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Drink and Drugs News

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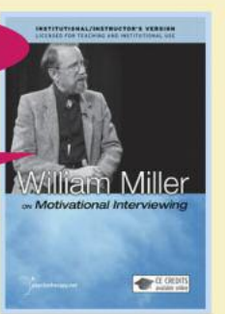

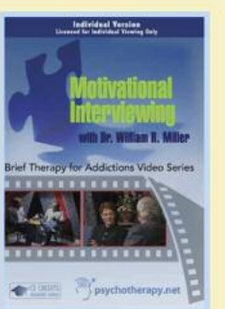

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Community spirit

Turning recovery from mantra to meaning

As we enter 'recovery month' with its impressive array of activities all over the country, the questions raised by our cover story (page 8) are particularly apt. How do you make recovery a meaningful concept right through the treatment system and relevant to providers as well as clients? Cumbria's experience seems like a case study worth sharing, with the willingness of different organisations to address the needs of the area's diverse communities. It's a story that illustrates the terms co-production and asset-sharing and fills them with meaning.

Talking of shared experience, Findings editor Mike Ashton gives a guided tour of the most amazing resource on page 14. The matrices, with their wealth of free information, offer must-read documents that will help you understand the evidence base for whatever area of addiction treatment you work in – a godsend for practitioners and commissioners. Dip in and take a look – the links are all there for you to benefit from the largest live drug and alcohol library in Britain.

And we begin our own good practice initiative in this issue with the launch of our 'Exchange' feature on page 12, where Natasha Bray starts us off with a successful naloxone training idea. Please get in touch with us if you'd like to share your innovative work by emailing DDNexchange@cjwellings.com – we'd love to hear from you.

This issue

FEATURES

REGULARS

NEWS IN BRIEF

TALK IT OVER

A guide for parents on how to talk to their children about club drugs has been published by Adfam, the Angelus Foundation and Chelsea and Westminster Hospital's club drugs clinic. 'The involvement and support of parents and families can make a big difference to someone's health and how they deal with taking legal highs and club drugs,' says *Talking to your children about legal highs and club drugs: a parent's handbook*. *Available at www.angelusfoundation.com*

TB CAPITAL

London has the highest TB rates of any western European capital, according to a report from Public Health England (PHE). Thirty-nine per cent of the 8,751 cases of TB reported in the UK in 2012 were in London, although UK rates have remained 'relatively stable' since 2005. More than 7 per cent of cases had 'at least one social risk factor' such as problem drug or alcohol use, imprisonment or a history of homelessness, says *Tuberculosis in the UK 2013* report. 'TB remains a critical public health problem, particularly in parts of London and among people from vulnerable communities,' said PHE's medical director, Dr Paul Cosford. *Report at www.gov.uk*

STYAL-ISH SERVICE

A new drug and alcohol recovery service has been launched by the Lifeline Project at women's prison HMP Styal in Cheshire. The fully integrated programme will operate in partnership with Delphi Medical and Acorn Treatment and include 'ambitious recovery outcomes relating to health and wellbeing, employment and self-esteem'.

YOUR VERY GOOD HEALTH

The World Health Organization (WHO) has published a report on alcohol and health in Europe, looking at consumption levels and harm as well as the effectiveness of recent policy developments. Meanwhile, nearly 40 per cent of ten to 17-year-olds who use social networking sites had seen images of their friends drunk, according to research from Drinkaware. 'Children as young as ten are seeing drunkenness normalised,' said Drinkaware's marketing and communications director Anne Foster. *Status report on alcohol and health in 35 European countries 2013 at www.euro.who.int*

Black people six times more likely to be stopped and searched for drugs

Black people are stopped and searched for drugs at 6.3 times the rate of white people, according to a new report from Release and the London School of Economics and Political Science (LSE).

Asian people are also stopped at 2.5 times the rate and those identifying as mixed race at twice the rate, says *The numbers in black and white: ethnic disparities in the policing and prosecution of drug offences in England and Wales*.

Black people are also more than twice as likely to be charged if any drugs are found, it says. In 2009/10, 78 per cent of black people caught in possession of cocaine by the Metropolitan Police were charged and 22 per cent given cautions, while among white people 56 per cent were given cautions and just 44 per cent were charged. Black people are also five times more likely to be charged for possession of cannabis.

Members of the black community are also more than four times more likely to be subject to court proceedings and found guilty for possession offences, and five times more likely to face immediate jail, states the document.

The Crown Prosecution Service brought more than 43,000 prosecutions for drug possession in 2010 – the highest since the introduction of the 1971 Misuse of Drugs Act – 60 per cent of which were for cannabis offences, while 1.2m criminal records were issued for drug possession offences between 1996 and 2011. More than half of all stop and searches are for drugs, compared to 10 per cent for offensive weapons and less than 1 per cent for guns.

'The policing and prosecution of drug offences is not being equally applied to all those who use drugs,' the report concludes. 'It is impossible for the state to police the estimated 3m people who use drugs annually in the UK. Instead, certain groups are the focus of enforcement,' with the 'deliberately inflicted pains of drug control' falling most heavily on 'poor and visible minorities'.

'This research shows that stop and search is not about finding guns or knives but about the police going out and actively looking for people who are in possession of a small amount of drugs, mainly cannabis,' said Release executive director and co-author of the report, Niamh Eastwood. 'Black people are more likely to get a criminal record than white people, are more likely to be taken to court and are more likely to be fined or imprisoned for drug offences because of the way in which they are policed, rather than because they are more likely to use drugs. Despite calls for police reform of stop and search little has changed in the last three decades – this is why the government needs to take action and change the law.'

Release has called for drug possession offences to be decriminalised in order to 'eliminate a significant source of discrimination with all its damaging consequences.'

Report at www.release.org.uk

See news focus, page 6

New psychoactive drug deaths double

Deaths involving new psychoactive substances in England and Wales have almost doubled in a year, from 29 in 2011 to 52 in 2012, according to the latest figures from the Office for National Statistics (ONS). There was also a large increase in the number of death certificates mentioning PMA or PMMA, from just one in 2011 to 20 the following year, although the report states that 'a small number of these deaths also mentioned ecstasy'.

The number of deaths involving heroin or morphine 'fell slightly' in 2012, to 579. However, deaths involving the synthetic opioid tramadol – at 175 – were more than double the number recorded four years previously. The overall number of male drug misuse deaths fell by 9 per cent to 1,086, while female deaths fell by 1 per cent to 410.

Despite the continuing decline in heroin deaths, the 'significant increases' in deaths involving other drugs was worrying, said DrugScope chief executive Martin Barnes. 'The number of deaths involving PMA is, for example, concerning. In all probability people would have believed they were taking ecstasy, but PMA is far more toxic while at the same time taking longer to take effect. This can make users believe that the pill isn't working, encouraging them to increase the dose with sometimes fatal results.'

Meanwhile, the use of psychedelic drugs like LSD, peyote and psilocybin mushrooms does not increase a person's risk of developing mental health problems, according to a study of 130,000 people by researchers at the Norwegian University of Science and Technology.

The study's authors also claim 'some significant associations' between use of psychedelic drugs and fewer mental health problems. 'After adjusting for other risk factors, lifetime use of LSD, psilocybin, mescaline or peyote, or past-year use of LSD was not associated with a higher rate of mental health problems or receiving mental health treatment,' said co-author Pål-Ørjan Johansen, although the document does not 'exclude the possibility' that use of psychedelics might have a negative effect on mental health for some individuals or groups.

Early speculation that psychedelics could lead to mental health issues was based on 'a small number of case reports and did not take into account either the widespread use of psychedelics or the not infrequent rate of mental health problems in the general population' said co-author Teri Krebs. *Deaths related to drug poisoning in England and Wales, 2012 at www.ons.gov.uk*

Psychedelics and mental health: www.plosone.org

Scots record second-highest number of drug deaths

Scotland recorded its second-highest number of drug deaths in 2012, although the number of deaths in under-25s was down by a fifth, according to new figures from the Scottish Government.

Overall drug-related deaths stood at 581, three fewer than 2011's record number (*DDN*, September 2012, page 4). More than 60 per cent of deaths were in people over the age of 35, while the number among people under 25 fell by 20 per cent to 46.

Methadone was implicated in 38 fewer deaths than 2011 – at 237 – including 12 deaths where methadone was the only drug present and 68 where it was the only drug implicated apart from alcohol. There were also 47 deaths where new psychoactive substances were present – the first time they have been included in the report – including five where they were the only drug present.

'The Scottish Government is dealing with a legacy of drug misuse which stretches back decades and, as in previous years, the statistics published today show that many of these deaths are older drug users who have become increasingly unwell throughout the years,' said community safety minister Roseanna Cunningham.

The high level of deaths among older opiate users re-emphasised the need for services to be 'more targeted towards the needs of this group of people, who are likely to have a range of complex needs', said Scottish Drugs Forum director David Liddell. 'The Scottish Government's programme to distribute naloxone – an emergency antidote for opiate overdoses – is one of the measures to help cut the drug deaths toll in Scotland but more needs to be done to ensure greater distribution and take up across Scotland. Our view is that at least 40 per cent of the estimated 59,600 people with very serious drugs problems in Scotland need to be provided with naloxone in order to make a substantial impact on the deaths.'

The number of deaths in 2011 involving methadone led to much debate in the Scottish media and a call for a parliamentary enquiry. However, the report of the government-commissioned Independent Expert Group Review of Opioid Replacement Therapies in Scotland has concluded that the use of opioid replacement therapies – particularly methadone – should continue as part of a range of treatment options. 'Opioid replacement is an essential treatment with a strong evidence base,' says the document. 'Its use remains a central component of the treatment for opiate dependency and should be retained in Scottish services.' The report also recommends that local information systems be improved to identify people's progress towards recovery and more consideration be given to addressing the link between health inequalities and problem substance use.

'Opioid replacement therapies, including methadone have had a beneficial effect in preventing the spread of viruses among drug users,' said Scotland's chief medical officer, Dr Harry Burns. 'However, they often simply switch one form of drug use for another, albeit a safer one. That's why we need to find more ways of helping people access a range of treatments and support, tailored to their needs and their aspirations for sustained recovery.'

Meanwhile, a report from NHS Health Scotland has found that while alcohol sales in Scotland fell by 3 per cent between 2011 and 2012, Scots still drink around a fifth more than the English or Welsh. Nearly 90 per cent of the difference in 'per adult sales' was the result of higher off-trade sales, particularly spirits, says *MESAS alcohol sales update 2013*. 'Cheap vodka' was 'fuelling much higher levels of harm, which results in 100 alcohol-related hospital admissions a day and costs Scotland £3.6bn each year – £900 for every adult', said public health minister Michael Matheson.

Drug-related deaths in Scotland at www.gro-scotland.gov.uk

Delivering recovery-opioid replacement therapies in Scotland – independent expert review at www.scotland.gov.uk

MESAS alcohol sales update 2013 at www.healthscotland.com

US signals softer stance on drug sentencing for non-violent offenders

The US administration has indicated a softening of its stance on drug sentencing, with proposals to abolish mandatory minimum sentences for non-violent drug offenders. The country has long been the subject of criticism for its drug policies, with around a quarter of the 2m people in its jails estimated to have been convicted of a drug offence.

US attorney general Eric Holder announced plans to abolish the use of mandatory sentencing in certain drugs cases in a speech to the American Bar Association. The Obama administration previously indicated an intention to divert non-violent drug offenders away from the prison system in its *2012 national drug control strategy* (*DDN*, May 2012, page 5), while earlier this year an open letter to the US government signed by more than 175 civil rights leaders, celebrities and business figures called for more alternatives to incarceration for non-violent drug offences (*DDN*, April, page 5). Holder said in a radio interview before the announcement that 'unintended consequences' of the war on drugs had included 'a decimation of certain communities, in particular communities of colour.'

Executive director of the Drug Policy Alliance, Ethan Nadelmann, called the announcement 'incredibly significant – the first time a US attorney general has spoken so forcefully or offered such a detailed proposal for sentencing reform, and particularly notable that he framed the issue in moral terms.'

NEWS IN BRIEF

NEW RELEASE

Release has launched its new website, featuring a dedicated harm reduction section as well as enhanced policy and legal advice pages. 'We're really excited about the new website, which we believe is one of most comprehensive and informative sites in respect of drug information, harm reduction and legal issues faced by people who use drugs and their families,' said executive director Niamh Eastwood. 'The format is attractive and accessible and we hope people will sign up to the newsletter to keep up to date with Release's work and developments in the field.' *See news focus, page 6.*

RE:COVER YOUR TALENT

Phoenix Future's Re:Cover music project wants to hear from people who have been affected by drug or alcohol addiction – whether their own or someone else's – and have 'a passion for making music'. Those selected to take part will get an expenses-paid day in a studio with an industry mentor to record songs offering an insight into addiction, with the final versions posted online for a public vote. Winners will receive a prize package worth £1,500. *Details at www.phoenix-futures.org.uk*

MAKING CONNECTIONS

A report on homelessness and substance use has been launched by the London Drug and Alcohol Network (LDAN) and DrugScope. Statistics suggest that only a quarter of rough sleepers in central London do not have support needs relating to drugs, alcohol, mental health or a combination of the three, says *Making connections to build recovery*. *Available at www.drugscope.org.uk*

CARE CASH

Voluntary sector funding to help 'improve people's health and wellbeing' has been announced by care and support minister Norman Lamb. The Innovation, Excellence and Strategic Development (IESD) fund will be awarded to organisations that can demonstrate a commitment to personalisation and choice of care, compassion and improving public health. *Details at www.gov.uk/government/publications/voluntary-sector-funding-available-for-health-and-care-projects*

EQUAL IN THE EYES OF THE LAW?

Police stop and search policy is exacerbating racial inequality in the criminal justice system, says a new report from Release and LSE

Black people are not only six times more likely to be stopped and searched for drugs by the police, but more likely to be charged – and receive a harsher sentence – if drugs are found, according to a powerful new report from Release and LSE (see news, page 4).

As well as analysing the government's own figures, the authors of *The numbers in black and white: ethnic disparities in the policing and prosecution of drug offences in England and Wales* sent freedom of information requests to police forces across the country, and carried out a particularly detailed analysis of the Metropolitan Police Service, which carries out half of all stop and searches for drugs.

'Discussion of stop and search is usually about knife and gun crime, but that's actually a tiny proportion – 0.8 per cent last year in London for guns and just about ten per cent for offensive weapons,' Release executive director and co-author of the report, Niamh Eastwood, tells *DDN*. 'Overwhelmingly stop and search is about drugs, and it's about low-level possession offences. That was also identified in Her Majesty's Inspectorate of Constabulary (HMIC) in their last report, so it's not just us saying it.'

Was she surprised by the report's findings – the actual extent of the differences in the figures for black and white people? 'There were some things that we anecdotally already knew,' she says. 'In terms of the actual stop and search rates, because of the sheer number of times that the young people in London we speak to are repeatedly stopped and searched, we weren't that surprised. What we were surprised by was the differential treatment that black people faced in relation to charging for drug possession offences. That was really shocking, because obviously you're talking about like-for-like and the police making a decision to treat people in a significantly different way.'

What may also come as a surprise, despite some media commentators arguing that drug possession is essentially de facto legalised, is that 2010 saw more prosecutions for possession than ever before. One reason was the reclassification of cannabis to class B the previous year, she believes, while another was 'the targets that had been set under the previous government and now lifted – but that performance indicator, target-driven culture is still embedded within police behaviour'.

The notion that the police find it easy to go after the 'low-hanging fruit' of low-level possession offences is backed up by the experiences of another of the report's authors, Daniel Bear, who spent time with one London force. 'He'd go out in a patrol car at the start of a shift and the police officer would say "right, we need to go down to the park and pick up some kids who've got cannabis so we can get our sanction detections",' she says. 'Then for the rest of the night they could actually focus on policing that the community cares about. They used it as a tool to meet the targets. I don't know whether the police actually want to do that, but it's a very easy way to justify your performance to your senior officers.'

The cumulative effect is an erosion of trust and confidence in the police and an undermining of the criminal justice system itself, the report argues. 'We would like to see the decriminalisation of drug possession,' she states. 'If you look at other jurisdictions that have had similar experiences with drugs policing and the aim to contain and control certain groups – for instance the black and Hispanic population in New York – you've seen senior politicians saying that policy needs to change. They've recognised that the police can't overwhelmingly change their behaviour, and we would argue that that's the same here. Despite controversy after controversy, the police have just not adjusted their practices to reduce the levels of racial disparity.'

The Home Office is conducting its own review of stop and search at the moment. Is she hopeful that the document will have an impact? 'We are, especially coming on the heels of the HMIC report,' she says. 'The Metropolitan Police have put forward some proposals, including 50 per cent reductions in stop and searches overall and in negative stop and searches, but we're really concerned that, one, that doesn't address racial disparity and, two, it could lead to the police actually going out to target those they know will be in possession of drugs in order to avoid the negative stop and searches. So they'll continue to police the usual suspects, if you like. And also that we could have a situation where police officers aren't properly recording stop and searches where no drugs have been found. We don't believe that the approach taken by the Met will have any significant impact on police behaviour.'

'Overwhelmingly stop and search is about drugs, and it's about low-level possession offences.'
NIAMH EASTWOOD, RELEASE

Even a reduction of 50 per cent would be from a peak of 280,000 people stopped for drugs to 140,000, she points out. 'And that's if they reach their target. It would just bring us back to 2006 figures. It doesn't go far enough.'

Report at www.release.org.uk

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Spreading ROOTS

How do you make recovery visible and relevant to a diverse community? **Ashley Gibson** shares Cumbria's experience

In early 2012 Cumbria DAAT decided to go out to tender for a recovery-oriented, asset-based service with one lead provider. Those of us involved in Cumbria service provision felt it to be a forward thinking step – we really wanted more people to get well and we liked how the focus on recovery had impacted on other areas of the country, and the North West in particular. It was also clear from consultations with people accessing services that they wanted change too, and the tender specification accurately reflected the needs of those surveyed.

Back then Cumbria, like many other parts of the country, was struggling with the numbers in treatment. Having learned to bring people into treatment and minimise harm, we were finding it difficult to move people through the system, despite service provision that encouraged uptake of support programmes. We weren't wholly unsuccessful – the Straight Ahead programme and Bridging the Gap were proving themselves as recovery building assets – but there were question marks over the necessary visibility of recovery in Cumbria.

Obstacles to change included the geographical distances between local communities, Cumbria being pretty much the same size as the rest of the North West. It has a mixture of affluence and rural poverty, with pockets of high unemployment in areas like Barrow and the west of the county, and some significant housing challenges. Centralised approaches to working in the diverse communities of Cumbria were just not demonstrating enough relevance to local needs.

As a treatment system made up of different providers, we struggled to pay enough attention to what happened to people who were leaving treatment and we were not proactive enough regarding feedback that there was no aftercare available. We supported the set-up of Smart Recovery but at that time we didn't have enough people at that level of recovery to sustain it. We had a lot to learn – and still do. Our contact with, and knowledge of, 12-step recovery was sporadic at best.

Cumbria had three main providers, covering prescribing and clinical, criminal justice, and structured day care services. This created some really positive joint working and some not so positive competition. Everyone recognised the importance of keeping people who access services at the heart of the process – but I am not sure that this always happened, however hard most of us tried.

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Greater Manchester West Mental Health NHS Foundation Trust were successful in their bid to provide a recovery-focused asset-based service in Cumbria, with a contract beginning on 1 July last year. For those like myself, whose previous experience had always been with third sector organisations, it was an interesting prospect. GMW senior management were very clear with us all that recovery would be at the heart of the way forward and that we would be working with an asset-based approach. It sounded exciting; in my role as a third sector service manager in Cumbria I had already been involved with asset-sharing ideas, particularly in Barrow, and had previously attended a John McKnight asset-based community development seminar in Kendal. I am also in recovery and the prospect of what felt like going back to my own roots in my work was a really inviting one.

As the result of a consultation exercise, Unity, with a strapline of 'recovery in your community', became the new name for the 'one provider' service. The name reflected the need of people from the previously separate services to unify with people already in recovery and those accessing services. It also felt like a message to ourselves as we built the foundations of our co-productive approach within Cumbrian communities.

Taking an innovative approach, and recognising that recovery networks are key to people getting and staying well, Unity set up an asset building fund. This takes bids during each year of the contract from groups and organisations that wish to contribute to recovery and its further development in Cumbria. As well as this, a new role of community development lead (my role) was introduced into the Unity management structure. Its purpose was to support recovery development by letting us share assets through joined-up work between people and services in the community. We recognised – and it was also commented on in Cumbria DAAT's modernisation consultation with service users – that both drug and alcohol services and recovery support needed to be relevant to local communities. One size definitely does not fit all in Cumbria.

'What we try to do is listen and support as opposed to tell and regulate, in the belief that recovery is not owned but shared.'

Different recovery groups and organisations with local connections were already set up or were starting to develop their ideas. These groups were encouraged to apply for support from the Unity asset-building fund – a great opportunity for them and for Unity to start to build a co-productive approach. Those successfully shortlisted would be invited to participate in a 'friendly *Dragon's Den*' – a nod to the popular TV programme.

Key to the accessibility of the asset-building fund was Unity's recognition that the process needed to be very straightforward. Although bid-related goals were agreed, these would be flexible according to the specific local requirements of the group needing funding. Unity, through my role, and also the commitment of the local recovery service teams, support all groups, whether they are funded yet

or not, to play their part in the local community.

What we try to do is listen and support as opposed to tell and regulate, in the belief that recovery is not owned but shared. We also try to help those who wish to design and develop recovery support networks to realise their aspirations. The growing mutual respect was highlighted by the contribution that different recovery groups from around the county made to our recent workforce development training. They played a major part in helping Unity staff teams develop their understanding of recovery and this co-working continues to bear fruit.

In practical terms, Unity work closely with local groups – Vulture Club in Whitehaven, New Beginning in Workington, Cumbria Gateway and Jigsaws in Carlisle, ReFocus in Penrith, and New Roots in Barrow – to develop their ideas further and make the groups more visible. These organisations are all inspired to support recovery in Cumbria and choose to work closely with Unity to develop strong and meaningful links with other organisations in their local communities.

*****

In Barrow and Workington we have recently taken our next step in recovery asset building. Following an inspirational visit to friends at the Scottish Recovery Consortium and some practice at our workforce development days, we have joined the brave new world of 'recovery conversation cafés', inviting people who access local services, carers and people from the community to talk about what recovery means locally. This is a great way to have everyone who supports recovery get together, make use of the links we have, forge new ones and decide on actions that relate to recovery in the local communities of Cumbria.

Mark Reeve of New Roots Support Group, left, receives a donation of fishing equipment, as featured in the North West Evening Mail, Barrow

The informal café atmosphere is designed to help everyone feel at ease and talk openly about real ideas that will support recovery networks and their development. It is ideally suited to the asset-based approach as it brings focus to the sharing of strengths and assets in a positive environment. So far the Barrow and Workington conversation cafés have been vibrant and full of ideas that have included such things as social media development, ways to challenge stigma and sharing of workspace.

We have also begun work to build relationships with 12-step and other mutual aid organisations. North West representatives from Narcotics Anonymous came out to Barrow-in-Furness to put on a 'myth-busting' event to support positive, reality-based links that ensure people accessing treatment services get a full range of recovery choices, and Unity are now working to support the set up of new NA meetings in Cumbria. In Carlisle the Unity team and partners linked with an Alcoholics Anonymous public meeting, building important relationships to facilitate more informed choice for people accessing services. This linkage has been further developed after Mark Gilman's visit to the city to promote mutual aid facilitation, as AA will be hosting an open meeting to introduce the 12 steps at Unity's Botchergate centre from September. In HMP Haverigg we will soon have Smart Recovery meetings taking place, with staff members currently in training.

To mix metaphors for us, recovery is not a bull at a gate but a rising tide, as it becomes more visible in Cumbria. What I love about it is its diversity – each locality doing its own thing, demonstrating, I think, that we were right not to centralise our ideas. The beauty of it is how, as the varied organisations and their members develop in their own local communities, there is increasing talk of wanting more contact with each other, and we hope to help everyone get together this month for our very own Cumbria recovery walk. **DDN**

The next recovery conversation café is planned for 24 September in Carlisle.

Ashley Gibson is community development lead at Unity Drug and Alcohol Recovery Service, Cumbria

LEGAL LINE

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

BEATEN UP BUT THE POLICE REFUSE TO HELP BECAUSE OF MY DRUG USE

READER'S QUESTION:

Last year I was badly beaten up, and the police never found the person who did it. I have been in and out of hospital for operations; I am still in pain and am very anxious when I go out by myself. I applied for compensation but was refused because the police said I had been drinking and taking drugs and 'provoked what happened'. I had a few pints that night and smoked cannabis earlier in the day but wasn't drunk or stoned, and was minding my own business when I was attacked.

'There are rules that decide if someone should get any money...'

KIRSTIE SAYS:

Compensation for criminal injuries is dealt with by the Criminal Injuries Compensation Authority (CICA). There are rules that decide if someone should get any money, and if so how much. Each injury has an amount of money attached to it, and this can be decreased for a variety of reasons.

An award might be refused or reduced because of the way the victim behaved during the incident. CICA will look at police reports, witness statements and other documents to decide what happened and if you contributed to what happened in any way. It may be that witnesses have said that you started the fight or were acting aggressively before being attacked. The use of drugs and alcohol alone isn't enough to refuse or reduce an award but, combined with the behaviour described in statements, it might lead to CICA deciding not to give you compensation. Being under the influence of drugs or alcohol can't excuse a victim's actions.

The character of the victim will also be considered, and involvement with illegal drugs is one of the factors here. This does not necessarily mean convictions for drugs offences, but unspent convictions for any offence will also play a big part in whether an award is made.

You can ask CICA to review their decision within 56 days of the date the decision was made. You will need to provide supporting evidence, which might include statements from independent witnesses, medical tests showing the level of alcohol and drugs in your system at the time and expert reports on the effect of this. A different claims officer will look at your application again and decide if you should get the full amount for your injuries or a lower amount.

If you still disagree with the decision after review you can appeal to an independent tribunal within 90 days of the new decision. You should think carefully about this as the panel can withdraw any offer that has been made. Legal aid is not available for these appeals, but some solicitors offer representation on a no win, no fee basis where you only pay them if they win the case. CAB or local law centres might also be able to advise you.

Will you share your issue with other readers? Kirstie will answer your legal questions relating to any aspect of drugs, the law and your rights through this column. Please email your queries to claire@cjwellings.com and we will pass them on.

LETTERS

ON THE BANDWAGON

As a community-based provider of substance misuse services I was interested to read John Jolly's views on procurements and tendering which will no doubt resonate with many in the field (*DDN*, August, page 20). He clearly makes some valid points.

Throughout the years there have regularly been calls for the substance misuse field to unite and work together so as not to pit one provider against another to the detriment of, as John puts it, the 'local third sector organisation operating and attuned to local communities'. However, we all know this hasn't happened and we all probably know why, when 'profit motivation', 'survival' or 'growth' have got in the way of ethics.

But isn't it best not to put all the blame on commissioning when organisations have been so keen to jump on this bandwagon. Maybe it would be better to make sure our own practices are in order first and that we too aren't, in some way, a part of the demise of a vibrant local provision, before we point the finger elsewhere.

Sue Kenten, CEO, DASL

HIGH AND DRY

I'm worried about the hidden alcoholics. They have always been left out of the loop. They don't come under Supporting People because they don't have housing issues as they own their own houses. They don't come under peer mentoring as they don't need education, training or employment as they work or own their own businesses or are retired. They don't come under DIP as they don't have a criminal record. If they score under 20 or have come out of detox or rehab, they are no longer seen by the substance misuse service. There is no aftercare or relapse prevention for them. They are left high and dry, worried that they will relapse (which in most cases they do) without support.

We need empathic support workers who can offer relapse prevention and who can visit them in their own homes where they feel more comfortable. Hidden alcoholics are proud people who don't understand why they have reached rock bottom. They are too embarrassed to admit it to their families. In most cases they want instant support, because they don't know the procedure or system that they have to go through to get help.

We also need sympathetic, empathic people to visit service users in hospital. Some have never been under the treatment services (this world is alien to them) when they are left by their families, partners (who don't understand why they drink or take drugs) to languish for weeks on end. With no one to speak to, in some cases they come across unsympathetic medical staff who don't realise that most alcoholics drink because of something that has happened in their lives.

I've spent hours sitting by the bedside of clients who just want to see a friendly face. I founded AGRO because there was no support for service users in the evening and weekends. I'm now in the process of helping to start something similar in Pembrokeshire called The Peer Project with a lady called Leigh Proctor.

As a recovering alcoholic myself, I spend a lot of my spare time thinking of ways to support fellow service users to make their lives easier. Every new project I come up with has come from what I have seen and heard while working as a substance misuse support worker for more than ten years.

Huw Harries, co-founder/chairman, Anglesey & Gwynedd Recovery Organisation (AGRO)

SEEING RED

As a supporter and practitioner of most Green Party topics, I have considerable respect for Caroline Lucas, but not in regard to her attitude towards addiction issues.

The fact that in 2013 she still 'wants the government to acknowledge that current policy is flawed' (*DDN*, August, page 16), and also that she would 'like to think that there's a point at which ministers have to change course', is strong proof that she has not read the current coalition government's 2010 drug strategy.

For some 61 years, the sort of policies she rightly condemns have been condoned by successive governments of all colours – until the election of this government, who

immediately acknowledged that the existing policy was flawed and declared that the country had to change course in major ways to head us towards a drug-free society.

And the strategy they announced was fabulous when compared to what had gone before for six decades, *ie* pretty much what Caroline Lucas appears to look for.

The first strand of their new policy is 'reduce demand', which they are striving for by seeking to recover addicts from their addiction – because they have understood that it is addicts who create demand, not non-users.

They have also set a goal for 'recovery to lasting abstinence' in place of 'habit management', and underlined this by disbanding the NTA and introducing Payment by Results based on a certified outcome of '12 months free of addictive substance usage'.

But it takes time to dismantle and replace the deeply embedded failed policies of more than 60 years, especially as there has been not only the usual inertia and natural resistance to change, but also determined efforts both overt and covert by the long incumbent treatment providers, commissioners and prescribers to protect their jobs, incomes and the tolerant lack of real results they have long enjoyed.

So let's avoid uninformed calls for changes until the current 2010 drug strategy is actually out of the starting blocks and into delivering a return to the natural state of relaxed abstinence into which 99 per cent of the population is born.

Kenneth Eckersley, CEO Addiction Recovery Training Services (ARTS)

ARE YOU A SOCIAL WORKER?

Or perhaps you have a colleague who is? The British Association of Social Workers (BASW) Special Interest Group (SIG) in Alcohol and other Drugs is looking to establish a database of social workers specialising in substance use.

The SIG is keen to ensure its events and resources meet the needs of professionals who specialise in substance use as well as those who specialise in other areas of social work practice and who want to learn more about responding to substance use.

We would use the database for consultation on policy responses, as well as consultation on future events and resources.

If you would like to be added to our database, please contact Sarah Richards at BASW on s.richards@basw.co.uk or the chair of the SIG, Sarah Galvani, on sarah.galvani@beds.ac.uk.

Sarah Galvani

MAKE MUSIC

The Phoenix Re:Cover Music Project (see news, page 5), is looking for anyone who has been affected by addiction and want to use their passion for making music to communicate their experience and story.

The project will give a small number of people the chance to record two songs, one original and one cover, both of which tell a story or give an insight into addiction. Each solo artist or group will have a day in a recording studio to record their songs with the help and support of an industry professional mentor. The final recorded songs will be posted online for the public to vote on their favourite and the solo artist or group with the most votes will receive a prize package worth £1,500 (to spend on, for example, making a music video, vouchers for musical equipment, or music training sessions).

Have you or someone you know been affected by drug or alcohol addiction? Do you have a passion for making music and want to communicate your story? If so you can apply today.

Any support for the project is really appreciated; we need people to spread the word and we'd also be interested in speaking to anyone who'd like to partner with us for an even more ambitious Re:Cover in 2014.

To find out more about supporting, or applying to, the project, visit www.phoenix-futures.org.uk/recover or contact me at recover@phoenix-futures.org.uk.

Vicky Holdsworth, marketing officer, Phoenix Futures

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.

FAMILY MATTERS

VOICES OF STRENGTH

Adfam's Family Voices competition turns the darkest times into inspiration for other families, says **Joss Smith**

WHILE THE SUN IS STILL SHINING and we enjoy the rest of the summer at Adfam HQ, our thoughts have turned to chillier festive times as we start to plan our annual carol concert. Each year this event is lit up by the words of families who have lived through a loved one's addiction and entered our Family Voices competition. It always serves as a wonderful reminder of their strength and resilience to get through the dark times, but also in speaking out to share their stories.

Last year's winners aged from seven years to in their 60s, highlighting the huge impact drugs and alcohol can have across the whole life journey of family members. Our winner last year was a grandmother who shared the pain of seeing her grandson grow up with parents who use drugs.

MY GRANDSON

A tiny baby wrapped up so tight
Crying helpless through the night
What's wrong? He looks fine to me
But his pain is deep where we cannot see
A pain that was put there by his mummy
Because she took heroin while he was in her tummy
This tiny baby is growing up strong, looks around and thinks 'what's gone wrong'?
Why has my life been so sad when all I want is a mam and dad?
A mam and dad he needed most but instead he was passed from pillar to post
First his dad, then his mam, but he always had to go back to his gran
His gran was the one who held him tight, kept him safe through the night
But he knew this wasn't how things should be, why could one of them not see?
They tried and tried but all in vain to rid themselves of all the pain
One would duck one would dive one would run one would hide
One way out... they had to split to rid themselves of all of it
They did the thing they thought was right
But one won the battle... one lost the fight
Now 16 years and college bound that tiny baby won't look around
He's come through so much but he's not sad
Today he's happy... he lives with his DAD

If you would like to enter this year's competition you can find the details on our website or email your entry to carols@adfam.org.uk.

Joss Smith is director or policy and regional development at Adfam, www.adfam.org.uk

Life-saving knowledge

Launching our DDN good practice exchange, Natasha Bray **of the Wallich Community House Team in South Wales shares how she delivered a successful naloxone training initiative**

THE WALLICH COMMUNITY HOUSE is a unique homelessness project specifically for people with co-presenting mental health and substance use issues. We provide semi-independent supported accommodation for 33 service users across eight properties, and place an emphasis on harm reduction.

A key aspect of the *Working together to reduce harm strategy 2012* is the development of 'take-home' naloxone. After working with service users with dual diagnosis, I noticed there was very little motivation to attend the training despite initial interest. Very few service users had taken up the training in the 18 months I had worked at the project.

An initial survey revealed that one in four service users could not accurately describe what naloxone was. According to the non-fatal overdose questionnaire, 58 per cent of service users had experienced non-fatal overdose involving an opiate, with over 85 per cent of these accidental. Despite this, there were only three kits among current IV users in our eight project houses.

I developed a new initiative for engaging and training people with dual diagnosis in overdose awareness and naloxone. The purpose of this pilot was to make naloxone training more accessible in an attempt to increase safety in the project houses. It was also important to empower service users to be more responsible for reducing harms associated with substance use by increasing their knowledge and confidence in dealing with overdose. The aim was to have a minimum of one trained person and kit available in each house.

I started the initiative by using the Welsh Assembly Government naloxone poster campaign to raise awareness in the houses in the weeks before training started. However planning too far in advance or putting signs up with dates and times of training did not have as much success as talking to clients face to face and making arrangements to do training within the next couple of days. Groups consisted of between one and four service users, and training was offered in their own homes with refreshments provided.

The training was approximately 45 minutes to an hour, depending on group size, and consisted of a presentation adapted from the original training to make it more service user friendly. Emphasis was placed on overdose information, myths and risk factors, before discussing naloxone, practising injecting on an orange, a naloxone DVD, and a question and answer session on the important points to remember. The sessions concluded with further discussion of first aid, CARA and practising the recovery position.

I worked in partnership with Jo Simmons of the CAU to facilitate prescription of naloxone, so that each prescribed service user received two kits, one of which is kept in a communal area known to all other residents.

I also used the naloxone training as an opportunity to promote the Wallich in-project needle exchange and harm reduction advice. I took a portable 'needle exchange' selection with me and provided paraphernalia to those who needed it. This provided opportunities to intervene in any poor injecting practices, and promote foil and sterile water. It also created an opportunity to provide people living in the same accommodation with different colour 'nevershares' to reduce likelihood of accidental sharing among residents. The uptake of our needle exchange was previously quite low and has now increased significantly.

Forty per cent of clients took up the first training session offered in their shared accommodation and the feedback was good. Residents liked the fact the training was brought into their own homes and was more relaxed. Twelve service users were eligible for naloxone prescription, bringing the total to 15 trained service users with naloxone kits among the eight project houses, with a minimum of one trained person with a kit in each house (compared to only three kits in the eight houses previously). Three new staff members were also trained.

This form of intervention needs intense staff preparation, implementation and time. I would like to get all staff trained and involved in delivering the training in line with service user support plans, and make it part of the role of project workers within our team. I would also like to get service users involved in the delivery of training.

I conducted a questionnaire before and after to gauge knowledge and confidence in dealing with overdose, and it identified that all clients felt they had learnt something new. Knowledge in regard to recognising overdose and about naloxone had increased from 76 per cent to 90 per cent, and confidence in dealing with an overdose situation increased from 79 per cent to 93 per cent.

I think the approach is working for a number of reasons – I took an assertive approach and made the training more accessible and less formal by conducting it in clients' homes. I also made the training flexible and responsive to the needs to service users.

In the future, I would recommend regular weekly training sessions, especially if there is a high turnover of clients. Naloxone training should be discussed with service users during induction, as this pilot helped identify people at high risk of overdose and allowed for more intensive interventions.

Natasha Bray is a project worker at the Wallich Community House

If you have a bright idea or a successful initiative to share with other readers we'd love to hear from you. Please email DDNexchange@cjwellings.com

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

As the world's drug habit shows, governments are failing in their quest to monitor every London window box and Andean hillside for banned plants. But even that Sisyphean task looks easy next to the fight against synthetic drugs... The arguments for legalisation – that it protects consumers, shuts out criminals and saves money while raising tax – are familiar to readers of this newspaper. Yet it requires careful regulation to ensure that its outcome is not worse than widely ignored prohibition.
Economist editorial, 10 August

We may be approaching a tipping point. And yet, with unforgivable ignorance and myopia, our prime minister uttered the following words last year: 'We have a drugs policy that actually is working in Britain.' This is self-delusion, and beyond parody. For such vanities are children murdered, landscapes destroyed and whole cities run according to the whim of barons and barbarians.
Amol Rajan, *London Evening Standard*, 5 August

At the very least, the Home Office should hand over responsibility for drugs policy to the Department for Health. And if even that feels too risky, then start developing policy based on evidence rather than emotion.
Guardian editorial, 20 August

Barack Obama would be hard pressed to end the war on drugs before 2016, but his administration at least appears prepared to draw it down.
Tim Walker, *Independent*, 13 August

[Melissa Reid and Michaella McCollum Connolly, charged with drug smuggling in Peru] are young but so are many who die in gutters degraded by drugs, who suffer long term and unpleasant psychological problems as a result of substance misuse, who prostitute themselves or steal to maintain their habit, who sacrifice families and prospects upon the altar of cannabis, cocaine, ecstasy and heroin, who keep the dealers in business including those at the school gates.
Ann Widdecombe, *Express*, 21 August

If you hit hard times, the system will support you. But for Ed Miliband and those eyeballing benefits as a one-way ticket to easy street, I have a wake-up call for you: those days are over. Universal credit has started and the benefits cap roll-out is in its final stages. Together they will build a welfare state we can all, once again, be proud of.
Iain Duncan Smith, *Mail on Sunday*, 11 August

Politicians have saddled the NHS and other public services with impossible expectations. They promise perfection and, when it is not achieved, decide that more reorganisation, more competition, more centrally determined targets, more consumer choice and more private-sector input are required.
Peter Wilby, *Guardian*, 8 August

Not only do we drink at too high a level, we know that the nature of that drinking is also frequently damaging, with binge drinking still far too common. Meanwhile, attitudes to drinking to excess need to change, with less trivialisation, less jokey acceptance of hazardous drinking in peer groups and social settings.
Herald Scotland editorial, 20 August

Many employers, whose commitment to diversity and equality is otherwise impeccable, will simply not countenance hiring ex-offenders. They have become, if you like, the equivalent of HIV-Aids sufferers in the 1980s. And the discrimination they face is similarly illogical and misconceived.
Jocelyn Hillman, *Guardian*, 13 August

INTO THE MATRIX

Exploring *Findings'* new matrices opens up a vast resource of addiction treatment evidence that no practitioner should be without. Editor Mike Ashton **gives a guided tour**

The evidence base for addiction treatment is enormous, hard to encompass, and even harder to assess. Wouldn't it be great if we could somehow identify the major documents practitioners should read, even if they read nothing else? Just such a discussion took place in a sub-group of the Substance Misuse Skills Consortium (www.skillsconsortium.org.uk), the sector-led partnership that aims to develop the substance misuse treatment workforce in England. I participated as editor of the Drug and Alcohol Findings Effectiveness Bank site (http://findings.org.uk).

Findings had already constructed a matrix for the consortium, which mapped the evidence-base universe, though for a different purpose. Funded via the National Treatment Agency for Substance Misuse (now absorbed in Public Health England) *Findings* undertook to develop this framework into matrices, presenting the most important documents and resources for treatment practitioners and commissioners to understand the evidential basis for their work and to implement its most important lessons.

The level of ambition involved can hardly be overestimated. Despite the obvious need, no agency, no matter how well funded or expertly staffed, from multi-million dollar US government institutions to the European Union's drug centre or the UN's World Health Organization, had attempted such a project.

In Britain it could only be envisaged within a reasonable time frame and limited resources because for the past 16 years *Drug and Alcohol Findings* had been monitoring and collecting evaluation research, assessing the studies, and selecting and analysing those of greatest relevance to the UK. Along the way, seminal research had been identified and analysed in its own right (the Old Gold series in *Findings* magazine – see http://bit.ly/19MCk6l) and as the backdrop to understanding more recent work. Reviews were collected and read to help understand the significance of each individual study and guidance documents helped make sense of what they might mean for the UK.

This work had accumulated into the largest live drug and alcohol library in Britain, holding 17,000 documents relevant to the 'what works' agenda. The managing committee's experience in collating and disseminating information about addiction and its treatment preceded by decades the advent of *Findings* – in the case of the editor, back to 1975. With the groundwork already done, this ambitious superstructure could be constructed.

'The level of ambition involved can hardly be overestimated. Despite the obvious need, no agency, no matter how well funded or expertly staffed, had attempted such a project.'

In May 2013, the result was the Matrices – one for harm reduction and treatment of problems related to the use of illegal drugs (http://bit.ly/1ca1bA3), and one for brief interventions and treatment of alcohol-related problems (http://bit.ly/12aGdQd).

The best way to envisage them is of course to take a look. We liken them to a grid-map of territories in the alcohol and drug treatment worlds, segmented to reflect practical divisions in the delivery and organisation of services. Across the top are five columns, moving from the intervention itself (Is it feasible? Does it work? How does it work?) to the contexts within which interventions are implemented – by practitioners, who are managed and work

in organisations, which coalesce into whole treatment systems. All of these affect the treatment's feasibility and impacts – contexts variously of greatest interest to frontline staff, supervisors and managers, management committees and commissioners.

Intersecting the contexts down the side are five rows. Choose whether your interest is harm reduction (drugs only), brief interventions (alcohol only), cross-cutting treatment issues, medical treatments, psychosocial therapies, or criminal justice work.

For both drugs and alcohol, the result is a five-by-five grid totalling 25 cells. Within each cell are the major historical and contemporary research landmarks in that territory, reviews offering a panoramic view, expert guidance based on this research, and an option to explore beyond these dozen or so selected documents by searching the Drug and Alcohol Findings Effectiveness Bank. Each document entry can be clicked on to access the original document, either directly or via the Effectiveness Bank's analysis of the study.

Some cell territories have only rarely and partially been explored, while others are relatively well mapped. As well as signposting the achievements, the Matrices expose the gaps in the evidence base. Arrangements are being made to update the Matrices, probably on an annual basis, piggybacking on the work *Drug and Alcohol Findings* continues to do to identify and analyse documents for the Effectiveness Bank.

So what can you do with the Matrices? As a manager, they list the documents you could advise your new staff to read to help them understand the basis of addiction treatment, those you could commend to your existing staff to advance their professional development, as well as giving you practice-improvement clues from the world's leading researchers.

They will help practitioners understand the most important foundations of their work and how to build on them, and help commissioners appreciate the different ways they can influence effectiveness. Familiarity with these relatively few documents could be seen as an indicator of an important dimension of the quality of an organisation and its staff – an appreciation of the key evidence on which practice has been built and can be improved.

As Audrey Freshman, director of professional development and continuing education at Adelphi University, said: 'Wow – this is terrific stuff.' **DDN**

Mike Ashton is editor of Drug and Alcohol Findings (http://findings.org.uk), a national UK collaborative project involving the National Addiction Centre, DrugScope and Alcohol Concern and supported by Alcohol Research UK and the J Paul Getty Jr Charitable Trust.

Mike explains the Matrices' development at Lifeline's FEAD video bank: http://bit.ly/16JqzJu

An updated version of the presentation's slides is available at: http://bit.ly/17IxiMd. This drills down to one study in one cell of the Alcohol Matrix – a seminal study from the 1950s that demonstrates that such work still has considerable current relevance.

POLICY SCOPE

What is happening to the commissioning landscape and how will it affect us, asks Marcus Roberts

WHAT'S GOING ON?

WITH THE NEW COMMISSIONING STRUCTURES NOW STARTING TO KICK IN AT LOCAL LEVEL, what, if anything, do we know about the impact on drug and alcohol services?

Recent figures from the Department of Communities and Local Government (DCLG) suggest that investment in our sector may have risen slightly this year compared to 2012-13. The unappetisingly titled *Local authority revenue expenditure and financing: 2013-14* suggests that 37 per cent of the local public health budget is going into drug and alcohol services.

The figures are described, however, as 'the latest national statistics on budget estimates' rather than a record of the actual spend. At least one unitary authority is recorded as budgeting nothing on substance misuse, while others record surprisingly large rises. It is also unclear what significance the government attaches to this analysis. It appeared like a bolt from the blue without herald or fanfare (although DCLG is required to 'share' the findings with PHE which will 'review' them on behalf of the secretary of state for health).

DrugScope has also been dipping into joint health and wellbeing strategies emerging from health and wellbeing boards. We can report that some of them have more to say about drugs and/or alcohol than others. It's more difficult to know how to interprete this. It is a worry if key strategic documents are muted or silent on substance misuse. But some local areas could be developing their strategies to hone in on areas where they want to innovate or improve (or they could be developing separate strategies for particular types of service). From this perspective, a lack of reference to drug and alcohol services could be more a signal of broad satisfaction with local provision, than a mark of indifference. Again, it's hard to say.

We can also report that it is messier out there in local authorities than an organogram derived from national policy might lead one to expect – although I guess that is what one should expect from 'localism'. DrugScope has, for example, been in contact with the London boroughs to find out how their commissioning structures may be morphing post April 2013. Only three said drug and alcohol commissioning was now located in public health.

DrugScope is currently developing an 'observatory' as part of work with the Recovery Partnership to monitor what is happening in local areas. Perhaps the main message from our initial forays is that marshalling and analysing current resources can feel a bit like a combination of wrestling jelly and sitting a particularly vexing exam. Still, landmarks and signposts are beginning to emerge from the fog, and, hopefully, a clearer sense of what is happening will take shape in the months ahead. The truth is it may be 2014-15 (or the year after) before all the pieces fall into place and a full picture of the overall impact takes shape.

The DCLG statistics referred to in this column are at http://bit.ly/15uXGDH

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

'I think it's quite important that people in recovery are open about being in recovery. It's part of the agenda for tackling the stigma around both substance misuse and mental health... I've always been very open about my own recovery status.'

OPPORTUNITY KNOCKS

KCA chief executive Ryan Campbell talks to David Gilliver **about how services can take advantage of the new commissioning landscape**

'There's a great deal of potential for the sector to start to see ourselves as less of an isolated world of "we only do substance misuse interventions", and much more as a part of an overall health and wellbeing public service,' says Ryan Campbell, who took over as chief executive of KCA in April.

KCA provides mental health and troubled families services alongside its drug and alcohol work, and he believes there's enormous potential for organisations to make more of their skills and capabilities – against, of course, the backdrop of financial uncertainty. 'Most organisations in the sector are going through a process of change to adapt to the new commissioning arrangements and the new contract formats, and KCA, like everybody else, is working out where we fit into that new environment.'

The same features that made the KCA role attractive to him will, he hopes, make the organisation attractive to commissioners and communities, and KCA has been working on its new three-year strategy, which goes live next April. In the meantime, priorities are to work in partnership with other providers to meet 'more public health needs', as well as to support the professional and personal development of its own staff. 'One of the by-products of the contracting and retendering culture, mixed with financial constraints and uncertainty about the future, is that organisations have been under pressure to minimise their cost base, and that can sometimes threaten the amount of support and development they're able to give staff. But to support the health and wellbeing of our service users we need to be committed to the health and wellbeing of our own staff.'

The organisation remains unusual in providing both substance use and mental health services, and he's also chair of mental health charity Mind. Does he think there's enough support for people with a dual diagnosis? 'No I don't, and I actually take issue with the term "dual diagnosis",' he states. 'It's another form of compartmentalising people. Very few people fall into the technical definition of dual diagnosis – you tend to have to have very severe and entrenched needs in both substance misuse and mental health, and of course if you have entrenched needs in both of those areas the chances are you'll have some quite considerable needs in other areas too. So to parcel up a small number of people under the label "dual diagnosis" I find quite problematic.'

Is it limiting people's access to support? 'I think it certainly is,' he says. 'The other thing that limits access is that dual diagnosis tends to operate on the basis of different kinds of organisations coming together, so it's unusual for most mental health services to be delivered by a substance misuse provider, and vice versa. That means that a client who's got a range of needs – and they're not different facets of your situation – has to get those interventions from different organisations in what's often quite a complex series of pathways and protocols and strategic meetings. It isn't the best experience for the client or the most efficient way of delivering a service.'

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The recent Brighton and Hove drug commission recommended that adult and young peoples services be kept separate, so that young people get age-specific care and aren't in contact with older service users (*DDN*, May, page 5). As KCA does both, what's his take on that?

'At the moment [the services] are quite separate, although there's quite a considerable hinterland between the two,' he says. 'If we've got someone who's been in young persons' substance misuse services, to just say on their 16th or 18th or 24th birthday or whatever that they have to enter an adult service can be quite difficult, so we try to make sure there's access into both so they get the service that's most appropriate. I don't see any reason why those services can't be delivered under the same umbrella, but overall I'm very supportive of the idea that working with young people is a distinct specialism.'

One reason is that adults and young people tend to present at different stages, he says. 'Not many young people think of themselves – or should be thought of – as entrenched, serious drug users and to try to put a young person through a typical adult pathway just isn't appropriate. It's more about how they manage the risks in their lives and their own behaviour, and how they manage their substance use within that. That's quite a distinct specialism.'

He's been in the voluntary sector for more than 16 years and came to KCA after five years at RAPt, which he joined from Age Concern. But he also has personal experience of both mental health and addiction issues. 'I think it's quite important that people in recovery are open about being in recovery,' he says. 'It's part of the agenda for tackling the stigma around both substance misuse and mental health. The general population often get messages about substance misuse and mental health which are purely around chaos, harm caused to self and others, and which really don't focus on the recovery aspect. There are a lot more people in some form of recovery than there are in those chaotic phases, and I think it's really important that that's visible. I've always been very open about my own recovery status.'

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KCA has doubled in size in the last five years to employ around 450 people, and one of his ambitions is to be able to broaden the support it offers. 'I think we're missing a lot of opportunities to help people to the fuller path of recovery, so I'd like KCA to be seen as part of a health and wellbeing approach where we support people and families into full recovery, which isn't just isolated into 12 weeks of treatment and a little bit of aftercare.'

Another ambition is to continue to develop in 'what is quite a difficult environment with additional risks – as well as opportunities – around payment by results and all those sorts of things,' he states. He's previously said that one of the downsides of PbR was a growing culture of secretiveness – is that still the case? 'I think people are starting to open up a bit more but I think it's still a risk, and not just around payment by results – it's around the commercial confidentiality that enshrouds contract tendering in general,' he says. 'But it can be particularly prevalent in payment by results contracts.

'I've always worked in the voluntary sector, so I can remember in my days with Age Concern there was rivalry and competition for grant funding, but I would take it as a point of pride that if my organisation was doing something really well I wanted every other organisation to do it. Yes, I wanted us to get some credit for it, but I wanted everyone else to do it. Now my fear is that we've got this atmosphere where if your organisation is doing something well you keep how you do that a very closely guarded secret so that you can take someone else's contract off them in the next couple of years. That does worry me – that we've got a way of working that limits the dissemination of ideas, which has always been a strong feature of the voluntary sector.'

So is the risk that things will become even more cutthroat? 'I'm a born optimist, and I think things will get better,' he says. 'That's partly because no one wants to work in a system that's inefficient or unpleasant to work in, and where it has happened I believe it's been accidental.'

There are already signs of improvement, he feels. 'There was a time around three or four years ago, for instance, when no provider or commissioner would have an open discussion about whether wholesale re-tendering of services did or didn't add value, whereas that now seems to be a feature of discussion at conferences and policy forums and the like – people are actually examining what we're doing and asking whether it's good or bad.'

There's also a sense of regret in the sector about smaller organisations going under, he says. 'Sometimes that's the way of the world, but if happens as a by-product of a system then it's a tragic shame because it's difficult to build something like that back up. So we're now having open discussions around how we can protect the real jewels of the voluntary sector, who are sometimes quite small and unable to compete in a massive contract, payment by results world. I can really feel a movement to make sure that doesn't happen, and make sure we have a well-functioning system that puts the needs of our clients above the needs of our individual organisations.'

It's even possible that financial constraints could make that more likely, he believes. 'One big area of growth in the voluntary sector was in the 1970s when charities started to not be run in that parochial, slightly patronising hangover from the Victorian, "worthy poor" type way, and instead became more organised, grassroots organisations. That happened at a similar time of political uncertainty, severe financial uncertainty and poor outlook. There's something about a financial crisis or recession that brings out in the voluntary sector, and people as a whole, their will to work together and make the absolute best of the limited resources they've got.' **DDN**

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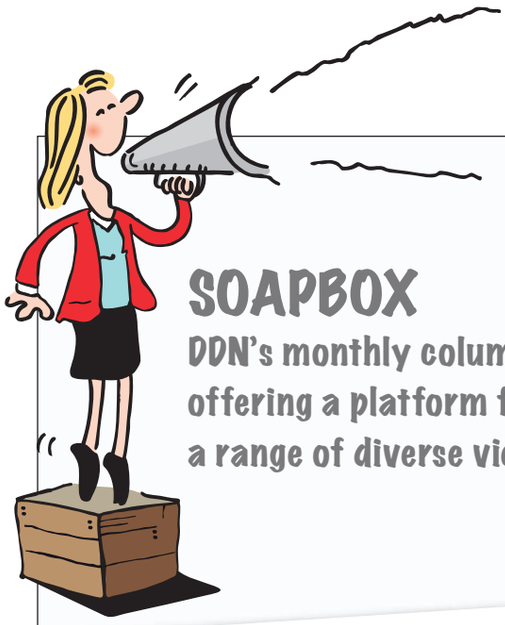

SOAPBOX

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

GET THEM YOUNG

It's time to overcome our paralysis on tackling young people's drug use, says Kate Iorpenda

ARTICLE 3 OF THE UN CONVENTION ON THE RIGHTS OF THE CHILD declares that in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. With this in mind, the issue of drug use among children – and in particular injecting drug use – is one that raises a number of ethical dilemmas and consequent heated debate among practitioners.

Perhaps it's because we find the reality of children and adolescents using drugs too difficult to face. Or perhaps it's because supporting young people to use drugs more safely seems irresponsible and contrary to the values of protecting children. Whatever the reason, the comprehensive services that are available to young people in some countries are not currently translating into service provision in poorer countries. In such contexts we need to be asking ourselves: have we consulted with young people to find out what they want and are we well enough informed about the types of drugs they take and their patterns of use? Otherwise we run the risk of being paralysed by the ethical dilemmas and conflicting values about what it might mean to be providing teenagers with clean needles.

Injecting drug use is a key driver of HIV epidemics in regions like Eastern Europe and Central and South East Asia, and the little available data we have indicates that in some countries children start injecting at a very young age. The lack of funding and attention to the needs of young people who use drugs has resulted in a situation where we lack concrete data on the extent of their drug use. However we do know that children with histories of abuse, mental health problems, and drug dependence in the family are among those at higher risk.

Adults have rights and choices about services and can be helped to seek other support – counselling, debt advice, housing – but with children there is a duty of care, and so service providers need to think both about safeguarding that duty of care and about how far it extends, given the complex and multiple needs of many young people who inject drugs.

Children and young people are often hidden within harm reduction services due to age restrictions and fears around asking and documenting age. In some countries, legal systems criminalise children as young as eight for drug use but deny them access to harm reduction services until they are 18. Additionally, service providers are often poorly prepared to work with young people, running programmes that don't meet their needs and which have been designed without their input.

What kind of system punishes a child for drug use by incarcerating them in an adult prison? So many rights are being denied while we make up our minds on such issues. We need to know so much more about young people and their drug use and to recognise the diversity involved: different ages, different contexts, different genders, different drugs. We have to find ways within existing legal frameworks, good or bad, to ensure that we listen and respond. We need to collectively challenge the systems that continue to deny young people access to evidence-based interventions because of their age, but we also need to go beyond global policies.

Instead we must face the problems head on and listen to young people, find the missing data, face the unpalatable truth about the extent of their drug use and the systems that violate their rights. We need to confront uncomfortable choices to ensure that young people have access to information and services that they need and respect, and to support and protect their ability to make decisions. Easy to say and so much harder to do, but we are going nowhere unless we get over our paralysis.

Kate Iorpenda is senior advisor on children and impact mitigation at the International HIV/AIDS Alliance, www.aidsalliance.org

The International HIV/AIDS Alliance is supporting the Support. Don't Punish campaign (supportdontpunish.org) which calls on governments to bring an end to the criminalisation and punishment of people who use drugs.

Families First

The 2nd Adfam/DDN family conference



Adfam
Families, drugs and alcohol

DDN
Drink and Drugs News

Putting families at the centre of recovery

How can we support families to cope with the many facets of their loved ones' addiction?

The Families First conference brings together family members, treatment and support professionals and those who are willing to share their expertise from experience to create a highly valuable one-day event.

Through a programme steered by premier family support charity Adfam, it will offer inspiring examples of ongoing support, effective coping mechanisms, useful legal knowledge, and essential networking.

Invited speakers include: **Nick Barton**, CEO of Action on Addiction • **Anna Soubry**, public health minister • **Lindsay Henderson**, from social enterprise First Contact Clinical • **Sheila Hancock**, actress and author of *Two of Us*, her memoir detailing her marriage to actor John Thaw and the struggles with his alcoholism.

This is the annual must-attend event for family members affected by substance use and for all agencies and organisations who genuinely want to support them.

EARLY BIRD DELEGATE RATES for bookings before Friday 20 September

Family members £80 + vat
Professionals £135 + vat

JOINT TICKET SPECIAL OFFER: One family member plus one professional – £195 + vat (save £20)
(An additional £10 will be added to bookings made after 20 Sept)

Full programme and online booking at
www.drinkanddrugsnews.com
e: conferences@cjwellings.com
t: 01233 633 315

Thursday, 21 November 2013
BIRMINGHAM

Expressions of interest

OXFORDSHIRE COUNTY COUNCIL

FRAMEWORK FOR THE PROVISION OF RESIDENTIAL DETOXIFICATION AND/OR RESIDENTIAL REHABILITATION FOR ADULTS WITH PROBLEMATIC SUBSTANCE MISUSE

Oxfordshire County Council (CPU786)

Oxfordshire County Council Public Health Directorate are seeking expressions of interest from organisations interested in joining a Framework for the provision of Residential Detoxification and/or Residential Rehabilitation for adults with problematic substance misuse.

Oxfordshire make approximately 25 residential detoxification and 100 residential rehabilitation placements per year, the majority of which are placed with providers who sit on our current framework that was tendered in 2010; only exceptional placements are made outside of this agreement.

The intention is to procure a new framework and commission in the region of between 10-20 providers to sit on the Oxfordshire Framework. We intend to procure a range of services offering different philosophies and treatment types. It is expected that the Framework will commence on 1 May 2014, and will be for a period of 4 years.

The majority of our annual placement budget, which is currently in the region of £850,000 per annum (but may be subject to reductions), will be spent on individual placements from this framework list, which will include facilities for male and female only placements, people on Probation orders, people with learning disabilities and people with more complex physical or mental health needs. Details of the form of Framework, Call Off procedure and Individual Contract will be available as an attachment on the business portal below at the invitation to tender stage of the procurement currently scheduled for 18 October 2013.

The Framework will include service providers who can offer one, two, three or all of the following placement stages:

- *Residential detoxification only (as a standalone treatment option);*
- *Residential detoxification, as preparation for residential rehabilitation;*
- *Residential rehabilitation stage one;*
- *Residential rehabilitation stage two.*

We do not fund placements that total 26 weeks or more for all stages.

Our tender process will be conducted under a two stage procedure. Oxfordshire County Council will not be bound to award any contract under this tender process.

To express an interest please register on the southeast business portal **www.businessportal.southeastiep.gov.uk** then submit via the "express an interest" function. The Pre-Qualification Questionnaire will be available on the portal from **28 August 2013**.

The closing date for completed pre-qualification questionnaires is 12 noon on 30 September 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 please contact: Helen Wake, email: helen.wake@oxfordshire.gov.uk

INVESTORS IN PEOPLE

SMHS
St Martins Healthcare Services CIC

Providing NHS services

Exciting opportunities for Medics and NMPs to work in Substance Misuse

We have exciting opportunities in a growing Community Interest Company, delivering high-quality, service user centred, innovative substance misuse services in the North of England. We are interested in hearing from individuals seeking opportunities in this specialist field and with our excellent record of supporting staff in their personal development, this could be the opportunity for you to learn new skills and progress your career. The following vacancies are currently available:

CLINICAL DEVELOPMENT DIRECTOR

(GP or senior NMP, Half to full time)

To support the Executive Clinical Director in development, implementation and delivery of new and existing clinical services. This is a post which requires experience in service development and management.

GP SPECIALIST PRESCRIBER (Hull)

(Minimum 1 session per week, up to Half time)

To deliver drug and alcohol prescribing services within our Hull service – training is available.

GP SPECIALIST PRESCRIBER (Hull)

(Maternity Leave cover – Minimum 1 day per week, up to Half time, initially for 9 months)

To deliver drug and alcohol prescribing services in our Hull service.

LOCUM GPS AND NMP (Leeds, Hull, Bolton)

We have regular sessions available for those wishing to deliver temporary, locum services. Training is also available for locum posts.

Closing date: 27 September 2013
For further details or to receive an application pack please contact Emma Haigh on 0113 244 4102 or email: ehaigh@nhs.net

Birmingham City Council

MARKET DAY

Birmingham Drug and Alcohol Treatment Services

Birmingham City Council intends to re commission all of their adult drug and alcohol treatment services with new contracts being issued during mid-2014.

As part of this process we would like to invite suitably qualified and experienced organisations to a market day event to share the vision for the future alcohol and drug treatment and recovery services in the city and the procurement process it plans to adopt.

The market day will take place on **Monday 11th November 2013** from 9am-1pm. If you are interested in attending, please email **Priscilla.brown@birmingham.gov.uk** for further details.

A formal public consultation of the proposed commissioning intentions is now running until 26th September 2013. Consultation documents which inform the market day can be seen on

https://www.birminghambeheard.org.uk/

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You will be working in a busy team, managing a caseload of clients and running workshops - both CBT and 12-Step.

You will need to have a thorough understanding of 12-Step treatment and be able to deliver therapeutic interventions.

We will consider applications from candidates with a nursing or criminal justice background, and from those in recovery themselves.

We are extremely proud of our evidence based services, which reduce reoffending and change lives.

If you would like to join our team and become part of our success, please contact our recruitment manager Kate Summers for more information

recruitment@rapt.org.uk

Excellent salary and benefits offered. For more details about us, please check out our website: **www.rapt.org.uk**

INVESTORS IN PEOPLE

Wiltshire Council
Where everybody matters

Wiltshire Assembly Community Safety Partnership

EXPRESSIONS OF INTEREST

SUBSTANCE MISUSE RESIDENTIAL PLACEMENT FRAMEWORK – DCS0620

The Wiltshire Community Safety Partnership is looking to commission a Framework for Substance Misuse Residential Placements and is inviting expressions of interest from suitably experienced and qualified organisations who wish to be included on this Framework.

Contracts will be awarded to the successful organisations for a period of three years, commencing 1st April 2014.

Providers should register their expressions of interest no later than **17:00 on Friday 20th September 2013** via an electronic tendering system through the ProContract portal, by registering with Supplying South West using the link **www.supplyingthesouthwest.org.uk**.

If you have any queries please contact **emma.wootton@wiltshire.gov.uk**.

EXPRESSIONS OF INTEREST

safe & sound
Dudley's Community Safety Partnership

On Behalf of Dudley Metropolitan Borough Council

Safe and Sound, Dudley's Community Safety Partnership, invite expressions of interest to tender for the provision of Drug and Alcohol Services in the Dudley Borough

Dudley's Community Safety Partnership is seeking expressions of interest from suitably experienced and qualified organisations to deliver the following services in the borough of Dudley.

A) Integrated Adult Substance Misuse Service
B) Substance Misuse Clinical Interventions
C) Young Person's Tier 3 Substance Misuse Service

The funding available for all three specifications is in the region of £3,200,000

The services will be delivered from 1st April 2014 until 31st March 2017 with an option to extend subject to satisfactory performance and service delivery.

Prospective providers are invited to tender for all three services, a single service or combination of services. Commissioners will also welcome consortium tenders from interested providers.

Expressions of interest are sought from suitably qualified organisations that can demonstrate knowledge and ability to deliver high quality substance misuse services.

The successful applicant will be required to work with other providers and partners in the borough as part of a commissioned integrated treatment system, and contribute to the continued development of this treatment system.

Closing date for receipt of completed tenders will be 12 noon 7th October 2013.
It is expected that interviews will take place week commencing 11th November 2013.

This exercise is being conducted in electronic format (e-tender).
If you wish to take part please register with Dudley MBC e-tendering website ***https://www.blackcountrybusiness.co.uk***

δelphi

Raising the Standard

Delphi Medical are the leading independent provider of drug and alcohol medical treatment in the North West, bringing to the third sector the required clinical expertise, governance and medical staff to meet and exceed standards in the field of substance misuse. Our approach is grounded in the values of creativity, accountability, consistency, accessibility, patient centeredness and sustainability – values reinforced by a commitment to raising the standard of substance misuse treatment throughout the UK.

As a GP led private and independent healthcare organisation we combine lots of valuable NHS experience with the required clinical expertise, governance and medical staff to meet and exceed the standards set by NHS bodies in the field of substance misuse treatment. This enables us to deliver flexible and innovative treatment solutions that provide a real expectation for recovery.

Our aim is not just to raise the standard of our work but to inspire those we work with to better achieve their potential. This is our 'noble cause' and we strongly believe that this crystallises our strengths as an organisation.

LEAD CLINICIAN
(SUBSTANCE MISUSE)
GENERAL PRACTITIONER
(PRISON HEALTHCARE)

Salary negotiable dependent upon experience – pension provided
37.5 hours per week over 5 days (Monday to Friday)

We have two exciting opportunities to join the team at Delphi.
The Lead Clinician will provide strategic clinical leadership across our prison and community substance misuse services across the North West and Midlands. The General Practitioner will deliver prison healthcare treatment across the North Lancashire prison establishments and other potential sites. We are willing to consider applications for full, part time and sessional work for our GP post. Full time applicants are preferred for the Lead Clinician role.

The successful candidates will be responsible for implementing, developing, managing and leading on the medical aspects of delivery across our services, which include general practice, medically assisted withdrawal, detoxification and stabilisation and reduction programmes. Working closely with our experienced management team, including clinical staff, doctors and non-medical prescribers, they will be role models responsible for driving forward change and shaping service delivery and clinical excellence.

The Lead Clinician role will require at least five years experience in delivering substance misuse treatment or within general practice. They will deliver specialist substance misuse training and be experienced in carrying out research projects. Communication skills are vital in particular in developing strong working relationships with staff, stakeholders and commissioners. Qualification to RCGP Part 2 Certificate in the Management of Substance Misuse in General Practice or equivalent is preferred.

GP applicants with prison or substance misuse treatment experience will be preferred. Part 1 RCGP Management of Substance Misuse certificate is required, however for suitable applicants training towards RCGP Part 2 Certification will be supported.

Working effectively with the Clinical Managers they will ensure service outcomes are delivered in line with contractual requirements.

Current and full registration with General Medical Council is essential as well as full UK JCPTGP certification of completion of training in general practice OR MRCPsych.

If you are interested in these opportunities, please forward your expression of interest by email to *suzy.knowles@delphimedical.co.uk* no later than Tuesday 10 September 2013.

Delphi are proud of their core values; Creative and Accountable, Consistent and Accessible, Patient Centred and Sustainable. We value Loyalty and Integrity.

Successful candidates will be subject to an enhanced CRB check and prison clearance
Delphi Medical Consultants are an equal opportunities employer

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Practice Manager

£40,108 - £43,835
Permanent – Countywide
Reference number: ASC 3014

Practice Manager Drug and Alcohol Use Disorders: Assessment and Care Management – Local Area Single Assessment and Referral Service (LASAR)

East Sussex is recommissioning its services for adults with drug or alcohol use disorders into an assessment and care management service (LASAR) and a separately managed drug and alcohol recovery service (DARS). Both will have a clear recovery based focus. The LASAR is to be developed and managed within Adult Social Care and will be operational by 1st April 2014.

The aim of the LASAR is to rapidly engage people in effective structured treatment which enables them to recover. The LASAR will assess suitability for treatment, assign a complexity tariff and develop initial recovery plans and broker access to appropriate treatment pathways including residential rehabilitation. The care management role will enable the team to review treatments, validate outcomes and discharges and promote a safeguarding adults at risk role, as well as support for carers.

There will be a high degree of integration between LASAR and DARS with staff co-located and functioning together. The managers of the services are expected to work collaboratively and to have close service links with a range of agencies.

This is an opportunity to take a key role in setting up this exciting new development and to monitor and shape the service as needed. You will be managing a multi-disciplinary team based on different sites across the county. The post requires strong decisive leadership and a focus on performance, alongside excellent communication and networking skills. You will need to demonstrate a commitment to close collaborative working with the DARS, a focus on and culture of recovery based practice and high standards of safeguarding practice.

For an informal discussion, please contact, Madeleine Iddison, on **01424 726601**.

To apply for this post please visit **www.eastsussex.gov.uk/jobs**

Closing date: 22nd September 2013.

POSITIVE ABOUT DISABLED PEOPLE

East Sussex County Council

TENDER OPPORTUNITY

POLICE AND CRIME COMMISSIONER FOR AVON AND SOMERSET

AVON AND SOMERSET ARREST INTERVENTION REFERRAL SERVICE

The newly appointed Police & Crime Commissioner has now set out local Police and Crime priorities in the Police and Crime Plan to take effect from 1st April 2013 and this has set the strategic priorities across Avon & Somerset. In addition 2014 will see the implementation across Avon &Somerset of a major restructure in custodial suite provision which radically alters the custody profile.

In line with these changes an exciting and visionary opportunity has arisen for a supplier to deliver the Avon & Somerset wide Arrest Intervention Referral service from 1st April 2014, across the four new custody suites located at Patchway near Bristol, Keynsham near Bristol, Bridgwater and Yeovil. This new model will seek to offer core arrest referral services to those suffering from drug and alcohol misuse and will be designed to build on the success of previous models and must help to provide seamless care throughout the criminal justice system into recovery and beyond.

The service will retain much of the effective practice which has been recognised during the last 10 years and build upon current expertise. The service will be delivered 7 days per week at the four new custody suites, using extended operating hours to ensure the maximum number of potential clients are engaged. It will ensure brief interventions are available, ensure rapid referrals into community and custody services, identify clients whom may be suitable for community orders, work in partnership with Impact teams and work alongside custodial clinical, mental health and Young Peoples services.

The successful supplier will recognise the need for more effective information and data management including tracking clients through the journey from Police custody into local drug services and will offer specialism in implementing dedicated care pathways for Integrated Offender Management Unit (Impact) cases and the identification of detainees suitable for statutory orders such as DRR's and ATR's. The successful supplier will also have experience in managing hard to reach groups such as mental health, victims of DV and Black and Minority Ethnic communities.

The full tender notice has been placed on the Official Journal of the European Union (OJEU).

To view the tender notice and further details of how to participate in the tendering exercise please log onto the following website:

https://www.bluelight.gov.uk
Reference Number: CONTRACT-QTLE-8YBB4T

Please note the deadline for submission of a Pre-Qualification Questionnaire under this tendering exercise is midday on 30th September 2013.

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