SPRING RESIDENTIAL TREATMENT DIRECTORY INSIDE

DDN
Drink and Drugs News
www.drinkanddrugsnews.com
ISSN 1755-6236 April 2013

'Too many women are imprisoned unnecessarily in the UK... Community provision for non-violent women should be the norm.'

WORK WORKS

POSITIVE STEPS TO REFORM WOMEN'S JUSTICE

First Steps to Your Own Private Practice

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One of the past delegates, Tracey Hampton – Smith, Senior CBT Therapist says:

"Having worked in the NHS for the best part of 30 years the prospect of going it alone in private practice was daunting to say the least. Actually, it was downright terrifying! I had no idea where to start to even think about whether it would be a possibility for me, tax and financial things bought me out in a cold sweat, what if I got it all wrong?

So, when I saw that there was a workshop which would answer my questions, I dived straight in. I just needed to have all my questions answered, even though I am not planning to go into private practice at the moment!

By halfway through the morning, I'd got my money's worth! Most of my questions were answered, or on the way to being. Colin Clerkin was an excellent presenter, keeping us engaged throughout, enthusiastic about the subject and clearly knowledgeable…

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Dates & Venues

LONDON (The British Psychological Society)

20 MAY 2013

Course Tutor:

Dr Colin Clerkin, HCPC-Registered Clinical Psychologist & Coach

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DDN Drink and Drugs News

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

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: Chris Price/iStock

Editorial - Claire Brown

Toxic trap

Giving women support over punishment

'A vicious cycle of victimisation and criminal activity develops, creating a toxic lifestyle that is extremely difficult to escape.' This comment from the 2007 Corston review of vulnerable women in the criminal justice system demonstrates why prison is not always the answer and can often compound problems to become a lifetime's involvement with incarceration, with all the heartbreak and family break-up that entails.

In our cover story this issue, Katy Swaine Williams and colleagues share knowledge from the Prison Reform Trust, making a very powerful case for community solutions over short prison sentences – an argument backed by research demonstrating cuts in reoffending rates. They acknowledge that there is still much more to be learned about how such women can be supported to access treatment in the community – underlining the value of debate at the recent Kaleidoscope Project conference in Cardiff (see report on page 10). Bringing together speakers from the police, social research, healthcare and charities gave a powerful perspective on the many pressures that drive women into destructive behaviours – and highlighted the desperate need for support in breaking cycles of self-destructive behaviour. It makes obvious sense of the Prison Reform Trust's call for a statutory requirement for 'appropriate, gender-specific provision', in every area of the country.

This issue

p06


p10


p16

FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES AND TENDERS

CENTRE PAGES: SPRING RESIDENTIAL TREATMENT DIRECTORY

NEWS IN BRIEF

COUNCIL CALL

London's drug and sexual health services are failing to respond appropriately to gay men's drug use, according to NAT (National Aids Trust). The trust has written to councils calling for action to address a 'recent and rapid rise' in the use of mephedrone, crystal meth and GHB/GBL in London's gay scene, citing high levels of injecting drug use and needle sharing. 'We are calling on the London councils as they take on their new responsibility for commissioning both sexual health and drug services to meet this challenge and commission integrated sexual health and drugs services tailored specifically for gay men,' said NAT chief executive Deborah Jack. 'This is essential if we are going to reduce the high rates of HIV and STI transmission.' *See news focus page 6*

EC WARNING

The ongoing economic crisis will see more young people selling and producing drugs – especially home-grown cannabis – at the same time as budget cuts hit treatment and harm reduction services, according to a new report from the European Commission (EC). The study was a 'wake-up call for Europe', said EU justice commissioner Viviane Reding. *Study available at ec.europa.eu*

RURAL RELIEF

UNODC and the United Nations Industrial Development Organization (UNIDO) are to promote grassroots development in poor rural communities dependent on the cultivation of drug crops. 'We need to ensure that they are provided the tools to support their livelihoods, through capacity-building activities and job opportunities,' said UNIDO director general Kandeh Yumkella. Afghanistan could serve as a pilot country to develop a joint UNODC-UNIDO project, he added.

DRUG LEGACY

Fewer young people are entering drug treatment in Scotland, according to figures from ISD Scotland, with the proportion of people aged 30 and under at initial assessment falling from 49 per cent to 38 per cent since 2006/07. While the statistics were a 'welcome sign of progress' they were also a reminder that Scotland is 'dealing with a long legacy of drug use', according to community safety minister Roseanna Cunningham. 'The majority of individuals accessing treatment are older drug users, many of whom will have been using drugs for several years if not decades.' *www.isdscotland.org*

Huge increase in alcohol-related liver disease in under 30s

The number of hospital admissions for alcohol-related liver disease in people under 30 has risen dramatically in the last decade, according to figures from Balance, the North East Alcohol Office.

There was a 117 per cent increase in admissions for under 30s in England between 2002 and 2012, with 115 people under the age of 30 admitted to hospital last year compared to just 23 in 2002/03. The North East, however, saw an increase of 400 per cent over the same period.

The total number of admissions across all ages rose from 25,706 in 2002/03 to 49,456 in 2011/12 – an increase of 92 per cent. Admissions for women have increased by 91 per cent in England, rising to 114 per cent in Yorkshire and the Humber.

> **'We have to start taking this seriously – if this was any other illness immediate action would be taken...'**
> Eric Appleby, Alcohol Concern

Alcohol Concern chief executive Eric Appleby said the figures were 'terrifying', showing an increase in alcohol-related liver disease 'across both sexes, in every age group, in every region of the country. It's particularly sad to see the number of young people with this awful disease more than doubling. We have to start taking this seriously – if this was any other illness immediate action would be taken to halt this, so we call on the Department of Health to outline what action it intends to take.'

There have also been steep rises in hospital admissions for alcohol-related cancers, as well as in admissions for over-60s with alcohol-related mental health problems.

The number of over-60s requiring hospital admission for alcohol-related mental health issues rose by 150 per cent in the decade to 2012, according to research by Dr Tony Rao, consultant psychiatrist at South London and Maudsley NHS Foundation Trust. Admissions in people aged 60-74 for mental and behavioural disorders related to alcohol rose from 3,247 to 8,120, and there was also a 140 per cent increase in the number admitted for Wernicke Korsakoff syndrome, a form of alcohol-related brain damage.

'More people are waking up to the devastating impact alcohol can have on their liver but we rarely talk about the mental health problems it causes,' said Dr Rao. 'Increasing numbers of older people are living with alcohol-related dementia, anxiety and depression – and it's their loved ones, carers and the rest of society who are left picking up the pieces.'

Meanwhile, hospital admissions for alcohol-related cancer have increased by 28 per cent in eight years, according to a report from the Alcohol Health Alliance UK (AHA). Admissions rose from 29,400 in 2002/03 to 37,600 in 2010/11, says AHA, and although alcohol can cause cancer of the mouth, larynx, oesophagus, pharynx, bowel, breast and liver, four out of ten people are still unaware that it is a risk factor.

'There's strong scientific evidence that alcohol increases the risk of a range of different cancers, but this still comes as a surprise to many drinkers,' said Cancer Research UK's executive director of policy and information, Sarah Woolnough. 'It's not just heavier drinkers who are at risk – the more you can cut down on alcohol, the better.'

AHA is among the organisations urging the government to stand firm on its commitment to introduce a minimum price per unit of alcohol, following indications that it may abandon the idea. 'The only opposing force that has emerged against MUP [minimum unit pricing] in recent times has been a high profile, well-funded campaign led by the global alcohol producers,' said AHA chair Professor Sir Ian Gilmore. 'This is a group with a clear interest in prioritising profits over public health.'

However, according to figures from the Office for National Statistics, the number of people reporting that they drank heavily – categorised as drinking on five or more days a week – fell in the five years to 2011, but the report cautions that surveys record lower levels of consumption than could be expected from alcohol sales data and that 'obtaining reliable information about drinking behaviour is difficult.'

- *Liver disease figures at www.balancenortheast.co.uk*
- *Trends in alcohol related admissions for older people with mental health problems: 2002 to 2012 at www.alcoholconcern.org.uk*
- *Alcohol and cancer at www.rcplondon.ac.uk/projects/alcohol-health-alliance-uk*
- *Drinking (general lifestyle survey overview – a report on the 2011 general lifestyle survey) at www.ons.gov.uk*

Local authorities unready for hep C responsibility

Local authorities are 'not ready to take responsibility' for hepatitis C, according to an audit of English commissioners and local councils by the Hepatitis C Trust.

Despite local authorities assuming responsibility for public health, just a quarter are aware of how many people in their area are living with – or at risk of – hepatitis C, says *Opportunity knocks? An audit of hepatitis C services during the transition*, while only 20 per cent have an appointed hepatitis C lead. Fewer still have a strategy for tackling the virus, and just 40 per cent have arrangements in place with NHS commissioners to coordinate hepatitis C work. Almost half of NHS commissioners, meanwhile, have no measures in place to increase treatment.

All local authorities need to develop a comprehensive hepatitis C strategy, jointly agreed with commissioning groups and taking account of local need, says the document, as well as having a designated liver health lead on their health and wellbeing board with hepatitis C a clear part of their remit. The report also calls for Public Health England to set out plans to establish a national liver intelligence network, and for authorities to ensure that preventative measures are targeted to all at-risk groups in their local communities.

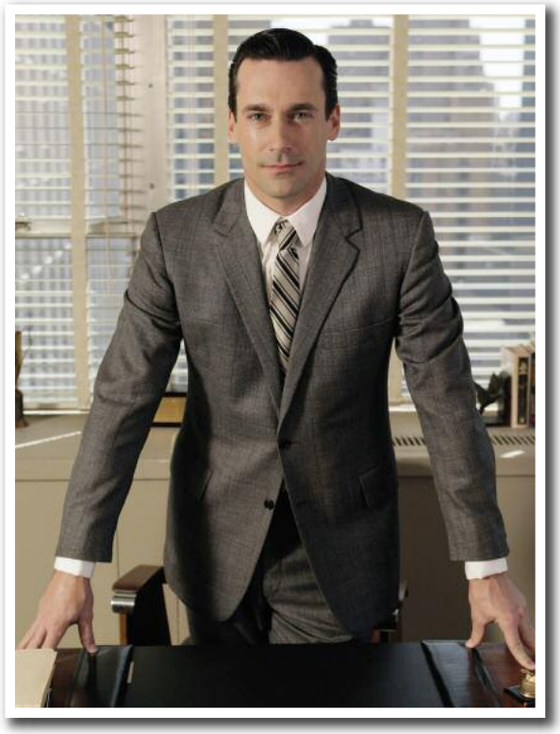
Around 216,000 people are thought to be infected with the virus in the UK, while the government has still to deliver its 15-month-overdue liver strategy, the Hepatitis C Trust points out. 'We face a real challenge in ensuring that public health and NHS services are commissioned holistically,' said chief executive Charles Gore. '2013 is a critical year for the NHS and local authorities. With the correct action, it can also be a turning point for hepatitis C. We could eradicate hepatitis C in the UK in a generation. What a tragedy to look back in 20 years and realise that we didn't eradicate it when we had the opportunity.'

Meanwhile the Health Protection Agency (HPA) has confirmed that a person who injected heroin has died from an anthrax infection in Suffolk, while NHS Greater Glasgow and Clyde also confirmed the death of an injecting drug user who had tested positive for anthrax.

The deaths bring the number of UK cases in the current outbreak to eight. Five of these have been fatal, and there have also been non-fatal cases in Germany, France and Denmark. 'We have advised local agencies to talk to their service users who inject drugs about the risk of anthrax infection,' said HPA consultant in communicable disease control Dr Chris Williams.

Research published in the scientific journal *Eurosurveillance* shows that the same bacillus anthrax strain could be responsible for all of the cases of anthrax among European drug users dating back as far as 2000, when a drug user in Norway became infected. The results 'indicate the probability of a single source contaminating heroin and that the outbreak could have lasted for at least a decade', it says.

www.eurosurveillance.org



Please Mr President: *Mad Men* star Jon Hamm is one of more than 175 American entertainment figures, civil rights leaders, business leaders, academics and others who have signed an open letter to the US administration urging it to implement more alternatives to incarceration for non-violent drug offences. Among the policy recommendations are measures to reduce the sentences of those jailed for crack-related crimes, to make them 'more consistent with the magnitude of the offence'. Offences related to crack dealing, which has been largely confined to America's black community, have historically attracted far more severe punishments than comparable crimes involving powder cocaine, and one in nine black children in the US now has an incarcerated parent, compared to one in 57 white children. *More at globalgrind.com/endthewarondrugs*

NEWS IN BRIEF

ADDICTED TO PUNISHMENT

Some non-violent drug offenders in Latin America receive harsher penalties than murderers, according to a new report from human rights organisation the Washington Office on Latin America (WOLA). Penalties for offences including small-scale selling have 'skyrocketed' over the last decades, says *Addicted to punishment: the disproportionality of drug laws in Latin America*, and consistently fail to 'distinguish between the severity' of different crimes. 'Not only is disproportionate sentencing unjust, but it also overloads prison systems and draws funds and focus away from legitimate regional concerns,' the document states. *Available at www.wola.org*

MENTAL EFFORT

A report on steps the government needs to take to achieve parity between mental and physical health has been issued by the Royal College of Psychiatrists. It highlights the 'significant inequalities' between mental and physical healthcare and lower funding rates for mental healthcare 'relative to the scale and impact' of mental health problems. The document calls on the government to establish equivalent rates of access for mental health services, and for public health programmes to focus on the 'mental health dimension' of issues like substance use. 'The government says it wants to put mental health on a par with physical health but this report shows how much needs to be done to make that a reality,' said Rethink chief executive Paul Jenkins. *Whole-person care: from rhetoric to reality at www.rcpsych.ac.uk*

CONCERNING ISSUES

More than 500 health and NGO professionals from 60 countries have signed a 'statement of concern' about the activities of global alcohol producers. The statement, which has been sent to the World Health Organization's director general, urges that 'unhealthy commodity industries' should have no role in forming public health policies. 'What we are witnessing is the global alcohol producers adopting the same tactics that the tobacco industry used for years in their efforts to prevent public health policies that could save lives,' said chief executive of Alcohol Focus Scotland Dr Evelyn Gillan. *Statement at www.globalgapa.org*

CRIMINAL GUIDANCE

A briefing paper on commissioning and provider arrangements for healthcare services in custodial settings has been published by the Revolving Doors Agency. The document includes an overview of changes as well as guidance for organisations 'engaging with the new health commissioning landscape'. *Supporting vulnerable people in custody and at court at www.revolving-doors.org.uk*

DO EMERGING DRUG USE TRENDS IN PARTS OF LONDON'S GAY SCENE RISK CREATING A NEW HEALTH CRISIS?

DDN reports on the National Aids Trust's call for urgent action

Late last month NAT (the National Aids Trust) wrote to London councils calling for action to address the 'recent and rapid rise' in the use of crystal meth, mephedrone and GHB/GBL on London's gay scene, particularly 'in the context of high risk sex' (see page 4).

In a very short period this has become 'one of the most pressing issues for gay men's health', the letter states, with the three drugs responsible for 85 per cent of all presentations to Antidote, the capital's only LGBT drug support service, last year, compared to just 3 per cent in 2005.

'The vast majority use these three drugs to facilitate sex', the letter states, with further evidence of the connection between sexual health risk and problematic drug use in the rise in referrals to Antidote from sexual health clinics – up from 8 per cent of presentations in 2005 to 63 per cent in 2012.

Worryingly, the number of crystal meth and mephedrone users injecting the drugs in a sexual context leapt from 20 per cent in 2011 to 80 per cent in 2012, with 70 per cent of those injecting reporting sharing needles. Around 75 per cent of the men using Antidote's services are HIV positive, with 60 per cent failing to adhere to their HIV treatment when under the influence of drugs.

'We'd obviously known for many years that there was significant drug use on the gay scene,' NAT's director of policy and campaigns, Yusef Azad, tells *DDN*. 'What has changed is the sort of drugs that are used and the context in which they're used. We'd heard about crystal meth in the US and I recall asking health promoters in the UK about it and being told it wasn't an issue here, but it became an issue and I'd guess about three to four years ago we first started hearing anecdotal reports of slamming [injecting], as it's known.'

The overall prevalence of this sort of drug use remains unclear, and one priority is for more research, he stresses. 'What is clear is that there is enough of this sort of drug use going on for it to be very problematic for the health of the individuals concerned. There have been a few deaths, and certainly a real transmission risk around HIV and hepatitis C. Maybe what we can say is that among some gay men who were engaged in risk activity, their risk is becoming even higher risk as a result of these changes in drug use and sexual behaviour.'

The letter also cites evidence from Chelsea and Westminster Hospital's Club Drug Clinic and the 56 Dean Street sexual health clinic that reflect Antidote's findings. 'I think it shows there's something of a health crisis, without wishing to be sensational, that we need to act on now – speedily, effectively and urgently,' he says.

Does he feel that drug services are geared up to respond? 'No,' he states. 'We held a roundtable in January on HIV and injecting drug use generally, but what was fascinating was how the gay men's issue really shot up the agenda. One of the things that was clear is that traditional drug services – which we absolutely support and which have done amazing work – are used to opiate users, used to providing harm reduction with needle and syringe packs with citric acid for heroin use. They're not necessarily trained in what harm reduction means for these

'The number of crystal meth and mephedrone users injecting the drugs in a sexual context leapt from 20 per cent in 2011 to 80 per cent in 2012, with 70 per cent of those injecting reporting sharing needles.'

new drugs, nor are they necessarily trained in discussing drug use in the context of gay men's sexual behaviour, and sometimes quite sort of esoteric sexual behaviour.'

Gay men have reported drug workers being uncomfortable or embarrassed by the sexual context of the drug use, while service users could also be uncomfortable if they think the worker might be judgemental. Is training the answer?

'We probably need a two-pronged approach, one of which is that generic drug services become much better at identifying the distinctives around the particular drug use we're talking about, but also that they're trained in terms of non-judgemental discussion, discussion of sexual risk and that they know whom to refer to in terms of service support. But we also need some new specialised services, and that of course is where there's a question mark.'

Does NAT get the impression that this is something that's limited to younger people? 'I don't think it is,' he states. 'If you look at the proportion of service users who are HIV positive, it's 75 per cent at Antidote and knowing the age profile of people with HIV there will be some young men but there are certainly are men in their 30s, 40s and 50s. It's not just young men early on the scene – many are very experienced on the gay scene and have moved on to these drugs from other club drugs.'

The letter has been sent to London local authorities – is it largely a London issue, or is there evidence of similar trends elsewhere? 'If it's a London issue then it is a national issue, because so many men come to London for clubbing and sex parties and so on,' he says. 'So far all the data seems to come from London, but that's partly because the main services are in London and it's the services that are gathering this information. There have been some requests for support from Brighton and Manchester, but there does not as yet seem to be the same levels of use of these drugs in the contexts described in our letter, which of course means we must use this window to prevent such problematic use spreading to other gay centres in the UK.'

With drug treatment, HIV prevention and sexual health services now under the public health remit of local authorities, there are opportunities to join up services and do things 'differently and better', NAT urges, and the letter calls for well-funded 'open access, appropriate and tailored services' to be commissioned as soon as possible. But with many drug services feeling they might not be seen as a priority in the new public health landscape, how confident is NAT that the money will be there?

'We weren't confident unless we did something, which is why we wrote the open letter. This is obviously a time of immense change – the good thing is that there's a pretty decent national public health allocation, and sometimes new people can look at need freshly. We focused on councils taking on these responsibilities as an opportunity for innovation and to implement change, and we know from talking to them that a lot of councils are up for that, so I don't think we should be by default pessimistic on this.'

Is the public health argument also just too strong to overlook? 'We certainly think the public health argument is immensely important. We're not claiming this is the majority of gay men – far from it – but if you have a group of gay men where there is very high drug and sexual risk taking, and very high HIV and hep C transmission rates, this has a ripple effect on the level of transmission in the whole gay community, because men in this group will have sex with other people as well.'

There are also, of course, the harmful impacts of crystal meth on mental and physical health generally. 'Yes, we need to look at this holistically,' he states. 'We need to be worried about mortality again, about HIV, hep C and mental health and, in that context, equip drug services to deal with a very fast changing drug use scene and equip them to deal respectfully and with some degree of knowledge and appropriateness with gay men.

'One of the things raised at the round table, given the rate that legal highs proliferate, is that maybe there should be some generic harm reduction advice even if you have no idea what it is that the person's taking. The letter isn't a criticism of drug services as such – it's tough to keep up with these things.'

www.nat.org.uk

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

In a rare outbreak of common sense, ministers are axing plans for a minimum alcohol price. The hardest-up and responsible drinkers would have been clobbered, with supermarket booze rising sharply. It was always a misguided solution to alcohol abuse. It is not the job of governments to set shop prices.
Sun editorial, 12 March

Even if the case for drink pricing were not medically overwhelming, it is obvious that any decent person would prefer to be on the same side of an argument as Dr Sarah Wollaston, the admirable Totnes MP, as opposed to the wheedling teen-poisoners of the drinks industry.
Catherine Bennett, *Observer*, 17 March

Increasingly, the shame is being taken out of poor-shaming. It didn't seem so long ago that most people would think twice about denigrating fellow citizens who were having a hard time. These days, it appears to have been sanctioned as a new national bloodsport, regularly slipping under the PC-radar as little else manages to.
Barbara Ellen, *Observer*, 3 March

This is the tedious narrative. Poverty is sinful, and it must be punished... And so the state must shrink to a nub, because the humans who need it don't deserve it. Not that the government will say this publicly yet; it is still better, at this stage, to lie to parliament, to the media, to us all.
Tanya Gold, *Guardian*, 25 March

Still the welfare bill keeps rising though the coalition has repeatedly pledged to reduce it... Work must be seen to pay and a life on welfare must be made to seem infinitely less attractive than it does now. Until that fundamental change occurs, the bills will keep going up.
Express editorial, 26 March

Many of today's parents smoked weed; quite a few will have snorted coke, but nervously, in a nightclub loo. For their children, however, the taboo against drugs is weaker than at any time since Victorian ladies injected themselves with morphine at tea parties.
Damian Thompson, *Telegraph*, 2 March

The mentality and behaviour of drug addicts and alcoholics is wholly irrational until you understand that they are completely powerless over their addiction and unless they have structured help they have no hope.
Russell Brand, *Guardian*, 9 March

If drug 'addicts' can give up their drugs by using self-control, then 'addiction' doesn't exist. They can stop if they want to. Obvious, isn't it? Not to my old foe Russell Brand, now pontificating grandly on the subject in the *Spectator*, the *Guardian* and the *Sun*. This alleged comedian, in his designer rags, is fast becoming the voice of the Establishment. Perhaps the Tory Party – in its endless quest to be fashionable – could skip another generation, and make him its next leader.
Peter Hitchens, *Mail on Sunday*, 10 March

The brutal indifference towards the bedroom tax indelibly shames ConDem ministers... Work and pensions secretary Iain Duncan Smith married money and lives in wife Betsy's ancestral home, with its swimming pool and tennis court. He should hang his head in shame for the pain he'll inflict on families which are less fortunate than his own.
Kevin Maguire, *Mirror*, 6 March

DOING WHAT

Katy Swaine Williams and **José Aguiar** discuss much-needed steps to reform women's justice

Too many women are imprisoned unnecessarily in the UK, many on remand or serving short sentences, and most for non-violent offences. For many of these women, drug and alcohol issues are intimately connected with their offending behaviour. In turn, problematic substance use all too often coincides with underlying mental health needs and domestic abuse.

Research shows that women are more likely than men to report that their offending was to support someone else's drug use, as well as their own. As one commentator quoted in the 2007 Corston review of vulnerable women in the criminal justice system put it, 'A vicious cycle of victimisation and criminal activity develops, creating a toxic lifestyle that is extremely difficult to escape.'

For some, prison does provide a form of escape, albeit temporary. It may prove a refuge from domestic violence or sexual abuse, or it may be the place where women first access treatment for drug or alcohol problems – although for others it is where substance use problems first develop. However, while drug treatment services in prison are better than they were, problems persist with the transition from community to prison and vice versa, and short sentences are unlikely to allow for effective treatment. Release is a dangerous time, with women prisoners nearly 70 times more likely to die during the week after leaving prison relative to the general population, with 59 per cent of those deaths drug related.

More often than not, prison compounds the problems that may have contributed to women's offending behaviour in the first place. The trauma of separation from children, loss of income and housing and the breaking of links with health and social care services all contribute to the damage that can be caused, even by short sentences.

This is why the Prison Reform Trust, supported by the Pilgrim Trust, has adopted a three-year programme to reform women's justice. We are working alongside civic society organisations including the Soroptimists and the National Council of Women to put an end to the unnecessary imprisonment of women who pose no risk to the public, including those affected by drug and alcohol issues.

The Corston review concluded that 'community provision for non-violent women should be the norm' and received cross-party support, yet women's prison numbers remain much too high and gender-specific community support and supervision – often provided through women's centres – lurch from year to year with uncertain and increasingly limited funding.

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Government research has shown that community sentences are more effective in reducing reoffending than short prison sentences, and gender-sensitive community sentencing – taking account of childcare needs and carried out in safe environments – is known to help reduce offending behaviour. Sentences can include mandatory treatment for mental health, drug and alcohol problems, and while this may present ethical dilemmas for treatment providers it is surely preferable to seeing women locked up by magistrates who hope that they will get the treatment they need while inside.

Through our Talking Justice programme, supported by the Monument Trust, we aim to increase public understanding of community solutions to women's offending and inform public debate. The solutions include improving and extending specialist community support for women at risk of offending, as well as ensuring that liaison and diversion services for those with mental health needs and learning disabilities – currently available in some police stations and courts, and due to be extended across England and Wales – make appropriate provision for women.

As in the prison system, women represent a small minority of community drug and alcohol treatment service users. Mainstream services can help to redress this balance by holding women-only groups and drop-in sessions, and by working closely with specialist partner organisations like Women's Aid and local women's centres. However, treatment providers acknowledge there is

WORKS

much more to be learned about how women can be better supported to access treatment.

The Kaleidoscope Project's conference in Cardiff last month (see page 10) provided a welcome opportunity to examine how better use can be made of community solutions. There is room for optimism in Wales, and the opportunity to lead the way in delivering effective community services for women, with Wales Probation and the Association of Chief Police Officers (ACPO) Cymru working together to tackle women's offending. The Integrated Offender Management (IOM) Cymru board has endorsed the development of a women offender pathfinder to manage women offenders under a coordinated 'whole system' approach from first contact with the police onwards, and the National Offender Management Service (NOMS) has committed to reducing the number of Welsh women in prison by increasing the community sentencing options and prevention activities.

The Ministry of Justice is undertaking a review of the women's prison estate which hopefully will lead to a reduction in women's prison places and the eventual development of a network of smaller, local units for the minority of women offenders for whom prison is the only option. The department has to reduce its resource budget by 23 per cent by 2014/15, which should provide a powerful incentive to make prison a genuine last resort and focus investment on community solutions.

This means ensuring appropriate, gender-specific provision is made in every area across the country to allow women to be supported and supervised in the community to address the underlying causes of their offending behaviour, and we are calling on the government to make it a statutory requirement under the Crime and Courts Bill for this provision to be made available nationwide.

Radical steps to reform women's justice are also being taken in Scotland following the Commission on Women Offenders, and Northern Ireland's Department of Justice has set out an ambitious programme aimed at addressing women's offending in the community where possible. And the Ministry of Justice's strategic objectives, published last month, show encouraging signs that justice ministers in Westminster share this determination to reform women's justice and do what works. **DDN**

Katy Swaine Williams is head of outreach at the Prison Reform Trust, José Aguiar is an educational consultant. With input from Jenny Earle, Reforming Women's Justice programme director, Prison Reform Trust

www.prisonreformtrust.org.uk

FACTS – women, drugs and prison

- ***Between 2000 and 2010 the women's prison population increased by 26 per cent. A total of 10,181 women were received into prison in 2011***
- ***Forty-five per cent of women leaving prison reoffend within one year***
- ***An estimated 17,240 children are separated from their mother each year by prison and about two babies are born each week to women prisoners in England***
- ***Most women entering prison under sentence in England (81 per cent) have committed non-violent offences. Among the most common are theft and handling stolen goods***
- ***Over half the women in prison report having suffered domestic violence and one in three has experienced sexual abuse***
- ***Thirty-one per cent of women interviewed for the* Surveying prisoner crime reduction *study reported having spent time in local authority care, compared to 24 per cent of men in prison and fewer than 1 per cent of all children in the general population***
- ***30 per cent of women in custody have had a psychiatric admission before entering prison***
- ***Women account for 31 per cent of self-harm incidents in prison despite representing only 5 per cent of the prison population***

Neglect and abuse in childhood is a common characteristic in the personal histories of many female drug users, writes José Aguiar

PARENTAL NEGLECT, as well as the trauma of physical or sexual abuse, are recurring themes that make women vulnerable to developing drug problems and which, in the absence of adequate support, can contribute to a downward spiral. I have been working with women in prison for the last seven years, and many shared common characteristics:

- *Most were mothers. Some had their children with them immediately prior to custody, others had handed them to relatives or their children had been taken into care or adopted*
- *They were drug users, or alcoholics, and prostitution and shoplifting were ways to pay for drugs*
- *A great number had been sexually, emotionally and physically abused*
- *They self-harmed and had mental health problems*
- *They were poor.*

When I spoke with Kay*, a young woman in a female prison in London, the first thing that struck me was when she said, 'I became a woman in prison'. Kay is 21 and has been in prison since she was 15. She comes from a very dysfunctional family in Wales, with a history of violence and alcohol abuse at home.

'I couldn't cope with it,' she says. 'My family was my crowd on the streets. It was the only place I felt some affection. I didn't know where to go, I didn't know where to find help. When I was 13 years old, I felt that I hadn't had any support, I hated to be alone and I stabbed knives in the walls, drank a lot. I couldn't socialise without being high. I ended up doing shoplifting, and get into fights all the time. People saw me as a violent person. I'm not. I just didn't know better. I stabbed a person, because I was attacked, but "they" don't want to know...'

Kay is serving an indeterminate sentence for public protection (IPP), and is waiting for her parole board hearing.

'It's been adjourned so many times. I don't know what to do. Probation wants to put me in a hostel miles away from my home town. Hostels are terrible. They don't make me feel safe. I keep thinking, what's the point of sending me to prison? I lost my teenage years in here. If I had the right support when I was a child, it would have been a very different story.

Prison doesn't have the facilities to provide the support I needed. I had to struggle in prison against drug addiction. There are a lot of drugs in prison. I really need to be strong to resist the temptation.

I'm waiting to be released, I'm trying to do my best to prepare for my life outside, but I don't know what's going to happen. I have been here for so long. What was the point of putting me in prison?'

**Not her real name*

INNER STRENGTH

Kaleidoscope's recent conference stimulated valuable debate on how women affected by drug and alcohol issues could be better supported in the community. Sarah Orrell **reports**

Cardiff City Stadium hosted Kaleidoscope's informative and inspirational March conference, *Women affected by drug and alcohol issues*. More than 200 delegates attended and the packed itinerary included persuasive speakers from the police, social research, healthcare, and a range of charities supporting transformation and empowerment for women.

Kaleidoscope's co-founder Mary Blakebrough opened with an account of the charity's 45-year journey, giving the metaphor of a kaleidoscope as a rallying call; the delegates' diverse roles and perspectives being like multicoloured glass fragments in the patterns of a kaleidoscope. It was a strikingly gentle symbol given the challenging themes under discussion, but nevertheless powerfully demonstrated in the mutual goodwill and collaborative enthusiasm that was tangible across the (all female) speakers and (mostly female) delegates.

Interconnected themes concerning drug and alcohol issues and how these relate specifically to women emerged throughout the day, together with the often overlooked impacts on children, families and wider society. Amanda Davies, CEO of the Seren Group, predicted that increasing economic pressures and welfare reforms would mean a rise in behaviours such as gambling, doorstep lending and cannabis farming, and thereafter to more evictions and homelessness. Domestic pressures often drove women further into destructive behaviours, reinforcing their disempowerment, and compounding the problems for their dependents.

'One in ten children in Britain have at least one parent with a significant drink or drugs problem,' said Pam Webb, head of Zurich Community Trust. Moreover, 'children who have a parent with an alcohol or drugs problem are eight times more likely to end up with a similar problem themselves'. Webb gave encouraging reports from the trust, which focused on helping to create a positive future for children by breaking the cycle of parental substance misuse and providing a safer environment for children to flourish.

Jenny Earle represented the Prison Reform Trust, whose values included reserving prison for serious offences that could not be served in the community. She claimed that, 'of the 11,000 women in England and Wales who are imprisoned every year, 81 per cent have committed non-violent offences.' Links were made between crime and drug-related issues, with the claim that 'over half of women in prison report having used heroin, cocaine or crack in the four weeks prior to entry.' The Prison Reform Trust advocated treating prisoners and their families with 'humanity and respect,' and Earle described women in prison as the 'neglected minority,' with 31 per cent of all self-harm incidents in prison relating to women, even though women made up only 5 per cent of the whole prison population. Women prisoners tended to receive far fewer visitors in comparison to men, were imprisoned further from home because of the lack of appropriate facilities, and their children were far less likely to be cared for by the other parent during their imprisonment.

Deputy police and crime commissioner Sophie Howe pointed out that women affected by substance misuse were more vulnerable to crime, as well as being at greater risk of domestic violence and unplanned pregnancies while under the influence. She called for a more joined-up approach between the police and other services and agencies. This need was underlined by Dr Gail Gilchrist, head of the Centre for Applied Social Research at the University of Greenwich. Her work on intimate partner violence (IPV, which included physical, sexual and psychological harm, coercion and controlling behaviours) showed that risk factors extended to education, finance, family history, and exposure to substance misuse in either

'Women are resilient, resourceful and very strong. The service provider's job is to help women find that inner strength.'

AMANDA DAVIES, CEO SEREN GROUP

partner. However, IPV services did not routinely treat substance misuse, and substance misuse services did not treat IPV.

Meanwhile, cuts to funding in the areas of domestic violence and sexual abuse meant even less support for IPV issues. 'This means that substance abuse agencies need to get involved in dealing with IPV and other problems more effectively,' said Gilchrist. Dr Bernadette Hard from Kaleidoscope advocated increased use of long acting reversible contraception (LARC). Contraceptives that were effective by default, without relying on the woman's actions, could help to address the imbalance, where vulnerable women were forced to exercise a greater sense of responsibility than men.

Workshops included a presentation on service user involvement, by Rondine Molinaro of Gwent service user group The Voice. Rondine described service users as 'experts by experience' and made the case for a wider awareness of the 2007 service user involvement framework (online at http://bit.ly/ZHBzDD) which set out a ladder diagram depicting ways in which service users can be involved in influencing and improving services. Head of legal services at Release, Kirstie Douse, examined the issue of service users' rights. She claimed that benefits systems tended to favour those with a non-stigmatised, visible disability. Alcohol and drug-related claimants needed to spell out clearly what their problems were, take someone with them if necessary, and appeal if the result went against them. She advised contacting Release for advice, since 95 per cent of appeals were successful with legal assistance.

Drug and alcohol awareness in education was addressed in a workshop by Debbie Blakebrough and Leanne Teichner from Kaleidoscope. They looked at realistic and beneficial educational aims, including empowering young people to make informed choices of their own. Other approaches, where schools excluded children for drug taking, and police focused on criminality, had been found to stigmatise and isolate people, and even glamorise drug-related behaviours. The workshop ended by encouraging women to celebrate their strengths and assets, rather than feel they just had to survive in a world seemingly designed around men. Likewise, Rebecca Daddow from the RSA encouraged delegates to consider 'recovery capital' – the various resources and empowerment that could come from a holistic look at human life in all its dimensions, for the benefit of recoverers.

It was a stirring conference and a fascinating overview of a complex subject, which will hopefully lead to more opportunities for services and agencies to work more closely together for the good of women and society.

Sarah Orrell is a freelance journalist

The BIG Debate

Chaired by Adele Blakebrough, The Big Debate was the evening event of Kaleidoscope's conference on women's issues. The panel included politicians – Kirstie Williams, leader of the Liberal Democrats in Wales, Suzy Davis for the Conservatives, Jocelyn Davies from Plaid Cymru, Julie Morgan of the Labour Party – and solicitor Kirstie Douse, head of legal services for the charity Release. Questions were welcomed on all aspects of women's issues, with the following relating more specifically to drink and drugs:

How will services be maintained in rural areas with the loss of rural weighting from Welsh funding? Kirstie Douse said that people in rural areas should be encouraged to lobby for increased accessibility. Julie Morgan argued that funding was scarce and there were more people in urban areas. It was generally accepted that problems could be more hidden, though no less real, in rural areas. Suzy Davis advocated better use of human rather than just financial resources, but acknowledged that this would also require funding.

Should the Welsh Assembly push for a minimum pricing policy for alcohol? The point was made that there were indications that Westminster intended to abandon these plans. However a show of hands saw a majority vote in favour of minimum pricing. Julie Morgan said Labour would support it, but they didn't have the powers. Suzy Davis argued that minimum pricing made addiction more expensive, and this was echoed from the floor, when a woman, describing herself as an alcoholic, contrasted drinking in city centres with the very different issues facing a mother feeding her children less, in order to fund her secret drinking habit. Kirstie Williams claimed that minimum pricing on its own would not change behaviour, since every addiction was different, but it may play a part as a deterrent.

Is rehab a luxury reserved for men? It was claimed that rehab units tended to be designed around men's needs rather than women's. Jocelyn Davies said that the lack of women's facilities wasn't deliberate, but happened because historically they were designed for men. All the panel agreed this was something that needed action, for example by providing childcare and single-sex facilities where women would feel less intimidated. Similar points were made about prisons and integrated defender intervention.

What is being done about IPV and substance abuse? The link between IPV (intimate partner violence) and substance use had been discussed during the day conference. Kirstie Williams advocated more informed, holistic approaches, with joined-up services and an overarching campaign. She said that this would be more cost effective, and would also encompass a more realistic understanding of the relevant issues.

Is it time for an impact assessment concerning the failure of prohibition? Jocelyn Davies said that legalising drugs would mean there were more things, like tobacco and alcohol, that 'everyone tries,' which in itself had further implications. The panel welcomed the idea of wider debate on the subject and noted the difficulties politicians faced when taking an individual stance on this.

Other questions included the so-called 'bedroom' tax, prison facilities in Wales, and the work/life balance for women with families.

View from THE FRONTLINE

How well do frontline workers think the sector is responding to parental substance use? **Oliver French** shares Adfam's findings

SINCE THE PUBLICATION OF *HIDDEN HARM* back in 2003, we've seen a great spike in the attention given to parental substance use in official strategies, guidance and protocols. What's been lacking, however, is information on the views and experiences of the frontline practitioners who deal with these issues day in, day out. Adfam's report, *Parental substance use: through the eyes of the worker*, aims to redress this balance.

A big positive from the research was that practitioners in drug and alcohol services were adamant that the sector has improved in relation to parental substance use, backed up by other recent research like the NTA's *Parents with drug problems: how treatment helps families* and Ofsted's *What about the children?*

However, there was a feeling among the treatment staff we interviewed that the issues raised by *Hidden harm* had been embraced more by the drug and alcohol workforce than by social workers. Some of those working in substance use still felt isolated from their partners in children and family services, and when partnership did flourish it tended to be based on individual professional relationships built up over time through work with mutual clients. Many were worried that, as well as losing experienced staff members, cuts could also mean the loss of the productive partnerships they'd built up.

A local parental substance use coordinator argued that not looking at parenting meant 'missing a huge part of the picture'. This doesn't mean that everyone in the treatment workforce has to become a family expert overnight. As one drug worker told us, 'looking at the family doesn't double your workload or mean workers are meant to become "family therapists" – it makes your work more effective.'

Treatment workers need to foster therapeutic relationships that are honest, supportive and challenging, and help parents to understand the impact of their addiction. As the coordinator stated, 'parental substance users want the best for their children just as much as any parent does, and understanding the impact they're having can help them make changes that wouldn't be seen otherwise.'

A good relationship with a drug worker can give parents a new perspective on how their behaviour and lifestyle impacts on their children, even if they – as is common – underplay their children's knowledge of their drug taking. It's important to look at strengths rather than just risks – 'treatment workers need to feel comfortable talking about parenting, not just safeguarding.'

We shouldn't forget that 'the capacity to be an effective and caring parent' is named in the drug strategy as a key outcome in a recovery-focused system, but we can't simply assume that this box is ticked if a parent enters treatment, their drug use declines, or they show progress in other areas of their own recovery. We have to keep a true focus on the welfare of the child, ensure they are listened to, and address their needs – as well as bearing in mind that parenting can improve even if substance-using behaviour does not.

As the treatment system adapts and changes, there are questions to be asked about the child's conception of recovery – how do they understand lapse and relapse, for example, and how are they affected by this journey? If their parent is disengaged from treatment – either in a 'planned exit' or through dropping out – what does this mean to the child?

Of course we have to build and celebrate recovery, but this can be a long and difficult process and we have to confront the fact that lasting damage can be done to children's lives. We need to minimise the impact on children, not only through identifying parenting issues at the first opportunity, but also through providing them with support in their own right.

Treatment agencies also need effective referral chains with local family support services, especially those supporting kinship carers. Grandparents in particular may take care of children when things are at their most chaotic, when the user goes into rehab, or when they need the space to pursue the early stages of their recovery without the pressing responsibilities of childcare.

The practitioners we spoke to were full of praise for low-threshold support services for parents, drugs, including mutual aid groups. The feeling was that such fellowships – operating a little under the radar, without statutory backing – play a key role in parenting, even if they don't explicitly intend to.

Mutual aid could be there for parents if they were vulnerable to trigger events, were struggling to readjust to family life, or needed help in maintaining changes. Parents need support on an ongoing basis, not just when things go wrong. As one practitioner said, 'addiction is like a slippery slope – if the right support isn't provided on the way up, you can end up right at the bottom again.'

The main concern of many of the workers we spoke to, however, was leadership. The plea was: don't just make parental substance use a 'tickbox issue', and don't skim over it in supervisions. One drug worker put it succinctly: 'the confidence of the workforce is directly related to the level of support they feel from above', and it's up to our managers in treatment, and leaders in the whole sector, to provide this.

Oliver French is policy and communications coordinator at Adfam.
Report at www.adfam.org.uk

'Some of those working in substance use still felt isolated from their partners in children and family services, and when partnership did flourish it tended to be based on individual professional relationships...'

FAMILY MATTERS

MORE FOR LESS

Adfam's new survey showed family services are struggling to stretch scant resources to answer a surge in demand, says **Joss Smith**

'The willingness of family support services to engage with change is cause for optimism...'

RAISING AND SUSTAINING FUNDS is often the biggest challenge faced by voluntary sector providers, especially within the current economic landscape. There is some evidence from NCVO that the budgetary cuts and harsh economic conditions are disproportionately affecting the voluntary sector and donations also reportedly dropped by 20 per cent between 2010/11 and 2011 /12.

Within this context Adfam set out to examine how this financial environment is affecting services which offer support for the families of drug and alcohol users, aiming to highlight any trends and understand the impact on the sector as a whole. A concurrent aim was to explore how family support services are adapting and responding to the challenges they face – for example how they are arguing their case in a more competitive funding environment, and how they demonstrate the effectiveness of their work.

The results of Adfam's survey highlighted a few clear, if not hugely surprising, trends, often mirroring the state of the voluntary sector as a whole. Almost three-quarters of the family support services who responded said that their overall level of funding had either decreased or remained static over the last two years, and over half reported having no reserves. Nine out of ten respondents reported that the demand for their service had increased over the past two years and they saw no sign of this abating. Overall, services supporting families affected by drugs and alcohol are trying to provide more for less, seeing an upsurge in demand for their support alongside a reduction in the resources with which to deliver it.

Although the results paint a very unsure picture for the future of family support services, these organisations are working hard to adapt and are considering a variety of different options to navigate the tricky terrain. Of course, simply hiring more volunteers without training, supporting and supervising them, or firing off funding applications far and wide without reference to their relevance or purpose, serves nobody; action still needs to be taken in a logical, well-planned and properly thought-out manner. But the willingness of family support services to engage with change is cause for optimism that they recognise the realities of the environment they have found themselves operating in and are working creatively to address their funding gaps.

We may also see family support services moving more and more towards utilitarian arguments that their service helps enhance the outcomes of drug and alcohol treatment, bring down crime, save children from going into state care and improve mental health in the community – even if this wasn't the main priority when the service was set up in the first place. Some could see this as 'mission drift' for these organisations – however it could also be viewed as a means of survival.

Joss Smith is director or policy and regional development at Adfam.
Funding family support *can be found on Adfam's website, www.adfam.org.uk*

FIRST PERSON

NOTHING TO DECLARE

In the second part of his personal story, **Mark Dempster** leaves for London, takes tips from a terrorist and heads towards the 'big time'

It didn't take me long to go from using drugs to dealing them. Even since I was a kid I had hung around older boys who were into drinking and drugs and the hippy, traveller lifestyle. Some of them dealt hash and I saw the respect they got – nobody messed with them. I saw the girls they got to be with. I saw their flashy cars, their money. I could do that easily, I thought.

Yet, between leaving school and my 18th birthday I had been arrested twice and chucked out of an apprentice scheme that would have set me up with a job for life. None of that caused me worry – if I could get a good supply, some good contacts and start afresh in a bigger city like London I could become a big time dealer and get the respect I deserved.

Walshy and some other friends came to London with me. In the '80s it was easy to scam the system. We made multiple benefit claims with false identities and I got myself into a bit of cheque fraud. I met Nick a few days after getting to London. He was sitting in the middle of a squat lounge, like a Buddha meditating, surrounded by piles of hash and hundreds of LSD trips. I watched him pop pill after pill and smoked hash with him while he served customer after customer.

Life in London with my new friend Nick and plenty of drugs was going well – but it wasn't long before the police arrested me for the cheque-cashing scheme. I was going to prison and I knew I wouldn't be able to hack it. My dad had been to prison and told me about the beatings and rapes and murders. Nick took me to the only person he knew who could get me out of the fix I was in – his drug supplier, Terrorist Brian.

Brian had been involved in the IRA and had a house with floorboards full of drugs and guns. When Nick introduced me, Brian had a pile of cocaine in front of him and was paranoid that the terrorist squad was watching his house. I thought it was all front. I would learn that there was nothing phony about Brian's terrorist persona. He told me how to get out of a prison sentence – what to say and how to plead. Then he told me that I could repay the favour one day. I knew that would be trouble, but there was something inside me that felt like I had won the jackpot.

As I left his house my eyes searched for the terrorist squad. I couldn't see anything but I felt watched. I got a buzz from being around Brian – a terrorist, a drug dealer. Brian was big stuff and somebody that could help me make my plans a reality. This was a buzz of danger. I was part of that danger now. I was heading towards the big time.

Mark Dempster is author of *Nothing to Declare: Confessions of an Unsuccessful Drug Smuggler, Dealer and Addict*, available now on Amazon.

Next issue: Mark tries his hand at drug smuggling as his drinking and drugging escalates

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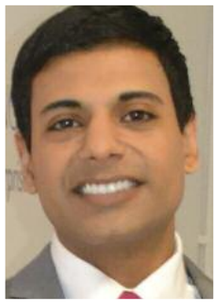
ENTERPRISE CORNER

EMPLOYMENT REVOLUTION

Turning negatives into positives is the challenge ahead, says **Amar Lodhia**



AT STRATEGIC POINTS IN THE YEAR I find it important to reflect. At base camp, we are striving for a vision of using entrepreneurship to create an inclusive society that doesn't hold people back from becoming successful.

As the accountability of interventions becomes ever more confusing, it's important to remember that our responsibility to transform society hasn't. This may sound 'fluffy', but it really isn't.

Statistics on the number of drug-related offences demonstrate that we certainly have some work to do. But at TSBC we view this as a massive opportunity to transform the drug-offending population by helping them to transfer existing negative enterprise skills into contributory ones that work towards the growth of local economies and small businesses. These will be hiring people, young and adult, not to run their drug rings but to help with food preparation, social media, marketing and administration. We know we have a lot to do and we need to think of new, more collaborative, integrated, innovative and effective ways of doing this.

You may have seen our new Local Enterprise and Employability Service (LEES), which is running from the heart of the CRI building in Barking, featured on the BBC news last month. There, our 'business experienced' local enterprise and employability workers assess service users and work alongside their key workers, police, social workers and the job centre to ensure a planned exit from treatment which is coordinated and stakeholder-led. They also help service users by matching them with jobs through our job board and brokerage service, 'Breaking the Cycle'. Service users are paid subsistence and travel expenses and get their first exposure to the work environment. At the same time, those wanting to set up their own micro-enterprises and/or social enterprises work with our entrepreneur trainers in an academy-style programme, usually outside of the treatment environment, to create their own jobs. For TSBC, this is the future of delivering a wraparound service in an innovative, integrated and informed way.

Should we worry then, that the ringfence is coming off the London Mayor's MOPAC budget for substance misuse, which contributed 13 per cent of the budget for substance misuse for London? Authorities in the capital are, and will continue to, scramble with resources amid cuts and restructuring, rehousing their services within a myriad of directorates from social care, community safety and health.

What we have the power to do is to shape, transform, design and deliver collaborative and innovative services which can continue to deliver even more for less. We have managed to reduce the investment required per service user to participate on our programme by 45 per cent, with a third of that being paid on results (PbR). We call it the retributive rehabilitation revolution and it is delivered through innovation, enterprise and collaboration.

To view the BBC news clip you can visit our website, www.tsbccic.org.uk/press. To get more information about TSBC, our work and new services, please email Sue Rathe sue@tsbccic.org.uk or call 0203 651 3112.

Amar Lodhia is chief executive of The Small Business Consultancy CIC (TSBC)

POST-ITS FROM PRACTICE

Pain, but no gain

Proactively monitoring repeat prescriptions can save a patient from addiction to their medication, says Dr Steve Brinksman

A FEW WEEKS AGO I was handed a prescription request for a man in his late 30s asking for soluble tramadol to be put on his record as a repeat prescription for back pain. Looking at his notes, I saw he had three previous prescriptions for this medication since joining our practice at the end of last year. I decided to see Tom before making this a repeat and asked the receptionist to pass the message on to him that he needed to arrange an appointment.

The next day I was the on-call doctor and there was an urgent slot booked to request I call this patient, as he had told the receptionist that he quite simply must have the tablets as he was addicted to them. I made the requested call and spoke to Tom and arranged for him to have enough tablets to last him until he could get to an appointment with me.

Three years earlier he had injured his back at work and been given tramadol by his GP. He told me that after a few days of nausea he had started to look forward to each dose and felt less stressed after taking them. He had gone back to work after a week but, having tablets left over from the initial consultation, he had used these after a stressful day at work. Before too long he had been back to the GP complaining of a recurrence of his back pain, which led to a further prescription. By now he was using the tablets every day and his usage went up even more after he lost his job.

Towards the end of last year he had seen a new GP who had challenged him about his medication use and that had triggered him to change practices, so he had registered with us. However, something about being challenged by the previous doctor had struck a chord with him and by the time I saw him, having accepted that he had a problem, he was open to the idea of trying to change.

We discussed the available options and he decided to start an incremental reduction in his daily dose, with regular reviews. We also discussed a switch to buprenorphine and then withdrawing from that, so we had a 'plan B' as well. He readily accepted a referral to our local IAPT [improving access to psychological therapies] service and although at present he doesn't feel he wants to engage with a mutual aid group, we have raised this as a possibility too.

Addiction to medicines is increasingly being recognised as a growing problem and while it may be more obvious in the case of those who are also using illicit drugs or repeat benzodiazepines, there are a lot of patients who move almost imperceptibly from mild to moderate to strong prescribed opioids. Our practice has now brought in a system whereby any patient who is about to have strong opioid analgesia added as a repeat should be discussed with a colleague and this documented so we can audit the concordance.

Most patients don't present – as Tom did – with the words 'I'm addicted to them' on their appointment note, but as these are prescription-only medicines, there are opportunities to ask questions and monitor usage. It is important that practices develop consistent policies to address this.

Steve Brinksman is a GP in Birmingham and clinical lead of SMMGP. www.smmgp.org.uk. He is also the RCGP regional lead in substance misuse for the West Midlands

Bridging th

Sarah Galvani has spent much of her career promoting awareness of substance issues among social workers. She talks to David Gilliver about bringing the fields together

'Social workers are not expected to be specialists in substance use in the same way alcohol and drug specialists are not expected to be social workers,' said Dr Sarah Galvani when she launched the British Association of Social Workers (BASW) special interest group on alcohol and other drugs' pocket guides on substance issues (*DDN*, January, page 5). 'But we do still need to know enough to confidently ask about substance use and its effects on our clients and families.'

She set up that group and remains its chair, as well as being assistant director of the University of Bedfordshire's Tilda Goldberg Centre for Social Work and principal research fellow at its Institute of Applied Social Research. Her determination to improve knowledge and understanding of substance issues in her profession also led her to develop the *Social work, alcohol and drugs* website (www.swalcdrugs.com), where it explains how working with substance use is still often not seen as the social worker's remit. Is that beginning to change?

'I think currently – and probably since *Hidden harm* – there's a sense that parental substance use needs addressing,' she says. 'But I think social work as a profession has been very slow on the uptake. There are more moves within children's social care than adult social care to recognise that it's an issue we need to be involved with, but I don't think we've got to the point yet of thinking that it's our job. It's very much still "yes, we see it all the time," but from what I hear from social workers they don't feel confident or competent in how to identify it, what questions to ask, how to respond.'

People need support to ask the right sort of questions, she stresses. 'They need the knowledge, so they know what to ask and what the answers might mean, and they need the supervision and leadership. I don't think we're there at all yet – we're a long way off having all social workers trained in even the basics of substance use.'

*****

Joint working has long been a mantra in public services, but the reality usually falls short of the ideal. How good is collaboration between drug and alcohol services and social work departments? 'There is good practice – I'd hate to tar everyone with the same brush,' she says. 'There's some good joint working in some places, but it's very much at a local level and it's usually about having dynamic and creative leadership and commissioners who can see the benefits of funding particular services. But generally joint working suffers because of a lack of resources.'

If social workers and treatment professionals were really to 'joint-assess, joint-visit and joint-manage' everyone with overlapping issues there wouldn't be enough resources on either side, she states. However, a survey by her special interest group found that when social workers do approach a substance use service they find it 'hugely helpful'.

'Certainly, they feel they've shared a burden. The other side is a minority of social workers who find that substance use services are unhelpful if service users don't fit the right boxes – if people have learning difficulties or particular disabilities that prohibit access in some way, if they're an older person who's going to feel embarrassed about going to a service or a parent who wants help but there's no crèche facilities or outreach. So there's certainly very positive feedback about joint working when it happens, but we also hear that services can be restrictive in terms of who they'll see.'

Is she hopeful that things might improve with the increased focus on localism? 'It could – if we're looking from a glass-half-full point of view – present some real opportunities for better joint working, joint service delivery and a much more holistic approach to dealing with the complex needs that people often present with. But again it's about local leadership and commitment to what are often marginalised services, ensuring that the commissioners are able to secure that funding. If you have a health and social care group that works closely together and agrees those kinds of priorities and funding arrangements, and is creative in its leadership, then I think there are huge opportunities.'

The flipside, of course, is that where those things don't exist it will be a case of 'traditional one-to-one services based in community offices – if you're lucky there's a community detox, there won't be much conversation between the two, and there'll just be a postcode lottery,' she says. 'Only time will tell.'

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Her interest in substance issues started when she was doing voluntary work for Crisis at Christmas in the late '80s, at the same time as temping for the *Financial Times*. 'I saw a lot of people who had alcohol and drug problems as part of the reasons that they were homeless. I used to go from work to the shelter and do a night shift and then go back to work, and every other night I'd go home and sleep. I did that for a couple of months and realised I was getting much more out of my voluntary work than my day job.'

When the Bruce House hostel in Covent Garden opened soon after she took a full-time job as a project worker – 'I was in social care and homelessness and substance use, and it seemed the right place to be' – before choosing to do her social work training at the University of Hull because it had specialist substance use modules. Seven years ago she made the move from social work and social care practice to full-time research, becoming director of the Tilda Goldberg Centre in 2009.

She's still a registered social worker, however, a profession that can be a favourite target for some newspapers. Can that affect morale? 'It's probably more frustrating and irritating than anything else. Negative media profiles never reflect the reality of a social worker's role and decision making, and of course social workers aren't allowed to stand up and say, "actually that's wrong – this is

e gap

how it works." But I think the morale issues really come from the amount of cuts that everyone's experiencing – jobs are being frozen, people aren't being replaced, redundancies are being made and yet we hear "you need to do better and you need to do more." Well, give us the resources. And then of course people like me turn around and say, "and you need to know more about substance use and be asking about it and responding to it,'" she laughs.

Her other specialist area is the overlapping issues of substance use and domestic violence. While alcohol plays a role in around half of all domestic violence incidents, as her website points out 'alcohol and drugs do not cause domestic violence' or 'delete our understanding of right and wrong', and she stresses the need for treatment services to challenge people when they blame substance use for their actions. Are they doing that?

'Some do, but I think most don't,' she says. 'It's a bit like social workers asking about substance use – there's a recognition that there's an issue, but people need to feel confident to ask the right questions in the right way. Part of that can be very easily resolved because there's lots of good practice guidance out there, for example from the Stella Project. The important thing to remember is that these people are already in your service – they're not a new service user group that have yet to come through the door. These are the people who sit in front of us – clients who are behaving in an abusive and violent way and who may or may not be disclosing it.'

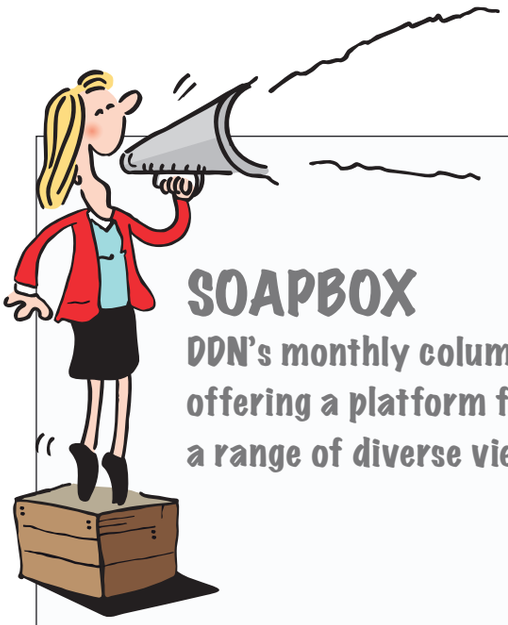
A key part for workers is simply learning to recognise disclosure, she stresses. 'Simple references like, "oh, you know, sometimes I have a bit of a short fuse". It's about picking up on things that may indicate perpetration of violence or abuse and just exploring that, because it may be that person testing the water and seeing how you react. If that's met with an inappropriate or dismissive response – "oh, so do I" – the person either will feel it's nothing for them to worry about or that they're not going to go any further with talking about it.' Crucially it's also about the worker picking up on the safety of the partner and children, she states – 'seeing not just the person in front of them but the whole family as part of their concern.'

Another key issue, of course, is that of domestic violence victims using alcohol or drugs to cope with abuse – or deal with abuse issues from the past – which can make them even more vulnerable. As she pointed out before in *DDN* (16 November 2009, page 6), the majority of women in treatment will have suffered domestic abuse at some point. 'You're looking at two thirds, if not more, depending on how you define abuse and violence,' she says. 'So again these are people who are already in treatment – they're not new people.

'It's ensuring that the substance use specialists and professionals feel equipped to ask about it and are prepared to ask again later on, because sometimes people won't disclose the first time. There are those myths around "I don't want to pry, or ruin the relationship, or put them off coming to the service," but you ask about all sorts of personal things so something about their own safety may be just what they need. You don't know unless you ask.' **DDN**

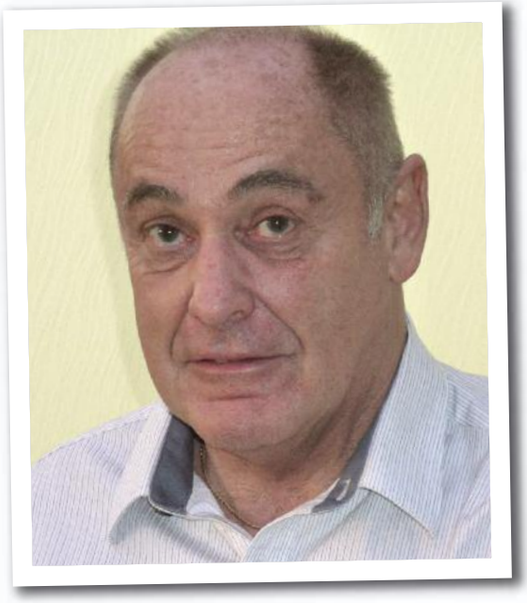
The BASW special interest group is holding a child protection and substance use event in Durham on 30 April. Details at www.basw.co.uk/event/?id=107 The group is building a database of social workers in the substance field and is keen to hear about events or resources people would like to see – email s.richards@basw.co.uk

Crucially it's... about the worker picking up on the safety of the partner and children – seeing not just the person in front of them but the whole family as part of their concern.



SOAPBOX

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



NO SMOKE WITHOUT FIRE

E-cigarettes are coming to your service shortly. Should we be concerned, asks Professor Howard Parker

It's becoming clear that e-cigarettes are going to be very popular in the UK. The market, already worth around $250m in the USA, is growing rapidly here. The majority of drug misuse service users are also tobacco smokers, part of the country's 10m heavy smokers. Many will soon be seeing e-cigarette users in their social worlds and will be contemplating trying or using these new gadgets. The presence of e-cigarette use will in turn become an issue for our services.

E-cigarettes have prospered from being both outside tobacco regulation and new medicines approval. Regulation across the world is thus chasing rising consumption. There is no international consensus, so while strict sales restrictions are in place in Australia, Canada and some EU countries, in others like the UK there is essentially no national governance. Proposals for EU-wide regulation is a faraway promise whereby if any prohibition does emerge it will be after the 'vaping' market has been saturated and fully established and all the structures, if required to run an illicit market, have bedded in.

E-cigarette prototypes were created by Chinese pharmacists during the last decade and China continues to be the global supplier of a wide range of e-kits. In the UK, sales began via the internet and through small-scale retailers with market stalls, kiosks and small shops – usually in 'poor' areas. Still prohibited on eBay, these cigarettes are sourced from China mainly via Alibaba.com. However, while the small players are doing very well and expanding rapidly, so rich are the potential pickings that major companies like E-Lites have moved in. With recent national TV advertising and flashing billboards at Sky televised football matches to support a major growth in retail outlets, the vaping market is going to be very big business. Essentially we now have a product which has not been 'approved', and which is banned in many countries, on sale in Tesco and Morrisons.

For the uninitiated, e-cigarettes deliver a nicotine hit as liquid nicotine, held in a small cartridge. It is vapourised as the user pulls on their mock cigarette as if smoking normally. The delivery is powered by a cell or rechargeable battery. The ranges of products and kits are enormous and sophisticated. The upmarket paraphernalia, sold in supermarkets and garage forecourts, tends to be smartly packaged in mock cigarette-packets while other more industrial kits are found on market stalls. It will be interesting to see if regular users develop a psychological attachment to their paraphernalia, as we associate with drug-taking rituals around bongs and pipes. That the nicotine comes in multiple flavours including coffee and chocolate suggests suppliers have an interest in maintaining their customers and thus their profits. These profits will be made from starter kits priced at between £25 and £40 and the cost of replacement nicotine cartridges, on which a regular user will spend around £15 a week.

Intuitively a device that delivers nicotine without the carcinogenic chemicals in cigarette tar and smoke looks like a harm reduction winner for heavy tobacco smokers. If no major risks are identified from vaping, then eventually we may have a product which, when set in a CBT-type programme, aids smoking cessation and/or reduces morbidity. The market makers emphasise that vaping is very satisfying and suppliers argue that e-refills are cheaper than the heavy use of cigarettes. They indeed promote the harm reductions in switching to e-smoking, emphasising that there is no dangerous smoke to harm others and no legal restrictions on vaping in public places.

E-cigarette use will pose some interesting issues for health professionals in general and alcohol and drug services and smoking cessation programmes in particular. The harm reduction benefits are hard to dismiss for heavy smokers, yet e-cigarettes do not have a scientific clean bill of health, with key public health monitors and recent research studies urging caution. So it won't be easy to form clinical views or provide information and advice packs about e-smoking.

Other knotty issues include: should services allow clients to vape on the premises or indeed bring the kits to appointments or on programmes, and if so at what age? Just recharging your G9 battery in the IT suite? Should staff be allowed to use e-cigarettes at work? Should vaping nicotine be included on assessment documents? How can e-cigarette use be recorded on databases without being lost in 'other'? Should incidents of exploding batteries or clients dismantling the kits as part of risky behaviour be recorded and reported, and to whom? Should pregnant clients be advised to use or not use e-cigarettes as an alternative to their addiction to tobacco and/or cannabis? Are the kits to be considered a safeguarding risk, given drinking liquid nicotine can kill small children?

No doubt there'll soon be a sociology PhD – e-cigarettes as a global symbol of postmodern consumption. For those working in the substance use and primary care fields, e-cigarettes bring harm reduction versus abstinence back into focus. Some intelligent pragmatism will be required in developing policy and practice and it will be worth listening to the first wave of vaping service users in trying to develop sensitive responses to their new habit. Better an e-cigarette than a crack pipe.

Professor Howard Parker has worked in the drug and alcohol field for more than 25 years as a lecturer, researcher, author, trainer and consultant.

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DDN Drink and Drugs News

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CQC compliance – whatever next?

18 JUNE 2013

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The report of the Mid Staffordshire inquiry and the proceedings of the Health Select Committee have meant that CQC is re-evaluating its own approach to inspection. CQC's own strategic review came up with proposals which will be out for consultation soon.

SO WHAT CAN WE EXPECT FOR THE FUTURE?

Firstly, each sector may be differently inspected. So how will this impact upon the drug and alcohol treatment sector?

Secondly, having completed the first inspection of your service what will this year's inspection look like? Inevitably there will be a focus on some of the outcomes not previously inspected, some of which may be challenging, so how do you need prepare?

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

Places are only £135 + VAT.
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This one-day course will run from 10am-4pm and full lunch and refreshments are provided. The Malmaison Hotel is in central Birmingham just two minutes walk from New Street Station.

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Action on Addiction

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BASED RELAPSE PREVENTION (MBRP)

with Sarah Bowen, Ph.D., University in Washington

29th Jul – 2nd Aug 2013

CPD COURSE AWARDING AN ACTION ON ADDICTION CERTIFICATE OF CONTINUING PROFESSIONAL DEVELOPMENT (35 hours) at the Centre for Addiction Treatment Studies, Warminster, UK

Sarah Bowen is the lead author of *Mindfulness-Based Relapse Prevention for Addictive Behaviours, a Clinicians Guide*. This model has at its centre a non-judgemental, compassionate approach toward ourselves and our experiences. The practices taught are intended to foster increased awareness of triggers, habitual patterns, and seemingly "automatic" reactions. These practices support the ability to pause, observe present experience, and bring awareness to the range of choices before us in every moment. Clients begin to change their relationship to discomfort, learning to recognise and increase the capacity for challenging emotional and physical experiences, responding to them skillfully, rather than reactively.

This five day intensive training will offer theoretical and empirical foundations underlying the programme, as well as the opportunity to experience MBRP from the perspective of a group participant. Trainees will learn to facilitate the core practices of the programme in a supportive and interactive environment.

The Training is designed for professionals with a regular personal meditation practice who want to gain personal and professional experience in teaching a mindfulness-based approach focused in the area of relapse prevention for addictive behaviours.

Training is strictly limited to a maximum number of 20.
Course Teaching: £650.
Half board accommodation: £41.50 per night.

To book, please call Devin on 01985 843789 to assess the courses suitability to your needs and circumstances. Enquiries about future training courses for beginners to mindfulness are also welcome.

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Stephen Lewis
Former UN Secretary-General's Special Envoy for HIV/AIDS in Africa

President Ruth Dreifuss, Former president of Switzerland, member of the Global Commission on Drug Policy

Ethan Nadelmann
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Michel Kazatchkine - UN Secretary-General's Special Envoy for HIV/AIDS in Eastern Europe and Central Asia

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Brighton Oasis Project

5th September 2013

Audrey Emerton, Post Graduate Centre, Brighton

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