SPECIAL REPORT – HRI CONFERENCE, LITHUANIA

DDN
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'The goal is to build the power of low-income people who use drugs, and end the drug war – which is very much a racial and economic justice issue.'

EMPOWER AND ORGANISE

HARM REDUCTION ACTIVISTS GATHER IN VILNIUS

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BIRMINGHAM CELEBRATION EVENT

SUNDAY 22ND SEPTEMBER 2013

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FINISH POINT:

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Published by CJ Wellings Ltd,
57 High Street, Ashford,
Kent TN24 8SG

Editor: Claire Brown
t: 01233 638 528
e: claire@cjwellings.com

Assistant Editor:
Kayleigh Hutchins
t: 01233 633 315
e: kayleigh@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Advertising Manager:
Ian Ralph
t: 01233 636 188
e: ian@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Publishing Assistant:
Annie Hobson
e: annie@cjwellings.com

Subscriptions:
t: 01233 633 315
e: subs@cjwellings.com

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Life challenges

Harm reduction's global reach

Going to the International Harm Reduction Conference is a humbling experience. Harm reduction workers attend from countries with drug and alcohol problems of a scale that you would think are insurmountable, yet they come to share experiences, learn from colleagues abroad and take back practical, life-saving knowledge. We were at the conference to produce newspapers, the *Daily Update*, for each day of the event and we've given you a taster of them in this month's issue.

This year really brought home that the harm reduction movement is a global family whose pragmatism outweighs political posturing and the outmoded mantra of 'just say no'. Now, more than ever, we are in a position to appreciate that public health should be at the heart of our own drug policy. When you hear how hard it is to get someone in Dar es Salaam past exclusion and stigmatisation to gain treatment for TB, or how harm reduction services in Bucharest are trying to save the lives of children who are using drugs in the face of wholesale funding cuts, you wonder how our ideology back home can ever waver – health must always come first. See all the conference stories – as well as the latest pictures from the successful *Support. Don't Punish* campaign – on our website at www.drinkanddrugsnews.com.

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FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES AND TENDERS

NEWS IN BRIEF

CARE CONSULTATION

The Care Quality Commission (CQC) is carrying out a consultation to get feedback on its plans 'to help ensure that people receive high-quality care'. The consultation, which is open until 12 August, is 'the next step towards making the changes needed to deliver our purpose', the organisation says. The regulator's chair recently stated that the organisation's previous board was 'totally disfunctional' in the wake of a number of high-profile scandals.
Consultation at www.cqc.org.uk

EDUCATE AND PREVENT

A new Alcohol and Drug Education and Prevention Information Service (ADEPIS) has been launched by Mentor UK, in partnership with DrugScope and Adfam. As well as a website with free resources and guidance for schools and others working with children and young people, the DfE-funded service is developing a set of standards and good practice guidelines. *mentor-adepis.org*

BANNING FURY

Two groups of legal highs, 'NBOMe' and 'Benzofury', will be illegal for a year under a temporary class drug order (TCDO) while a decision is made on whether they should be permanently controlled. 'This temporary class drug order will protect the public and give our independent experts time to prepare advice,' said crime prevention minister Jeremy Brown. ACMD chair Sir Les Iversen said in a letter to home secretary Theresa May that the action was 'appropriate as a pre-emptive measure in advance of the summer music festival season'.

TROUBLE TIME

The government's 'troubled families' programme is to be expanded, with £200m invested 'to help 400,000 high-risk families' and incentives for health, social service and criminal justice agencies to work more closely together. The government was 'extending the approach to a wider group of families who, for example, are struggling with health problems or parenting, where their children are not in school or are at risk of being taken into care,' said programme head Louise Casey.

TIME TO C REALITY

Governments need to acknowledge that 'drug policy approaches dominated by strict law enforcement practices' perpetuate the spread of hepatitis C by exacerbating marginalisation and undermining people's access to harm reduction and treatment services, according to a report from the Global Commission on Drug Policy.
The negative impact of the war on drugs on public health: the hidden hepatitis C epidemic at www.globalcommissionondrugs.org

Alcohol dependency prescriptions up three quarters in a decade

Prescriptions to treat alcohol dependency have risen by 73 per cent in a decade, according to figures from the Health and Social Care Information Centre (HSCIC). More than 178,000 prescriptions were issued in 2012, compared to just under 168,000 the previous year and fewer than 103,000 in 2003.

The 2012 figure is the highest number ever recorded by HSCIC, with a 'net ingredient cost' of £2.93m, says *Statistics on alcohol: England, 2013*. The report illustrated 'the impact of alcohol misuse on hospitals in England', according to HSCIC.

'It is extremely important that patients who are dependent on alcohol have access to drugs that can help them recover,' said Royal College of Physicians advisor on alcohol, Dr Nick Sheron. 'However, the rise in prescriptions of drugs to treat alcohol dependency is indicative of the huge strain alcohol abuse puts on our society.'

While the report looked at the number of prescriptions being used to treat dependency, the 'real issue' was 'the vast numbers of people who are not getting help for their alcohol addiction', said Alcohol Concern's director of campaigns, Emily Robinson. The charity estimated that just one in sixteen people with an alcohol problem received specialist help, as 'there is just not enough treatment available', she said.

Meanwhile, a report from the National Confidential Enquiry into Patient Outcome, and Death has concluded that patients with alcohol-related liver disease are being failed by some hospitals. *Units: a review of patients who died with alcohol-related liver disease* calls for all patients presenting to hospital to be screened for alcohol misuse, and all those presenting to acute services with a history of potentially harmful drinking referred to alcohol support services for 'a comprehensive physical and mental assessment', with the results sent to their GP. It also recommends that a consultant-led multidisciplinary alcohol care team be established in every acute hospital.

'The first thing I found surprising was how many of these extremely ill people were admitted under doctors who claimed no specialist knowledge of their disease, and how many of them were not then seen by an appropriate specialist within a reasonable period,' said NCEPOD chair Bertie Leigh.

'As well as raising standards of care for these patients, we need to make sure we can intervene earlier to prevent this shocking loss of young lives,' said chair of Alcohol Health Alliance UK, Sir Ian Gilmore.

Statistics on alcohol: England, 2013 at www.hscic.gov.uk

Units: www.ncepod.org.uk

UN highlights 'alarming' rise in new drugs

New psychoactive drugs are proliferating at an 'unprecedented' rate and pose 'unforeseen public health challenges', according to the United Nations Office on Drugs and Crime (UNODC) *2013 world drug report*.

While use of traditional drugs appears to be declining in parts of the world, there is an 'alarming' rise in the use of new psychoactive substances, it says, with the number reported to UNODC rising by more than 50 per cent between 2009 and 2012 and new formulations 'outpacing efforts to impose international control'.

Seventy-three new psychoactive substances were notified for the first time in Europe last year (*DDN*, June, page 5) and a total of 158 in the US, and for the first time their number is now greater than the total number of illicit drugs under international control. 'What is actually known today, however, may be just the very tip of the iceberg,' says the report, as systematic studies on the spread of the substances do not exist.

'The emergence of NPS [new psychoactive substances], increasing non-medical use of prescription drugs and polydrug use continue to blur the conventional distinction between users of one or another illicit substances,' the report states.

Opiate use has remained stable, says the document, with heroin use apparently declining in Europe, while the cocaine market is expanding in South America and in Asia's emerging economies. Around 1.6m people who inject drugs are estimated to be living with HIV, and there are 'many regions where evidence-based drug dependence treatment and care are still not available or accessible' says the report.

The document was issued on the International Day against Drug Abuse and Illicit Trafficking, and ties in with UNODC's 2013 global awareness campaign Make health your new high in life, not drugs.

However, the *Support. Don't Punish* campaign (*DDN*, May, page 20, June, page 4, including London, above) sought to 'reclaim' the date with an international day of action that saw demonstrations in cities across the world to promote 'reform, alternatives and more human responses'.

Green Party MP for Brighton Caroline Lucas (pictured) joined activists demonstrating outside the Houses of Parliament.

'Governments now need to take an approach based on evidence – and one which deals with drugs as a health issue, not a criminal one,' she said.

Report at www.unodc.org

Glamourised 'lifestyle' promotions must be banned, says Alcohol Concern

Alcohol advertising that promotes 'lifestyle' images of drinkers or scenes that glamourise drinking should be banned, according to a report from Alcohol Concern. The recommendation is one of several in *Stick to the facts*, which maintains that self-regulation is failing.

The charity wants to see a ban on alcohol sponsorship of all sports, music and cultural events as well as on cinema advertising for everything except 18-rated films. The report also calls for restrictions on advertising content, so that only images and messages related to 'the characteristics of the product' – such as origin, ingredients and means of production – are allowed. The measures are necessary to 'protect children and young people from excessive exposure' to alcohol advertising, the charity says.

Regulation also needs be statutory and independent of the alcohol and advertising industries, with meaningful sanctions such as fines for non-compliance – based on 'the size of marketing budget and estimated children's exposure'. Regulating digital and online content presents a particular challenge however, the document states, with self-regulation failing to adequately protect the young. Advertising body ISBA responded by saying that self-regulation was effective and that the UK had 'some of the toughest advertising rules in Europe'.

Alcohol Concern chief executive Eric Appleby, however, said that children and young people reported that they were better able to recognise alcohol brands than those of cakes or ice cream. 'This has to be a wake-up call to the fact that the way we regulate alcohol advertising isn't working. It's time we reset the balance between commercial and public interest. That's why we want advertisers to stick to the facts alone and for alcohol advertising to be banned at sporting, cultural or music events.'

A separate report from Alcohol Concern Cymru, *On your doorstep*, has also found that children and young people are increasingly using online shopping services to buy alcohol. In nearly half of test purchases organised by South Wales Police, alcohol was handed over to 15-year-olds without any requests for proof of age.

'The process of purchasing alcohol online, for example via supermarket websites, is unique in that the sale is made in private and with relative anonymity, away from traditional retail premises,' said Alcohol Concern policy and research officer Mark Leyshon. 'Young people have told us that these sites offer less robust age verification practices and provide a quick and easy way to get hold of alcohol, especially for younger teenagers who would likely have greater difficulty in buying alcohol in person from in-store at a supermarket or off-licence.'

Meanwhile, a report evaluating the impact of the Licensing (Scotland) Act has been issued by NHS Health Scotland. Among the aspects of the act that had been viewed most positively since its full implementation in 2009 were fewer irresponsible promotions, increased powers for licensing boards and training for board members and trade staff. Issues that 'provoked a more mixed response', however, included the impact on the off-trade sector and the collection of national and local data in a way that allowed 'meaningful comparison'.

'The Licensing Act has reduced irresponsible promotions in pubs and clubs, but cheap, high-strength alcohol is still being sold in off-sales, particularly supermarkets,' said chief executive of Alcohol Focus Scotland, Dr Evelyn Gillan. 'Action that licensing boards take to reduce the availability of alcohol in order to reduce harm will be limited while alcohol continues to be sold at pocket money prices.'

Stick to the facts and On your doorstep at www.alcoholconcern.org.uk

An evaluation of the implementation of, and compliance with, the objectives of the Licensing (Scotland) Act 2005: final report at www.healthscotland.com

RECOVERY CUTS IT: The Recovery Kitchen, which teaches culinary skills to people in recovery, has seen its first graduations. The eight-week course, launched by Turning Point Zephyr in partnership with Birmingham City Council and Event Masters catering company, is taught by a Savoy-trained chef. 'After only a few weeks we opened our shutters and started serving a three course meal to other service users and providers,' said one graduate.

NEWS IN BRIEF

KHAT IN THE BAG

Khat is to become a class C drug, home secretary Theresa May has announced. Although the ACMD did not recommend banning the drug, the decision would 'help protect vulnerable members of our communities', she stated, and the government has promised a 'proportionate' policing response in terms of possession for personal use. DrugScope said it was 'concerned and disappointed' that the government had gone against the ACMD's advice, while Release said that 'once again, the government chooses to ignore the evidence when it comes to drug policy'.

STRATEGY SUPPORT

More consideration needs to be given to the specialist needs of women involved in prostitution and substance use when planning strategies and services, according to a report from DrugScope and AVA. 'We need more and better support from policy makers, planners and commissioners, and from services on the ground to help these women, many of whom have multiple and complex needs,' said DrugScope chief executive Martin Barnes. *The challenge of change at www.drugscope.org.uk. See news focus, page 6.*

PRESCRIPTION FOR CHANGE

New commissioning guidance on support for people addicted to prescription or over-the-counter medicines has been issued by Public Health England (PHE). Depending on local need, support could be delivered through existing services, developed in partnership with local GPs or via dedicated services and support groups, it says. 'Problems of addiction to medicines can occur in any community, so all local authorities should have a plan to assess and respond to local need,' said PHE director of alcohol and drugs, Rosanna O'Connor. 'While GPs should be the first port of call for problems of dependence on these drugs, specialist help should also be provided to anyone who needs it.' *Guidance at www.gov.uk*

MENTAL HELP

Mental health nurses are to join police officers on patrol in four pilot sites to 'improve responses to mental health emergencies', the government has announced. The nurses will accompany police to incidents where immediate mental health support is needed, so that people are not 'detained in the wrong environment'. The first pilots will take place in Derbyshire, Devon and Cornwall, North Yorkshire and Sussex, with more to be announced.

ON THE MARGINS

Although women who use drugs and are involved in prostitution are among society's most vulnerable and stigmatised groups, little specialised support exists. **DDN** reports

'I've been raped, I've been beaten up, fucking sodomised, punched the fuck out of,' says one woman interviewed for *The challenge of change: improving services for women involved in prostitution and substance use*, a powerful new report from DrugScope and Ava (Against Violence and Abuse). She also once had to knock on random doors after having been stripped and thrown from a car. 'How humiliating can it get?' she says. 'Once that happens you don't fucking forget.'

The report looks at current service provision and makes recommendations for both policy makers and services. Violence was an issue for most of the women interviewed, whether from partners or 'punters', and added to this were mental health issues – often from past physical or sexual abuse – poor physical health, increased HIV risk and 'very low' self-esteem.

The latter was often the result of dual stigma, the report states, with the stigma from involvement in prostitution often weighing more heavily – 'most women had told their families about their drug use, but many were concealing their prostitution', it says.

While 'women involved in street-based prostitution who misuse drugs and/or alcohol are one of the most marginalised and stigmatised groups in our society', it states, it's rare for them to be discussed in these terms and they are too often absent from 'policy and practice addressing the needs of the most vulnerable'.

That's because, DrugScope policy and engagement officer Gemma Lousley tells *DDN*, they remain a largely hidden group. 'The stigma associated with prostitution means that they often don't disclose their involvement, and in any event, few large scale surveys have collected information that can give us a reasonable estimate of the size of this group. Having said that, the *Drug treatment outcomes research study* found that 10 per cent of women starting drug treatment said they had exchanged sex for money, drugs or something else – although this probably captures involvement in "sex work" beyond what could strictly be defined as street prostitution, it indicates that the size of this group of women is significant and merits real attention.'

The 'process of change and recovery' is likely to be a lengthy one, the document stresses, making it vital that a range of support – from harm reduction to help in exiting prostitution and support for ongoing recovery – are provided. The report looks at the kinds of interventions that work best, as well as the women's own expectations and experiences of services.

Barriers to accessing help included a lack of flexibility and wider support around housing and employment, it says, while services also need to improve accessibility and develop a 'flexible approach' to missed appointments.

'It's important to recognise that there are some good services out there that are working to meet the specific needs of women involved in prostitution and substance use,' says Lousley. 'However our research found that, overall, there is a lack of specialist, tailored support. So, for instance, measures that increase service accessibility for these women – such as evening and weekend opening hours, outreach services, childcare provision and women-only sessions or times – aren't always in place.'

Although peer support was widely available in the services surveyed, they didn't always offer access to women-only peer support, she adds. 'So there's a question around how far this support is being provided by "real" peers, with similar histories and experiences. There's good evidence that tailoring of standard drug and alcohol programmes is an effective approach, but a relatively low proportion of the substance misuse services we surveyed reported providing advice and information around prostitution. Many of the women talked about wanting longer-term change in their lives – getting a job, having a nice home, being with their children – but felt that the support they were receiving didn't really extend beyond being put on a script.'

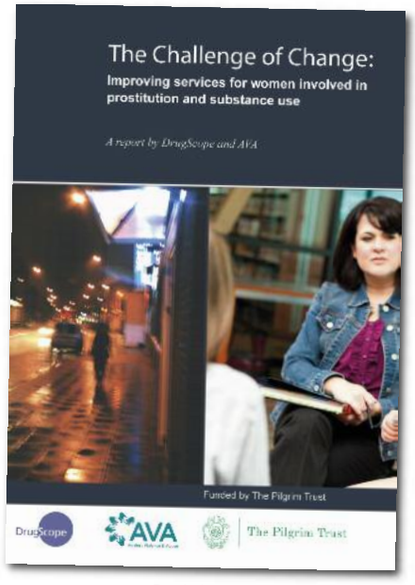
The report also calls for staff training and development to help tackle stigma, as well as 'robust' assurances of confidentiality. How much of an issue can the attitudes of some drug workers be? 'The issues we identified were less about attitudes as such, and more about awareness of the particular issues facing this group of women. Again, it's also important to say that many of the women interviewed spoke about receiving really good support from keyworkers. However, some did report stigmatising attitudes from staff – some of them felt that they were being "judged" or "looked down on" when they disclosed their involvement in prostitution – so it clearly is an issue for them.'

Staff turnover can also lead to issues around building trust and rapport, she stresses. 'Given the vulnerability of this group of women, this can be particularly problematic, and differences in age and gender too. As the research highlights, most of the women had experienced violence and abuse, therefore some reported problems with having a male keyworker.'

This means that – along with ongoing aftercare – women-only provision is vital, she says. 'Women may not feel able to talk openly about some things in mixed groups, and their safety needs to be considered too. Many of these women are extremely vulnerable, and some men will try to exploit this. Some of the women interviewed were in relationships with men who were manipulating and coercing them into sex work to get money to support their own use of drugs – so the need for women-only provision is clear.

'If it isn't possible for services to be women-only, then women-only groups or spaces should be made available.'

Report at www.drugscope.org.uk



'Many of the women talked about wanting longer-term change... getting a job, having a nice home, being with their children.'

GEMMA LOUSLEY

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Is there a link between life on welfare and the vile crimes which appear on our daily news schedules?... Of course the vast majority of welfare claimants are genuinely in need of help and would prefer to stand on their own feet. But for some it's a lifestyle choice that puts them outside the norms of conventional society. Not having to work frees up time, which, for those with few intellectual resources and low self-respect, sometimes leads to a reliance on alcohol, drugs and pornography. Killers [Mick] Philpott, [Stuart] Hazell and [Mark] Bridger were all, to some degree, assisted in becoming monsters by the welfare benefits system.
Peter McKay, *Mail*, 3 June

Drug use is a morally neutral subject in the British press. It's the identity of those concerned that dictates the tone. When aristocratic models are involved, it's glamorous; when powerful politicians are, it's youthful folly, and when anyone else is, it's a serious criminal offence. Working-class-girl-done-good Tulisa [Contostavlos] belongs to a group which the press takes particular relish in taking down a peg.
Ellen E Jones, *Independent*, 3 June

The saga of the Care Quality Commission (CQC) has progressed from tragedy through scandal to farce, and has now plumbed astonishing new depths of moral and political squalor... But the CQC cannot now be put right because the NHS cannot be put right. For the root of this moral and professional corruption is that the entire bureaucracy of the NHS – up through the secretary of state to the prime minister himself – conspires to tell the public the big lie that the NHS remains a national treasure because no other system matches it for decency and compassion. In fact, the opposite is true.
Melanie Phillips, *Mail*, 24 June

Specialist care can pull people back from the brink of the most devastating consequences of alcohol misuse, especially alcohol-related liver disease, give them back their self-respect and restore them to their families and communities. The development of high-quality, integrated prevention and treatment services for those with alcohol-related disease would be a wise investment for the future health of our nation, especially that of our young people.
Kieran Moriarty, *Guardian*, 3 June

All the evidence is there that we as a nation have a drinking problem, and we cannot handle it. Visiting tourists, including those from the US, gaze open-mouthed at our heavy drinking culture. And yet the government, for fear of being branded nanny statists, has failed to take action.
Jane Merrick, *Independent*, 4 June

After 50 years of prohibition, drugs are cheaper and more available than ever before. The collateral damage – particularly to countries that produce the drugs and those through which they pass – is devastating. Surely the governments of the world can do a better job of limiting harms than the cartels, whose only motivation is profit, and who are the principal beneficiaries of the present approach?
Amanda Feilding, *Guardian*, 14 June

Sometimes, I feel as if the greatest barrier to ending the nightmare is political inertia maintained by the hunger of political leaders to dip into the billions of dollars in funding earmarked for drug-war operations.
Javier Sicilia, *Observer*, 2 June

POLICY SCOPE

Using appropriate language is an essential step in supporting women involved in prostitution, says Marcus Roberts

RIGHT TERMS

I was in the House of Lords on 3 July for the launch of DrugScope and AVA's report The *challenge of change* on improving services for women involved in prostitution and substance misuse. The findings and recommendations of the report are covered in this issue (page 6), but I wanted to add a couple of general reflections.

The *Drug strategy 2010* talks about 'recovery' as an 'individual, person-centred journey', but is largely silent on matters of difference and identity. I was surprised to find, for example, that there are no direct references to 'women' or 'girls' in the strategy. There is a lack of intermediate space between abstract generalisations like 'treatment' and 'recovery' and invocation of the specific needs of particular individuals. I suspect this encourages a tendency to think and plan in terms of adult males as a 'default setting' unless gender is highlighted.

Evidence and experience suggest that gender is vital for engagement, treatment and reintegration. St Mungo's Rebuilding Shattered Lives campaign is highlighting the extent to which recovery is 'gendered', with women tending to place a greater focus on rebuilding relationships, including with children. Most obviously, women's involvement in substance misuse (and supply) is often framed by abusive and exploitative relationships with men, including domestic and sexual abuse. Local approaches therefore need to link up drug and alcohol strategies with violence against women and girls initiatives, for example.

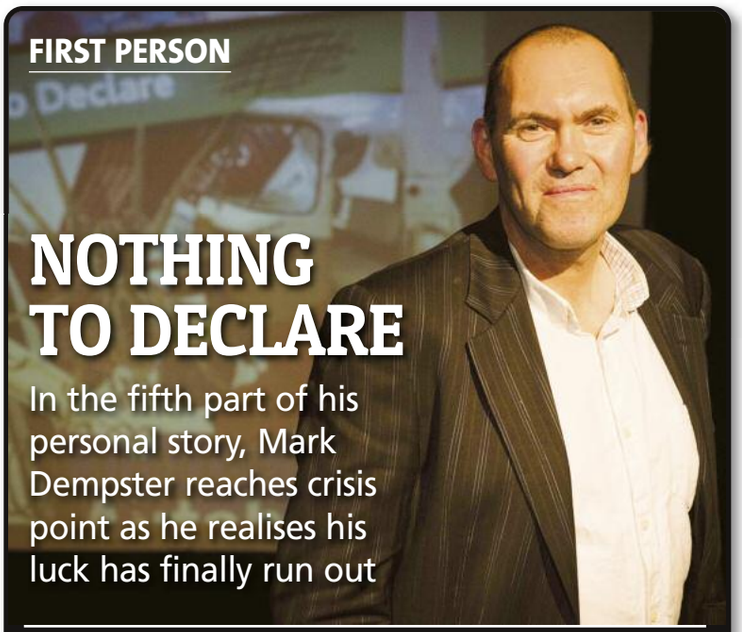
Conversely, I wonder if thinking about some women with drug or alcohol problems as 'sex workers' or 'prostitutes' can obscure the extent to which this group shares needs, aspirations and characteristics with other people in treatment (that's why we were very careful about language in our report, incidentally, opting after much discussion for 'women involved in prostitution'). For example, the women we spoke to valued the harm reduction services that were targeted at them (needle exchange, condoms and 'scripts') but equally they spoke about their aspirations for a decent place to live, a 'normal' job and a future for their children, and felt services sold them short when it came to reintegration and recovery. It is also striking how often the women we spoke with fitted the profile we associate with 'multiple needs' (including homelessness, recent imprisonment and mental health issues), and yet how marginal they have been to the recent evolution of – and investment in – this agenda.

The terminology of 'prostitution' can bring so much cultural baggage – and such a weight of stigma – that the risk is, as it were, that, paradoxically, we only see the particularities and miss the generalisations. While attention to the former is absolutely vital to providing good services, ignoring the latter risks selling women involved in prostitution short.

The 'challenge of change' is at www.drugscope.org.uk/POLICY+TOPICS/Prostitution+and+substance+use.htm

DrugScope/LDAN has also produced a report on domestic violence and at http://www.ldan.org.uk/PDFs/DVReport.pdf

Marcus Roberts is director of policy and membership at DrugScope, the national membership organisation for the drugs field, www.drugscope.org.uk



FIRST PERSON

NOTHING TO DECLARE

In the fifth part of his personal story, Mark Dempster reaches crisis point as he realises his luck has finally run out

I HAD GONE TO INDIA TO SORT MYSELF OUT – kick the heroin and get some hash to smuggle back to London once things had calmed down. Several years later and I was begging on the streets, scamming tourists, and my heroin addiction had gone from smoking to injecting. India wasn't turning out to be my saviour. I was dying and it had nothing to do with where I was. It was the alcohol and drugs killing me – but I couldn't stop.

I remember the moment of clarity. It was in a seedy bed and breakfast with my junkie girlfriend Debbie, her neck stuck out begging for a hit, a prostitute and her pimp boyfriend in the corner. For the first time I was watching myself from above. I didn't recognise me. I wasn't a big time dealer. I wasn't a popular guy. I wasn't even a half decent petty criminal. I was a junkie. A junkie with a needle in my arm and no friends who were any different. Worse than all that – I had a full-blown disease that needed medication every minute of every day and what was cheap before was now becoming impossible.

The worst of it was I couldn't muster the energy to care. I accepted this as my life. Nobody was coming to save me. It no longer mattered if it was India or London. I just had to do it until I died, which, by the look of me, wouldn't be long.

Shortly after my moment of clarity I returned to London, leaving Debbie behind. A few months later she was found slumped against a toilet door, dead. I was on the streets. A homeless bum mugging people and scamming people. I couldn't get any lower – I just stayed there for several years, as low as I could be. I got stabbed, almost burnt to death and overdosed more times than I can remember. Somehow, I was still alive. I contemplated suicide, but couldn't even do that. The change came for me in St Thomas's, hitting up in the toilet. I was sloping down the wall, passing out, finally dying.

I woke up. I didn't know how long I had been out, but I woke up and I couldn't see anything. I thought I was blind. It was the last straw for me. Then I saw a light from under the door as my eyes adjusted – I had just fallen asleep, which was worse. Nobody had checked on me for hours and the lights had been turned off. I had overdosed, passed out, and been left to die. Yet, here I was – still alive.

Tears were shaking down my face. I was crying and I was shaking and I was begging. I was on my knees and I was praying.

If there's anything out there, if there's anything... please help me. Take me from this miserable life or save me. I know I'm a waste with a waste of a life but please – save me. Give me life.

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

Next issue: Will Mark get the help he needs?

LETTERS

'I said I felt it was vital that drug use is treated as a health issue, not as a criminal issue and I was truly shocked to hear you say that you are in complete disagreement with this.'

OPEN LETTER FROM DR CHRIS FORD TO ANNA SOUBRY MP

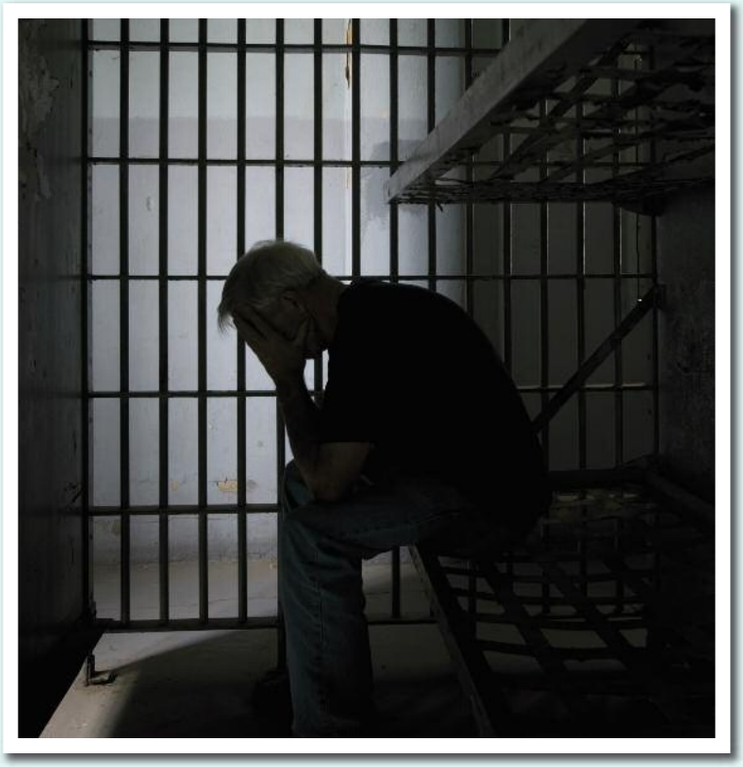
Dear Anna Soubry,

I would like to continue our discussion begun at the 18th RCGP working with people who use drugs and alcohol conference, *Joining the Dots* in Birmingham in May, when you took questions from the stage.

I said I felt it was vital that drug use is treated as a health issue, not as a criminal issue and I was truly shocked to hear you say that you are in complete disagreement with this. Your view is at odds with the recent BMA report *Drugs of Dependence: The role of the medical professionals* which clearly states the that the emphasis on health has been lost as the focus instead has been on the legal and criminal justice aspects of drug misuse. With the report, the BMA aims to refocus the debate on this as a health issue, led by the medical profession, which is well placed to take such a key role. To quote Professor Mansfield, 'The medical profession should look squarely at the issue and debate it as a medical problem'. Professor Mansfield adds: 'The BMA believes that drug users are patients first. That's why we want health to be at the heart of the debate about drugs policy'.

This view is also supported by the chief medical officer, Professor Dame Sally Davies, who said that at present illegal use of drugs was treated mainly as a law and order issue. She says the research suggests the focus on criminalisation is 'deterring drug users from seeking medical help' and 'I think we have a health problem, and we would do well as a nation to look at is as a health problem. I think there's quite a lot of evidence from other countries, and science, about how you could go about that.'

We know that the criminalisation of people who use drugs leads to increased stigmatisation and marginalisation, limiting the potential effectiveness of health interventions, particularly for problematic users. Criminalisation tends to maximise the risks associated with use, such as unsafe products, behaviours and using environments; increase the health harms created or fuelled directly by drug law enforcement, or indirectly through the wider social impacts of the violent illegal trade it creates, as well as creating political and practical obstacles for us as health professionals in doing our job addressing drug-related health problems and reducing harms, and



how they are obliged to work within a legal and policy framework that is often in direct conflict with fundamental medical ethics – not least the commitment to 'first, do no harm'.

I could continue ad infinitum with quoting from the evidence but I ask you to consider the above and give you the chance to respond to this letter.

Thank you in anticipation.

Yours sincerely

Dr Chris Ford,
clinical director, IDHDP,
www.idhdp.com, Twitter: @idhdp

RESPONSE FROM ANNA SOUBRY MP

Dear Chris Ford,

I am grateful for the opportunity to continue our discussion on this key issue. Of course, I agree there are serious health issues concerning drugs misuse

As a government, we set out our position in the response to the report on drugs by the Home Affairs Select Committee.

Within the overall drug strategy the Home Office leads on action to protect society by stopping the supply of drugs, and tackling the organised crime that is associated with the drugs trade. Crime is a major component of the social and economic costs of class A drug use. Current estimates suggest that crime accounts for 90 per cent of the total cost – and the UK's response relies on the crime fighting capabilities coordinated by the Home Office.

Treatment forms a very important part of our drugs strategy and the UK has consistently sought to help individuals who are dependent on drugs by treatment rather than the application of criminal sanctions. Healthcare is the responsibility of the four UK administrations' health departments. In England, the Department of Health leads the delivery of the drug strategy's ambition for more and more individuals each year to achieve and sustain recovery.

This shared responsibility for preventing and tackling the problems caused by drugs is also reflected in the structures at a local level. We have introduced police and crime commissioners, who will take responsibility for local action to drive down drug-related crime and anti-social behaviour, and Public Health England, which will support local authorities to tackle drug and alcohol misuse as a core part of their work, including supporting recovery-orientated drug and alcohol treatment services and delivery of prevention and other health services.

GPs who help their patients to tackle dependence are well placed to play an important role in the new local structures. With their understanding of public health issues and through their participation in clinical commissioning groups, they can help ensure that the planning and delivery of services are joined up in a way which meets all the support needs of people who are dependent on drugs or alcohol.

Anna Soubry, MP

LESSONS IN LOCALISM

In your last issue you said doctors at this year's GPs' conference were concerned about how localism could affect healthcare. While public health minister Anna Soubry had faith in local authorities, talking about the 'robust partnerships between stakeholders', delegates gave a 'messy picture' in reality, with 'massively reduced commissioning teams in some areas', disintegration of shared care in other areas and 'conflicts of interest everywhere' (*DDN*, June, page 8). Then in a recent *DDN Bitesize*, you asked readers about what's happening in our area and what our experience has been.

I work in northern Alberta, Canada as an addictions counsellor in a 60-bed residential treatment centre. I began work here in 1998 when we were under the jurisdiction of the Alberta Alcohol and Drug Abuse Commission and our province-wide service had around 600 employees. The commission was merged into Alberta Health Services in 2009. The purpose was good – to integrate addiction and mental health services with all other medical services. Other regional boards and local authorities were merged as well. Since then we have belonged to a single organisation that employs 90,000 workers to provide access to quality health care services for 3.9m people in Alberta.

As a frontline worker I didn't notice a lot of change at first. The most immediate ones were that all staff in my classification had to switch unions and pension provider. Our hours of work went from 7.25 hours a day to 7.75 hours per day. Then our software for human resources and training changed.

I think that in the long run it is for the best that we merged. I support the idea of eliminating some of the duplication of effort. We don't really need to reinvent the wheel and we can all use the same policies on infection control, use of computers, ethics, etc. Many people want to go for substance abuse treatment away from their home community and that is simplified by a single organisation. However we had a province-wide addictions treatment service since the '50s.

Now, however, a new service is in our building. Mental health workers run groups on anxiety, relationship issues, depression etc here. We can pop down the hall and discuss with them how they work with their clients. We're slowly learning from each other. I'm willing to keep working at it.

In the next ten years I hope I see a common database covering all of our clients that we can access. Right now, only our nurses can access the medical database, and I have no problem with that. However only addiction staff province-wide can access the database of the clients we see. I can enter notes on that database and anywhere in the province where a client sees an addictions counsellor who works for Alberta Health Services; a staff member can read notes from the treatment the client got here.

Trish Wright, addictions counsellor,
Business and Industry Clinic,
Northern Addictions Centre, Alberta

OUT OF TOUCH

Mark Gilman's recent interview in *The Guardian* (11 June), declaring 12 steps are best for addicts, demonstrates how out of touch his view of UK recovery movement is. I found the article divisive and if his beliefs are shared by PHE then that saddens me. What happened to choice and empowering people? Frog-marching people to a meeting may be OK in the US, but not in UK.

Carl Cundall, trustee,
SMART Recovery UK

VOLUNTEERS SPURNED

I live in East Yorkshire and run three self-help groups. We have recently had our funding for room hire withdrawn at short notice for no obvious reason. We find that some of the treatment providers see voluntary groups as a threat, and instead of working together, block our attempts to reach out to users who are desperate for help. We only exist to help people, but find obstacles put in our way. The provision for alcohol abuse intervention in our area is abysmal. Have other areas of the country come across this?

Stephen Keane, leader,
East Riding Alcohol Support Group

LETTERS

'Researchers from the University of Bedfordshire, Glyndwr University and the University of Lancaster have recently been commissioned to undertake some exploratory research about substance use and sight loss.'

HELP SIGHT LOSS PROJECT

Researchers from the University of Bedfordshire, Glyndwr University and the University of Lancaster have recently been commissioned (by Thomas Pocklington Trust and Alcohol Research UK) to undertake some exploratory research about substance use and sight loss. They are interested in understanding more about the prevalence and experiences of those people living with a combination of both. The project also seeks to acquire more knowledge about the nature of service provision to such individuals.

It is anticipated that the findings of the project will be able to inform future policy, research, service developments and support for those working within these arenas. The research team would like to hear from any service users, carers, practitioners or organisations that may have specific experience of working with the duality of these subjects, and have information or direct experiences you may wish to share.

For further information about the project, to express an interest in supporting it or be interviewed for the project, please contact me on 01978 293471 or w.livingston@glyndwr.ac.uk

Wulf Livingston,
senior lecturer in social work,
Glynd r University Wrexham

CORRECTION

In our coverage of the debate, 'Now is not the right time to decriminalise drugs', proposed by Dr Neil McKeganey and opposed by Steve Rolles, (DDN, June, page 21), we reported the result of the debate the wrong way round. The conclusion should have read: 'The motion was defeated by 70 per cent of the audience to 30 per cent'.
We apologise to the debaters and all involved.

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.

OBITUARY

ALAN JOYCE

8 OCTOBER 1959 – 4 JUNE 2013

It is with great sorrow that I announce the death of Alan Joyce.

I first came across Alan when he started working as a volunteer for the Methadone Alliance. He popped up on some of the harm reduction mailing lists, full of passion for his new role, and with an interest in politics and post-structuralist philosophy.

An ex-art student, Alan had studied Fine Art at St Martin's College and had had a career in the London theatre before his drug use eventually got the better of him. He'd been struggling with the implications of the policies of his local treatment provider when he learned about the Methadone Alliance, and had Bill Nelles, the Alliance's founder and director, advocate on his behalf. It wasn't long before Alan was volunteering for the Alliance himself, and then shortly after that he was appointed as senior advocate, handling the most complex advocacy cases across the UK.

And so, while there's a lot that I could say about Alan and his interests, his intelligence and his compassion, I'm going to limit myself to talking about his work for the Methadone Alliance, because I believe that that's the area of his life where he had the biggest impact.

Today, people are used to having access to high quality methadone treatment, with adequate doses and without arbitrary time limits. Back in the late '90s and early '00s though, the picture was very different. In some areas, methadone treatment offered just a short break from the chaos before being reduced to such a level that you were inevitably thrust back into it.

The Methadone Alliance was established to advocate for people to have access to high quality, evidence-based opiate substitution therapy, and after Bill Nelles, Alan was probably the most significant figure in building the early organisation. Just last week, I was in Southport when I ran into a man that Alan had advocated for in the past. His clinic was threatening to stop prescribing for him, and Alan had come up to Sefton to advocate on the man's behalf. Today, nearly ten years later, that guy was still grateful for the service that Alan provided:

'My life was about to fall apart. If Alan hadn't have come up and argued my case with the clinic, I'd have ended up back on the streets, my relationship would have split up, I'd have lost access to my kids – I can't begin to conceive of what my life would have been like had Alan not intervened.'

His other great strength was finding and recruiting new activists to the drug users rights movement. After he retired from The Alliance due to ill health, Alan worked tirelessly for the National User Network, where he served until his sad demise. But wherever he operated, his passion and his compassion shone like a beacon – attracting others to the cause, and to his warm personality. His achievements and reputation in the movement for drug users' rights is second to none.

Alan was 52 years old when he died, and leaves behind two children.

Peter McDermott

Bill Nelles adds:

I will greatly miss my friend and colleague Alan Joyce. He was the Alliance's first salaried drug treatment advocate, one of the first 'patient' advocates to be awarded the Royal College of General Practitioner's Certificate of Drug Treatment, and became an acknowledged expert by experience. After retiring from The Alliance he became a tremendous asset to the National Users' Network (NUN). He faced his end with characteristic bravery and passed away quietly with his family at his side. And I lost a good friend and colleague whom I will never forget.

Dialectical Behaviour Therapy

DBT is a treatment package that was developed for BPD (Borderline Personality Disorder), and has been adapted for many other problems including *substance misuse*, suicidal teenagers, eating disorders and treatment resistant depression.

DBT techniques can be incorporated into your style of practice. Each technique is a powerful therapeutic tool.

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One-day DBT course usually covers the following issues:

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Building Acceptance, Alliance and Trust How to a start with a therapist stance of acceptance.

Mindfulness: living non-judgmentally in the present with your problems

Validation: your behaviour makes sense in its context

Making a treatment hierarchy, prioritising problems.

Structuring a DBT session. Behaviour analysis, what is the target behaviour? Problem solving, finding solutions

Teaching clients skills: Teaching skills in groups. Coaching skills in one to one work. Coaching therapists during supervision. Coaching clients in crisis: risk management.

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Participants are encouraged to bring their own cases or even their own bad habits to use as material to demonstrate the DBT approach and will leave with a plan to apply skills in their own practice.

*Pending BPS LC Approval

Fiona's course is perfect.
S.B., Psychologist

Training with Dr Fiona Kennedy:

Dr Fiona Kennedy has a vast clinical experience in mental health (from anxiety through eating disorders and PTSD, to psychosis and personality disorders) and learning disability fields. Fiona's main orientation for many years has been CBT. For a number of years she was a Board Member/Trustee for the BABCP. She has extensive experience of teaching and presenting, giving regular input to doctoral training programmes. Amongst many other research projects she has studied dissociation after trauma that led to a new theoretical model and scale, as well as innovative new treatment, which was quoted as an example of national excellence by the governments' National Audit Office in its House of Commons report 'Safer Patient Services' 2005. She has received an award for clinical excellence from BUPA. With her deep knowledge of the subject and outstanding leadership qualities Dr Fiona Kennedy is a truly inspirational tutor.

Dates & Venues

LONDON (The British Psychological Society)
26 November 2013

For in-house training programme on DBT call
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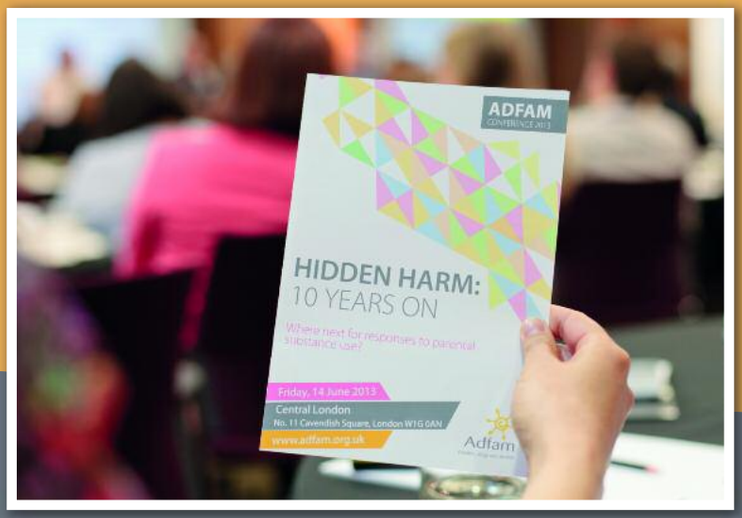
or e-mail
info@skillsdevelopment.co.uk

www.skillsdevelopment.co.uk



FAMILY FOCUSED

With 2013 marking the ten-year anniversary of *Hidden harm*, social care professionals gathered at the Adfam annual conference in London to reflect on the progress so far and what the future might hold. **Kayleigh Hutchins** reports. Photography by **Travis Hodges**

'Children don't care about the substance – drugs and alcohol are all the same,' said Adfam chief executive Vivienne Evans, introducing the day by highlighting the improved focus on the family since *Hidden harm*. But, she emphasised, much more work was necessary to ensure that families were getting the support they needed.

'Alcohol is a drug – it's a drug of dependence,' said Ian Gilmore of the Alcohol Health Alliance UK, highlighting the effects that changing drinking patterns in Britain were having on families. A combination of new products appealing to children and teenagers, low pricing at supermarkets and an 'alcogenic' environment had led to 10 to 15-year-olds being exposed to 10 per cent more advertising than adults. 'So long as we have alcohol 24/7, children are going to think it's normal to drink,' he said. Alcohol killed more people under 60 than drugs, tobacco, and unsafe sex. 'When put in context of harm done to families, there is public support for alcohol reforms,' he said, adding that the harms of passive smoking 'paled in comparison' to the harms of drinking.

Joy Barlow of STRADA gave delegates a snapshot of how services had become more responsive. 'Ten years ago, we wouldn't have seen the people or organisations here today,' she said, adding that multi-agency work had improved in recent years. Nonetheless, not enough emphasis had been placed on the effect of stigma and parental recovery on children, who 'deserved to be a part of recovery, as they had been a part of the addiction'. Care professionals would need to be mindful of the emotional impact on children as well as the physical, she said, noting that children were aware when they 'came second to a substance'.

Annette Dale-Perera of the Central and North West London NHS Foundation Trust urged delegates to 'work together more closely and more smartly.' Trends in adult drug use had changed significantly since *Hidden harm*, said Dale-Perera, adding that the new generation of young adults and parents had generated new issues. Lower engagement with drug services had gone hand in hand with high-risk trends such as poly-substance use and an increase in stimulant drugs among single parents to 'keep them going'. The long-term effects of these trends were still unknown, and the cuts to public spending and devolution to local authorities would offer both challenges and opportunities in the future, she concluded.

'Skilling up' the workforce was the priority for Ruth Allen of the College of Social Work, who identified by a show of hands that most delegates were employed in social work, but only one or two had received drug training. 'Social workers should be equipped to recognise the effects of substance use on children and the family,' she said. The workforce needed to feel empowered to challenge both stigma and the person affected – with the college there to support and train them. Professionals needed to 'make judgements without judgmentalism', said Allen, and to have a 'whole systems approach' to care.

Public Health England's perspective was given by Lynn Bransby. 'We see recovery as being defined by individuals, and we see it as being ambitious,' she began. People were receiving a different service now, she said, and were being shown they were capable of recovery. However, many with substance use issues still feared 'that talking about having children would lead to a negative intervention.' PHE's priorities involved early intervention and working with the 'troubled families' agenda, to make sure there was a working system at local level to identify families needing help. 'There are reasons for optimism in this agenda, and it would be a damn shame if it went backwards,' she said.

In the afternoon's 'practice minibites', Hardey Barnett, senior practitioner at the Family Drug and Alcohol Court, outlined its programme, which had been set up to help families cope with court proceedings to decide the permanent residency of children. Removing the adversarial element of the process, while offering support to the family, the pilot paved the way for an outcome that was best for the whole family, he said.

Sarah Ingram of Greenwich Children's Services identified that parental substance use was often 'just a part of a bigger picture,' and highlighted the need for accurate and age-appropriate information and support for children who were acting as carers for their parents. Professionals needed to develop a shared ethos, she said, and improve inter-agency working.

Ryan Campbell, new chief executive of KCA, discussed the charity's family intervention programme, which also recognised that substance use issues rarely existed in isolation. The programme was helping families to work through the surrounding problems, encouraging parents to find practical solutions and building trust with the workforce. 'Parents with substance misuse issues aren't bad – they love their children just as much as any other parent, sometimes more so,' he said.

ASK THE PANEL

Delegates' questions were answered by a panel of experts, chaired by broadcaster and Adfam patron Eddie Mair

VICKI CROMPTON, Cambridge Safer Communities Partnership: What can be done to break down the barriers to providing a joined-up approach in the workforce at senior management level?
SARAH GALVANI, Tilda Goldberg Centre: 'Keep going, don't give up. Get a meeting with the director of children's services, present to them what you do and what you can to offer them.'
EMILY ROBINSON, Alcohol Concern: 'One thing that motivates directors is money and targets, and if you can find the right money and targets that link up, that might be helpful. Rather than starting with the people, start with the targets and the numbers.'

LISA PHILLIPS, BEE Happy: How can more be done to cascade information about parental substance use to women of child-bearing age to prevent harm to unborn babies?
EMILY ROBINSON: 'It's going to be hard until we have a better idea of what is and what isn't a safe level of alcohol consumption. At the moment, alcohol guidelines are being reviewed, and perhaps we should be stronger about the restrictions on pregnant women.'

LIZ McGILL, Hampshire County Council: How can we deal with the expectations of service delivery versus recovery timelines?
ROGER HOWARD, formerly UKDPC: 'Recovery is a process, not a destination – and it's not the same as abstinence.'
KATHY EVANS, Children England: 'It's really important to be careful of dangling the motivation of getting your child back in treatment... to use that in the treatment process is high risk.'
NICK BARTON: 'Try to cut down to what is achievable within the timeframe that you've got.'

JAX BEATTY, Action on Addiction: What do the panel think about the social inequality between those that get to keep their children, and those that lose them?
ROGER HOWARD: 'It's the poor who get the social work and the crime and the police, and other people get something else. What do you do about that inequality? The biggest thing is social and economic improvement. How do you sensitise practitioners to this stigma and look at people differently? It's about culture change towards people, and that's a long haul.'

JAKE ROBINSON, Kirklees Lifeline: Is there anything we can do to foster better engagement, particularly to ensure better outcomes for children?
NICK BARTON: 'One of the places we think we can increase engagement is in schools, where problems often come to light first – but then you've got to have a confident workforce who feel comfortable confronting them.'
KATHY EVANS: 'Most human beings' first preference is to work through their problems with the help of their friends and family and not go to a professional. We need to think about how we equip ordinary people to understand how they can better support family members through problems.'

FAMILY MATTERS

NO HIDING PLACE

Adfam's conference highlighted the urgent need to understand the impact of alcohol on the whole family, says **Joss Gaynor**

HOSTING OUR CONFERENCE, *HIDDEN HARM 10 YEARS ON*, gave delegates the opportunity to consider not only the progress that has been made but also the distance we still have to travel to protect and improve the quality of life for children affected by parental substance use. Back in 2003, *Hidden harm* didn't address parental alcohol use and its specific impacts, but one strong theme from the presenters and delegates this year was the real and urgent need to improve our understanding of alcohol use on children. Sir Ian Gilmore from the Alcohol Health Alliance urged the audience to start thinking about the idea of 'passive drinking' and its potential impact on the children and other family members.

Some could suggest in policy terms that there is a lack of coherence around children, families and alcohol and the alcohol strategy does not offer any clarity or action on how to address this issue. What's clear is the significant needs of these children. The Office of the Children's Commissioner report, *Silent voices*, published last year, identifies that the size of the problem is relatively unknown. However, we do know that there are high levels of parental alcohol use in serious case reviews and children affected often come to the attention of children's services later and through different pathways than those impacted by parental drug use. *Silent voices* also goes on to point out that many children are coping with the alcohol use in their families – some of them very well – but this does not equal resilience. Resilience suggests a recovery from the adversity, which is often a far cry from the behaviours and actions children employ to keep themselves safe and cope with alcohol in the family.

One of the other strong themes from the conference was that parental alcohol use rarely sits in isolation and often children are impacted upon by a range of other inter-related issues, including conflict and violence. Delegates suggested that when parental alcohol use and family conflict co-exist that the negative long-term impact on the child could be magnified. It was also felt that the focus of some policy and strategic thinking concentrated on alcohol as a single issue, rather than looking at the cumulative effects of the wider social issues, leading to inadequate management of the family.

One of the differences between parental alcohol and drug use is alcohol's legal and socially accepted place in society. Our culture of drinking in this country can cause confusion and a reticence to understand and explore what might be harmful to children and their safe family life. *Silent voices* found that it cannot be assumed that higher levels of consumption equate to greater harm and that some less frequent, episodic binge drinking behaviours can be very impactful on children.

What is clear is that we need to do a lot more research, thinking and development to better understand the needs of children affected by alcohol misuse. Both national and local policy needs to be improved to pay more account of these children and not just those at the high-risk end. Those working in services need to be vigilant to the needs of children who are faced with the harms from parental alcohol misuse.

Joss Gaynor (formerly Smith) is director of policy and regional development at Adfam, www.adfam.org.uk

SAFE FROM HARM

Last month saw the 23rd International Harm Reduction Conference take place in Lithuania. **DDN** reports on a gathering of activists, policy makers and service users from across the globe.

RECLAIMING HARM REDUCTION

HRI EXECUTIVE DIRECTOR RICK LINES EXPLAINS THE REASONS FOR MOUNTING THE EVENT IN EASTERN EUROPE

'Eurasia is one of the regions that's been most severely hit by the HIV epidemic related to injecting drug use,' says HRI executive director Rick Lines of the decision to stage this year's conference in Lithuania – the first time the event has been held in the Baltic States, and its first time in Eastern Europe since 2007.

'It's also a region where the harm reduction response is underdeveloped,' he says. 'There are high levels of need and a lot of countries with generally poor harm reduction services, severely repressive drug laws and human rights violations against people who use drugs. Having the conference in the Eurasian region was an important way to call attention to these issues.'

Lithuania is also home to HRI's partner organisation, the Eurasian Harm Reduction Network. 'They approached us with a proposal to hold the conference here and they're a fantastic organisation so we jumped at the chance,' he says.

This year's theme is the *Value/s of harm reduction*, with a focus on two key issues. The first is the economic case – the fact that harm reduction 'not only saves lives but is also a very cost-effective public health intervention', he states.

'But we also wanted to focus on the values, because one of the things we're seeing is the pushback against harm reduction by conservative governments pushing a recovery agenda. Even five years ago the anti-harm reduction lobby was trying to argue against the scientific basis of harm reduction, but you rarely hear that now. Instead they try to frame harm reduction as this kind of morally suspect, very clinical response that doesn't value people and sees them as simply receptors of services. So it's also about reclaiming the moral, ethical and philosophical basis of harm reduction.'

THE RIGHT TO LIFE

HUMAN RIGHTS SHOULD NEVER BE SACRIFICED TO THE 'WAR ON DRUGS', SAID MINISTERS

'If you break stereotypes,' Lithuania's health minister Vytenis Povilas Anriukaitis told delegates, 'you break down walls.'

Human rights included the right to live, to have opportunities and to acknowledge that people are equal, he said. 'We must always remember that. It's predetermined positions that destroy people's lives – we have to fight for leadership.'

Human rights were not invalidated by drug use, former president of Switzerland Ruth Dreifuss told the conference. Lithuania was playing a pioneering role in harm reduction in Eastern Europe, she said, with HIV rates ten times lower than in some neighbouring countries. However, the 'ticking timebomb' of hepatitis C meant that adequate coverage of services was vital.

Ensuring that services were accessible and affordable for all was challenging, she said. International solidarity was essential, with financing from states and NGOs combined and pharmaceutical companies making their drugs affordable in poorer countries.

'HIV was a brutal teacher,' she told delegates. 'We learned that mass incarceration for drug possession – far from discouraging drug use – was the place where HIV, hepatitis C and drug use were allowed to flourish. Our approach has to be more comprehensive.'

It was also vital to consider harms 'beyond the public health approach', she said. These included the increased power of criminal organisations, which not only challenged weaker states but had actually come to threaten democracy and the rule of law in many parts of the world.

'Mass incarceration is a huge waste of public resources, and human rights violations are justified by the war on drugs,' she said. It also remained vital to fight for and finance harm reduction measures, and ensure they were accepted and understood by the public.

'We are all committed to achieving these aims,' she told delegates. 'And you are saving lives.'

THE HEAVY COST OF CUTBACKS

HARM REDUCTION IS A 'GLOBAL BEST-BUY'

'We all know why we need to worry,' said David Wilson of the World Bank, in a session on financing harm reduction. 'If we look at the prevalence of injecting, there are very high rates in Eastern Europe and Central Asia. The picture is alarming, but we all know what works.' The gaps in needle and syringe programmes (NSPs) coverage globally, however, were profound. 'Since 2010 we've actually seen NSPs scaled back in countries in Eastern Europe and Asia.'

'Harm reduction is cost-effective in every region...'

DAVID WILSON

The Global Fund was the largest harm reduction funder, and responsible for more than half of the funding coming to the region, he said. 'But harm reduction is cost-effective in every region, and the return on investment is very positive.' Total future returns were estimated at up to $8 per dollar spent, and the more interventions were scaled up the more cost-effective they became, he stressed, with figures from Australia showing an estimated yield of $27 per dollar invested.

'Inaction is costly,' he told delegates. 'And it's not the equivalent of doing nothing. Wherever we can, we need to get upstream before infections start.' The returns accrued to the whole of society, however. 'It's a global best-buy for public health and development money.'

Nonetheless, the trend for investment in HIV prevention for people who used drugs was going the wrong way, Daniel Wolfe of the Open Society Foundations International Harm Reduction Development Programme told the conference. 'The Global Fund is also likely to be a lot less global and a lot less prevention-focused

'If you break stereotypes, you break down walls...'

VYTENIS POVILAS ANRIUKAITIS

Photography: Ian Ralph

'Harm reduction programmes work... The evidence is there, and it's absolutely clear.'

LORD NORMAN FOWLER

than it has been,' he said, with countries in the region having to compete for decreasing resources.

'It's very strange to sit in a harm reduction conference and realise that the last needle exchange programme in Romania will close this year. We in harm reduction will increasingly be at the cold intersection of austerity and social exclusion. We need to press donors to do more on coordination, and we need to do better about deciding who can pay what the other can't.'

Advocacy for funding at national and regional levels would also be vital, he told delegates. 'In the same way that we taught people safe injection techniques and how to reverse overdose, we need to be able to read budgets, understand budget cycles and press for local funding.'

TIME TO BE BRAVE

POLITICIANS MUST LEAD PUBLIC OPINION, NOT FOLLOW IT

'We introduced harm reduction measures in 1986-87, and it was extremely controversial,' said former British health secretary Lord Norman Fowler. 'We were told it would increase criminality. That did not happen, but what did happen is that new drug-related infections have been consistently down to 2 per cent ever since. Harm reduction programmes work.'

One of the key lessons was that countries needed to be brave, he told delegates, with politicians leading public opinion rather than following it. 'I go around the world and I hear about all sorts of pilot projects, but I don't think we even need pilot projects any more. The evidence is there, and it's absolutely clear.'

Indonesia's harm reduction programmes had begun in 1999, Anton Djajaprawira of community-based organisation Rumah Cemara told the session, with 'huge interest' from donors ever since. 'But what this has meant is that at times there were the same interventions being implemented in one particular area.'

There was also often a lack of flexibility, he said, with needs going unmet and a general lack of community involvement. In response, community-based harm reduction initiatives had begun in recent years, with interventions now operating across three provinces.

'Community-based operations decide their actions based on community needs,' he stated. 'It's a participatory approach, and it fills the gaps rather than implementing the same interventions. It integrates all the available harm reduction services.'

Rumah Cemara's work now included prison pre-release programmes, capacity building, legal assistance, youth work, needle and syringe distribution and services for remote areas, he said. 'And for services to work, the involvement of people who use drugs at management level is essential.'

For now, however, programme sustainability still depended on donors and the government, he said. 'But grassroots communities can perform very well if they're given the trust and flexibility to do so.'

'The war on drugs has failed. When I have a business that fails I shut it down,'

Sir Richard Branson told the conference via a special video message. In 2016, the world would be forced to confront this failure at UNGASS, he said, and part of what made drug policy discussions so difficult was that current and former drug users were not properly listened to. 'If we want to help people we mustn't even think of throwing them in jail. Harm reduction makes financial sense and saves lives. It is the right thing to do.'

'The police are disillusioned about the ability of law enforcement alone to suppress the drug trade.'

DR EMILIS SUBATA

'The conference is taking place at the right time and at the right place...'

SERGEY VOTYAGOV

IN THE VANGUARD

THE VILNIUS CENTRE FOR ADDICTIVE DISORDERS WAS HOME TO THE FIRST METHADONE PROGRAMME IN A FORMER SOVIET COUNTRY, AS ITS DIRECTOR DR EMILIS SUBATA EXPLAINS

At this year's conference, Dr Emilis Subata prescribed opioid substitution therapy (OST) in the form of methadone and buprenorphine to delegates who were unable to export medication from their own country.

Dr Subata has led the Vilnius Centre for Addictive Disorders for more than 20 years. A psychiatrist by training, he has been an expert consultant for the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and United Nations Development Programme (UNDP) among others, and is also an associate professor at Vilnius University, itself a WHO collaborating centre for harm reduction.

While Eastern Europe has struggled with a well-documented HIV problem, it was at his treatment centre that the very first methadone programme in a former Soviet country was established, in October 1995 – something which may help to explain why Lithuania's HIV rates are among the lowest in the region.

'One of the reasons for that is that we implemented opioid substitution therapy in the three biggest cities in Lithuania before HIV had really appeared among injecting drug users,' he says. 'It wasn't a reaction to HIV cases among IDUs – it was prior to the first cases among IDUs. In those three cities, quite a large number of IDUs with long histories of injecting were able to access treatment programmes, and needle exchange programmes were introduced quite early as well – starting around 1996 in the sea port of Klaipėda and then in Vilnius in 1997. So we started harm reduction programmes much earlier than in Latvia or Estonia, for instance.'

Rates of HIV transmission through injecting drug use have fallen substantially in recent years, but it remains the case that HIV testing is not always easily accessible. 'It's done mostly by NGOs with external funding, so we might not have the most exact data,' he acknowledges.

Most of Lithuania's major population centres now have needle exchange programmes, however, and the ten largest cities have opioid substitution therapy, accessible free of charge. 'In most of the cities there are no waiting lists, although we do have some in Vilnius,' says Dr Subata.

His clinic also operates a mobile needle and syringe exchange service, which means that the service is accessible to drug users throughout the city. 'We used to have a mobile van – the "blue bus" – but we've replaced it with a more advanced vehicle,' he says. 'We've had a specially designed, heated bus with a counselling room for about two years now.' All of the service users' files at the centre are also managed by social workers rather than clinicians, which leaves the doctors free to concentrate on treatment. 'We find it's a big advantage, compared to the earlier practice when the physician was taking responsibility for the patient,' he says.

Things haven't always been easy, however, with attempts to close down his service as recently as 2005. 'At that time there was an attack from some politicians in the parliament who were very strongly against harm reduction,' he explains. 'But the programmes survived, and the funding was always available from the Ministry of Health, so there has been a mixed attitude. The ministry was always supportive of harm reduction and opioid substitution therapy, and the government's drug control offices were also always supportive of these interventions, but from time to time there were politicians who expressed negative opinions about harm reduction – there were discussions in the media, as well as between agencies and so on.'

It all depends on the political climate, 'the same as anywhere else in Europe', he states. 'We have conservative politicians who are critical of harm reduction, and more progressive politicians who are more accepting.'

Unlike many places, however, there has been very little resistance to the implementation of harm reduction interventions from the public, he says. 'I would say the general public is largely neutral. Some years ago there was a formal survey on attitudes towards opioid substitution therapy, and it found positive opinions. The police are also quite supportive of opioid substitution therapy and harm reduction because they're disillusioned about the ability of law enforcement alone to suppress the drug trade.'

RIGHT TIME, RIGHT PLACE

FROM THE OPENING SESSION, THE CONFERENCE STRESSED THE NEED FOR MEANINGFUL PARTICIPATION OF PEOPLE WHO USE DRUGS

'The conference is taking place at the right time and at the right place,' executive director of the Eurasian Harm Reduction Network, Sergey Votyagov told delegates.

Despite increasing wealth, most governments in the former Soviet region still did not invest in harm reduction programmes, he said, with international donors often the only ones providing 'the financial and moral' support. 'So this is the right region to hold the conference, although regrettably for the wrong reasons,' he said. 'Lack of investment in harm reduction costs lives.' Lack of money was not the only structural barrier, however. 'Money follows priorities and the money is spent on a

Key government figures from the Eastern European Central Asian region gathered at the conference for meetings with donors from UNODC and UNAIDS.

'This year we were able to expand our services to make them truly worthy of a harm reduction event.'

GILL BRADBURY

wasteful law enforcement approach.' Now was the time to make the transition from donor funding to investment by domestic governments, he said.

'Our long-term slogan is "nothing about us, without us", Eliot Albers of the International Network of People who Use Drugs (INPUD) told the conference. 'For us the centrality of meaningful participation is not negotiable, and a fundamental principle that should lie at the heart of all work.' No process, document or service could be said to embody this unless 'our community's input has been built in from the start', he stressed. 'It's not about being asked to endorse a document we haven't even seen.

'Some of us have been told we're troublemakers,' he continued. 'But our principles are non-negotiable. We are more than aware of the fact that our community is diverse, and you need to be able to bring that to the table. If you are committed to meaningful participation, you will find us a very willing partner.'

VOICES OF THE COMMUNITY

EMPOWERING PEOPLE TO CHASE OPPORTUNITY HAS BECOME THE ESSENTIAL MISSION OF A DRUG USERS' UNION IN NEW YORK

'It's not always easy to organise and mobilise people who use drugs,' said Anastasia Teper of VOCAL-NY (Voices of Community Activism Leaders), a New York-based drug users' union.

VOCAL was founded in 1997 as an organisation to find housing for drug users, but developed into a means of organising and mobilising people who were substance users and who were HIV positive. 'It started with two people and one organiser,' she said.

'The goal is to build the power of low-income people who use drugs, and end the drug war – which is very much a racial and economic justice issue. We have to find the fire in the belly of the people who are affected by these issues, and help to empower and organise them.'

The organisation recruited through member-led outreach, targeting people at needle exchanges and other services and then with 'relentless follow-up' by phone and in person, she said. 'Mobilising people is not easy – they can have a multitude of issues. But we follow up all new contacts, creating meaningful opportunities for people, and we also want to develop people into leaders – learning while doing.'

A key issue was empowerment, she told the conference. 'How do you speak to authority if you've been put down all your life? That's a very difficult transition to make.'

VOCAL-NY was able to show people that their participation would 'result in real and concrete improvement in the lives of people who use drugs', she said, and it had carried out successful programmes around securing housing for people with HIV, as well as police harassment for syringe possession.

'Seventy per cent of the people surveyed by VOCAL had been arrested for syringe possession,' she told delegates. 'And 87 per cent of them had been carrying documentation saying they were participants in official syringe exchange programmes.'

The organisation had held rallies and secured the attention of the media, and eventually a syringe access law had been passed in 2010. Among its current campaigns, meanwhile, were the mandatory offer of hepatitis C testing for people of the 'baby boomer' generation and marijuana decriminalisation.

'The issues are really deeply felt, because we're really trying to end the war on drugs,' she said.

INSIDE THE MEDICAL ROOM

GILL BRADBURY, RGN, COORDINATED THE CONFERENCE'S HEALTHCARE SERVICES. SHE TOLD US WHAT WAS INVOLVED

This year we were able to expand our services to make them truly worthy of a harm reduction event.

Dr Emilis Subata prescribed OST for delegates who were unable to export medication from countries such as Ukraine, Belarus, Kyrgyzstan, Armenia and Tajikistan. Arrangements were also made with a private doctor who facilitated treatment for delegates from Russia who were dependent upon opiates but unable to access OST, due to methadone and buprenorphine not being permissible in that country.

We offered an open needle syringe programme (NSP), with a variety of needles and syringes, along with other injecting equipment donated by Exchange Supplies, such as stericups (cookers), filters, citric acid and vitamin C, swabs and water. Foil for smoking was also available.

Sharps bins for safe disposal of injecting equipment were available in the main toilets within the venue, as well as in the medical room, and people were supplied with individual disposal units, handed in at the end of the conference.

A new feature of our service was the provision of naloxone, provided by Kaleidoscope drug services. We had more than 100 kits available for distribution, and offered training to those who needed it.

We were also able to provide confidential HIV testing, screening and advice with Demetra, a Lithuanian association for HIV affected women and their families.

As usual, we gave brief consultations relating to minor illnesses and injuries and offered basic first aid. The medical room was staffed by myself, a nurse from the Baltic American Clinic, and volunteers. Thanks to the volunteers, organisations that donated the necessary goods, EHRN and HRI staff, we were able to provide a comprehensive service.

'Women who use drugs should always be involved in the design of programmes...'

CLAUDIA STOICESCU

'We have a lot good practice – we just need to bring it together... and fill the many urgent gaps.'

IONA TOMUS

EMPOWER WOMEN THROUGH 'RESPECTFUL' SERVICES

INVOLVING WOMEN IN THE DESIGN OF GENDER-SPECIFIC SERVICES ENCOURAGES POSITIVE BEHAVIOUR CHANGE

'We have to make sure women can get treatment – we're empowering them to fight,' said Susan Masanja, in a session on developing harm reduction services for women who use drugs.

The fight was against blood-borne viruses, poverty and stigma in Tanzania, where injecting drug use was on the increase, more than a third of IDUs had HIV, and women frequently reported violence and rape. The socio-economic condition of many women who used drugs was poor, she said, with homelessness and lack of income making it difficult to access harm reduction services. Médecins du Monde's special focus on women had been effective in extending outreach, peer educator training and women-only initiatives, resulting in evidence of the first changes in behaviour.

'We need to extend outreach services to more locations and days a week and continue income-generating services,' she said, alongside calling for additional specialist training for medical personnel. 'We need to keep spreading harm reduction and strengthen advocacy.'

Visvanathan Arumugam shared experience from the Chanura Kol project in Manipur, India. Around 60 per cent of registered female injecting drug users were engaged in paid sex work, he said, and there were no government-funded targeted interventions. The project, implemented in three districts in Manipur and funded by the Elton John AIDS Foundation, provided comprehensive community-based harm reduction services for women who used drugs, including positive living, education and lifestyle advice, preventative measures, testing and follow-up services.

The outcomes were positive, with better education, more testing and an increase in the number of women who had successfully completed detoxification treatment. The project was 'the way forward, showing the need for safe spaces for female injecting drug users and access to harm reduction', he said.

'Drug use differs greatly between genders,' said Vlatko Dekov from Macedonia, who offered insights on integrating a gendered perspective into harm reduction programmes. 'One of the reasons for this is the gender roles in society,' he said. 'Men have the decision-making positions and women have more frequent roles in the private sphere.'

Women tended to be invisible in treatment programmes in the Balkans, he said, only becoming visible in life-threatening situations such as overdose. There was also a gender hierarchy in drug-taking, with women's injecting frequently initiated and continued by men. Making harm reduction gender sensitive depended on involving women who use drugs in the political decision-making process, he suggested, using their expertise to design services and including them on the staff of harm reduction programmes. On a day-to-day level, women should be encouraged to become more independent, he said, through education, job-seeking, training and employment.

Claudia Stoicescu told delegates that the HRI report, *The global state of harm reduction*, gave a comprehensive overview of the risks to women who used drugs, including guidance on gender-sensitive services. 'Services should be tailored to the documented needs of women in different contexts,' she said, pointing out that small additions to services could be effective in changing such behaviour as women's dependence on their partners.

'Women who use drugs should always be involved in the design of programmes to make sure they're respectful and appropriate,' she added.

REACHING OUT TO CHILDREN IN ROMANIA

STOPPING HARM REDUCTION FUNDING SPELLS DISASTER FOR MANY ROMANIAN CHILDREN

The first harm reduction outreach projects in Romania had begun in 1999, Iona Tomus told delegates in the *Children, young people and drug use* session. However, as of June 2013, all funding for harm reduction services in Romania would stop.

The implications were dire, she warned. Figures from 2011 showed that there were around 17,000 people injecting drugs in Bucharest, and far fewer syringes than were necessary because of lack of funds. 'Of course the consequences appeared immediately,' she said. 'In 2010 the HIV rate among people who inject drugs was 3 per cent. By 2012, it was 31 per cent.'

The problem was particularly acute among younger people, she said, exacerbated by rising rates of 'legal high' use, particularly mephedrone. The age of initiation could be as young as ten, and rates of equipment sharing were high. 'In order to have access to health and social services, however, you need the permission of parents. It's the opposite of "Nothing about us, without us" – it's "Everything about us, without us".'

The children using drugs were mostly in Bucharest, she said, and typically had low levels of education and literacy, as well as behavioural and health problems.

'We don't just talk about drugs, but about their life problems, their social problems – every aspect of their lives.' TESA SAMPURNO

'Young drug users must have the chance not to be imprisoned and not to become inmates.' IRENA YERMOLAYEVA

Rates of homelessness were also high. 'I am a harm reductionist, so what should I do?' she said. 'Officially, harm reduction service providers state that they don't offer services to children, but they do.' This could often lead to confrontations with police, she added.

'There are also moral questions – is it right to give syringes to a child, for example – as well as lack of funding and lack of proper instruments to create child-friendly services. But changing the law is an important issue and something that we're trying to do on an ongoing basis.'

It was also vital to standardise the methods by which the number of children using drugs was monitored internationally, she stressed. 'We need to know our epidemic and how it differs to that of adults, and make guidance specific, accessible and relevant. We have a lot good practice – we just need to bring it together internationally and fill the many urgent gaps.'

ENGAGING WITH INDONESIA'S YOUNG STREET USERS

YOUTH PEER-SUPPORT PROGRAMME THRIVES ON TRUST

'Young people who use drugs have unique developmental and situational needs that aren't addressed by traditional adult-orientated services,' said Tesa Sampurno of Indonesian peer-support programme Rumah Cemarah. Just over 2 per cent of the Indonesian population used drugs, he said, equivalent to between 3.8 and 4.2m people, with his service targeting young people in the city of Bandung. 'Many of them are street-involved, poly-drug users and experience a wide range of harm due to their drug use,' he said. 'And programmes are failing to reach them.'

Harassment from law enforcement made it even harder for services to access vulnerable young people, he stressed. 'They can be beaten up, and even hospitalised, by police officers or security staff just because they're walking in the mall, for example. So they become closed off.' His organisation, however, was directly engaging with young people in different parts of the community, he stated. 'Importantly, Rumah Cemarah has established the trust of young people who use drugs, who now freely share their experiences, seek advice and bring their friends.

Flexibility and creativity were essential when working with young people, he said, as were demonstrating respect for, and belief in, them. 'You need patience and the ability to demonstrate a safe and supportive environment, as you need to provide holistic, integrated programmes that recognise drug use as just one part of the broader needs of young people. We don't just talk about drugs, but about their life problems, their social problems – every aspect of their lives.'

CHALLENGING THE STATUS QUO

THE LAW STANDS IN THE WAY OF TREATMENT FOR TOO MANY YOUNG DRUG USERS IN KYRGYZSTAN AND TANZANIA

'When I started to use heroin I was only 18,' Irena Yermolayeva told delegates. 'There is a moment when all drug users want to quit, but in my country of Kyrgyzstan there was no accessible, free detox or rehab available. So I had to wait.'

Several years later she had met other drug users involved in harm reduction services and was inspired to help people in a similar position to herself, one of whom was a 15-year-old girl. 'She had syphilis but it wasn't possible to treat STIs without parental approval. Her partner was also beating her and forcing her to provide sexual services. She needed shelter, but the laws in our country meant that she couldn't get it.

'Young drug users must have the chance not to be imprisoned and not to become inmates,' she said. 'In Kyrgyzstan, there are no rehab centres available for young people and teenagers.' Young drug users were also experiencing violence from the police, she said, while Inspector Abdallah Kirungu of the Tanzanian police also described how drug users in Tanzania were being criminalised.

Forty-two per cent of injecting drug users in Dar es Salaam were HIV positive, he said, and the Tanzanian AIDS Prevention Project had initiated meetings with the police to discuss the impact that arresting drug users was having on their work. This prompted him to go incognito to see the actions of the police for himself.

'I found to my shock and dismay that the police were furthering drug-related harms,' he said, with officers ambushing drug users to confiscate and sell their drugs, harassing clients at HIV and methadone services, and extorting money and demanding sexual favours from sex workers.

'These practices called for an integrated harm reduction intervention for police officers. We need to educate our police force about drug harms to individuals and society, and the police need to be mandated and supported to take drug users for treatment rather than arrest. Police officers who extort sex workers and sexually violate them should also be subject to disciplinary action and prosecution, and we must also empower drug users and sex workers to protect their human rights.'

The Tanzanian police were not able to do this alone, however, he stressed. 'It needs to be supported by those already in the field.'

'We should never stop fighting for what's right... This is a matter of public health urgency.'

KARYN KAPLAN

'It's critical that we are able to talk about sex as much as we talk about drugs.'

CYNDEE CLAY

TACKLING THE SILENT EPIDEMIC

PANELLISTS AT A SESSION ON HEPATITIS C CALLED FOR COLLECTIVE ACTION TO MAKE TREATMENT HIGH ON EVERY POLITICAL AGENDA

'Sixty per cent of people who inject drugs worldwide are infected with hepatitis C – it's the silent epidemic,' said Azzi Momenghalibaf, chairing a session on access to hepatitis C treatment, before asking panellists to give a snapshot of the situation in their country.

'In Russia we have a very large number of people infected – between 3m and 7m,' said Sergey Golovin. 'But these are unofficial figures – we do not have a national programme.'

Fewer than 1 per cent of people with HCV in Russia were accessing treatment and drugs were often left unused at hospitals as people were not coming forward.

'We have highs and lows in Russia,' he said, the highs being prices, prevalence of HCV and need for treatment, and the lows being awareness, access and demand for treatment. There were signs of activism for a state-funded programme and pressure on producers to lower prices: 'There will be action and protests,' he said.

Amritananda Chakravorty spoke of the long fight ahead for drug users in India, where they were seen as criminals rather than patients. 'We need political commitment at national and international level,' she said. 'It is the ultimate obligation of the international community to respect the right to life of people who use drugs.'

Paisan Suwannawong outlined the scale of the challenge in Thailand, where 'the government still excludes people who use drugs'. 'We must continue to educate and advocate for people with hepatitis C,' he said. 'The most important thing is that we continue to fight for decriminalisation of people who use drugs and access to healthcare.'

Dasha Ocheret of the Eurasian Harm Reduction Network had been involved in mapping data. 'No one officially excludes people who use drugs from treatment, but there are huge gaps between official policies and what actually happens,' she said. If people injected drugs in Russia, for example, they would have a very low chance of treatment, depending on their doctor.

With the absence of good national guidelines, a 'recent wave of activism' was playing its part in raising the profile of hep C treatment. In Ukraine the government had reacted to pressure and adopted a treatment programme, and in Georgia civil actions and patient groups had been successful in starting a hep C programme in prisons.

'We should never stop fighting for what's right,' said Karyn Kaplan, who talked about the new generation of hep C medicine – direct acting anti-virus drugs without significant side effects – that meant cure rates of up to 100 per cent. 'We need to explore compulsory licences for safe and effective drugs,' she said. 'We need to make sure they're affordable.'

Calling for collective action, she added: 'This is a matter of public health urgency,' and encouraged delegates to sign an online petition at www.hepcoalition.org.

Michel Kazatchkine joined the session to give The Global Fund's support in advocating for hepatitis C and to launch the Russian edition of *The hidden global hepatitis C epidemic*. 'Two thirds of people who use drugs are affected by hepatitis C,' he said. 'It's treatable and curable but so few people are accessing treatment.'

'WE NEED TO TALK ABOUT SEX WORK'

A HEALTHY AND SAFE WORKING ENVIRONMENT IS A FUNDAMENTAL RIGHT

'It's critical that we are able to talk about sex as much as we talk about drugs,' said Cyndee Clay, executive director of the sex workers' support organisation HIPS, based in Washington, which offered non-judgemental support.

'For some, sex work is a really hard thing they have to do, for others it's the best option at the time, and for others it's what they like to do,' she said. 'That's the parallel with people who use drugs – there are varied experiences. We need to open our minds to this reality.'

Programmes at HIPS were 'client directed' and 'goal centred', with participants choosing what they were interested in, for instance reducing violence or making more money. The common thread was to help those engaged in sex work to be able to live healthy, self-determined, self-sufficient lives, free from stigma, violence, criminalisation and oppression, she explained. A major part of the team's work involved challenging structural barriers to health, safety and prosperity.

Harm reduction was used as a philosophy – 'what's going to make you happier today?' – and the 100 volunteers and staff were trained to help look out for and reduce isolation. For some, the service was the only support they had with the biggest aspect of their life.

The important thing to think about in providing services was the need to increase choice, reduce coercion and address circumstance, she said. 'This unpacks some of the ideas of whether sex work is good or bad... we need to be more comfortable talking about sex and not make assumptions.'

Anita Schoepp, of the Canadian sex workers' organisation Stella, said it was

Keep the promise: Representatives of Demetra – an association of HIV-affected women and their families – along with other national and international organisations call on Lithuanian leaders to change their HIV and harm reduction policies. Despite Lithuania's achievements compared to other countries in the region, there was still a need to scale up evidence-based interventions, they stated. 'We strongly encourage our politicians to take the responsibility to keep their commitments and implement international guidelines and recommendations,' said Demetra head, Svetlana Kulsis.

important to ask people what they needed from their outreach service, in the context in which they were living. Issues to consider included cultural barriers, family values and complex circumstances around relationships, such as intimate violence.

Working closely with psychiatrists, Stella explored different models of support, including motivational interviewing, and tried to make sure their clients were offered choices. 'Harm reduction should be a philosophy to apply to different types of social work,' she said. 'We need to help people make choices in the global context of their health.'

CONSTANT RISK

ADDRESSING TB AMONG PEOPLE WHO USE DRUGS SHOULD BE A PUBLIC HEALTH PRIORITY

'Access to TB services remains horribly low,' said Annabel Baddeley, in a session on harm reduction relating to the tuberculosis epidemic. 'We need to encourage stakeholders to be more mindful of TB in collaboration with services.'

Injecting drug users were more at risk of TB, she said, as their immune system could be impaired by lifestyle factors such as poor housing and nutrition. Those in prison were entering 'highly infective centres' and the risk of TB was consistently higher in inmates, particularly those sharing equipment. Stigma, discrimination and lack of continuity of care after release could add to the risk.

'Addressing TB among people who inject drugs is a public health priority,' she said. 'Harm reduction stakeholders should increase efforts to reach this at-risk group by including TB interventions in their services.'

TB had become an increasingly important issue for the drug using community, said Mat Southwell, who got involved in developing a practical advocacy guide in his role as a drug user activist. Referring to HIT's document, *TB advocacy guide for people who use drugs*, he explained how drug users from around the world came together to contribute to a 'rich resource'. The key messages included challenging stigma and criminalisation while giving access to anti-retroviral therapy and integrated services.

'We have to bring services to a common place, rather than expecting people to run around looking for them,' he pointed out.

Dickens Bwana, a programme manager in Tanzania, gave his experience of working at grassroots level, particularly in making TB care possible at home. Witnessing the exclusion and stigmatisation of a drug user attempting to gain access to treatment had prompted his organisation to integrate harm reduction into their services.

'With stigma attached to drugs, plus HIV, plus TB – you can see that these people need help,' he said. TB was the leading cause of mortality among injecting drug users, exacerbated by poorly ventilated consumption rooms – a breeding ground for infection – and interrupted treatment. Harm reduction education was needed on how to inject drugs and the importance of using condoms, as well as places to test for and treat the disease. Médicins du Monde had supported the opening of the Down to Earth medical centre in Dar es Salaam, a 'friendly open door' where trained volunteers offered interventions such as TB screening, HIV testing and referral to methadone programmes.

In addition, TanPUD (the Tanzanian network for people who use drugs) were giving training sessions to educate on treatment. 'Addressing TB among drug users should be a harm reduction priority,' he said.

'Addressing TB among drug users should be a harm reduction priority...' DICKENS BWANA

Lines of CON

HRI executive director Rick Lines has been making the case for a human rights-based approach to vulnerable populations for more than two decades. He talks to **David Gilliver** about getting the harm reduction message across

'Harm reduction is consistently having to re-fight battles that we've won in the past,' says Harm Reduction International (HRI) executive director Rick Lines. 'Because in many ways it can seem counter-intuitive to the dominant zero- tolerance, abstinence-based narrative.' This means those working in harm reduction having to explain 'again and again' to politicians, policy makers and the public about where it fits in 'a continuum of comprehensive health services', he says.

And he's been arguing these points for a long time, having become involved in harm reduction through prisoners' rights work. An activist in the late '80s and early '90s, in 1993 he took a job in what remains the only community-based HIV project in Canada working exclusively in prisons.

'I was one of the first staff they hired when they got funding,' he says. 'I had no background in HIV, but I knew prisons and I was comfortable working with people in prison. I started doing HIV counselling, and obviously when you're working with people in prison who are HIV positive you're inevitably working with drug users. So I became, by extension, an advocate for HIV and harm reduction services in prisons – it was really my interest in prisoners' rights that brought me into the HIV field, and pretty quickly thereafter into harm reduction.'

One of his specialisms over the years has been prison needle and syringe programmes. Is he surprised by how controversial an issue that remains? 'I am,' he says. 'I haven't done specific work on prison needle exchange for a while but it's a bit disappointing coming back to it seven or eight years since I did my last major piece of research and not a lot has changed. When I talk about it I always begin by saying that prison needle exchange is not a new thing. A lot of countries that have prison needle exchange – which is a small number of countries – have had these programmes operating for a decade, so it's not a new response or an untried response.'

At the same time it's not a response that's been picked up by many other countries, however, and even within countries that do have programmes there's 'not necessarily a growth in the number of prisons doing it', he points out. 'For most countries it's only in a handful of prisons – there are very few countries where it's a generalised programme across the entire system. But it is surprising to me the degree to which, even ten years later, the same arguments against it continue to be recycled again and again, even though they've been shown to be false.'

These are services for a population that is 'doubly, or triply or quadruply stigmatised', he stresses. 'Not just people who inject drugs, but people who are criminalised, who are incarcerated, often people who are living with HIV, people of

MMUNICATION

'We're left with a situation where the international donors are pulling out but the national donors aren't stepping in, so you have services under threat.'

colour, from ethnic minority communities, people who are young – almost stigmatised from every perspective. And so the response gets even further impeded by that. It's a disappointment, given the work that so many people have been doing – not just people like myself who have done research and policy, but people who have actually done the hard work of implementing and defending the programmes.'

On the subject of the criminal justice system, one of the biggest campaigning issues for HRI has been around the death penalty for drug offences. Although countries like Iran and Saudi Arabia have increased the number of executions, fewer countries with the death penalty for drugs on their statute books are actually using it. Is the tide turning?

'Well, the title of our last report on the death penalty was *The tipping point*, because we really feel that there is a growing global movement and change of attitude around the death penalty for drugs. The countries that actually use the death penalty for drugs are an incredible minority. Some of them are major, huge countries, obviously, like China and Iran, but the countries that are executing people for drug offences really are out of step – not only with the international community as a whole but even with other death penalty states.'

There is also a growing movement against capital punishment for drugs – and capital punishment generally – even within many of these retentionist countries, he points out. 'One of the things we heard when we first started up the death penalty project – primarily from harm reductionists from the west – was that this was a Eurocentric approach and "you can't talk about these issues in countries in Asia". But in fact we're seeing growing and robust debates in countries like Vietnam, China and Indonesia – not only constitutional court challenges being taken against the death penalty for drugs, but bills being introduced and debates in parliament. It certainly shows that it's a live issue, and that's obviously an important part of trying to move political and public opinion against the death penalty.'

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Another increasingly important area of work for HRI, with support from UNICEF, is around injecting drug use and people under the age of 18. Although the numbers of children injecting worldwide may not be huge they do represent a 'particularly vulnerable population and very much an invisible population', he says. 'They're not only at increased vulnerability because of their age and their injecting behaviours, but they're also typically denied access to harm reduction services because of age restrictions. And what we're finding is that those young people don't actually get recorded anywhere – they even fall between different categories in epidemiology studies, so you can't actually quantify them.'

Although harm reduction is now widely recognised as a cost-effective, evidence-based response, there remains a major funding gap between what's needed and what's available, he states, with many governments still reluctant to invest in programmes aimed at people who inject drugs.

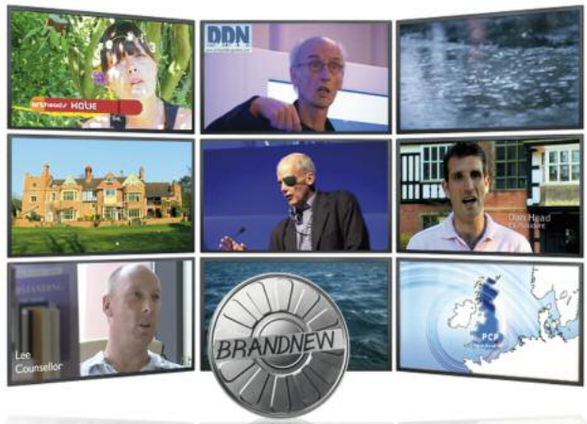
'The focus for us on the one hand is on international donors, obviously, but at the same time they can't be expected to carry the entire can,' he says. 'The other problem we're seeing – and it's a particular problem in the Eurasian region – is that a lot of countries, as they progress economically and move into middle income status in terms of their GDP, all of a sudden become ineligible for Global Fund aid or some of the international aid that they might have been relying on before, not just in terms of harm reduction programmes but their HIV programmes generally. So we're left with a situation where the international donors are pulling out but the national donors aren't stepping in, so you have services under threat. There is that responsibility of national governments to step up as well.'

As well as focusing on the economic case for harm reduction as a cost-effective public health intervention, one of the aims of this year's HRI conference was to provide a platform to reclaim its 'moral, ethical and philosophical basis' in the face of efforts to portray it as a 'morally suspect, clinical' response that fails to fulfill people's aspirations and potential, he says.

'We wanted to say that harm reduction obviously works but at the same time it's fundamentally based in recognising and respecting the dignity of people who use drugs, and to try to claim otherwise is just fundamentally wrong. So for us it's almost trying to rebrand harm reduction a bit and not surrender that kind of moral and ethical and value-based ground to the conservative elements of the recovery agenda.'

There is also often an attempt to suggest that harm reduction likes to propose itself as 'the sole approach to providing services for people who use drugs', he believes. 'Clearly none of us argue that. We do a specific and important piece of the health responses related to drug use, but it's only a particular specialised piece that speaks to particular needs. It's not the entirety of drug services, let alone the entirety of health and social services, so it's important that we don't allow ourselves to be painted into that.

'But at the same we need to say very clearly that our services are critical and essential and life-saving.' **DDN**



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THURROCK COUNCIL

TENDER FOR ADULT DRUG & ALCOHOL SERVICES

Thurrock Council wish to announce the intention to re-commission all Adult Drug and Alcohol services and will welcome expressions of interest from experienced and innovative organisations that can enable people to achieve tangible outcomes to improve the lives of individuals, families and communities who are affected by drug and alcohol issues.

Services will be expected to work closely with other health and social care providers (education, housing, employment etc) and community assets such as voluntary organisations and peer led initiatives to form a comprehensive drug and alcohol, support, treatment, recovery and advocacy service.

Our aim is to provide a locally delivered, integrated, multi agency response to the issues surrounding drug and alcohol misuse. The successful organisations will be required to deliver services in one or more of the following areas:

Lot 1 – Integrated Assessment and Care Management system
Lot 2 – Clinical Intervention Service
Lot 3 – Psychosocial intervention Service
Lot 4 – Service User/Carer Support and Advocacy

Contracts will be allocated in lots.
Providers may apply to deliver one or more of the services listed above.

This is an exciting opportunity to develop a range of services that are community based and aimed at working with service users and their families to improve their life chances and those of their children.

TENDER FOR YOUNG PEOPLE'S DRUG & ALCOHOL SERVICE

Thurrock Council wish to announce the intention to re-commission Young People's Drug and Alcohol services and will welcome expressions of interest from experienced and innovative organisations who can enable people to achieve tangible outcomes and improve the lives of individuals, families and communities affected by drug and alcohol issues.

Services will be expected to work closely with other young people's health, mental health, social care, education and other appropriate local providers.

Our aim is that this fits into a locally delivered, integrated, multi agency response to the issues surrounding drug and alcohol misuse across adult and young people's services.

OPPORTUNITY FOR INCLUSION ONTO AN APPROVED LIST, FOR DRUG & ALCOHOL RESIDENTIAL REHABILITATION SERVICES

Thurrock Council wish to announce the intention to invite applications to be included onto a framework to deliver Residential Rehabilitation services for Thurrock Council.

The Provider must be able to deliver rehab services to a range of client groups including, but not limited to, women only services, services for people under 18 years of age, for people with a dual diagnosis, for those with an alcohol only problem and those with extensive and current involvement in the criminal justice system.

The closing date for expressions of interest is Wednesday 31 July 2013. Details can be found on Thurrock Council website early in July 2013. www.thurrock.gov.uk

INVESTORS IN PEOPLE | Silver

THURROCK COUNCIL
www.thurrock.gov.uk

PHARMACY-BASED DRUG TREATMENT SERVICE
Tender Opportunity

Hampshire County Council (HCC) invites expressions of interest for the delivery of a Pharmacy-based Drug Treatment Service for its local adult population.

Working as an integral partner within our recovery orientated integrated treatment system, the Provider will deliver the following interventions via community pharmacy sites throughout Hampshire:

Needle Exchange
Harm minimisation advice
Health checks
BBV-testing including kits
Sign-posting
Supervised consumption

Starting 1st April 2014, the contract will be for 36 months with option to extend for a further 12 months. The annual value of the contract will not exceed £230,000 and, over the full 48-month period, will not exceed £920,000 (inclusive of all set-up and capital costs).

(The contract value excludes the costs of needle exchange supplies and associated clinical waste management services. The provision of these items is commissioned under a separate contract.)

Expressions of interest from consortia and community interest companies are welcomed.

Expressions of interest must be made using In-Tend.

More details regarding this tendering opportunity are available to view within Hampshire County Council's e-tendering system, In-Tend from **1st July 2013.**

Go to https://in-tendhost.co.uk/hampshire/ and then click on the Current Tenders button to view this opportunity. Guidance in the use of In-Tend can be found on the In-Tend site by clicking on the Information for Suppliers button.

Hampshire County Council

HAMPSHIRE DAAT
Drug & Alcohol Action Team

RAPt

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HEAD OF SERVICES

Prison & Community based Drug Treatment Services

London, £47,175 inc London weighting.

Closing date for applications: 18th July 2013 (10 am)

This post will play a vital role in the expansion and continuous improvement of RAPt's high quality and effective recovery services, enabling more people to move away from addiction and crime.

Full details and application forms available on

www.drinkanddrugsnews.com

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Derbyshire • County wide, Tier 3 Alcohol service

Partnership Managers

Durham • Community and Secure Estates

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Ref: 02-2659

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This is an exciting time to join Slough's DAAT Team and the newly formed Care Group Commissioning Team which has been restructured to strengthen the Council's corporate procurement and contract management capability. You will be experienced in developing services around substance misuse harm reduction and clinical services and will need experience of working with service providers, pharmacists and GPs. You will have the ability to resolve complex situations and take a lead on the delivery of the harm reduction and shared care agendas in Slough.

For an informal discussion about the post please contact Avtar Maan, SSP Performance and Data Collection Manager on 01753 477352.

Apply for this job online at www.slough.gov.uk/jobs
Alternatively email recruitment@slough.gov.uk or call our 24 hour message line on 01753 875074 for a pack, outlining the reference number above. Minicom service on 01753 875030.

Closing date: 5pm, Thursday 18 July 2013.

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Expressions of interest

OXFORDSHIRE COUNTY COUNCIL

CONTRACT FOR DRUG EDUCATION AND ALCOHOL EDUCATION IN SECONDARY SCHOOLS IN OXFORDSHIRE

Oxfordshire County Council Public Health directorate are seeking an innovative educator that can provide engaging and effective drug and alcohol educational packages.

The provider will deliver separate drugs education and alcohol education to all 34 secondary schools in Oxfordshire to year 8 and 9 pupils, plus Pupil Referral Unit's and where appropriate, special schools. The provider will work closely with schools to ensure each session has maximum benefit to pupils.

The service provider will be required to evidence a proven track record in the delivery of high quality services of the same nature and must be able to demonstrate excellent, pro-active partnership development experience and ability.

- *This is a two year contract, with the option to extend for a further two years.*
- *The contract will commence from 1st January 2014.*
- *The budget available for this contract is a maximum of £150,000 per annum.*

Our tender process will be conducted under a single stage procedure based on an output based specification. Oxfordshire County Council will not be bound to award any contract under this tender process.

Please send your expressions of interest via the **"express an interest"** function on the southeast business portal from 12th July 2013 **www.businessportal.southeastiep.gov.uk**

The closing date for our receipt of expressions of interest is by 12 noon on 02nd August 2013.

A fully detailed specification will be issued to all interested parties at the Invitation To Tender (ITT) stage. If, however, you have any general questions regarding this proposed service please contact: Pasquale Brammer, Jubilee House, 5510 John Smith Drive,Oxford Business Park South, Oxford, OX4 2LH Email: pasquale.brammer@oxfordshire.gov.uk Telephone: 01865 328607

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Southampton, UK

SUBSTANCE MISUSE WORKER (PRISON BASED)
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