DDN'S REVIEW OF THE YEAR INSIDE

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Merry Christmas to all our readers

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The call for minimum pricing is not going to go away, says Alcohol Concern p6

FAMILIES FIRST
The second national Adfam/ DDN conference for families and carers p8

PROFILE
Jacquie Johnston-Lynch on the new challenges facing the recovery movement p16

DDN Drink and Drugs News

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Editorial – Claire Brown

A listening ear

Why family support must be part of the system

Our second Families First conference with Adfam (page 8) had some intensely moving moments. We knew that family members and carers were coming, alongside practitioners and support workers, and we knew there would be lively debate throughout the day. But we were shocked by the predicament of those family members and carers who shared their desperation. Particularly unpalatable were accounts of unresponsive GP surgeries that turned a deaf ear to the effects of addiction on the family, even when parents described their need for help. Throughout the day came the call for commissioners to take notice of the valuable asset family members can represent in tackling addiction. Many of the small regional family support groups throughout the country are proof that a little love and understanding can go a long way in helping family members to cope. There are some remarkable activists out there, persistently putting notices in GP surgeries (even when they are regularly taken down) and mounting displays in local libraries. If we could bring more of this magic into mainstream commissioning we would surely be on the right track.

Once again this year we have run our Christmas card campaign (page 14), with proceeds helping to keep DDN free of charge. Our warmest thanks to everyone who has supported us – season's greetings and keep in touch over the holidays on Twitter @DDNmagazine and our DDN Magazine page on Facebook!

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THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES, TENDERS – AND YOUR DDN CHRISTMAS CARDS!

NEWS IN BRIEF

HIV ACTION

A new three-year HIV prevention programme has been backed by the leaders of all 33 London boroughs, with more than £3m allocated to run the project until 2017. Eighteen of the 20 local authorities with the highest diagnosed HIV prevalence are in the capital, which saw its first increase in new cases for a decade – 8 per cent – in 2012. 'It is alarming to see such a sharp increase in HIV diagnoses, but London boroughs have been quick to act,' said London Councils executive member for health, Theresa O'Neill. Earlier this year the National Aids Trust warned that London's councils were failing to respond appropriately to increasing levels of high-risk drug use in parts of the gay community (*DDN*, April, page 6).

WHAT'S ALL THIS THEN?

The Home Affairs Committee has announced an enquiry into the effectiveness of police and crime commissioners (PCCs). Despite being a 'key part' of the new policing landscape, their work 'has not been without controversy,' said committee chair Keith Vaz, while the Independent Police Commission's *Policing for a better Britain* report stated that the 'experiment' with elected PCCs had been 'riddled with failings'. A separate report has been issued by the Revolving Doors Agency, focusing on PCC responses to groups such as young adults and people with complex needs. Meanwhile, seizures of class A drugs fell by 3 per cent in 2012/13, according to the Home Office, while class B seizures fell by 10 per cent. *Policing for a better Britain at independentpolicecommission.org.uk, First generation: one year on at www.revolving-doors.org.uk, Seizures of drugs in England and Wales, 2012/13 at www.gov.uk*

PHOENIX FINALISTS

Welsh band CoverUp from Bridgend have been named winners of Phoenix Futures' Re:Cover music project (*DDN*, September, page 5). Other finalists were Common Ground from Glasgow, Leeds rapper Nate, singer/songwriter Adam Norrie from Sheffield, Essex-based Rob the Liar, London solo artist MJ Lines, Leicester band Maya and Phoenix Voices, a choir featuring community members from Phoenix's Wirral residential service. *Hear them all at www.phoenix-futures.org.uk/recover*

OLDER OPTIONS

A pocket guide on preventing alcohol-related harm to older people has been published by the British Association of Social Workers (BASW). The guide contains a section of dos and don'ts as well as effective approaches for interventions. *Alcohol and older people available at www.skillsconsortium.org.uk*

New injecting patterns fuel HIV risks

More people are injecting new psychoactive drugs, amphetamine-type substances and anabolic steroids, according to a report from Public Health England (PHE).

In England and Wales, HIV infection levels among people who inject image and performance-enhancing drugs (IPED), such as steroids or melanotan, is similar to that among people who inject heroin, warns *Shooting Up: Infections among people who inject drugs in the UK 2012*.

While needle and syringe sharing overall is lower than a decade ago, one in seven injecting drug users continue to share injecting equipment, says the report. The number of people injecting amphetamines or amphetamine-like substances such as mephedrone, however, almost tripled in the decade to 2012, with this using population less likely to have been tested for HIV or hepatitis C and more likely to report sharing.

While heroin remains the most commonly injected drug – either on its own or in combination with crack – changes in patterns of use 'that increase infection risk need to be detected and responded to promptly' in order to minimise harm, the document states. In many areas, IPED users are the largest group accessing needle exchange services, with one in ten having been exposed to one or more of HIV, hepatitis C or hepatitis B.

'Viruses don't discriminate,' said PHE's lead on injecting drug use, Dr Fortune Ncube. 'We must maintain and strengthen public health interventions focused on reducing injection-related risk behaviours to prevent HIV and hepatitis infections among all drug users. This includes ensuring easy access for those who inject image and performance enhancing drugs to voluntary confidential testing services for HIV and hepatitis, as well as to appropriate sterile injecting equipment through needle and syringe programmes.'

Meanwhile, the overall number of people in drug treatment has continued to fall, according to PHE's most recent statistics. The total number in treatment in 2012-13 was 193,575, down from 197,110 the previous year and a peak of almost 211,000 in 2008-09. People over 40 now constitute the largest group entering treatment, with 13,233 over 40s entering treatment for heroin or crack, up from 12,535 the previous year.

'Drug misuse is by its nature a highly challenging issue to address and the indications are that the going is getting even tougher for services in meeting the needs of an evolving and increasingly complex treatment population,' said PHE's director of drugs and alcohol, Rosanna O'Connor.

Shooting up: infections among people who inject drugs in the UK 2012. An update: November 2013, and Drug treatment in England 2012-13 at www.gov.uk/government/organisations/public-health-england

Marcus Roberts takes the helm at DrugScope

Marcus Roberts has been named as the new chief executive of DrugScope, taking over from Martin Barnes who steps down at the end of this month (*DDN*, October, page 4).

DDN columnist Roberts is currently DrugScope's director of policy and has worked in the voluntary and community sector since the late 1990s, including senior policy roles at mental health organisation Mind and crime reduction charity Nacro.

'It is a great privilege and responsibility to be taking over as chief executive at what is such a critical time for the drug and alcohol sector – and DrugScope itself – with significant opportunities but also uncertainties,' he said.

Much of the sector's work is about ensuring the 'right kinds of support are available at the right time for marginalised and stigmatised people and communities', he said, with 'significant' progress made over the last decade. 'We now face the challenge of taking this legacy forward and building on it at a time of radical policy change and with significant financial pressures. I believe that DrugScope has a critical role to play – informing, supporting, offering a focus for discussion and debate and providing effective voice, representation and leadership on key issues.

'I am also excited by the potential to reach out across the health and social policy spectrum to highlight the pervasive relevance of drug and alcohol issues across society, with the opportunities to initiate new dialogues and develop new kinds of intervention and support.'

See page 12 for a full report on DrugScope's annual conference

'DrugScope has a critical role to play...'

Marcus Roberts

Target 'enablers' of teen drinking, says think tank

People who buy alcohol on behalf of underage drinkers should face penalties including community service, shop bans or 'social shaming', according to a report from think tank Demos.

Information campaigns on underage drinking should also target parents, says *Sobering up*, while shop staff should be properly trained in how to refuse sales.

The report wants to see far tougher action on 'proxy purchasing' from local authorities and police, as a third of 11 to 15-year-olds surveyed reported obtaining alcohol in the previous month. One in five were given the alcohol by parents and the same proportion by friends, and 13 per cent had asked others to buy them alcohol compared to just 3 per cent who had illegally purchased it themselves.

Alcohol-related community service, such as clearing up city centres, would be a 'justifiable penalty' for proxy purchasing, says the document, along with prominently displayed 'name and shame' posters in off-licences. Although £5,000 fines are available in law for purchasing alcohol on behalf of a child, the current on-the-spot fine is £90.

'The majority of teens get their alcohol through parents, friends and older siblings, rather than buying it themselves,' said report author Jonathan Birdwell. 'However, these proxy purchasers aren't facing the consequences for the harm they are doing. All the evidence shows that underage drunkenness increases alcohol risks later in life.' Far tougher action than the current practice of test purchasing was needed, he said, including 'threatening parents who buy alcohol for their children to drink unsupervised with "social shaming" like community service'.

Meanwhile, a report from the National Foundation for Educational Research (NFER) states that giving young people 'the facts' about alcohol and equipping them to make informed decisions helps to delay the onset of drinking. Of around 4,000 12 to 14-year-olds surveyed, those who had learned about alcohol and making responsible choices in Personal, Social and Health Education (PSHE) lessons at school were 'significantly' less likely to start drinking than those who hadn't.

Meanwhile, Portsmouth – cited in the Demos report as the first local authority to introduce a hotline for people to report proxy purchasing – has launched a new initiative to persuade off-licences not to sell beer and cider with an alcohol volume of more than 6.5 per cent. So far 25 retailers have signed up to 'Reducing the strength', a partnership project with Hampshire Constabulary.

Sobering up at www.demos.co.uk

Talk about alcohol: an evaluation of the Alcohol Education Trust's intervention in secondary schools at www.nfer.ac.uk

For a full report on Alcohol Concern's annual conference, see news focus, page 6

Afghanistan sees record opium crop

Afghanistan's opium poppy cultivation rose by 36 per cent this year, a record high, according to the UN, while opium production was up almost a half on the previous year, at 5,500 tons.

The area under cultivation in 2013 was almost 210,000 hectares, says the United Nations Office on Drugs and Crime's (UNODC) *2013 Afghanistan opium survey*, higher even than 2007's peak of 193,000 hectares. Prices are also much higher than during the previous high-yield years of 2006-08, it says, with the 'farm-gate value' of opium production increasing by almost a third since last year.

One possible reason for the increased cultivation may be farmers trying to 'shore up their assets as insurance against an uncertain future' prior to next year's withdrawal of international forces, says the document. Almost 90 per cent of cultivation takes place in nine southern and western provinces, including 'the most insurgency-ridden provinces in the country', with a significant slowdown in Afghanistan's legal economy also predicted for next year.

The figures were 'a warning, and an urgent call to action', said UNODC executive director Yury Fedotov. 'If the drug problem is not taken more seriously by aid, development and security actors, the virus of opium will further reduce the resistance of its host, already suffering from dangerously low immune levels due to fragmentation, conflict, patronage, corruption and impunity.'

Available at www.unodc.org

'Farmers trying to shore up their assets as insurance against an uncertain future.'

NEWS IN BRIEF

UNDERLYING CAUSES

Drug services should increase their focus on underlying traumas and difficulties, according to a new report from the Scottish Drugs Forum (SDF). High quality psychological therapies need to be more widely available, says *Trauma and recovery amongst people who have injected drugs within the past five years*, with failure to respond effectively storing up future problems for individuals, families and society. Interviewees' drug use was primarily a 'dysfunctional coping response', says the document. 'We hope that the findings of this research will help challenge the all-too-common perception that a person's drug problem is a lifestyle choice or "self inflicted",' said SDF director David Liddell. 'We need to recognise and take action on the wider factors underpinning substance use dependency which have blighted generations of disadvantaged families across Scotland.' *Available at www.sdf.org.uk*

HEP STEP

A commitment to introduce an opt-out test for hepatitis C and other blood-borne viruses by next April has been included in a partnership agreement on co-commissioning health services in prisons between the National Offender Management Service (NOMS), NHS England and Public Health England (PHE). It is thought that up to one in ten prisoners has hepatitis C, a virus that is 'grossly underprioritised' according to the Hepatitis C Trust (*DDN*, November, page 4). Trust policy advisor Becky Hug called the agreement a 'brilliant step forward to improving public health, both inside and outside prison walls'.

PBR PROBLEMS

Payment by results has suffered from 'crude implementation', according to a report from the National Council for Voluntary Organisations (NCVO), with some contracts failing to account for the complex nature of services or containing targets irrelevant 'or even detrimental' to the desired outcomes. 'Implementing PbR effectively requires intelligent thought and carefully crafted incentives, but many PbR contracts fall well short of this,' said NCVO chief executive Sir Stuart Etherington. 'Crudely designed targets and contracts risk pushing expert voluntary sector providers out of public service provision.' *Payment by results contracts: a legal analysis of terms and process at www.ncvo.org.uk*

WELSH DEATHS DOWN

The number of deaths related to drug misuse in Wales fell to just over 130 last year from more than 150 in 2010, according to Welsh Government statistics. More than 200 lives have also been saved since 2009 through the take-home naloxone campaign, the government says. *Substance misuse in Wales 2012-13 and Working together to reduce harm: substance misuse strategy annual report 2013 at wales.gov.uk*

CHANGING THE CONVERSATION

Delegates at Alcohol Concern's conference heard about the need to reframe debate on alcohol, and how the call for minimum pricing was not going away. ***DDN*** reports

'WE STILL DON'T TALK ABOUT IT ENOUGH – NATIONALLY, AT HOME OR IN THE WORKPLACE,' said Alcohol Concern chair Richard Sumray of his organisation's conference theme, *Conversations about alcohol*. Many people were unaware of the impact of their own habits, he said, while the industry had 'held sway' on minimum pricing. 'But it's not something we intend to give up on. We don't intend to stay quiet.'

Although alcohol consumption in Europe had fallen in the 20 years to 2010, there were huge differences between countries, said alcohol and illicit drugs programme manager at the WHO regional office for Europe, Dr Lars Møller, with the UK's consumption rising over the same period. 'Even though it's now stabilising, that's still a message that should be concerning politicians, particularly with regard to groups like younger women,' he said.

Britain was losing the fight against alcoholic liver disease, said Professor Sir Ian Gilmore of the Alcohol Health Alliance, with a 'meteoric' rise since 1970 and the standard death rate for liver disease in under-65s dramatically bucking the trend for other conditions. Alcohol-induced cirrhosis at 35 was no longer uncommon, he added. 'When I became a hepatologist, cirrhosis was a disease of elderly and middle-aged men. But we can do something about it. We have a secretary of state for health who's committed to reducing premature death, but he's not following the evidence when it comes to things like pricing. Why does the precautionary principle not apply to alcohol – why is the onus on health advocates to prove harm? Because industry advocacy is more effective.'

The drinks industry 'pushed the paradigm' that harm was a problem of small specific groups like young binge drinkers, he said, rather than the product itself. 'But alcohol is not an ordinary product. It's a psychoactive substance and a drug of dependence. We need to begin to reframe the questions, and we do have the tools to change the culture. We need to work harder to bring society to where it will be ready to accept tougher regulation by working on the key messages of alcohol harm.'

'I'm very keen that Public Health England (PHE) shapes up to do something about the alcohol agenda,' its director of alcohol and drugs, Rosanna O'Connor, told the conference. 'We all know the problems are widespread, and that this isn't new. So why is it so difficult?' Alcohol was legal, provided jobs and was associated with very powerful vested interests, she said. 'And it's very much part and parcel of people's lives and culture. It's absolutely ingrained, and excess use is condoned on many fronts. It's in our face, all the time.'

PHE expected alcohol to be one of its top priorities for next year, she said, and the organisation would continue to 'advocate the evidence base and challenge government on minimum pricing. Just because things are quiet doesn't mean it's gone away – there's a lot of work going on to get it back up the agenda.'

PHE would also be producing guidance on using local health information to inform licensing decisions, she said, as well as encouraging people to drink within lower risk levels and working to reduce the impact on people who already experienced harm. 'Most of the population is kidding itself,' she told delegates. 'There needs to be a big debate and turnaround of people's attitudes. Alcohol is complex issue that needs a multi-layered approach at national and local level, but I take real heart in the way things have changed around smoking. I thought there'd be huge resistance to the smoking ban but people have really embraced the changes in policy.'

'The next 18 months are going to be crucial,' Alcohol Concern chief executive Eric Appleby told the conference. 'Is localism going to work, or will the lack of national direction leave local areas with too much of a challenge?' However, local authorities had a better understanding of, and links with, communities than PCTs, stated cabinet member for health, social care and culture at Hackney council, Jonathan McShane, and there was also great potential with health and wellbeing boards.

Scotland had decided to take a whole population approach to alcohol, which inevitably meant minimum pricing, said head of the Scottish Government's public health division, Donald Henderson. 'Price and affordability are an essential element. Lower prices equal higher consumption – that's a truth within a market economy.'

The greatest benefit came from targeting what the heaviest drinkers consumed, he said, which was the cheapest alcohol. 'We have a confidence in this policy, and we agree that if it doesn't have an impact it shouldn't be there.' There was to be a review of its effectiveness after five years, and the 'sunset clause' meant that without a positive parliamentary vote the legislation would 'automatically die', he pointed out.

'We've had minimum pricing for years,' director of the Centre for Addictions Research of British Columbia, Tim Stockwell, told delegates. 'All of Canada's provinces have some kind of minimum pricing for off-sales and/or bars, but they're not there for health reasons – they're to protect local businesses and government revenue.' However, when Saskatchewan had increased all of its minimum prices simultaneously in 2010 – and graded the increases according to strength – the results had been dramatic, he said.

A 10 per cent increase in minimum price had been associated with an 8.4 per cent overall reduction in consumption – 10.1 per cent for beer, 5.9 per cent for spirits and 4.6 per cent for wine. 'There was a significant shift away from higher-strength drinks, and deaths and hospital admissions were down in two to three years.' This meant that the Sheffield model for mapping the impact of alcohol policies [*DDN*, June 2012, page 4] was actually conservative, he stressed, as it saw the chronic disease benefits of minimum pricing only becoming apparent after ten years. 'Minimum pricing targets in a very focused way the people who are drinking the most and suffering the most harm.'

Ten per cent of the population drank around 47 per cent of all the alcohol consumed, said public health research fellow at the University of Sheffield, Dr John Holmes, part of the team that produced the model. Although it was frequently argued that minimum pricing would have an adverse impact on moderate drinkers on low incomes, 'the benefits of this policy largely accrue to lower socio-economic groups,' he said. 'Lower income people aren't in general heavy

'Just when you, the communicators, are sick to death of saying the same thing over and over again, that's the point at which it starts to touch the outer rim of public consciousness.'

ALASTAIR CAMPBELL

drinkers, but they do tend to suffer more harm as a result', perhaps because of a combination with other issues like tobacco and obesity.

'This is a fairly frustrating time,' keynote speaker Alastair Campbell told the conference. 'David Cameron came forward with what looked like a fairly decent alcohol strategy, and now that's not happening. But the thing with campaigning is you just need to keep going. The arguments build and build and just when you the communicators are sick to death of saying the same thing over and over again, that's the point at which it starts to touch the outer rim of public consciousness.'

Setbacks were inevitable but it was vital to 'keep making the same point', he stressed. 'David Cameron said he was going to do minimum pricing. He didn't, and deep down he probably still wants to. You just have to keep going. None of the big campaigns are easy but you have to keep working until you reach a tipping point.' Most people that campaigners were trying to reach were not 'inside your bubble', he pointed out. 'What persuades them in the end is the power of your arguments. Every time you make a point you're landing a tiny dot on the landscape, and over time those dots join up.'

Alcohol had been normalised at every level of society, he said, and the industry had been very effective at persuading people that minimum pricing was regressive and that the problem did not lie with them. 'These arguments have got to be countered, and it's about making sure that governments know. With ministers, don't assume too much knowledge – they're bombarded all the time, so you need to get inside their big picture, not just your own. The change will come if enough people keep making the same points. However bad it feels at the moment, if you keep going you can get there.' **DDN**

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

After 12 years of fighting, Afghanistan opium production is at a record high. The UN's drug agency says that the area under cultivation rose 36 per cent in 2013 and that Afghanistan now provides 90 per cent of the world's heroin. The country we invaded partly to liberate it from the drug trade has become a narco-state.
Telegraph editorial, 13 November

The trouble with a policy that looks at each drug in turn is that it is simply overwhelmed by the sheer scale of production of the legal highs. No less worrying, though, the UK government response effectively leaves young people as the guinea pigs in their own national experiment; only when the hospital admission statistics start to mount up will the government take action. That is a shocking abrogation of responsibility.
Neil McKeganey, *Scotsman*, 4 November

I predicted that we'd soon be deep into 'personal tragedy' territory as the Left tried to play down the louche behaviour of disgraced Co-op Bank chief, the Reverend Paul Flowers. Needless to say, the *Guardian* loftily dismissed his rent-boy and porn habits and serial drugs abuse as 'quite separate' from his stewardship of the bank. The *Grauniad* even went one better than I imagined and described it as a 'personal catastrophe'. My dictionary defines a catastrophe as a sudden disaster, usually beyond the victim's control. A tsunami is a catastrophe. Stuffing the horse tranquilliser ketamine up your nose, using male prostitutes and fiddling your expenses to the tune of £75,000, all over a period of years, is not a catastrophe. It's madness.
Richard Littlejohn, *Mail*, 22 November

The young people of the 70s, 80s and 90s were successively more prodigious drug-users than their forebears. You have to wonder what they will do for fun when the kids leave home and the mortgage is paid off. There may not be an army of older people out there buying drugs like the former Co-op chairman, but there may be one amassing just over the hill.
Leo Benedictus, *Guardian*, 18 November

Banal theories that cocaine was behind the credit crisis, propagated by the likes of Professor David Nutt, reveal far more about the critics' own prejudices than they do about the reality of drug use in the industry.
Seth Freedman, *Guardian*, 18 November

Alcohol is highly toxic to all bodily systems, locks about 10 per cent of users into addiction and is responsible for more deaths worldwide than either malaria or Aids. Estimates suggest alcohol-related harm in England costs the NHS £3.5bn a year. But when it comes to decreasing the potential for harm, minimum pricing strategies aren't exactly vote-winners with the public – and we already know that prohibition fails miserably.
Nat Guest, *Independent*, 13 November

Iain Duncan Smith is unfit for work. Not even an Atos test would pass Mr Cruel Incompetence as capable of doing a job. The courts regularly rule his Department for Work and Pensions is breaking the law. And his regular bullying of the disabled should earn IDS an Asbo.
Kevin Maguire, *Mirror*, 11 November

There's been plenty of progress in bringing family support to the fore – but there's still a long way to go to convince commissioners, heard the second national conference for families and carers. DDN reports

STEP BY STEP

'We might be fed up of banging on about the same old thing – but many families haven't heard it and it's important that they do,' Adfam's chief executive Vivienne Evans told delegates at the second Adfam/*DDN Families First* conference. 'We have to aim that people can speak out.' Much of Adfam's work was centred on promoting family support in its own right, tackling stigma, and developing forums and regional networks, she said.

Mark Gilman, national recovery strategy lead at Public Health England (PHE) believed in the essential value of support networks. 'Social relationships are a matter of life and death,' he said, adding that social isolation could be 'a death sentence alongside the chemicals.' This applied equally to families of loved ones, whose involvement with organisations such as Al-Anon showed better outcomes and support throughout the recovery process.

Nick Barton, chief executive of Action on Addiction tackled the difficult concept of 'tough love', commonly seen to mean not tolerating certain behaviours and often driven by helplessness.

'When someone comes up with a simple formula like tough love seems to be, there'll be plenty of takers,' he said. 'But the core question is, can you get someone to stop their addiction by the way you relate to them? My answer would be no. And can you improve your life by the way you relate to someone with addiction? The answer is yes.'

Setting boundaries was no bad thing between adults, but it had to be done for the right motives. Families needed to realise that it might have an effect, or it might not, he said.

'Addicted people often offer invitations to treat them badly,' he stated. 'We don't have to accept these – in fact they should be resisted. Don't take the addicted behaviour personally – it's not directed at you. It's about their difficulty in being themselves.'

A nurturing attitude to helping was usually better than confrontation, he suggested. 'There's no evidence for tough love. It can be counterproductive and make problems worse.'

Participants in a 'carers' rights' workshop were glad to hear this advice.

'It was so reassuring to hear Nick Barton's talk on tough love and that it doesn't necessarily work,' said a couple from Southampton. 'We had been living with guilt as we couldn't do it.' The couple's son had been 'cast adrift' from a young people's support service as soon as he'd reached 18, leaving them struggling, with nothing but the number of a local support group that had turned out to be a lifeline.

'We might be fed up of banging on about the same old thing – but many families haven't heard it and it's important that they do.'
VIVIENNE EVANS

The couple explained that they had been to their family doctor who gave no more help than to say 'I don't know how you cope,' leading to a discussion within the workshop about the need for GPs to be actively involved.

'The biggest theme to come out of this is that GPs should signpost information and support,' said Su Bartlett, drug and alcohol development worker at Carers in Hertfordshire, who led the workshop.

'Caring is tough whatever the rules,' she said. 'It's hard work and often a battle. The impact is on your physical and mental health – it's a huge, huge issue.'

It was even difficult to get people to identify with the label of carer. 'Some drug and alcohol carers feel that they shouldn't be accessing services,' she said.

A UK Drug Policy Commission (UKDPC) study suggested that around 1.5m

Clockwise from left:
Vivienne Evans, Adfam; Claire Robinson, PROPS North East;
John, Al-Anon;
Kate Peake, Adfam;
Nick Barton, Action on Addiction;
Sarah Rigden, Wiltshire Addiction Support Project;
Una Gordon, DHI

DRINKING AFFECTS EVERY FAMILY DIFFERENTLY

'Alcohol often gets left behind when people talk about substance misuse,' said Alcohol Concern's workshop programme manager, Lauren Booker, in a session about alcohol and families.

adults in the UK were affected by a relative's drug use, but other studies put this number closer to 8m, she said. Whatever the figure, there was no doubt of the significant negative impact on physical and mental health, emotional wellbeing, family relationships and finances, and the health and wellbeing of any children involved.

The workshop group brought family members and carers into discussion with practitioners, and the conversation frequently became impassioned as carers brought their day-to-day tensions to the group.

'I don't hate my son, but I hate what he does,' said a mother. 'It helps me to go to the support group. I hadn't really thought of myself as a carer till today – I'm his mum. My group takes us away on days, such as spa days, and I think "why am I here? Because my son's a drug addict."'

'My son was on drugs for nine years before I knew about support,' said another mother, highlighting how far family support still needed to go.

'So how can we encourage people to access support for themselves?' asked Su Bartlett. The Adfam stigma campaign would help to show that carers had a right to get angry and give them the way forward to deal with a lot of internal processes, said Esther Harris, an independent practitioner.

'A lot of parents believe it's their fault, and this erodes the belief that they deserve something for themselves.'

Adfam's Kate Peake addressed the issue of stigma at a plenary session later in the day and explained the charity's 'Speak Out' campaign.

'It's about telling the world this can happen to anyone,' she said. This isn't an additional extra, it's intrinsically related to the main agenda. It's about regaining humanity for family members.'

Family members were not comfortable talking about their issues, but could be encouraged to share, she said. Illustrating her point with an account of organising a flash mob with a carers' network in Tyne and Wear, she said the important message to convey was that 'things can and do get better'. This local initiative had enabled the participants to give out the message that 'family members need support and here's where you can get it'.

'There's still stigma, but there are huge changes and we need to learn from that,' she said. 'We have to take small steps.'

While alcohol had always received less money for services, people who gave up class A drugs often turned to alcohol, using it as a replacement, Lauren Booker explained. Roughly 1m children lived in a household with one or more dependent drinkers and almost a fifth of the population were affected by the alcohol use of family members.

The most common question asked by relations and friends of people with alcohol problems was 'What can I do to help?' While the World Health Organization defined dependence as 'when alcohol affects physical, emotional and social functions', it also applied to the functions of those around someone who struggled with alcohol issues.

During the workshop, case studies were given to groups describing a family of five with two parents who drank the same amount of alcohol per week (over the recommended number of units) but in different social and economic situations. Groups were asked to give examples of the effect of alcohol on the families – depression, break-up of the family, abuse, bad influences on the children leading to trouble at school or with the police, problems with household budget and negative impact on careers.

It was agreed that drinking affected every family differently and that there was no 'standard' pattern of what would happen. The environment surrounding the family and alcohol users had a big impact – it was never cut and dried. Alcohol was a short-term coping method, but caused more problems in the long term.

Participants discussed what could be done to help families who were experiencing alcohol misuse. The ideal was to catch it early before problems became serious. Failing that, what was necessary was early identification, assessment and referral pathways, coupled with better multi-agency working.

Effective approaches to helping family members included online forums, recovery communities, and workplace counselling and referrals. It was essential to know what different services were available and to recognise that treatment did not necessarily mean abstinence.

Alcohol was all around us, in our society, community and families, said Lauren Booker, and there was a lot we could do about alcohol-related harm. However, it would be a slow process, in the same way that society eventually began to realise that tobacco was harmful and the culture around it changed.

'We are at the start of a long-term mission to change the way the nation drinks,' she said.

'It breaks my heart and also makes me angry to see my daughter being treated as a criminal... Underneath I know there is a vulnerable damaged woman who struggles to cope...'

KATE MCKENZIE

SUPPORTING ROLE

Kate McKenzie tells of the seismic effect of her daughter's addiction

Hannah's struggle to overcome her drug addiction has been a very testing time – often heartbreaking, frequently frustrating and even at times surreal. It has had a great impact on all the family and changed us forever. My younger daughter dropped out of school, my marriage broke up, illness and money problems soon followed. Drug addiction doesn't just affect the lives of the addict but also those close to them.

Hannah is 26 and this struggle has been going on for over half of her short life. It began at 13 with anorexia, bulimia, self-harming and alcohol; from there it was a short step into the world of drug addiction. The descent was rapid and devastating and by the time she was 18 she was addicted to heroin.

At the time, my knowledge of drugs, and heroin in particular, was extremely limited. I knew it was dangerous, and that we should teach our children to 'just say no' and that advocating an abstinence policy was the way forward. My assumption that those who used drugs chose their lifestyle and somehow deserved to be sitting begging on the streets or selling the *Big Issue* was typical of many people's. I now know I knew nothing at all about drug addiction.

What I subsequently discovered is that many drug users are messy, damaged, chaotic individuals with very complex needs. Yet time and time again while trying to help my daughter I found the treatment available to her was piecemeal, complicated and punitive. Those who use drugs cannot be fitted into neat bureaucratic systems and there are no easy 'one size fits all' solutions.

After a period of almost two years of being clean, Hannah relapsed last summer. I was devastated as I could predict the vicious downward spiral of disease, degradation and crime she would inevitably be sucked into. I also knew the destructive impact this would have on her sister and me. Straightaway the trust between us was broken. We could no longer leave handbags lying around, I hid all my valuable jewellery, I changed the locks on my flat. I hated doing this, but I knew what would happen if I didn't.

The lies started, the money ran out. Moneylenders circled and drew Hannah in. Finally when the source of funding ran dry, the crime and prostitution began, swiftly followed by illness and overdoses. It was all too depressingly familiar. The relationship between us reached an all-time low on Christmas Day when I refused to pay for another hit. I was damned if I helped her and damned if I didn't.

Hannah's appearance in court earlier this year was one of many, and highlighted how punishing those who use drugs is a pointless exercise. Hannah was already in debt to moneylenders to the tune of £10,000 – a further £1,000 fine for stealing goods worth £30 was not going to achieve any positive outcome. Fortunately, simply because I was there, I convinced the duty solicitor to argue her case. The judge was sympathetic and she was given a 12-month discharge. I know very well that this would not have been the case for many others in a similar situation.

I asked myself what would make a difference to Hannah's predicament and also to the many others trapped, like her, in this all too familiar cycle of addiction and recovery. I came to two conclusions. Out of all her addictions – anorexia, bulimia, alcoholism to name a few – her drug addiction is the only one that is criminalised.

If Hannah had been able to be stabilised on prescribed heroin, then her need to find £20 for the next fix simply wouldn't exist. Her benefit money would continue to be used for food, not heroin. She would still be able to pay her rent and not be made homeless. She would not have to shoplift and steal.

On a personal level, it would remove so much of the anxiety and worry that I felt as soon as she relapsed. The trust would remain between us and the arguments over money for the next fix would cease. Most importantly though, the control and provenance of her drugs would be in the hands of doctors, not dealers. All the harm caused by black market heroin would be reduced considerably.

I know that prescribing heroin is not the only solution to this problem, but used in conjunction with other holistic forms of treatment and rehabilitation it makes sense to me. To allow Hannah to be stabilised on the drug of her choice, administered in a safe environment, would enable her to have more control of her recovery.

The second conclusion I came to concerns changing the focus of the treatment onto the cause of her addiction and not the symptoms. Hannah had been diagnosed as bipolar from quite a young age, leading to bouts of mania and depression. Because she is on heroin, no NHS psychiatrist will go near her. Their response is to say that until she comes off heroin they cannot treat her, yet she uses the drug to cope with her mental illness and so is caught in a catch-22 situation.

Some years ago she had a manic episode and attacked my younger daughter with the kitchen knives. I managed to calm her down and not knowing where else to go, I took her to A&E. After many hours waiting, the young doctor appeared and apologetically explained there was nothing he could do. The duty psychiatrist refused to be called out because Hannah was on drugs, so he suggested I took her home and hid the knives.

By contrast, her current treatment within the French health system has been a revelation. In April, Hannah went to stay with my sister in France in an attempt to detox. While there, she became severely dehydrated and was taken to

WE SHOULD BE DEMANDING NALOXONE

'WE NEED FAMILY MEMBERS OUT THERE ADVOCATING NALOXONE,' said drugs trainer Nigel Brunsdon, leading a workshop about this life-saving intervention. Who better to put pressure on commissioners than families, daughters, sons, mothers and fathers, he asked. 'We should be demanding naloxone. It shows we care. We care if someone lives or dies.'

'The more people that are trained, the more people can train,' said Dr Judith Yates, a GP in Birmingham. 'It should not be one and a half hour sessions, it should be normalised, part of life – not made an occasion.'

With an (award winning) video of his daughter demonstrating saving her teddy bear from an overdose (pictured), Brunsdon showed how administering naloxone correctly was 'child's play'.

'As long as it is injected into the thigh muscle it's fine – you cannot overdose from naloxone,' he reassured participants concerned about lack of knowledge. It was important to get naloxone into families with drug-using children or parents, he stressed.

For more advice and the naloxone film, visit www.injectingadvice.com

'I say to families, please share your story. Tell as many people as possible...'

JASON GOUGH

hospital. The next day she was transferred to a psychiatric unit and the consultant explained to me that her heroin addiction was just a symptom and not the cause of her problems. Until her bipolar illness was properly treated and controlled, she would continue to self-medicate on heroin.

This was a first! To have the focus shifted from the drugs to her bipolar totally changed how she viewed her situation. Instead of being labelled as 'just another junkie', she felt her illness was at last being taken seriously. Her whole demeanour changed and became more positive; she began to believe she could really get well again.

For me, it meant I no longer had to fight the system to get help – it was being offered willingly and without any conditions. I was able to leave her in France, knowing that she was getting joined-up care and support for her complex problems.

Seven months on, Hannah is still receiving excellent outpatient treatment and psychiatric support. She has just been over for a two-week visit and the progress in her recovery is encouraging. She no longer has cravings and is a lot calmer. Her ability to deal with normal everyday issues has improved dramatically and she is starting to look ahead and plan a future.

My journey alongside Hannah in the past ten years has motivated me to try to seek better understanding and treatment for those who use drugs. I want people to know and really understand the cause of drug addiction and not be misled by the sensationalist articles pedalled by the popular press.

It breaks my heart and also makes me angry to see my daughter being treated as a criminal. When she is in the grip of her addiction she can become a monster and do things that even I find hard to accept and condone. But underneath I know there is a vulnerable damaged woman who struggles to cope with life and uses the drugs to escape from her problems.

When clean, Hannah is a kind, thoughtful and vibrant daughter who deserves to have a happy and fulfilling life. One day I hope she will finally achieve that. Until she does, I will continue to shout as loudly as I can to tell people the truth about heroin addiction. Ultimately I hope we can change misguided assumptions and get a majority to understand that people like Hannah need help, not punishment.

Only then, when we have significant numbers of people behind us calling for a change in current drug laws and policies, will we persuade politicians to be brave enough to implement the changes needed and provide the joined-up care and treatment people like my daughter really need.

TOUGH LESSON

Jason Gough recalls realising the impact he was having on his family

While I was in active addiction I didn't understand the full impact of it on my family. Dad used to say 'if you want to see our front room, go to cash converters – it's all in there.'

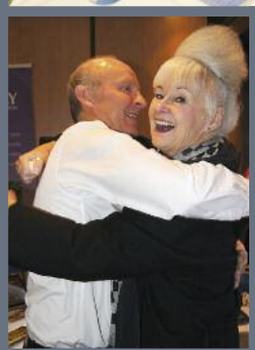
It was only later that I realised I'd made our home an unsafe place. My family became frightened of me. I was oblivious to this; I thought at the time that I was the one who was suffering. I imagined I was protecting them in some way. When I was relapsing I didn't say anything. I didn't want to spoil the joy of 'Jason's getting better'.

In the early days it was all about escaping and nothing about my family. One day I clicked on a YouTube clip of the effect of drugs on a family and realised the impact. Hearing what someone else said had a huge effect on me. I left Sheffield that day, went to my mum, and told her I was sorry, that I loved her. I began the process of looking at my parents as individuals with their own hopes and desires, not just people there to serve Jason.

I realised how my addiction had affected them – it felt like losing a limb. I could recover from it, but life would never be the same. It was extremely difficult, realising the effect on my family. Without their support I could never have got into recovery. Without their help I never would have made it.

My father and mum dealt with me differently. My mum could cut herself off, but my father was always there and visited me in prison. He passed away while I was in rehab and never saw me get a job.

So I say to families, please share your story. Tell as many people as possible. Commissioners have to put families first.



Adfam and DDN would like to thank everyone whose support made ***Families First***, the second national conference for families and carers, possible – our sponsors Martindale Pharma, all our exhibitors, the excellent speakers, workshop facilitators and panellists, and most importantly all the delegates whose participation on the day made the conference the success it was.

Hope to see you all next year!

GOOD vibrations

Kevin Westbury **tells DDN about Jam Straight, a place where people in recovery can relax, socialise and enjoy some good music**

THE VINEYARD COMMUNITY CENTRE in Richmond upon Thames was opened in 2012 with a vision to continue the work with the homeless and people in crisis that had taken place previously on the premises. A three-tier strategy was formed: a morning drop-in café to work with rough sleepers and people in need, a social café to provide an afternoon place to socialise for local people and 6AQLive, a provision of a local youth service. It is the youth service that has developed its own vision – to enable and empower young people to engage with issues of homelessness.

In January 2013 I was approached by 'Tom'. He was a man in recovery and a musician, and his idea was to have a safe meeting place for people who were in recovery from addiction and had an interest in music. We talked for a while about how this would look and how we would connect with groups in the area who might have an interest.

After coming up with the name Jam Straight, we held our first session in the basement on a Saturday night and 14 people came along. As a team we decided that this immediately felt like a family that we would like to support. The attendees were very keen to hold more sessions and invite more friends – so we decided on Thursday evenings.

6AQLive provides young people with training in all aspects of event management and café management and operation, as well as accreditation through the AQA unit award scheme. As Jam Straight began, we realised that this was a great opportunity for young people to practise the skills they had learned and also have more awareness of the delicate issues around addiction.

Having now run for several months, the Jam Straight sessions have more structure. We book in a local acoustic act to anchor the night, and attendees can bring their own instruments and perform to the group or just come to enjoy the atmosphere.

It has been a wonderful space to share with some amazing people, who are gifted and so friendly. It provides a safe place to socialise with freedom from temptation and a warm welcome. We want to promote this session, and in 2014 we will be holding one every fortnight so that it becomes a more regular venue for people in recovery.

The centre is fully equipped with a sound desk, lighting and PA, and includes a full café with ethically sourced coffee and homemade snacks. At present we are not charging for entry as we see the opportunity for people in recovery as more important – the café makes money and the young people get training opportunities.

'The centre is fully equipped with a sound desk, lighting and PA, and includes a full café.'

For the community centre, Jam Straight is becoming a family of like-minded people with a passion for music, and for the patrons it's more than likely the very same. For me, when we run the sessions and it comes to closing time I really don't want to go and wish we could just stay there for as long as possible. For the young people, I'm not sure that they see anything different about the people that come – only that the atmosphere is warm, inviting, and there is comfort in the safety of the venue.

Scott Cooper, a regular at the café, says 'I go to Jam Straight because I love music of all types – even more so if it's live! The atmosphere is nice and relaxed – it sort of reminds me of an old jazz club with the lighting and sound and leather sofas. Knowing that the money I am spending at the café is going straight back to help the community and people in crisis gives me a sense of wellbeing.

'Jam Straight is one of the only non-alcoholic music venues in south west London. The JBL sound system and onboard soundman make sure it sounds sweet, while the friendly staff and cosy sofas make it a perfect venue for a night of original sounds and good coffee (and bring your guitar!).'

Jam Straight takes place on Thursday evenings, and will run fortnightly from 9 January 2014. For more information contact kev@vineyardcommunity.org

ACCENTU

Among the now-familiar talk of emerging challenges and stretched resources, delegates at DrugScope's recent conference heard some positive takes on the new treatment landscape.

'Whatever views people take of the pros and cons of the times we're in, what everyone can agree on is we're charting very new waters in turbulent seas,' DrugScope's policy director (now newly appointed chief executive) Marcus Roberts told delegates at the organisation's *Game on: drug and alcohol services and the new local players* event.

Localism presented some significant positives and opportunities alongside the challenges, he said. Although the 2010 drug strategy was still setting a direction for services, many of the decisions that affected them were now made at local level, with a loosening of central control and the national drive to focus on crime reduction gone, 'or at least fading to grey'. The pooled treatment budget, however, had been 'swept into a bigger public health budget with no meaningful protection, or at least none that anyone can explain or understand', and there was now a need to convince local partners who may have previously had no engagement with the sector.

'Obviously, it's also a case of localism plus tight money and further cuts on the way,' he said, against a backdrop of the rise of new psychoactive substances and, 'absolutely critically, the role of alcohol'. But the generic 'problem drug user' had always been something of a cipher, he told the conference, and there was now much more meaningful work around specific groups like the LGBT community, women involved in prostitution and older people.

Financially, it was difficult to get a clear grip on what was happening, he said, although DrugScope research had found more than a third of services reporting a decrease in funding (including 10 per cent where it was the result of re-commissioning), 44 per cent reporting a decrease in frontline staff and 63 per cent an increase in the use of volunteers. More than 40 per cent also said they'd so far had no engagement with their local health and wellbeing board.

'Overall the findings have been suggestive, but not seismic, and they do point to some positives of good adaption and resilience. But it's worth emphasising that there are significant prima facie risks of disinvestment, and adapting to that may mean further rethinking and reconfiguration.' The crunch points could well come next April or the April after, he said, as many contracts would have rolled over into this financial year and new structures were still bedding in.

'I'd underestimated how long it would take for some of our systems to embed,' echoed director of public health for Barnet and Harrow councils, Dr Andrew Howe. Although there was an austerity agenda and a now-unprotected substance misuse budget, he was 'not hearing about any substantial disinvestment', he told delegates. 'But the challenge to local government is that the savings are to criminal justice and the NHS rather than them, and commissioning is fragmented.'

However, local government did fit very well with the aims of the field in that 'if it's about anything, it's about improving social capital', he said. 'I absolutely recognise that we're building on enormous success in the substance misuse sector, particularly around service user involvement – it's an exemplar of success for other services – and as a commissioner I'll be looking for outreach services from our service providers. I'm hoping that the new system will really help with integration.'

The advent of police and crime commissioners (PCCs) had also created uncertainty, said deputy PCC for the South Wales Police, Sophie Howe. PCCs needed to balance budgets and maintain services that local communities cared about, while working to develop partnerships such as the Drug Interventions Programme (DIP) – something that combined harm reduction and reducing reoffending and showed the two could complement each other. 'But evidence of effectiveness isn't enough in the current financial climate,' she said.

'The coming years are going to get more difficult,' CEO of Blenheim CDP John Jolly told the conference. 'I'm still mourning the death of the NTA – I think that's a huge downside for our sector because we don't have a body representing us at national government level.'

The NTA had done some excellent work around service user involvement, said chief executive of Build on Belief, Tim Sampey. 'The change to Public Health England and the tightening of purse strings is a real pity, and re-tendering is awful – it's dog eat dog and service users hate it. The buildings change, staff change – stability is really important for trust and building relationships, and without it the risk is that people drop out of treatment.'

The recovery agenda was also 'an awful idea', he added, and had made service users panic. 'When I was using I hated the expression "clean", and there's something about recovery that seems a bit judgemental – whether it's true or not, it's the perception that service users have.' Nonetheless, mutual aid could well be the future, he said. 'I've seen some great stuff around mutual aid, and I don't mean the 12-step stuff. What we need is community and family and somewhere to belong – if we can do that we can really help people.'

The 'elephant in the room', however, was the underfunding of, and unmet need for, alcohol services, said John Jolly. 'There's been a u-turn on almost everything in the alcohol strategy, and the resources that are already stretched are going to become even more stretched, with the risk that alcohol need is going to hugely reduce our capacity to deliver to other groups.'

There was also the challenge of new drugs, he said, with many users reluctant to access services and receiving no support. 'So it's about how we make our services relevant to specific groups such as older alcohol users and young people using new psychoactive substances – you have to give them something relevant or they won't come. They need to like what's on offer and like the people there.' In the current commissioning environment, however, there was huge unmet need and 'the risk of not being able to meet any of it'.

'Yes, the funding has changed and there are competing priorities in local

UATE THE POSITIVE

authorities for all their resources and for the public health grant, and I'm well aware that there's widespread redesign and retendering,' Public Health England's director of alcohol and drugs, Rosanna O'Connor, told the conference. However, there were fewer adults in treatment than ever, she said (see news story, page 4), and the number of people starting new treatment journeys had also gone down. 'Cannabis is the only primary-presenting drug that has any kind of increase and there are now more non-opiate clients than opiate clients,' she stated. However, there were still increasing numbers of over-40s coming into treatment for the first time and the number of successful completions had 'pretty much plateaued'.

'The existing health gains and recovery ambition need to be maintained and strengthened, the sector needs to be championed and strategic partners engaged,' she said. 'You must ask for the investment you need. We do expect for there to be appropriate local services and for them to be properly invested in. The task in terms of making sure every service user gets a half-decent chance of successfully completing treatment is not the same across the country, and that's not good enough.' PHE was offering enhanced support to more than 40 local authorities that were performing less well, she stressed.

The political interest in the sector was there, she emphasised, as recovery continued to be a key measure in national outcome indicators, closely monitored by ministers and PHE. Drugs recovery would also be priority indicator of the government's proposed 'health premium' if it went ahead, she said.

Particular challenges were the number of entrenched heroin users, for whom lasting recovery was often much harder to achieve, and the emergence of new psychoactive substances at an 'unprecedented' rate. Although the number of people seeking treatment for the latter remained small, 'the ability of all of us to keep abreast of this is a challenge', she said. Mephedrone presentations had almost doubled in the last year but should be seen against falling numbers of people seeking treatment for ecstasy, she added.

'What on earth do we call these things?' said toxicologist at St George's Hospital medical school, John Ramsey, of the new drugs. 'New psychoactive substances doesn't really trip off the tongue, and legal highs doesn't work either so I choose to call them new and emerging drugs of abuse.' The new compounds fell outside legislation with the consequences that people were being exposed to an 'ever-changing list' of chemicals. 'What do we do? If kids are having medical problems then you can't ignore it, but when you ban them you just get a whole lot of new ones.'

'There are genuine opportunities with Public Health England,' said outgoing DrugScope chief executive Martin Barnes, as he summed up both the event and his ten years at the organisation. 'But despite genuine high-level commitment to drug treatment and recovery, the government has created a situation where funding is at risk. Whatever your view of the NTA, it was effective at holding DAATs and providers to account. The pendulum of localism may swing back, but at the moment what ministers think is increasingly less important.'

Further local government perspective came from cabinet member for health and wellbeing at Birmingham City Council, Steve Bedser. 'There is a huge risk of disinvestment,' he acknowledged. '"Severe" is an understatement when it comes to the pressures on local authorities, and we are, of necessity, looking at the commissioning portfolios and practices we've inherited. Some of the services we've inherited have been very poorly commissioned indeed. We have to make sense of the money and find interventions that are cost-effective. We face hard choices on the use of public money and you will have to work hard to engage politicians.

'But if there's a sliver of a silver lining in the whole austerity agenda, it's that it does give us an opportunity to do integration properly. Have faith in health and wellbeing boards. They're good things, so make sure you influence them.' **DDN**

'Whatever views people take of the pros and cons of the times we're in, what everyone can agree on is we're charting very new waters in turbulent seas.'

MARCUS ROBERTS

POST-ITS FROM PRACTICE

Every step

We have a duty of care – from the recovery position to the recovery journey, says Dr Steve Brinksman

If you have read this column before, you will know that I am always keen to promote recovery, defined by the individual in respect of their own journey and not from a political or ideological concept. That said I am reasonably long in the tooth and, having worked with people who use heroin for 20 years, I am well versed in the concepts of harm minimisation. The truism 'dead people don't recover' springs to mind. Harm reduction is the solid foundation on which we can build future recovery.

With this in mind, the treatment system I operate within in Birmingham has now started actively encouraging service users to undergo training in the administration of naloxone for the treatment of suspected opioid overdose, alongside placing the person in the recovery position and calling an ambulance. I have been told that 'people in treatment shouldn't need prescriptions for naloxone', yet I have come across people in treatment who have used naloxone to reverse overdose in people outside of the treatment system, and I am sure we would all accept that, despite people's best intentions, use on top of a script occurs. There have been enough uses of naloxone in Birmingham for me to be confident that there are people alive today who would not have been were it not for the availability of naloxone.

To back this up there is growing evidence from around the world that it is not only clinically effective, but that it can be safely administered by peers and reduce overdose deaths. Our service users have embraced this, but in a system with a large number of GPs operating in a community setting, it is proving more of a stumbling block to get these clinicians involved, a vital step if prescriptions are to be issued. Talking to colleagues around the UK shows that we are not alone in this.

There are a number of ways to try and address this. The National Treatment Agency [NTA] supported a number of pilot sites and in 2011 produced a report recommending it – *The NTA overdose and naloxone training programme for families and carers*, *http://bit.ly/1cz0r99*

The Medicines and Healthcare products Regulatory Agency (MHRA) has just announced a consultation on a proposal to allow wider access to naloxone for the purpose of saving life in an emergency. The consultation runs until 7 February 2014 and is available online at *http://bit.ly/1aRGS9b*

At SMMGP we recognise that lack of knowledge and training are significant factors that hold clinicians back from adopting new treatment approaches, and so we have committed to developing a free to access e-module that will cover the rationale behind naloxone prescribing as well as the practical aspects.

We also need those of you who work with clinicians, those who commission services and those who provide education to recommend the prescribing of naloxone. Drug-related deaths from overdose remain a significant problem and I believe a widespread roll-out of naloxone could significantly reduce this. We have as much a duty of care to people who use, as we do to those at any stage of their recovery.

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

LETTERS

LOSING THE PLOT

• 'Personally I don't think you should be on methadone – it's legal smack!'
• 'Safer injecting information is just enabling.'

Quotations from right-wing press or substance misuse workers? Recovery is a word that is used a lot, a word that can inspire hope and positive change, but increasingly it appears to be a word that is losing its meaning. One certain aspect of recovery is that one person's version may differ from another's.

I'm witnessing an increasing amount of evangelical approaches in frontline working, which is capable of being mean spirited and lacking in compassion or understanding. Telling someone what they 'need to', 'have to' or have 'got to' do is not person-centred. Sadder still is that many adopting this style of working are ex-users themselves.

I have been labelled 'anti-recovery' in the past; I'm not, but I am pro-choice. Some might argue that addicts do not have the capability to make choices of their own, not good ones anyway. I'm not sure – and I'm also not sure if there is anything entirely 'wrong' with making the 'wrong choice'. Surely we have the capacity to learn from our errors and are empowered by doing so.

Having previously felt like some sort of pariah when airing my concerns, it often makes me wonder how it feels for our most marginalised service users who just 'don't get it' when it comes to embracing recovery. I doubt being told what to do adds much value to their often-damaged existence.

The recovery agenda has been penned by a government that does not care about vulnerable and marginalised people and it is naive to think otherwise. If recovery is a journey, then we must not lose sight of where someone is on their journey and what it means to them, if anything at all.

A Hindu swami once told me that there are hundreds of ways to reach the summit of a mountain; each path will let us admire the view. We may stumble along the way, we may stop on a ledge for some time and build a fire for warmth and comfort. These ledges may indeed be a summit enough for some. We were not discussing recovery but I think his words can still apply.
Jesse Fayle, DIP practitioner

CLEAR EVIDENCE

Malcolm Clayton responded to my Soapbox article in October's *DDN* on whether the drug laws are having an adverse impact on recovery by wondering where 'the faith in the criminal justice system to reduce the availability and accessibility comes from.' (*DDN*, November, page 10).

In a recent review of recovery in the *Annual Review of Clinical Psychology* (*'Quitting drugs: quantitative and qualitative features'*, 2013), G Heyman found that while drug dependency is often characterised as a chronic relapsing condition, in fact recovery was commonplace. In one of the reviewed studies, for example, Lopez-Quintero et al (*'Probability and predictors of remission from life-time nicotine, alcohol, cannabis or cocaine dependence'*, *Addiction*, 2011) found that of those addicted to cocaine, 27 per cent had stopped using the drug after two years, 51 per cent had stopped after four years, and 76 per cent had stopped after nine years.

According to Heyman, 'The strongest correlate of remission was legal status. For instance, the half-life of alcohol dependence was about four times longer than the half-life of cocaine dependence (16 and four years, respectively). The simplest explanation of this difference is that alcohol is legal and therefore more available.'

Within the addictions field we often prefer our personal views and experiences over the evidence. In this case however, the evidence does appear to show that there is a beneficial impact upon recovery from the fact that some drugs are illegal.
Neil McKeganey Ph.D, director, Centre for Drug Misuse Research

NOT SO SMART

I run Alcohol Support Project East Yorkshire (ASPrEY) and we have two groups, one in Bridlington and one in Beverley. We use the SMART Recovery process – I have completed their facilitator course and our meetings are published on their website. We engage with the NHS who advise their patients when they finish the Hull and East Yorkshire Alcohol withdrawal programme to get in touch with us for ongoing support.

The local authority (East Riding of Yorkshire Council), which is now respon-

sible under Public Health England for drug and alcohol treatment, take completely the opposite view. They claim they are not 'assured' we provide suitable advice, although they have no evidence whatsoever to back this up. In fact the people who attend our groups give excellent feedback to the NHS on how beneficial they have found our support.

I have challenged the local authority on why they have (seemingly without a shred of evidence) kept us outside the treatment loop in East Yorkshire, and received no response. We have even been funded by the lottery! They have also excluded us from their quarterly treatment forum, again for no apparent reason. I rather suspect this is all politically motivated. There are no other user support groups in most of East Yorkshire. In fact I referred someone to the East Riding Alcohol Aftercare service recently for some 1:1 support. They can't take anyone else on for a 'few weeks'.

I would have thought any voluntary user support would be most welcome. Apparently not. I wonder if any other readers have experienced similar obstacles?

Stephen Keane, chair, Alcohol Support Project East Yorkshire

FIRST-RATE LESSON

When I started working at the drug and alcohol inpatient unit I was told that one of my responsibilities would be to deliver the doctor's information group. My immediate thought was this sounds really interesting but I also felt a bit apprehensive as I didn't have any experience of this kind of teaching. Isn't it interesting how during medical training we only really get to see people on a one-to-one basis or with their relatives present?

Seeing a group of service users together to give direct education would have been something of a rarity despite the emphasis nowadays on public health and preventative medicine. I started to feel more anxious over the prospect of delivering the group but didn't have much time to ruminate as the first Friday soon approached. I had decided to talk about the link between substance misuse and mental health. I was struck by how honest the service users were about their personal experiences and my feelings of nervousness quickly diminished. There were a couple of occasions where I had to intervene as people were talking over each other, but apart from that it went smoothly.

It was interesting for me to see the group dynamics and I made some mental notes for the next week. Something else that became apparent to me during the group was that despite being able to identify many negative consequences of substance misuse this had not prevented them from becoming dependent. I would strongly recommend the experience of conducting groups to any trainee doctor and I feel privileged to have been given this opportunity.

Dr Tanya Walton, CT3 psychiatry doctor

WRONG DIRECTION

I read Ingrid van Beek's article with interest ('A fine balance', November, page 18). I think all these 'rooms' will do is to allow clients to view this as 'extra gear' or a 'side-order' of drugs in addition to what they will continue to use in any case, thus increasing the extent of their habits. It may well work with other types of intravenous substance misusers, but not opiate dependents, in my opinion.

There will also be 'diversion' of the clinical drugs issued onto others it was not intended for, a bit like the way communities are awash with street buprenorphine and methadone presently. I recently home-visited a client and he had accumulated six litres of methadone, stored in a kitchen cupboard! I once worked for a community drug service where 92 per cent of those clients already supposedly engaged with structured treatment journeys were still attending for needles, and with little motivation to change.

I can see it may help with the current harm reduction/maintenance philosophy, but for those of us working with an abstinence based model of treatment, this policy is of very little help, as experienced by the detrimental consequences of these 'rooms' throughout the Netherlands.

Neil Angus, drugs project worker and former heroin addict

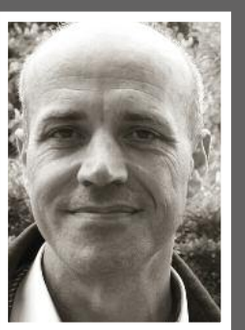
We welcome your letters...

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.

VOICES OF RECOVERY

SEEING PURPLE

Last month Alex Boyt took the recovery movement to task. **Alistair Sinclair, Richard Maunders** and **Melody Treasure** of the UKRF respond



In *DDN*'s November issue Alex Boyt shared some of his thoughts on the 'R' word and this prompted much discussion on social media among the recovery community. It would be interesting to know if something similar happened within services. While Alex, tongue located somewhere in his cheek, has a poke at the 'purple t-shirt' brigade (we're fully signed-up members) and the 'warm fuzzy feelings' found at recovery gatherings, it seems to us that he is principally 'venting' about services/commissioners and their interpretation of 'recovery'.

Alex is a SU coordinator in central London. In his article he refers to commissioners, the NTA, Theresa May and the PHE strategic recovery lead. We believe (and we met with Alex to talk about his piece) that he is asking some important questions: has the mass importing of recovery 'rhetoric' into the drug field and the establishment of recovery plans/ champions/ pathfinders /colleges/ trees *etc* resulted in services that are more recovery-oriented? Do new recovery-branded services 'speak' to the most 'disadvantaged, traumatised and neglected'? Or are they serving a politicised neo-liberal agenda (one recovery agenda among many) that increasingly commodifies support and people and, as Alex suggests, uses a 'recovery agenda' to categorise SUs as 'deserving' or 'undeserving'? These are uncomfortable questions, and we thank Alex for having the courage to ask them.

However, we're not sure that reducing the vast diversity of 'recovery' found in communities to purple-clad 'happy-clappy' individuals who enjoy a hug and a 'hurrah' is the best way to highlight important service issues. Sorry Alex. There is clearly a way to go before we can happily sit back and say we have recovery-oriented services, just as there is much work to be done by community members to increase access to inclusive recovery networks that support wellbeing. But – and it's a big but – there is evidence, and lots of it (check out the 2007 Foresight study, *Mental capital and wellbeing*) that wellbeing is generated and sustained through opportunities to be active, learn, take notice, connect and give (the 'five ways to wellbeing').

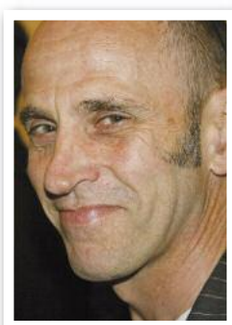
Most of the opportunities to do this can be found in what Edgar Cahn calls the 'core economy': family, neighbourhood and community. People have been finding their version of recovery, abstinent or otherwise, in the core economy for decades, centuries, long before services came along. The emerging recovery movement (in drugs and mental health) has started to make the core economy more visible in recognition of its increasing importance. Five thousand people on a recovery walk, many of them marginalised in the past, and 50 recovery events in recovery month is evidence of something, as is the emergence of new recovery communities all over the UK.

We need to work together to support new communities, encourage more traffic between them and widen the doors. We are all in this together and we believe, if we are going to find new ways of responding to old problems, we need to have more faith in the capacity of people within communities to define and shape their own recovery.

'Take the first step in faith. You don't have to see the whole staircase, just take the first step' – Martin Luther King, Jr.

The authors are directors of the UK Recovery Federation (UKRF)

A matter of LIFE and death



Why in the name of public health is naloxone distribution still a postcode lottery, asks Neil Hunt

I LIVE IN KENT, one of 16 sites from the 2010 NTA naloxone pilots for families and carers of heroin/opioid users. Locally, 'Take Home Naloxone' (THN) for service users, their families or carers has since become integral to our treatment system due to the numerous, ongoing, successful, documented overdose reversals. Yet this week, I received an email from a colleague 240 miles away in NW England asking if I knew how to help a man living 140 miles away in Peterborough, a city 120 miles from me.

He wanted THN for two close friends who were just leaving prison and – as he quite rightly understood – were at much heightened risk of overdose. He is highly educated and computer literate, yet had been unable to obtain this potentially life-saving medicine. To see if he was overlooking anything obvious, I did the natural thing and Googled 'Peterborough' AND 'naloxone'; however, I couldn't find any information about its availability, let alone how a heroin user, their lover, parent, son or daughter might obtain it.

The latest published UK drug-related death data show that, annually, Peterborough has 6.21 drug-related deaths per 100,000 population – largely opiate-related *ie* ones for which THN is relevant. This is pretty much the midpoint rate between those UK localities with the highest and lowest drug-related death rates. In plain English, in Peterborough and places like it, year-on-year a modest number of opiate users die from overdoses, some of which are almost certainly preventable.

'THN is an affordable intervention that naturally fits within public health and could potentially benefit from comprehensive PHE advocacy and support.'

It's important to emphasise that the fact that this happened in Peterborough is almost entirely incidental. It's just where one persistent guy lives. I barely know the city/its services and have no reason whatsoever to think they are any better or worse than those elsewhere. On the contrary, Peterborough's services could be truly excellent in all respects other than its THN service. I honestly have no idea.

The crucial point is that this well-informed, justifiably concerned friend could have lived in numerous, similar English cities where THN is unavailable. Or, conversely, assorted other areas where THN is actively promoted. His ability to take measures to reverse a friend's potentially fatal opioid overdose is determined in an arbitrary way, according to where he lives. A situation that would be regarded as intolerable if it were applied to, say, provision of patient-held adrenaline for people with a history of anaphylaxis from bee-stings.

Clearly, we should be cautious about deducing too much from one isolated case, however many hundred miles of unnecessary communication it involved. Nevertheless, I'd argue that this example warrants serious consideration for several reasons:

a) A Peterborough citizen and taxpayer who cares for his friends and understands the risks and issues around heroin overdose sought help via two perceived 'experts' on different sides of the country across about 500 miles, only to be told, 'Sadly, it's up to your local commissioners. If they don't fund THN then you can't get it.' This seems a very potent illustration of well-informed demand in an area where drug-related deaths need to be reduced.

b) Anecdotally, harm reduction, needle exchange, active drug user and recovery networks often hear that the 'THN availability problem' is widespread, yet no reliable mapping of English THN outlets/availability exists. An interactive naloxone finder database is being developed for Scotland in a way that could be extended across the UK (www.naloxone.org.uk), but England currently lacks both coordination and strategic vision in its approach to THN, rendering it both less effective than it might be and probably with higher unit costs too.

c) Public Health England (PHE) is currently navigating its way through complex political and organisational changes and clarifying its role at a time of economic austerity. THN is an affordable intervention that naturally fits within public health and could potentially benefit from comprehensive PHE advocacy and support. At present, many commissioners and providers of drug services and, vitally, many of the people who are most likely to witness an overdose – opiate users and their friends, families and lovers – seem barely aware of its existence.

Take Home Naloxone is a potentially important test of the role that Public Health England will fulfil in the new system in which we are now operating. PHE is not responsible for the THN policy shambles it has inherited. Nevertheless, in 12 months time, if people who need THN to protect the lives of those they care for are still jumping through such tortuous, long-distance hoops, only to discover that they are arbitrarily denied services that are readily available in an adjoining locality, I think many people may be left questioning whether 'public health' has been well served, and how PHE can in any way claim to be an agency that serves all of 'England'.

Neil Hunt is honorary research fellow, The Centre for Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine and honorary senior research associate, School of Social Policy, Sociology and Social Research, University of Kent

David Gilliver talks to social entrepreneur of the year Jacquie Johnston-Lynch about risk, determination and the new challenges facing the recovery movement. Picture by **Paul Cooper**

Brink of success

It was on a personal leadership course in Vancouver that Jacquie Johnston-Lynch got the idea for The Brink, the alcohol-free Liverpool bar and venue that's seen her named Lloyd's Bank social entrepreneur of the year (*DDN*, November, page 5). 'They were asking people their ideas to take back into the world, and that was mine,' she says.

This was in 2008, and when she came back to the UK she put the idea to her employers, Action on Addiction, who 'weren't that keen', she says. 'Treatment was what they knew. They didn't really know about community development or social enterprise, but eventually I just wore them down. I kept saying that if you want to be the trailblazing organisation that leads this new movement then you'll have to get behind this, and eventually they absolutely did.'

She was given the green light to look at the venues she'd already been secretly visiting, and The Brink finally opened late in 2011 (*DDN*, December 2011, page 12), 'a dream come true', she says.

'Everybody loved the venue, and that's because we'd decided it wouldn't be what addicts are usually given – backstreet places, church halls, community centres. Why, just because people have stopped drinking and using, should they have less than anyone else, especially when they're not going to be sick or trash the place? Why can't they have better? So that's what we aimed for –a really amazing venue with great quality food and drinks and a great design.'

The Brink now has 18 staff and 11 volunteers, with more than 75 per cent in recovery themselves, and customers are split 50-50 between members of the public 'who really like the ethos of the place, and recovery folks who really want to be in there', she says. Services are also offered in the building, 'so we'll have people in who are still using and drinking but their behaviour's impeccable because they're coming into the building to aspire to be in recovery,' she says. 'They want to be part of the community there, so they're not going to jeopardise that.'

As well as live music several times a week, there's a film night, an arts and crafts club, open mic sessions and more. 'There's loads of stuff,' she says. 'We had a chocolate-making workshop, a women-only sleepover where they had a pamper night and watched a chick flick and the staff cooked them breakfast the next morning. Chris Difford from Squeeze has played a few times because he really likes the vibe and he's out about being in recovery himself.'

So is it doing well as a business in its own right? 'With all social enterprises there's a point where you can't any longer rely on grants or philanthropy,' she says. 'The idea is that we move to an 80-20 position, where 80 per cent is trading, sales and contracts and 20 per cent is donation or grant-based. We're never going to make a huge profit on food or drinks because we try to keep the prices low so that the recovery pound can afford that good quality food, so I think we'll always need to have an 80-20 principle to our income base.'

'With all social enterprises there's a point where you can't any longer rely on grants or philanthropy...'

*****

After nearly ten years at SHARP and Action on Addiction she's now moved on to work for two organisations, one of which is Clearmind International, organisers of the training workshop where she first had the idea for The Brink. 'They're based in Canada but I'm going to develop their organisation here,' she says. 'It just seems like it's come full circle.' The other, meanwhile, is something that's been a well-guarded secret until now.

'There's a woman called Paula Gunn who runs abstinence-based accommodation where we'd regularly refer people from SHARP so they wouldn't have to go back to a using and drinking hostel or anything. We were both seeing returning veterans really not doing very well at all in mainstream treatment projects, so what we've decided to do is set up the UK's first ever veterans-only residential addiction treatment project.'

The project will launch in the spring as Tom Harrison House, named after Gunn's grandfather, a navy veteran. 'Paula herself is in recovery and when she was trying to get clean and sober one of the things she'd do was focus on doing that for him to see, so she's set up this in his honour. It's going to be a low-level, more sensory-focused programme, rather than cognitive or too much talking therapy that can invoke a lot of anxiety for people who've experienced traumatic events. It's 16 beds, so it's quite a small rehab but enough for us to be effective for the amount of money. We'll have mostly beds for Merseyside but we'll have some beds later around the UK, and people will be able to refer in.'

Leaving Action on Addiction has been difficult, however, especially as she'd set up SHARP and The Brink herself. 'The actual projects and the people who worked in them were incredible and I found it very difficult to leave them, but I felt like my time in that kind of charity had come to an end,' she says.

'I think sometimes charities that do a lot of very good quality work and a lot of due diligence don't really understand the need to take risks, and in addiction treatment we're encouraging people to take new healthy risks,' she explains. 'I think it's bad if we stay stuck. In Liverpool we'd taken an asset-based community development approach to recovery and the charity was a little bit distant from that – we love that whole community development approach and our demographics are different to what you might see in [Wiltshire-based] Clouds House. So while I absolutely think the work of Action on Addiction is fantastic, I also think the culture might need to change in order to be more proactive around social enterprise and asset-based community development approaches to treatment.'

*****

An eating disorder saw her enter a 12-step fellowship herself in 1997, and her first husband also had issues around gambling and alcohol. 'I remember trying to get him into Gamblers Anonymous but he wasn't having it, so I had some experience of 12-step from years ago but didn't really understand it – it was when I went into treatment for an eating disorder that I got more of a 12-step message.'

Working in the field, however, she began to understand the need for choice, she says. 'I advocated that SHARP Liverpool should change from just 12-step to more ITEP-based as well, so that people could come in and say "this is the modality I'd like to follow and if it doesn't work I'll swap and do something else", and let the client have the power over that, not us telling them what works.

Another powerful motivation for entering the field, however, was the death of her brother 21 years ago, killed by a drink driver. 'The man who killed him was a repeat offender and I just thought "what did he ever get?"' she says. 'He just got punishment, his licence taken off him or whatever, but he wasn't just somebody who'd got drunk at an office party and tried to sneak home and got caught, he was doing this constantly. He had a problem and no one ever offered him any help. At Clearmind they teach about turning your pain into purpose, and I thought that all that painful grief had to be given some purpose.

'People aren't bad and needing punishment,' she continues. 'They aren't very well and need to have a whole new realm put in front of them of "these are the possibilities of getting well", if that's what they want. If they don't want it, that's a choice too and I'm absolutely happy for people who say, "I don't want to give up drinking and I'm happy to stay scripted". If that's working for them, that's OK.'

On that note, she's pleased that the field seems less polarised and entrenched these days – 'people are absolutely moving towards working together and trying to join up all the dots' – but the political and economic landscape has created new challenges, she believes.

'I think that what we've got to be really careful of now is the recovery agenda being hijacked so that it becomes a decoy for just getting people off benefits and methadone. Recovery is about what kind of quality of life are people having, and we've got to be really careful that the government doesn't hijack it as a means to a political end, because when that happens those people who are harm reduction advocates aren't able to see us recovery folks in a well-meaning light.

'They just see us as being part of the Tory agenda, and we're absolutely not,' she states. 'That's my concern.' **DDN**

www.cooperphotos.co.uk

JANUARY

With welfare reform set to be one of the key issues of the year, TUC general secretary Frances O'Grady warns of the dangers of conducting policy 'on the basis of prejudice and ignorance', while outgoing UKDPC chief executive Roger Howard stresses that most people have yet to fully appreciate 'the profound reshaping of public spending' still to kick in. Meanwhile, the Royal College of GPs issues a statement stressing the risks of long-term prescribing for medicines that carry a risk of dependence.

FEBRUARY

Hundreds gather at Birmingham's National Motorcycle Museum for *Be the change*, *DDN*'s sixth annual service user conference. 'The place was buzzing like a bee hive,' commented Recovery Radio UK's Jaine Mason. 'It was absolutely brilliant to experience.' There's yet more evidence of shifting patterns of drug use as an EMCDDA report highlights how the internet has been a 'game changer' in the production and distribution of drugs, the NTA announces the number of heroin and crack users has fallen below 300,000 and the proportion of drug-related deaths involving heroin drops by nearly 10 per cent.

MARCH

A shocking 117 per cent increase in the number of under-30s being admitted to hospital for alcohol-related liver disease leads Alcohol Concern to demand the Department of Health outline a plan of action. Meanwhile the Hepatitis C Trust warns that local authorities are unready to deal with the challenge of the virus as they prepare to take over responsibility for public health, and the National Aids Trust calls on London councils to ensure appropriate support for people involved in high-risk drug use in parts of the city's gay scene.

APRIL

The treatment landscape changes forever as Public Health England comes into being, taking over the responsibilities of the NTA, while Sarah Galvani of the British Association of Social Workers urges drug workers to challenge clients who blame violence towards their partners on substance use. 'People need to feel confident to ask the right questions in the right way,' she says.

MAY

Minimum unit pricing for alcohol fails to make the Queen's Speech, widely perceived as the result of industry lobbying – 'the red-faced rants from the multinational drinks corporations', says Katherine Brown in the *Guardian* – and a government desperate not to seem out of touch with the concerns of ordinary people, although ministers claim the policy has not been abandoned. Kevin Flemen advises *DDN* readers on how to keep on top of the dizzying array of new psychoactive substances and the Organization of American States issues a landmark report looking at different options for the future of Latin American drug policy.

JUNE

The 23rd International Harm Reduction conference sees policy makers and service users gather in Vilnius to 'reclaim' harm reduction from those who seek to define it as a 'morally suspect, clinical response', says HRI executive director Rick Lines. The *Support. Don't Punish* campaign's international day of action on 26 June sees activists calling for more humane drug policies and a hard-hitting report from DrugScope and Ava highlights the lack of support for female drug users involved in prostitution.

DDN looks back on a year that saw the drug treatment landscape transformed with the end of the NTA and the advent of Public Health England, while austerity, alcohol and new psychoactive drugs continued to dominate debate

THE

JULY

The government's response to its alcohol strategy consultation finally contains a firm statement that minimum pricing 'will not be taken forward' – and shelves plans to ban multi-buy promotions for good measure – while public health minister Anna Soubry and IDHDP clinical director Chris Ford debate whether drugs should be a health or criminal justice issue in *DDN*'s letters pages.

AUGUST

Scotland records its second-highest number of drug deaths while a powerful report from Release reveals that not only are black people over six times more likely to be stopped and searched for drugs, they are more likely to be charged if any are found and receive harsher sentences than the white community. Alcohol Concern chief executive Eric Appleby, meanwhile, tells *DDN* that members of the Alcohol Health Alliance are more determined than ever to keep minimum pricing at the forefront of debate. 'The government's arguments that there's not enough evidence are plainly just wrong, and the very obvious sense that they've just bowed down to the alcohol industry is only going to fire people up more,' he says.

SEPTEMBER

Public Health England hits back at a Centre for Social Justice document that depicts a treatment system full of 'vested interests', resistant to change and 'unambitious for recovery', while a UNAIDS report shows that many Eastern European countries are still failing to address the challenge of drug-related HIV infections. Meanwhile, recovery month is marked by bigger than ever recovery walks as well as sporting tournaments, conferences, art exhibitions and much more.

OCTOBER

Just 3 per cent of people infected with hepatitis C are treated each year, despite it being curable, according to a report from the Hepatitis C Trust. 'Just because you're using drugs doesn't mean you don't have the right to treatment,' the trust's chief executive Charles Gore tells *DDN*, while outreach worker Philippe Bonnet describes his fight to open a consumption room in Birmingham, a city where more than half of injecting drug users are infected with the virus. Meanwhile, a government reshuffle sees Norman Baker controversially replace Jeremy Browne as crime prevention minister, 'the most eye-catching, head-scratching ministerial appointment in Westminster history', says the *Independent*'s Matthew Norman.

NOVEMBER

As *DDN* celebrates its ninth anniversary, Mat Southwell and Lana Durjava describe how services can best engage with the diverse and ill-served population of ketamine users, while Alex Boyt remains unconvinced by recovery cheerleading. 'For many, there is something disturbing and unattractive in trying to plaster optimism over the struggles of the often disadvantaged, traumatised and neglected,' he writes. The second Adfam/*DDN* families event sees a day of passionate debate in Birmingham and delegates at DrugScope's conference discuss ways to make the most of the new treatment and commissioning landscape.

DECEMBER

As an era-defining year for the sector draws to a close, plans are already well under way for *Make it happen!*, the seventh *DDN* user involvement conference. Make sure you don't miss it.

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Phoenix Futures

Phoenix House (operating as Phoenix Futures) is a registered charity in England and Wales (No.284880) and in Scotland (No. SC039008)

RAPt

THE REHABILITATION FOR ADDICTED PRISONERS TRUST

stopping addiction. stopping crime.

HEAD OF GOVERNANCE AND QUALITY – PRISON & COMMUNITY BASED DRUG TREATMENT SERVICES – LONDON

Hours: 35 hrs p/w
Location: London (Head Office) with some travel
Salary: From £42,840 depending on experience + regional allowance £4,335

RAPt are one of the UK's leading providers of drug and alcohol treatment services. We deliver services – in prisons and in the community – which help people move away from addiction and crime. These services provide a variety of support, including advice, counselling, group work and intensive treatment.

As Head of Governance and Quality you will work under the guidance of the Deputy Chief Executive and in collaboration with other departments and individuals. You will develop and manage our governance structures and systems to ensure good organisational governance. This includes overseeing the organisation's Clinical Governance systems, to ensure quality and continuous improvement in how we deliver services, and to ensure that we meet all legislative and best practice requirements.

To be successful in your application you will have detailed knowledge and experience of Care Quality Commission standards and practice, preferably in the field of substance misuse or similar health /social care services. You will have experience of using a Root Cause approach to analyse incidents and concerns and an understanding of Criminal Justice system. You will be clinically qualified with current registration with a professional body and/or hold a vocational or post-graduate qualification relating to governance and quality.

RAPt offers an excellent benefits package including work-related clinical supervision allowance, Healthsure coverage, competitive annual leave entitlements and a contributory pension scheme. We also support our employees to achieve both professional and personal development.

All applications will need to be made with a RAPt application form, which you can download from our website. We are unable to accept CV's.

Closing date for applications: 3rd January, 2014. Interviews will be held on the 15th January, 2014

www.rapt.org.uk/workforus

INVESTORS IN PEOPLE

MANCHESTER CITY COUNCIL

Manchester City Council – Public Health Manchester

ALCOHOL NEEDS AND CAPACITY ANALYSIS

Manchester City Council is seeking suitably a suitably qualified and experienced provider to carry out a comprehensive and independent assessment of current and future alcohol-related need in Manchester, including a review of current strategic and service responses to these.

Interested individuals or organisations should request an information pack, which will include a specification outlining commissioners' requirements and details of information required in quotations, by emailing dast@manchester.gov.uk by 13th December 2013. **The deadline for returning detailed quotations will be 27th December 2013.** Quotations must not exceed £30,000, and the successful bidder will be required to complete work by no later than 14th March 2014.

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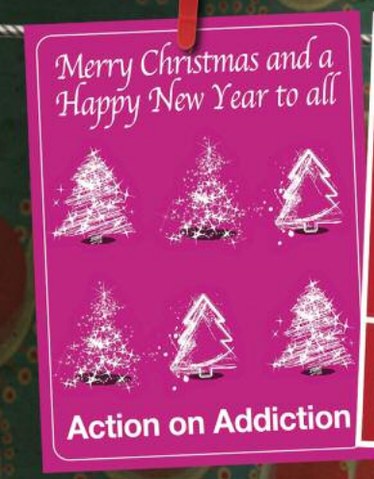
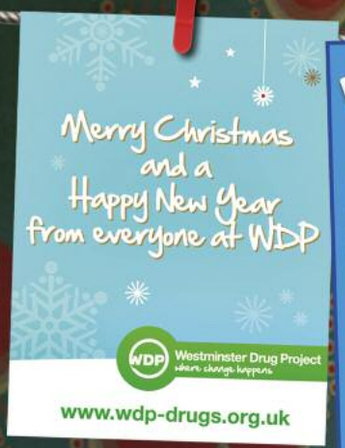

Merry Christmas and a Happy New Year to all
Action on Addiction


Merry Christmas
from all at SAM Recruitment
Recruitment & Consultancy Agency for the substance misuse sector.


Season's Greetings
from the FDAP team


Season's Greetings
KFx
Thanks to DDN and all who supported KFx in 2013


Merry Christmas and a Happy New Year from everyone at WDP
WDP Westminster Drug Project
where change happens
www.wdp-drugs.org.uk


Merry Christmas
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from SMMGP
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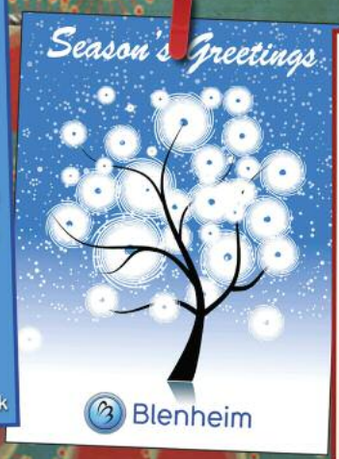
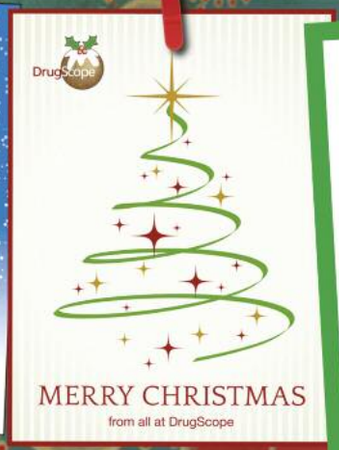
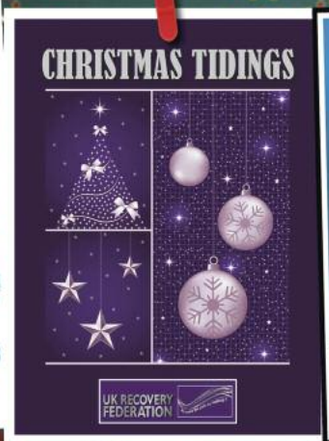
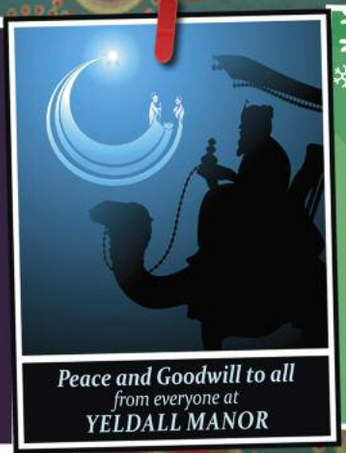

Season's Greetings
Blenheim


DrugScope
MERRY CHRISTMAS
from all at DrugScope


Christmas Wishes
RECOVERY
Releasing Your Potential
From everyone at East Coast Recovery


Christmas Wishes
From all at BROADWAY LODGE

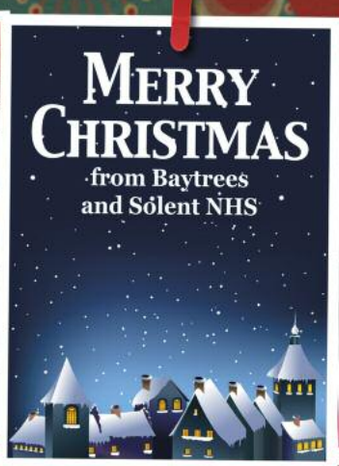

CHRISTMAS TIDINGS
UK RECOVERY FEDERATION


Peace and Goodwill to all
from everyone at
YELDALL MANOR


Merry Christmas & a Happy New Year
from
frontiermedical group


MERRY CHRISTMAS
from Martindale
Prenoxad Injection


Season's Greetings
from Injecting Advice and HIT


MERRY CHRISTMAS
from Baytrees and Solent NHS


A VERY MERRY CHRISTMAS
to all DDN readers from everyone at
MATRIXDIAGNOSTICS