to that level?**

Yes, and one of the areas where there's variation is access to mutual aid. We would hope that every drug user within the treatment system will be offered at least the opportunity to access mutual aid groups to build on the benefits they're making while in treatment and receive ongoing peer support to sustain those benefits.

**In terms of reintegration, have you had much feedback on how it's working out with the Jobcentre Plus coordinators?**

It's working really well in most areas. We've set up clear pathways between Jobcentre Plus and treatment services in every area, and the NTA regional teams are working very closely to make sure those pathways work. A lot of activity has been about making sure individuals who might have a treatment need are identified and steered to the relevant services. One of the next stages is to help drug users in the treatment system get job-ready, with the skills and experience they need to re-enter – or enter – the job market, and to look for employment opportunities for drug users who are ready to move on. To sustain the benefits from treatment they're going to need somewhere stable to live, a job, good relationships with their family.

**Are you happy with the level of family and relationship counselling services in place now, or could that be built on?**

It could be built on. There are some partnerships that have prioritised this over the past few years and others that are still working on it, but it's something we would expect all partnerships to be looking at and prioritising. The family has the potential to be a significant source of support and provide more stability than an individual can get from their drug service, because they're there all the time.

**The guide says it's important for partnerships to have ambitious but realistic goals. Do you think with some of aspects of the recovery movement it's in danger of going beyond that? There's been talk about giving people unrealistic expectations.**

I think we need to be clear about meeting the ambitions that service users have – to make sure we're not pushing people too fast or in a direction they don't want to go. We also need to be clear about how realistic we are, within being ambitious – some people will still potentially need a long time in the system and we're not saying everybody has to recover and reintegrate within a certain period of time. It's about the right treatment and the right amount of time, being ambitious within what the service user wants and feels able to achieve and encouraging service users to have that ambition for themselves.

**It talks about abstinence for those who can achieve it. There's been – not least in our letters pages – controversy about 'recovery'. What would you say to people who maintain it's become a vague and woolly term or that it's been hijacked by abstinence hardliners who won't acknowledge the benefit of any other approach?**

The business we're in is helping people get better, and for different people that will mean different things. Having a hardline approach one way or another isn't going to help any of those individuals get better. For some people getting better will be about stabilising their drug dependency while they get other things sorted, while others might be able to enter abstinence-focused services at a very early stage. It's about making sure we have a personalised approach where people can get the right treatment at the right time, based on their individual needs, rather than trying to slot them into a rigid system.

*Available at www.nta.nhs.uk*

David Finney **simplifies the new rules on registration for treatment providers**

# Deal or No Deal?


**THE WORLD OF REGISTRATION IS ABOUT TO CHANGE** for many treatment providers in the coming months. If you are a provider here is a brief guide to what may be in your box, to help you work out if you are affected or not. The Health and Social Care Act 2008 set up the Care Quality Commission (CQC) which will register an increasing range of health and social care services. In their publicity CQC point out that 'it is a serious offence to carry out a regulated activity without being registered', so as this carries the force of law it has to be taken seriously.

The five big changes about to happen in the substance misuse sector are:

- All existing residential services will have to re-register. This will involve an application form, but no additional cost.
- Services that may be described as 'quasi residential', or combine accommodation with treatment will have to register for the first time.
- Community services which provide treatment and have a health or social work professional in their team have to register for the first time.
- Inpatient services in NHS hospitals will be registered as part of the registration of NHS Trusts.
- Prison drug rehabilitation services are included.

The overall aim of statutory registration is to provide protection for people who are vulnerable and to establish essential standards of quality and safety, across the board in health and social care settings.

Additionally many commissioners of services now insist on purchasing only services which are registered, and as the CQC reviews the performance of NHS trusts and local authorities it holds them accountable for the status and quality of the services they purchase.

So what does all this registration look like? And when is it all going to happen? Under section 20 of the Health and Social Care Act 2008 there are:

- Registration regulations – which tell you how to register
- Regulated activities regulations – which define what activities should be registered
- 'Essential standards of quality and safety' – which tell you what standards are expected to provide safe services
- The 'Judgment Framework' which tells you how CQC will come to a decision about whether or not to accept an application for registration.

The timetable for implementation is – from April to October 2010 applications for registration can be submitted to CQC, with 1 October 2010 being the date on which registration will become effective. From the information on the CQC website it appears that this timetable applies to all eligible providers, whether they have an existing registration or are new to registration.

It may be useful to specifically highlight issues that impact on the substance misuse sector:

**1.** For residential and quasi-residential services there is a new regulated activity called 'accommodation and treatment together for people recovering from substance misuse'.

This means that if accommodation is on a separate site from the treatment but is contractually linked to the treatment provision then it should be registered. As I understand the situation, services which are purely Tier 3 day services do not yet come into the scope of registration, although it is something which the Department of Health are actively considering for the future.

There is also a new 'service type' called a 'residential substance misuse treatment/rehabilitation service'.

Interestingly this can include treatment for withdrawal from drugs or detoxification from alcohol and can employ a broad range of health and social care professionals. This service type is distinct from care homes or care homes with nursing and, importantly, the same standards for room sizes and physical accommodation do not apply. This will allow more flexibility for services to configure themselves appropriately to meet the needs of their client group.

**2.** For community services the regulatory requirement takes a little more explaining:

- 'Treatment of disease, disorder or injury' must be under the supervision of a health care professional, or a multi-disciplinary team which includes a health care professional, or a social worker where treatment is for a mental disorder.
- 'Mental disorder' means 'any disorder or disability of the mind, including dependence on alcohol or drugs'.
- 'Treatment'. One aspect is defined as 'the ongoing assessment of a service user's mental or physical state'.

It seems to me that many community prescribing or drug and alcohol treatment services will come under this definition and be required to register for the first time. This could have major implications for up to 700 services throughout England over the coming months.

In essence the standards aim to focus on the individual needs of the service user. My view is that good treatment providers will be able to meet these standards albeit with some rewriting of policies or procedures to encompass the new emphasis. Help will be at hand through masterclasses helping people prepare for registration, through *DDN* workshops, directly through me or from other training providers. I hope you are able to establish whether, for you, registration is 'deal or no deal'!

*A full description of the standards can be downloaded from the CQC website or hard copies can be ordered from their publications department (03000 616161).*

*David Finney was the policy lead for substance misuse services in the Commission for Social Care Inspection and is now an independent consultant and trainer. Further information at www.davidfinney.org.uk*

*David's next DDN workshop, 'Masterclass: registration with care quality commission' is on 23 February in London. For more details of this and other workshops see page 17 and 18.*

# KEEPING IT TOGETHER

**David Gilliver** hears about a Liverpool-based supported housing project providing intensive, round-the-clock support for families affected by substance use

DDN has spoken to countless people over the last few years that have made an impassioned case for more services to meet the needs of the families of drug users. Official policy acknowledges the crucial importance these services can have in determining the effectiveness of treatment, but – although things are undoubtedly improving – the situation on the ground often doesn't match the rhetoric. In Liverpool, however, a supported housing project is taking the concept to its logical extreme and providing accommodation and support for whole families affected by drug or alcohol problems.

It's estimated that there are around 1.5m adults in the UK caring for someone with a drug problem, and the Summergrove project was developed after extensive consultation with both commissioners and service users. 'Traditionally people have worked with children or parents – they don't tend to work with whole families,' says service manager Keri Tozer. 'After a lot of consultation the plan became to create supported accommodation for families. It's completely holistic – it looks not only at parents and children and the dynamics of that relationship, but the dynamic of the extended family as well. When people have been using substances and come out of that chaos, the relationship with their wider family is affected. Often their children are placed with the wider family, so it's about bringing that entire family dynamic back together.'

Opened in 2003, Summergrove is operated by Manchester-based social business the Big Life Centres. Funding comes from Liverpool PCT's integrated commissioning for addiction and offender health and Supporting People and the building – owned by Maritime Housing Association – is divided into 11 two-bedroom self-contained flats with 24-hour cover. The facility employs seven project workers and two night staff, alongside a part-time administrator, holistic therapist and in-house counsellor.

'It's a small team and we work a rolling rota,' says Tozer. 'We make sure there are always two people on hand 24/7 because of child protection issues and, when people's sleeping patterns are so disrupted, it's important there's someone they can come downstairs and have a chat with. There's no sharing of facilities, which means families can have their normal family life but have the support there when they need it. Because there are 11 families, people socialise together so it's also about learning to socialise drug-free. There are lots of activities for people to come together.'

The project offers intensive, coordinated support, with parenting and home management classes alongside a range of therapies and day programmes, and residents are also supported to find voluntary placements. People can self-refer or come via social services, treatment services across Liverpool or local women's prison HMP Styal, and referrals are welcome from single parents or couples. Although people can be using drugs at the point of referral, they must be drug-free on entry. 'They need to provide a negative sample, but when we assess people if we know there are still issues around substance misuse we can make Summergrove a part of their plan,' says Tozer. 'We'll refer them to detox and work with partner agencies to put together a support plan with Summergrove as the end of that road.'

Accommodation is offered on a 12-month assured shorthold tenancy basis and everyone signs a resident's contract on admittance. 'A 12-month tenancy is a big commitment, but change doesn't happen overnight and it gives security to the family,' says Tozer. Summergrove also helps arrange move-on accommodation – within three months of a family moving in, staff are already looking into long-term plans for resettling in the community.

Testament to its success is the fact that the project been almost fully occupied for the last two years – residents aren't rigidly limited to 12 months however. 'We never say "your 12 months are up now, off you go"' she says. 'After 12 months of the client investing their time and us investing our time, why risk that recovery if there are things that haven't fallen into place yet?'

Drug-free for two years, Amanda has been at Summergrove for the past 18 months, after hearing about the project at a local NA meeting. Originally from Cheshire, she ended up in Liverpool via a bail hostel. 'I'd been in recovery before,' she says. 'It lasted six years but I had a massive relapse and was using again for six years. In that time my children had to go and live with my mum and dad. I got in a relationship and had another child but I was still using. I was under social services anyway but it got to the point where my house got raided, the dad got nicked and my son got placed in foster care.'

It was at this point that she discovered she was pregnant again. 'I was at a crossroads,' she says. 'It was either carry on and lose the children or start my recovery. I went from detox to a hostel to have my baby. My partner, the father, was still using. I explained this to someone at the NA meeting and they gave me the number for Summergrove. That was the turning point.'

Desperately worried about her child being put into care, she was convinced that she would be too far down the list to qualify for Summergrove in time. 'I was prioritised to stop my youngest child being taken into foster care,' she says. 'I was asked to come for a viewing of a flat and I moved in with my child. I've accessed everything available to me here, all the different courses and I've taken on the support from the key worker and the whole of the staff. The support is there any time you need it.'

After demonstrating she was consistently drug-free, social services changed the terms of contact to allow her three-year-old son to come to the to the flat, but the situation was still traumatic. 'They allowed me to have contact with him in my flat in Summergrove but obviously it's difficult having your child for a couple of hours and for him to have to go. I was finding it very difficult and so was he. The staff could see this and contacted my social worker on my behalf. My son was so distressed it was taking three people to put him in a car seat. Why should he have to go through that?'

Eventually he was allowed to move in with the family at the facility. 'I had to show I was serious about my recovery for my son to come here,' she says. 'Things just seemed to fall into place and it's gone from strength to strength. The staff have showed their commitment to me and my family because I've demonstrated my commitment to living here.'

Summergrove can take children of any age up to 16 but is best suited to those up to about 14, says Tozer. 'The older ones tend to struggle a bit with the curfew, and there are also issues of not wanting to bring friends back because of the stigma – we're not walking around with name badges on and it's quite an informal

atmosphere but they still have to explain where they're living.'

Being at Summergrove has also meant many children being taken off the child protection register, as well as children being returned to their parents from local authority care or the care of other family members. 'It's about building the family back up,' says Tozer. 'Children's services are happy to place families with us because they get the feedback, they get the negative drug tests – we're overseeing, monitoring parenting skills, putting things in place. The vast majority of children who come here are subject to a child protection plan but, providing the parents are abstinent and working towards a long-term recovery, that will be removed.'

While there's no funding for outreach – something Summergrove would very much like to secure – staff will stay in touch with clients after they've moved on. 'It's a way of lessening the impact of the move after 12 months of living in the project and relationships being built,' she continues. 'Once a week a key worker will go out for a cup of tea and a chat and to make any final adjustments for the support plan, but we also put in place long-term support through partner agencies.'

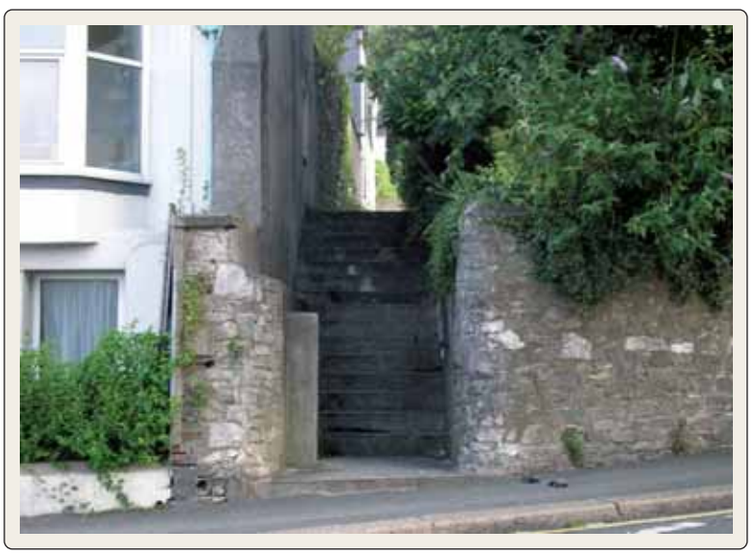
Partnership working is crucial to the project and ensures continuity of care when clients move out. 'We rely on our partner agencies,' she says. 'We're not a treatment centre in that we don't do group work – we have an in-house counsellor and holistic therapist, but the bottom line is about our partner agencies putting in that support. Clients can then take that package of support into the community with them. It's not like rehab, where the treatment stops.'

Tozer believes it's crucial that more places like Summergrove are established across the country, particularly for the growing number of people with alcohol problems. 'More supported accommodation for families is definitely needed, along with longer-term investment,' she says. 'I think there needs to be a single stream of funding for families – we get caught up in funding for adults and funding for children but it needs to be one single stream. At the moment Summergrove's funded for adults so we've had to put in for grants to do work with children – we've been really lucky that Sure Start have funded some of our activities but we're not guaranteed that. If we don't support children who've been through so much with parental substance misuse then we're looking at the next generation of problematic substance misusers.'

Meanwhile Amanda is now mentoring for a local drugs organisation as well as doing voluntary work for the NSPCC. Where would she be if she hadn't come to Summergrove? 'I don't know,' she says. 'But it wouldn't be a good place.'

**'I had to show I was serious about my recovery for my son to come here... Things just seemed to fall into place and it's gone from strength to strength. The staff have showed their commitment to me and my family because I've demonstrated my commitment to living here.'**

# Q: Which of the four settings below do you think may be a public injecting site?



# A: All of them

New research demonstrates the importance of understanding injecting drug use in public settings. **Stephen Parkin**, **Ross Coomber** and **Gary Wallace** look at a controversial issue

**'Public injecting is a "risk multiplier" for... health concerns because of the nature of the sites themselves and of the populations that use them – the most marginal and "disconnected" of the injecting drug user population.'**

To many people, the notion of injecting illicit drugs in public or semi-public settings may seem like behaviour representative of antisocial and chaotic drug use that has spiralled out of control. However, while this may be true for some exceptional cases, findings from a recently completed study at the University of Plymouth suggest that public injecting should not necessarily be regarded in such a stereotypical manner.

Instead, the research proposes that public injecting is more characterised by highly organised and logical responses to conditions that make injecting practice difficult for drug users. The research identified almost 70 different public injecting sites within one square mile of Plymouth city centre and a total of 78 sites when areas beyond the immediate central area were included. Significantly, most of these sites were not necessarily recognised by the general public, drug services or outreach workers as locations used by local drug users for injecting purposes.

This unawareness obviously relates to the fact that injecting normally involves the use of secret or hidden settings in a rushed manner to avoid interruption or detection by non-drug users, especially the police. As such the world of public injectors typically remains clandestine and deliberately unknown to those not directly involved in the activity. So important is the issue of concealment to public injecting that it is highly probable that anyone reading this article may pass at least one such setting on a regular basis as they travel to and from their place of work, without being aware that injecting drug use occurs there on a frequent basis.

Bloodborne viruses like hepatitis and HIV, wound sepsis and death by overdose continue to be real and significant risks to injecting drug users, and the NTA has re-emphasised the need to deliver good harm reduction services to minimise these and other drug-related hazards. Public injecting, however, is a 'risk multiplier' for all of these health concerns because of the nature of the sites themselves and of the populations that use them – the most marginal and 'disconnected' of the injecting drug user population.

The research also identified several issues that counteracted local harm reduction interventions and had the effect of increasing opportunities for risk taking among injectors when using drugs in hidden, public places. Environmental and political factors meant that local drug users simply could not apply fundamental harm reduction advice when injecting drugs in public settings.

Plymouth DAAT and the University of Plymouth decided to research the issue of public injecting in 2006, in order to inform strategic responses to an issue about which very little was known. In addition, concerns had been raised prior to the study from the local council, police and DAAT members regarding issues like drug-related litter and fatalities in public and community settings. The study therefore aimed not only to identify the extent of public injecting throughout the city and map the variation in settings, but also to identify appropriate means of managing and responding to this particular public health concern.

The research concluded in the summer of 2009 and identified a wide range of settings throughout the city used for public injecting. These included public toilets, bus and train stations, car parks, parkland, derelict buildings, alleyways, doorways and even rooftops – all of which contained their own particular environmental characteristic that served to increase injecting hazards and/or diminish harm reduction advice provided by local drug workers. The research was greatly helped by 31 local injecting drug users who were interviewed about their experiences of public injecting – with their help the researchers identified a wide range of place-based harms that ranged from minor, such as plastic burns resulting from using swabs as 'lighters', to major hazards like fatal and non-fatal overdoses.

Overall, the research has greatly informed Plymouth DAAT and its strategic response to local drug policy, service delivery and needs assessment with regard to public injecting. The study identified various difficulties relating to the way in which needles and syringes may be accessed and/or distributed as well as the shortcomings of local policies that made the legal ownership and possession of unused injecting paraphernalia difficult for injecting drug users, and it provided recommendations regarding more appropriate public health responses to drug-related litter in particular settings.

The study identified a range of settings that may increase the opportunity for drug-related harm, including bloodborne virus transmission and death, as well as particular 'at-risk' populations who may benefit from hepatitis A and B vaccination. Other benefits included identifying what factors increased the risk of harassment or arrest and information on the influence of policing and displacement practices and local hostel and housing policies on risky behaviour, as well as suggestions on more appropriate placement of needle bins in city centre locations.

In describing injecting environments and practices, commissioners and services were able to identify opportunities where harm reduction services could be both targeted to, and disseminated through, 'low-level drug seller' networks and peer using groups as a further means of reaching out to equally hidden and at-risk populations that may not necessarily frequent outdoor, public injecting sites.

The research and its recommendations have enabled Plymouth DAAT to better target services and develop policies that are likely to mitigate rather than increase risk, reduce waste – both in terms of discarded 'clean' equipment and services that are not needed or inappropriately sited – and develop partnerships and practices designed to reduce deaths associated with public injecting.

Following this localised project, the team has taken the decision to extend the study to other areas of the UK as commissioned research. The aim is to provide DAATs in other parts of the country with an awareness of public injecting and recommendations regarding appropriate responses – whether in rural, urban or suburban environments.

The service aims to provide commissioners with a snapshot of public injecting within a given DAAT area, conducted within a relatively short time frame – such as two to three months – and provide service-relevant data on the range and variation of public injecting sites via multi-agency and local drug user participation, as well as details on drug-related litter and other visual data.

For these reasons, the project has been named the Public Injecting Rapid Appraisal Service (PIRAS) and details of availability and cost are available from Dr Ross Coomber, director, Drug and Alcohol Research Unit, School of Applied Psychosocial Science, Faculty of Health, University of Plymouth, Drake Circus, Plymouth PL4 8AA or ross.coomber@plymouth.ac.uk

*Dr Stephen Parkin is a research fellow and Dr Ross Coomber is director at the drug and alcohol research unit, University of Plymouth. Gary Wallace is manager of Plymouth Drug and Alcohol Action Team.*
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NHS
National Treatment Agency
for Substance Misuse

# COMMISSIONING FOR RECOVERY

*"Most users want to become free of their drug dependency"*

***"Reintegration options will be an integral part of care planning"***

*"Improved local systems of support are critical to progress"*

***"Partnerships may wish to build links to mutual aid groups into all local systems"***

*"Local treatment systems seek to maximise the numbers who overcome addictions and sustain long-term recovery"*

**Download the full document at**
**www.nta.nhs.uk/commissioningforrecovery.pdf**

EFFECTIVE TREATMENT
CHANGING LIVES

DDN Drink and Drugs News

fdap

# DDN/FDAP WORKSHOPS

## We are pleased to offer the following workshops in 2010

**23 February**
### Masterclass – registration with Care Quality Commission
All currently registered services will need to re-register with CQC between April and September 2010. Quasi-residential and community services will also need to register. David Finney, author of the national guidance for inspectors of residential services, will show you how to meet the new compliance criteria. *Cost: £135 + vat*

**24 February**
### Healthy eating for a better life
Helen Sandwell, nutritionist, DDN columnist and author of the DDN nutrition toolkit offers advice and guidance on healthy eating for clients with drug and alcohol problems. Attendees of this workshop will receive a free download of DDN's nutrition toolkit, *Healthy eating for a better life*. *Cost: £115 + vat*

**3 March**
### Legal highs and other new developments in drug use
This workshop will look at some of the latest developments in the use of pychoactive chemicals. It will cover information on mephedrone (4-mmc, miaow, m-cat), methylone, butylone, synthetic cannabinoids (Spice) and many others. Find out about tomorrow's drug use – today! The course is run by Ren Masetti, training co-ordinator for the Drug and Alcohol Action Team in Suffolk and freelance trainer. *Cost: £115 + vat*

**18 March**
### What is clinical supervision?
Good performance management and clinical supervision are key elements of providing safe, efficient and effective services to clients. Where staff are not supervised and their practice monitored there is a risk of danger to the client, the organisation and to themselves. This one-day workshop explores best practice in clinical supervision and how to achieve this in your organisation. Run by Fiona Hackland. *Cost: £135 + vat*

**19 March**
### What is management supervision?
Line managers are often expected to cope with everything and are not always given the support to provide staff with the resources they need. This course will help managers look at different elements of their role and identify how best they can ensure they offer appropriate, timely and effective supervision, so staff can develop their skills through reflective practice. Run by Tim Morrison. *Cost: £135 + vat*

***15% discount to FDAP members.***

**All courses run from 10.00 am – 4pm in central London, and include lunch and refreshments.**

**For more details about these workshops email ian@cjwellings.com or telephone 020 7463 2081. 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.*

# STAKEHOLDER AND USER CONSULTATION

Adfam, the Alliance, Drugscope and EATA have received funding from the Department of Health to form a Drug Sector Partnership. For the first year of the project, the Alliance's specific contribution to the partnership is to consult on and put forward a proposed set of values, expectations and responsibilities for working with users on the personalisation agenda.

The Alliance will be holding a series of consultation events across England to do this. There will be two half-day events in each region which will be held on the same day. The morning event is open to non-service user stakeholders in drug treatment and the afternoon event is for service users only.

**These events will be free to attend but places are limited. If you want to attend please email Daren Garratt at daren@m-alliance.org.uk to book a place.**

*Stakeholder consultations will run from 10.30am to 1pm and service user consultations will run from 2pm to 4.30pm on the following dates:*

| | |
|---|---|
| **5 Feb 2010** | **BIRMINGHAM**<br>Smallbrook Suite, Holiday Inn, Smallbrook, Queensway, Birmingham B5 4EW |
| **8 Feb 2010** | **NOTTINGHAM**<br>NVAC, 7 Mansfield Road, Nottingham NG1 3FB |
| **10 Feb 2010** | **CAMBRIDGE**<br>Express by Holiday Inn, 15-17 Coldhams Park, Norman Way, Cambridge CB1 3LH |
| **15 Feb 2010** | **LONDON**<br>Room 6, NCVO, Regent's Wharf, 8 All Saint Street, London N1 9RL |
| **16 Feb 2010** | **GUILDFORD**<br>Guildford YMCA, Lewis Carroll Room, Bridge Street, Guildford GU1 4SB |
| **22 Feb 2010** | **TAUNTON**<br>Lyngford House, Sedgemoor Room, Selworthy House, Priorswood, Taunton, Somerset TA2 8HD |
| **24 Feb 2010** | **MANCHESTER**<br>Peterloo Room, The Mechanics Institute, 103 Princess Street, Manchester M1 6DD |
| **25 Feb 2010** | **LEEDS**<br>Express by Holiday Inn, Armouries Drive, Leeds LS10 1LE |
| **26 Feb 2010** | **NEWCASTLE**<br>Jury's Inn, Scotswood Road, Newcastle NE1 4AD |

Adfam DrugScope EATA The Alliance

The drug sector PARTNERSHIP

NHS Bedfordshire

Bedfordshire PCT was established in October 2006. We are now known as NHS Bedfordshire, which more fully reflects what we do and our role as the leader of the NHS in Bedfordshire. NHS Bedfordshire is responsible for the health of all people living in Bedfordshire, serving a population of 420,000.

A number of opportunities have opened up within the substance misuse team in HMP Bedford, working with external substance misuse providers, and contributing to the introduction of the Integrated Drugs Treatment Service (IDTS) throughout the prison.

## Staff Nurse Substance Misuse

**Base: HMP Bedford**

**Band: 6 £24,831 - £33,436 plus environment allowance of £1,452 per annum**

**Full-time: 37.5 hours**

**Ref: 642-BED01621-BCHS-RC**

An exciting and interesting opportunity has arisen for an experienced nurse to join the multi disciplinary substance misuse team, working alongside external substance misuse providers. This is a unique opportunity to be part of the Integrated Drug Treatment Service to prisoners of HMP Bedford.

We are looking for a highly motivated and skilled Band 6 nurse to lead a small team, providing high quality services to prisoners with a substance misuse problem.

You will be qualified as an RMN or RGN and have substantial experience of working in the substance misuse treatment or prison healthcare field.

If you feel you have the energy and enthusiasm to meet this challenge and can contribute to developing a high performing team then we would like to hear from you.

## Substance Misuse Nurses

**Base: HMP Bedford**

**Band: 5 £20,710 - £26,839 plus environment allowance of £1,452 per annum**

**Full-time: 37.5 hours**

**Ref: 642-BED01623-BCHS-RC**

This is an exciting and interesting opportunity for experienced nurses to work within the substance misuse team within HMP Bedford.

You will work within the substance misuse team, working with external substance misuse providers, and be part of the Integrated Drugs Treatment Service (IDTS) throughout the prison.

The posts offer the ideal mix of professional challenge, peer support, career development and quality of life.

The ideal candidates will be qualified as either a RMN or RGN and have relevant Band 5 experience in healthcare, preferably in secure environments, prison health care or substance misuse.

You will be enthusiastic and motivated to develop both the service and yourself.

If you can contribute to our developing team and want to play a key part in it, bringing your energy and skills, then this challenge is for you.

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Informal visits are encouraged. For further information, please contact: Dr Lux Parmilelagan, Substance Misuse Doctor on 01234 373139 email: Dr.Parimelalagan@bedfordshire.nhs.uk or Jackie Edwards, Clinical Services Manager on 01234 373139 email: jackie.edwards@hmps.gsi.gov.uk

**Closing date: 14th February 2010.**

**To apply on-line please visit our website at www.bedfordshire.nhs.uk or for an application pack please contact our Employment Services Team on 01525 636965 quoting the vacancy number.**

Further benefits include: NHS Pension and Life Assurance, training and development, childcare concessions and flexible working practices.

*NHS Bedfordshire is committed to safeguarding and promoting the welfare of children, young people and vulnerable adults, and expects all staff to undertake this commitment. Applicants will be subject to robust safer recruitment processes.*

*NHS Bedfordshire will apply for a Criminal Records Disclosure from the CRB before the post may be taken up.*

*We actively promote equal opportunities and positively encourage applications from suitably qualified and eligible people regardless of sex, race, religion, sexual orientation or disability. All full-time posts are open to job-share.*

**Visit our website at www.bedfordshire.nhs.uk**

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# TRAFFORD COUNCIL

Prosperity, Planning & Development
Community Safety

## 18 – 25 Transition Worker

Band 6, £23,405 - £25,940 • Ref: PPD352

Fixed term until March 2011

**Closing date: 15 February 2010. 5pm.**

**Interviews: w/c 1 March 2010.**

Safer Trafford Partnership

For an application pack, please visit www.trafford.gov.uk or alternatively ring 0161 912 1010. Minicom AD 0161 912 2102 option 6, ext 1264.

We are members of NowPeople – nine councils, one website, countless opportunities, please see the website at www.nowpeople.co.uk

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Coventry Partnership

*Towards a safer, more confident city*

**Coventry Community Safety Partnership**

## Hepatitis C Support Service Invitation to Tender

The Coventry Community Safety Partnership is seeking an organisation to provide services for current or former drug users with Hepatitis C resident within Coventry. The service will provide practical and emotional support to:

- encourage current or former drug users at risk of HCV to access existing testing services
- assist HCV positive clients to access and complete medical treatment
- assist the families of HCV positive clients to cope with diagnosis and treatment
- train staff of treatment agencies around HCV support issues

**The contract will be for two years from June 2010.**

This is a new service and organisations tendering should be aware that TUPE will not apply to this service.

Within the tender, organisations should be able to prove:

- a track record in either supporting drug users and/or supporting individuals with chronic conditions
- a strong background in providing counselling services
- an innovative approach to engaging socially excluded clients

**This is an e-tender and the tender pack is available at**

www.coventry.gov.uk/etendering

**Closing date for tenders: 29 March 2010**

*To receive further details contact Barry Eveleigh via email on barry.eveleigh@coventry.gov.uk or telephone on 024 7683 2094 by no later than 23 March 2010.*

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