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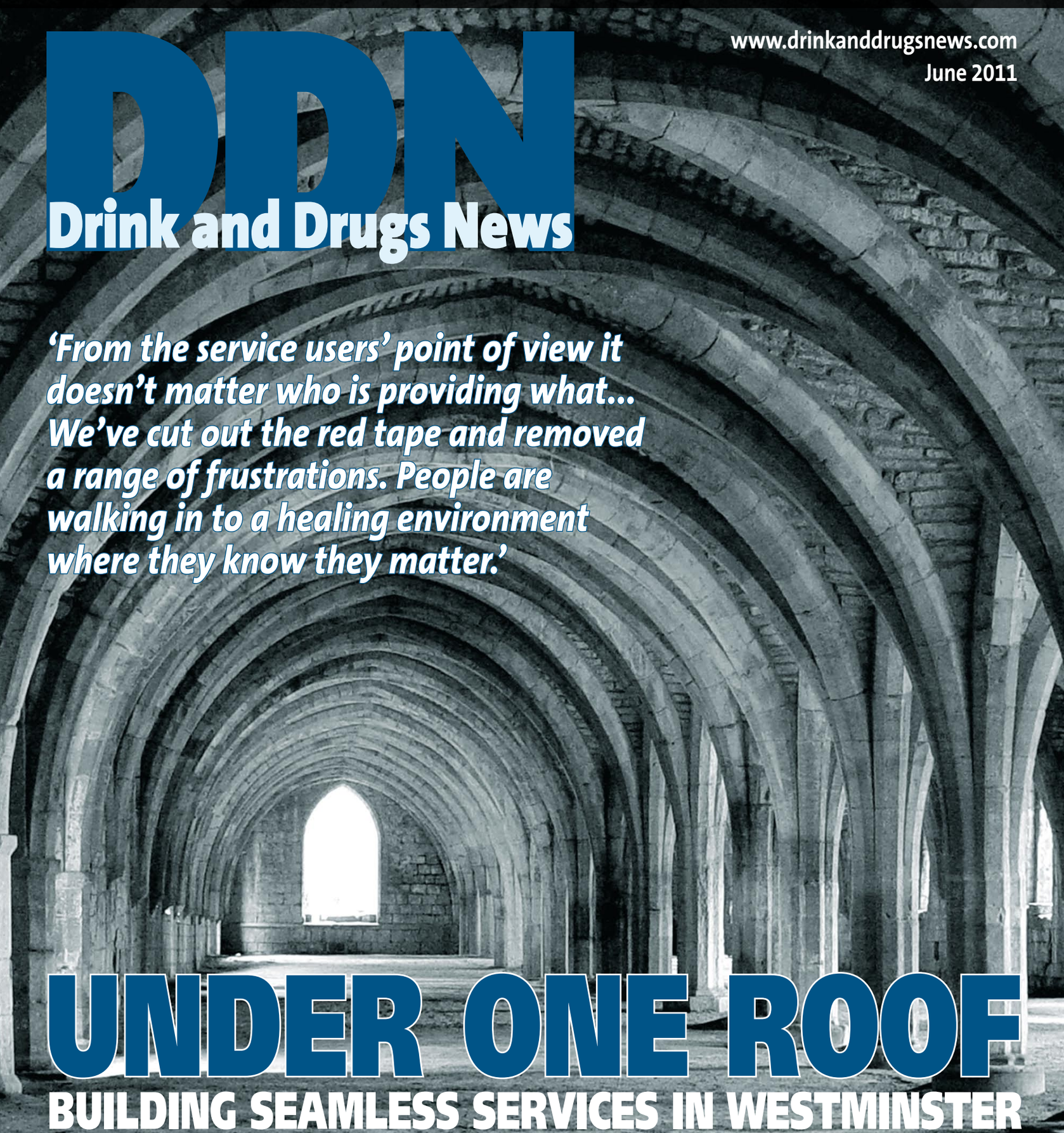
DDN
Drink and Drugs News

www.drinkanddrugsnews.com
June 2011



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UNDER ONE ROOF

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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

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Editorial – Claire Brown

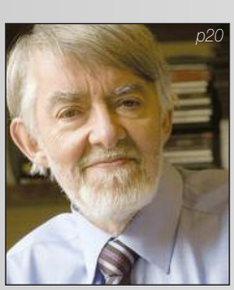
Beyond definition

Recovery can mean whatever it needs to

With recovery sounding more mainstream every minute, GPs began their two-day conference in Harrogate eager to know what it meant (page 10). Audience members offered definitions at many of the sessions, but the resounding message from speakers was that one model definitely didn't suit all and there was no handy generic patient to treat at the surgery. Recovery was a highly subjective concept and delegates agreed at the end of two days, through their consensus statement, that it should provide focus for whatever treatment journey and support each person needed. The important thing was to open up viable treatment options and make it possible for GP practices to liaise effectively with drug and alcohol workers, commissioners, pharmacists, housing workers, social services – as we all know should happen, but rarely does.

With 'joined-up' working for maximum efficiency fully in fashion again, Westminster Drug Project tell us how they galvanised the process with their local partners (page 8); while on page 18 we report from the South East Alcohol Innovation Programme – an effective healthcare partnership in action. Both models ably demonstrate how they are keeping the service user at the heart of the process.

This issue



FEATURES

REGULARS

News in Brief

SAFE SERVICES

Service providers need to take a more preventative approach to protecting children from neglect and harm and identifying families that need support, says a new guide from the NTA. *Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services* makes a range of recommendations on how people seeking treatment should be assessed, along with how – and when – family and children's services should be involved. *Available at www.nta.nhs.uk*

FRANK FALL

Calls to the government's FRANK helpline fell by 22 per cent and web visits by 17 per cent following the coalition government's freeze on 'non-essential marketing expenditure', according to a Department of Health report. The government has now announced it will spend £44m on new public health campaigns in England. *Changing behaviour, improving outcomes available at www.dh.gov.uk*

PREGNANCY PRACTICALITIES

A new practical guide for everyone providing care for women who use drugs or alcohol 'before, during or after their pregnancy' has been published by DrugScope. *The essential guide to problem substance use during pregnancy* is aimed at drug and alcohol workers, nurses, GPs, health visitors, social workers and midwives, and contains best practice, official guidelines and research from the UK and worldwide, along with factsheets and intervention strategies. *More information at www.drugscope.org.uk*

ROUGH PLANS

London's Westminster City Council has announced that it will not go ahead with controversial plans to ban rough sleeping in part of the area around Victoria Station, following a public consultation. The ban was originally proposed because of the number of people drawn to 'soup runs' in the area. The Conservative-run council's cabinet member for society, families and adult services, Daniel Astaire, said he hoped the strength of feeling on both sides of the debate could be 'put towards a solution we can all be satisfied with – providing for rough sleepers in the safest and most effective way possible.'

Ex-presidents call for reform

A report from the Global Commission on Drug Policy has called for 'fundamental reform' of the global drug prohibition regime and a 'major paradigm shift' in worldwide policy.

The commission – made up of the former presidents of Brazil, Columbia, Mexico and Switzerland along with former UN secretary general Kofi Annan, and former US secretary of state George Schultz, among others – wants to see an end to the 'criminalisation, marginalisation and stigmatisation of people who use drugs but who do no harm to others'.

It also calls for the application of human rights and harm reduction principles to drug users and those involved in 'the lower ends of illegal drug markets' such as farmers, couriers and small-scale dealers, and for a range of treatment modalities to be made available including heroin-assisted programmes. It also wants to 'encourage experimentation by governments with models of legal regulation of drugs', especially cannabis, to reduce the role of organised crime. A petition in support of the report – which was launched in New York last week – was handed to the UN secretary general, while other members of the commission include Richard Branson, writers Mario Vargas Llosa and Carlos Fuentes, Greek prime minister George Papandreou and Global Fund executive director Michel Kazatchkine.

'Fifty years after the initiation of the UN Single Convention on Narcotic Drugs, and 40 years after President Nixon launched the US government's global war on drugs, fundamental reforms in national and global drug control policies are urgently needed,' said former Brazilian president, Fernando Henrique Cardoso. 'Let's start by treating drug addiction as a health issue, reducing drug demand through proven educational initiatives and legally regulating rather than criminalising cannabis.'

'We can no longer ignore the extent to which drug-related violence, crime and corruption in Latin America are the results of failed drug war policies,' said Colombian ex-president, César Gaviria. 'Now is the time to break the taboo on discussion of all drug policy options, including alternatives to drug prohibition.' Head of external affairs at Transform, Danny Kushlick, called the report 'a watershed moment that puts legal regulation of drugs into the mainstream political agenda worldwide'.

Meanwhile, Release has launched a new campaign in the UK calling for an overhaul of the country's drug laws. 'The failure of the current system is clear,' says the charity. 'It's time to stop criminalising tens of thousands of people in the UK every year.' Black people are nine times more likely to be stopped and searched and six times more likely to be arrested, Release points out, while criminal records for drug offences act as a barrier to employment, education and travel. As part of *Drugs – time for better laws*, a letter has been sent to the prime minister signed by QCs, former chief constables, and celebrities including Julie Christie, Dame Judi Dench and Mike Leigh.

www.globalcommissionondrugs.org
www.release.org.uk/ decriminalisation-campaign

Family court 'success'

The Family Drug and Alcohol Court (FDAC) pilot scheme is cutting rates of substance misuse and saving money for local authorities, according to an evaluation report from Brunel University.

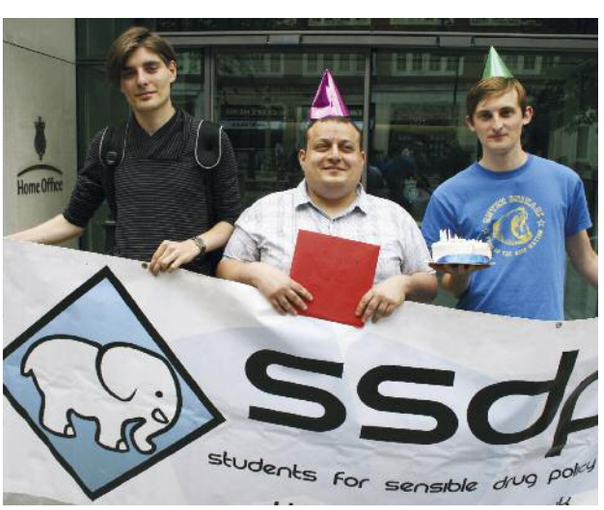
The aim of the pilot project, which runs until next year in London, is to break the 'inter-generational cycle of harm associated with parental substance misuse'.

Parents see the same judges each time they appear, and the pilot also features rapid and coordinated assessment and treatment intervention, two dedicated district judges and 'non-lawyer review hearings in which the judges encourage and motivate parents to turn their lives around'. In ordinary care proceedings there are no dedicated judges, little judicial continuity and assessments can take months. The report found that 36 per cent of fathers had stopped using substances by the time of the final order, compared to none in the comparison group, and 48 per cent of mothers were no longer using, compared to 39 per cent in the comparison group.

FDAC parents accessed services more quickly and were more likely to stay in services than the comparison group, and were almost twice as likely to be reunited with their children, with fewer contested hearings.

Shorter care placements and shorter court hearings meant lower costs, said the evaluation, although the average cost of the FDAC team per family is £8,740 over the lifetime of the case. This is offset by savings 'from more children staying within their families', it states.

www.brunel. ac.uk/research/centres/iccfyr/fdac



UNHAPPY BIRTHDAY? Members of Students for Sensible Drug Policy UK (SSDP) gathered outside the Home Office to mark the 40th birthday of the Misuse of Drugs Act and the publication of the Global Commission on Drug Policy report (see story above). SSDP members serenaded Home Office staff with a rendition of 'Happy Birthday', before a representative came out to accept the card – but decline the cake. 'After 40 years of drug policy that hasn't worked, the government needs to think how it's going to act,' SSDP member Alasdair Sladen (left) told *DDN*. 'If prohibition works now, I'd hate to see what it's like when it doesn't work. We don't have to go down the "legalise everything" route, we just need to have a sensible conversation.'

Use consumer protection legislation to control 'legal highs', government urged

New synthetic drugs could be controlled by trading standards legislation rather than the Misuse of Drugs Act, according to a new report from the UK Drug Policy Commission (UKDPC) and think tank Demos.

The act is becoming 'increasingly unenforceable' as the number of new drugs continues to rise and enforcement agency resources come under more pressure, says *Taking drugs seriously* (see news focus, page 6).

More than 40 psychoactive substances were reported to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol last year, according to a joint report from the two agencies – nearly double the number reported in 2009 and almost three times the number the year before that.

In the UK, more than 600 substances are now controlled by the 40-year-old Misuse of Drugs Act, with the easy accessibility of drugs online meaning that the legislation is 'no longer fit for purpose', says the UKDPC/Demos report.

Using the act to control 'legal highs' could inadvertently increase harms, it says, as it would stop people choosing them over more dangerous drugs. The use of planned temporary bans on new substances (*DDN*, 13 September 2011, page 4) could also mean that more suitable options are overlooked, the organisations warn.

As well as considering use of already available consumer protection legislation to control supply, the document proposes a comprehensive 'harmful substances control act', including alcohol and tobacco, to help create policy more relevant to today's situation and more credible to young people. National lead on drugs for the Association of Chief Police Officers (ACPO), Tim Hollis, said the idea of control by trading standards officers was 'worthy of consideration'.

'Forty years ago, the Misuse of Drugs Act was passed in a world where new drugs came along every few years, not every few weeks,' said UKDPC chief executive Roger Howard. 'The argument about whether to be tough or soft about drugs is increasingly redundant in the era of the internet and global trade – we have to think differently. It might be time to say that those who seek to sell new substances should have to prove their safety, rather than that the government should have to prove otherwise. Controlling new substances through trading standards legislation offers a new vehicle to achieve this.'

Meanwhile, psychiatrists in Scotland have published the first known case series documenting the adverse psychological effects of mephedrone, the legal high banned by the government last year (*DDN*, 26 April 2010, page 4). Seventy per cent of those studied – who had been admitted to either emergency departments or acute mental health services after taking the drug – experienced severe agitation, while 40 per cent developed psychotic symptoms including hallucinations.

'It is clear that mephedrone use can result in both physical and mental harm – similar to that caused by other controlled stimulant drugs,' said consultant psychiatrist at NHS Lothian, Dr Mark Taylor, who led the research, published in *The Psychiatrist* journal. 'The UK Advisory Council on the Misuse of Drugs has been criticised for prematurely recommending that mephedrone be classified as a class B drug, but our data would suggest that mephedrone use can have serious harmful consequences. However, market forces have meant that as soon as one substance is made illegal, similar alternatives are produced.'

Scientists at Angela Ruskin University have also been studying the long-term health risks associated with BZP (Benzylpiperazine), banned in 2009. 'It was found that BZP itself is toxic to the kidney, whilst the starting material, piperazine hexahyrdrate, showed toxicity' in the liver, said Professor Mike Cole. 'The work is important because it begins to provide an explanation of why people who have taken these drugs exhibit the symptoms that they do in A&E rooms.'

Demos/UKDPC report available at www.ukdpc.org.uk
EMCDDA/Europol report available at www.emcdda.europa.eu

Alcohol admissions now over a million

The number of alcohol-related hospital admissions in England has topped 1m for the first time, according to figures from the NHS Information Centre.

There were 1,057,000 alcohol-related admissions in 2009-10, a 12 per cent increase on 2008-09, says *Statistics on alcohol: England, 2011*.

More than 60 per cent of admissions were men, with the report estimating the total cost to the NHS at £2.7bn. There were 6,584 deaths directly related to alcohol in 2009, slightly down on the previous year but representing a 20 per cent increase on the number a decade ago. Alcohol Concern said the figures were 'worrying but not at all surprising' and that the government's 'ongoing failure' to tackle the causes of alcohol misuse meant admissions would continue to rise.

'Local alcohol services are at the forefront of tackling misuse but they are being hit by a double whammy of NHS reform and reductions in budgets,' said chief executive Don Shenker. 'In the meantime we have fig leaf proposals such as the ban on selling alcohol below the cost of alcohol duty and VAT, and a responsibility deal with drinks producers and retailers not worth the paper it is written on – all the evidence shows these policies will have no impact.'

The statistics were 'yet further evidence that the government needs to treat alcohol misuse as seriously as the misuse of illegal drugs', and invest equally in treatment provision, said Turning Point spokesperson John Mallalieu, who called for specialist alcohol staff for all A&E departments.

A report from the Office for National Statistics (ONS), meanwhile, shows that men whose jobs are classed as 'routine' – such as labourers or van drivers – are three-and-a-half times more at risk of dying from alcohol-related disease than men in managerial or professional roles. Women in jobs classed as routine, such as cleaners or machinists, faced a 5.7 times higher risk than women in higher professional jobs. Alcohol-related deaths in 'the less advantaged groups tend to be younger as well as more common', it says, with mortality peaking in middle age.

NHS report available at www.ic.nhs.uk/pubs/alcohol11
ONS report available at www.statistics.gov.uk

News in Brief

TRANSITION TIME

The Department of Health and the Inter-Ministerial Group on Drugs have approved the NTA's work programme for the transition year of 2011-12 – while the new Public Health England service is being set up – the NTA has announced. The NTA will 'play a full part in creating an integrated system of recovery that helps people overcome their dependence for good, increases access to treatment and reduces the harm that addiction causes to our communities' says the agency. *NTA action plan 2011-12 available at www.nta.nhs.uk*

PARENTAL SUPPLY

Three quarters of 15 to 17-year-olds don't like being drunk and more than two thirds feel ashamed of themselves after drinking too much, according to research from Drinkaware. The study found that while peer pressure played a role in teenage drinking, families were the main suppliers of alcohol for 15 to 17-year-olds, with more than 60 per cent of those who had drunk at home in the last week saying they had been given alcohol by their family, and more than one in ten saying they drank at home two or three times a week. 'While we know parents worry about their children's vulnerability, they often don't realise that giving their child alcohol at home could increase their risk of immediate and long-term health harms,' said chief executive Chris Sorek.

LONDON FORUM

The next London User Forum will take place on 29 June at Kensington and Chelsea Town Hall. The free event starts at 12 noon, with all London service users and professionals welcome – service users' travel expenses will be paid.

WELSH WARNING

Better joint working is needed between local older people's services and alcohol treatment services in Wales, according to a new report from Alcohol Concern. Research is also needed into whether unit guidance and screening methods for alcohol misuse are relevant to older people, says *Hidden harm? Alcohol and older people in Wales*. *Available free at www.alcoholconcern.org.uk*

HOW SHOULD WE REGULATE 'LEGAL HIGHS'?

A report from UKDPC and Demos recommends that new synthetic drugs be controlled through trading standards legislation rather than the Misuse of Drugs Act. Could it work? ***DDN*** reports

'Making new substances illegal leaves the trade in the hands of un-regulated criminals who constantly adapt their methods of distribution,' states *Taking drugs seriously*, a report from the UK Drug Policy Commission (UKDPC) and think tank Demos (see news story, page 5). With the Misuse of Drugs Act 40 years old this year, the time has come to consider 'whether 20th century drug control legislation is fit for the 21st century drugs market' it says.

With most 'legal highs' made in China and sold on the internet, their distribution and manufacture are almost impossible to regulate, it states, with the sheer number of new substances coming on to the market rendering the Misuse of Drugs Act 'increasingly unenforceable'. The report recommends that new legal highs could be better controlled through existing trading standards legislation.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was notified of more than 40 new substances last year, a good proportion of them reported by the TICTAC drugs identification service at St George's University in London, which is used by the healthcare, law enforcement and pharmaceutical sectors. 'If you look at the EMCDDA figures for the number of compounds reported each year it's almost a 45 degree line – it's almost doubling year-on-year,' says toxicologist Dr John Ramsey, who runs TICTAC. 'But what we don't know is how much they're used – just because they're detected and reported doesn't mean they're used in significant quantities.'

The UKDPC/Demos report expresses 'significant concerns' that the government's proposed temporary bans on new substances (*DDN*, 13 September 2010, page 4) could mean 'neglect in considering other control options', but Ramsey is not convinced. 'I think they're a good idea,' he says. 'The government need to put themselves in a position where they can act quickly in case we did come across something toxic. The problem is that we don't have the resources to carry out the next stage of the ban, which is to risk assess. The Home Office will have to use them sparingly, because if they don't they will completely swamp the resources of ACMD to do a risk assessment.'

Does he feel that the report's proposal to use trading standards legislation is a sensible one? 'I think we need to be a little bit more innovative than just relying on the Misuse of Drugs Act, but I don't think controlling them – however we do it – is going to work. Prohibition of drugs hasn't worked for anything, ever, so I don't see why we should suddenly think it will work for these. Trading standards was appropriate when people were selling things as bath salts and plant food, but now they're selling them as research chemicals, so which trading standards legislation applies to a research chemical? I don't completely disagree with it – I just don't see it as a terribly productive way forward either.'

He's also unconvinced by the report's recommendation that suppliers should be made liable for proving substances are safe, rather than legislators being required to prove they're hazardous. 'Even if the people selling them were inclined to do it, they couldn't possibly afford to,' he says.

The argument put forward in *Taking drugs seriously* that using the act to control new drugs could do more harm than good – as it would deter people from using legal highs instead of more dangerous substances – is also flawed, he believes. 'We don't know what the dangers of taking these new compounds are – that's the whole point. We're not saying they're horrendously dangerous, we are genuinely saying we don't know. They might be dangerous, but they haven't been tested. The only hope is to try and persuade kids that the risks are too great. One of the difficulties is that we haven't seen a horrendously toxic compound yet – there haven't been bodies on the street, and for heaven's, sake let's hope it never happens. The compounds have been fairly benign in an acute sense, but what we don't know is what the chronic risks are – they might cause brain damage, they might cause birth defects, they might cause all sorts of problems which the people using them can't test for.'

The UKDPC/Demos report expresses 'significant concerns' that the government's proposed temporary bans on new substances could mean 'neglect in considering other control options'.

Worryingly, there is a precedent here, he stresses. MPPP was an opioid compound produced in America in the 1970s and '80s that contained an impurity, MPTP, which caused permanent Parkinson's disease-like symptoms after a single dose. 'There's the risk that we'll stumble on something like that – we just don't know. It's naïve to think that you can tweak a molecule a little bit and not change the risks.

'I don't think prohibition will ever work, but that's not to say you shouldn't do it,' he continues. 'There's been a recent death attributed to MDAI in the Isle of Man – that's not an illegal compound, but suddenly people say, "Why isn't it illegal? Why haven't we banned it?" And in a way, if it's killed somebody, that's not an invalid point of view. Shouldn't we be protecting other people from dying inadvertently through taking this compound? I think we probably should.' **DDN**

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

The classification system of substances into degrees of harmfulness... is ignored by users and dismissed by many scientists. Its only practical use seems to be in determining prison sentences, and filling our jails with drug users has had no deterrent effect on use... It is hard to think of a legal approach to any other problem that has failed so thoroughly without political consensus emerging around the idea of trying something else.
Observer editorial, 15 May

There is no point in suggesting straight decriminalisation, because more than half the population oppose it, and because no politician would be able to withstand the storm of protest that would result. Yet muddling along just as we have been doing isn't proving to be good policy, socially, economically or individually.
Jenni Russell, *London Evening Standard*, 16 May

It always gravely saddens me to see Professor Sir Ian Gilmore, a distinguished doctor who has dedicated his life and mind to the cure of disease and the easing of pain, supporting the dangerous campaign to soften our drug laws. If successful, this will lead to greatly increased pain, misery and disease. The pro-drug lobby – much like Big Tobacco when the link between cigarettes and lung cancer was first made – is hostile to any facts that contradict its claims.
Peter Hitchens, *Daily Mail*, 23 May

This isn't about health, it's about showing us who's boss. One minute, it's red meat on the hit list. The next it's red wine, even though all the evidence proves that both are good for us – within reason.
Richard Littlejohn, *Daily Mail*, 6 May

Human rights have never been respected in Mexico – but since the war on drug trafficking began, rights violations have dramatically increased. Scores of civilians have been shot dead in their cars at military checkpoints. In many parts of the country there are severe restrictions on press freedom.
Luis Hernández Navarro, *The Guardian*, 9 May

Public funding is not everything in the charity sector but it is much more important than Mr Cameron and others seem to understand. So is time. The government cannot expect charities to leap into areas where the state is rapidly withdrawing.
Independent editorial, 23 May

Lansley's fundamental problem is one that seems hard-wired in governments. When you have worked so hard to develop your policy, and to square Treasury and Cabinet colleagues, it becomes almost impossible to believe that anyone could disagree with you. Yet that is, at least nine times out of ten, what will happen when your plan hits the real world.
John McTernan, *Daily Telegraph*, 11 May

LEGAL LINE

'CAN I TRAVEL TO THE US WITH MY CRIMINAL RECORD?'

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

Reader's question:
I'm going on holiday to America in a few months – my partner jokingly said he hopes I don't have a criminal record as I'll get stopped and sent home. Is this true? I'm really worried because I have a couple of convictions but they're so old I didn't think they matter. I know people with criminal records who have got into America with no problems but I would be so embarrassed if I was stopped at the airport.

Kirstie says:
Under normal circumstances a British citizen can travel to the US for a holiday under the visa-waiver programme (VWP). This is done via an electronic system (ESTA), which authorises travel. However, in order to be granted travel in this way you must be able to meet certain conditions, one of which is that you have never been arrested. This is clearly a very low threshold. Even if you had only been arrested, and not prosecuted or convicted, unfortunately you would not meet the criteria.

This does not mean that you will be unable to travel to America, but you should apply for a visa in order to do so. This can be a long process, often involving an interview at the US Embassy, so should be started as early as possible before travel and ideally before anything is booked. Whether or not a visa is granted will depend on a number of different factors including the offence, the time since it was committed and the sentence received. Generally the less serious the offence and sentence and the more time that has passed, the greater chance there is of the visa application being approved. If granted, the visa may be issued for a certain period so the process does not have to be repeated for every trip. However, if the visa is refused, this will be recorded and you will be prevented from applying again for a specified period.

'Generally the less serious the offence and sentence and the more time that has passed, the greater chance there is of the visa application being approved.'

Release has heard of people with convictions travelling to the US under the VWP, but we also have reports from those who have been stopped and sent back to the UK on the next available flight. Even if travel is authorised via ESTA, the US Customs and Border Protection can still refuse entry. The UK and US do share some information so there is a risk of the convictions being revealed – it will then be clear that you completed the VWP application dishonestly and your entry is unlikely to be authorised on a future occasion.

Every country will have slightly different visa and entry conditions so it is advisable to check with the individual Embassy or Consulate before making travel plans.

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 travelling with a criminal record please contact the Release legal helpline on 0845 4500 215.

A SEAMLESS SERVICE

Westminster Drug Project describes how its unusual partnership in central London is bringing down barriers and meeting the full range of service users' needs under one roof.

A collaboration between the voluntary and statutory sector is changing the face of drug and alcohol services in one of the capital's busiest districts. Westminster Drug Project (WDP) is leading a partnership with Central and North West London NHS Trust (CNWL) and fellow charity Foundation66 to provide all tier 2 and 3 services across north Westminster in a truly-integrated model.

The change for service users has been immediate. When they walk in to the North Westminster Drug and Alcohol Service they find a friendly team of people who can meet their needs under one roof – doctors and nurses, drug and alcohol workers, mental health specialists and social workers are just some of the professionals working together to ensure that people get the right treatment at the right time.

'This is an innovative way of providing an integrated service to individuals who are trying to stop using drugs or alcohol and are looking to take the difficult steps of re-building their lives and becoming active members of the community,' said Westminster City Council's cabinet member for adults and health, Cllr Daniel Astaire. 'This kind of centre is a great example of the voluntary and statutory sector working together to provide value for money. Westminster's drug and alcohol team is one of best in the country but we are always striving to make improvements to the service so we can best help those residents who need our support.'

The service embodies the vision that the Westminster DAAT (WDAAT) developed with its partner organisations and local service users – a vision of the same team supporting the client throughout, a focus on someone's overall health and wellbeing as well as their substance use and working with children, families and carers as a matter of course. In short, all the things everyone in the field wants but which can be so difficult to achieve.

The WDAAT decided to organise all services into two 'mini-treatment systems', one in the north and one in the south of the borough, each providing the whole range of services. Turning Point provides the service in the south with the Camden and Islington NHS Foundation Trust and the Hurley Group.

So what tools actually make the integration work?

ONE PARTNERSHIP STEERING GROUP

This is an internal management group to maintain a strategic overview, oversee performance, review structures, monitor the external environment and ensure the service is responsive and balanced.

ONE SET OF POLICIES

The policies and procedures of the three organisations were reviewed and the best practice developed into a single set of standard operating procedures.

ONE GOVERNANCE STRUCTURE UNDERPINNED BY CQC GUIDELINES

CNWL lead on governance because they were recognised to have the most robust and thorough practice. The system ensures that clients experience a high quality service and commissioners are confident that it is delivered in a robust quality framework.

ONE ELECTRONIC CASE MANAGEMENT SYSTEM (THESEUS)

While the challenge of migrating data and training everyone involved should not be underestimated, the benefits of a single case management system are clear – better data which supports the continuous care of the service user and gives robust evidence of outcomes.

EMPHASIS ON COMMUNICATION AND CROSS FERTILISATION

The aim of the integration has been to maintain professional specialisms but remove the barriers between them. Communication through away days, team meetings, learning sets and visits has been key, and nurses are training drug workers and vice versa. All sorts of innovative methods of cross fertilisation within and across teams are being implemented, so there is understanding about who does what and where synergies lie.

ONE ROOF

Each mini-system has a neighbourhood 'one stop' centre and structured intervention centre at its core, with satellite services referring in. 'The beauty is that service users have the physical experience of progress, from the neighbourhood centre to the structured intervention centre,' says chair of WDP Yasmin Batliwala. 'But all the time they are in contact with the same key workers, supporting the journey.'

SHARED LEARNING AND EQUITY BETWEEN NORTH AND SOUTH

The two partnerships, led by WDP in the north and Turning Point in the south, are committed to ensuring

the same quality and access. They have open and clear lines of communication with regular forums to ensure shared learning and achievement of Westminster-wide priorities.

A key element of the shared vision is to integrate family work, a recovery perspective, and service user and carer involvement throughout the service. A family coordinator is leading the process to improve support for children and families affected by drug and alcohol use, service users get a parent assessment at the start, and the M-PACT (Moving Parents and Children Together) programme is provided to support children affected by parental substance misuse. Staff work closely with children and family social work teams and do outreach in family centres. One of the staff is based in the family recovery project team, a social services initiative for families at risk.

A dedicated community integration coordinator ensures that aftercare is planned from the start, not tacked on at the end, and the service user and carer involvement coordinator supports a fully functioning committee, peer advocacy and mentoring and a variety of mutual aid groups including Families Anonymous. A stand-alone carers' service is dedicated to finding out what carers need and using their experience to encourage more carers to become involved.

The Drug Interventions Programme (DIP) has also been streamlined into the new model. Service users are referred in the same way from police stations and courts but instead of going via the old through-care and aftercare teams, they go straight to the neighbourhood centre and their treatment needs are managed in the same way as all other service users. The more linear process allows better tracking of a person's progress through treatment which means that the criminal justice outcomes can be mapped in a much more robust way. **DDN**

WHAT THE PEOPLE SAY

YASMIN BATLIWALA, CHAIR, WDP

We are really excited about this flagship service. It is an excellent example of how voluntary sector organisations can work with an NHS trust to provide an effective, joined-up model that works really well for service users. It also delivers the government's recovery agenda as envisaged in the drug strategy and *Building recovery in communities* consultation whether they have a problem with illegal drugs, over-the-counter and prescription drugs or alcohol, working with the service user's aspirations and planning for reintegration from the start – they are all part of the service model.

Setting up an integrated service like this has inherent challenges but it is great to see how different providers working in true collaboration can really pay off.

CAROLINE GILLAN, NORTH WESTMINSTER OPERATIONS MANAGER, WDP

Our model starts with a thorough assessment, combines drugs and alcohol and offers brief interventions as well as intensive care. We are committed to providing ETE support, family work, reintegration support and peer mentoring – people can get help straight away with the things that are holding them back and they can begin to see early on how their life could change. The beauty of the model is that it gives people the skills and opportunities to have the best chance to reintegrate.

The service is designed to respond to the needs of the local community. We are not only focused on heroin and crack users – we run cannabis groups, support to stop smoking, whatever people in Westminster need. We'll pull in specialist advice – for instance on healthy eating – when needed. We don't see ourselves in a silo, and the way we work internally supports external stakeholders like GPs and health advisers.

In north Westminster we specialise in working with families, BME communities and women. The south Westminster service specialises in homelessness. We're building on the historic needs of each district and sharing the best practice across the borough.

PATRICK COYNE, SECTOR MANAGER WESTMINSTER, CNWL

The three partners share a massive frustration with the barriers that have existed between providers in the past and have therefore created barriers for service users. When people come to CNWL they are usually in a crisis, needing tier 3 services, and now the speed at which they get to us is much quicker, as is the speed at which they move on to wrap-around services.

The role of navigator – coordinating an individual's care from start to finish – is indicative of the new approach. There is nothing worse than someone relapsing because it took too long to get on to the next level of support. Here, moving on to the next level is pre-programmed.

Cobbled-together partnerships present a mess to the service user – this is a well-coordinated partnership. We want to work together and it's creative. There is an ambience of welcoming and getting things done.

The CQC standards have proved to be a good reference point for our shared design and delivery. They are very service-user focused. It is unusual for partners to share this level of enthusiasm for clinical governance and CQC standards.

ANNIE-MAE SHAW, AREA MANAGER, FOUNDATION66

F66 were pioneers in providing BME specific services. New Roots, our community engagement and outreach service, started in 1996. That and our background in alcohol services are some of the strengths we bring.

All three partners have worked in the borough for years, and had worked together before. The fact that we are all excited and full of energy to create a genuinely integrated service is what's special. It is still unusual for voluntary and statutory sector providers to deliver a seamless service together – London is leading the way – but I think it will become more and more common. It makes so much sense.

From the service users' point of view it doesn't matter who is providing what. They just don't have the hassle any more of trekking across London or having to get to know new people or give the same information all over again. We've cut out the red tape and removed a range of frustrations. People are walking in to a healing environment where they know they matter. It's about face-to-face meetings, building relationships and being there for the long term.

THE RECOVERY POSITION

'RECOVERY – WHERE, HOW, AND WHAT NEEDS TO BE DIFFERENT?' was a major thread running through this year's SMMGP conference. GPs, commissioners, activists, people who use drugs, and people who considered themselves to be in recovery contributed a chequerboard of different perspectives, as *DDN* reports.

At the end of two days, the GPs' annual conference on working with drug and alcohol users in primary care agreed on a consensus statement. It welcomed 'the increased options for individualised recovery pathways that the recovery focus offers' and 'agrees that recovery is a journey that encompasses more than abstinence and looks forward to the commissioning of services that support national clinical guidance.'

Some passionate views had helped to shape the consensus. Some speakers wanted to share the opportunities offered by their own version of recovery; others warned that the politicisation of the recovery agenda was jeopardising choice and endangering health. Many delegates, particularly GPs, had come to learn how they could work more closely with colleagues in the wider health field on a shared vision or recovery for all, whatever their ethos and medical background.

REASONS TO BE CAUTIOUS

Mat Southwell:

'A smokescreen for pushing abstinence'

'I'M VERY SUSPICIOUS – not of the recovery movement or people being in recovery – but of this political drive at the moment, the "recovery model",' said Mat Southwell, a drugs specialist and member of the International Network of People who Use Drugs (INPUD). He explained that he had been head of a drug service for ten years before 'coming out' as a drug user and ended his career in the NHS – 'an experience that showed me discrimination was alive'.

The 'politicisation of the recovery model' was, he believed, 'a smokescreen for pushing abstinence-based models, which is not what the genuine recovery movement is actually about'.

Southwell proposed an agenda of 'meaningful participation', by which he meant 'a stretching of quality, a stretching of expectations'. He was, he said, 'incredibly appreciative of the British model' and wanted to 'challenge the field to defend the model we've got – this model what we've spent so long building and which I think is seriously under threat at the moment'.

In his experience, many people were not going to services because of fear of being judged, a result of the system 'not being truly empathic'. 'The new recovery – the political version of recovery – in many ways brings that out,' he said. 'It says "we have expectations of what you will do in treatment". We're not running patient-centred models that say to you "what is it that you want? What is it that you're trying to do? How are you trying to move your life forward and how can drug treatment help in that process?"'

Southwell called on GPs to preserve 'the dynamism of shared care' and the 'absolutely essential learning relationship that comes between a patient and a GP'. He also drew attention to WHO's evidence that community-based models were a highly effective way of reaching out to active drug users, and blamed the NTA for 'actively suppressing this form of drug user organisation in the UK' in favour of 'corralling us exclusively into service user groups and treatment fan clubs'.

There was little to be optimistic about in the 'new politicised recovery agenda' according to Southwell. 'It's saying it'd be better if we didn't exist – that we should all recover. Personally I don't think I'm sick – I'm a person using drugs that makes full choices. Sometimes I've fallen over and needed professional help, other times I've had a lot of fun. I don't see my life within this recovery framework.

'How can we find a place where we're championing people's health, but respectful of their right to choice?' he asked the conference. 'The key thing we have to do is set out clearly how we will all work together, so this dynamic relationship continues and flourishes.'

Beryl Poole:

'There's a frisson of fear'

BERYL POOLE, HELPLINE CO-ORDINATOR at The Alliance, found the new recovery climate 'really worrying'. 'A self-defined voluntary journey is what it should be,' she said. 'But when I work on our helpline and hear that someone's being pressurised to come off their script, that's coercion. There's a frisson of fear underpinning things – a fear of having to lie to get a script.'

If people were being pressurised into reduction, the logical end point was abstinence – and that, she said, would not be right for everyone, herself included.

'If that happened I'd be back on the streets like a whippet, scoring again. I'm 59 years old and on a script – it's as good as it's going to get,' she said. With an understanding GP 'who treats me as any other person' and a regular script, she was worried about a future where 'methadone is going back to being the bad boy or woman of the drug field'.

'I'm told by kids that recovery shouldn't be about a script, but should be about housing, jobs and joy in a life worth living. But there aren't houses or jobs and the underdogs aren't going to be top of the list,' she said.

She was equally concerned about the impossible demands on people who were required to pick up their methadone daily.

'If you're going to get people back into work, don't put them on daily supervised consumption. Don't make it hard for them,' she said.

Dr Chris Ford:

'Recovery has to be self-defined'

'RECOVERY IS A SELF-DEFINED PROCESS – a journey that has no time limitations,' said Dr Chris Ford. 'But when I mentioned this in primary care I was shot down and told we had to take on the new agenda – get people off methadone, get them into work and housing, make them reach their recovery potential.

'I agree with all that except one – they have to come off methadone in their own time, when they want.

'With payment by results we have to be careful we don't go back to the '80s psychobabble. Methadone isn't bad and can assist recovery. Recovery is not the same as abstinence.'

Steve Brinksman:

'A process, not an end point'

'RECOVERY AND ABSTINENCE are not synonyms – anything that's restoring you to normality is recovery,' said Steve Brinksman, a GP in Birmingham.

'The NTA said substitute prescribing should only be used in exceptional circumstances, but that's like putting two children of different sizes and weights on a seesaw,' he said.

'The politicisation of the recovery model is a smokescreen for pushing abstinence-based models'
Mat Southwell

'When I work on our helpline and hear that someone's being pressurised to come off their script, that's coercion'
Beryl Poole

'Recovery is a process, not an end point'
Steve Brinksman

'Recovery is a self-defined process – a journey that has no time limitations'
Dr Chris Ford

'The good thing about recovery is that we talk about it as rehabilitation – getting our function back'
Nat Wright

'We chose to come out of the NHS and this allowed us to move forward'
Andy Pearson

Primary care offered the widest scope for helping people and 'was a fantastic place to deliver', but GPs needed to be able to put patients in touch with additional support, whether employment and training, housing and benefit advice, access to community detox, drug worker support, or mutual aid and self-help groups.

'Recovery is a process, not an end point,' he said. 'But people must define their own recovery. If you balance something too much, it tips up.' He paraphrased Aneurin Bevan, 'this is my truth, tell me yours' as 'this is my recovery, tell me yours.'

WHAT SHOULD 'RECOVERY' LOOK LIKE?

Nat Wright:
'Include the criminal justice system'

THE RECOVERY AGENDA should make health available to all – including those in the criminal justice system, said Nat Wright, clinical director for substance misuse at HMP Leeds and GP advisor to the UK Department of Health Prison Policy Unit.

'We talk in terms of polarised crime reduction and public health agendas, but social exclusion is inextricably linked to societal factors such as employment,' he said, recalling the explosion of illicit drug use in Yorkshire in the 1980s as the mines were closed.

'The good thing about recovery is that we talk about it as rehabilitation – getting our function back,' he said. This meant 'giving people meaningful lives around employment, family and relationships' and recovery in its broadest sense would encompass rehabilitation, he said.

Sainsbury's Mental Health Centre had challenged 'us on the coalface' – *ie* prison healthcare – about working in silos, he said. He recognised they needed to consider prison diversion schemes for those whose offences were not serious, yet related to mental health, and they needed to be 'more clued up' about providing treatment and targeted health promotion messages about drugs and alcohol.

'Criminalisation and public health is largely a false dichotomy,' he said. 'Crime reduction leads to improvements in health and engaging healthcare leads to reductions in crime.'

Andy Pearson:
'Creating a different way of working'

'WE NOW FEED INTO RECOVERY – and not the NTA's version,' said Andy Pearson, shared care coordinator with Wakefield District Community Health Services, which had formed Spectrum Community Health, a community interest company (CIC). 'We chose to come out of the NHS and this allowed us to move forward.'

They brought 43 substance misuse members of staff with them and they were consulted at all stages, he explained. 'Our vision statement highlighted respect, dignity and care for all, including the vulnerable,' he said.

Benefits of the new way of working had included greater flexibility in engaging with patients, carers and service users, particularly in making sure service user involvement wasn't tokenistic. Working in three business units that covered prison primary healthcare, sexual health and community substance misuse, they had felt able to innovate more freely and engage more readily with other local stakeholders.

They had even brought commissioners on the journey with them, said Pearson. 'They understand what we want to do.'

Tim Sampey:
'It's about reintegration'

TIM SAMPEY, SERVICE USER CO-ORDINATOR in LB Kensington and Chelsea, warned of the need to be careful how recovery was defined.

'We've put a lot of effort into harm minimisation over the last few years and a lot has come out of it. For me recovery's about reintegration into society,' he said.

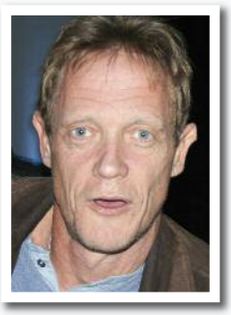
He was concerned that payment by results could pose a threat to this: 'How do we define successful outcomes? Don't say abstinence – that will never work. From a service user's perspective, PbR is really dangerous – are you going to start judging us by the severity of our problems? Will you pick people [for treatment] who won't fall through the cracks? Are we in danger of providers discouraging service users from coming back for six months?'

Most service users were busy dealing with their addiction problems,' he pointed out, and called for more partnership working: 'You have a moral responsibility to fight on our behalf before the political system defines what treatment should be and people start dying from it.'

Vicky Clarke:
'A new commissioning climate'

'COMMISSIONING FOR RECOVERY doesn't just mean retendering every year,' said Vicky Clarke, a former drug worker in harm reduction and needle exchange services who moved into commissioning seven years ago. 'With such big changes happening, we're having to look at whether everything's effective, rather than just setting up systems.'

Becoming a commissioner, 'I was treated as though I was leaving the field and moving into the dark side,'



'We've put a lot of effort into harm minimisation over the last few years and a lot has come out of it'
Tim Sampey

'The confusion in the field is because many treatment providers think they do recovery'
Alistair Sinclair

'Recovery to me means pottering in my garden, listening to Radio 4... It should be whatever you want it to be'
Annemarie Ward

'Services have cooperated and contributed to building something everyone can relate to'
Vicky Clarke

'When we sing songs we try to reflect how we feel about our recovery – "I got my freedom, I got my life"'
Oaktrees Choir

she said. But she saw it differently, as 'an opportunity to see how services could come together more easily.'

Using Leeds' treatment recovery framework, 'services have cooperated and contributed to building something everyone can relate to', she said. 'Each area is commissioning services that contribute to recovery goals.'

Peer mentoring, mutual aid support, recovery communities and recovery champions had become common terms in Leeds, she said, and a SMART group was being set up. Housing stock was being assessed to see that there was provision for people in recovery.

She felt that the recovery climate was a positive one for her area. 'All our services are welcoming, respectful, innovative, challenging and passionate,' she said.

'THIS IS MY RECOVERY, TELL ME YOURS.'

Danny Wild:
'No stigma, no war stories'

'SMART RECOVERY'S PEER LED and covers recovery at every stage,' Danny Wild told the conference. 'It's open to everyone. We don't look at how you've got where you are, we look at where you are now – and there are no war stories.'

With the balance of people, if someone had made recovery work for them, others could learn, particularly if they were going through difficult stages such as night sweats and shakes. No two recoveries would ever be the same, said Wild, but there were simple but effective tools such as cross benefit analysis (CBA) – looking at what's beneficial about acting in a certain way, what could be lost, and how to behave positively as second nature.

'We try to build motivation in people,' he said. 'Each meeting is completely different and you take what you want, like a toolbox. Stopping addiction is easy – it's maintaining it that's the hard part. As you start feeling better, your thought patterns start changing – and there's no stigma.'

Alistair Sinclair:
'It's about seeing what's there and using it'

'THE CONFUSION IN THE FIELD is because many treatment providers think they do recovery,' said Alistair Sinclair of the Recovery Federation. 'But it's about individuals, families and communities and relies on connectedness to others... there are many pathways to recovery – no one can claim it.

'It transcends harm reduction and abstinence-based approaches – recovery is about openness, honesty and self-awareness.'

Sinclair warned against developing new forms of management speak. Recovery was about 'seeing what's there and using it' rather than identifying gaps.

'It's about moving from passivity to activity, from glass half empty to half full,' he said. 'It's about moving from being a service user to a strong human being.'

Annemarie Ward:
'Recovery's whatever you want it to be'

TELLING HER OWN STORY of being born into an alcoholic home with a sexually abusive father, Annemarie Ward explained what recovery meant to her. Throughout her heavy drug use from the age of 11 to 25, she had 'functioned as normal', gaining qualifications and employment. Taught by her proud family not to 'wash dirty linen in public', she didn't consider herself in the same bracket as people without a home or a job.

Eventually, with help from mutual aid organisations and a psychodynamic cognitive therapist, she learned to acknowledge her triggers to addiction and realise that 'when I was addicted I was wounded. I harmed myself, my family and my community.'

Coming into the drug and alcohol field 'by accident', through a part-time job, she was struck by the competition, conflict and isolation and through working with the UKRF, was campaigning for an all-inclusive version of recovery.

'Recovery to me means pottering in my garden, listening to Radio 4, wearing gardening gloves from Laura Ashley. It should be whatever you want it to be,' she said.

Oaktrees choir:
'Recovery rocks – we do recover!'

'OUR MESSAGE IS A SERIOUS ONE – recovery does rock, we do recover,' said Jan, a graduate of Oaktrees in Gateshead. Their choir gave the conference rousing renditions of songs such as Nina Simone's 'Ain't got no – I got life'. Between songs, choir members gave snapshots of their experience.

'I'd just come out of prison – I thought that was going to be my life,' said Jason. 'But then I went into Oaktrees and recovery meant I learnt how to deal with life.'

'I was in active addiction for 12 years and didn't think I'd come out of it,' said Daniel. 'I kept swapping one drug for another... I thought that was how my life would end. I was given a last chance at Oaktrees. When I joined the choir I was lacking in confidence, a broken man. I met a group of lovely people who support us – that's what recovery's about.'

'I was an alcoholic,' said Paul. 'When we sing songs we try to reflect how we feel about our recovery – "I got my freedom, I got my life."'

Questions and Answers

BACK BY POPULAR DEMAND!

Last issue Nicky wanted creative ideas to deal with a massive cut in funding...

We've just been asked to deliver the same service as before but with a massive cut in our funding. Our core cost is staff, but the last thing I want to do is make redundancies. Does anyone have any creative ideas for sharing the burden across the whole of our workforce? *Nicky, by email*

Prune downwards: I'm afraid from what I've witnessed, voluntary redundancies, rewriting your service plan, asking people to reapply for jobs according to a new spec with associated downgraded and fewer positions, and interview coaching for all who wish to take it up, seem the fairest way. You could start with the highest grade and prune downwards. I also think that it's time to start consulting staff, particularly any innovators in the team who may have great modernisation ideas but need your backing. Good luck! *Julian Coxon, DDN Facebook page*

In this together: While David Cameron and the Tory party's cry of 'we are all in this together' may sound as convincing as the child catcher from *Chitty Chitty Bang Bang's* offer of all free sweets today, in this case there may be an element of truth in it. This is the opportunity for senior managers to lead from the front. You need to act decisively and have your senior team make the first sacrifice in terms of any pay cut and loss of benefits that have to be made. If you do this first, it will make selling the idea to the rest of staff a lot easier. Instead of just cutting wages, you need to also look at offering alternative benefits, such as the option of unpaid leave. You would be surprised how many staff, including very well paid managers, would relish the chance to take that trip of a lifetime. The next thing you need to do is sit down with all of your suppliers and renegotiate the contracts. While they might not want to take a cut in the agreed price, in most cases they would rather do so than lose the contract altogether. If there is no other option to reducing the wage bill, then this should be distributed as fairly as possible across the whole of the workforce, along with a plan for growth and realistic expectations of wage increases going forward. *Mandy, by email*

Grasp the nettle! You should grasp the nettle, and clear the deadwood! Does everyone in your organisation have the same amount of talent and dedication – do all workers contribute equally to providing the best service? I thought not. All organisations are carrying people, but under normal circumstances it's not always possible to do much about this. Now is your chance. Use the financial cuts to conduct a spring clean of your workforce and leave yourself with a leaner, fitter, more dynamic team fit for the future. *Alan, by email*

NEXT ISSUE'S QUESTION...
Can you help out a fellow DDN reader?

I enjoy a reasonable level of success treating people for their drug and alcohol problems, but the one addiction that the majority of my clients (and many of my colleagues) maintain is to cigarettes. While it is not their primary reason for presenting to our service, I feel I should offer some sort of intervention. Does anyone have suggestions on how to do this and what's available? *Derek, by email*

Email your answers for Derek to claire@cjwellings.com by *Tuesday 28 June* for publication in our next issue. Send any questions you have about any aspect of your working life or treatment experiences and let our readers help you out.

Post-its from Practice

Never a straight journey

Detox is just the beginning of the road, says Dr Chris Ford

JENNY WAS CRYING when she came into my room, repeating over and over that she had failed and let me down. Eventually she stopped and told me what had happened – she had relapsed after having completed inpatient detoxification ten days previously.

Jenny had first presented four years ago for treatment when she had found herself pregnant. She had settled well on methadone, had a supportive partner and family, and gave birth to a healthy boy. By accident she quickly became pregnant again and had a second uneventful pregnancy and birth. During the second pregnancy she decided she wanted to come off methadone after having her baby. We talked about the various options. As she had support, Jenny decided to do inpatient detoxification and then follow-up with counselling and care in the community via the surgery, mutual aid meetings and a local women's group.

Although we knew getting funding for mothers and children together in our area was virtually impossible, we were still keen that she went to rehab post detox. She felt she didn't need it and in any case, did not want to either take the children or leave them for so long.

Jenny was allocated a place for inpatient detox when her youngest was four months old. She had reduced her methadone to 30mg and was using nothing on top. She had worked hard in the pre-detox groups and had regular counselling sessions. My only remaining worry was that, no matter how often we discussed it, she seemed to see the detox as the end rather than the beginning. She wanted it signed off – a quick pill and she would never take drugs again.

Physically and mentally the detox was far more difficult than she had anticipated and being away from her kids was almost impossible for her. The staff felt she engaged well with the groups and we all hoped Jenny would be able to complete her post-detox plan, but she ended up leaving two days before the end. At the time she blamed the poor food, but on the day we spoke she admitted she couldn't stand the withdrawals any more. Upon leaving she came immediately to the surgery and we talked things through. I gave her medication for symptomatic relief and set up counselling sessions three times a week, which sadly she didn't attend even though we chased hard.

When she came back to the surgery after ten days, she admitted she had used heroin to deal with her withdrawals. She had not been to a meeting or her group and was full of shame. We talked it through and Jenny was soon able to see that she had learnt much through this experience. She had realised that detox was the start, not the end; that she was able to come off methadone; that she needed support and couldn't do it alone. Ultimately she realised that she was even more determined to become drug-free for herself and that she had not failed.

Jenny was changed by this experience and I certainly did not feel she had let me down or in any way wasted funding. She is now doing a short community buprenorphine detoxification with lots of individual and group psychological support. She knows that she can become drug free this time and will remain so if she wants to and continues to get the support she needs.

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical lead for SMMGP, www.smmgp.org.uk

VICIOUS CIRCLES

Many women turn to substances to deal with the trauma of abusive relationships – and substance use itself can render them vulnerable to more abuse and exploitation – yet gender-specific services remain a gap in service provision. **DDN** reports from the Brighton Oasis Project's second conference

'Recovery is a word that's bandied around a lot these days, but many female substance misusers presenting at services have far lower recovery capital than their male counterparts.' Substance misuse consultant at Innovation With Substance, Julia Boas, was addressing the Brighton Oasis Project's second annual conference, *Where now for women substance misusers?* Drug use did not 'come out of the blue' she told delegates. 'When we look at female substance misusers, initiation often comes out of relationships – they're introduced to substances by a partner – or to cope with the trauma of sexual or physical abuse, or to self-medicate for some pre-existing mental health condition.' Drug use could then leave them vulnerable to transactional sex and repeat victimisation, she stressed.

Research had shown that there tended to be more rapid escalation of use among women than men, she said, as a result of psychosocial or perhaps even biological factors. 'People are just starting to explore the potential differences in the way women experience drugs – it's a new and interesting area of study that includes looking at experience of drug use at different stages of the hormonal cycle.' Women also tended to have different triggers for relapse, such as their response to stress and dealing with difficult emotions.

Not only did women's use escalate faster but they tended to present at services with more severe physical harm, psychological symptoms and social harm, she said – the stigma and shame 'associated with cultural expectations, like being labelled a bad mother or that her morals aren't up to scratch'. Women tended to see stigma as 'rejection by society', she told the conference.

'Stigma is one of the most serious hindrances to recovery,' Brighton GP Dr Elaine Clarke told delegates. 'For me, patients with substance use problems are patients with a chronic condition – like hypertension or diabetes – and we treat them exactly the same way. The most important thing is a non-judgemental attitude, and every time we get a new receptionist we explain that this is what we do.' Many of her patients were young women from 'terribly broken homes' with no role models, she said. 'One of them, a girl of 15, told me she had never seen a meal being prepared.'

One of the greatest barriers to recovery women could face was a drug-using partner, Boas told the conference. 'If she is in a controlling relationship she could face sabotaging attempts when she tries to reach out for support.' While an accessible and safe environment in terms of services was important for anyone, it was particularly the case for women, as was attendant emotional support. Gender-specific groups were crucial in order for women to feel comfortable about opening up emotionally, along with gender-specific care and planning. Family services were clearly vital and, while studies indicated that peer support was useful, 12-step services for women needed to be provided with sensitivity and caveats around concepts such as powerlessness (*DDN*, 16 November 2009, page 6, and 15 March 2010, page 14). Financial independence was also crucial, as were building and rebuilding self-esteem.

'Women need integrated services and we need to continue with the push to make sure that services are not provided in a fragmented way,' she said. 'Safe accommodation is an obvious one, but there's not enough provision – mixed hostels for women leaving prison are not an option. There's a growing idea that women are the missing piece of the recovery puzzle, but I was disappointed by the 2010 Drug Strategy's lack of specific mention of women.'

On the question of whether community-based or residential treatment was more appropriate for women, Gavin Beard of the Priory Group told delegates that 'one could fit quite easily into the other' when appropriate. 'I don't see it as community versus inpatient at all – I think we should be talking about seamless services and effective links. I see residential treatment as an absolutely viable option for both men and women – by the time clients reach us they've exhausted a lot of lower level interventions.'

While he acknowledged that it could be helpful for mothers to remain in the

'Not only does women's use escalate faster but they tend to present at services with more severe physical harm, psychological symptoms and social harm... Women tend to see stigma as "rejection by society".'

community, he told delegates that 'at times we have to weigh up the pros and cons of stepping out of the family and community environment into a neutral setting' – away from using partners and friends, and dealers. 'It's how the service, and service user, maintains the relationship with the children that's crucial. We have to think about the length of the treatment as well – at the Priory it's only four weeks but to a four-year-old that's a lifetime, so we do make provision for that contact.'

Ex Oasis Project service users Sarah Daniels and Goda Ostraukaite told delegates about the SMART Recovery groups they had been running locally, after completing SMART training (see feature, page 16). 'It's a safe environment where women can come and talk about things they wouldn't discuss in front of men,' said Daniels. Childcare was available and the aim was now to make the groups available to women from the wider community, she said.

Many women faced issues of 'triple diagnosis', mental health initiative coordinator at the Stella Project, Jennifer Holly, told the conference – domestic violence, substance use and mental ill health. The Home Office's definition of domestic violence as 'any incident of threatening behaviour, violence or abuse – psychological, physical, sexual, financial or emotional – between adults who are or have been intimate partners or family members, regardless of gender or sexuality' did not do it justice, she stressed. 'It's not a one-off incident, it's a pattern of behaviour.'

Domestic violence involved living with threats and humiliation on a daily basis, having to give up work and being prevented from contacting friends and family, she said. 'When we do reviews of domestic violence homicides we find that physical violence is not always present before the homicide. What is present is the coercion, intimidation, isolation and threats.' Despite the fact that these were recognised methods of mind control used on cult members and prisoners of war, women were still often blamed for not leaving abusive relationships. 'And if women are using substances and have mental health problems they're also often told they're making it up – "it didn't happen, you were stoned, you're a nutter". Mental health issues and substance use problems also make women more vulnerable to abuse, more isolated and less likely to seek help, and substance use itself can be used as a tool to abuse and control someone.'

Often perpetrators would say, 'I was drunk', she told the event. 'But what we know from working with perpetrators and talking to women is that a drunk perpetrator will be a sober abuser.' Between 60 and 70 per cent of female service users will have experienced domestic violence at some point in their lives, she said. 'It needs to be part of the core business of drug and alcohol services. Domestic violence can act as a barrier to each and every one of the outcomes listed in the 2010 Drug Strategy. If someone's being forced to use or to drink, how can they achieve freedom from dependence?' The effects on physical and mental wellbeing could be present years later, she said, and there were clear and obvious impacts on parenting and maintaining sustained employment.

Access to refuge accommodation and women-only services were vital, and survivors and children needed to be offered appropriate support to keep them safe, she said. 'Couples counselling is a no-no, and sending a perpetrator on an anger management course will just serve to make them a better abuser.' AA and NA group leaders also needed appropriate training to ensure they dealt with these issues appropriately, she said.

'It's up to us to ask women. They won't always say, for a variety of reasons – fear of not being believed, of being judged, of the worker freaking out, or of just being referred on to yet another service. Women are passed from pillar to post, and eventually they'll just go home. We need to commission services that women want, and we need to tell commissioners that this is what women want – we can all play our part in demanding services and supporting colleagues to understand these issues and work more effectively with women with more complex needs.'

Accessing sexual health services, meanwhile, involved describing a 'history of risk', which meant that disclosure and discussion were huge barriers for women with a background of abuse, sexual assault or sex work, said senior research fellow at the University of Brighton's faculty of health and social sciences, Natalie Lambert. This meant low uptake of cervical screening and high rates of sexually transmitted infections. Inequitable relationships both increased risk and limited access to sexual health services, she said. 'We've spoken to women whose partners time them taking the kids to school, so there's no way they could access a GUM clinic.' For other women it was 'almost like they were offsetting sexual health and substance misuse services,' she told delegates. 'They were saying, "which bit of me should I look after?"'

Routine enquiry and monitoring needed to be built into service provision, Holly told the conference, alongside clear referral pathways and a consistent approach across agencies, which would require relevant training for all staff, as well as opportunities to meet colleagues from other sectors. 'We have to make sure all workers have the opportunity to cultivate these relationships, not just the managers. Developing partnerships and taking on new areas of work is not easy, but it is worth it. We must all start asking about domestic violence, and taking action.' **DDN**

www.oasisproject.org.uk

A SMART PLA

Growing out of a recognition that mutual aid is effective but the 12-step approach doesn't suit everyone, SMART Recovery is now a force to be reckoned with on both sides of the Atlantic. **Richard Phillips** sets out the organisation's history, philosophy and future aims

SMART Recovery is an abstinence oriented recovery organisation which helps people gain control over their addictive behaviours and achieve balanced, meaningful and satisfying lives. What makes SMART Recovery different from treatment is the focus on self-help and peer-led meetings – to put it in simple terms, SMART Recovery is a secular and science-based alternative to AA, NA and other mutual aid networks.

The tools and techniques of SMART Recovery are derived from rational emotive behaviour therapy (REBT), cognitive behavioural therapy (CBT) and motivational enhancement therapy (MET) – similar to the psychological interventions used by most addiction treatment services in the UK.

If you observe a SMART Recovery meeting you'll see both differences and similarities with the fellowship meetings you may be more familiar with. The biggest difference is that meetings are led by trained facilitators, run to a standardised 60 or 90-minute format and focus primarily on the present and near future – 'war stories' are discouraged. There is also an emphasis on 'cross talk' – different members of the group directly helping each other in learning how to use the various tools. Some people attend both SMART meetings and fellowship meetings and seem to get different things from each, so we make it clear that criticising other approaches has no place in our meetings.

The best way of becoming a facilitator is to attend meetings, preferably for six months or more, and then do the facilitator training offered by SMART Recovery UK. At present this is only available online – though we will be launching face-to-face training soon – and anyone in recovery who wants to start a meeting can access it free of charge. It has been amazingly popular, with over 500 applications since December, more than half of which have been from people in recovery.

Nearly all SMART Recovery meetings in the community are peer led and the

organisation is proud to be part of the wider mutual aid movement. It does, however, have a very different history to the fellowships and works more closely with professionals. SMART Recovery was founded in the USA by addictions psychologists and people in recovery based on the recognition that, while mutual aid works, 12-step approaches are not for everyone. This resulted in an organisational structure with roughly half of the board of trustees (for the UK as well as the USA) in recovery, and a unique approach to the ongoing development of the programme.

SMART Recovery maintains a dialogue between people in recovery running meetings and addictions psychologists, resulting in a science-based programme where new elements can be introduced or things removed as the evidence evolves. It also means a pragmatic programme where the tools or methods used 'make sense' to meeting participants and form a coherent approach overall. We are supported in this by being able to draw on the expertise and experience of the pre-eminent addictions specialists who sit on our international advisory board, such as William White, Aaron Beck, Carlo Di'Clemente, Stanton Peele and, until recently, Alan Marlatt, who has sadly died.

From this foundation the network has grown to more than 600 weekly meetings worldwide, and has doubled in size in the UK in little more than six months. Compared to the fellowships, however, SMART Recovery UK is still very much the small fry of the addictions mutual aid world and a great deal of thought has gone into finding an approach to make SMART meetings available across the country.

Looking at the history of SMART Recovery in this country (or indeed any other) we saw no evidence that we could expand quickly and safely purely by the 'organic' growth of people moving from participating in one meeting to starting another – this will always be something we value and support, but it is hard to replicate across the country and has not worked well outside of the north west. Perhaps in several decades this approach could get us into every area, but the SMART family is more ambitious than that.

The breakthrough for SMART Recovery was the Alcohol Concern pilot scheme (*DDN*, 15 March 2010, page 8) where we saw just six partnership sites blossom into 25 free-standing peer-led meetings over a two-year period. Far from undermining peer-led mutual aid, the partnership model encouraged it to flourish. Amazingly, most of the current SMART Recovery meetings in the UK owe their 'ancestry' to this small number of sites in the Alcohol Concern pilot, and we could not ignore that kind of success.

If that's what can happen from just six sites, what about 40? That's how many sites SMART Recovery UK has now agreed with a range of treatment providers, with CRI having the most. We are aiming for 100 partnered sites within the next six months and more beyond that, and organisations that have signed up to the partnership scheme since April include Blenheim CDP, CODA, Compass Hull, Derbyshire Mental Health NHS Trust, Foundation66, Homeless Action Resource Project, NACRO Shropshire, Supporting Futures and HMPs Erlestoke, Kirkham and Manchester, alongside many more. If the scheme is only a fraction as successful as the Alcohol Concern pilot we will easily achieve impressive growth in free-standing meetings across the country.

Under the partnership model there will also be SMART Recovery within treatment services that may not always be peer led, but this enhances rather than detracts from the wider network of meetings. SMART Recovery champions – professionals who have done the facilitators course – will introduce literally thousands of people to SMART Recovery who would otherwise never come across it and encourage many of these to become facilitators and start their own meetings.

The model is a win-win approach. The champions enhance their own service and also help build a sustainable network of SMART Recovery meetings in the community that are, from their point of view, a valuable source of aftercare. For people in recovery, the model provides opportunities to hear about SMART Recovery and a helpful 'leg up' for those that decide to become facilitators and get meetings off the ground.

This model is also attractive to commissioners, who see the benefit of having non-12-step mutual aid as well as the fellowships in their local areas. In some cases commissioners are simply encouraging their local providers to sign up as partners, while others are writing SMART partnership into tender invitations as a core requirement for a service or offering to cover the license costs for their local providers to encourage them to get involved.

A more ambitious approach is a 'whole area rollout project', such as that being planned in Bristol. The aim is to get all, or nearly all, local providers into the partnership, with an even larger number of champions trained up, and a large proportion of staff having at least basic training in what SMART Recovery is all about. We have also agreed for a staff member on the Safer Bristol team to have an adjusted job description with specific responsibilities to help project manage the roll-out. The plan is to have a strong and sustainable network of peer led SMART Recovery meetings in Bristol along with close and ongoing links with the treatment services.

'SMART Recovery maintains a dialogue between people in recovery running meetings and addictions psychologists, resulting in a science-based programme where new elements can be introduced or things removed as the evidence evolves.'

An alternative strategy is being put in place with a partnership across the Lothians region of Scotland, including Edinburgh. The commissioning group is funding a one-year SMART Recovery facilitator mentor post, employed by SMART Recovery UK. This role will support the creation of new meetings, offer mentoring to new facilitators and get champions up to speed, and the aim is again to create a vibrant and sustainable network of SMART Recovery meetings so that there is genuine choice in mutual aid across the region.

Although the partnership scheme has taken a lot of work to put in place, having a bit of stability and being able to pay a few bills will directly benefit our growing network of peer facilitators. Work is already underway to review and improve the manuals and handbooks and we should be able to print posters and the other materials that will help local meetings and hopefully run more training, events and conferences to support facilitators. We already have monthly online peer supervision/support sessions for facilitators and are looking at other ways of supporting the network.

SMART Recovery is an unusual animal in the recovery movement as it has always been a partnership between people in recovery and treatment professionals. To some, this collaborative approach might seem to be a threat to the 'purity' of the recovery movement. Certainly we have had to put safeguards in place to make sure SMART Recovery cannot be misused by others, but we should be truly grateful that commissioners and provider organisations want to see SMART Recovery spread and are prepared to step up and do things to help make this happen. This is truly a win-win approach that benefits both peer-led mutual aid and the providers and users of treatment. **DDN**

Richard Phillips is interim director of SMART Recovery UK
www.smartrecovery.org.uk

INNOVATION on a shoestri

The South East Alcohol Innovation Programme has demonstrated that, in these straitened times, effectiveness needn't cost the earth. **DDN** reports

Set up in late 2009 with the aim of devising new approaches to tackling alcohol-related harm and reducing drink-related hospital admissions, the South East Alcohol Innovation Programme has reached its final stages. Last month the Centre for Public Innovation (CPI) ran a second 'innovation showcase' to celebrate the programme's achievements and share the lessons learned.

When CPI was commissioned by the Department of Health to run the scheme it was 'never predicated on doing lots of fun activities that spring briefly to life and then disappear after three months,' CPI managing director Mark Napier told the event. Rather it was about trying to influence long-term change and thinking, and demonstrating the role of innovation in tackling alcohol-related ill health.

'In the first phase we gathered ideas, but from beyond the usual suspects,' he said (*DDN*, 13 September 2010, page 6). 'We made the bidding process as simple as possible in order to get bids from as wide a range of people as possible.'

Year one saw more than £145,000 worth of funding given out to test ideas, but in year two the programme changed tactic. 'Of the 25 or so projects we had, we decided to narrow it down to five "high impact" models that we thought really had potential,' he said – hospital 'frequent flyer' projects, clinical nurses in hostels, supported housing self-help groups and brief advice from hospital healthcare workers and in pharmacies. 'Anyone could still bid, but they had to bid against these models – we were trying to test whether it was the concept that worked or whether it was because the innovator was so driven and charismatic that they could make pretty much anything work.'

Year two saw roughly the same amount of money spent, but this time on just eleven successful bids based on the five models, a 'more meaningful investment in a smaller amount of projects,' he said. 'Delivering the programme during a time of what we could politely call "political flux" was a real challenge. The landscape was changing rapidly, with the disappearance of PCTs and the challenges around recruiting staff, and the time frame was also overly ambitious. We had to be pragmatic and provide people with flexibility, rather than pinning them down to a narrow service spec – it's the results we're interested in.'

And some of these results have been impressive. Cranstoun's 'frequent flyers' programme saw hospital admissions among the original project caseload reduced from 178 to 14 in the first quarter. The aim was to work closely and intensively with clients and their families, said Darren Carter, who for the first ten months ran the project on his own. The typical client was 40-plus, living in poor housing and with a poor history of engagement with services, he told the showcase, with one patient alone costing the NHS more than £240,000 – with no change in behaviour. 'Most didn't want to change, or saw change as too big a barrier,' he said.

However, the scheme had now recruited two more workers based on its outcomes, and funding had been mainstreamed using resources allocated for brief interventions. 'The key thing is the intensity of the work – it's about really chipping away, painstakingly slowly at times,' he said. 'The main part of my role is to have a fresh outlook and perspective, to see what we can do differently this time, and we've found that other services then become motivated to give the patient another chance.'

CEO of Action for Change, John Reading, told the event how his organisation's frequent flyer scheme – which used four part-time workers – had led to a much-improved relationship with A&E managers and staff.

'Some people complain about A&E and say that when you approach them the shutters tend to come down,' he told delegates. 'A&E staff are very busy people, but when you walk in and say "we've got something that can help you," they want to engage. It's not just about the numbers coming into them, it's about the behaviour of the clients and the effect they have on the other patients waiting there. These clients are not very easy to find and engage with, and levels of need are very high, but so far none have returned to A&E.' Cost savings to the PCT had been estimated at £173,000, he said, based on funding of £12,500 from CPI.

A&E and the emergency services had constituted the primary healthcare of Brighton-based hostel manager Rob Robinson's client group, he told delegates. 'They certainly weren't engaged with GPs.' A hostel-based nurse provided clinical support to alcohol-dependent clients in the pilot scheme, working alongside CRI, the community alcohol team and others. The nurse attended weekly meetings with hostel staff, community alcohol teams and a steering group made up of representatives of each partner agency, and each hostel also appointed its own recovery champion.

Many clients had life-threatening health conditions that were not being addressed 'mainly because of fear', Robinson told delegates. 'They continued to drink to cope with the fear about the conditions that they knew they had.' There had been high levels of hospital attendance and ambulance call outs, on a daily basis for some residents – 'we're talking very, very heavy usage of emergency services'. However, all of the clients engaged with the nurse, who enabled 60 per cent to safely detox in the hostel, and there was not a single call out or A&E attendance in the client group during the 16-week pilot.

'These are highly personalised support packages tailored to individual client needs,' he said. 'For clients with chaotic lifestyles, there's a huge difference between having to get yourself across town for an appointment or just coming downstairs and seeing the nurse. It's a client group that's thought of as not wanting to change, but this has shown that they do want help and support – just help and support that's different to what's traditionally been available to them. A conservative estimate of cost savings in just ambulance call outs alone is £40,000, and there are indicative overall cost savings of more than £100,000.' The pilot had cost a tenth of that figure, he stressed.

Peer recovery facilitator for Portsmouth City Council, Wayne Liversedge, however, found that his scheme to work with alcohol-dependent people in supported housing hit an early stumbling block when taking the concept of recovery 'into supported housing settings where there were entrenched negative views' towards accessing help. 'These are clients who are going through a cycle of street homelessness, prison and hostel accommodation,' he said. 'The initial communication with some supported housing providers also wasn't as positive as we'd hoped for, but we hope to make some progress there.'

However, there was now one established SMART Recovery-based group in a hostel, attended by half of the residents, with a second group about to start in the same venue as well as a new one in a different hostel. 'Anecdotal feedback suggests that the culture of the hostel is changing, with people going on to complete detox and residential rehab,' he said. 'People who have had a very defeatist attitude towards engaging with treatment and had given up on themselves are now accessing services in the community.'

Identification and brief advice (IBA) in pharmacies, another of the five high impact models, was the subject of a trial by Berkshire East PCT, local pharmacist Lorette Sanders told delegates. 'Pharmacies are already set up to do lots of things, including medicine use reviews, so we thought we could tag on a brief intervention, as well as opportunistic brief interventions – for example with people requesting a hangover cure or emergency contraception. We really wanted to broaden the availability of advice – more than 90 per cent of our pharmacists have private consulting rooms, so you have a private setting with very easy access and late openings.'

Twenty-two local pharmacists were trained but, despite good publicity and incentives like gift vouchers, the number of IBAs was 'disappointing', she said. 'We had half a dozen who were fantastic and really stormed away, but some had already done their full quota of medicine use reviews and others had a reluctance to approach customers about alcohol. You can have all the training in the world, but the more you do it the easier it becomes. It's been a bit of a slow burner, but we're not giving up yet.'

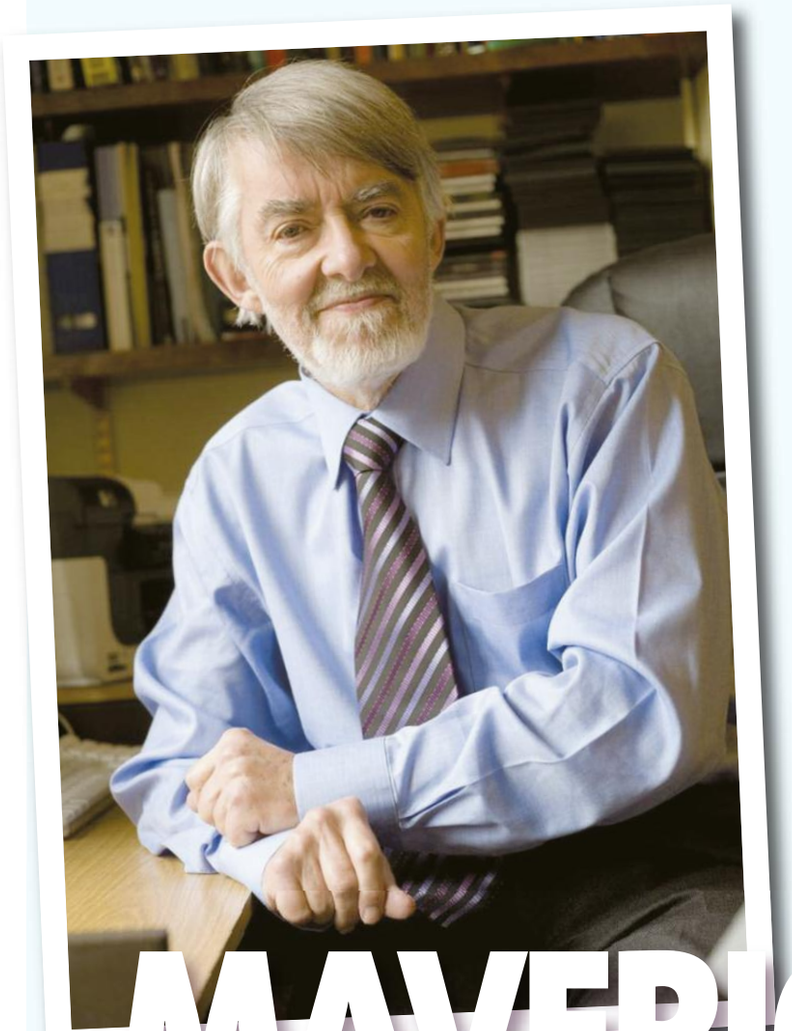
'It's about getting at the creativity, energy, enthusiasm and knowhow of the people on the frontline...'

'We trained pharmacists, but really we should have been training everyone in the pharmacy, and that's what we're going to get on and do,' said Diane Clemison of Berkshire East PCT. 'Getting pharmacists to change their way of working is the first challenge – rather than getting the patient to change, to a certain extent we've got to get health professionals to change.'

'The south east is one of the wealthiest and healthiest regions in the country, but there are huge differences in alcohol-related harm and an upward curve in cirrhosis,' South East alcohol lead for the Department of Health, David Sheehan, told the event. 'These are huge challenges, but we're in a much better position to tackle them than in the past, with more knowledge about where we need to be targeting our innovations, who we need to be looking at, and more knowledge about the type of interventions we have at our disposal and how much resources and effort they take.

'It's shown the enthusiasm, creativity and bloody determination of a few people to make a difference, and the innovators have created new knowledge that can be taken forward. It's about getting at the creativity, energy, enthusiasm and knowhow of the people on the frontline, and it's a measure of what you can do with very little.' **DDN**

www.southeastalcohol.org.uk



MAVERICK SPIRIT

Paul Flynn MP has been a thorn in the side of mainstream drug policy for decades. However, it's those politicians who timidly toe the party line that risk the public's contempt, he tells David Gilliver

Never one to mince his words, Paul Flynn informed the latest meeting of the Cross-Party Group on Drug and Alcohol Treatment and Harm Reduction (see column, facing page) that the 2010 Drug Strategy in general – and payment by results in particular – was variously 'another futile activity', 'a PR exercise' and 'bollocks'.

He'd gone before I could ask him to elaborate, but when I phoned him the next day he was more than happy to expound. 'It's exactly the same as every other drug strategy,' he says. 'Self-admiring, futile and the product of the cowardice and stupidity of politicians.'

The problem is that those politicians never look back and learn from the results of their previous initiatives, he believes. 'I don't know of any time when any government, any minister, has assessed their policy and the outcome and decided whether it's achieved anything. For example, the one that came in a great burst of trumpets and trombones was the [1998] "drug tsar" strategy, when they wanted to reduce the use of some drugs by 50 per cent – hard to believe now that they'd be so stupid as to say that. The only success they could claim was to put more people in treatment, but all the other targets failed miserably. In fact, most went in the opposite direction.'

What's important to ministers is to give the appearance of activity, he says – 'to run around in little circles' but achieving very little. 'It gives the appearance that we're doing something, we're active. And being tough – that's the overriding rule. No drugs minister's ever claimed to be intelligent when it comes to drugs, just tough. You must appeal to the lowest common denominator, what the tabloids want, and the tabloids want tough policies. And when tough policies are proved not to work we go to even tougher policies, so we end up in the position we've been in for most of the last 40 years of the toughest policies and the worst outcomes.'

Called 'the thinking man's Dennis Skinner' by *The Guardian*, he became a councillor in Newport in the early 1970s, and was elected Labour MP for Newport West in the 1987 General Election at the age of 52. He's never been particularly worried about offending his Commons colleagues – his website has a section called 'Moronocracy' detailing some of their less impressive utterances and activities. What does he make of the current crop of ministers in charge of drug policy? 'We've got a couple of boy scouts running it at the moment, who are not only preaching this drivel but actually appear to believe it, which is worrying,' he says. 'We do have a particularly naïve group of people running the show now.'

Are there any exceptions anywhere in government? 'Ken Clarke is one of the few ministers who've said that the rising prison population isn't a success, it's a failure – he's recognised that. Oliver Letwin has said that with all the governments we've had in the last 40 years we haven't reduced recidivism one iota, so there's some hope that some of the thinking people in the government might bring some improvements.' He also praises Tory MP Sue Wollaston for her stand on alcohol legislation (see column, facing page). 'She's taking on the government – she's virtually an independent MP in the way she's been behaving.'

When did he first become interested in drug policy? 'I've never seen the point of prohibition,' he says. 'I think you should have policies that work. I think the first time I had a bill on medicinal cannabis was 20 years ago, and nothing's changed. You go on repeating the same things.' Isn't that dispiriting? 'I think you have to keep it up. I don't think it's been a waste of time – someone has to put their head above the parapet and make the points.'

One of the points he made at the cross-party group meeting was that payment by results would mean those results being fiddled, a view he stands by. 'I know exactly what will happen,' he says. 'One of the results is about getting people in employment, so someone will ring up and say "I'm desperate, I've got my targets

and I've got someone here, she won't work, she won't turn up, but if you put her on your books and say she's working for you – if you scratch my back, I'll scratch yours." So when you set those targets, they'll be met. People will fool themselves – even though they said they'd get rid of targets, that's exactly what these are.'

For successful policies, ministers should look to Portugal, he believes. 'There are other parts of the world where they've tried things other than harsh prohibition, but there's no movement in that direction here. It's all a question of politicians following public opinion – however stupid it is – and following the *Daily Mail*, rather than showing any leadership. The job of politicians is to lead, to do the right thing even if it's not popular, and the right thing is to do what they did in Portugal. When they introduced their depenalisation there was hardly any support – most of the public and the press were against them, but they took a courageous decision and were proved right.'

Presumably the Commons is a lonely place if he's always out on a limb – how many people share his views? 'Well, if you talk to them in the Strangers Bar or on the terrace you find that most of them do. But if they come to make a speech about it or vote on it, then about 5 per cent do.

'We've got a couple of boy scouts running [drug policy] at the moment, who are not only preaching this drivel but actually appear to believe it, which is worrying.'

'The usual thing when we've got a problem and we don't know what the hell to do about it is we'll have a comprehensive, holistic, multi-faceted, multi-layered, multi-disciplined new policy that will be carefully integrated,' he laughs. 'It doesn't mean a thing, you just throw lots of adjectives at it. Something's not working, so you just do it in a slightly different way. You don't change the policy, you just give it a bit of a makeover – it's entirely cosmetic. DAATs were the answer under Blair, which were supposed to bring everyone together – police, social services, doctors. But if you put a lot of people together without a new idea, you don't improve things. If you join one bad idea with another bad idea you don't get a good idea, you get a bigger bad idea. And that's the history of DAATs – it's the same old crap.'

He published his autobiography, *The Unusual Suspect,* last year, with a foreword by Tony Benn. Was writing the book a cathartic process? 'Oh definitely, it was a wonderful experience to get it all down,' he says. One of its themes is that, contrary to what people might think, going against the flow is far from electoral suicide.

'I can point to my election result,' he says. 'There was a swing against Labour but if the swing against me in Newport West had been the same as in Newport East or Torfaen or Merthyr I would have lost my seat. But the swing against me was much smaller, and part of that is because I appear to be independent and support causes that are not necessarily the popular ones. It really is an advantage to do that – people don't seem to realise.'

While he might lose some votes from people of his own generation, he gains them from younger generations, he stresses. 'Politicians in general are too timid, and the ones that toe the party line without a crease in their knickers get thrown out. They should say what they think and follow the policies that are right, not the policies that appear to be officially acceptable.

'The adjective that has been used about me over the years is "controversial", which means that everyone agrees with every word you say years after you say it. It's just a question of being patient.' **DDN**

The Unusual Suspect by Paul Flynn is published by Biteback.

PARLIAMENTARY BRIEFING

Payment by results, the unmet needs of armed forces veterans, and a Gallic approach to alcohol marketing legislation were the focus of the latest meeting of the Cross-Party Group on Drug and Alcohol Treatment and Harm Reduction. DDN **reports**

THE MAY 2011 CROSS-PARTY GROUP meeting began with a presentation from Dr Sarah Wollaston MP on alcohol regulation. 'The evidence base is very clear,' she told group members. 'It's about pricing, it's about availability and it's about marketing.'

She had introduced a Private Member's Bill calling on the government to adopt measures based on the French 'Loi Évin' (a law named after the health minister who introduced it), which aims to protect children from exposure to alcohol advertising. 'It says what you can do, and therefore everything else is automatically not allowed, which means it's much more difficult to find loopholes,' she said. 'Advertising is allowed in certain parts of the print media, for example, and on radio after 9pm, but viral marketing or advertising to mobile phones are not allowed.'

This contrasted with the 'huge hotchpotch' that characterised UK regulation, she said, with the government determined to pursue the self-regulation approach despite no evidence that it was effective. 'The French model is about isolating it where children can't be exposed – a much better way of doing it. For example, you can't advertise at football matches if there's going to be TV coverage, which has had no negative financial effect whatsoever, despite dire predictions. Let's get them out of sport – the evidence is that people will easily find other sponsors. The Loi Évin is an off-the-peg measure that the government could easily adopt.'

The meeting also heard an update from Paddy Costall of the Conference Consortium on the progress of the Armed Forces Bill and the inadequate service provision for ex-service personnel with alcohol and drug problems, discussed at the last meeting (*DDN*, 25 October 2010, page 9).

'Large numbers of people presenting to services have experience of being in the armed forces,' he said. 'We need a very clear steer from the people piloting the bill in terms of what information they need so that treatment organisations can supply it.' The 'vast majority' of military charities had 'not been pulling their weight collectively' in support of veterans, said meeting chair Lord Ramsbotham, who was campaigning for the minister for veterans' affairs to be moved to the Cabinet Office from the Ministry of Defence to give the post a more central role.

On the 2010 Drugs Strategy agenda item, Compass chief executive Steve Hamer said that although payment by results represented a 'great opportunity to do something different', he was concerned about 'conflicting' approaches. 'There's an attempt to market manage those taking part, coupled with a laissez-faire approach of deferred payment – very few providers could carry the cashflow implications of that,' he said. 'There's a lack of cohesion that's really quite scary.'

David Burrowes MP acknowledged that although this was a 'challenging area', local accountability would address 'laissez-faire' concerns. 'I would be less sceptical,' he said, 'but let's see what comes out of the eight pilot areas.'

'We're always at year zero with drugs,' Paul Flynn MP told the meeting. 'We're always coming up with new wheezes, but no one ever looks back at what's happened before. What payment by results means is that people will just lie about the results.'

LETTERS

'The problem with qualified people (like Mr Joe, I presume) is that they are so detached from reality that meeting any service user on a human level is almost impossible.'

EXPERIENCE DOES NOT EQUAL EXPERTISE

I was interested to read Denis Joe's letter (*DDN*, May, Page 28) in response to the views expressed by Andy Ashenhurst (*Soapbox*, April, page 22) about unqualified drug workers.

Aside from an attack on the 12-step approach and ex-users working in drug services, it was an interesting viewpoint on drug services and service user involvement.

Mr Joe paints a picture of drug services staffed by unprofessional ex-service users. I would tend to agree partly on the points raised about NA/AA. A competent substance misuse team includes professionals from all walks of life – some may be ex-users who have gone on to gain degrees and postgraduate qualifications, some may be ex-army, ex-police, ex-nurses, professional sportsmen, newly qualified graduates; the list goes on.

The reality is that some people can do the job as well as any qualified person and if they were excluded from employment in services because they were ex-service users, service provision would suffer. The problem with qualified people (like Mr Joe, I presume) is that they are so detached from reality that meeting any service user on a human level is almost impossible.

I agree that being an ex-user does not turn someone into an expert and, as in 12-step based-programmes, the subjective approach is perhaps wrong. But if it stops people from living destructive lifestyles, then it works for some people.

It is clear from the views expressed that the recovery model is not something which has been taken into consideration – and if it has, then it seems it is something that Mr Joe is not in favour of.

A professionally qualified drug practitioner, Bradford

LESSONS IN LIFE

Denis Joe talks about 'unqualified workers' in the addiction field. Presumably treatment centres employ sober alcoholics because they are qualified – in recovery, that is their field of expertise.

They are practitioners of the 12 steps, which are the basis of therapy in many centres. But treatment facilities also have a responsibility to ensure their staff have academic and professional qualifications too – and that includes their alcoholics and addicts – and not just 'short-term vocational training'. They should be able to talk the talk as well as walk the walk.

Alcoholics Anonymous has no opinion on such 'outside issues' (Tradition 10), but it has issued a guideline for AA members employed in the alcoholism field (Guideline 10, available from AA's General Service Office at York). It urges that people working in the field should have 'several years of good, uninterrupted sobriety' behind them (five years is suggested). And contributors to the guideline 'overwhelmingly agreed that it is professional skill and experience, not AA membership, which qualify one for professional positions'.

One man wrote, 'Remember that your basic training in alcoholism is subjective, personal experience. Non-AA's naturally have to see the illness objectively, from other, outer directions, not from the inside. This does not necessarily mean one view is better than the other. They are different, but both can be true, good and helpful to the sick alcoholic.' The guideline cautions: 'Do your own job well and let AA justify itself. It is not your job to turn the whole alcoholism world into AA fans...'

Laurie Andrews,
former Quaker prison chaplain

UNDERVALUED EMPATHY

Denis Joe raises some interesting points about both user involvement and the role of empathy. However I strongly disagree with his conclusions.

Regarding user involvement/consultation, I agree that this is often poorly planned and tokenistic, though I think that this is usually the fault of the organisation rather than the ex-user.

There is also a significant difference between user involvement and user consultation. In the 1980s I had the good fortune to work with a community worker whose job was to help articulate local people's problems and to further help them provide their own solutions. This led to a number of projects with the people most affected by the problem being involved in its solution.

An example included a youth club, organised by local parents who obtained the funding and employed the youth worker, with the young people directly involved in the recruitment of the youth worker and on the management committee. When the youth club was taken over by the statutory service, its opening hours were restricted to the needs of the workers rather than those of the users.

In west London there are three established user-led projects. FIRM runs a social club for ex-users, run by ex-users; SUDRG runs a social club and services both for those in recovery and those still using, and both these services are open at the weekends when most statutory services are closed. Similarly the Outside Edge Theatre, run by an ex-user, provides drama relating to substance misuse, taking this to treatment centres and community centres and running weekly drama classes for any ex-user.

All these services were set up by ex-users, who used their own experiences to provide a relevant, accessible service. Whatever your position on AA/NA philosophy they provide a free service, accessible when most other services are closed.

User consultation can be badly organised, tokenistic or done because it is a monitoring requirement. However this does not invalidate the benefit of doing it properly. A problem can occur if a token ex-user speaks on behalf of all users/ex-users. Cynicism often occurs because it is never clarified what will happen as a result of views expressed; so people express their views about changes in services, which becomes an end in itself rather than leading to possible changes.

I know many ex-users who have been through treatment, have undergone training and now work in the drug and alcohol or mental health fields. No one would know they were ex-users, unless they chose to disclose, so it is ridiculous to suggest they are unable to be objective.

Lastly, on the value of empathy, I would argue that without this important skill, academic knowledge you may have gained will be totally ineffective in helping someone. In fact the ability to show empathy rather than sympathy is one of the key factors in assisting someone changing their behaviour. At a crisis centre I worked in, the person who had the most admissions sent us a postcard from rehab, saying the reason our centre worked was because each time he came in we believed in his ability to change – despite all the evidence to the contrary.

John Gordon-Smith, by email

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 CARD FROM Plymouth

The Plymouth Service Users Representative Forum (SURF) was formed in 2009. Our aim was to join with other service users in recovery in the city, to share information and resources and to have a dialogue with local agencies and service commissioners.

Currently our members are mostly from Broadreach House and Hamoaze House but we are developing relationships with other groups, both locally and nationally.

We're launching a service user magazine called 'Our Voice' to enable us to share ideas, information and resources. The magazine will also include music, affordable fashion, cooking on a budget and articles from recovery champions who have been able to enjoy their progress through recovery and want to share their successful strategies with others.

The new government social and treatment proposals can, on the surface, appear to be daunting to service users. However, we feel that it's our best chance in a decade or more to be actively involved in the recovery programme. It's important that local service users find and use their independent voice to lead the recovery we receive in our communities.

We would like to thank Plymouth DAAT, NTA and DDN for their support in enabling us to have a platform to represent Plymouth service users. It's vitally important that our treatment centres support and encourage our independent voice and we would like to thank Broadreach House and Hamoaze House for enabling that.

Rab Smith, Plymouth SURF
Email: surfplymouth@gmail.com

MY CANNABIS DIARY

In the third part of his story, Nigel Chambers tries to juggle his cannabis use with employment

MOST OF MY ADULT LIFE I have found and stayed in various different jobs, but again cannabis ruled the way I functioned. How I managed to stay in employment is beyond me. I've worked in many different roles throughout my life because I never stuck to one job. But how I ever got through the interviews I do not know – I always made sure that I was topped up with cannabis before I went.

I had a shopfitter's job which included working at heights of over 30 feet. When I think back to that I realise that not only did I endanger my life, but those of other employees. Not only was I stoned before going into work, I also rolled joints for my break time – I don't know how I got away with it.

As a shopfitter I was travelling all over the country to various different stores. I had a company van and am I pretty shocked when think back to how I was driving under the influence of drugs. I never told my employers that I had a drug problem as I thought it would do me no good. I would have certainly lost my job and they'd probably also have informed the police.

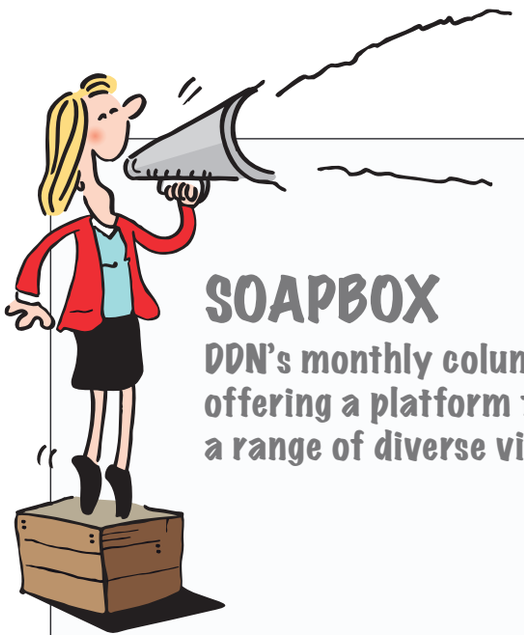
I thought I was leading a normal life, but I now realise that I was probably physically impaired, with slower reactions. There I was, working from heights with people working underneath me – thankfully I never injured any of my colleagues. I think it was down to my tolerance of the drug that I couldn't function for the first hour of the 12-hour shifts I was working, but I kept topping up the levels of cannabis during my breaks.

I also worked in hotel kitchens as a chef, where there could have been many accidents. I just don't know how I managed to work in such highly demanding environments with my drug addiction. I used the cannabis to control my mood swings as I didn't like being rushed at work – after all I wasn't getting paid a fortune, so why should I run about? My attitude towards employment was to do as little as possible.

When there were gaps in my employment, I also sat quite a few free college courses while claiming job seeker's allowance. How my brain absorbed the information about the subjects I do not know, but passed the exams so it was all well and good. I thought that it was normal to live in two different worlds.

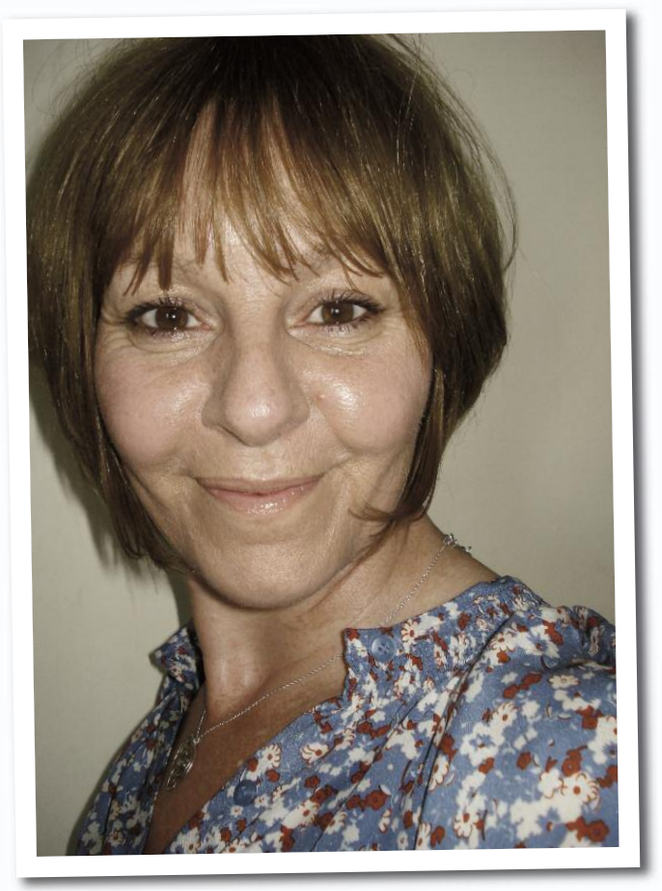
It was hard to recognise the effect that cannabis was having on my behaviour in those days. I was having a good time rebelling against society and my family life, so spotting the long-term effects didn't even come into play. But as I continued to use, I became reclusive and paranoid to the extent of thinking the whole of society was looking at me. My mood swings became intolerable – one minute I was up and the next I was severely down. Anxiety and stress became a big part of my life and I was too scared to even answer a knock at the door, let alone open the mounting pile of debt letters. It was now affecting me financially as well as mentally.

Next month: Nigel tries to access treatment



SOAPBOX

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



ALL CHANGE PLEASE!

We need a major shift in thinking to be more creative and less prescriptive if we're to help our clients in the current climate, says Amanda Allmark

I RECENTLY ATTENDED THE RCGP/SMMGP 16TH NATIONAL CONFERENCE: *Working with drug and alcohol users in primary care*. One of the specialist interest sessions that particularly stood out for me was 'An overlooked aspect of the recovery agenda: managing drug users who are not doing well in treatment'.

I felt a sense of excitement and anticipation on entering the room – I was going to be taking away new and innovative ideas to enhance my work. We were led through a series of slides telling us why this particular client group were difficult to engage and 'not getting better'. They were the obvious reasons, social issues such as lack of housing, employment, poor health, crime – the list goes on. The tone of the presentation felt negative and uninspiring. There appeared to be no attempt at finding a solution.

It became clear that my expectations were unfounded. I could feel a degree of impatience rising in me and a nagging voice saying 'cut to the chase'. The upshot of the session was 'we need to work harder'. It was difficult to swallow this statement, especially given that I was in a room with people who were carrying caseloads in excess of 90 clients. I am uncertain how any quality service can be provided in what can only be described as a 'sausage factory'.

I felt compelled to challenge this, by asking, 'Is it not rather patronising to generalise and make the assumption that people are not already working hard?' I would add at this point that I am not resistant to change – I personally would like nothing better than to see service users empowered and moving forward with their lives drug free, rather than being entrenched in a system that has facilitated the 'ball and chain' of prescribing.

I went on to say that perhaps a more positive approach would be to be more creative and less prescriptive in our work, that surely more money should be invested in developing practitioners' skills, and that we should be working in a more holistic way if we are to make any progress on the journey to recovery.

Following several rounds of ping-pong it became evident that I was flogging a dead horse when the response I got was 'we should not be so arrogant to think we are perfect'! I think it is a little arrogant to suggest that anybody that took the time to enter this forum had the preconception that they were perfect. It was at this point that I decided to make my exit, and it was only afterwards when I bumped in to another person who had been in the room that I was told that 80 per cent of the room had followed me out. To me that spoke volumes.

I am a key worker, and the definition of key is 'a small metal instrument specially cut to fit into a lock and move its bolt'. I take this role very seriously – clients literally put their lives in our hands. Evidence shows that the most important aspect of our role is the therapeutic relationship we have with clients, and this is central to providing patient-centred care. Therefore, surely, there is a duty to support us in fulfilling this role, safely, ethically and effectively. If we are to embrace the changes ahead, and indeed succeed, then attitudes have to shift.

One hat does not fit all. We are working with individuals who each have their own unique map of the world. It is very often our core beliefs and values that define who we are. Sometimes those beliefs and values can become skewed along the way, and are very often put on us by other people from an early age. It is about having the tools to help individuals unlock and recognise this, creating an opportunity to break negative patterns and move forward.

Within our remit, the 'value' is making sure clients' needs are met and that they get the best possible outcome from our services. As practitioners, GPs, managers and commissioners we all have our own 'beliefs' – providing the best possible client-centred care, meeting health and prescribing needs, making sure targets are met, making shoestring budgets stretch further... the list is endless, while adhering to the 2010 Drug Strategy.

Values and beliefs determine how we communicate. Aligning our values and beliefs through a shift in thinking, how we use language, and recognising and using our inner resources to create positive states to become more cohesive, can only enhance the effectiveness of what lies ahead. **DDN**

Amanda Allmark is a drug and alcohol practitioner in South West England

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Author Catherine Dixon is a wellbeing being coach, therapist and teacher with nine years' experience in professional practice

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Dr Amal Beaini, *Detox 5*
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Huw Harries, *Anglesey & Gwynedd Recovery Organisation*

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Cambridgeshire County Council

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Cambridgeshire DAAT are a partnership of key agencies including county council, health, police, prisons, probation and others and this role works on behalf of these partners to reduce the harm caused by substance misuse in the county, inclusive of community and prison. This is a wide and varied role and you will need the ability to communicate and work effectively with a range of individuals and organisations including Chief Executives, Strategic Health Leads, frontline staff and those receiving our services.

You will work to the DAAT Criminal Justice Lead and report to relevant partnership groups, to ensure that what we are delivering meet the values and service delivery principles of the County Council. **Ref: JAC414**

To apply visit www.jobsincambs.com or call 01223 507222 quoting reference number. Alternative formats on request.

Closing date: 14 June 2011.
Short listing date: 21 June 2011.
Interview date: 1 July 2011.

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West Sussex County Council

Local Partnerships Promoting Recovery for Drug and Alcohol Users

The West Sussex DAAT Partnership are planning to procure a range of specialist drug and alcohol treatment services some of which are locality based and some which are county wide. West Sussex wishes to consult with providers to explore the way forward on how, a range of services to support drug and alcohol service-users, can best be provided from 1 February 2012.

The West Sussex DAAT Partnership have a strong focus on commissioning services for people with drug and alcohol problems, that provide the opportunity to deliver abstinence, treatment completion and long term sustained recovery. West Sussex expects to witness a firm integration between treatment services and the role of mutual aid and expects a key outcome of this procurement will be to deliver this integration through improved access to community resources, active peer support and prominent recovery focused activity. In addition, these services will provide a range of high quality interventions that support effective retention in treatment.

The market consultation event will be held on 28 June 2011. It is anticipated that the outcomes of this event will help inform the scope of the procurement exercise.

Further information is available from the County Council's eTender portal at: https://westsussex.bravosolution.co.uk/web/login.shtml

Organisations who wish to attend the market consultation event must register on the e-tender portal in order to access the additional information when available. The deadline for submitting your intention to attend the event is **17:00 on Friday 24th June 2011.**

Oxfordshire drug & alcohol action team

Oxfordshire Drug and Alcohol Harm Minimisation and Brief Intervention Service

Oxfordshire DAAT is designing a new treatment system as part of the national PbR Pilot. More information can be found on our website at www.oxfordshiredaat.org.

The Harm Minimisation and Brief Intervention (HM&BI) Service will run alongside our Drug and Alcohol Recovery Framework to ensure that the needs of all drug and alcohol users are met. The Service will be to provide harm minimisation and brief interventions for people who are not ready, do not want or do not need, to access recovery services. The service will proactively support 'recreational' drug users, stimulant users and heroin users to minimise harm, reduce harmful use and prepare, where appropriate, users for recovery. The service will also proactively seek and deliver interventions to all alcohol users that who would benefit from an enhanced brief intervention approach to reduce their alcohol use. The service will be provided across Oxfordshire, and will include a city based specialist needle and syringe programme, Level 3 (PH Needle and Syringe Programmes Guidance (NICE2009). This element compliments the 36 pharmacy based needle exchange sites in the county.

The scope and scale of this service is detailed in a Memorandum of Information (MOI) which can be accessed by all interested organisation via the Procurement website referred to below. Oxfordshire DAAT is seeking to procure one provider to deliver this county wide service.

Timings:

The PCT would like to be in a position to appoint a provider by October 2011 and implement the new service from January 2012.

The Procurement Process:

For further information about the procurement process, interested parties are invited to access the electronic portal www.pro-cure.bravosolution.co.uk where all Pre-Qualification Questionnaire (PQQ) documentation and a Memorandum of Information (MOI) can be accessed.

The Procurement will be conducted via this e-tendering website and if you want to express an interest in this opportunity please:

- *Register your organisation on the www.pro-cure.bravosolution.co.uk website.*
- *Access the Pre-qualification Questionnaire for the Harm Minimisation and Brief Interventions Service for Oxfordshire DAAT.*

Please note that the latest date for receipt of expressions of interest and the completion of PQQs is 17:00 on Monday 20th June 2011. All PQQs to be completed and returned via the website.

PQQs received/posted to the website after 17:00 on the Monday 20th June 2011 will not be allowed or evaluated.

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Closing date: 26th June 2011. Sorry but we do not accept CVs. No agencies please.

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for the treatment of alcoholism and other addictions

CASTLE CRAIG HOSPITAL IS LOOKING TO RECRUIT:

- **A TREATMENT COORDINATOR**
- **A LEAD THERAPIST / MANAGER FOR THE EXTENDED CARE UNIT**
- **AN ADDICTIONS COUNSELLOR / THERAPIST (TRAINEE)**

Castle Craig Hospital is the largest addictions treatment centre in the UK, and the only major hospital dedicated to the treatment of addictions. Our patients come to us from throughout Scotland and the United Kingdom as well as from mainland Europe and North America. We treat patients funded through the NHS, through personal or other insurance and through private means. Castle Craig is located in the Scottish Borders, half an hour south of Edinburgh and only an hour from Glasgow, and delivers a 12-Step based treatment programme.

TREATMENT COORDINATOR

This is a new position at Castle Craig Hospital. The treatment coordinator will oversee the management of a team of 27 therapists across two separate units (comprising a first and second phase of care), and will oversee the strategic development of the therapeutic programme. Maintaining the high standards of treatment and streamlining therapeutic treatment across the two units will be a particular priority of this role. As part of the senior management team, the treatment coordinator will be expected to contribute to policy making and ensure implementation of senior management policies. The treatment coordinator will be expected to maintain an interface with external agencies and purchasers as well as to attend and present at conferences.

The treatment coordinator will report to the Hospital Manager. The successful candidate will be required to have a master's or equivalent professional degree and / or at least eight years of relevant experience in the sector including management experience. A degree or diploma in counselling, psychology or nursing is preferable. Strong leadership, organisational, and communications skills will be required. Candidates must have a passion for and want to contribute towards the promotion of the 12 Step based treatment model, and residential rehabilitation care.

LEAD THERAPIST / MANAGER FOR THE EXTENDED CARE UNIT

The lead therapist / manager in the extended care unit will manage and oversee the professional development of a team of up to 10 therapists. The lead therapist will oversee the management of the delivery of the second phase of care for our patients. This is a challenging role which includes the line management and supervision of staff and coordination of the various components of the programme.

The job of lead therapist / manager of the extended care unit entails: overseeing caseloads; managing patient transfer from the detox and intensive unit (first phase of care); coordinating eventual patient discharge; involvement in public relations; as well as establishing systems and processes to monitor the smooth running of the unit.

The successful applicant should have experience in staff supervision, strong partnership working skills and should be ready to ensure that the services delivered to our patients consistently meet the high quality standards of the programme and our regulators. The successful applicant will also be required at times to manage a small case load and will be supported in their career development.

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We are seeking an enthusiastic trainee addictions counsellor to join our therapy team at Castle Craig Hospital. A degree or diploma in counselling, psychology or nursing is preferable. Experience in the 12 Step /Minnesota Model is required. Duties and responsibilities will include providing individual, group and family therapy for patients with alcohol and drug dependence. Successful candidates will also be expected to act as case managers for patients – working to coordinate all aspects of care for each patient, including developing individualised treatment plans and follow up with referral sources. An in-house training programme for the successful candidate's ongoing professional development will be provided.

For an application pack for any of these positions please contact: Mrs Mary McCann, Governance Assistant Manager, Castle Craig Hospital, Blyth Bridge, West Linton, Peeblesshire, EH46 7DH. Telephone: 01721 722763. Email: m.mccann@castlecraig.co.uk. Please note the closing date for applications is Friday 15th July 2011. For further information about Castle Craig Hospital please visit: www.castlecraig.co.uk

Havering
LONDON BOROUGH

EXPRESSION OF INTEREST FOR
Young People's Substance Misuse Services

The London Borough of Havering's Drug and Alcohol Action Team wish to invite expressions of interest from suitably qualified Service Providers for the performance of the following contract:

> **To provide a Children and Young Peoples Substance Misuse Service within the London Borough of Havering. The Service Provider will be expected to deliver a range of substance misuse services to young people including a Prevention and Early Intervention Service and a Specialist Structured Treatment Service.**

With a start date of April 2012, the Contract will be awarded for 3 years with an option to extend for another 2 years subject to consistently high performance. The tender process will follow the restricted procedure. The Pre-Qualification Questionnaire (PQQ) will be evaluated on the basis of: Financial Appraisal, Previous Experience, Commercial Aspects, Quality Assurance Methods, Policies and Procedures.

> *The Transfer of Undertakings (Protection of employment) Regulations 2006 may apply.*

Expressions of Interest can be communicated either by email or by formal request sent via email to sophia.rashid@havering.gov.uk or in writing to Sophia Rashid, Contracts Officer, Havering Drug & Alcohol Action Team, 3rd Floor Scimitar House, 23 Eastern Avenue, Romford, RM1 3NH. Telephone 01708 433093

Interest to be received no later than 12 noon on Friday 17th June 2011 following which the PQQ will be sent to the Service Providers who have expressed an interest in this Contract.

MY TURNING POINT

"It was when I saw how much happier my girlfriend was when she got clean – it motivated me to do the same."

Everyone's Turning Point is unique. It's the moment when they realise they've made a small, but important, step forward. Very often, that small step is the start of something bigger. But only when the right support, advice and services are in place. That's where you come in, providing joined-up support for people struggling with substance misuse throughout Somerset.

Nurse / Project Workers / P/T Support Worker

Whether you've worked in substance misuse before or have a related background in, say, nursing or criminal justice, find out more at **turning-point.co.uk/workforus**

TURNING POINT
turning lives around

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want to join a young, dynamic, expanding team?

TTP Counselling Ltd – Vacancies this month

Due to continued expansion, we are pleased to offer the following exciting opportunities

CHORLEY

Administrator – experience with benefits and multi-agency working preferable 14k

Primary Counsellor – With Counselling Diploma and at least two years experience in the substance misuse field essential. 21-25k

Bank and Full time Nurses – RMNs and RGNs for our new Inpatient Detox Facility. 21-25k

LANCASTER

Housing Support Workers to work evenings and weekends in our new Recovery Academy. 14k

Recovery Training Assistant to support the multi-disciplinary team. 14k

LUTON

12 Step Counsellor. This is an exciting new position to facilitate the growth in our flagship centre. 21-25k.

Housing Support Workers to work evenings and weekends. 14k

BRADFORD

Primary Counsellor – For a new, exciting Residential unit. With Counselling Diploma and at least two years experience in the substance misuse field essential. 21-25k

Bank and Full time Nurses – RMNs and RGNs for our new Inpatient Detox Facility. 21-25k

Housing Support Workers to work evenings and weekends in our new Housing Project and Recovery Community. 14k

COVENTRY

Autumn starts:

Housing Support workers to work evenings and weekends in our new Housing Project and Recovery Community.

Recovery Coaches with experience in delivering substance misuse groups and peer support. An ideal opportunity for recently qualified or workers in training. 14-17k

WARRINGTON

Trainee Counsellor/Recovery Coach to work within our multi-disciplinary team. 14k

Internal applications from within TTP and IHP are encouraged. For an application form and job description, please call Angela Cochrane on 01582 589040 or alternatively contact by email on angela.cochrane@ttpcc.org. TTP is an equal opportunities employer. Those with personal experience of addiction or dependency on drugs/alcohol and who are at least two years drug free/ sober are also encouraged to apply for the above positions.

ttp counselling — alcohol and drug rehab — www.ttpcc.org