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DDN
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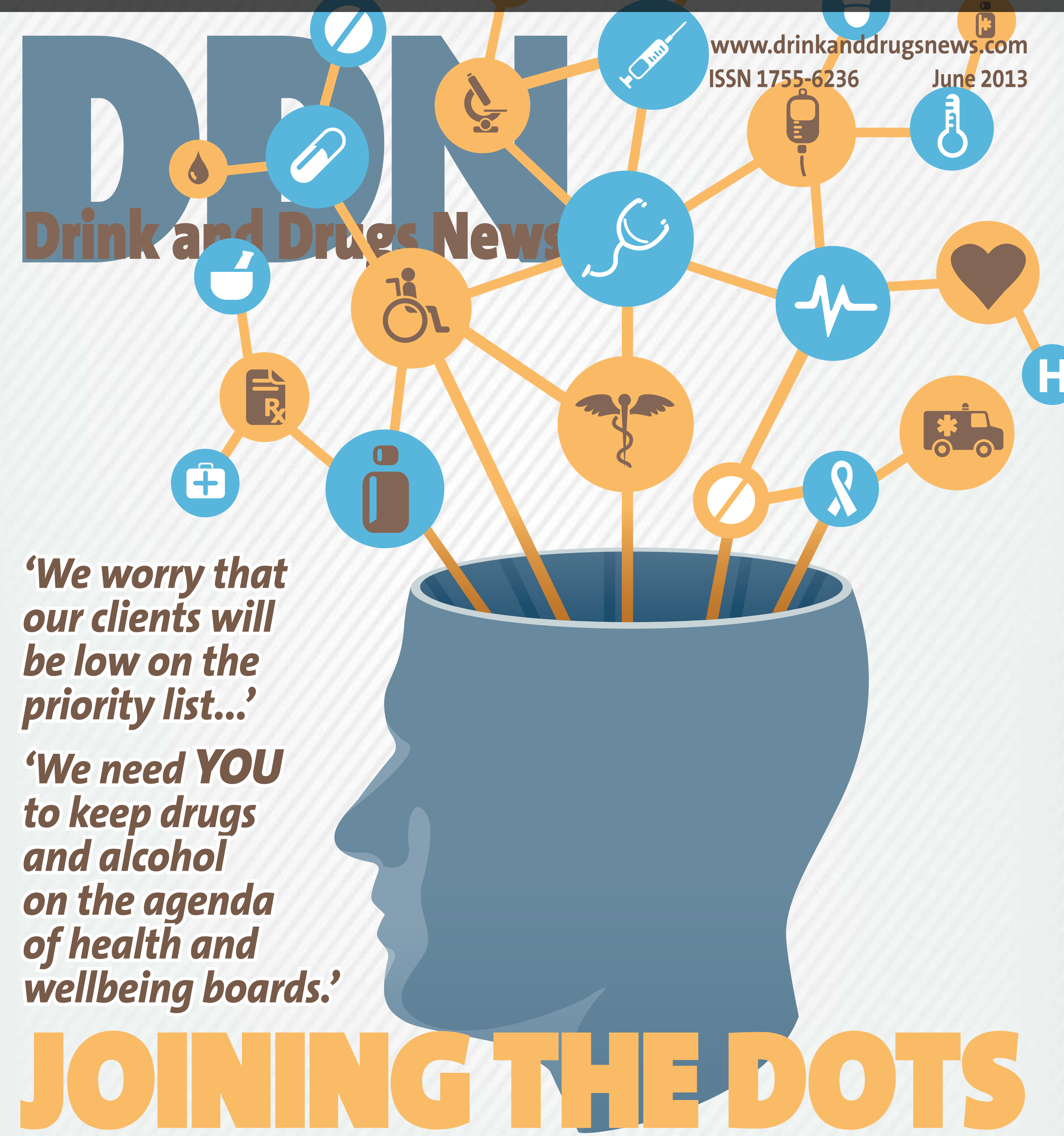

'We worry that our clients will be low on the priority list...'

'We need YOU to keep drugs and alcohol on the agenda of health and wellbeing boards.'

JOINING THE DOTS

MAKING SENSE OF THE NEW PUBLIC HEALTH AGENDA

NEWS FOCUS
What effect will payment by results have on the probation service? p6

POSITIVE ACTION
Raising awareness of hepatitis C in Swindon and beyond p12

PROFILE
Eric Appleby on how minimum pricing can help to focus alcohol campaigning p16

Essential Supervision Skills

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2 day course

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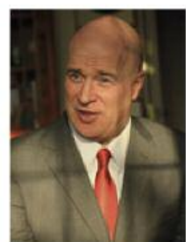

Clinical supervision is one of those activities that are typically conducted without much training. It is often the case that you're dropped in at the deep end with a supervisee and have to conduct things as best you can. And you make a pretty good job of it!

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Firstly, it is one of the very few short training courses that's received approval from a professional body – The British Psychological Society Learning Centre. That doesn't mean incidentally that it is just for psychologists, but it does mean that we have successfully negotiated and submitted the course for national professional approval from a body that's been in the forefront of supervision developments for the last sixty years.

Secondly…

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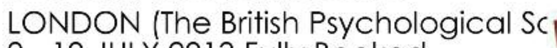
2 - 3 JULY 2013 Fully Booked



LONDON (The British Psychological Sc FULLY BOOKED
9 - 10 JULY 2013 Fully Booked

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19 – 20 SEPTEMBER 2013 Places available

GLASGOW (Novotel)
12 – 13 November 2013 Places available

MANCHESTER (Manchester YHA)
14 – 15 November 2013 Places available

LONDON (The British Psychological Society)
21 – 22 November 2013 Places available

BPS Learning Centre confirmed that Essential Supervision Skills 2 day course from SDS Ltd meets the standards required to confer eligibility to **the British Psychological Society's Register of Applied Psychology Practice Supervisors (RAPPS).**

STOP PRESS

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Editorial – Claire Brown

For better, for worse?

Will localism be good for our health?

At last year's RCGP conference we heard early warning shots on how localism could affect health priorities. This year, with Public Health England in place and the NTA swallowed and almost digested, delegates had an opportunity to question public health minister Anna Soubry and confer with each other about the new landscape. In his column last issue (*DDN*, May, page 11), DrugScope's Marcus Roberts looked at the possible impact of localism on drug and alcohol services; the conference confirmed that the picture is a confusing one, showing huge variation throughout the country. Are commissioners in a spin? Drug services under threat? Service user involvement on the back burner? Well it seems to depend on where you live, and the conference workshops brought out many concerns – as well as opportunities to knit together different services to make best use of resources for 'whole person' care.

The positive message from the event was that there are many GPs and other health professionals who are passionately committed, not just to their own areas of expertise, but also to liaising with colleagues to make shared care as responsive as it can be. The challenge is to pull together to make sure localism never means exclusion. The conference was one snapshot; please let us know what localism means so far to your area.

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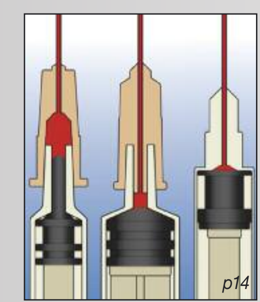
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The first Medway recovery festival organised by service user groups and local provider KCA celebrated recovery in the local community. DDN joined the celebrations.

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THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES AND TENDERS

NEWS IN BRIEF

MIXED RESULTS

The overall performance of the drug and alcohol Payment by Results (PbR) pilots has been 'mixed' so far, according to a report from the Department of Health. However it remains 'too early to judge', says the document, as changes to services will take time to embed, and the reports will now be updated every quarter. *Performance of payment by results pilot areas: April 2012 to February 2013 at www.gov.uk*

ACT IMPACT

Alcohol sales in Scotland fell by 2.6 per cent per adult in the year after the introduction of the 2011 Alcohol etc. (Scotland) Act – which included a ban on multi-buy promotions – according to figures from NHS Scotland. There was a 4 per cent drop in the amount of wine sold in off-licences as well as an 8.5 per cent fall in sales of pre-mixed drinks such as alcopops. Factors such as changes in income and price were taken into account, say the researchers. 'These findings show that the Alcohol Act has had the intended impact of reducing alcohol consumption in Scotland by placing restrictions on how alcohol is displayed and promoted,' said study lead Mark Robinson. *www.healthscotland.com*

STARK WARNING

NHS Lanarkshire has issued a public health warning following the notification of two cases of the 'flesh eating' necrotising fasciitis infection in injecting drug users, both of whom have died. There is also a third possible case, the agency has said. 'We would advise drug users not to inject heroin and warn that muscle-popping, skin-popping, and injecting when a vein has been missed are particularly dangerous,' said NHS Lanarkshire public health consultant Dr Josephine Pravinkumar. 'Smoking heroin carries much less risk than injecting it. If there is any pain or swelling around an injection site drug users should seek urgent medical attention.'

SETTING STANDARDS

A new quality standard on preventing harmful alcohol use will be developed by NICE, in partnership with Public Health England, the agency has announced. NICE quality standards set out high-priority areas for quality and apply across the NHS, social care and public health. The standard would be 'a valuable tool for local authorities as they take on their new public health functions', said deputy chief executive Professor Gillian Leng.

Minimum pricing fails to make Queen's Speech

Plans to introduce minimum unit pricing (MUP) for alcohol were absent from last month's Queen's Speech, which set out the government's legislative programme for the year ahead. Health secretary Jeremy Hunt, however, told BBC Radio 4's *Today* programme that a final decision on minimum pricing – a key part of the government's alcohol strategy (*DDN*, April 2012, page 4) – had still not been made.

Chair of the All-Party Parliamentary Group on Alcohol Misuse, Tracey Crouch MP, also told Alcohol Concern's conference that MUP was 'not dead and buried' and public health minister Anna Soubry has recently stated that it was 'still official policy' (*DDN*, May, page 4). 'The debate is open and the Scots are leading the charge. We want to keep that debate going,' said Ms Soubry at last month's RCGP conference.

The Faculty of Public Health said it was 'profoundly disappointed' that the measure – along with standardised packaging for cigarettes – was not part of the speech. 'When it comes to policy decisions that affect everyone's health, it's actions, not words, that make a difference,' said president Lindsey Davies. 'From compulsory seat belts to the smoking ban, we've seen that governments of all political persuasions need to show leadership and courage to protect people's health. Previously unthinkable interventions have become an everyday part of most people's lives because governments acted on the evidence for making groundbreaking policy decisions.'

Meanwhile, a petition – by the Scotch Whisky Association, European Spirits Association and Comité Européen des Entreprises Vins – for a judicial review to challenge the legality of the Alcohol Minimum Pricing (Scotland) Act has been dismissed by the Scottish Court of Session.

Lord Doherty refused the petition on the grounds that 'the Act was not outside the legislative competence of the Scottish Parliament' and that the proposed setting of a minimum price per unit was 'within the powers' of Scottish ministers. The legal challenge had been one of the reasons why minimum pricing had not appeared in the Queen's Speech, said Jeremy Hunt in his BBC interview.

'We have always believed minimum unit pricing is the right thing to do to tackle Scotland's problematic relationship with alcohol,' said health secretary Alex Neil. 'We now look forward to being able to implement minimum unit pricing and making that transformational change in Scotland's relationship with alcohol.'

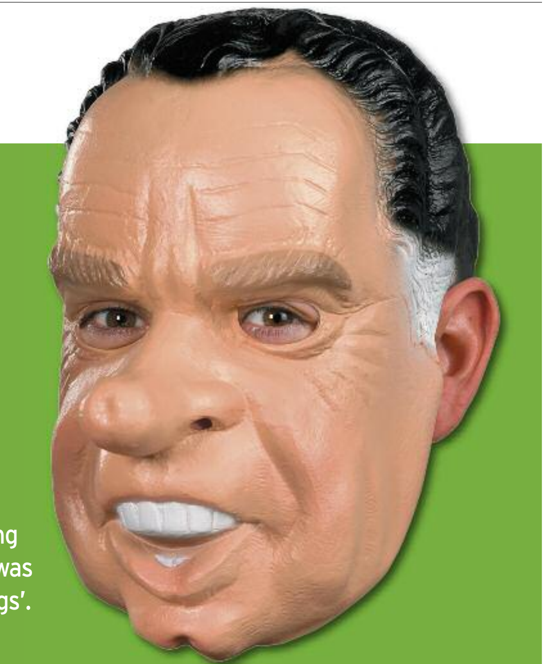
However, while the court's decision to dismiss the petition was 'disappointing', it was 'just the first step in a long legal process', said chief executive of the Wine and Spirit Trade Association, Miles Beale.

Meanwhile, research by Ofcom has found that children saw an average of 3.7 alcohol adverts on TV per week in 2010 and 3.2 in 2011, compared with 2.7 in 2007. Children's viewing habits have shifted towards channels with more advertising, says the report, while most viewing by older children is of adult programming.

'Children watch adult programmes in large numbers, but very rarely constitute a sufficient proportion of the audience to trigger rules excluding alcohol advertising,' it says. Ofcom has now asked advertising regulators to 'review the rules that limit children from being exposed to alcohol advertising on TV'.

Children's and young people's exposure to alcohol advertising at www.ofcom.org.uk

See page 16 for a profile of Alcohol Concern chief executive Eric Appleby



FACE OF REPRESSION? Supporters of the *Support. Don't Punish* campaign (*DDN*, May, page 20) will don Richard Nixon face masks as they 'reclaim' the UN's international day against drug abuse and illicit trafficking with a day of action on 26 June. The former president was the first high-profile politician to talk of the 'war on drugs'. *Details at supportdontpunish.org*

Latin American states consider consequences of drug reform

Tackling the drug problem requires a 'multifaceted' and flexible approach, as well as a conviction to 'maintain unity in the midst of diversity', according to a report on Latin American drug policy by the Organization of American States – which includes all 35 independent states of the Americas (*DDN*, May, page 18).

There is no single 'drug problem in the Americas', it says, but rather a range of issues relating to different stages of the cultivation, production, transit, sale and consumption processes, and the impacts they have on the countries of the region. The 400-page report is split into two documents – an analysis of the current situation and a 'scenarios' document looking at what might happen if different approaches were taken, including if certain countries no longer deployed the police and armed forces against the drug cartels.

The aim was to 'show the problem just as it is and how it manifests itself in different ways in our various countries and sub-regions', said OAS secretary general José Miguel Insulza. 'To show the volume of money that changes hands and who benefits from it; to show how it erodes our social organisation and how it undermines the health of our people, the quality of our governments and even our democracy.' Decriminalisation of drug use 'should be considered on the same basis as any public health strategy', the document states.

The reports represented 'empirical evidence without prejudice', said Colombian president Juan Manuel Santos at their launch. 'Now the real work begins, which is the discussion at the political level. Let it be clear that no one here is defending any position, neither legalisation, nor regulation, nor war at any cost. What we have to do is use serious and well-considered studies like the one the OAS has presented us with today to seek better solutions.'

The documents also 'set the scene for a vibrant high-level debate on alternative approaches' in the run up to the 2016 UN General Assembly special session on drugs, said senior policy analyst at Transform, Steve Rolles, where they would 'feed into the global debate' on policy reform. 'It will rightly be seen as a watershed moment for the doomed global war on drugs.'

While leaders had previously talked of a move from criminalisation to public health in drug policy, abstinence-only approaches had still dominated, 'even in the health sphere', said director of the Open Society International Harm Reduction Program, Daniel Wolfe. 'These scenarios offer a chance for leaders to replace indiscriminate detention and rights abuses with approaches that distinguish between users and traffickers and offer the community-based health services that work best for those in need.'

The drug problem in the Americas and Scenarios for the drug problem in the Americas: 2013 -2025 available at www.oas.org

Euro drug scene in 'state of flux'

New threats are continuing to challenge Europe's established models of drug policy and practice, according to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), with the drug problem in a 'state of flux'.

Positive developments regarding more traditional drugs – such as fewer new heroin users, less injecting and declining use of cocaine and cannabis in some parts of the continent – continue to be offset by concerns around new psychoactive substances, says the agency's annual report.

Seventy-three new psychoactive substances were notified for the first time in 2012, compared to 24 in 2009, 41 in 2010 and 49 in 2011. There is no sign of 'a slowing down in the number of new drugs being reported in Europe', the report states, with 30 new synthetic cannabinoids discovered in 2012 alone. 'Driven by globalisation, technological advancement and the internet, an open market for new drugs has now developed which presents significant challenges to public health, law enforcement and policymaking,' says the agency, with organised crime drawn to the 'rapidly developing and expanding market' by high profits and comparatively low risks.

The number of people entering treatment for the first time for heroin problems, meanwhile, has continued to fall, with reductions 'most apparent' in western European countries, and smaller proportions of injectors. Recent HIV outbreaks in Greece and Romania, however, have 'interrupted this positive trend' and underline the need for adequate harm reduction and treatment services, says the document.

A key theme of the report is that drug treatment remains 'a cost-effective policy option, even at a time of economic austerity', and it stresses the need to focus on continuity of care – including for prisoners – social reintegration, and investment in new interventions around hepatitis C and overdose prevention.

'Signs that current policies have found traction in some important areas must be viewed in the light of a drugs problem that never stands still', said EMCDDA director Wolfgang Götz. 'We will need to continue to adjust our current practices if they are to remain relevant to emerging trends and patterns of use in both new drugs and old.'

DrugScope supported the report's conclusion that the EU drug scene was in flux, particularly regarding the 'bewildering' array of new synthetic substances. 'Names such as Black Mamba, Annihilation and Clockwork Orange should give some indication of the risks being taken and the challenges that those providing advice and support for young people are having to face,' said chief executive Martin Barnes.

'While the heroin using population is clearly ageing, and overall drug use has fallen, we have to stay focused on the problem,' he added. 'There are still nearly 300,000 people needing help with serious drug problems at a time when there is no longer any ring-fencing for drug treatment funding and competing pressure on local budgets is intense.'

European drug report 2013: trends and developments at www.emcdda.europa.eu

NEWS IN BRIEF

MUTUAL AID

A 'comprehensive package of measures to help the voluntary sector and mutuals compete for contracts to cut reoffending' has been announced by the Ministry of Justice and the Cabinet Office as part of the government's controversial *Transforming rehabilitation* programme. The measures will 'support new and existing providers from the voluntary, social enterprise and private sectors, changing the way offenders are rehabilitated through the gate and into the community', says the government. *www.justice.gov.uk/transforming-rehabilitation/voluntary-sector-and-probation-mutuals* *See news focus, page 6*

SEE ME

Many pupils have gaps in their knowledge and skills in 'serious safeguarding areas' of personal safety including mental health and alcohol misuse, according to an Ofsted report on PSHE provision in primary and secondary education. *Not yet good enough: personal, social, health and economic education in schools at www.ofsted.gov.uk*

McLELLAN MOVE

Former deputy director of the White House's Office of National Drug Control Policy (ONDCP), Tom McLellan (*DDN*, 15 March 2010, page 6) has been appointed as an independent adviser by Public Health England (PHE). 'As an internationally recognised authority on addiction treatment and recovery, he will provide immensely valuable input to our developing programmes of work,' said PHE director of health and wellbeing, Professor Kevin Fenton.

NOT WORKING

The government's Work Programme is 'unlikely to reach the most disadvantaged long-term unemployed people', according to a report from the Work and Pensions Committee, with the programme's performance 'poor' in its first 14 months. The findings confirmed DrugScope's concerns that the programme was failing people with drug and alcohol problems, said chief executive Martin Barnes. *Report at www.publications.parliament.uk*

TESTING TIMES

Hepatitis C testing in prisons should be a 'continuous offer', according to a report from the Hepatitis C Trust. Just 6 per cent of inmates were tested for the virus in 2011, despite an estimated one in ten prisoners living with hepatitis C. *Addressing hepatitis C in prisons and other places of detention at www.hepctrust.org.uk*

WHAT EFFECT WILL PAYMENT BY RESULTS HAVE ON THE PROBATION SERVICE?

DDN hears reactions to the government's controversial *Transforming rehabilitation* plans

'Radical reforms to the way criminals are rehabilitated' will mean every offender leaving prison having to serve a minimum of 12 months under supervision in the community, justice secretary Chris Grayling announced last month.

Also promised is a 'new, joined-up' approach to tackling problem drug use – from prison to the community – in partnership with the Department of Health, as well as a network of 'resettlement prisons' to allow offenders to be released into the areas where they will live and be supervised. There will also be a focus on 'life management', with reformed offenders mentoring people in 'the difficult days and months' after release.

The government is calling it 'the most significant change to short custodial sentences in a decade' with 65,000 prolific offenders serving sentences of up to two years receiving 'extended, targeted rehabilitation', including access to treatment services, housing, training and employment. The reforms are a 'golden opportunity' to halt the revolving door of the prison system, claims Grayling. They will also, however, see 'a far greater role' for private and voluntary sector organisations, on a payment by results (PbR) basis, with contracts awarded 'based on best value and innovation in tackling reoffending'.

While RAPt said it was 'pleased to see' plans for greater involvement of the private and voluntary sectors, other agencies have been less enthusiastic. 'Evidence shows that payment by results is not effective, but perversely the government is going ahead with plans,' said chair of Westminster Drug Project (WDP), Yasmin Batliwala, with PbR likely to increase 'pressure to release clients without the support they need'.

Probation union NAPO has called the plans 'a disaster waiting to happen', meanwhile, and the Probation Association and the Probation Chiefs Association (PCA) have issued a joint statement that the government was 'dismantling [probation] trusts at the very moment that it needs them most'.

The proposals would also 'destroy the effective network of local partnership approaches', a PCA spokesperson tells *DDN*. 'The government has announced that there will be a smaller national probation service and 21 contract package areas to deliver rehabilitative services – these areas do not align to the current boundaries of local authorities or the areas overseen by the newly formed police and crime commissioners. It appears that while the government is committed to localism – with police and health all becoming more local – the Ministry of Justice and probation work has gone in the opposite direction.'

Effective strategies to reduce re-offending are only achievable through strong cooperation and shared strategic planning by local agencies, the association believes, with the proposals putting this at risk. The timetable is also unrealistic, the PCA states, as it means attempting to outsource more than 80 per cent of probation work at the same time as restructuring the remainder of the service into high-risk offender management – something that's unlikely to be achieved within the justice secretary's 18-month time frame 'without causing serious damage' to service delivery.

The government is effectively redesigning public sector probation at the same time as 'introducing a complex and untested payment method', says the organisation, with public sector bodies – even those that can demonstrate excellent results – unable to bid for the community supervision work.

'Payment by results excludes probation trusts because they are prevented by treasury rules from taking on financial risk,' explains the spokesperson. 'In order to bid, individual members of probation staff would have to form mutuals, management buy-outs, joint ventures or the like, with someone who can carry financial risk. The competition shouldn't be about which sector delivers it but about the skills and experience in that sector, with all sectors having a chance to contribute. Probation trusts are already delivering the year-on-year reductions in re-offending, which Grayling says is all he expects *Transforming rehabilitation* to deliver, so we would ask why is he dismantling it? Especially given there is no impact assessment as to how these proposals will reduce re-offending and costs.'

But plans for reformed offenders to mentor people as they leave prison must be a good idea – as long as there are enough suitable candidates to go around? 'We have long recognised that there is a gap in follow-up for short sentence prisoners. Probation had not been asked in past to supervise them, on the grounds that it would be too costly. We welcome the renewed focus on all short custodial offenders, but it is important to have a credible answer to how this additional supervision will be resourced, particularly against the pressures for savings.'

The reforms are a 'golden opportunity' to halt the revolving door of the prison system.
CHRIS GRAYLING, MP

The government would no doubt maintain, however, that probation organisations are only voicing objections because of vested interests? 'The Probation Chiefs Association wants to ensure that any changes the government makes to probation services achieves the aims of reducing costs and re-offending, while keeping the public safe,' the spokesperson states. 'Professional expertise and experience is not a vested interest. We do not object to competition and already provide and commission across all sectors.

'With no clear aspiration for the levels of payment by results in the new contracts, the rationale for excluding probation trusts from bidding also remains unclear.'

Transforming rehabilitation – a revolution in the way we manage offenders at www.justice.gov.uk/transforming-rehabilitation

LETTERS

'Is there a new adulterant around, which is dissolved by acid, or is the heroin simply being adulter-ated even more?'

CITRIC QUESTION

As a harm reduction worker at the Cairn Centre, the main needle exchange in the centre of Dundee, I wondered if any of your readers could answer a question.

We have noticed lately that our clients are asking for lots of citric – much more than they need. We asked them why and it turns out that the IDUs in this area have changed the order in which they prepare their hits.

They put the heroin in first, then put in the citric, and then the water – instead of putting the water in before the citric.

So we have been reminding clients of the correct order. However, a few of them are now telling us that the reason they need much more citric is to dissolve the adulterants in their heroin. They are telling us that the mixture is very white.

Is there a new adulterant around, which is dissolved by acid, or is the heroin simply being adulterated even more, with the usual stuff?

It would be great to hear what other NX workers, or others, think.

George Donald, Cairn Centre, Dundee

SUPPORTING REAL LOCALISM

Marcus Roberts talked about localism (*DDN*, May, page 11), pointing out that while Public Health England (PHE) is the 'expert national public health agency' how effective it is will depend on its ability to persuade those with power at a local level to listen to its 'evidence-based' recommendations.

PHE will be presenting 'evidence-based' recommendations not just for drugs and alcohol, but for all areas of public health, which is a massive cause for concern for ongoing funding of drug treatment. Drug dependency, despite the terrible consequences for individuals involved, is a minority sport. The scale of the harm caused pales in comparison to that of alcohol, smoking, and poor diet. On top of that we all know how far down the list of priorities it is for most members of the public and therefore their elected representatives. If we are relying on PHE alone to make the case and ensure the continued investment in drug treatment, I think we have scant chance.

However the one thing that I think provides a faint glimmer of hope is the continued rise of the service user and recovery groups. As a regular attendee of the *DDN* user involvement conference, I have witnessed the changes and growth of different user-led organisations over the past few years. These groups operate on a local level and are increasingly becoming more established and providing a wide-reaching range of services that benefit the whole community.

You cannot underestimate the positive message this sends out of the value to the whole of society gained by helping those with drug problems. In order to capitalise on the positive PR this creates, these groups need to be supported and given the tools to help them continue to make their case and lobby for ongoing funding. If PHE works in partnership with them, and uses the resources and networks available locally, then maybe there is a chance to both make the case and most importantly have it listened to.

John Walton, 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.

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

It appears that those who have the biggest budgets shout the loudest, as the supporters of minimum pricing cannot be heard over the red-faced rants from the multinational drinks corporations.
Katherine Brown, *Guardian*, 8 May

Tellingly, the Queen's Speech excluded a host of politically correct bills that had been demanded by progressive campaigners, such as minimum alcohol prices and the introduction of plain packaging for cigarettes. Both proposals highlight the finger-wagging spirit of the public health lobby at its worst, devoid of any understanding for the concepts of personal responsibility.
Leo McKinstry, *Express*, 9 May

The mistake 'health experts' make is failing to understand that general pleas asking people to moderate their drinking in a vacuum, regardless of the personal situations or pressures they feel offer justification for alcohol use, are just too big an ask.
Deborah Orr, *Guardian*, 10 May

An offender might be turfed out of jail somewhere in the North of England at the end of his fifth short stretch inside... We buy him his train fare back and put £46 in his pocket before he leaves prison, in the vain hope that he will use it to get back on his feet. Within days he's living rough in London, the money has gone on drugs and he needs his next fix. So he mugs an old lady in the high street, creating another needless victim.
Chris Grayling MP, *Telegraph*, 8 May

After decades of the welfare state merry-go-round, people look to the state to pick up the pieces. (By the way, what is wrong with a cut in housing benefit for people living in state-funded homes with rooms they do not need or use?)
Nick Ferrari, *Express*, 19 May

TV commissioners tend to come from relatively privileged backgrounds, and are interested in sensationalism to attract viewers. And so we've ended up with poverty porn – the latest being Channel 4's *Skint* – that helps build the image of an undeserving, beer-swilling, drug-taking poor, sticking their fingers up at the taxpayers they're living off. The reality, tragically, remains far from our screens.
Owen Jones, *Independent*, 24 May

John Humphrys chortled through a *Today* programme 'debate' as two think-tank spokesmen both advocated decriminalising drugs... But isn't the BBC supposed to be impartial? Aren't lives hideously damaged by illegal drugs? Don't many people still want them banned? Yet the giggly item gave no space to their views. Why should we pay a licence fee to be treated like this?
Peter Hitchens, *Mail on Sunday*, 12 May

At the time of the initial invasion in 2001, Tony Blair insisted that one of the reasons for occupying Afghanistan was because 'the Taliban are causing the deaths of young British people who buy their drugs on the streets'. But clearly some people misunderstood what Blair meant. They were saying that the Afghan heroin trade wasn't fulfilling its potential, and with the right management they could treble it.
Mark Steel, *Independent*, 2 May

This year's GPs' conference had the tricky task of linking primary care to each element of the new and uncertain public health agenda, while urging colleagues to keep calm and carry on. **DDN** reports

JOINING THE DOTS

'Joining the dots' was the theme of the Royal College of General Practitioners' annual primary care conference. As GPs and health workers gathered in Birmingham to hear speakers examine the critical role primary care plays in working with drug and alcohol users, their families and carers, it became apparent that while the dots were being joined in many areas of clinical expertise, the overall public health picture was far from complete.

Would drug and alcohol treatment survive the maelstrom of competing priorities now commissioning had been handed to local authorities as part of Public Health England (PHE)?

'We worry that our clients will be low on the priority list,' a delegate told Anna Soubry, public health minister, in a session that she turned over entirely to Q&A. 'In the last 20 years we have had improved drug services, but the top priority for politicians is potholes in the road.'

Soubry replied: 'I have faith in local authorities to do the right thing. For example, teenage pregnancy rates are as low as they are, and dropping, because local authorities worked with health authorities. Drug services can be the same. The robust partnerships between many stakeholders, including police and housing, will help councillors understand that public health coming back to local authorities gives them both great responsibilities and opportunities for their local area.'

Rosanna O'Connor, director of alcohol and drugs at PHE, said that drug recovery and the alcohol agenda would be one of the top priorities that PHE would track and monitor on a regular basis. The joint alcohol and drugs function would include prevention, treatment and recovery and would 'hold the banner for evidence-based practice', she said.

With local structures 'shaping up as we speak' a key piece of work for PHE was to support local authorities in altering the behaviour of local communities.

But with many health and wellbeing boards prioritising alcohol over drugs, she warned of the need to be 'mindful' that 'other public health priorities may prevail at local level' now that the drug treatment budget was proclaimed 'unringfenced'. 'We need you to keep drugs and alcohol on the agenda of health and wellbeing boards,' she said.

A workshop session on 'commissioning in the new public health environment' provided an environment for airing concerns.

'Should we be dancing in the street at the chance to influence the localism agenda?' asked SMMGP's Kate Halliday, who chaired the session.

'It's time to fasten our seatbelts,' said Gill Burns, shared care manager at Tower Hamlets clinical commissioning group (CCG). 'Health and wellbeing boards have all been formed in different ways,' she said. 'They haven't really firmed their agendas up.' With different power bases in each area and the threat of more cuts to come, there was a risk that money could be moved away from patient choice. What was needed was a framework that meant the relevant voices could feed into commissioning reference groups. 'It's about getting smart,' she said, 'and thinking of integration and cooperation with our public health colleagues on things like sexual health and mental health. There are opportunities if we get smart.'

Jim Barnard, manager of Inclusion Drug and Alcohol Services, gave a provider's perspective of the commissioning environment. Contrary to the expected scenario of more integration, simpler service specs, more focus on outcomes and the achievement of financial savings, it was a 'messy picture' in reality, with 'massively reduced commissioning teams in some areas', complicated service specs, and complete disregard of TUPE in some tender notices.

Other delegates added their concerns. 'In Sunderland there's no shared care – we've built informal shared care for alcohol,' said John Devitt, CEO of Counted4 CIC. 'Understanding of drugs and alcohol has disappeared from tenders and this is dangerous... it's not joined up.'

Dr Joss Bray of the Huntercombe Group said commissioners were turning their backs on residential rehab as expensive, compared to daycare – the only option in the North East. 'If you don't want that, that's it,' he said. 'What happens to people who need something else? It's cheaper for local authorities to have deals with one or two providers to get a better price.'

Dr Anna Livingstone, a GP in Tower Hamlets, said welfare cuts meant many more families would be affected, accentuating the divide between 'poor people and rich drug companies profiting. There are conflicts of interest everywhere – we need to be clear that our service users deserve services,' she said.

Dr Tim Horsburgh, a clinical lead of adult services in Dudley, said it was important to be clear about the difficulties. 'The amount of money in deprived urban areas is going to be reduced. An unringfenced budget for drug users isn't going to fly very far. There's local talk of evicting drug users – we're facing a tidal wave that's going to be very difficult for councils to cope with. Our service

Photography: www.prestigephotography.co.uk

'I have faith in local authorities to do the right thing...'
ANNA SOUBRY MP

'We worry that our clients will be low on the priority list..the top priority for politicians is potholes in the road.' DELEGATE

user council is going to find it very difficult to be heard.'

Pete Burkinshaw, skills and development manager, Public Health England, acknowledged the difficulties faced by a substance misuse sector that was 'waking up to clinical governance and the importance of research'. Localism would bring 'all kinds of permutations', he said, with some areas having a 'grossly inaccurate' idea of their spending.

'Local engagement is absolutely key,' he said. 'Take your seatbelts off and get out of the chair. Don't let stuff happen to you, because the game is local – power and autonomy are in local areas.'

Integrating effectively with the new public health agenda meant acknowledging that public health colleagues had 'different DNA', he said. 'Public health naturally goes upstream – they want to be mending the hole in the bridge, not hauling bodies out of the water. They've never been responsible for trawlers in the estuary before – we need to remind our public health colleagues about the trawlers.'

Despite the challenges, Burkinshaw believed that voicing such concerns was having an impact: 'Because these things are said a lot, we're starting to see embryonic change,' he said. 'We need to build on that.'

Mark Gilman, strategic recovery lead, PHE, saw public health as bringing ambition and aspiration to the world of treatment. 'We know from public health that you are influenced by the people you hang out with. If you want recovery, identify someone in your network who's already got it. Move away from the negatives – it's like a barrel of crabs dragging each other down; misery loves company, and that's what's happening in areas where recovery's not catching on.'

...ISSUE BY ISSUE

HOW CAN WE ENGAGE WITH PARENTS ABOUT SUBSTANCE MISUSE?

'It's difficult,' said Prof Donald Forrester, director of the Tilda Goldberg Centre for Social Work and Social Care. 'They often lie as they're in denial or likely to minimise problems.' Good practice required combining both cynicism and optimism.

'I recommend you engage, focus, elicit, plan and action,' he said. It's all about building a relationship, building a plan and making people believe they can change.

'You can't make people change, so the key is to try and make people explore their own motivations. The more you push, the more people push back,' he said. 'Motivation is created in differences between your life now and the life you want to lead – seeing the difference between who we want to be and the life we're providing. The skill is how you get people to do this for themselves.'

HOW CAN WE PROVIDE SEXUAL HEALTH SERVICES?

We need to communicate effectively with women of fertile age, said Rosie Mundt-Leach of SLAM.

'One of the reasons we're not engaging is we don't want to give the impression that if you're a substance user, you shouldn't be having a baby. But it's about delaying it until stability in drug and alcohol use has been reached.'

Educating women about the effects of drugs on their fertility would help to avoid unwanted pregnancy – and those who did want to get pregnant would benefit from advice on taking folic acid and giving up smoking.

Delegates in the sexual health workshop highlighted the difficulty of getting these services into different projects – and those that did often found it difficult to engage effectively. 'Our clients aren't ready to think about contraception. They think it won't happen to them,' said a worker at a homeless hostel.

Dr Bernadette Hard, a GP in Wales, said that all women should have easy access to impartial advice. 'People in addiction are used to high-risk situations – when you're injecting, your threshold for risk is much higher and acute intoxication makes women vulnerable to risky sexual practice.'

Practitioners also needed to be aware that treatment and support services – such as providing housing – was likely to increase fertility. On the plus side, there had been a cultural change, she said, with clients now embracing the fact that substance misuse services asked about contraception and bbv risk.

Dr Matthew Young said that contraception, bbv screening and smears should be incorporated in treatment as a matter of course and called for RCGP to incorporate easy streamlined standards in their management of drug misuse qualifications.

WHAT SHOULD WE KNOW ABOUT FOETAL ALCOHOL SPECTRUM DISORDER (FASD)?

This condition is more prevalent than we realise, said Dr Shirrin Howell. Usually a hidden disability, it causes birth detects, commonly to the heart or kidneys, effects on the nervous system, and complex learning disabilities. 'In talking

'If there's an adult that takes an interest in them, it can make a huge difference to a child's life.'

DR LESLIE IRONSIDE on family issues

'We don't want to give the impression that if you're a substance user, you shouldn't be having a baby.'

ROSIE MUNDT-LEACH

about prevention, the advice has to be "no safe amount" of alcohol in pregnancy,' she said.

'If you adopt a child in the UK today, you are more likely to adopt one with FASD than not,' said Julia Brown, CEO of the Foetal Alcohol Spectrum Disorder Trust (www.fasdtrust.co.uk). 'We're working in nice middle class areas, but 10 per cent of the pupils in two schools have FASD. It doesn't just affect the poor, or those "over there".

'Don't pigeonhole them – you will be coming across these children,' she said. 'We need to raise awareness and reduce the prevalence rate.'

FAMILY TIES

The role of the family was a central theme of the conference, which gave perspectives from GPs and other experts, and families themselves

'Our families are one of the biggest influences in our lives – and now we've entered an era of extended families and relationships,' said Dr Steve Brinksman.

There was plenty for GPs to look out for, he told the conference. Children in the care system were more likely to become drug and alcohol users themselves; parents needed help in challenging the stigma of being a 'bad parent' with a drug or alcohol problem; and how often did GPs think of asking patients with anxiety and depression whether it was linked to caring for a substance user?

'Families should be a source of love and support,' he said. 'In primary care we're uniquely placed to support not only the drug user, but also their family.'

Dr Leslie Ironside explained the effects on the child of living in a troubled family, and called on GPs to take 'absolute interest' in the children of their patients.

'Reaching out and being accepted is crucially important and can be neglected. If there's an adult that takes an interest in them, it can make a huge difference to a child's life,' he said. Toxic levels of stress could be very bad for children, whether from a 'scare giver', who exposed them to domestic violence, or a parent that didn't give them enough attention.

'A child gets an idea of what the world's like from their parent,' he said. 'How can we get this person in a difficult place to trust the outside world?'

At a workshop on working with families experiencing substance misuse, Claire McCarthy of the charity 4children said that current provision for alcohol and drug treatment lacked a family focus. The charity's survey with ComRes showed that a third of adults drank more than recommended, and 47 per cent were worried about the effects of drugs and alcohol on their lives. With alcohol a major factor in a large percentage of child protection cases, there was a lack of partnership working and funding, and the charity had recommended that the alcohol industry funded more support.

TWO SIDES OF THE STORY

The conference heard from Steve, aged 42, and his father Alan (not their real names) who spoke about Steve's 20-year drug history and its effects on each other and their family

STEVE: 'It's been a lonely journey but my dad's been my backbone.

I'm about to go for a two-week detox. It's been a long road for me to decide to do this – I hadn't realised how far this life had gone past me. I lost my little brother to this lifestyle. I've been in prison. I've never had a bank account. One day I thought, 'enough's enough – I have to do this now'. My little brother died and the older one's still using. My mum died when I was using. My dad's been my backbone.

It's been a lonely journey, even with support of my dad. When I first went to my local GP practice, I weighed nine stone. I look a completely different person now. I can be a person society can accept. I know there's someone there to listen to me.

The daily grind of having to get up and shoplift, being wanted by the police, ducking and diving, not knowing what was going to happen that day, having no one to talk to. I started to think this was how it'd stay.

I realised, with my GP's help, that you have to put the effort in. Every day on methadone I still wanted to use heroin. If I didn't put the effort in, someone else would take my place. It's not been easy and it's still not easy. I'm still scared of what's ahead of me in rehab.

Through everything I've put my dad through, he's had no support. Sometimes I could see by the look on his face, he's been relieved I've been in prison. I have to show my dad his hard work hasn't been for nothing.

You need your family. Without my dad, who knows what could've happened to me. I know people not as fortunate, whose families have turned against

them. Mine's always had a bond with me and it's important to have someone there for you.

There have been negative influences – brothers and partners. I had three kids with a non-user but that failed and every partner since has been a drug user. There's no trust. It's hard to get people to trust you – sometimes people don't know the bigger picture. They treat you all the same. Sometimes though, you try and mask the situation – I didn't want dad to know the whole picture.

Once I've completed rehab, I've been told there'll be voluntary work. It'll give me hands-on experience of nine to five. I've never had stability or a chance to prove I can sustain a proper lifestyle. I hope I'm not on any substance whatsoever by then.

I want to come out and see a direction for once – stay clean and have some stability. Have an address that's secure, that's mine.

For me, this rehab's going to be a sanctuary – I'm going to grasp it with both hands and hopefully I'll still have support from a drug worker who can point me in the right direction.'

ALAN: 'It's been a never-ending nightmare – I'd like to see him helped.

I supported him all the time in prison. I found him accommodation time and time again and spent hours in courts. It was a never-ending nightmare. Visiting someone in prison, you're treated like a criminal yourself, with fingerprints and sniffer dogs. It's not very nice.

My three sons were addicted. We've never had a normal family. From time to time I was tempted to wash my hands of them. There were constant demands for money. I had to live at secret addresses. My elder son was very abusive. I've had no support. Eventually I went to our GP practice, but up till then I had no help.

After all these years, I can see light at the end of the tunnel. I have grandchildren and have 100 per cent hope that they won't turn out like that. But I will never know how my sons turned out like they did. I brought them up in a good residential area and made them work for their pocket money.

Tough love doesn't work – your heart rules your head. My younger son was involved with a drug service and we had to do a home detox for two weeks. It was horrendous. After a month, he was back on drugs.

Steve's going into a six-month programme. When he comes out I'd really like to see him helped to find employment and somewhere respectable to live.' **DDN**

Post-its from Practice

Family matters

Always look beyond the symptoms at the wider picture, says **Dr Steve Brinksman**

I have just returned from the RCGP/SMMGP annual substance misuse conference in Birmingham. The theme of the conference was 'Joining the dots', encouraging us to look at the wider picture and consider the impact of substance use on more than the individual. I was asked to talk about the role of families and their impact – positive and negative – on someone who uses substances problematically, but also the effects that their addiction can have on their family.

If you have read this column before, you will know that I am a passionate advocate of the role that primary care can play in working with those using drugs and alcohol, and a key part of this is the continuity that helps build a relationship with a patient, sometimes over many years.

Despite this I can be a bit slow on the uptake at times! I had been seeing John for about three years for his heroin and crack use; he was fairly chaotic, injecting and funding his use through acquisitive crime and borrowing money from family. His engagement with treatment at that time would be best described as tangential and he was a frequent non-attender. After a couple of consecutive failures to keep appointments, I found out from our shared care worker that he had been sentenced to 18 months in prison for drugs-related offences.

Over the same period I had been seeing Linda, a 40-year-old woman who had significant anxiety and depression. I had started her on citalopram – an SSRI antidepressant – and referred her to our primary care based counsellor, and she had had a couple of short courses of diazepam over the last few years when she had presented 'at the end of my tether'.

I saw her one day and she seemed much more relaxed than usual. She told me that she felt much calmer as her son had been sent to prison for 18 months and she felt this would give her the chance to try to sort herself out – and it was then that the penny dropped. She was John's mother, and although they shared the same (albeit relatively common) surname, I had not made the connection as they were registered at different addresses and I hadn't thought to ask her if her anxiety related to caring for someone with substance misuse problems.

I had made the common mistake of focusing on Linda's symptoms and not exploring the wider context of things happening in her life by direct questioning. Instead I assumed I would be told all the issues by the patient. Linda felt stigmatised because her son was someone who uses drugs. She had lost friends, and she also expected us to treat her as if she wasn't worthy because of this, so she didn't volunteer the information.

The time John spent in prison did help him to make some progress and he engaged with treatment services. Over the five years since he was released he has been more compliant with medication and (usually) keeps his appointments, but he does still use a couple of times a week. However Linda feels she has the ability to cope with the situation and no longer blames herself for all of his problems. Interestingly, as John has had more appointments, she has had less.

As for me, I hope I try to look at a wider picture when seeing those patients presenting with anxiety and depression – even if this means sometimes asking difficult questions.

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.

POSITIVE ACTION

As NHS reforms put the future of hepatitis C services in the UK in question, Phil Spalding tells Kayleigh Hutchins **how the Hep C Positive project has raised awareness about the virus in Swindon**

With almost half of NHS commissioners having no measures in place to increase hepatitis C treatment in the UK, according to a recent Hepatitis C Trust report (*DDN*, April, page 5), the importance of disseminating accurate information about the virus and how to access treatment seems more crucial than ever. As a former service user and hepatitis C sufferer himself, Phil Spalding set up the Hep C Positive support group to offer others affected by the virus much-needed support and advice on how to test for and cope with the disease. From starting out as bi-monthly meetings, they grew into weekly sessions as it became apparent that more support and information was needed, not only for sufferers, but also carers and the wider community. Spalding was made hep C coordinator by Swindon's community safety commissioner, and given the opportunity to develop the project further.

This gave Spalding the chance to reach out to existing health and social care services – in particular drug and alcohol services – to encourage referrals. He found that a lack of accessible information and general education about the virus had brought about massive stigmatisation around hepatitis C, similar to the public opinion of HIV in the eighties. It became obvious to him that there was an underlying idea that hepatitis C 'only happened to bad people' or people who 'weren't worth it', and that 'all hep C sufferers were drug addicts and criminals'. To maintain the success of the project, Spalding worked to dispel the negative connotations and get people into treatment.

'Most "addicts" don't like the label society gives them and it's one of the reasons they may not like to talk about hep C. It's just another negative label,' he says, and so it became crucial to his role to raise awareness and distribute the correct information to clients, their families and the community. The aim was to make it easier for those who needed it to find a pathway to testing, treatment and support.

To do this, Spalding sought to publicise both the virus and the project, reaching out to professional organisations like the Hepatitis C Trust and DHI, as well as the local DAAT and drug services, and getting coverage from the BBC and press agencies. He also organised an educational evening in partnership with Swindon Borough Council, giving health professionals and patients a chance to interact and learn more about the disease.

As the work done by the project depended heavily on the workers within health services making referrals, Spalding aimed to demonstrate how the Hep C Positive project could help their clients, giving them a safe place to talk to others who understood the problems they were facing. 'It's about giving people choices and opening as many doors as we can, enabling service users and patients to, hopefully, find something that will motivate them into taking responsibility and moving forward with their lives.'

Spalding approached each new client as both peer and counsellor, discussing their feelings and encouraging them to go to the support group to open up to others who are living with hepatitis C. 'Some people are uncomfortable with this idea at first because they are usually frightened and ashamed,' he says. But once they realised they were among peers and could relax in a friendly and non-judgemental atmosphere, they were able to open up, giving Spalding the chance to signpost other services that the client might need.

'My role involves a lot of advocacy and what I call "hand holding",' he says, which included helping clients to schedule and keep appointments at GP surgeries and hospitals. Having gone through treatment for hepatitis C himself, Spalding was able to explain complicated medical terms and inform clients and their families about the treatment process in a way that was not too overwhelming, and easier for them to come to terms with.

The Hep C Positive project has now helped many people from different backgrounds develop the courage to get tested, and follow through to treatment for the virus. It boasts a number of success stories to show how effective the project has been, and the group is eager to share its members' journeys to support others around the country who may be experiencing hepatitis C.

In Grant's case, the group meetings were a way of combating his isolation from society, says Spalding. 'When I first met Grant he was extremely nervous

OSITIVE

LEFT: Phil Spalding. ABOVE: members of the Hep C Positive art therapy group. MAIN GRAPHIC: Jamie Whittaker

and appeared to be hiding behind his scarf with just his eyes showing beneath the brow of his woolly hat. He was a long-term drug user who, apparently, had no real social life except his round of health and social care appointments and a weekly card game in a pub.' Grant was able to connect with Spalding as a fellow drug user, and began his journey by asking him a number of direct questions about the disease.

From being reluctant to join the group at first, he has connected with the others, and is now confident enough to speak in front of them. After following his course of treatment for hepatitis C, he is now clear of the virus, but he still attends the group to offer support to those going through the same journey.

Hannah was another client whose involvement with the Hep C Positive project helped her seek treatment. Diagnosed HIV positive at the age of 23, she felt that she had no one she could talk to apart from her drugs worker, who had referred her on to the group. At first she just sat in the circle and cried, finding it difficult to explain how she was feeling or the pain she was in, but in time she began to open up to others in the group and find the help she needed.

'Whilst she hasn't been ready to confront some of her emotional issues and most probably doesn't fully understand them, our feelings are that as long as she's coming to us every Monday evening, it gives her a haven at least once a week and keeps her safe for that time,' says Spalding. 'Whilst we have opened the door for her, she's the one that's had to walk through it.' Like Grant, she also sought treatment and is working on her issues with the group's help.

The future of the Hep C Positive project is bright, but Spalding is keen to spread the work in Swindon further afield, and has been asked to look into starting similar projects in other regions. 'The most consistent effort has to be put into awareness and information,' he says. 'I'd like to see more referrals from people and areas that have yet to access the project, encourage more people to come our group and continue raising awareness wherever and whenever that may be.' **DDN**

ENTERPRISE CORNER

THREE-PRONGED APPROACH

Partnership working is showing promising results for London's keen entrepreneurs, says **Amar Lodhia**

OVER THE LAST SIX MONTHS, the TSBC team and I, City of London Corporation staff and high profile entrepreneur guests have all been involved in the delivery of an inspiring self-employment programme, which was 50 per cent funded by our foundation. It has resulted in eight new enterprises being formed and 15 City of London staff engaging in mentoring and volunteering their time to the programme – all of which has contributed to participating adults already coming off benefits and creating a job for themselves in a climate where jobs are more difficult to find, particularly for those with convictions and other barriers to employment.

The 20 residents (mainly female ex-offenders) from across Islington, Southwark, Tower Hamlets, Camden and Westminster participated in this programme, which was made up of ten weeks of core delivery and will end in December 2013, following a year of mentoring and post-programme support.

The programme was unique and its success can also be attributed in large part to the City of London staff from different departments, such as housing, media and economic development, who were trained as mentors and also co-delivered activities within the sessions.

On 14 May, the City of London Corporation, and its chief executive John Barradell, hosted their annual employee volunteering reception, in which charity partners and employees met up to celebrate and encourage volunteering. During the event, he commended the work of TSBC and his Economic Development Office as well as the corporation's employees. As part of their commitment to promoting corporate responsibility and economic regeneration, the City of London Corporation gives all staff the opportunity to take the two days (or equivalent) of volunteering leave each year.

TSBC is calling on other local authorities to learn from this prime example of employee engagement in the public sector, particularly those within which it operates, including Islington, Southwark, Tower Hamlets, Hounslow, Barking and Dagenham, Newham, Haringey, and Melton Mowbray.

This programme showed the 'tri-sector' approach on the front line, with real partnership working between entrepreneurs, public sector workers and charities. In my February column, I wrote about how participants also heard from award winning entrepreneurs like Seema Sharma – Channel 4's *Slumdog Secret Millionaire* and local Tower Hamlets dentist.

Wendy Lunn, City of London Corporation's employee volunteering programme officer said, 'The main focus of our programmes over the last six months has been our flagship $E=MC^2$ programme. This programme has involved 20 unemployed local residents taking part in workshops to help boost their employability skills and to help those that wish to set up their own business to develop their enterprise skills. The workshops engaged more than 15 volunteers in sharing their expertise and helping the participants to develop their skills.'

To enquire more about our work please contact me at ceo@tsbccic.org.uk and follow me on Twitter @amarlodhia or @tsbclondon – don't forget to use the #tag DDNews when tweeting!

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

Can reducing the 'dead space' in injecting equipment save lives, asks **Jamie Bridge**

For the more than 100,000 people who inject drugs in the UK, needle and syringe programmes have proven invaluable since their official adoption by the mid-1980s Conservative government. These services have helped to avert an HIV epidemic among this population – with HIV rates now consistently below 2 per cent among current and former injectors nationwide – and a huge international body of evidence has been developed to demonstrate how these services can reduce not only risk behaviours and HIV transmission, but injecting frequency and returns of used equipment. They also enable referrals to drug treatment and save public money, hence their adoption in 86 countries around the world and their inclusion in the UK *Drug strategy 2010*.

The impact on viral hepatitis, however, has been much more modest – around half of all people who inject drugs in the UK may be infected with hepatitis C, with little change since 2001. This reflects the fact that the hepatitis C virus is more easily transmissible than HIV, and so requires even higher coverage levels for prevention services. According to the Health Protection Agency (HPA), 57 per cent of people who inject drugs in England receive enough needles to cover every injection, yet a quarter of current injectors aged under 25 still reported needle and syringe sharing.

Emerging evidence, however, suggests that the design of the needles and syringes themselves could help to further reduce HIV and hepatitis C transmission – depending on how much 'dead space' they contain.

Every syringe inevitably retains some fluid when its plunger is fully depressed, in what is known as the dead space. As the diagram shows, some types of syringe will contain more of this dead space than others. 'High dead space' syringes with detachable needles will retain fluid in the tip of the syringe, the hub of the needle and the needle shaft itself. In 'low dead space' designs with permanently attached needles – such as the 1ml insulin needles used by many people who inject drugs – fluid is only retained in the needle shaft.

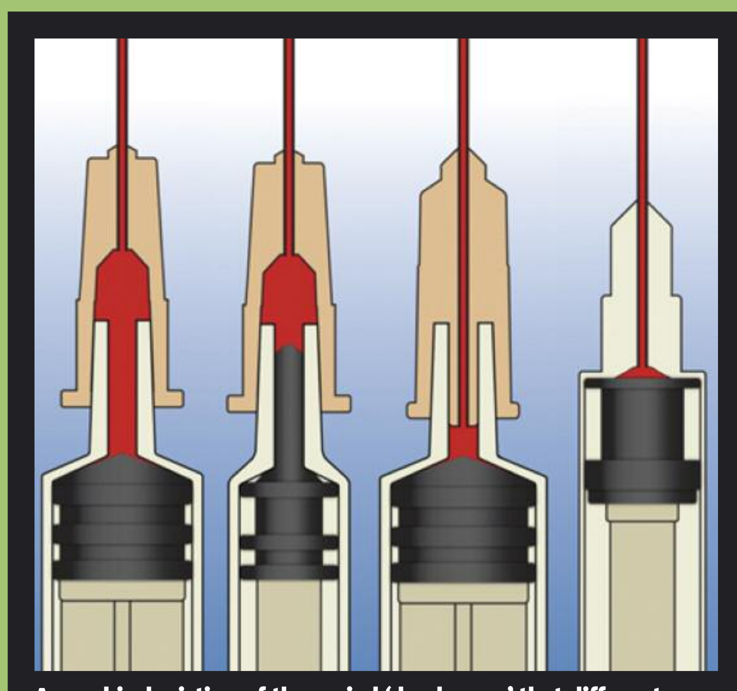
The difference can be up to 40 times more fluid being retained in high dead space syringes compared to low dead space ones. In laboratory experiments that simulated common injection practices, low dead space syringes retained up to 1,000 times less blood than high dead space syringes, so if a person shares a low dead space syringe with someone living with HIV there will be less blood retained in the syringe and therefore less viral load and a lower risk of transmission.

Modelling work by Dr William Zule and colleagues in the USA has helped to quantify what this could mean in the real world. Their results suggest that injection-related HIV epidemics could be stabilised, reversed or avoided altogether when the majority of people who inject drugs use low dead space syringes. Laboratory studies have also shown that the hepatitis C virus can survive for up to 60 days in high dead space syringes, compared to just one day in low dead space alternatives – hence the inclusion of low dead space syringes in the latest World Health Organization guidance on viral hepatitis prevention among people who inject drugs.

More research is needed, particularly to assess how effective low dead space syringes can be in the real world, rather than in models and laboratories. But it is an area of great promise. Provided it is managed carefully, the transition from high dead space to low dead space syringes is also a risk-free intervention for services to provide as part of a comprehensive harm reduction package. It must never be a substitute for the highest possible coverage of harm reduction services, but rather a complementary string to the bow to make these programmes even more effective.

Crucially, a shift from high dead space to low dead space syringes should never be forced upon someone. People who inject drugs may prefer a wide range of different syringes and needles and this needs to be respected. In particular, 1ml insulin syringes with fixed needles – which often have the lowest dead space –

DEAD OR A



A graphic depiction of the varied 'dead space' that different needles and syringes may contain – from left to right: a standard (high dead space) syringe with detachable needle; a low dead space syringe with standard detachable needle; a standard syringe with a low dead space needle; and a low dead space insulin syringe with a fixed needle.

may be unsuitable for the injection of certain drugs, or for injecting in certain parts of the body. It is essential that clients are widely consulted in order to ensure the appropriateness of any equipment supplied, and it's important not to lose the emphasis on the potential harms of injecting and – particularly – sharing needles and syringes.

To facilitate this consultation, low dead space alternatives are now available in a range of sizes and with both fixed and detachable needles. Exchange Supplies have developed a range of 'Total Dose' low dead space needles and syringes which have a plastic 'spike' that fits inside the tip of the syringe while the syringes have a 'spike' on the end of the plunger. Importantly, these products are also available at prices similar to high dead space needles and syringes whereas traditionally low dead space alternatives have been perceived as being too expensive to justify.

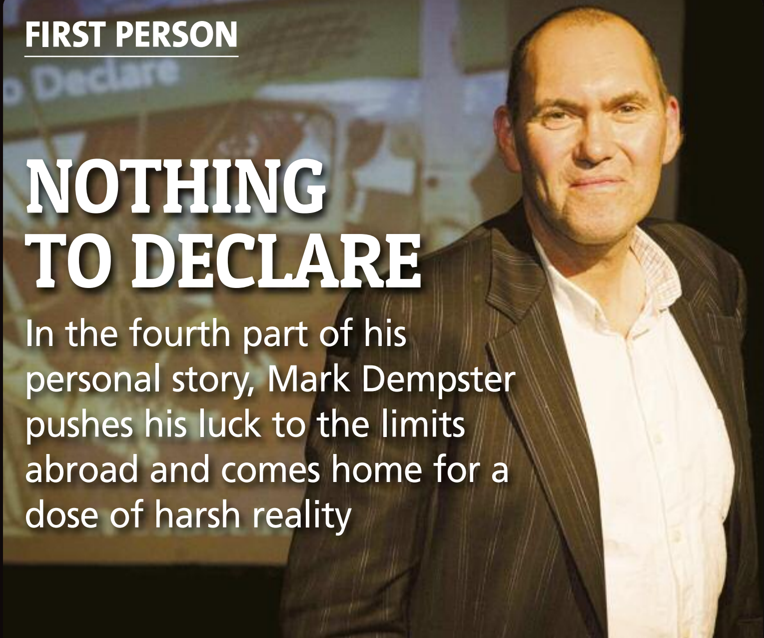
Low dead space needles and syringes are a potentially crucial addition to the harm reduction armoury. Do you know what kinds of needle and syringe your local services are supplying?

Jamie Bridge is chair of the National Needle Exchange Forum (NNEF).

Low dead space needles and syringes will be among the topics discussed at the NNEF meeting on 20 September, free to attend for needle and syringe programme workers, users and advocates. See www.nnef.org.uk for details.

FIRST PERSON

NOTHING TO DECLARE



In the fourth part of his personal story, Mark Dempster pushes his luck to the limits abroad and comes home for a dose of harsh reality

I spent my break in Morocco drinking poppy tea and smoking hash. I hitched a lift in the middle of nowhere with some German tourists. We stopped by some woods so that I could wrap my hash and swallow it to cross the border – that's when I saw a young soldier with a rifle pointing at my head. Next thing, he was nudging us over with his gun to a tree, motioning for us to pull our pants down and bend over – I begged him not to. I tried to convince the Germans to take one for the team, but they wouldn't – I was scared he was going to kill us. After several hours of negotiation, we traded money and hash for our freedom. I was glad to be leaving Morocco.

Despite nearly being buggered and murdered by a soldier, I didn't learn my lesson. My next trip was to Spain to swap some LSD for hash. This time I was caught and ended up in a Spanish prison. I expected to be there for years – I had no trial and no defence. All around me people were beaten near to death and I had to act hard to stay alive. I got lucky again – but my friend had to do five years. I thought that somebody must have been looking out for me.

Back in London, Walshy had messed up the business. I had been gone for too long and he had lost our customers to a rival. We were back to a few deals and had hardly any money. I thought a party for my 25th birthday would be the start of a comeback – all the big dealers were there, including Brian. The party was going well and then Walshy overdosed on heroin. We put him in a bath and slapped him about – he was looking better and just needed to sleep it off. So did I. I found him the next morning dead.

I ran around the house searching for anything that would numb what I was feeling. Although I hadn't given him the heroin that killed him, I felt responsible. For several weeks I locked myself away and drank myself into blackout so I could forget everything that had happened. Everybody blamed me for what happened – nobody would do business with me, Brian wanted money from me and Walshy's family wanted me dead.

Mum was worried about me and begged me to get off the drugs – she thought if I could get clean I would be OK. I thought that if I could quit the heroin then I could still drink and smoke hash – I just needed to go to a place where nobody knew me and I could get some distance from London. Time would heal things and I could kick the heroin habit in India. Besides, I could always smuggle some drugs back when I got sorted and start again – this time would be different. I didn't know this was the beginning of the end.

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

Next issue: Mark becomes a beggar in India, homeless in London and reaches a crossroads in his life

Although minimum pricing didn't make the Queen's Speech this time around, Alcohol Concern chief executive Eric Appleby tells David Gilliver **how it's helping to frame a consistent campaigning message**

'It's not going to go away, that's the main thing,' says Alcohol Concern chief executive Eric Appleby of minimum unit pricing, following its much-anticipated non-appearance in last month's Queen's Speech (see news story, page 4). 'I think, ultimately, we will get something like minimum pricing, but it's clearly not going to be in the next six months.'

Alcohol policy is now at a point where there is a general understanding that action along those lines is necessary, he believes. 'If you look at the 2012 [alcohol] strategy, that's a step up from previous ones in that it does acknowledge the need for some population measures. All the evidence shows that price and availability are the key issues when it comes to reducing, not just consumption, but harm, and certainly those of us whose job it is to campaign on these things are not going to let them forget that. There's still all to play for, really."

It will be a tough battle, however, as the 'resources and power' of the industry are huge, he acknowledges. While Scotland may be over the first legal hurdle in terms of implementing a minimum price, the industry has inevitably warned that it will be the first of many.

So what's the best way to counter the industry's influence – is it to just keep plugging away at the public health message? 'You try to put the public health argument as strongly as you can but it's tough, because it's a general message rather than a very specific one,' he says. 'I think you just have to continue to point out that the industry has a vested interest. Whatever else they say, their legal duty is to make profits for their shareholders, and they do that by selling more booze. And governments have to be realistic in this and not involve the industry in policy making.'

He cites the recent statement from the World Health Organization (*DDN*, April, page 5) as one that government should heed – that the industry can 'have a role in perhaps mopping up some of the problems they cause, but that shouldn't be about them picking and choosing what they do,' he says. 'They need to put money into something like a blind trust to help deal with some of the consequences, but it should be up to the public health community and treatment services to decide what works best and what needs to be done.'

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A new problem seems to have emerged, meanwhile, in the shape of Nigel Farage and UKIP. ASH has already cited them as perhaps part of the reason a government increasingly wary of being seen as 'anti' alcohol and tobacco dropped plans for plain cigarette packaging. Does Appleby think this is a real issue?

'I think it is,' he says. 'Whether it was a factor in that particular decision, I'm less sure, but I think it is a factor. You've always got this iconic image of him with a pint in his hand, supposed to symbolise your average punter. A lot of that is to do with this idea of the public wanting politicians who look like real people instead of people who've just come through a political machine, and I think that is of some significance. It's certainly going to make governments more nervous about taking measures on drinking.'

A key problem, he acknowledges, is that although campaigners have been very clear about how minimum pricing would target 'a limited number of drinks that are sold very cheaply, largely in supermarkets' – with no impact on the pub trade – getting that message across to a general public who, understandably, 'aren't engaged with the detailed niceties of policy,' is tough. 'We just have to keep making the point that it's a very targeted measure about addressing harm – it's not about telling everybody what they should do,' he says.

When the alcohol strategy was published last year, Alcohol Concern stressed the need for more funding for treatment and advice services alongside action on price and marketing. How worried is he that alcohol won't get the money if it's not seen as a priority locally?

'I think that's all very much up for grabs,' he states. 'Theoretically, moving public health and alcohol into local authorities so it joins up with things like licensing and social care ought to be a very good move. Local authorities are, by

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'The industry has a vested interest. Whatever else they say, their legal duty is to make profits for their shareholders... And governments have to be realistic in this and not involve the industry in policy making.'

and large, saying alcohol is a priority, but we've seen this before and we know that when it comes to the crunch, a) the money is short and b) they're not experienced in commissioning alcohol services, don't necessarily know an awful lot about it and perhaps don't appreciate how the whole pathway thing works.'

While the drug sector is also concerned about loss of investment – and perhaps some of it potentially shifting to alcohol – there's a danger that local authorities will 'confuse and conflate' the two, he says, and although there is a good deal of overlap between drug and alcohol services, it's the differences that are key.

'The early pathway of an alcohol career, if you like, is usually different to the pathway of a drug user – the nature of alcohol, the ubiquity of it, the different pressures in terms of socialising, all that sort of stuff you've got to provide for and try to get early interventions to stop people getting too far down the line,' he says. 'Obviously when you get to the dependent stage it's very much the same, but at that early stage it's a bit different and they need to understand the nuances of that. The worry is they'll have neither the time nor the resources, because they've got a hell of a lot of other stuff on their plate as well.'

The sector needs to engage with local commissioners as far as possible, and give them 'a sense of the spectrum of alcohol treatment', he says. 'Make sure they understand that you save money by putting that continuum of services in place – if you just put your money into the far end of it, you're going to be spending a lot more than you need to. Obviously, identification and brief advice [IBA] is important, but there's that tranche of people who are beyond IBA but aren't severely dependent yet – there's a lot to be achieved in that mild dependency area.'

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This is his second stint as head of Alcohol Concern, having joined in the late 1980s as director of services and professional education, following a period setting up adult literacy schemes in the community. 'The job was about trying to develop new local and community-based services, so in a sense the crossover was more about community services than it was specifically about alcohol,' he says.

'I didn't start out with any sort of crusade. I recognised there was a problem but the more you get involved with it, the more you realise what a big issue it is. When it looked like I might actually get the job there was that thing of "do I want be seen as a professional killjoy?" but you do the job for about a week and you realise that you're certainly not going to apologise for anything like that, because of the massive amount of harm and misery being caused out there.'

He ended up staying for 14 years, the result of nothing else seeming 'as interesting, or with as many dimensions to it, or so important'. He's now back as interim chief executive, a part-time post that's partially the result of the organisation, like many charities, taking a major funding hit in recent years.

'The world had changed and Alcohol Concern needed to change with it,' he says. 'My job is to set us up with a long-term sustainable future, and we're well on the way to that. When I was last here we had just under 40 staff and now we have 11, so we have to be much more focused on trying to achieve change.'

While the organisation may be different, in terms of the wider policy field perhaps less has changed, he says. 'There's a lot of talk about alcohol policy and still nothing much gets delivered. But, on the other hand, I do think that having a focal point for campaigning – minimum pricing – has been important, because it's provided the rallying point for those with an interest to come together and have a coherent and consistent voice.'

There are also many more bodies getting involved in the alcohol debate, he points out. 'The Alcohol Health Alliance is made up of 30-odd organisations, and there's a much more concerted and persistent interest in alcohol among children's charities as well, for example. It is gaining depth, and part of the job is that we make sure that campaigning is coordinated and coherent.

'Because governments like nothing more than a whole bunch of different people saying different things to them. It gives them an excuse to do nothing.' **DDN**

Harnessing the POT

Is the sector ready for co-production, asks **Alistair Sinclair**

'Co-production is an idea whose time has come,' states *Right here right now: taking co-production into the mainstream*, a New Economics Foundation (Nef) and NESTA report on how involving users in the design and delivery of services is the way ahead for public services. 'The idea, put simply, is that people's needs are better met when they are involved in an equal and reciprocal relationship with professionals and others, working together to get things done,' it says.

Is 'recovery' ready for co-production? I considered this question a few weeks ago while attending a recovery conference hosted by Derbyshire Healthcare NHS Foundation Trust in partnership with Phoenix Futures. A wide range of professionals and people from the UK recovery community gathered to share some of their knowledge and experience and talk about the assets that exist within services and communities.

Delegates heard from Professor John Strang of King's College, London, Phoenix Futures chief executive Karen Biggs and Seamus Watson, national programme manager for wellbeing and mental health at Public Health England. Themes included the individual nature of recovery, the need to improve treatment and recovery rates and the importance of engaging in 'conversations' with service users, families and communities.

The conference was a 'fantastic opportunity for individuals and groups to demonstrate their passion, motivation and drive to champion recovery – not as a buzzword but as an individual journey that services must support and be focused on,' said deputy chief executive of Derbyshire Healthcare NHS Foundation Trust, Ifti Majid. 'Some fantastic examples of what works and what doesn't were showcased and discussed. The energy in the room was palpable.'

'Family, neighbourhood, community are the core economy...'

There was a real sense of a shared enthusiasm for change and for doing things differently, and the importance of quality of life and community in the initiation and sustaining of recovery was stressed many times. Though the word was never used, it felt – with all the reference to assets and engaging with the community – that what many people were perhaps talking about was the need for 'co-production' and a greater recognition of the importance of the 'core economy'.

'Family, neighbourhood, community are the core economy,' says Professor Edgar Cahn in the Nef manifesto. 'The core economy produces love and caring, coming to each other's rescue, democracy and social justice. It is time now to invest in rebuilding the core economy.'

I believe that the Derbyshire Trust, in its drive to establish a strategy for 'whole system' recovery orientation, its commitment to recovery awareness training for all trust staff and its intention to establish 90 'recovery guardians' is beginning to explore what co-production means and its central role within recovery-oriented services. We are seeing similar beginnings in many other services but there's a long way to go and there's always the danger of buzzword substitution, something we've already seen with 'recovery'.

As another Nef document states, 'If we get it right, then co-production will help rebuild public services as equal and reciprocal partnerships

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between professionals and the people they serve. If we get it wrong then we may see the post-war welfare state dismantled without sustainable alternatives, while citizens – especially those who are poor and powerless – are left to fend for themselves.'

If you'd like see a real attempt at a bottom-up approach to co-production you could start small (but beautifully formed) and pay a visit to the Recovery Initiative Social Enterprise (RISE) in Kingston-Upon-Thames. This community-led enterprise has been quietly developing an approach to co-production that may well see them established as the backbone to a recovery revolution in Kingston.

I attended a RISE co-production workshop last month and heard how they were working on equal terms with local services, academics, clinicians and the community to establish something new – an integrated community-led model which will bring recovery, asset-based community development and co-production principles together to create RISE Community CONNECT, its explicit aim being to 'tackle poverty and inequality through access to community and education'.

As Elvis Langley, an independent consultant who has been involved with RISE since its beginning said at the workshop, 'Service user involvement is not co-production, consultation is not engagement. Co-production provides opportunities for personal growth and development to people, so that they are treated as assets, not burdens on an over-stretched system.'

We live in interesting times. The demands on the welfare state are not going to diminish and it will increasingly struggle to provide care to those in need 'from the cradle to the grave'. As austerity continues to bite we are faced with a stark choice – we can sit and agree that times are awful and 'somebody should do something about it' or we can look to the neglected 'core economy' – our community – and begin to rebuild and recover.

Another report from NESTA and Nef, *Public services inside out*, published in 2010, outlined a co-production framework with the following key characteristics – recognising people as assets, building on people's existing capabilities, promoting mutuality and reciprocity, developing peer support networks, breaking down barriers between professionals and recipients and facilitating rather than delivering. Recovery in the community has been developing within this framework for quite some time. Perhaps it's time for services to catch up? **DDN**

CELEBRATING RECOVERY IN KENT

The first Medway recovery festival organised by service user groups and local provider KCA celebrated recovery in the local community. DDN joined the celebrations

THE BRAINCHILD of the Medway service user groups, the Medway recovery festival was organised by local service users alongside Peter Hawley, KCA service user representative, and his team of volunteers.

'It's our privilege to help someone into recovery', said new KCA chief executive Ryan Campbell, explaining that he was in recovery himself. 'Recovery is about more than treatment, it's more than stopping using, it's about changing a whole lifestyle, being a good parent, moving into employment, and becoming a valued member of society.'

The one-day event celebrated the achievements of those in recovery in the Medway, with more than 100 people's hard work and determination recognised through an awards ceremony. The festival was attended by local director of public health Dr Alison Barnett, and MP for Chatham and Aylesford, Tracey Crouch – also chair of the All Party Parliamentary Group on Alcohol. In a short speech, Crouch said how hearing the recovery stories of people at the festival made her more passionate about campaigning for better treatment and explained that she had been moved to lobby parliament for improved alcohol services following a friend's experiences of being unable to get the help she needed for her alcoholic partner.

'Services need to be different for everyone – we need to offer both residential and community treatment,' she said. A prominent supporter of minimum unit pricing, Crouch added that it was necessary to change society's attitude to drinking and deal with the easy availability of cheap alcohol.

The focus of the day however wasn't politicians, treatment providers or healthcare professionals, but rather an opportunity to celebrate recovery and what it meant to the individuals concerned. This was highlighted by three very different service users telling their inspirational personal stories and reading their own poems.

Guests also heard from Alistair Sinclair from the UKRF and Paula from the Kingston RISE peer support group about building on people's assets to create a recovery community. Colm Whitty and Geoff Wheeler from Air Football then explained the work they did in partnership with KCA to take individuals beyond treatment and help them in the later stages of their recovery.

Event organiser Peter Hawley summed up the feeling in the room by saying that only five years ago there had been just a handful of individuals in Medway in recovery. Now events like this were possible and recovery was visible everywhere.

Group shot: KCA chief executive Ryan Campbell celebrates with event organisers and award winners

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Friday 11th October 2013 at The Megacentre, Sheffield

SASS presents the third national **Recovery in the Community Conference** bringing together people involved, interested and inspired by addiction recovery.

This year's theme: Into the Unknown

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Highlights include:

- Predicting the Next Five Years - interactive panel with the country's leading drug and alcohol CEOs
- The European Approach - Portugal's limited decriminalisation, Denmark's 'fixing rooms' and Sweden's zero-tolerance policy
- Speed Networking
- The Recovery Factor
- CBT and Mindfulness Masterclass

www.sheffieldalcoholsupportservice.org.uk/conference/

'Now is not the right time to decriminalise drugs'

PROPOSER: Dr Neil McKeganey,
founder, Centre for Drugs Misuse Research, Scotland

We're not discussing decriminalisation, we're discussing the timing. Humans have an unquestionable desire for any drugs. Why is criminal law involved in this area? It's society's attempt to limit the scale.

The impact of treatment on dependency is modest. You can exhort people to give up drug use – and you can keep them alive until they decide to do it for themselves. Some believe that the best that prevention can do is delay the onset of drug use. That's why there are criminal justice barriers – to reduce to a minimum the drug use in society.

We know informally that the policy of decriminalisation is being pursued in the UK; cannabis is dealt with in a 'softly softly' way, and I think this is preferable. But there is no need for a grandiose statement and the biggest change in drug laws in 50 years. There's a downward spiral in drug use – the latest British Crime Survey shows the biggest drop since we started recording data.

But the biggest point in favour of the motion is the changing nature of drug use in the UK. The continuing escalating curve of heroin use is not being borne out and we're also seeing a reduction in people contacting drug treatment services. So the actual profile of the drug using population is changing.

It's not all rosy in the garden of drug use statistics – there's a continuing propensity to use psychoactive substances. But we're seeing the most dramatic reduction in people using drugs. Now is not the time to look at decriminalisation – there's a risk of reversing the overall downward trend we're now witnessing.

It's arrogant to say it's just a public health issue. I find it staggering that you think there is no role for criminal justice to play.

SECONDER: Humphrey Narebor, DATUS

The criminal justice system helped me on my path to abstinence. When I heard there was a debate going on, I thought I have to dissuade you from this crazy line of thinking.

Decriminalisation will increase drug use or sustain it among current users. Drugs, legal or otherwise don't work – say no to decriminalisation.

OPPOSED BY: Steve Rolles,
senior policy analyst, Transform Drug Policy Foundation

We're criminalising certain risk-taking behaviour in a way that's arbitrary. There are about 6m people in the UK who are criminalised by the law as it stands. Very few people go to prison for possession in the UK – but they do globally, and it creates a criminal record.

There's a lack of research into the deterrent effect of decriminalisation. Neil noted that we're adopting a less punitive approach – this undermines his argument. Punishment is at the heart of the paradigm – but there's not much evidence for its effect. And in moving to decriminalisation, there's no link with increase of use.

There's enormous variety in the way different countries have adopted this – but not an explosion of use. It's been endorsed by a surprising array of organisations including the Red Cross – not marginal groups.

Criminalisation creates key harms. It pushes use into unhygienic high-risk environments. It leads to people who use drugs ending up in prison. It's unethical from a public health perspective – you're harming people you want to serve.

Criminalisation is intended to stigmatise use. It has led to discrimination against people who use drugs and deters them from seeking help. It negatively impacts life opportunity and access to housing and employment.

To not question the system is to allow harms to continue. It's unethical. It makes you complicit in the harms it creates.

Historically, drug policies have been framed in the criminal justice element. It's about reversing the balance so it's predominantly health.

SECONDED BY: Rueben Ambler, DATUS

I'm not in favour of drugs, but in favour of minimising their effects. Decriminalisation is overdue in this country. In Portugal, the taxpayers' money has been spent on treatment. People sometimes produce statistics that show the increase in drug use after decriminalisation – but this was already happening.

I hid my drug use from my family and friends, so I didn't get the help I needed. When I overdosed, my friends dumped me outside in the snow because they were afraid of the police. It wouldn't have happened with decriminalisation.

This debate was held at the RCGP primary care conference in Birmingham last month. The motion was carried by 70 per cent of the audience to 30 per cent.

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

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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.

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- **Eric Appleby**, Chief Executive, Alcohol Concern
- **Dr Owen Bowden Jones**, Chair of the Faculty of Addictions at the Royal College of Psychiatrists and Club Drug Clinic lead
- **Dr Gillian Tober**, Leeds Addiction Unit
- **Annette Dale-Perera**, Strategic Director of Addiction and Offender Care for Central & North West London NHS Foundation Trust
- **Mike Ashton**, Editor, Drug and Alcohol Findings
- **Lauren Booker**, Workplace Programme Manager, Alcohol Concern
- **David Stuart**, Education, Training and Outreach Manager, Antidote at London Friend
- **Plus**, A representative from Public Health England

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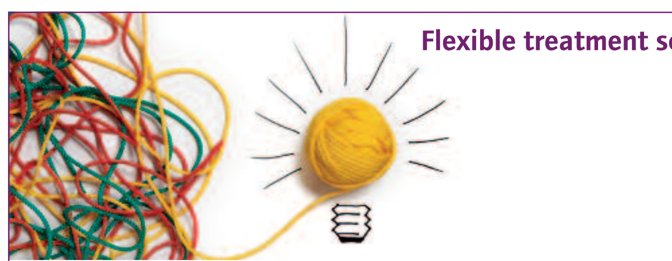

Flexible treatment solutions

Specialist Female Residential Placements

Females have traditionally faced more challenges in larger mixed residential services. In recognition of the need for more specialist support our unique Family Service in Sheffield now accepts single female placements.

We aim to ensure female residents feel more comfortable and secure and so more confident to engage in treatment.

For details contact us at our National Specialist Family Service
0114 268 5131
sheffield.family@phoenix-futures.org.uk

Registered charity number 284880 (England and Wales) and SCO39008 (Scotland)

THE ROAD TO RECOVERY FOR WOMEN AND CHILDREN

Brighton Oasis Project

5th September 2013

Audrey Emerton, Post Graduate Centre, Brighton

Women in Recovery
Impact on Children
Innovation within Women's Services
Working with families affected by Substance Misuse

Brighton Oasis Project has 20 years experience delivering community based substance misuse interventions to women. Our unique portfolio encompasses services for: *Women offenders* • *Sex workers* • *Children and Young People affected by familial substance misuse* • *Services for young women*

Bringing together speakers from a variety of disciplines to address and debate the issues affecting female substance misusers and their children. Themes to be covered in both plenary sessions and workshops include: *Substance abuse and child neglect* • *Communities of Practice – developing best practice within the treatment system* • *Prescription medication* • *Working with women with multiple and complex needs* • *Safeguarding Children* • *Recovery* • *Evidence based practice* • *The recovery journey for women*

Delegate rate: £140 per person including lunch and refreshments

For more information, please e-mail info@brightonoasisproject.co.uk or call 01273 696970 or look at our website

www.oasisproject.org.uk

Change through People

Training • Consultancy • Coaching • Supervision

Bring out the best in your organisation.

Work in partnership with us to manage and respond to your training and development needs.

The Training Exchange has 16 years experience in drugs, alcohol, supported housing & criminal justice sectors. Improving outcomes for service users by building a confident and responsive workforce.

Our courses cover:
People skills
Management skills
Training and presentation
Drugs and alcohol
Mental health

Book onto our open course programme (see listings opposite or contact us for full programme details), or bring us in to deliver training tailored to your organisational or area needs.

For an informal discussion contact Mandy, Eve or Jo on 0117 941 5859 or info@trainingexchange.org.uk

Visit our website

www.trainingexchange.org.uk

the TRAINING exchange

Training Exchange programme 2013-2014

Bristol venues

All courses closely mapped to DANOS

One day courses (£125 + VAT)

Course	Date
Group supervision	*13 June 2013*
Addiction, dependency & recovery	*24 September 2013*
ITEP & Node link mapping	*1 October 2013*
Over the counter, under the net	*10 October 2013*
Steroids & other body building drugs	*6 February 2014*
Difficult & aggressive behaviour	*12 February 2014*
Contingency management	*25 February 2014*
Resilience skills	*30 April 2014*

Two day courses (£225 + VAT)

Course	Date
Controlled drinking programme	*20 & 21 June 2013*
Training & presentation skills	*25 & 26 June 2013*
Supervision skills	*26 & 27 September 2013*
Brief solution focused therapy	*3 & 4 October 2013*
Motivational interviewing	*5 & 6 November 2013*
CBT based relapse prevention	*28 & 29 November 2013*
Management & leadership*	*12 & 13 November 2013*
Working with concerned others	*14 & 15 November 2013*
Community Reinforcement Approach (CRA)	*3 & 4 December 2013*
Groupwork skills	*30 & 31 January 2014*
Mental health first aid	*10 & 11 March 2014*
Dual diagnosis	*20 & 21 May 2014*

**Management & leadership £275 (+VAT)*

Online booking available

Families, drugs and alcohol

CONFERENCE

14 June, Central London

HIDDEN HARM

10 years on – where next for responses to parental substance use?

If you are a policy maker or practitioner working within the sector of health, social care, drugs and alcohol services, children's services, education or criminal justice this conference is for you.

SPEAKERS INCLUDE:

- ***Professor Sir Ian Gilmore*** *– Chair of the Alcohol Health Alliance UK.*
- ***Joy Barlow*** *– leading academic in the field of children and problematic drug/alcohol users.*
- ***Annette Dale-Perera*** *– member of ACMD and senior manager of drug and mental health services at CNWL*

The conference will also feature an extended 'Question Time' style panel in the afternoon, chaired by broadcaster **Eddie Mair**.

Full programme and online booking

www.adfam.org.uk

TENDER OPPORTUNITY

INTEGRATED COMMUNITY ADULT DRUG AND ALCOHOL INTERVENTIONS

Staffordshire County Council wish to invite expressions of interest from innovative and experienced organisations that can enable people to achieve a range of outcomes that will improve the lives of individuals, families and communities affected by drug and alcohol issues.

The procurement exercise will involve three Lots, each covering separate geographic areas, as defined by the boundaries of the eight district councils within Staffordshire (excluding Stoke-on-Trent):

Lot 1 ***'North' – Newcastle-under-Lyme and Staffordshire Moorlands***
Lot 2 ***'West' – Cannock Chase, Stafford and South Staffordshire***
Lot 3 ***'East' – East Staffordshire, Lichfield and Tamworth***

Each of the three Lots will involve a single contract that will cover a comprehensive range of community (i.e. non-residential) interventions for adults (and their families), representing the majority of specialist drug/alcohol services in the defined geographic areas.

The interventions will be expected to enable people to holistically address their problems and build the strengths (skills and interests) required to achieve sustainable recovery. Services will be expected to work closely with other health and social care providers (education, housing, employment etc.) and community-assets, such as voluntary associations and peer-led initiatives.

Whilst a single contract will be held by a lead or prime provider (or joint venture/collaboration – acting as the lead) in each area, the lead/prime provider is expected to sub contract some interventions to organisations with specialist expertise.

The new contracts will commence on April 1st 2014 and are likely to be worth between £2m-£2.5m per lot each year for an initial period of three years with the possibility of extending for up to two further years.

This will be an e-tender opportunity therefore interested organisations should register NOW on http://www.staffordshire.alito.co.uk/. Here you will be able to read further information about the tender and receive alerts once the tender has been advertised.

Pre-Qualifying Questionnaires (PQQs) are likely to be issued mid-June with a closing date for submission likely to be around mid-July.

SUPPORT WORKERS
Catch 22, Hampshire

KEY WORKERS AND COUNSELLORS
Street Scene, Hampshire and Dorset

ADDICTION COUNSELLORS
Action on Addiction, Essex

LOCUM DOCTOR
SAM recruitment, Surrey

See these and more jobs on
www.drinkanddrugsnews.com

To advertise your vacancy, in print, online and via email contact
ian@cjwellings.com

isore media

Film production services for disadvantaged groups and organisations

- **isore media is a not-for-profit film production & training provider.**
- **We are an NOCN training provider offering NOCN acredited film making courses for up to 8 people at your site.**
- **We offer Naloxone Training for Professionals.**
- **We work with socially marginalised groups, from both addiction treatment and crimnal justice services.**
- **We take all your film ideas from concept to finished production - script writing, shooting and editing services avaliable.**

e-mail: admin@isoremedia.org
Phone: 07869292697
Website: www.isoremedia.org
Community Interest Company no: 7370672

Building Recovery In Communities
BOURNEMOUTH DAAT

EXPRESSIONS OF INTEREST

APPROVED PROVIDERS LIST FOR RESIDENTIAL REHABILITATION / QUASI REHABILITATION SERVICES

Bournemouth Drug & Alcohol Action Team acting on behalf of the Pan Dorset DAAT's invite expressions of interest from suitably experienced, qualified and established residential / quasi rehabilitation providers for inclusion onto the Pan Dorset DAATs Approved Providers List for the provision of substance misuse Residential Rehabilitation services.

The Contract will be for a period of 3 years with the option to extend for a further period of up to 2 years. The anticipated start date is 1st April 2014.

We are seeking a range of providers that have a proven track record in delivering quality residential services, focus on a recovery model, and the social integration of Service Users into the Community. Providers will be expected to liaise closely with the home authority Care Co-Ordinators to ensure that an aftercare residential plan is in place for when the Service User leaves residential treatment.

Service Provision must be within 3 hours travelling distance (Car/Bus/Train) of Bournemouth. Providers must be registered with CQC, have a NDTMS registered agency code and be able to submit data to the NDTMS on a monthly basis.

In order to be considered for invitation onto the approved list, providers are required to register their interest by emailing their request to louise.pogorzelski@bournemouth.gov.uk quoting residential rehab.

Expressions of Interest must be made before **Friday 12th July 2013**. Completed documentation must be returned by 16:00 hrs on **Friday 13th September 2013**.

Bournemouth Borough Council

Building Recovery In Communities
BOURNEMOUTH DAAT

EXPRESSIONS OF INTEREST

Bournemouth Borough Council invites expressions of interest from both individual organisations and consortia's for the provision of:

LOT 1: STAGE ONE (PRE TREATMENT) SERVICES and

LOT 2: STAGE THREE (AFTERCARE AND RE-INTEGRATION) SERVICES

Contracts will be for a period of 3 years with the option to extend for a further period of up to 2 years subject to performance and funding. The anticipated start date for services is 1st April 2014.

Organisations should be able to demonstrate knowledge, innovation, added value and the ability to deliver recovery orientated services in the community. The successful applicant(s) will also recognise the importance of the wider family and community, focus on a recovery model and social re-integration of Service Users and be required to work in partnership as part of a clearly defined treatment system with other commissioned Providers.

The value of the Contract will be in the region of approximately £825,000 lot 1 and £485,381 lot 2 over the life of the Contract.

Organisations applying should note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 may apply.

In order to obtain tender documentation, Providers are required to register their interest by emailing their request to karen.wood@bournemouth.gov.uk quoting Lot 1 or Lot 2.

Expressions of Interest must be made before **Friday 12th July 2013**. Documentation will be sent out to organisations week commencing 15th July. Completed documentation must be returned by 16:00 hrs on **Friday 13th September 2013.**

Substance Misuse Personnel

Permanent • Temporary • Consultancy

Supplying experienced, trained staff:

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

SAM

Call today: 020 8987 6061

Register online:
www.SamRecruitment.org.uk

Solutions Action Management
Still No.1 for Recruitment and Consultancy

London Borough of Newham is preparing to re-commission its community based substance misuse services. We would like to share with providers our requirements and procurement procedures. We would also like feedback from providers on tendering options we are considering.

The event will take place on: 21st June 2013
10:30-12:30 (refreshments available from 10:15)
Stratford Town Hall, 29 The Broadway, Stratford E15 4BQ

If you would like to attend this event please contact the Substance Misuse Commissioning Team.
Email: substancemisuse.commissioningteam@newham.gov.uk Tel: 020 3373 0881

If you are not able to attend you can request a pack from the same address

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

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