INSIDE – THE ESSENTIAL TRAINING DIRECTORY

DDN
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'Ketamine knocks out the conscious mind and with it a person's capacity to problem-solve, and this can reduce people's ability to find their way out of dependent use.'

LIVING IN DREAMS

MANAGING THE REALITIES – THE STORY OF KETAMINE

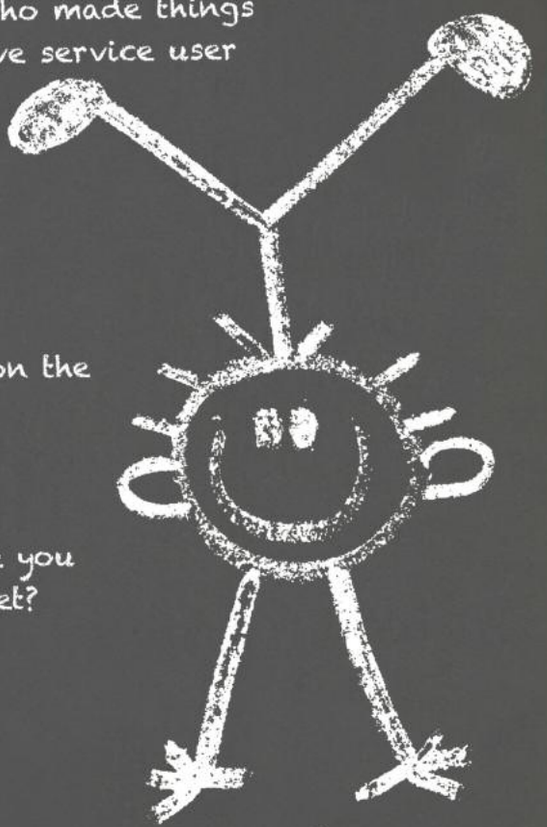
SAVE THE DATE!

Q: Where will you be on Thursday 20 February 2014?

A: At the national service user involvement conference with friends and colleagues from all over the country.

Q: What will you do there?

A: Challenge unfair policy. Make sure of my right to fair treatment. Get inspired by activists who made things happen. Learn from fantastic proactive service user and recovery groups from all over the country. Network like I've never networked before. Have the most amazing day of the year.



Q: Why should I be there?

A: Because I'd hate to see you miss out on the conference that shapes our future.

Q: What will be on the programme?

A: Everything that's important to us. Have you joined the programme consultation yet? Fill in the quick survey at www.drinkanddrugsnews.com/SU14 by Friday 29 November to help shape the conference you want.

DDN 7th service user involvement conference
Thursday 20 February 2014, Birmingham

MAKE IT HAPPEN!

DDN
Drink and Drugs News

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Crossover challenge

Public health meets public order

'The story of ketamine is a powerful illustration of the risks of abandoning a public health response and limiting drug policy to crime reduction,' say our cover story authors on page 8. Their article helps to redress this, suggesting an empathic approach to people who use this drug and seeking to provide an appropriate route to harm reduction.

Another important public health response is featured on page 18, where Ingrid van Beek talks about Sydney's medically supervised injecting centre. Ingrid calls the project 'a textbook example of engaging vulnerable groups and the broader communities in which they live to produce a strong public health outcome, while also addressing public order concerns at the local level.' As we go to press, Durham police and crime commissioner Ron Hogg appeared on the BBC news backing consumption rooms in the UK as a logical step towards taking drugs off the streets and reducing crime. Are we starting to see some crossover in the UK between public health and public order?

Finally, DDN is nine years old this issue! We hope we're still engaging you with a diverse and challenging menu of news, features and opinion. Help us into our tenth year by letting us know what you think!

This issue

FEATURES

REGULARS

NEWS IN BRIEF

COCA REVIEW

A report commissioned by the All-Party Parliamentary Group for Drug Policy Reform is calling for a review of the illegal status of the coca leaf under the UN along with proper exploration of the potential medical and economic benefits of the crop. 'One of the most cruel consequences of the "war on drugs" has been its impact on the lives of coca growers in South America,' said group chair Baroness Meacher. 'The illegality of coca leaf under the UN conventions has stifled research into the potential for coca leaf farmers to earn a legitimate livelihood from their produce.' *Coca leaf: a political dilemma? at www.undrugcontrol.info*

SHOULDERING RESPONSIBILITY

A breakdown of the roles and responsibilities of directors of public health has been produced by the Department of Health's public health policy and strategy unit. 'Local authorities must take the action that they decide is appropriate to improve the health of the people in their areas – it is not the job of central government to look over their shoulders and offer unnecessary advice,' says *Directors of public health in local government: roles, responsibilities and context. Available at www.gov.uk/government/publications/directors-of-public-health-role-in-local-authorities*

AGING DEBATE

There is still a gap between alcohol age limits in Europe and the age 'that is advised from a medical point of view', as brain development continues until the mid-twenties, according to a new EU study. Most EU countries have an age limit of 18, although a few have 16 or 17 and three use an age limit of 20 for stronger drinks. *Eyes on ages: a research on alcohol age limit policies in European member states* collects good practice and relevant priorities from across the continent. *Available at ec.europa.eu*

EXPLORING OPTIONS

Public Health England should develop a youth social marketing programme to 'engage young people around exploratory behaviours' such as alcohol and drugs, according to the chief medical officer's annual report Our children deserve better: prevention pays. The report uses 'exploratory' rather than 'risky' behaviours 'in order to be fair and destigmatise'. *Document at www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays*

EDGY DRAMA

The Outside Edge Theatre Company has set up a new drama group for women in recovery. The group will meet every Friday afternoon from 15 November at North Westminster Drug Project in London, and attendance is free. *For more information email cathy@edgetc.org*

Hepatitis C 'grossly under-prioritised', warns charity

Just 3 per cent of people infected with hepatitis C are treated each year, despite it being curable, says a new report from the Hepatitis C Trust.

The virus is 'grossly under-prioritised' by health services, warns *The uncomfortable truth: hepatitis C in England*. Half of the estimated 160,000 people living with hepatitis C remain undiagnosed, it says, with up to £22m spent on emergency hospital admissions for 'potentially avoidable' complications in 2010-11 alone. Deaths and admissions for hepatitis C-related end-stage liver disease and liver cancer, meanwhile, have almost quadrupled in the last 15 years.

As the virus affects 'the poorest in society' the trust is calling for it to be made a major health inequalities issue by Public Health England, local authorities, the NHS and commissioning groups, with measures to encourage case finding by drug services, prisons, GPs and councils. Earlier this year the charity warned that just a quarter of local authorities were aware of how many people in their area had the virus (*DDN*, April, page 5). 'Has [hepatitis C] been ignored and under-prioritised because most of the people living with, and dying from, the virus are from the most marginalised, vulnerable, deprived groups of society?' says the document.

The charity also wants to see 'improved access to sterile drugs paraphernalia' and action to step up the treatment of current injecting drug users to 'reduce the pool of infection', while more public awareness work is also needed to reduce stigma and encourage testing. Other recommendations include that peer-to-peer awareness and support programmes be made available in all drug treatment centres, 'opt-out' testing be introduced in all prisons and that local referral pathways and support mechanisms are developed to 'ensure that everyone who is diagnosed is successfully referred to specialist care'. The government is still to publish its national liver strategy, four years after it was promised, the report adds.

'There must be no more excuses for the rising tide of deaths from hepatitis C,' said the trust's chief executive, Charles Gore. 'It is a preventable and curable virus, yet huge numbers of people still remain undiagnosed and a mere 3 per cent of patients are receiving treatment each year.' Instead of allowing the virus to 'continue to take the lives of the poorest fastest' it could be effectively eradicated in England within a generation, he stated. 'To do this we must diagnose and offer care to everyone, regardless of their geographical location or background.'

See news focus, page 6

Disadvantaged young 'a public health time bomb'

The UK's high level of young people not in employment, education or training (NEETs) – particularly the long-term unemployed – constitutes a 'public health time bomb waiting to explode', according to the chair of a major review of Europe-wide health inequalities, Sir Michael Marmot.

The World Health Organization and ICL Institute of Health Equality (IHE) review calls for action to address the immediate causes of inequity within and between countries, including alcohol consumption. 'Effective strategies go beyond providing information and include taxation and regulation,' says *The review of social determinants and the health divide in the WHO European region*.

'We are failing too many of our children, women and young people on a grand scale,' said Marmot. 'I would say to any government that cares about the health of its population: look at the impact of their policies on the lives people are able to lead and, more importantly, at the impact on inequality. Health inequality, arising from social and economic inequalities, are socially unjust, unnecessary, and avoidable, and it offends against the human right to health.'

Report available at www.euro.who.int

SPEAKING OUT: The recent *Feminism in London* conference featured art created by women who had been through substance use, pornography and other difficult situations. 'Wandering along the corridor of a substance misuse treatment centre, I noticed the incredible art work on the walls,' said conference project manager Lisa-Marie Taylor. 'The pictures were the most powerful I had seen.' Inspired, she arranged for a selection of artworks to be displayed at the conference and for the artists to attend. 'I hope that they realise what a valuable contribution they made to the day,' she said. 'Hundreds of people saw their portrayals of addiction – the raw painful truth of substance misuse, and the hope of recovery.' *www.feminisminlondon.co.uk*

PHE: alcohol treatment 'performing well overall'

The treatment system for alcohol dependence among adults in England is 'performing well overall', with increasing numbers of people accessing and completing treatment, according to Public Health England (PHE).

There are around 110,000 people in specialist alcohol treatment, although it is 'vital to continue to widen the availability and accessibility' of support, says PHE. Approximately 1.6m people are estimated to have some level of alcohol dependence, with roughly 250,000 thought to be moderately or severely dependent and in need of intensive treatment.

Most people seeking treatment are in the 30-54 age range, with a total of 109,683 people treated in 2012-13, up from 108,906 the previous year. Almost 76,000 were new clients and 58 per cent successfully completed their treatment, says PHE.

It was vital that treatment was easily accessible, said PHE's director of alcohol and drugs, Rosanna O'Connor, with the full range of NICE-recommended options available and services 'properly joined up with the NHS and other partners, including mutual aid groups. Prevention is better than cure, and PHE is working to support a range of initiatives,' she said. These included better identification of those at risk, improvements in hospital-based alcohol services and use of local health information by councils to inform licensing decisions.

Meanwhile the Irish government has committed itself to minimum unit pricing in its forthcoming Public Health (Alcohol) Bill, along with measures to toughen regulation of marketing and sponsorship. It will also consult with the Northern Irish authorities to make sure there are no significant differences in pricing structure over the border. The British government shelved its plans to introduce minimum pricing earlier this year (*DDN*, May, page 4).

'Alcohol misuse in Ireland is a serious problem with two thousand of our hospital beds occupied each night by people with alcohol-related illness or injury,' said Irish health minister Dr James Reilly. 'The average Irish person over the age of 15 is consuming the equivalent of a bottle of vodka a week. The government is committed to tackling these problems and this week's decision marks a significant further step in that direction to create an environment where responsible consumption of alcohol is the norm.'

'The average Irish person over the age of 15 is consuming the equivalent of a bottle of vodka a week.'
Dr James Reilly

Recent research by Drinkaware found that almost half of 10 to 14-year-olds had seen their parents drunk, the charity has announced. 'While setting rules about alcohol and speaking to children about the risks is a positive step, equally important is that parents understand their significant influence as role models and feel confident to set a good example,' said chief executive Elaine Hindal.

Alcohol treatment figures at www.nta.nhs.uk/statistics.aspx

Government announces new drug powers as Baker replaces Browne

The government is creating new powers to seize chemicals suspected of being used as cutting agents for illegal drugs, as part of its *Serious and organised crime strategy*. The move will 'drive up the cost and risk for organised criminals', it says.

Other measures set out in the strategy include doubling the size of HMRC's criminal taxes unit – which uses tax interventions to 'attack the finances' of people involved in drug trafficking and other offences – and moves to increase pubic recognition of offences, with the document citing a recent Home Office-funded 'crimestoppers' awareness-raising campaign on cannabis cultivation that led to a 25 per cent increase in public reporting. There will also be more use of intervention programmes around gangs and troubled families.

The document states that, although drug use is falling in the UK, the country's illegal drugs market is still worth around £3.7bn a year and is 'controlled by organised crime'. The strategy 'focuses on preventing people from getting involved in organised crime, improving Britain's protection against serious and organised criminality and ensuring communities, victims and witnesses are supported when serious and organised crimes occur', the government says.

Meanwhile, Norman Baker has replaced Jeremy Browne as crime prevention minister in a government reshuffle. His responsibilities will include the drugs strategy, alcohol – including the Licensing Act and police and local authority powers – public health, domestic violence and homelessness. The appointment is a controversial one, in part because Baker is the author of a book arguing that the verdict of suicide in the death of former weapons inspector Dr David Kelly was 'not credible'. Elsewhere, Jane Ellison has taken over as public health minister from Anna Soubry.

Serious and organised crime strategy at www.gov.uk

NEWS IN BRIEF

BRINK BREAKTHROUGH

Jacquie Johnston-Lynch, founder of groundbreaking dry bar The Brink in Liverpool (*DDN*, December 2011, page 12), has been named Lloyds Bank social entrepreneur of the year. The award comes with a £10,000 prize, which will be put towards training for staff in early recovery, refurbishment and a new marketing campaign for the venue. 'Winning this award is such a huge validation of all the hard work of every single staff member of The Brink,' she said. 'It recognises the transformation we are making in a city that was previously known for its high levels of binge drinking and drug taking. And it is also an acknowledgement to all those miraculous people who have literally "come back from the brink" in their own personal lives.'

RECOVERY ROCKS

An alcohol-free evening of live music is taking place at The Bodega in Nottingham on 22 November, presented by Double Impact and SCUF. Money raised at Recovery Rocks will go towards providing sleeping bags for homeless people during the winter months and the establishment of Sobar, an alcohol-free venue due to open early next year. *Details and tickets at www.alt-tickets.co.uk, or contact Double Impact on 0115 824 0366*

WOULD YOU CREDIT IT?

A new universal credit factsheet has been produced by DrugScope and the Recovery Partnership, setting out key issues that services and professionals supporting people with drug or alcohol use may want to consider, including eligibility, making a claim and the 'claimant commitment'. The government says it is committed to delivering universal credit – which has been dogged by controversy and IT problems (*DDN*, October, page 4) – across the country by 2017. *Available at www.drugscope.org.uk*

MONEY MATTERS

A new one-to-one money advice service for clients has been launched by Swanswell, in partnership with the Severn Trent Trust Fund. 'Some of the people using our services have been particularly affected by the recent welfare reforms, so we felt it was really important to offer more support around managing debts and budgeting,' said regional development manager David Lewis.

VINTAGE VOLUNTEERS

A range of refurbished original furniture pieces from the 1950s-'70s has been launched by social enterprise RE:SOURCE, in partnership with Addaction. The RE:SOURCE Vintage range has been restored by volunteers and is available at www.resourcevintage.org.uk, with profits going towards further training.

WHY ISN'T MORE BEING DONE TO TACKLE HEP C?

A new report is calling for hepatitis C to be prioritised as a major health inequalities issue by Public Health England, the NHS and local authorities. ***DDN*** reports

Although hepatitis C is a curable virus, just three per cent of those infected are treated each year in England, according to a new report from the Hepatitis C Trust (see news, page 4).

This has led not only to vastly expensive emergency hospital admissions for potentially avoidable complications, says *The uncomfortable truth: hepatitis C in England*, but an almost fourfold increase in deaths and admissions for hepatitis C-related end-stage liver disease and liver cancer in the last 15 years.

Around half of the people in England who inject drugs are infected with hepatitis C and access to sterile injecting equipment is vital, says the document, as is 'treatment as prevention' – treating people to reduce the likelihood of future transmissions. The report also explicitly refutes the assumption that drug users' lifestyles are too chaotic for them to adhere to treatment programmes.

'That's not the evidence,' Hepatitis C Trust chief executive Charles Gore tells *DDN*. 'People keep asking the wrong questions – instead of asking, "can we give these people treatment?" they should be asking, "how can we give these people treatment?" If you ask that, you find a way – it's really not that difficult. People can adhere to treatment as long as you arrange it so that it's convenient. There are undoubtedly some people whose lives are too chaotic, but there are people who aren't using drugs whose lives are too chaotic – in the middle of an incredibly messy divorce, say. It should be assessed in exactly the same way.'

One major problem is the huge variations in service provision – and waiting lists – across the country, he points out, alongside variations in who will actually treat drug users, 'or indeed substance users – I heard in the last few days about somewhere where they were insisting on people being abstinent from alcohol for six months before treatment, which is ridiculous,' he says. 'In other parts of the country people are very unconcerned about that – it's "are you ready for treatment, can we support you properly?"'

The trust published a report earlier this year that said local authorities weren't ready to take responsibility for hepatitis C, with only a quarter actually having any figures on how many people were infected in their area (*DDN*, April, page 5). Has there been any improvement on that front? 'We haven't done a follow-up yet, but anecdotally I'm not at all sure that they've completely got their heads around public health,' he states. 'On a more positive note, I do think that Public Health England are definitely getting themselves in order and they do seem to understand that hepatitis C needs to be a priority – they're certainly looking to really improve things in prisons, for example.'

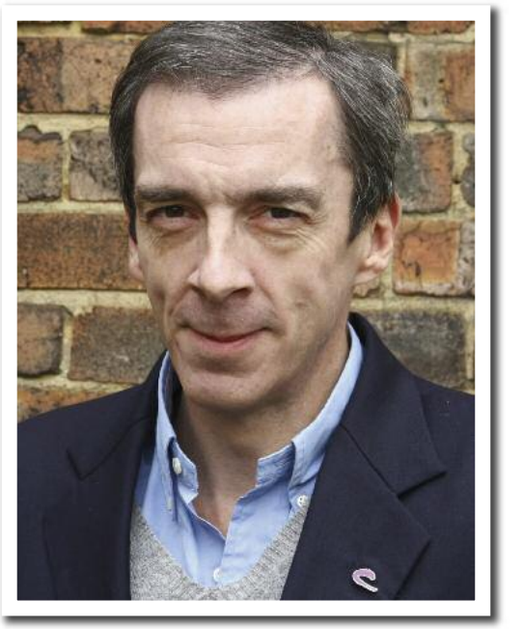
When it comes to drug services, the report calls on them to establish peer support programmes and encourage testing, among other measures – does he think that hepatitis C is enough of a priority for them? 'No, and too many make assumptions about people's readiness and priorities. Everyone they come into contact with should be tested for hepatitis C. Then they should be referred, and it's not up to a drugs worker to take a decision about somebody's readiness – and more importantly, their need – for treatment. How do you know they don't have cirrhosis? It's not enough to say "they've got other priorities" – their priorities might change if they're told, "if you don't do treatment now you're not going to be able to do it, and you're going to be looking at a liver transplant". It's about testing, then it's about referral, then it's about supporting people into referral.'

Given that many people with a substance use history have not always 'been treated so fantastically well' in hospital they may not necessarily be inclined to go, he says, and may need motivational help. 'But it's not about forcing them onto very difficult treatment – it's about assessing them and giving them choices. They're not going to be forced to have a biopsy, which is another fear people have. It's about making sure they're in the system so if they need to do treatment they have the option, and if they don't they can do it a point that's good for them. Given that we're moving to this era of much easier drugs for a much shorter duration, it would be sad if they didn't have that option.'

It's also vital that the right information gets out to drug users, he stresses, and the message is a simple one. 'The first thing is, it's really important to get tested, because if you're negative you can be given the information about how to stay negative. Very often people think they're infected, whereas 50 per cent of injecting drug users don't have it, so you might well be in the 50 per cent who don't, and you can avoid it. If you're positive, it's about how not to transmit it and that there's treatment available, so you can get rid of it.

'Just because you're using drugs doesn't mean you don't have a right to treatment, and the trust is there to fight for people if they come across snooty hepatologists who say "no, you're too difficult". You have the right to treatment. And it'll cure it.'

The uncomfortable truth at www.hepctrust.org.uk



'Just because you're using drugs doesn't mean you don't have a right to treatment.'

CHARLES GORE, HEPATITIS C TRUST

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

The victims of the war on drugs in Britain are predominantly the working class – be they black, white or Asian. The manner in which the war on drugs is carried out protects the wealthy from prosecution; exemplified by the late Eva Rausing, from a billionaire family, who only received a caution in 2008 for the possession of 2.5g of heroin and 60g of cocaine.
Avinash Tharoor, *Independent*, 2 October

In many ways, alcohol is the new tobacco. It is a multibillion-dollar international industry dealing with market-friendly governments, enjoying virtually unrestricted access to advertising despite the growing evidence that the substance they sell has significant health risks.
Ann Dowsett Johnston, *Guardian*, 3 October

Stigma is what society uses, in an ad-hoc manner, to control behaviour which is antisocial or harmful to an individual. If you insist that we should not stigmatise young single mothers, for example, you will one day have many more young single mothers.
Rod Liddle, *Spectator*, 19 October

I don't actually care whether Gideon [Osborne] had a toot or not. Nor do I care if he got off on any activity with Mistress Pain. He has certainly inflicted enough pain on the rest of us. I do care that we cannot have any kind of open conversation about drug use from the political class. What he may have put up his nose remains his business. He should keep that nose of his out of ours.
Suzanne Moore, *Guardian*, 14 October

People who want to get rid of what's left of our drug laws always make a great fuss when senior policemen join their side, as if this were a hugely important surprise. In fact, the police have been prominent in this campaign for years.
Peter Hitchens, *Mail on Sunday*, 6 October

Why Nick Clegg chose to give Jeremy Browne's job to Norman Baker is a bit of a mystery. The Lib Dem leader was unhappy with the way Mr Browne let himself be used as a doormat by [Theresa] May... But it doesn't follow that Mr Browne should be replaced by one of those green-ink cranks who make public life so interesting.
Benedict Brogan, *Telegraph*, 8 October

Baker is of course not the first man prone to seeing secret plots and shadowy schemes in every corner – but he is the first such man to be in charge of the national crime agency, drug and alcohol policy and forensic science... At last he can discover the truth! Unless, of course, this is all a trick by the authorities – and that's exactly what they want us to think.
Jonathan Freedland, *Guardian*, 8 October

The most widely credited theory advanced thus far contends that Mr Clegg, the mischievous sprite, sent Mr Baker to Theresa May's department solely to send the home secretary into a frenzy of incandescent rage. Since she was not consulted about the move, and would rather be saddled with Fidel Castro, this he has achieved... What seems dead easy to predict is that Mr Clegg will now be torn to the tiniest shreds – and not only by the Tories and the papers who support them – for the most eye-catching, head-scratching ministerial appointment in Westminster history.
Matthew Norman, *Independent*, 8 October

OBITUARY

MIKE STEWART

11 SEPTEMBER 1950 – 19 SEPTEMBER 2013

Mike was not just a man of expertise, but someone with great compassion.

Mike Stewart was well known to many of us working in the drugs field, in particular for his expertise and championing of the importance of training and employment.

Back in 1999 central government recognised that there was a need to develop employment programmes for those who had experienced drug problems. With an ambition to double the number of people in treatment, it was recognised that something needed to be done to help people through the system and that employment was a key part of helping individuals regain control of their lives.

With his background in working with the resettlement of offenders and an understanding of the broad range of issues that affected this group, Mike was the right man in the right place at the right time. He was instrumental in establishing Progress 2 Work, which was a genuinely pioneering programme. Testimony to this lies in the fact that it was the Treasury itself which supported its funding.

Mike was not just a man of expertise, but someone with great compassion, who was prepared to challenge preconceptions and orthodoxies for the benefit of some of our most disadvantaged citizens. He possessed considerable powers of analysis, though not infrequently this led to him declaring that certain policies or aspects of delivery were 'bonkers'. In this he was invariably proved right.

The drugs field has lost a valuable expert, though many in the treatment system well benefit from the work he developed. He was also a great friend to many and his warmth and support will be greatly missed.

David MacKintosh, policy advisor, LDAPF

Getting

The ‘dream drug’ ketamine can bring its users face to face with some stark realities that aren’t readily understood by health professionals. **Mat Southwell** and **Lana Durjava** offer practical advice on understanding and meeting their needs

The story of ketamine is a powerful illustration of the risks of abandoning a public health response and limiting drug policy to crime reduction. UK drug policy has shifted from being driven by public health concerns in the HIV era to being dominated by crime prevention. Indeed, the National Treatment Agency (NTA) refused repeated requests to tackle ketamine, arguing that it was only a regional problem and not a priority because ketamine users did not commit crime.

In the face of this inaction, a coalition of healthcare professionals, academics, drug agencies and drug user activists stepped in with the aim of providing credible information.

EARLY ENTHUSIASTS

The first group of people to recognise ketamine’s non-medical value were psychonauts – adventurers who sought to investigate their minds using intentionally induced altered states of consciousness. Psychonauts’ primary motivation for the use of ketamine-induced spiritual journeys was to transcend the external world, experience the separation of consciousness from the body and gain an insight into the nature of existence and the self. They were in the habit of taking extremely large doses as they were deliberately trying to go into a ‘K-hole’, but since they were mostly using ketamine on a fairly non-regular basis, their risk of developing K-dependency was pretty low.

In the early nineties ketamine arrived on the New York and London gay club scenes, where it found an entirely different body of admirers. If psychonauts appreciated the drug for its hallucinogenic and dissociative properties, the new audience, called klubbers, discovered its potential to act as a highly effective stimulant. Ketamine is one of those drugs that are extremely dose-dependent, and while psychonauts were injecting 100-200ml shots to try to achieve out-of-body experiences, klubbers were taking small bumps of ketamine, which usually did not exceed 25ml per dose.

K-dependency was never a high risk for either of these two groups of ketamine users, given the patterns of dosing, breaks between episodes of using and a pattern of remaining hydrated – a particular feature of dance drug use. In this context, ketamine appeared to be an almost dream drug that managed to offer the cocaine-like stimulation, the opiate-like calming, and the cannabis-like imagery, while at the same time providing a full-on dissociative and hallucinogenic experience, with no apparent disadvantages or collateral damage.

WHEN K WENT DARK

The new century brought several changes to the drug market. On 1 January 2006 ketamine was officially designated a class C drug on the basis of the linkage between its frequent use and kidney and bladder damage, as well as memory impairment. Up to this point ketamine was an unscheduled drug for which one could not be prosecuted for possession, but only for supplying. One might argue that the previous approach towards ketamine was the closest that the UK drug policy ever got to a Portuguese-style model of decriminalising people who used drugs. Reclassification changed this dramatically and contributed to the growing harms associated with the drug’s use.

Because of the increased difficulties with smuggling the drug (which were also connected with post 9/11 hysteria and implementation of harsh anti-terrorism laws), ketamine was no longer available as a liquid on the black market but emerged in crystal form. This led to consumers baking the drug with little knowledge that this procedure actually destroyed the quality of ketamine and resulted in users needing to take more of the drug for the same effect – which also meant increased danger of ketamine-bladder syndrome.

At the same time, the price of the drug dropped drastically. If psychonauts and klubbers has been buying it for about £50 a gram, the new generation of ketamine devotees could get the same amount for a mere £10. A natural consequence was a vast diffusion of the drug’s users, as this new generation of K-users, referred to as wonkers, were coming from a very different cultural and social background from the psychonauts and klubbers. Wonkers were often very young kids from both rural and inner city areas, with limited education about the drug and its risks, who valued ketamine for providing a state of intoxication that offered a way out of challenging, frustrating, alienated and marginalised lives. Some people in these new groups wanted to escape from the trap of repetitive and damaging patterns of drug use.

While diverse in nature and background, the wonkers were rapidly increasing their doses and frequency of use. Since they did not understand how to manage crystal, they were also likely to bake the drug, lowering its quality and requiring them to take more for the same effect. Although very few of them overcame the needle barrier, they were all too often faced with K-bladder, mental health problems, poor attention span and impaired memory, which are all closely related to heavy use of the drug. In addition, ketamine's potential for dependence has taken the majority of its users by surprise.

However, it is important to recognise that there are both psychonauts and klubbers among the new generations, and these categories are presented as a way of promoting debate and understanding about the diversity of ketamine users, rather than attempting to oversimplify or stereotype. Nonetheless, while accepting this diversity of experience, public perception of ketamine is that it has become a drug that causes significant damage, giving it a status equivalent to heroin and crack. Of greatest concern is the rise in worrying health conditions such as ketamine bladder syndrome and ketamine dependency, which pose new challenges to both people using ketamine and drug services.

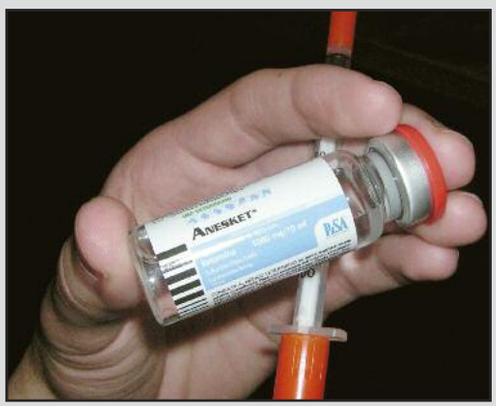
RESPONSE FROM SERVICES

Ketamine users are a diverse population that have not traditionally been engaged by drug services that can remain overly focused on opiate and crack use. However, at its core, the response to problem ketamine use reinforces the importance of a client-centred, empathic approach that responds to ketamine users by offering chances to explore risk reduction, self-control or cessation.

The key harm reduction messages for active ketamine users revolve around dose management and hydration. Understanding how to dose, avoiding dose stacking and learning to take breaks between using sessions are all key to avoiding unintended K-holes and managing the risk of rising tolerance. Learning

REAL

to grind rather than bake ketamine crystal ensures that it is suitable for sniffing without the product being degraded in quality, which offers a practical way of driving down the amount of ketamine people are putting through their systems. Hydration has been shown to be essential in ensuring that ketamine passes through the body, and particularly the bladder, without hardening the bladder wall and damaging the kidneys and liver.



Coact has also developed the K-check tool, which is a triage, health assessment tool for ketamine users that supports GP and drug workers to objectively assess the risks and harms being faced by problem ketamine users, as a basis for delivering appropriate advice and guidance. Importantly it also helps workers identify and refer on those showing signs of ketamine bladder syndrome. However, it is important that drug services work with urology services to help them manage people who may struggle to stop ketamine use, despite the severe impact on their bladder and kidneys. Frightened and physically damaged young people need help to come to terms with the impact of ketamine bladder syndrome, the challenges of often painful and invasive treatments, and the need to cease ketamine use once the chronic condition has set in.

On a positive note, ketamine dependency is relatively easy to treat and withdrawal symptoms are not too severe; people mostly need time to sleep, help with breaking compulsive using cycles, and encouragement to hydrate and eat. However, ketamine knocks out the conscious mind and with it a person's capacity to problem-solve, and this can reduce people's ability to find their way out of dependent use.

Promoting self-control can be a useful step – an interim one for some and an alternative path for others. The challenge is to draw someone into a space where they are taking breaks from ketamine, thus creating the scope for reflective engagement with the conscious mind fully functioning. For those with lengthy histories of regular use, it may take up to three months after cessation for their memory to fully kick back in and this may need to be explained and managed within a treatment or rehabilitation context.

Finally, it is important to understand that many people experiencing problems with ketamine will have particular world views around spirituality, given their journeying with this drug. The blunt application of recovery models has been shown to be off-putting to a group unfamiliar with this discourse. Drug services need to reflect on how to meet this different type of user, acknowledging that practices like yoga, meditation and general mindfulness training may be both effective and culturally attractive to this group of spiritual journeyers who lost their way. **DDN**

Mat Southwell is partner in Coact and an organiser with Respect. Lana Durjava is a postgraduate student of psychology at the University of Westminster. For more detailed harm reduction advice on ketamine from Coact see the online version of this article at www.drinkanddrugsnews.com

'The key harm reduction messages for active ketamine users revolve around dose management and hydration. Understanding how to dose, avoiding dose stacking and learning to take breaks between using sessions...'

LETTERS

'Drug laws that permanently and harshly impact on people's lives and futures have no place in a society that espouses ideals of fairness. Police, prison and probation aren't good settings for the delivery of health services.'

MISPLACED FAITH

In your October issue (page 21) Neil McKeganey stated his case for keeping a dual focus on health and criminal justice as equally important elements in tackling drug problems. Although he outlined his argument with clarity, several comments made me pause for thought.

It seems to me that it's possible that countries with liberal drug policies and lower numbers in contact with formal treatment organisations may be a good thing. Perhaps they have fewer problems that require a massive bureaucratic system to 'sort out' for them and instead rely on the same support that the rest of the population use (*ie* their own GP and other community services) and peer support, that won't be captured in official numbers, for their needs.

With reference to the availability of heroin versus alcohol, he stated, 'In contrast, heroin is much less available and the recovering addict has to work less hard to avoid being exposed to the drug.' Heroin is cheap, available 24/7, can be delivered to your door and payment made at a later date. Your 'friendly' dealer will also ring you up (whether you want them to or not) to let you know a new batch of heroin is in town. In addition many people struggle to move away from areas high in drug use, and social circles where class A drug use is normalised, due to a lack of money and debts racked up from drug use. This hardly seems like an easy scenario in which to avoid drugs.

Drug laws that permanently and harshly impact on people's lives and futures have no place in a society that espouses ideals of fairness. Police, prison and probation aren't good settings for the delivery of health services. Just look at the news and you can see examples of poor performing, overcrowded, drug filled prisons and police using inappropriate and sometimes lethal methods to deal with issues they don't understand. Police, prison and coerced treatment isn't the same as holistic, service user centred treatment and support.

Drugs are cheaper and more available than ever. I'm not sure where the faith in the criminal justice system to reduce the availability and accessibility comes from...

Malcolm Clayton, by email

KICKING THE HABIT

I made a film on how to get off heroin for ITV in 1985, called *Kicking the Habit*. ITV have now asked me to do a follow-up to see what happened to the people in the film. Some were in Phoenix House's Featherstone Lodge in Forest Hill, some in Roma, which was a therapeutic community, some in Chester. There have been follow-ups over 30 years so I hope to trace as many staff and ex-clients and their families as possible.

One person I want to trace especially is Dee Halpen, the social worker who ran Roma. Please get in touch if you can help – my email is dcpsychologynews@gmail.com

All information and contacts will be treated in total confidence. (Since few, if any, TV companies are called Psychology News, I should explain that was a small magazine I once ran – and the name has stuck.)

Many thanks.

David Cohen, Psychology News

STIGMA STORIES

Unlock is an independent award-winning charity providing information and advice services for people with criminal convictions to help others overcome the long-term problems that having a conviction can bring (www.unlock.org.uk).

As part of this, Unlock supports a volunteer-run online magazine for people who are no longer offending but are having to deal with all the problems that come with having a criminal record. We are always on the lookout for stories of how people have overcome the discrimination and stigma that having a criminal record brings or illustrate the barriers that are put in the way of people trying to turn their lives around. So, if you have a good story, either positive or negative, we'd love to hear from you. Just email us at the address below.

Richard, co-editor,
email: therecord@outlook.com;
www.the-record.org.uk

KNOWLEDGE GAP

Martin Blakebrough is right to say 'inserting the word "recovery" into a drug strategy does not in itself change very much at all' (*DDN*, October, page 10), but he fails to add: 'unless there is a viable procedure available to deliver a lasting return to the natural state of relaxed abstinence into which 99 per cent of the population is born.'

As soon as an addict recovers that state, the other factors in the Coalition's brilliant 2010 drug strategy start to become available, not only to the recovered individual but also to his whole community.

But without that initial lasting relaxed abandonment of addictive substance usage, we do not get reduced demand or any of the other 2010 strategy objectives.

Martin is also right to say: 'bullying people into recovery through the threats of the criminal justice system or reduction of benefits' is not the key, but the 'evidence-based approach' he and Caroline Lucas advocate is apparently nothing more than 'a reduction of drug-related harms' – not a reduction in drug usage and not a reduction in the number of addicted drug users, both voluntary and involuntary.

In my 38 years of experience of training addicts to cure themselves of addiction, I have learned that 70+ per cent of individuals who have been addicted for seven days, seven weeks, seven months or seven years have all tried, often daily, to quit their habit but, having failed, still want to quit.

So, willingness is not their problem, it is lack of knowledge of what to do to quit. Which means training them in addiction recovery techniques which they apply to themselves.

These techniques are currently delivered in 169 centres in 49 countries and over each of the last 47 years they have delivered thousands of addicts to lasting relaxed abstinence – a result capable of satisfying the 'PbR' criteria which the 2010 drug strategy logically demands, *ie* 'results based' – not just 'evidence based'.

We don't need royal commissions or anything new to defeat the 'vested self-interest in perpetuating the failing status quo'. We just need to substitute effective inexpensive 'training' for failed costly 'treatments'.

Kenneth Eckersley, CEO Addiction Recovery Training Services (ARTS)

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.

THE 'R' WORD

Alex Boyt is having trouble climbing the steps of the recovery bus

'When I am exposed to discussions about recovery communities I have much the same reaction as when the devout knock at my front door and ask if I am interested in salvation...'

MAYBE IT IS THE CIRCLES I OPERATE IN, or those that I gravitate towards, but when I mention the word 'recovery' there is good chance that low level groans are emitted, and eyes will roll as the glint of defeat replaces the sparkle of indifference. On the face of it, this doesn't make sense – surely recovery is a positive thing, speaking of hope, lives saved and purpose regained?

A commissioner said to me the other day, 'If we put the word recovery in enough strategic documents and action plans, people are bound to get better faster.' You couldn't accuse them of being serious but it did wag a finger at the gap between theory and practice. Visible recovery was brought to the front because it was contagious. We all have success stories in our treatment system; get them chanting 'you can do it too' in our prescribing services and erm, well...

When I am exposed to discussions about recovery communities I have much the same reaction as when the devout knock at my front door and ask if I am interested in salvation. Show me a purple t-shirt and bright eyes and my soul will implore you not to sing a bloody song. As WB Yeats said, 'the worst thing about some men is that when they are not drunk, they are sober.'

Nonetheless, if there is evidence that lives are being saved, that all this visible recovery is drawing otherwise lost souls into a contagious leap forward, then I really ought to stop my moaning and hop aboard the bandwagon hurtling into a brighter future.

So how would you measure the success of this new(ish) push for recovery networks and communities. Is it the number of people on a recovery walk? Well... no! Is it the volume of cheers when a recovery champion talks about their new found hope.... no! Is it the number of people engrossed in an asset mapping exercise... hmm. Is it the number of residential rehab providers on a parliamentary group insisting that they have an 80 per cent success rate... erm... definitely not!

There are parts of the country where it is well known that 'recovery communities are strong, something we should replicate elsewhere'. I was never really sold on this, but before the NTA was subsumed into PHE, I did ask someone there what the successful completion rates were like in these areas – you know, how well are they delivering the national drug strategy? In the immortal words of Theresa May, 'people should not use drugs, and if they do they should stop.'

The response was along the lines of: there doesn't seem to be much of a link between strong recovery communities and people coming off drugs, well not so far, but we haven't looked at the data properly yet, and there will probably be a delay between changing a treatment system and the data coming through, etc etc.

Of course there is nothing wrong with celebrating recovery; there is something uplifting in a group 'hurrah' and you can't begrudge the warm fuzzy feeling it gives to those in the huddle. But is it attractive to the distrusting and marginalised, looking at the clinch from outside? Not in my experience. For many, there is something disturbing and unattractive in trying to plaster optimism over the struggles of the often disadvantaged, traumatised and neglected.

I am not alone in taking a step or two backwards when exposed to excessive enthusiasm, a rallying battle cry or a drive to push from the dark into the light. As George Bernard Shaw said, 'The fact that a believer is happier than a sceptic is no more to the point than the fact that a drunken man is happier than a sober one.' I heard Anne Milton during her brief stint as health minister talk about commissioning miracles. You know she meant well, but really.

The recovery agenda has right on its side: 'You don't want the recovery we offer? Then I am not sure you deserve our help.' I work with many courageous, determined, talented and resilient people who make progress in spite of the national drug strategy and recovery rhetoric, not because of it. A nice little shaming prod, pointing out the lack of personal ambition, doesn't always help the self-esteem.

Those that fail to acknowledge the holy grail of recovery are somehow guilty of colluding in the problem instead of championing the solution. It is worse than refusing to delight in how cute your neighbour's dog is, so I thought I should keep quiet. The other day, however, I noted that someone at the centre of national strategy – a champion of recovery, with all national data at their disposal – was after many years, trying to find a link between recovery communities and successful completions. I decided I ought to write something.

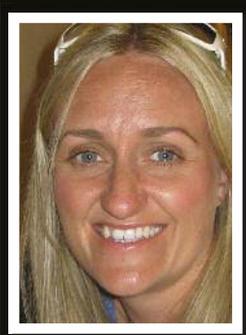
Alex Boyt works in central London as a service user coordinator

A COMMON

There is no shortage of negativity in the drug and alcohol field. Crime, social exclusion, lack of education and employment opportunities, depression and anxiety, services under enormous pressure and increasing hospital admissions – are all familiar features of the lives of service users, providers and commissioners. However, the recent transfer of public health to councils and the establishment of health and wellbeing boards offer a fantastic opportunity to address alcohol and drugs challenges synergistically with communities and public services. This article describes how a growing understanding of asset-based perspectives has influenced the transformation of a local drug and alcohol strategy and shone a different – and much more positive – light on a number of key issues.

Asset-based approaches have some obvious attractions; it is much more satisfying to take an optimistic view of situations and to focus on opportunities rather than problems. This perspective certainly influenced the early stages of the most recent developments of the drug and alcohol strategy in Staffordshire. However, as this process progressed, asset-based ideas became increasingly relevant to many of the key challenges, and a common thread emerged between what were originally conceived as a number of separate ideas that may actually be mutually supportive – possibly suggesting something of a 'virtuous circle' in this inherently risky and problematic field.

The new approach to drugs and alcohol in Staffordshire is placing an increasing emphasis on prevention and early intervention, but perhaps the most significant development is the current redesign of the treatment system, which has incorporated a number of asset-based themes.



The new focus on public health is an opportunity to involve the whole community in addressing alcohol and drugs challenges through an asset-based approach, say **Tony Bullock**, **Dr Samantha Weston** and **Dr Aliko Ahmed**

COMMUNITY ASSETS

The first of the ideas being developed is the key role that community assets are likely to play in the redesign of the treatment system, which is currently out to tender. The multiple and complex needs of clients – often including polydrug/alcohol use combined with inadequate housing, unemployment, mental health problems and a range of other issues – presents a major challenge in the county. Given the demands on interventions (not least from the high prevalence of dependent drinkers that dwarfs problematic drug use), it is unrealistic to expect service providers to have the capacity or expertise to comprehensively address this array of issues. Consequently, a core feature of the model outlined in the tender specification is the requirement for the new care pathway to be thoroughly embedded within the existing abundance of people, voluntary associations and mainstream health and social care services that have the potential to help those with drug and alcohol problems, in terms of housing, relationships, education and employment.

The recognition of clients' complex needs and the benefits of multi-agency working are nothing new or unique to asset-based approaches. There are excellent examples of innovative partnerships between services locally and elsewhere. However, while multi-agency working with mainstream services features in best practice guidance and in many aspects of service delivery, it appears to be often somewhat peripheral to the perhaps more central concerns relating to the technical requirements of delivering evidence-based interventions.

These concerns were highlighted in a study of community treatment services in the north of England that found excellent examples of keyworkers working closely with other health and social care agencies for the benefit of their clients (*Sick, deviant, or something else entirely: The implications of a label on drug treatment progression, recovery and service delivery*, University of Manchester). However, this interaction was highly variable with, in some cases, staff in the

N THREAD

'Given the social elements of drug/alcohol problems and their concentration in often closely defined localities, the "community" could perhaps become the focus of prevention...'

same agencies working in the same room having a very different understanding and experience of working with mainstream services. This isolation was starkly contrasted with the close relationships observed within criminal justice agencies, where joint working protocols were clear, expectations on both sides were well documented and co-location of service delivery normalised. There were some examples where mutually beneficial relationships had been fostered in other areas, but this was far less systematic. These points are by no means meant as criticism of people with high caseloads of complex people in difficult working environments, but help to illustrate the peripheral nature of multi-agency working within some sectors.

Acknowledging the potential benefits of community assets, we are working with Baseline Research and Development to 'map' resources (local people and organisations), build connections between them and explore how they could potentially enhance existing provision. This process will help us to understand how community-led initiatives are initially formed and developed, and this learning will be used to help establish similar activities where they do not currently exist. Ultimately, we hope to encourage strong relationships between specialist interventions, mainstream services, voluntary associations and local individuals that will enable the co-production of a vibrant pathway that both draws from and gives back to local communities.

BUILDING STRENGTHS

A second way in which asset-based approaches are being explored in Staffordshire is through the recognition of the role that the development of personal assets (strengths and interests) can play in people's recovery – ideas that were firmly established through the emphasis on 'recovery capital' in the 2010 drug strategy. In the same way that health is much more than the absence of sickness, recovery is perhaps much more than the absence of addiction, and the development of protective factors have a role to play alongside the alleviation of problems or deficits.

There are a number of ways in which strengths and interests are being encouraged in Staffordshire, including the recent launch of RIOT radio (www.riotradio.co.uk) – an internet-based radio station run by people in recovery. The station provides the opportunity for people to express their talents, as well as develop new skills and interests. Following a small amount of investment and training, the station broadcasts for up to ten hours a day, five days a week and is hoping to apply soon for an FM licence to broadcast locally as a traditional community radio station with a recovery twist. Not only does the radio station provide the opportunity for people in recovery to build and display their skills, and thereby strengthen their recovery, it also provides the opportunity to give something back to the community – one of the founding principles of the station is that it broadcasts a positive message, a highly visible (or audible!) form of recovery.

PEOPLE AS ASSETS

Through the radio station and other similar projects it is apparent how the people in recovery and recovery communities become assets to the wider community, helping other people struggling with drug and alcohol problems, breaking down stigma, and contributing to society through fund raising and huge amounts of voluntary work.

Observing such positive activities sparked the idea of this article: people in recovery (not least through recovery communities) can be enormous assets to their local neighbourhoods and community-led organisations. These initiatives have huge potential to enhance specialist treatment provision – while services can encourage the development of personal strengths and interests, they can also enable people to become assets themselves, presenting what might be considered a 'virtuous circle'.

A real 'light-bulb' moment occurred at one of the asset-mapping workshops that wonderfully illustrated the potential of asset-based approaches. What became clear from the session was that there are numerous local people and organisations that are putting huge amounts of time and effort into developing their community, not for financial reward but because of a deep-held desire to make their areas better places for people to live. However, this begged the question of how much these community assets could achieve with just a small amount of external support and resources, given the inherent motivation and time contributed without cost.

While the activities of some of the local organisations may not have a direct impact on people's recovery, they did raise the possibility that asset-based community development (ABCD) could potentially operate as a form of prevention. While drug and alcohol problems clearly impact across all communities, they are disproportionately concentrated in the most deprived areas, where risk factors are high and protective factors low. However, the evidence base for effective prevention appears to primarily relate to initiatives focused on changing the behaviour of individual people (such as education in schools) and to some extent families (such as the Strengthening Families programme).

Given the social elements of drug/alcohol problems and their concentration in often closely defined localities, the 'community' could perhaps become the focus of prevention. An ABCD approach offers opportunities to make communities more cohesive, build connections and enhance protective factors, all of which could act to prevent drug/alcohol problems developing in the first instance. While this, at the time of writing, is very much only a germ of an idea, exploring community-focused initiatives with an asset-based approach is perhaps something worthy of further examination.

The asset-based perspective has contributed much more to the development of the local strategy than was originally anticipated. This is probably because the insights outlined above touch on what are fundamental but sometimes under-estimated issues: people with complex needs can benefit from the community and not just specialist resources; building strengths/protective factors can complement addressing needs/deficits; and people in recovery are often enormous assets to recovery and wider communities. While asset-based perspectives may not offer wholly new ways of working (all of the examples cited above draw from existing approaches), they nevertheless suggests a common thread between what otherwise appear as somewhat disparate ideas and could usefully galvanise them in the same way that the term 'binge drinking' did not create the issue but helped to add sense and communicate a concept.

The approach also helps in creating a positive atmosphere of wellbeing that promotes better partnerships across disparate public services and the people and communities they serve. It will remain at the core of delivering the Staffordshire Health and Wellbeing Strategy. **DDN**

Further reading: McKnight, J. Block, P. (2010) The Abundant Community. Berrett-Koehler Publishers, San Francisco, California.

Anthony Bullock is commissioning lead for alcohol, drugs, smoking and mental wellbeing, Public Health Staffordshire; Samantha Weston is lecturer in Criminology, University of Keele; and Dr Aliko Ahmed is director of public health, Public Health Staffordshire.

Back of the net

Doncaster Rovers Community Sports and Education Foundation describe how their new education programme is helping to boost confidence and wellbeing

Doncaster Rovers Community Sports and Education Foundation have been working with the NHS and Doncaster Metropolitan Borough Council to deliver an education programme for people directly affected by drug and alcohol problems in the region. The Sky Bet Championship team have become the first football club in the country to actively run the multi-skills course, designed to engage and educate adults who have had issues with substance misuse to help build a better future.

The course is structured to enable learners to acquire a wide range of new skills and enhance their pathways to employment and further training. The foundation encourages people on the programme to make positive life choices, while also helping to improve their confidence and happiness. Throughout previous courses, Doncaster Rovers have offered individuals who excelled on the course work experience within the club, as well as linking learners on to other local businesses, such as Doncaster Cultural Leisure Trust and Doncaster Wildlife Park.

NHS drug and alcohol services in Doncaster refer clients on to the two-month programme, which takes place three days a week at the Keepmoat Stadium. The foundation has been running the scheme for two years, overseeing an 80 per cent completion rate over four courses, which continue to both improve and be successful.

'The course is innovative and not only gives clients of drug and alcohol services accredited qualifications, but works on their motivation to change and feel part of a team to build confidence,' said public health improvement officer for substance misuse in Doncaster, Andrew Collins. 'It's great to see individuals who have shied away from conventional education really embrace the programme and not want the course to end.'

'The course is designed to develop a wide range of transferable skills...'

There are several vocational and non-vocational areas of study selected for the programme. These qualifications are chosen because of the proven success they have had with providing learners with employment, further education and training.

Qualifications include Sports Leaders UK level 1 and 2 awards in sports leadership and emergency first aid. Other activities include team and confidence building, along with basic literacy, numeracy and computer skills. All of these areas give learners the ability to set targets for life which are key features of the multi-skills course.

Alongside working with the participants on attaining qualifications, the foundation also offers a support network. The club provides support for personal issues over the course of eight weeks and has helped the groups overcome barriers to studying and employment.

Project co-ordinator at the Doncaster Rovers Community Sports and Education Foundation, Sam Parkin, said of the initiative, 'Over the past two years, we have successfully delivered four multi-skills programmes to a total of 50 participants. The course is designed to develop a wide range of transferable skills suitable for many employment pathways.

'We have had countless success stories since the course's inception, with several of the learners going on to gain full-time employment. Alongside the achievement of nationally recognised qualifications, it is wonderful to see the participants regain their confidence and develop as individuals as the course progresses.'

During their time on the course, learners are asked to score several areas of their life on a scale of one to ten. This is completed on the first and last week of the programme, to see if there has been an improvement in health, happiness, career prospects and ability to cope with alcohol and drugs.

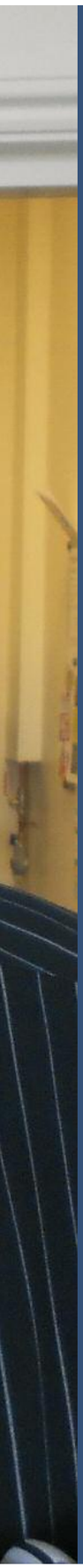
Answers to the questions have shown a clear improvement in each of the specified areas at the end of the course, compared to at the start. Over previous courses, there has been a significant improvement in all areas, particularly in the learners' confidence. This indicates that the participants give their full commitment to the course, proving that the multi-skills programme is having a positive effect on them.

John Northridge, who took part in the latest programme, said, 'This course has helped me so much. When I started it I didn't know what to expect but my confidence has improved and the goals in my life have changed from none to loads! The tutor Sam Parkin helped me lots, making me feel welcome from the start to the end.'

For more information on the education programme, visit www.drfc-community.co.uk

Chief executive of the award-winning Broadway Lodge, Brian Dudley, tells **David Gilliver** about the importance of providing specialist care and dispelling preconceptions about the 12 steps

A step ahead



'For drug and alcohol services to actually get some recognition for the work we do was incredible, because we never get any praise,' says Broadway Lodge chief executive Brian Dudley. His organisation was named 'independent specialised care provider of the year' last year and, in this sector, 'hitting the headlines for the right reasons is an absolute boost', he says.

Established 40 years ago, Broadway Lodge was the first UK service to provide treatment via the abstinence-based Minnesota Model, and now employs more than 100 people. As well as a 33-bed residential centre in Weston-super-Mare there are an additional 22 places in adjacent houses, with primary care addressing steps one to five of the 12 steps and the remainder dealt with in secondary, with its focus on social and life skills. The organisation also has two third-stage houses for reintegration and its own detox unit.

'That means we can just do a detox, or it can then lead into primary care, secondary care and then the third-stage, move-on houses,' he says. 'We're fully medical so our primary is quite intense, then the secondary is a step down where they'll start to look more at what's happening after treatment. We've got our own recovery centre now as well.'

Broadway Lodge feel so strongly about the need to dispel what they see as the myths around the 12 steps that they've now produced a series of short DVDs on the subject. 'The only similar work is 1970s American stuff, so we're putting it into a 2013 English context,' he says. 'We've really addressed the cult issue and the God issue, so it's not this frightening cult thing that people think of. The feedback we've had has been amazing.'

The DVDs have been bought by other treatment centres, here and overseas, and Public Health England were also impressed, he says. 'It's really useful for commissioning groups as well as people who don't know anything about the 12 steps. People are telling us that their clients are getting a lot out of it.'

It's specialist care that the organisation is most committed to, however. The service has established a new 12-step women-only project, Ashcroft House in Cardiff, after acquiring the unit earlier this year, and it's on course to be around 90 per cent full by the end of this month. 'It's about having somewhere where women can deal with not just the addiction issues,' he says. 'There might be abuse issues, self-harm issues, domestic violence issues as well. It's a sort of place of safety where they can deal with more than just the addiction.'

Several of the speakers at the recent Brighton Oasis Project conference pointed out that, despite making up around a quarter of the service user population, women remain essentially invisible when it comes to the design of services (*DDN*, October, page 8). Do he feel that's fair comment? 'I think so,' he says. 'I only know maybe three or four other women-only units in the whole of the country. There's hardly anything – probably under a hundred beds – and there's a massive need.'

Broadway Lodge's specialist provision extends further than most, however, offering services for eating disorders, gaming and gambling addiction. Is gambling something that's overlooked by services generally? 'We're contracted by [industry-funded support service] Gamcare to provide residential treatment facilities for gambling,' he states. 'It's funded by the gambling industry because there's no other funding. Your local DAAT commissioner or your local council won't provide any funding for gambling, but the gambling industry's put money into treatment – the Gordon Moody Association in the Midlands and ourselves are the two residential places that they fund.'

Are there many referrals? 'No, we probably get about half a dozen a year,' he says. 'I think the need is there but the money doesn't follow it. What we're paid doesn't even cover our costs for people to come into treatment, but obviously there's a lot of comorbidity. Someone will come in with a drug or alcohol problem but when we actually start working with them we might well find their primary addiction is gambling, but they'd never have got funded. So we do come across it an awful lot in treatment, but not with people coming through from being funded. Because there's no funding there.'

The organisation is also unusual in that it provides services around co-dependency, something he feels can be a neglected issue. 'Within the field what we do know is that you'll find mothers or fathers actually going out and buying drugs for their child, because they think that's safer. Their own health becomes totally dependent on that of their children or siblings. We don't get many, but again we get a few.'

Although Broadway Lodge addresses this more in its family programmes than residential, some people have been in residential treatment for co-dependency 'when their life's become totally dependent on someone else's – it's frightening,' he says. 'We've been running a three-day residential family programme now for about 30 years, and we tend to do a lot of work in that. A lot of the time the child or the family friend will come into treatment and the family's only known chaos, so you're putting someone who's been through treatment back into that environment and they haven't got a clue what to do. So it's educating them as much as the actual person in treatment.'

*****

Dudley has been at Broadway Lodge for seven years now, before which he worked in social housing, and although he'd done a lot of work in the charitable sector he admits to having some 'very pre-conceived' ideas about the field before taking up the post. 'I was just totally blown away very quickly in getting that understanding, going from quite a stigmatised approach,' he says. 'I thought an alcoholic was someone on the park bench swigging White Lightning and drug addicts were 18-year-olds going around mugging everyone and shooting up in alleyways. But it changed remarkably quickly. Once you come into this place you buy into it really, really quickly because you're involved from day one, seeing clients, meeting clients, learning their stories. The transformation was incredibly quick and now I'm just absolutely passionate about it.'

Broadway Lodge has also joined with up with RAPt (Rehabilitation for Addicted Prisoners Trust) for a project in one prison that it hopes will become a blueprint to be applied elsewhere. 'Again, it's sort of new within the field – a residential provider partnering up with a specialist prison service,' he says. 'We're doing all the clinical work but are also involved in the therapeutic. It's about what more we can offer when people come out of prison, joining up treatment.'

Initial feedback has been exceptionally good, he says, and the commissioners

'If you don't use us you lose us...'

are happy. 'They've gone away from the old model of an NHS provider providing the service towards specialists. They can see the benefits – both RAPt and ourselves have been around for a long time. We've got a contract with Turning Point in Gloucester and we've just had our six-monthly review and were just staggered because everyone who completed treatment at Broadway Lodge and went on to the Turning Point programme is still clean after six months. What a change of investment, from an NHS mental health ward to a totally joined-up way of working.'

Other plans for joined-up work include partnering with a housing organisation to provide longer-term accommodation, as all but five of the 27 people to pass through the organisation's third stage are now in education or employment. 'We know that long-term investment works, but there's a lack of it,' he states. 'We know only 2 per cent of people in the UK are offered rehab and we know funding's getting cut.'

Against that backdrop, his ambitions are for the organisation to remain a specialist provider, focusing on the south-west and the services 'that aren't really available at the moment', such as the women's unit. 'We'd like to set something up for young people as well, because there's no residential rehab for young people in the UK. It's about being a specialist provider because I think that's where the funding will be, but also hopefully taking over some of the services the NHS run at the moment. Because we're half the price, and we can join it up – we can provide the whole front end.

'We've got the skills, the quality, the pricing to save money but we're in the same boat as all other rehabs. If you don't use us you lose us.' **DDN**

12-step DVDs available at broadwaylodge.org.uk/dvds

A fine b

In our October issue, Philippe Bonnet spoke passionately about his campaign for drug consumption rooms in the UK (page 17). Here, **Ingrid van Beek** shares her experience of overcoming challenges to establish such facilities in Australia

The Sydney Medically Supervised Injecting Centre (MSIC) opened in 2001 with strong support from both the local residential and business communities – the result of a constructive dialogue between relevant stakeholders in the Kings Cross community more than a decade earlier. This support has continued to strengthen ever since, despite the significant gentrification of the area, which has in part occurred as a result of this important public health initiative.

In October 2010 the New South Wales Parliament passed legislation to lift the MSIC's trial status, following several independent service evaluations demonstrating that it was meeting its service objectives.

As with all successful prevention efforts, the future challenge is to convince newcomers to the area that this initiative is still needed to maintain the status quo.

The MSIC is, I believe, a textbook example of engaging vulnerable groups and the broader communities in which they live to produce a strong public health outcome while also addressing public order concerns at the local level.

To achieve 'health for all', health and social welfare services for vulnerable populations need to be accessible, acceptable, affordable and equitable as originally enshrined in the Alma-Ata Declaration of 1978 and now an integral part of public policy in organisations such as the World Health Organization (WHO).

A key lesson to be taken away from the MSIC experience was that such a project needed to be sustainable over time, for the disease prevention and health promotion efforts associated with it to be effective.

Implicit in any successful public health initiative of this kind is the appreciation that the issues facing vulnerable populations are often complex. Inequities in these communities are often entrenched; the chronic relapsing nature of drug and or alcohol dependence is frequently associated with instability, which can be compounded by mental health issues, transience and high mobility, unstable accommodation, involvement in crime and risky sex work, pending legal issues and time spent in custodial settings.

At the same time it is crucial to recognise the importance of an enduring and successful coexistence of diverse groups based on the respect of cultural differences – or better still, communities should be encouraged to embrace such diversity as part of living in a rich and vibrant modern society.

However, the right to have a sense of community belonging, respect and inclusiveness should go hand in hand with a sense of social responsibility towards the community. Vulnerable populations should be considered equal (full) members of their respective communities rather than just being tolerated, or even accepted as an act of altruism/charity towards 'the weak'.

There is also a need to ensure a balance between public health and public order. While the broader community has to understand the need and support efforts to achieve good public health, the right to live in a safe and secure community should also be acknowledged – even if these do not seem pertinent to certain individuals in that community.

It is also important to delineate real threats to public order from perceived threats and it is here particularly that law and order authorities have a central role to play. This is not to say that perceived threats should be ignored. Instead they need to be addressed in different ways, and also monitored to

balance

'It is important to delineate real threats to public order from perceived threats and it is here particularly that law and order authorities have a central role to play.'

ensure that they are overcome.

The MSIC and indeed my ongoing work at the Kirketon Road Centre, where we deliver a comprehensive range of integrated harm reduction and sexual health services in the same area of the city, have convinced me that local solutions are needed for local problems – one-size solutions will not be a neat fit for all communities.

Experience at the local level of service delivery has also taught many of us public health practitioners that what works in a local community today may not be appropriate tomorrow, so an ongoing dialogue between the diverse community stakeholders is needed to keep checking in on existing issues and identify emerging ones, hopefully enabling intervention in a timely way.

These stakeholders should be tasked with developing community indicators of both public health and public order, to objectively monitor how well they are achieving a balance between both.

But the sustainability of harm reduction service provision on the ground will ultimately rest on the legitimacy of the provider in the eyes of the community. Providers are often considered by the community, especially in the first instance, as the default 'representatives' of people who inject drugs. This may be appropriate given this group's own social marginalisation and transience, which may be a barrier to effective participation in community processes.

But providers need to be conscious from the outset of the often common perception that they are 'outsiders' coming into the community to foist their client base onto the 'legitimate' community. To be recognised as full members, service providers need to gain local community respect and understanding, which requires a genuine long-term commitment to being part of the community to achieve solutions for all its residents and not just for their particular constituency.

The supervised injecting facilities in Sydney, Europe and Canada, are, I believe, prime examples of local solutions to both public health and public order issues associated with street-based drug injecting.

Dr Ingrid van Beek was the founding medical director of the Medically Supervised Injecting Centre in Sydney, Australia, the first in the English speaking world. In 2008 she resigned from this role to continue as director of the Kirketon Road Centre in Kings Cross, Sydney.

She will address the upcoming City Health 2013 conference being held in Glasgow on 4-5 November. www.cityhealth2013.org

POLICY SCOPE

When do specialist drug and alcohol services play a part in the wider public health agenda, asks Marcus Roberts

RIGHT FOR THE ROLE

IN THE LAST COUPLE OF DAYS I've been involved in two 'summits' organised by DrugScope on behalf of the Recovery Partnership: one on older people's experience of drug and alcohol problems; the other the latest in a series of regional summits on 'building recovery in communities' that we hosted in Leeds for the Yorkshire and Humber region.

Three big (and related) policy themes emerged as common ground across these two events – the relationship between 'recovery' and 'public health', the distinction between 'services' and 'interventions' and the challenge of 'keeping it real' on disinvestment and balancing an appreciation of the financial constraints on commissioners (notably local authorities) with a robust defence of investment in our sector.

The older people summit focused on two distinct groups – an ageing population in existing drug and alcohol services, and a larger group of people in later life who may be using drugs (including prescription or over-the-counter drugs) or (much more commonly) alcohol in harmful ways, often as a way of 'self medicating' to cope with experiences associated with aging such as bereavement, loneliness and isolation.

I don't need to spell out the significance of the distinction between 'recovery' and 'public health' in this context. What was less obvious to me is that the wider public health agenda for older people looks like it is more about 'interventions' than specialist 'services'. We heard from some great projects working with this age group which clearly have an important role to play, such as DASL's Silver Lining project in the London boroughs of Bexley and Greenwich. But there is also a big agenda of work to equip and support generic and older people's services to deal confidently with drug and alcohol issues – for example, GPs, mental health services and residential care programmes.

The wider significance of this point was brought home at the Regional Summit in Leeds where one of our speakers observed that public health naturally thinks and works with 'interventions' rather than 'services' as such. This raises the question of when, why and to what extent specialist drug and alcohol services are best suited to deliver the interventions that are part of the wider public health agenda now emerging on drugs and alcohol.

This links to the broader issues about funding. The point was also made at Leeds that with local commissioners facing swingeing cuts they would be 'laughed out of the room' if they sought increases in investment in drug and alcohol services in the coming years, with the implication that it is not easy arguing for sustaining current levels of investment in local authorities facing budget cuts of 30, 40 or 50 per cent. Even allowing for a lot of creativity and collaboration this raises the obvious question of how this circle can be squared without either reducing access or cutting cost and quality.

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

FACE TO FACE

Last month's recovery summit in Scotland brought together people from all walks of life to explore what they could do for recovery, as Kuladharini **explains**

SCOTLAND'S SECOND NATIONAL RECOVERY SUMMIT TOOK PLACE IN GLASGOW AT THE END OF LAST MONTH. The event was hosted by the Scottish Recovery Consortium, a small charity funded since 2010 by the Scottish Government to promote the implementation of our drug strategy *The road to recovery.* A total of 420 people registered for the free event, which was hosted by a crew of 40. People gave their time and talents to make it happen and the Scottish Government's drugs policy unit sponsored the event.

So, what is a recovery summit? For us the summit is a 'walk your talk, practise what you preach', encounter between tribes of recovery, their friends and allies in treatment and public life, and people in power who are new to the whole idea of recovery.

A recovery summit is not a conference. It is a place and time where the informal and formal networks connect, engage in dialogue across round tables, drink coffee, eat lunch and inspire each other. We appreciate each other's contributions. There are no speeches, just 'seeds' – small nuggets that stimulate thinking about our next steps individually and collectively.

It is not particularly about my or your individual recovery. The beating heart of the recovery summit is the altruistic dimension of recovery. To paraphrase President Kennedy: 'Ask not what recovery can do for you, but rather ask, what you can do for recovery.' Now this is a no-brainer for people in long-term recovery. Recovery communities and mutual aid members are past masters at Zen koans [parables], like 'you can't keep it unless you give it away'. Increasingly we find that paid staff at all levels of public service delivery are also seeing it this way.

On the day of the summit our focus on grassroots and bottom-up approaches to recovery in the community and in treatment came of age. Grassroots activists chaired and hosted the event. The minister for community safety and legal affairs, who holds the portfolio for the recovery policy in Scotland, made her contribution and then took to the dialogue tables to share and learn from the collective wisdom in the room. Alcohol and drug partnership leads were alongside local recovery activist groups from all over the country. Four mutual aid fellowships (SMART, CA, NA and AA) public information committees presented in the studio parallel sessions, and even our healing room was staffed by qualified alternative therapists in recovery. Rank and file treatment workers pondered together with recovery college graduates, heads of major national organisations, police, prison officers and recovery elders.

First names only. No job titles and please, no hierarchy and status, which can get in the way of us finding what unites us as humans. Dialogue begins around questions that really matter to us – what have you contributed, what are you noticing and what do you imagine? From there the sparks fly, the ideas emerge and each of us forms a next step commitment to building recovery. Longer tea breaks and a good lunch break allow the conversations to continue naturally. Our working assumption is that the wisdom is in the room. You are invited to the recovery summit intentionally, because you already contribute to building recovery or because we need you to contribute!

The recovery summit is a catalyst, an alchemical melting pot if you will. We are a small country, urban and rural, that uses natural assets (talkative, cheeky, irreverent and passionate) in pursuit of a shared love. This vision is of a more humane, inclusive, connected, community spirit that is alive, thriving and has a place to live on your street.

There is a future we can now see emerging where we put the 'better than well' effect to work – not just to build better treatment and access to mutual aid, but where the community strength that visible and growing recovery brings is put back into helping to heal the very communities we ravaged with our addiction. Scotland has enormous challenges and some of its many assets – once lost to addiction, now found in recovery – are available and willing to help.

How on earth do you make such a vision manifest? All we have to do is 'take the next right step' and see what happens.

Our fundamental message is that people do recover. This can be a challenging message for those not involved in the recovery community or those with a 'glass half empty' approach to life. We believe that the importance of reconnecting face to face to inspire each other, at gatherings like the recovery summit, cannot be underestimated. We find it creates a recovery 'bounce' – enormous creativity that goes into action to strengthen recovery across the country, both locally and nationally.

That, my friends, is a national Recovery Summit in Scotland.

Kuladharini is director of the Scottish Recovery Consortium

DARA Thailand
DRUG & ALCOHOL REHAB ASIA

THE DIGNITY OF CHOICE:
12 Step and CBT Treatment Programmes

DARA, Asia's premier and preferred international destination for drug and alcohol rehabilitation, recently opened Steps to Recovery™, a 12 Step based programme in Chanthaburi, Thailand. With their Koh Chang centre renowned for CBT (cognitive behavioural therapy), their new facility further broadens their ability to address unique clinical needs, ensuring every client has the best chance for recovery.

FOR SOME CLIENTS, the 12 Steps are extremely effective. The 12 Step model is group focused, encourages and even relies on a higher power, and ultimately, provides the practitioner structured guidelines for living. Although this approach was historically the only option in 90 percent of the treatment programmes worldwide, it doesn't meet everyone's needs. Instead of turning their will and life over to a power greater than themselves, some people are more interested in learning practical techniques to improve their behaviour and address the self-defeating issues that are negatively affecting their lives.

DARA recognised that each client should be treated as an individual and that the programme they participate in should meet their unique clinical needs.

DARA KOH CHANG:
COGNITIVE BEHAVIOUR THERAPY

Located in a stunning National Park on the Thai tropical paradise of Koh Chang (Elephant Island), DARA Koh Chang is situated in a beautiful, secluded isle noted for its safety and security. The centre aptly combines an intensive rehabilitation centre with luxury accommodation:

- *50 staff including 15 full-time, internationally certified therapists.*
- *40 private villas: garden view, sea view and pool.*
- *Air-conditioning, DVD, large en-suite bathrooms, private verandas and refrigerators in all villas.*
- *Resort facilities: beautifully landscaped tropical gardens, 25 metre pool, fully equipped gym, meditation centre, massage room, dining area, lounge, library (book & DVD), and free WiFi.*
- *Weekly group excursions: beach visits, deep-sea fishing, island hopping, jungle trekking, Thai cooking classes and temple tours.*

While DARA has enjoyed excellent success at the Koh Chang facility, they soon recognised that the CBT model alone was not sufficient to meet everyone's needs. Twelve months ago DARA began the process of applying ITM (integrated treatment model), a modality that combines physical, social, psychological and spiritual aspects through a variety of individual and group-orientated activities. It not only encompasses CBT, but also other psychotherapeutic approaches such as DBT (dialectic behavioural therapy), transactional analysis, schema therapy, motivational interviewing, gestalt therapy, relapse prevention therapy, and other holistic services. Interestingly, the clinical results have been outstanding and the clients appreciate the diversity of this process. Nevertheless, many people seeking or referring others for treatment are familiar with and interested in the 12 Step model, needing a different approach in the ongoing quest for recovery.

DARA CHANTHABURI:
STEPS TO RECOVERY™

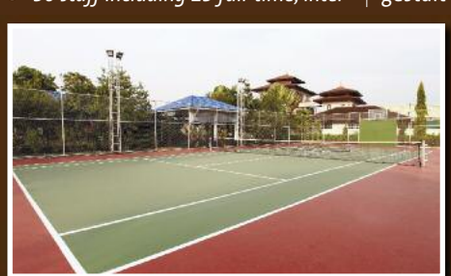
The good news is that in May 2013 DARA opened a new centre, DARA Chanthaburi, exclusively employing Steps to Recovery™, a 12 Step based treatment programme governed by ITM. Popularly known as the 'city of the moon', Chanthaburi is a sleepy, rural Thai town famous for its tropical fruits, fantastic seafood and coloured gemstones. Located on the mainland about one hour from their Koh Chang facility, DARA Chanthaburi provides the following:

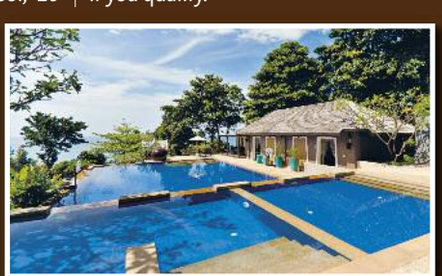
- *20 staff including five full-time, internationally certified therapists*
- *16 private rooms: deluxe, superior and suite.*
- *Air-conditioning, premium cable television with HD channels and en-suite bathrooms in all rooms.*
- *Resort facilities: 20 metre pool, 10 metre Koi pond, fully equipped gym, tennis court, meditation centre, massage room, dining area, lounges, and free WiFi.*
- *Weekly group excursions: beach visits, jungle trekking, village visits and temple tours.*

ONE SIZE DOESN'T FIT ALL

The schools of thought regarding best practices in addiction treatment are frequently diametrically opposed, but by offering a menu of services you're actually addressing what each client needs, as opposed to shoehorning people into certain types of treatment. As professionals, we should all value the validity and effectiveness of both 12 Step and CBT programmes. After all, it is not about the approach, but rather providing every client with effective and empathetic treatment that meets their individual needs.

If we're honest, in addiction rehabilitation – as in life – one size does not fit all. Every client deserves the dignity of choice, albeit guided by empathetic and experienced professionals to help them make the right decision. DARA continues to provide free visits to their facility for industry professionals, contact them today on **+66 87 140 7788** or email **info@alcoholrehab.com** to see if you qualify.



Families First

The 2nd Adfam/DDN family conference

BOOK NOW!

Adfam
Families, drugs and alcohol

DDN
Drink and Drugs News

Putting families at the centre of recovery

While addiction can tear families apart, family support can be a huge factor in driving the successful recovery of both the individual and the whole family.

Families First brings together family members, professionals and policy-makers to exchange expertise, coping mechanisms, legal knowledge and networking with those who truly understand the complex nature of addiction in the family.

With expertise from premier family support charity Adfam, this is a must-attend event for family members affected by substance use and for all agencies and organsations who genuinely want to support them.

Full programme and online booking at

www.drinkanddrugsnews.com

e: conferences@cjwellings.com t: 01233 633 315

CONFERENCE PROGRAMME

9.30–10.30AM

10.

Cha… Adf… exe… **Vi**…, this …on will feature **Kate** …, n… an… vist, … w…ive a fa…y perspective on th… ca… ir t… ent… **Mar… lman**, Public Health England's recove… y le… o w… ook… how families can help their loved ones achiev… recove… while looking after their own welfare.

11.40AM **COFFEE BREAK**

12.00PM–12.20PM **SESSION TWO**

Nick Barton, chief executive of Action on Addiction, looks at 'tough love': how do you keep a loved one's recovery on track while looking after the needs of the family in their own right?

12.20PM–1.00PM **'ASK THE EXPERTS'**

Question time debate, with panelists from the drug and alcohol sector and family support.

1.00PM–1.50PM **LUNCH AND NETWORKING**

1.50PM **WORKSHOPS**

Young people and families, with **Kama McKenzie**, Family Development Coordinator– Adfam.

Rights, roles, responsibilities – The legal side of living with a drug or alcohol using relative, with **Kirstie Douse**, Head of Legal Services, Release.

Alcohol and Families, with **Lauren Booker**, workplace programme manager, Alcohol Concern.

Club drugs and legal highs, with **Becky Harris** and **Galit Haviv-Thomas**, The Club Drug Clinic.

Carers' rights, with **The Princes Trust**

Naloxone, with an expert trainer.

2.50PM–3.10PM **COFFEE**

3.10PM: **AFTERNOON SESSION**

Kate Peake, of Adfam, shares how new publicity techniques such as flash mobs can be used to talk about the challenges and benefits of speaking out for families. **Jason Gough** shares personal insights into the journey he and his family took through recovery and repairing their relationships.

4.00PM **FINISH OF CONFERENCE**

4.00PM–5.00PM

Open group taster sessions with **Al-Anon** and **Famanon**

Thursday, 21 November 2013 – BIRMINGHAM

SUBSTANCE MISUSE DOCTOR
London

SOCIAL WORKER
Middlesbrough

DIP WORKER
London

CLINICAL OPERATIONS MANAGER
Oxford

RESIDENTIAL DRUG AND ALCOHOL NURSE
Leicestershire

INFORMATION ANALYST
Kent

RECOVERY WORKERS
London

RESOURCE OFFICERS
East Sussex

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EXPRESSIONS OF INTEREST

Community Drug and Alcohol Treatment Services Tender Opportunities

Redcar and Cleveland Borough Council are seeking suitably qualified and experienced organisations to deliver a range of community based drug and alcohol treatment services within the Borough of Redcar and Cleveland.

Three separate tender opportunities are presented and prospective providers may submit expressions of interest against one, two or all three opportunities but should submit individual expressions of interest against each contact.

The three opportunities presented are for a Prevention service, a Substance Misuse Recovery Coordination service and a Through care/Aftercare service. Further explanation of each opportunity will be provided on the NEPO portal from 1st November 2013, where a tender pack will also be available from this date.

Organisations wishing to express an interest must register, download tender documents and submit their tender via www.nepoportal.org

Each contract will be for a period of 3 years commencing 1st April 2014 with an option to extend for a further 2 x 12 months.

If you have queries regarding registering on the NEPO Portal please contact Jane Turner by email at jane.turner@redcar-cleveland.gov.uk. The closing date for the receipt of completed tenders is 12 noon on 25th November 2013.

Salford City Council

Tender

Salford City Council intends to procure an

Integrated Drug and Alcohol Recovery Treatment System

For further information please go to The Chest
https://www.the-chest.org.uk

The deadline for submission of PQQ is 29th November 2013

Nationally Accredited Phlebotomy Training

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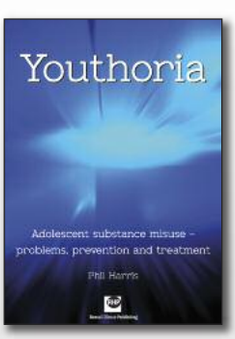


New in 2013!

Youthoria

Adolescent substance misuse – problems, prevention and treatment

By Phil Harris

"A unique book… arguably unrivalled in its scope… an engaging, informative and essential read." *British Journal of Social Work*

"In this book I explore the evidence from many sources that strongly suggests there are very distinct pathways into substance use. They offer very helpful guiding principles to assess, evaluate and benchmark interventions - whether they are preventative or treatment based." *Phil Harris*

"The author does a remarkable job in synthesising extensive research findings to provide a comprehensive and coherent framework for understanding and effectively responding to substance use by today's youth… provides invaluable insights, strategies and tools." *Professional Social Work*

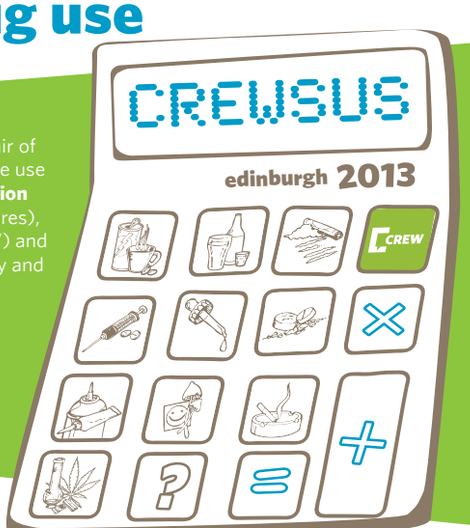
Large format. 280 pages. 978-1-905541-82-9. £27.95

www.russellhouse.co.uk

Tel: 01297 443948 **e-mail: jan@russellhouse.co.uk**

Chemical Cocktails: the nature & impact of polydrug use

Keynote speakers **Fiona Measham** (chair of ACMD polysubstance use working group), **Marion Logan** (Phoenix Futures), **Carole Kelly** (CREW) and others discuss policy and practice issues in polydrug use plus workshops for effective treatment for people using more than one substance



CREWSUS 2013

in association with Edinburgh Alcohol & Drug Partnership

November 29, 2013 - Edinburgh City Chambers - book now online:
crewsus2013.eventbrite.co.uk
Regular tickets £125, Exhibitors £325 (including 2 tickets)
More info: events@crew2000.org.uk

Crew 2000 (Scotland) is a company limited by guarantee, registered in Scotland, company number SC176635, and a charity also registered in Scotland, SCO 21500 Registered office: 32/32a Cockburn Street, Edinburgh EH1 1PB Email: admin@crew2000.org.uk tel: 0131 220 3404

ADVISORY PANEL ON SUBSTANCE MISUSE

CHEMIST/ PHARMACOLOGIST AND CRIMINOLOGIST MEMBERS

Time Commitment - Minimum 6 days per annum. Remuneration – unpaid but reasonable expenses will be met.

The Advisory Panel on Substance Misuse provides the Welsh Government with independent advice on substance misuse issues and on the impact of policy development in related fields.

Applicants should have significant relevant expertise and working knowledge of substance misuse issues, in either chemistry/pharmacology or criminology.

The closing date for applications 15th November 2013.

For further details and to apply go to **http://wales.gov.uk/publicappointments** or for queries contact the HR Helpdesk on **029 2082 5454** or email **hr-helpdesk@wales.gsi.gov.uk.**

A large print, Braille or audio version of this advert can be obtained by request from 029 2082 5454.

Llywodraeth Cymru
Welsh Government

www.cymru.gov.uk

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INVESTORS IN PEOPLE

More jobs online at: www.drinkanddrugsnews.com

East Sussex LASARs Team

East Sussex County Council is re-commissioning its services for adults with drug or alcohol use disorders into a new county wide assessment and care management service (LASARs).

We are looking to recruit:

Senior Practitioner (Social Work Qualified)
£35,979 - £38,689 Full-time, Permanent
Countywide Ref: ASC3063

Social Workers x 3
£26,555 - £34,646 Full-time, Permanent
Countywide Ref: ASC3062

Resource Officers x 4.8
£26,555 - £28,684 Permanent
Countywide Ref: ASC3061

For an informal discussion, please contact: Kate Simblet, Acting Practice Manager on 07585 306 428.

To apply please visit: **www.eastsussex.gov.uk/jobs**

Closing date for all posts Sunday 10 November 2013.

Interviews will take place week commencing Monday 18 November 2013.

East Sussex County Council

POSITIVE ABOUT DISABLED PEOPLE

MY TURNING POINT

"It was when I found the right support at exactly the right time."

Are you ready to shape the way substance misuse services are provided in the UK? Do you have the expertise to respond creatively to the complex and highly individual needs of service users? And would you relish the opportunity – and freedom – to drive the growth of one of the country's most influential and successful social enterprises? Then it's time to join Turning Point.

Area Operations Managers

London or South West c. £45K

Area Development Managers

London or Home based c. £35K

These key roles call for substantial experience in substance misuse at a managerial level. But they also demand exceptional leadership skills, a passion for improving performance and the ability to identify and develop emerging opportunities in this rapidly changing sector.

Find out more and apply at: **turning-point.co.uk/workforus**

TURNING POINT
turning lives around

Brighton Oasis Project aims to improve the lives and maximise the potential of the diverse range of women, children and young people affected by substance misuse. We are currently looking to recruit for the following positions:

SUBSTANCE MISUSE RECOVERY WORKER (FEMALE*)

£21,067- £24,663 negotiable depending on qualifications and experience
(37.5 hours per week)

We are seeking to appoint an experienced substance misuse worker to join our existing adult services team. The team aims to deliver sustainable recovery for women, enabling them to achieve their goals and live healthier, more socially included lives.

The successful candidate will be committed to taking an empowering, holistic and individually tailored approach to case management and the delivery of a range of psychosocial interventions. They will continually develop and maintain meaningful and positive relationships with clients; maintain accurate and detailed case notes and help clients to access other relevant services.

Applicants must have a sound understanding and commitment to safeguarding children, experience of delivering individual and group work interventions to clients with complex needs, an ability to identify and manage risk, and be able to work effectively in partnership with multiple agencies.

HEALTH AND WELL-BEING COORDINATOR (FEMALE*)

£17,980 (37.5 hours per week)

We are seeking to appoint a health and well-being coordinator to promote the health, wellbeing and skills of men and women across the drug treatment system. The project has a focus on food and nutrition but encompasses other aspects of health that relate to recovery and address health inequalities facing this client group. The worker will utilise a range of health promotion approaches and knowledge of food alongside practical skills to promote a healthy diet for substance misusers. Alongside the health benefits the project aims to promote recovery for clients via supported volunteering opportunities and support to develop employment skills.

The health and wellbeing coordinator will work with agencies across the city to develop, deliver and support initiatives which will increase cookery skills and improve knowledge on healthy eating and food hygiene. They will be responsible for inputting into the programme work plan, effective programme delivery and ensuring that a robust system of monitoring and evaluation is implemented to maximise the long term stability of the project.

Applicants must be able to demonstrate a sound understanding of nutrition, food hygiene and health and safety, experience working with people with substance misuse issues would be an advantage or a similar client group. An ability to communicate and motivate others is essential.

**These posts are exempt under paragraph 7 (2) of the Sex Discrimination Act.*

CLOSING DATE: MIDDAY 14TH NOVEMBER 2013
INTERVIEWS: 21ST NOVEMBER 2013

To apply for either post please go to our website www.oasisproject.org.uk to download an application pack. To receive a pack in the post please call 01273 696970 or e-mail info@brightonoasisproject.co.uk. For an informal chat about the post, phone Stella Vickers on 01273 696970.

BOP is committed to equal opportunities and welcomes applications from people with relevant life as well as professional experience, and those with disabilities who are currently under-represented in the organisation.

People from Black and Minority Ethnic communities are underrepresented in our organisation and we particularly welcome applications from this group. Charity no: 0165503. Company no: 3447762.

INVESTORS IN PEOPLE

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Specialist Drug and Alcohol Service (SDAS), Bournemouth

Clinical Nurse Specialist

Job Ref: 342-DA073-0913
Salary: Band 7 £30,764 - £40,558 pa

This is an exciting opportunity for an experienced Clinical Nurse Specialist – Independent Non-Medical Prescriber to join the Specialist Drug and Alcohol Service (SDAS) in Bournemouth.

As part of this role you will provide clinical leadership and expertise to community substance misuse treatment services. You will be responsible for the continued development of substance misuse services within Bournemouth.

You will also be responsible for the assessment of needs, the planning and implementation of treatment and care to meet those needs as agreed within the Multidisciplinary Team and/or Supervisor, co-ordinating care (with supervision) and contributing to the evaluation of care across a variety of settings where specialist treatment is available.

Liaising as appropriate with other members of the Multidisciplinary Team, and other external agencies involved in the care if individual service users is an essential aspect of this job.

Leadership in the Integrated Governance process is a key aspect of this job as is contributing to the monitoring of service provision and performance and standards of care, through data collection and audit processes.

You will be required to liaise with partnership agencies, stakeholders, service users and carers within the substance misuse treatment service and other health and social care services.

For further details regarding this vacancy, please contact Daniel Willingale, Team Manager on 01202 977010 or email: dan.willingale@nhs.net

Closing Date: 12 November 2013

Apply online: www.awp.nhs.uk/working-for-us/vacancies/ using the job reference.

The Trust is committed to improving working lives and there are opportunities for flexible working.

the care forum

Advocate
(Drugs and Alcohol)

Salary £22,269 - £24,708
37 hours/week

The Care Forum is the lead voluntary sector umbrella organisation working in health and social care in Bath & NE Somerset, Bristol, North Somerset, Somerset and South Gloucestershire. It provides a range of services including Well Aware online directory of health and social care, Local Heathwatch and a range of advocacy services.

As part of the new Recovery Orientated Alcohol & Drugs Service (ROADS) in Bristol, The Care Forum is subcontracted to deliver advocacy support to people who use drugs and alcohol services in Bristol.

Applicants should have experience of providing advocacy and a current working knowledge of drugs and alcohol services and legislation.

We welcome applications from all sectors of the community. Our offices in Fishponds, Bristol are free from barriers and fully accessible.

For a job pack, go to www.thecareforum.org or email angelabragg@thecareforum.org.uk or telephone 0117 958 9302

Closing date for the post is 5pm, Monday 18 November 2013
The interview date is Wednesday 27 November 2013