SPECIAL EDITION – SERVICE USER CONFERENCE 2014

DDN
Drink and Drugs News

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'There's no one story when it comes to addiction – everyone has their own...'

MAKE IT HAPPEN!

TAKING A STAND FOR POSITIVE CHANGE

THE UK RECOVERY FESTIVAL

1st and 2nd July 2014

Central Hall, Westminster, London

Housing and employment are two of the biggest determinants to the success of an individual's recovery.

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Full details and programme available

www.recoveryfestival.org.uk

DrugScope

Recovery Partnership

Substance Misuse Skills Consortium

recovery group uk

THE RECOVERY FESTIVAL 2014

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DDN Drink and Drugs News

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Strength in numbers

Taking inspiration for the battles ahead

The new *State of the sector* report confirms that treatment is just one of the things that contributes to a successful outcome, the rest being improved health, a job, somewhere to live and friends (page 6). Add to that creative fulfillment, demonstrated by this month's 'Practice Exchange' (page 7), where Spitalfields Crypt Trusts' service users said that one of the hardest things in their early days of recovery was filling the time once the drink and drugs were gone. Their experience of building a social enterprise project together has been transformational.

Peer support was further demonstrated at our *Make It Happen!* conference last month, when more than 600 delegates came together in Birmingham. Sophie Strachan shared the experience of offering friendship and support to people with HIV; Tim Sampey urged service users to believe in their capacity to run an organisation independently; David Lawson advised on drawing strength from user involvement, and Lester Morse took us on his journey from the soup kitchen to setting up a treatment centre. Alongside the inspiration was the reality of how much needed to be done on fair and adequate prescribing, treatment and facilities, naloxone distribution, and proportionate funding, particularly for alcohol treatment. With plenty to do and nothing to be complacent about, it was powerful to see a room full of people prepared to make change happen.

This issue

FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES, TENDERS

NEWS IN BRIEF

VOICING CONCERNS

Public Health England (PHE) has not yet 'found its voice', developed a clear set of priorities or demonstrated that it is sufficiently independent of the Department of Health, according to a report from the Health Committee. There was now an 'urgent need' for PHE to show it could 'speak truth unto power', said committee chair Stephen Dorrell MP 'PHE should not look to the Department [of Health] or other parts of government to prompt its research or, still less, to authorise its findings,' he stated. 'PHE can only succeed if it is clear beyond doubt that its public statements and policy positions are not influenced by government policy or political considerations.' *Public Health England at www.parliament.uk*

COUNCIL CALL

The Local Government Association (LGA) has called on social media companies to introduce health warnings about internet drinking game NekNomination. 'This is an utterly reckless and totally irresponsible craze which has tragically claimed lives,' said chair of the organisation's wellbeing board, Katie Hall. 'The LGA is looking for these corporations to show leadership and not ignore what is happening on their sites. We are urging Facebook and Twitter executives to sit down with us and discuss a way forward which tackles this issue head on.'

MMM... DANOS

The revised National Occupational Standards (NOS) for drug and alcohol workers have now been launched by Skills for Health. 'The continued development of competent practitioners, volunteers, managers and commissioners in the substance use sector is crucial for the delivery of high quality effective services which meet the needs of the individuals and communities we serve,' said FDAP chief executive Carole Sharma. Revised DANOS at *tools.skillsforhealth.org.uk/competence_search/*

STOPPING STEREOTYPES

A youth alcohol summit organised by Alcohol Concern saw young people call on policy-makers to see them as 'part of the solution to the alcohol problems the country is facing, not part of the problem' and attempt to challenge stereotypical views of the young as binge drinkers. 'Young people are often spoken about in alcohol policy discussions but rarely asked for their views,' said Alcohol Concern policy programme manager, Tom Smith. 'It's time for this to change.'

Improved support needed for older people

Improved support is needed for older people with drug and alcohol issues, says a new report from DrugScope. While the focus of policy and media attention remains young people, there is a significant and growing problem with older people's use of substances, says the charity.

Alcohol-related hospital admissions for men and women over 65 rose by 136 and 132 per cent respectively in the eight years to 2010, says *It's about time: tackling substance misuse in older people*, while alcohol-related death rates among over-75s are now at their highest recorded level.

While the aging population being treated for heroin problems has become, according to Public Health England (PHE), one of the 'key features of drug treatment in England', and many of the trends highlighted in the report 'partly reflect the health consequences of long-term drug or alcohol use', there are also a significant number of 'late starters' using substances to self-medicate the physical and mental issues associated with growing old, it stresses. The physiological changes associated with getting older also mean that this population group can be at increased risk of adverse effects from substance misuse, 'even at relatively modest levels'.

While there is some effective service provision for older people, more awareness is needed as a first step to providing age-appropriate specialist services as well as better support in primary and social care settings, says the report. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) estimates that the number of older people needing treatment for substance misuse will have more than doubled from 2001's figure by 2020.

Among the report's recommendations are 'age-appropriate, non-time-limited treatment' for people who are drug or alcohol-dependent, as well as brief interventions for people drinking at risk and support for problems with prescription or over-the-counter medications. Commissioners also need to recognise the importance of services for older people and ensure continued funding, while services themselves should make sure their services are accessible and relevant to this client group.

'Drugs and alcohol issues may affect older people differently, but that does not make them less real or important,' said DrugScope chief executive Marcus Roberts. 'They may be a symptom of other problems, such as loneliness and isolation, caring for a partner, bereavement or the struggle to make ends meet. The facts and figures in the report speak for themselves and with the numbers of older people as a percentage of the population continuing to rise, this is not an issue that we can ignore.'

Barriers to accessing support need to be addressed, he urged, ranging from embarrassment at having to ask for help to a belief among professionals that 'older people can't change'. 'It's time to bring this largely "invisible" issue into the light and to improve the support for older people with drug and alcohol issues.'

Report at www.drugscope.org.uk

A third of services report funding decrease

More than a third (35 per cent) of drug and alcohol services reported a decrease in funding last year, according to a report from DrugScope, compared to just a fifth that reported an increase. More than half also reported large increases in caseloads.

The funding picture is 'mixed and complex', says *State of the sector 2013* – which is published on behalf of the Recovery Partnership – although there are so far 'no clear signs' of widespread disinvestment. The potential effect of frequent recommissioning and retendering was also a concern, however, in terms of staff morale and disruption to service provision, while public health restructuring and changes to criminal justice commissioning have also had a 'significant impact'. Some services reported a lack of engagement with police and crime commissioners and health and wellbeing boards, although others said relationships had now been established.

Almost 170 services from across the country were surveyed for the report, with many respondents highlighting 'significant' problems in offering support around housing, employment and mental and physical wellbeing. Almost half, meanwhile, said they were employing fewer frontline staff and six out of ten reported an increase in the use of volunteers.

'Public service delivery of all kinds has undergone a period of significant transformation in recent years,' said DrugScope chief executive Marcus Roberts. 'It's clear that organisations delivering drug and alcohol treatment are facing challenges, not only related to funding, but also to engagement with the new structures shaping service delivery on the ground. There is a concern about securing access to some of the vital resources that support recovery, including housing and employment.

'However, responding to the challenges, it is heartening to hear that the agencies which took part in the research are adapting and innovating in the new environment,' he continued. 'The priority is to keep providing support to those who need it – and many agencies are developing new partnerships with and beyond the sector to ensure they support the ambitions and aims of people in recovery.'

Report at www.drugscope.org.uk

See news focus page 6

Government accepts ACMD's ketamine recommendation

Ketamine is to be upgraded to a class B drug, crime prevention minister Norman Baker has confirmed. Baker has written to Advisory Council on the Misuse of Drugs (ACMD) chair Sir Les Iversen to say that he accepts the council's recommendation that the drug be reclassified in the light of health concerns and the numbers of people seeking treatment (*DDN*, January, page 5).

The government will now consult to assess the impact of reclassifying on the medical and health sectors, said Baker, with the parliamentary process to reclassify to begin 'shortly'. Excessive ketamine use has been associated with a range of health harms including chronic bladder and other urinary tract damage. However, Baker acknowledges in the letter that 'ketamine use in adults in the UK has gone down in the past two years, although it is too early to establish whether this downward trend will continue'.

Meanwhile, the latest figures from the National Programme on Substance Abuse Deaths (NPSAD) at St George's, University of London, show a 600 per cent increase in the number of deaths caused by new psychoactive substances between 2009 and 2012 – from 10 to 68. The prevalence of the new drugs in post-mortem toxicology reports also increased from 12 cases to 97 over the same period.

The total number of drug-related deaths reported to NPSAD during 2012 was 1,613. Opiates – alone or in combination with other drugs – accounted for 36 per cent, up 4 per cent on 2011 and reversing the declining trend of recent years (*DDN*, March 2013, page 5). There was also an increase in the proportion of deaths involving stimulants including cocaine, following a decline in 2009 and stabilisation in 2010.

Norman Baker

London had the highest proportion of cocaine-related deaths at 15.2 per cent, while Liverpool recorded more drug-related deaths than Manchester for the first time since 2006. The highest rates of drug-related deaths per 100,000 adult population were in the DAAT areas of Liverpool (12.57 per cent), Blackburn with Darwen (11.45 per cent) and the London Borough of Hammersmith and Fulham (11.34 per cent). More than 72 per cent of deaths were in males, and more than 67 per cent in under-45s.

'We have observed an increase in the number and range of [novel psychoactive substances] in the post mortem toxicology results and in the cause of death of cases notified to us,' said NPSAD spokesperson Professor Fabrizio Schifano. Clearly this is a major public health concern and we must continue to monitor this worrying development. Those experimenting with such substances are effectively dancing in a minefield.'

Scottish alcohol-related deaths fall nearly 40 per cent in a decade

Alcohol-related death rates in Scotland fell by 37 per cent – from 39.5 to 24.8 per 100,000 population – in the ten years to 2012, according to figures from the Office for National Statistics (ONS). Death rates in England rose by 2 per cent over the same period, although at 14.7 per 100,000 population in 2012 they remain much lower than Scotland's.

There were 8,367 alcohol-related deaths in the UK overall in 2012, 381 fewer than the previous year, with males accounting for 65 per cent of the deaths. Death rates were highest among men aged 60-64.

Meanwhile, a new modelling study from the Sheffield Alcohol Research Group has concluded that minimum pricing is an effective way to target high-risk drinkers, with 'negligible' effects on low-income, moderate drinkers. 'Because harmful drinkers on low incomes purchase more alcohol at less than the minimum unit price threshold compared with other groups, they would be affected most' by a policy of a minimum price of 45p per unit, says *Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study*. Much of the opposition to minimum pricing has been based on the impact it could have on moderate drinkers.

A 45p minimum price would mean an estimated 860 fewer alcohol-related deaths per year, says the study, and nearly 30,000 fewer hospital admissions. The research provided 'further evidence' of the effectiveness of the policy, said director of the Centre for Public Health Excellence at NICE, Professor Mike Kelly.

The Home Office has also announced 20 new 'local alcohol action areas' across England and Wales, with licensing authorities, health bodies and the police working together to address drink-related crime and ill health. The areas had 'the potential to build strong evidence of what works to tackle alcohol harms in the community', said director of health and wellbeing at Public Health England, Professor Kevin Fenton.

Alcohol-related deaths in the United Kingdom, registered in 2012 at www.ons.gov.uk

Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study at www.thelancet.com

NEWS IN BRIEF

IN DENIAL

The International Narcotics Control Board (INCB) has expressed 'concern' at US initiatives to legalise the 'non-medical and non-scientific' use of cannabis. Launching its annual report, INCB president Raymond Yans said the organisation 'deeply regretted' developments in Colorado and Washington, which 'contravene the provisions of the drug control conventions'. INCB was 'in denial' of calls for a meaningful debate on global drug policy, however, said International Drug Policy Consortium (IDPC) executive director Ann Fordham. 'The board is apparently oblivious to the growing number of member states questioning the status quo and exploring alternative policies.' *INCB annual report 2013 at www.incb.org*

POOR PROVISION

Homelessness services are still failing to support women effectively, says the final report of the St Mungo's *Rebuilding shattered lives* project, as they are predominantly designed by, and for, men. More than 10,000 women accessed UK homelessness services last year, says the document, with many more 'hidden' homeless. 'This report evidences a sad chronicle of missed opportunities where women fail to get the help they need,' said St Mungo's chief executive Charles Fraser. 'National leadership is key.' *Report at www.mungos.org*

WINGING IT

Prison drug recovery wings (DRWs) need to be segregated from the wider establishment, with clear referral pathways and strong support from senior management, says a new report from the National Offender Management Service (NOMS). Commissioners should also consider delivering 'a range of recovery-focused interventions including accredited drug treatment programmes' as part of their DRW regimes says the document, which studies the five DRWs launched in 2011. *Drug recovery wings set up, delivery and lessons learned: process study of first tranche DRW pilot sites at www.gov.uk*

VITAL SIGNS

The London Drug and Alcohol Policy Forum (LDAPF) has launched a new version of its *Vital info* guide to drugs and their associated risks. *Available free in leaflet form from ldapf@cityoflondon.gov.uk or to download at www.cityoflondon.gov.uk/ldapf, with an optimised web version coming soon.*

THE STATE WE'RE IN

Paul Anders shares some key findings from, and the thinking behind, the Recovery Partnership's *State of the sector 2013* report

Drug treatment in the UK is regarded as world class – effective, evidence-based and supported by a wealth of data, with figures from the National Drug Treatment Monitoring System (NDTMS) showing how far the sector has come.

However, it's now acknowledged that treatment itself is only one of the things that contribute to a successful outcome. Making a long-term transformation relies on a range of factors – referred to as recovery capital – that can be boiled down to straightforward ideas like improved health, a job, somewhere to live and friends. Building these resources is an important part of starting to make a change, and often an essential part of sustaining it.

The advantages to building recovery capital are clear but the environment is, if not hostile, then certainly challenging. The treatment sector is in a state of flux and the external environment is also changing, with jobs and homes hard to come by and public services undergoing significant changes.

The Recovery Partnership was keen to learn more about how the sector is adapting to the changing environment, and how it is managing to provide the type of support needed to build lasting recovery. While NDTMS and the other hard data the sector collects tell an important story, to learn more about non-treatment related activity and the reality at a local level, talking to services and the people who work in them was crucial.

The *State of the sector 2013* research (see news story, page 4) aimed to do this by a number of means – an online survey, telephone interviews with chief executives and local managers and four regional 'Building Recovery in Communities' summits last autumn in which more than 200 people participated. The survey itself was completed by around 170 services, while around a dozen interviews were conducted, primarily with services in local authority areas where there was an especially low or especially high public health allocation.

Given the breadth of what the Recovery Partnership wanted to learn about, it's hardly surprising that the findings are best described as mixed. Some key points include:

- *There is no evidence so far of systemic disinvestment. Roughly twice as many services reported a decrease compared to those reporting an increase, but the average increase was larger than the average decrease. This may be evidence of a trend towards larger contracts and fewer providers in a given area and this is consistent with in-year figures from the Department for Communities and Local Government, which suggest that, broadly speaking, funding has been maintained in 2013-14.*

- *There is some engagement with health and wellbeing boards and police and crime commissioners, but variable levels of awareness of the contents of joint strategic needs assessments (JSNAs) and police and crime plans – particularly the latter. Where people were aware of the contents of local plans and assessments, several expressed concern that the focus was more on crime and anti-social behaviour than treatment. In the case of JSNAs, there were concerns that drugs and alcohol were insufficiently reflected, which may not be problematic if the boards are working on the principle that if it's not broken, don't fix it, but it's something to watch out for.*

Generally, services appear to be facing challenges around supporting people to accumulate recovery capital, with housing, jobs and support for complex or multiple needs all highlighted as areas of concern:

- *Housing was the most commonly encountered support need after support to overcome dependency – unsurprising, as NDTMS data indicates many people accessing treatment have some sort of housing problem. However, housing and housing support was the most commonly identified local gap, including the ability to access particular types of accommodation, such as drug and/or alcohol-free supported housing.*

- *Management of overall health was the second most encountered support need. While availability of physical or general health services does not seem problematic, more respondents felt that access to mental health services had worsened than improved over the last 12 months. Several expressed concern about the threshold for mental health support and that raising it meant that many people were going without. The problem of support for people with complex needs or dual diagnosis remains unresolved.*

- *Employment, training and education (ETE) came fourth on the list of support needs and was the third most mentioned local gap. What's interesting is that, in response to another question, very few respondents said ETE support wasn't available locally, and many services reported a partnership with Jobcentre Plus and/or Work Programme providers. It may be that while the support is available, it isn't achieving the sort of results services would like to see and be part of.*

'In short, while the findings aren't calamitous – and in some respects are pretty positive – there are some areas of work that look as though they're struggling.'

In short, while the findings aren't calamitous – and in some respects are pretty positive – there are some areas of work that look as though they're struggling, and many of the areas where services and partnerships appear to be facing difficulty are related directly to recovery capital.

Later this year, we'll be repeating the exercise to see how the sector is faring now that the new commissioners and funders are bedded in, and we'll be looking in more detail at the findings from 2013. As *State of the sector 2013* focused primarily on community and residential drug and alcohol treatment, we're also aiming to do some work looking at prison treatment and young people's services. Please keep your eyes open for them – the more people who take part, the more reliable the findings will be.

Full report at www.drugscope.org.uk

Paul Anders is senior policy officer at DrugScope

Enterprising ideas

Graham Marshall shares how Spitalfields Crypt Trust's social enterprises have helped service users build the confidence to get back to work

LOOKING BACK, setting up a painting and decorating social enterprise was something of a no-brainer. For all sorts of reasons, employment is quite low on the list of priorities for the majority of people that we work with. Some of that's down to lack of skills, confidence and experience – and now, especially in the current economic climate, it's also due to limited employment prospects. Learning to paint in a safe and understanding environment seemed like a good way to change all that.

The seed of the idea actually came from our own service users. I used to ask the guys in our recovery hostel about our work and how we could improve it. Time after time, I would hear the same thing: 'There's not enough to do, Graham.' Filling the time once the drink or drugs are gone is one of the hardest things in those early days of recovery. They often used to ask permission to paint their own bedrooms and the communal rooms, and so it all started.

They came up with the business name YourTime, which for them captured both the fact that it was both 'their' time and 'their' opportunity. After the first two years of working on both paid and voluntary jobs, we pitched our services to our landlord, the Providence Row Housing Association. Many of their clients were single, homeless people with alcohol and drug problems – lives we were used to encountering. Providence Row was sympathetic to our work and highly supportive, and we soon started receiving regular work from them. They awarded us a contract to decorate their 'voids' – vacated rooms in need of decoration – which was fantastic, if a steep learning curve.

'Train, train, and then train some more...'

Buoyed by the impact of using enterprise as a tool for recovery, we enthusiastically embarked on our second venture, a coffee-bookshop in the heart of trendy Shoreditch. Our plan for Paper & Cup was three-fold – make it look, feel and taste like a serious business and not a charity, support our trainees to the best of our ability through great training, and when appropriate, provide a route out of benefits and into work while fostering a culture of care and fun. We followed this approach not only for business reasons, but therapeutic ones also. We wanted customers to come into our shop because they liked it, and then have them discover that we are a charity. We also wanted recovering service users to feel a sense of pride and aspiration through working in a first-rate coffee shop.

In our enterprises we want not only to raise people's expectations, but to also exceed them. We want to ease them back into working life by engendering a culture of trust and really help people to begin the journey away from dependence, into independence.

We have just launched our third foray into the world of social enterprise. Restoration Station, an upcycling furniture project, is the offspring of our training and development centre, the New Hanbury Project. Having developed out of our furniture-making classes, we recently opened our doors onto Shoreditch High Street to greet customers with the tagline, 'Restoring furniture, rebuilding lives'. We've already sold our products alongside some fantastic designers at the East London Design Show.

It has been amazing to watch our volunteers' enthusiasm and passion for the project grow daily. One of the volunteers recently said, 'To have strangers come into the shop and say they love something you've made and then buy it is a wonderful feeling. It's been the best buzz I've had in recovery! I've really started to believe in myself. I felt well proud.'

So what have we learned? Well, a lot! It's been such a worthwhile journey, and one that I'm glad we've taken. We've given people a taste of full-time employment, witnessed the adoption of healthy new behaviour and helped raise self-esteem.

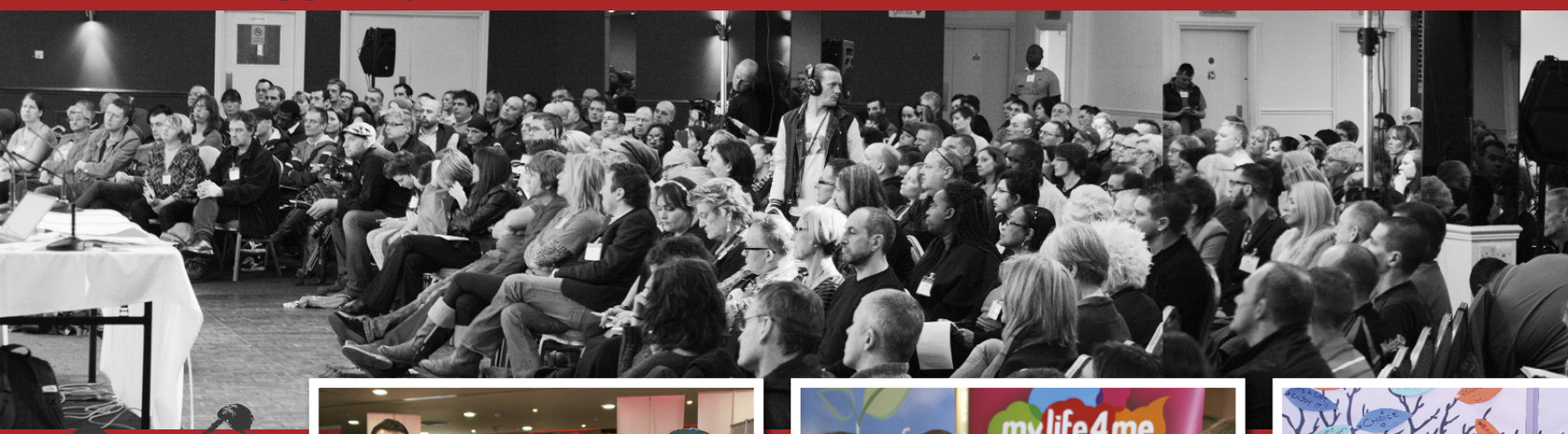
I would offer three main tips to anyone thinking of setting up a social enterprise: go slowly, ask other entrepreneurs lots of questions and learn from their mistakes.

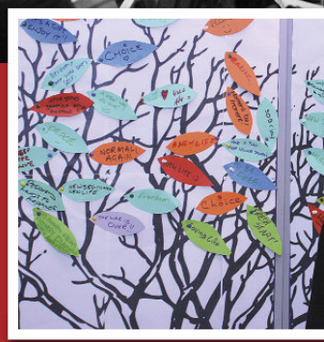
Don't be perceived as a cheap or easy option. Avoid promising to do a job any cheaper than anybody else – unless there is a heavy reliance upon volunteer labour – or the needs of beneficiaries will be neglected. A successful social enterprise is one that provides its beneficiaries with great employment and training opportunities, at a cost that is sustainable.

Train, train, and then train some more. At SCT, we have pledged that our social enterprises will always be characterised by great support. We will provide comprehensive learning and work experience that will prepare people for a real work environment.

Social enterprises have now become an integral part of our 'pathway to recovery' to help people put their lives back together. The energetic transformations we have witnessed on our journey have been powerful. There is absolutely no doubt that the sense of achievement that our trainees and volunteers feel are good for them.

Graham Marshall is CEO of Spitalfields Crypt Trust (SCT), www.sct.org.uk





FLYING THE FLAG

Make It Happen!'s opening session heard from representatives of three service user-driven organisations

'I'm a recovering addict,' ***Sophie Strachan*** of Positively UK told delegates at *Make It Happen!*'s opening session. 'I've chosen complete abstinence. I'm also HIV-positive and have been living with HIV for 11 years.'

Positively UK had been an established charity since 1987, she told the conference, after being set up in someone's living room. 'We go to clinics and prisons and we're all living with HIV – it's the therapeutic value of one person helping another. We'd love to go into more prisons but we don't receive any funding for that.'

Her organisation also had a mentoring programme, she told delegates – recruiting and training people to Open College Network accreditation level – as well as a pregnancy project, a youth project and a forthcoming a children and family project. 'It's that single intervention of alleviating isolation, because so many people with HIV live in isolation.'

Issues for HIV positive drug users included co-infection of hepatitis C and drug-resistant TB as well as denial of problematic drug use and their HIV diagnosis, she said. 'I have a big group of friends and some of them don't want to get tested, but there are so many positives – excuse the pun – about knowing your status. Knowledge is power – you get to look after your health and reduce onward infection.'

Anyone living with HIV knew the impact that the associated stigma could have, she told the conference. 'At one point it was thought that having access to treatment would help to reduce that, but that hasn't happened. People aren't informed, and we can play a key role in that – I'm one face of thousands of people living with HIV.' Peer support was vital, she stressed. 'When I got my diagnosis I was in prison, and it was another positive person who sowed the seed of hope. We know that peer support works.'

Positively UK was also involved in lobbying, advocating, capacity building and human rights awareness, she said, producing a report called *HIV behind bars* that looked in depth at human rights abuses in UK prisons, including gender-based violence.

'I've turned my HIV into a gift,' she said. 'I felt so powerless when I was given the diagnosis – I was raging – but I've turned that around. No one should have to deal with a diagnosis alone. And they don't.'

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Danny McCubbin of the San Patrignano UK Association described how the Italian long-term residential rehab facility had helped more than 25,000 people since it was founded in 1978, with a 72 per cent success rate and 1,300 people currently on the programme.

'It's similar to a kibbutz,' he said of the Rimini-based community. 'Everyone gets involved in the cooking and farming and helping out.' San Patrignano had quickly begun selling its own produce and was now firmly established as a social enterprise, he explained, marketing a range of products including furniture, glassware, ceramics and cheese. The facility received no government funding but raised millions of euros a year through sales and charitable donations. 'When I first visited I expected it to be very hippy-herbal, but nothing prepared me for the enormity of it,' he said.

'There's no one story when it comes to addiction – everyone has their own story,' he stated. 'At San Patrignano young people are given the context to confront why they took drugs in the first place, and after that they can start to rebuild their lives.' The whole process took three to four years, he said, with the first the most intense. 'It's very, very hard work and there are a lot of rules. The first year is incredibly strict, but when people come to the community they learn to respect each other.'

The UK association helped people to go to San Patrignano and offered opportunities to those who had been through the community, he said, and its aim was now to make links with like-minded organisations. 'It's very challenging for young people in this country to have a voice in terms of what they want for their recovery. What I love about the community is that it's based on the individual. It offers a chance for young people to develop lasting skills and build pride in their achievements. It's one of the most successful drug rehabilitation projects in the

'There are so many positives – excuse the pun – about knowing your status. Knowledge is power...'

SOPHIE STRACHAN

'I enjoyed school and sports and I went on to be a sea cadet... So how did I go from that to living in the back of a shed in Grimsby?'

DAVID LAWSON

'It's very challenging for young people in this country to have a voice in terms of what they want for their recovery.'

DANNY MCCUBBIN

world, and I think that governments should really be taking notice.'

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David Lawson of DISC's peer-led recovery community, BRIC (Building Recovery in Communities), then told the conference what had led him to user involvement. 'My childhood was quite happy – I enjoyed school and sports and I went on to be a sea cadet. I wanted to join the marines. So how did I go from that to living in the back of a shed in Grimsby?'

He'd been in and out of prison since 1986, he said, and as his drug use grew so did the length of the sentences. 'I knew that I was going to die. All my relationships had been ruined, and I felt safe in prison.' After he was released, however, he made the decision to engage with treatment services.

'Accepting help was my first step on the road to recovery. Recovery is everywhere, all around us. We might not see it but it continues to grow, and everybody's journey is different. I reduced in the community – with the right support it is possible to detox in the community. I'm also a member of NA and I used to go around saying that was the only way to do it, but it has to be about choice. It's horses for courses – that's the only way – and as I've healed my family have needed time to heal as well. I've become more responsible and started to build up relationships with them.'

Part of how that had happened had been through user involvement, he stressed. 'It's all about relationships for me. For many years I distanced myself – through guilt and shame – and it was difficult for me to have relationships. All of that's changed now, through recovery. It's also about looking after myself, because I've damaged my body. But I want to live.

'The last thing I wanted to do was work in services, believe me,' he told delegates. 'It can be challenging, we can be adult babies – we want what we want and we want it now – but I get so much from working with people. You're all flying the flag for recovery, and showing that recovery is possible. We made this happen.'

www.positivelyuk.org

www.sanpatrignano.org

'...being made to feel guilty about staying on methadone is just as bad as being forced.'
ANNA MILLINGTON

The focus of the morning's panel discussion was the 'challenges to making it happen'

FACING THE CHALLENGE

'Scripts should be available whenever anyone needs them – if the recovery message in local areas is about time-limiting, then that needs to be changed,' stated ***Pete Burkinshaw*** of Public Health England (PHE) in the morning's second session.

Chaired by service user coordinator ***Alex Boyt***, *Challenges to making it happen* saw a panel of speakers discussing questions sent in by *DDN* readers. The first of these was, 'When the NTA's responsibilities were merged into PHE we were promised that recovery would be inclusive, but in our local area funding seems to be only for abstinence-based services. What's the future for those on scripts?'

Kirstie Douse, head of legal services at Release and *DDN*'s legal columnist, told the conference that it had been her experience that people were being 'forced to detox and reduce much faster than they would like, and that's completely unacceptable'. Forced recovery was a 'quick route to relapse' added Bob Campbell of Phoenix Futures, while Birmingham GP ***Dr Judith Yates*** told the conference that, 'we know methadone works for most people. There's no one in the higher-ups that's advocating time-limited treatment.' Service user activist ***Anna Millington***, however, stressed that 'a lot of it is passive aggressive – being made to feel guilty about staying on methadone is just as bad as being forced.'

'There is an incentive to get people off scripts,' stated one delegate. 'It's called payment by results,' while ***Bob Campbell*** stressed that, 'like anything, it's all about short-term measures. There's no investment in people's futures.'

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The second question for panellists was, 'In my area there's only one GP who will see patients with drug problems. This is disgraceful. Why is it treated differently from any other illness?'

Services were not possible without some level of funding, said Judith Yates, and it was now down to people in local areas to campaign for them. Despite all of the arguments for shared care, however, drug treatment was 'big business' and increasingly in the hands of large organisations, said Kirstie Douse. 'Unfortunately, that's the direction it's moving in.'

'When I started in 1986, 0.2 per cent of general practice was looking after people who had problems with drugs and alcohol,' said retired GP and former DDN columnist, ***Dr Chris Ford***. 'By 2011, the last year the figures were compiled, that had risen to 32 per cent.' Part of that had been the result of service user advocacy, she stressed, but the field had entered 'a period of chaos' now. 'How can people get care when their organisation is just going into tender or just coming out of tender? We need specialist care, and we have to stand up and be counted. We need to stand together, wherever you are on the spectrum – drug-free or using every day.'

'If you want the services, do it yourself, love,' said one delegate. 'At Lancashire User Forum we did, and we're massive.'

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The session's final question was on alcohol. 'As it causes more harm to more people than drug use, why aren't treatment resources allocated proportionately?' panellists were asked.

There was no doubt that funding should be distributed proportionately, said ***Pete Burkinshaw***. 'I'm not arguing with that at all. But there seems to be a feeling of Newtonian Law developing around commissioners – that if you invest in alcohol then you need to disinvest in drugs.'

Funding for drug treatment was ten times that for alcohol, the session heard, while the government had also abandoned its plans to introduce minimum pricing. 'The alcohol industry is a multi-million pound industry,' said one delegate. 'It's like the Taliban or the Medellin Cartel having an influence on government policy.'

'The only time money is given to drug treatment is when it affects mainstream society – the HIV crisis, crime,' said another. 'Now that crime is going down, what's going to happen?'

'There's absolutely no distinction between drugs and alcohol,' stated Pete Burkinshaw at the session's end. 'We're seeing more and more completely integrated services. It's totally down to local areas.'

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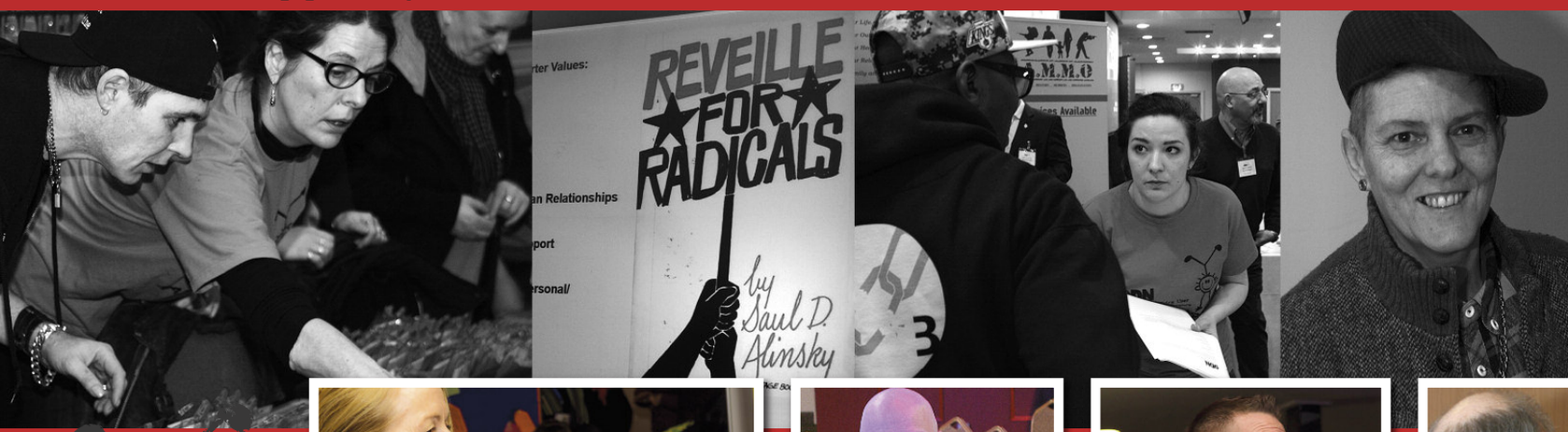

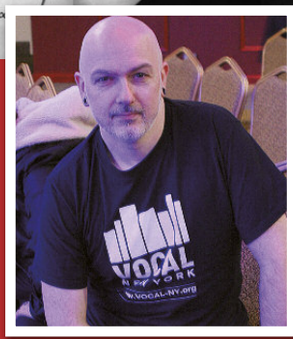

GETTING IT IN PERSPECTIVE

Delegates at the afternoon's opening session heard a range of personal viewpoints from six very different speakers

'My perspective is based on 49 years living on this earth, 22 of them in recovery,' said ***Alistair Sinclair*** of the UK Recovery Federation (UKRF) as he introduced the afternoon's *Perspectives* session. 'I've also worked in social care, on and off, for 26 years, and I'm still in recovery from that,' he said.

Recovery was an ongoing process of change and self-definition that challenged all discrimination, he told the conference. 'There are many pathways to recovery – no one has the right to claim ownership.' It had also sometimes come to be seen as an excuse to dismantle services, he added, 'but that's about how it's co-opted and presented'.

'Recovery is a move from deficits to assets, focusing on strengths rather than weaknesses,' he told delegates. 'If you listen to our politicians, all you hear about are weaknesses and gaps. But people are coming together to organise, mobilise and make a difference – they're telling a different story. If you look at the things that get done, they're not done by services. They're done by families, neighbourhoods, communities, and they always have been.'

UKRF's values included shared learning and support, self-determination, personal and community strengths and reciprocity, he said. 'We, as human beings, have a basic human need to give and receive. That's how we work. As John Ruskin said, "when love and skill work together, expect a masterpiece".'

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The next perspective came from ***Nigel Brunsdon*** of Injecting Advice and HIT, discussing naloxone. 'It's an opiate antagonist – it reduces the effects of a heroin overdose and that's all it does,' he said. 'It doesn't do anything else – it's not addictive, it's not poisonous, and it's not a replacement for other overdose interventions.'

It was also not a 'universal cure' for overdose, as someone else needed to be present to administer it, he pointed out. 'But 50 per cent of people who overdose do have someone else with them. That means that 50 per cent of the people who've died from an overdose in this country needn't have.'

Naloxone, was 'prescription-only, unfortunately', he told the session. 'It can only be supplied to the person at risk of overdose, or families and loved ones if there's a letter of consent from the person whose prescription it is. I'd love for this to be changed.'

Scotland had a national programme of naloxone distribution in place, he said, and 365 overdoses had been reversed since its implementation. While Wales and Ireland had also introduced national programmes, in England it had been 'left up to localism', he said. 'You should all be persuading your commissioners that we need naloxone. Even from a purely economic standpoint it makes sense. You need to get angry. Thousands of people need this drug.'

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Delegates then heard from ***Pete***, ***Emma*** and ***Kerry*** from Lancashire User Forum (LUF), which was now a registered charity with commissioning responsibility. 'We grew it, based on a few principles – focusing on what's good and positive,' Pete told delegates. 'We're a grass-roots organisation and service-user led to the bone.' Public Health England chief executive Duncan Selbie had visited the organisation's last forum because 'he saw something different here. He called it "commissioning ahead of its time".'

'We had a DAAT that really believed in what we were doing on the ground,' added Kerry. 'They put their money where their mouth is and we now have a £200,000 budget that's been pulled out of services, pan-Lancashire. A consultant psychiatrist's salary for six months would be about £50,000 but we've spent that on social enterprises – photography, art, catering – and six jobs that range from three to 12 months in things like construction, admin and catering. We've funded a netball team, a football team, a choir, a boat, £10,000's worth of training, several environmental projects, recovery hubs. It's about building people's recovery capital – opportunities with real depth and weight.'

The 'LUFStock' art, music and sports festival had also grown in size from 70 to 270 people in the space of a year, Emma told delegates. 'What we have here is unity – we're one group of people with one goal. We're a family, a community. No matter

'My recovery journey was a bit reluctant, but once I got into it I really thrived...'

JIM CONNEELY

'We're a grass-roots organisation and service-user led to the bone.'

LANCASHIRE USER FORUM

what your recovery journey is you have an invitation – you belong.'

'I'm a former chemist robber, which is not a good lifestyle choice,' outreach worker for the Hepatitis C Trust, ***Jim Conneely*** (*DDN*, January, page 6) told the conference. 'My recovery journey was a bit reluctant, but once I got into it I really thrived on it.'

He'd had a supportive GP who genuinely wanted to help – 'a miracle' – he told delegates, only to then be diagnosed with hepatitis C and told there was 'nothing' that could be done. 'There was no internet then, so I asked around,' he said. 'There was no information, no leaflets, but I heard about a support group and then found out about this new drug, interferon. I had to fight to get that – a pretty crappy drug – and I eventually got clear of the virus. I feel great and really feel that I've got my life back. Some of that's down to my recovery but it's also about my physical health.'

As he travelled around the country in the Hepatitis C Trust's testing van he found that 'an awful lot of people think they've got it – why?' he said. 'But if you're injecting you need a test, and there is treatment' – with new breakthroughs all the time, he stressed.

The Hepatitis C Trust was one of the original service user groups, he said. 'We're a group of patients who got together because there was no information about hepatitis C. You need the facts, but we're out there.' Many people living with the virus were 'in a daze', he said, doing nothing about it. 'I just want to raise awareness – let's stop the stigma.'

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The next perspective came from drug outreach worker ***Philippe Bonnet***, making the case for a drug consumption room in Birmingham (*DDN*, October 2013, page 16) – a campaign that now had the backing of hundreds of GPs and the local police and crime commissioner. Problems related to street injecting included increased rates of blood-borne virus transmission, abscesses, femoral injecting, needle litter and overdose deaths, he said, while the solution was a 'simple, effective, pragmatic and humanistic approach' that was evidence-based. 'We don't want a multi-million pound set up, just a couple of portakabins.'

Switzerland had opened the first DCR in 1986, he told the session, and there were now almost 100 worldwide, mainly in Europe. 'They needn't be controversial and they're not a vote loser,' he said, and they also led to an increase in access to treatment and wraparound services. 'And nobody has ever died of an overdose in a DCR. Ever.'

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The final perspective was from ***Lester Morse*** of East Coast Recovery, who described how his recovery journey had led to him to establishing facilities of his own. From helping out at a soup kitchen he'd moved on to setting up houses for people struggling with addiction, often in the face of opposition from the local authority.

'I'm a service user – I've been at the frontline of addiction – and my intention was just to help people. We can talk about addiction, but we need to get you sorted out with the rest of your life. Recovery is the foundation, and the important bit that gets looked over is that MPs and doctors don't understand the problem.'

His organisation tried to 'centre everything around the brain', he told delegates. 'To have a healthy brain you need a healthy environment, and that's what we try to create in our treatment centres. We have a coffee shop, we do wood chopping, and people can train for City and Guilds to get good qualifications. It's based on people helping each other and keeping busy. It's a real community project.'

'They need us more than we need them...'
TIM SAMPEY

REASONS TO BELIEVE

The day's final session heard from Tim Sampey of Build on Belief on the importance of self-determination

'Service user involvement is something I've been doing for ten years and something I believe in very strongly,' ***Tim Sampey*** of Build on Belief (BoB) told the conference. His organisation had been built up exclusively by service users, without professional involvement, he stressed.

Recovery should be enjoyable, he said, which was why one of the key elements of BoB was a social club. 'I realised early on that there's something about getting together and having fun, and I'm a service user so I say what service user involvement is. But you have to negotiate. I ended up sitting on the DAAT and I didn't understand it, but we learned to negotiate.'

It was also vital not to be afraid to try something new, he stated. 'Amateurs built the ark but professionals built the Titanic. Work as a team – control freaks kill. Some of the best things to have come out of BoB were done by other people.'

Services and commissioners were obliged to engage with service users, he told the conference. 'What I didn't realise for years and years and years was that they need us more than we need them. They have to have service user involvement – it's written into their contracts. We hold all the cards.'

He had set up BoB because he was 'tired of talking', he said. 'I didn't want to be identified as an ex-addict. I wanted to be identified as a human being, and to do that you have to get back into the community. You need to give people a place to belong, friends around them and fun. BoB means getting yourself a life, and I'd die by that statement. My recovery belongs to me – I own it. If I mess it up I mess it up, but you may not tell me how to live.'

The vital thing was to 'do it yourself' and learn to take risks, he said. Anyone could access BoB, with 80-90 per cent of the organisation's volunteers in recovery and the rest from the local community. 'We built a family for ourselves. It wasn't easy – it was hard, hard work. You need to get used to people getting in your face, to people not liking you. One of the weaknesses we sometimes have as a community is an attitude of "gimme, gimme, gimme", so there's something about just going away and doing it yourself, showing what you can do.

'Stick with what you're good at, stick with your strengths, and stick to your own principles,' he urged. 'The world is moving really fast, and the money in the treatment system is going down, but I believe you guys are the future. We're the people who are going to do it, who are going to set up our own services. Raise your own money – it impresses people. We shouldn't rely on handouts. And finally, stick to your own recovery – define it for yourselves. You can't go around defining other people's, and it won't work if you do.'

BUILDING ON BELIEF

In January 'Build on Belief' (BoB) officially launched our charity from the House of Lords.

It was the culmination of a little over nine years hard work by more than 500 volunteers, who had designed, implemented and run their own independent service user organisation since 2005. BoB runs socially based weekend services and, lately, recovery cafés across West London, enabling a seven-day-a-week service provision in those boroughs.

A month later I was asked to speak at the *DDN* National Service User Conference on some of the things we had learned over the years about building and running an independent service user charity. I was delighted to be asked because I believe that service user involvement has changed the treatment system for the better and that peer-run projects are the future. So with that in mind, here are some of the things we've learned.

Independence: Although difficult to do, independence from service providers or the local authority is important. It allows the freedom to experiment, makes it easier to avoid being unduly influenced by the agenda of another organisation, and most importantly by far, empowers people to take control of their own service and their own lives.

No specific model of addiction or recovery: BoB does not differentiate between drugs and alcohol, and neither does it advocate any particular model of addiction or recovery. We believe that recovery is a profoundly personal viewpoint and therefore journey, and by taking a particular stance, you risk excluding those who do not agree with it. Therefore all models are valid, because, in essence, we see recovery quite simply as reintegration into society without dependence on a mind-altering substance. This did cause some interesting discussions

Following on from his rousing speech at Make it Happen, **Tim Sampey** shares invaluable learning points from running an independent service user organisation

between those of us who believe in total abstinence and those who do not, but we learned that we can work together far more effectively by agreeing to distinguish between our personal needs and beliefs and the greater journey we were collectively taking, which was the rebuilding of our lives to the point where we were happy and not controlled by our addiction.

Board of trustees: Don't use your friends – it's the road to hell! A good board of trustees (and BoB is blessed with a beauty!) have skills, experience, knowledge and contacts that you do not, enabling the organisation to grow and develop. They are there to guide, support and if necessary challenge you, not be your mates. The clue is in the name 'trustee'. Trust in them to trust in you and work collectively for the greater good, not personal ambition.

Partnership working: Commissioners and service providers are not the enemy. We can achieve more through negotiation and partnership working than through conflict. Ultimately, we are all working for the same end – it helps to bear that in mind.

Volunteers: The people that volunteer for BoB are the life-blood of the organisation, and we have learned to look after them. Travel expenses and something to eat are a given, but there is more that can be done. For six years we have held award ceremonies in the local town hall, inviting volunteers, their partners, commissioners and local service professionals to see the incredible effort our volunteers not only put into their own recovery, but also into helping others.

Training: Not only is training necessary if you are to run your own services safely, it is also important never to underestimate people's desire to learn. We believe in writing and delivering our own training, both to meet the needs of our charity and ensure that our volunteers take an active part in the process of supporting each other and learning together. It can be easy to access some of the professional training in your local area, but it often does not meet the needs of a service user organisation. When in doubt, develop your own!

Ethos: I cannot overstate the importance of developing your own organisational ethos. Be clear about what you believe in, why you work the way you do, and stick to it. Examples? BoB does not pay minimum wage, we consider it unethical. We pay well or not at all. BoB does not advocate any specific model of recovery, believing that all are equally valid. We will not change this, even if it loses us funding or contracts. BoB believes we are all equal. Anyone can volunteer with BoB providing they are not dependent on drugs and alcohol and not a risk to themselves or anyone else. Everyone has a place with us if they want one. Cherry picking is for farmers.

Support: With a few exceptions, we are all in recovery and we must never forget this. Peer-to-peer supervision, which includes support around personal issues as well as day-to-day problems, is crucial if an organisation is to flourish and its volunteers feel valued. With 80 to 100 volunteers problems are bound to arise, including internal conflicts, lapses and relapses, family problems and so on. Having a means to address this and look after your volunteers is vital.

Ambition: Everyone has a reason for volunteering. For many it is the idea of 'giving something back', or a desire to work in the drugs and alcohol field. For others it is a chance to build a safe support network as a part of their recovery, or simply to get out of the house. However, it is important to give everyone a chance to challenge themselves and move up through the organisation. With that in mind, BoB has a range of roles from team leader, to supervisor, group facilitator and service manager.

Use the skills of your peers: Many of the best ideas that allowed BoB to grow and develop were not mine, but came from the volunteer team. I didn't start the music workshop; I can only play two chords and have no sense of timing! My role was to empower those musicians in the team to develop their own project, and to ensure it was safe, fun and open to all.

Employment: Everyone wants to earn a living. BoB has four full-time and two part-time members of staff, and all of them were recruited from the volunteer team. If you are good enough to volunteer, you are certainly good enough to get paid for what you do! It is a part of our ethos to employ from within our own volunteer team and only to advertise outside the organisation if we cannot fill the post internally. A word of advice though – while it's fine to write your own job descriptions and interview questions, it's best to get an independent panel to undertake the interviews. This avoids any accusations of playing favourites, and has the added advantage of getting an external opinion on the strengths and weaknesses of your own volunteer team.

Trust your instincts: Don't be talked out of doing what you think is right and meets the needs of your service user organisation. Five years ago there was a perceived wisdom in some quarters that what we did was not service user involvement because it did not meet the 'standard definition' of said service user involvement. Of course it didn't... we were breaking new ground. These days we are flag-bearers, not only for recovery in the community, but for peer-run organisations and partnership working between service providers and service user groups. As one of my personal heroes, Gandhi, said: 'First they ignore you, then they laugh at you, then they fight you, then you win.' I think that might be the motto for all of us seeking to build our own organisations. It's certainly one of mine.

For more information see www.buildonbelief.org.uk

Independent spirit

'If you're getting involved in user involvement for the thanks you've picked the wrong thing, but when you see people evolving in their own way it's incredible...'

Service user group B3's name stands for 'be heard, be motivated, be free'. **David Gilliver** hears from project manager Ossie Yemoh about the importance of autonomy

'WE'RE NOT OWNED BY ANYBODY – the commissioner isn't keeping us under the thumb,' says Ossie Yemoh of B3, a rapidly growing organisation that's the official service user council for Brent DAAT in north-west London.

B3 offers peer support and advocacy services alongside training and awareness-raising. It celebrates its fifth anniversary this year, while its weekend centre B.Safe (Brent Social Access For Everyone) has now been running for three years. Yemoh has been involved in B3 for more than four years himself – becoming project manager last year – but it's been a long journey to reach that point.

'In 2010 I was diagnosed with a major clot, which was so severe that apparently we could have called it a day,' he says. 'I could barely walk or breathe. As painful as it was, it was like I was given a sign to get it together and I did, but it wasn't easy.'

His addiction had 'kicked in relatively late', he says. After school he trained as a hairdresser, going on to work for some of London's top salons and staying very close to his brother, four years his senior. 'I was in my 20s and I looked up to him – he was always hustling and doing his stuff to make ends meet. I always knew there were drugs around but I never knew what they were. I knew about hashish and weed, but not this white stuff.'

He'd take his pay cheques to a local shop to cash but as time went on he'd wake up to find the money gone. 'My brother and his missus would have been through all of it. This went on for months and it was always, "we'll pay you back". I never understood.'

However, he slowly became intrigued by what he now knows was the aroma of crack smoke. 'I thought, "that doesn't smell too bad". Then came the day when he said, "do you think you'd ever try smoking a pipe?" I remember just replicating what they did – I didn't know what I was doing – but it was so intense. From that day I went rapidly downhill, chasing the highs. The so-called enjoyment factor was very shortlived, but the addiction kicked in quite quickly – not wanting to do anything else other than smoke. I was around 26, 27 and I'm 43 now, and until about four and a bit years ago my addiction never really stopped.'

He spent long periods overseas – in Amsterdam, the US, South America and Africa – eventually ending up in prison, he explains. 'I was trafficking on all different scales. I was in prison in South America, Holland, a short sentence in America as well. I would make a shedload of money then that would go, possessions started going, my appearance, all the usual.'

The clot then put him in hospital for several weeks in 2010 and when he finally came out he 'knew something was different', he says. 'My brother had come out of jail and got himself together, so I went with him to Addaction and got a keyworker.' It was during those initial sessions that he learned about B3 and their plans to start a Saturday service. Curious about volunteering, he went along to find out more.

'Two or three of them really took me under their wing, and that first Friday meeting turned into every Friday without fail. I got involved very quickly because I was committed and turning up every day. My input was being valued so I thought, "maybe I can do this". Members came and went but I just stayed with it and eventually I inherited the chair role.'

He volunteered in that post for around three years, going through the basic training while also putting himself through college, and all the time developing more and more of a rapport with the local commissioner and other managers. 'I was finding that managers were actually calling me by name – I was paranoid and thinking I'd done something wrong,' he says. 'Senior people from the Met, from the DAAT would say, "Ossie, what do you think?" and I'd be, "are you shitting me?" Some of it was tokenistic, I know that, and there were times when we only had a skeleton staff of volunteers, but by now I had full understanding of what user involvement meant and what it meant to empower service users.'

Part of this also meant coming to terms with his own issues, he explains. 'I can't carry the guilt and shame forever – I have to lead by example. Yes, I fucked up many times and did things I'm not proud of, but it is what it is. It's done.'

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B3 became a registered charity at the end of last year, and he's been project manager – a paid post – since last June. 'It's been a slow journey, and at times very hard, but I love my job. It's frustrating, but the outcomes and the self-worth you get out of it are priceless. If you're getting involved in user involvement for the thanks you've picked the wrong thing, but when you see people evolving in their own way it's incredible. And you can be a part of their development and support them.'

When B3's B.Safe facility started three years ago it was only on Saturdays, but since last year it's been a full weekend service, taking on a momentum of its own. 'We didn't plan beyond a year to begin with, but now on a busy weekend we could have 70-plus people come through the door. It's for people who are struggling, people who are doing well, people who feel isolated or lonely – they know they have a safe space to come. Recovery isn't nine to five, Monday to Friday. It's about picking up people's morale – just a social, safe space and it works because of the simplicity of it.'

B3 is also involved in training recovery champions – almost 50 in this financial year alone, spread over three groups. 'The dropout rates have been the bare minimum – one or two at the most – and that's phenomenal, even when you compare it to training for professionals,' he says.

The course covers areas like buddying, outreach work and personal development, but B3 is adamant that the focus isn't just on drugs. 'It's about how they take what they've learned to support and advise people, but it's also about recognising that not everyone who does the course necessarily wants to go into the field,' he says. 'People who've been through treatment have the tendency to say, "I want to give something back", which is brilliant but it doesn't necessarily have to be related to drugs and alcohol. You may want to do young people's work, go back to studying or just back to something you've got love for. Whatever you choose to do, it's OK.'

Partnership is central to B3's work – with Addaction, CRI, WDP, EACH, Junction and Lift, alongside GPs and housing providers – and the organisation is now involved in developing a new version for people living with HIV, 'BPositive', as well as looking to do something similar for mental health. Both the weekend service and the recovery champion course, meanwhile, are funded by the DAAT. 'We're very, very lucky in Brent with our commissioner, Andy Brown. He's phenomenal, very hands on, and I'm very aware that peers and colleagues in other boroughs – in the current financial climate – don't have what we have.'

However, while partnership with the DAAT and others is key, 'I always make it clear that we're not under the umbrella of any other organisation,' he states. 'When I see literature that says, "our project" I say, "please change that – we're not your project, we're your partners". It's about arguing the point in a professional manner.'

One ambition now is to develop 'a clear package of user involvement so that if you want to get involved in that you can come and see what we do', he says, as well as, hopefully, part-time funded posts for committed volunteers and forging links with boroughs that don't have such a strong user involvement structure, 'approaching them to see if they want to buy us in. We're not keeping all our eggs in one basket, and we're trying to bring in additional funding. The more funding I can bring in the more opportunities I can give to volunteers.

'I don't think anyone really saw what was coming – how evolved B3 has become,' he says. 'Challenges come up, but it's about staying firm. What we're doing works.'

http://b-3.org.uk

DDN volunteers spoke to delegates throughout the day, collecting thoughts and comments. Here's a selection of them, along with pictures of those brave enough to have a go in the photobooth

'I'm looking around and there are lots of different peer mentoring-based schemes and I think that's the way forward… I've been through the system a few times, and you just get the basic counsellors – just people in suits really, who don't have any understanding.'
Ellena Lillie, CAIS

'What makes it all the more interesting is that it's coming from service users, and that just makes it all more believable. I remember when I was in recovery, I had many support workers… who learned everything from textbooks. That's not to say I didn't get good support from people who weren't service users, but you can relate to people who have been through it a lot easier.' *Larry, CAIS*

'I got on top of my recovery because I was listening to someone who had actually been there – they weren't a textbook.' *Simon Hudson, The Quays*

'Harm reduction saved my life and harm reduction stopped me from getting hep C and HIV, and saved my veins… harm reduction has its place.'
John Gauntlet, Leicester Recovery Partnership

'This conference is vitally important. The service user is the expert – it's an inspiring space, people want recovery and providers need to know the impact the cuts are making. HIV needs a platform – stigma has not gone away.'
Sophie Strachan, Positively UK

'Great opportunity to network and to see what is going on in the recovery community across the UK.'
Donna Gardiner, Newleaf Project

'It's great that we have open discussion with the professionals. Make it happen.'
Neil Williams, Passion4Recovery

'Seven years in and you're still making it happen. The best networking event and celebration of service user involvement in the UK.'
Steve, Swanswell

'I've fully enjoyed my first experience of the DDN conference. The mix of service users and private business I thought was excellent. A place for us all to come together and explore different pathways of recovery. Spot on, well done DDN.' *Neil, CAN Partnership*

'DDN is great for service users to engage and link with networks and people. UKRR enjoys detailing events that help anyone in their recovery – brilliant.' *UK Recovery Radio*

'Emotive speakers with real passion and drive. Recovery focused but there's still room for harm reduction and maintenance. Great opportunity to hear how people have really moved on with their lives. Very inspiring.'
Claire Pennell, PHE

Conference quotes

'I believe in the Chicago recovery motto: "any positive change". One of the dangers to be avoided when stopping using opiates is filling that hole with alcohol. Very dangerous. The hole needs to be filled with life.'
Dr Judith Yates

'It's great meeting new people. And to know that there are loads of different groups all working as one, we can help a lot more to get clean.' *LJ*

'Seven years in and you're still making it happen. Best service user network no matter what.'
Mat Woodfield

'Thanks to DDN for making networking possible with like-minded and fantastic people. Keep up your hard work.'
Emily Goodyear

'I brought my 11 and 13-year-old boys today. Our kids are the future and should see the recovery after living with the damage.'
Rose (LUF/Red Rose Recovery)

'Very informative and its always inspiring to hear other service user's stories and the diversity – how it works and how it happens.' *Bonnie*

'The best event for meeting friends old and new, sharing ideas – and the food's great too!' *Pete B*

'It's my first conference and it was brilliant.' *Simon Hudson*

'A great opportunity to connect with people all over the country, supporting each other in recovery. Great event, nobody left out.' *Mel, Datus*

'Good opportunity to network and see what's going on in other areas of the UK, keep it going.'
Jason Turner, iSore Media

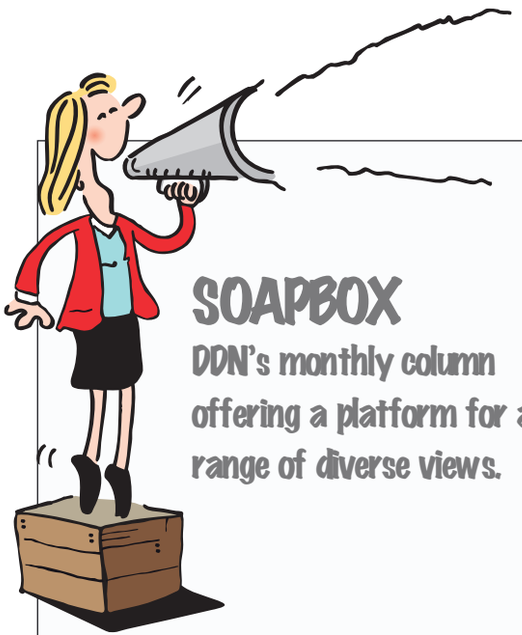
'Thank you so much for all your hard work again this year, we loved every single minute of it. Big, big hug from us all at the UK Recovery Walk Charity.'

'This is my first 'Make It Happen' and I thought it was so positive and a wonderful feeling to see so many people in recovery.'
Karen Kirby, Broadway Lodge

'As always the DDN conference is a great opportunity for people and services to reconnect and form new relationships. It means a lot to see the success stories, the hopes, the ideas and the love!' *Stacey Smith, Inspire*

'I love the networking, I love seeing people in recovery, and I love the different approaches to recovery – there are many ways to skin a cat. One size doesn't fit all.'
John Gauntlet, Leicester Recovery Partnership

'Another brilliant day! Great to see our community growing each year. So many inspiring stories. Thanks DDN and everyone who made it such a powerful day.' *Rich, UKRF*



SOAPBOX

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

STICK IT TO THE MAN

Whatever's happened to true user activism, asks **Daren Garratt**

'I saw the best minds of my generation destroyed by madness, starving hysterical naked, dragging themselves through the negro streets at dawn looking for any angry fix.' *Howl*, by Allen Ginsberg (1956)

What did we fight our battles for? What did we bury our loved ones for? Why did we galvanise, organise, demand our voices be both heard and acted upon and allow ourselves to believe we were actually changing anything? Why did we forge local, regional and national alliances, help bring waiting times down from 18 months to 18 days, advocate to move from 30ml 'ceilings' to optimal doses, or establish a culture of personal choice, clinical governance and equitable public health responses?

Why did we ever even bother wasting our anger, 'cos after ten years we've devolved into the pre-civilisation of user activism.

Now don't get me wrong, I'm not writing this through a rose-tinted, halcyon haze. Of course we made mistakes. Of course we didn't get it all right. Of course we were a divided, bitchy, back-stabbing, frustrating and oppositional bunch. It was a far from perfect movement that was riddled with faults and clashing egos, but at least we were united in a divergent cause.

As 'newbies' coming into the field we were inspired because we saw and heard the creativity and calculated risk-taking that UKHRA, the Methadone Alliance, Exchange Supplies, NDUDA, Mainliners, HIT and Lifeline were utilising to tackle inequalities, challenge the status quo, pioneer harm reduction initiatives and reduce drug-related deaths... and we picked up the torch, carried it on, shared in the successes, learned from the mistakes and suddenly we had Morph, NUN, the reconfigured Alliance, *DDN* and injectingadvice.com.

'We were newly energised, had belief, dedication, support and, as activists, we had each other...'

We were newly energised, had belief, dedication, support and, as activists, we had each other. We also had a (flawed but) functioning system of state-endorsed user engagement that encouraged and enabled locally commissioned flashes of brilliance to evolve, but because peer-led interventions were too reliant on the politics of location, personality and luck, it also proved unsustainable.

It was, I repeat, far from perfect but certainly inspiring and inspirational, and our conferences were our defining moments. They were our limited means to meet up, share ideas and best practice, hatch plots, put the world to rights, stick it to 'the man' and settle our personal wrongs... and they were effective.

I write this immediately after attending the 7th *DDN* conference, *Make It Happen*, and I just feel hollow, sad and... angry because I'm thinking about the sacrifices that were made in order to introduce equity, dignity, effectiveness, fairness and pride into the user activism movement, yet I saw no user activism present. The only movement was a sleight of hand; an illusion. It felt deceitful and fraudulent because this wasn't our 'user conference' anymore. This was now a meeting of people who don't take drugs anymore but insist on proudly and defiantly defining themselves, not by what they are but what they are not.

And because a large proportion of this demographic have clearly become so oppositional to active drug use and users, an ugly, pernicious streak has crept in. Now this isn't a divisive sneer at 'recovery', because it is a viable lifestyle choice for some and deserves a celebratory platform. Neither is it a cheap, lazy criticism of *DDN* whose tireless commitment and organising is often unjustifiably maligned despite being only able to work with, and respond to, whatever local commissioners and market economies dictate.

No. This is a sad eulogy to a once vibrant movement that allowed the *Make It Happen* conference become the 'Let It Happen' one. The passion, spark, fight, resistance and anger has been replaced by a-whoopin' and a-hollerin', but in an area as emotive as drug use there is no 'sense' in 'consensus'.

As John Lydon once said, 'anger is an energy', and energy propels, and propulsion is, literally, the way forward. But is there a way forward? Who are the next generation to break through and kick over the statues? Where's the new breed? What will they howl? I can't answer that, but I hope beyond hope that somebody out there can.

This article is dedicated to the memory and work of Alan Joyce. Ours is a fractured society in which the smallest of mercies are increasingly embraced with the greatest relief and I, for one, am relieved to know that at least the 'Big Man' didn't live to see where our years of emotional struggle, direct personal action and targeted political activism have brought us.

Daren Garratt plays drums for The Fall.

LETTERS

SHOW ME THE CURE

I was very interested to read your report on the *Creating Recovery* conference (*DDN*, February, page 18), and welcome any initiative that looks to challenge stigma and celebrate recovery – especially one that comes with an announcement of new much-needed funding available to help community groups.

I was however incredulous at the reporting of the comments made by Benjamin Lloyd Stormont Mancroft, the 3rd Baron Mancroft. In your report you quote Lord Mancroft as saying: 'The healthcare profession can't cure addiction. Doctors do not understand addiction – it's not in their radar.' While the healthcare profession may not have all the answers to 'cure' addiction, I'm yet to encounter one type of treatment that can. A person's recovery from addiction comes around from a combination of many factors, usually beginning with their desire for recovery, but aided and supported by a range of services including healthcare professionals. Doctors might not be perfect but are a group of well-trained individuals working with evidence-based treatment, who are often the first step on an individual's recovery journey. To write them off in one sweeping statement is incredibly arrogant and ill informed.

Lord Mancroft went on to assert that the NHS was the 'most dangerous dealer in the world, for prescription drugs' and said that after '30 years of very close observation' he had 'never seen anyone benefit from substitute prescribing for any but a very short length of time'. His Lordship has previous for making sweeping statements that are not backed up by any evidence, and his comments on nurses a few years ago earned him criticism from all quarters including his own party leader who said he should 'think more carefully before opening his mouth'. It seems he has not paid heed to this.

Baron Mancroft is as entitled to his views as any other service user and his inherited privileged position in society has given him a platform to make them, but it is important that they are not reported with the same weight as those of knowledgeable professionals. Unless, of course, he would like to provide the evidence to support them.

David Prentice, via email

GIVE US A CLUE

'There are figures on both sides of recovery and human rights/harm reduction who share views and are looking for points of connection and trying to collaborate,' says Mat Southwell in your interview (*DDN*, February, page 17).

This may be true, but the evidence in my area is very thin on the ground. Our attempts at a fully inclusive service user group have gone out of the window since our members became preoccupied over whether we're a 'user group' a 'service user group' or a 'recovery group'. Personally I don't think it matters, but to many of our members the label has become more important than what we actually do. We're in danger of degenerating into an unstructured mess and losing all our members.

So if there are 'figures' on any side who have advice on connecting and collaborating with those of us out there struggling to keep service user involvement alive, please give us some pointers!

Jane, by email

HAVE A STAR

'What is the REC-CAP?' ask the authors in their article, 'How far have you come?' (*DDN*, February, page 14). What indeed. So taking elements of established engagement, outcome and recovery measures can create a flexible online recovery mapping measure, can it?

Am I the only one to feel slightly depressed by the idea of a 'clinical recovery tool'? We used to talk to our clients and make sure they had the right key worker. Now we are expected to process them and send them away with a great big recovery star – sorry, a 'visual map of recovery wellbeing'.

Paul Ainsley, by email

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity – please limit submissions to 350 words.

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

The choice we have to make now is how we do things differently. Repeating the mistakes of the past is not the way to solve this problem in the future. Put simply, if you are anti-drugs, you should be pro-reform.
Nick Clegg, *Observer*, 9 February

Instead of proposing any action, [Nick Clegg] is resorting to the nervous refrain of calling for more debate on a subject that has been debated for decades. Sadly, he appears to be doing this only for the most naked and short-term political reasons, as part of his desperate efforts to find some definition for his flailing party.
Ian Birrell, *Independent*, 10 February

When liberals, libertarians and Tea Party Republicans find themselves nodding in unison on drug law reform, it's fair to say that the issue's time has come.
Kasia Malinowska-Sempruch, *Observer*, 9 February

The death 'in recovery' of Philip Seymour Hoffman emphasises the dangers addicts face when they start to use again... The lesson of Hoffman's untimely death may well be that simplistic views of recovery and abstinence-only treatments leave addicts vulnerable to relapse, and increase the risk of death.
David Nutt, *Guardian*, 4 February

There are no winners in the illegality of drugs, except the lucky ones who make money from it without getting caught. The only hope is that high-profile casualties such as Hoffman's might lead a few legislators to see the damage done by these laws and correct their ways. At least in some American states the door of legalisation is now ajar. Not so in Britain, where the most raging addiction is inertia.
Simon Jenkins, *Guardian*, 3 February

Drugs can give you pleasure, relaxation and sociability. If you try to use them to escape a shitty life, you find your life is even shittier when you come round. But we're all potential rats on the pleasure pedal and anyone who can't stop repeatedly using a substance (sugar, credit card or cocaine), even when we know it's not doing us any good, is an addict.
Dr Phil Hammond, *Telegraph*, 18 February

People are going to use drugs; no self-respecting drug addict is even remotely deterred by prohibition. What prohibition achieves is an unregulated, criminal-controlled, sprawling, global mob-economy, where drug users, their families and society at large are all exposed to the worst conceivable version of this regrettably unavoidable problem.
Russell Brand, *Guardian*, 6 February

I am not bothered about Russell Brand. His petition demanding a parliamentary debate has become the stuff of comedy, given his earlier public strictures on ignoring democracy. Beyond celebrity groupies and metropolitan admirers, his erratic and self-serving ramblings won't persuade.
Kathy Gyngell, *Guardian*, 20 February

There are no hard and fast rules in addiction; there's no neat definition of it as a 'disease', whatever addicts are told in rehab. Some folk pass through a phase of addiction and then the compulsion leaves them... But for many – perhaps most – addicts, the addictive urge doesn't leave you just because you've stopped using drugs, or drinking, or gambling, or gazing for hours at internet porn, or bingeing on cupcakes until you make yourself sick.
Damian Thompson, *Telegraph*, 3 February

YOU CAN QUOTE ME ON THAT...

'Mutual aid doesn't work for everyone – that's just a reality. If it works for you, great, but it's not for everybody.'
Anna Millington

'It's been my experience that people are being forced to detox and reduce much faster than they would like, and that's completely unacceptable.'
Kirstie Douse

'You're all flying the flag for recovery, and showing that recovery is possible. We made this happen.'
David Lawson

'The alcohol industry is a multi-million pound industry. It's like the Taliban or the Medellin Cartel having an influence on government policy.'
Delegate

'We're a family, a community. No matter what your recovery journey is, you have an invitation – you belong.'
Emma, LUF

'MPs and doctors don't understand the problem. To have a healthy brain you need a healthy environment.'
Lester Morse

'My recovery belongs to me – I own it. If I mess it up I mess it up, but you may not tell me how to live.'
Tim Sampey

TWEET OF THE DAY

Danny McCubbin @dannymccubbin
No better way to speak about @San_Patrignano than through eyes of special people who have been there @DDNMagazine

DDN Magazine @DDNMagazine
Politicians want something that's evidence based. There's so much evidence of effectiveness of drug consumption rooms. – Philippe Bonnet

Rosie@RRR/LUF @roselatham1971
@punkmarx @DDNMagazine proud to be a part of Lancashire... we made it happen. Great partnerships and a lot of hard work

DDN Magazine @DDNMagazine
Stop being frightened of hep C, stop the stigma. – Jim Conneely at #ddnconf

DDN Magazine @DDNMagazine
When I came into recovery it was suggested I had an unhealthy dependency on prison. I felt safe there. – David from Bric

Ricky Bhandal @ranjitbhandal
Great day @DDNMagazine, simple as that!

DDN Magazine @DDNMagazine
I'm not in competition with the treatment system – they saved my life. It's about partnerships. – Tim Sampey, BoB at #ddnconf

JudithYates @judithyates1
@DDNMagazine very proud to be part of this brilliant conference. Make it happen!

DDN Magazine @DDNMagazine
How many of us have to die before we do something about it? – Andria Efthimiou Mordant

Deb D @Debd2222
@J2RDave was brilliant! Passionate, heartfelt recovery just what we @UKRWCharity love to hear. Good stuff at #ddnconf

DDN Magazine @DDNMagazine
This is where service user involvement can have an impact – if there's only one GP who'll treat drug problems, campaign. – Anna Millington

Stockton Recovery @Recovery_SRS
Service users and staff from Stockton Recovery Service on route to Make It Happen! Proud to be a part #Recovery #makeithappen #SRS @DDNMagazine

DDN Magazine @DDNMagazine
Everyone should have access to naloxone. Persuade your commissioners. Lobby MPs. Get angry. – Nigel Brunsdon

BRICWORKS HULL @J2RDave
@UKRWCharity great day @DDNMagazine, recovery in action... is there any curry left?

DDN Magazine @DDNMagazine
In our group we focus on what's good and positive – if you're going to moan, go over there! Pete, LUF

Stockton Recovery @Recovery_SRS
LUF doing what they do best "@DDNMagazine: The LUF is service user led to the bone.' Lancashire User Forum at #ddnconf" #inspiring #recovery

DDN Magazine @DDNMagazine
I'm 11 years drug free – not 11 years clean. I was never dirty in the 1st place. – Philippe Bonnet at #ddnconf

Rosie@RRR/LUF @roselatham1971
Fantastic day at the @DDNMagazine. David inspired me, and Sophie

DDN Magazine @DDNMagazine
We need to go back to our local areas and challenge, challenge, challenge. – Anna Millington

Danny McCubbin @dannymccubbin
@DDNMagazine #ddnconf proud to be speaking about @San_Patrignano at their annual conference

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S.C., Drugs Worker, Manchester

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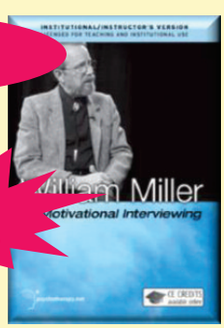

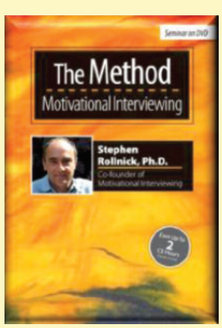

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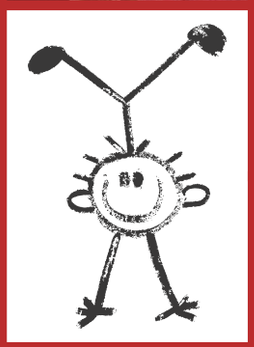
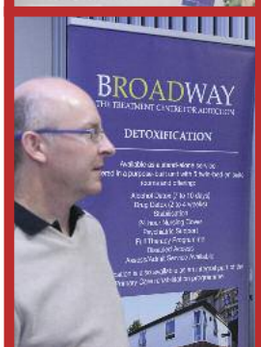


MARTINDALE PHARMA
Making lives better

DDN would like to thank everyone who helped to create *Make It Happen!*, the seventh national service user involvement conference – NUN, UKRF, FDAP; main sponsors Martindale Pharma; all our speakers and exhibitors; therapists Lois and Jo, yoga instructor Karen, and auricular acupuncturists Acudetox Plus; everyone who contributed to the conference programme consultation; our volunteers: Lee Collingham, Beryl Poole, Jules Hunt, Si Parry, Sue Tutton, Carole Sharma, Tidjane Gbane and members of the Coventry and Birmingham recovery communities – Rich Maunders, Emily Goodyear, Kam Sidhu, Carole Darch, Indy Thandy, Mark Quinn, Robin Toft, Carl Allcott, Azad Sparnie, Leon Kearney, Leon Gallagher, Gary Graytrex, Neil Williams, Matt Woodfield, Darren Steele, Paul Carter, William Campbell and Scott Bowren; Paul Husband, photographer at LUF – and most importantly all the delegates whose participation made the conference a success.

Hope to see you all next year!



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Two years on, Louise Weston updates us on the progress of an effective information campaign

MY RECOVERY MY CHOICE

With 260,000 people across the UK dependent on opioids, and only 166,000 people engaging in treatment, there is an ongoing need for quality information on opioid dependence and the options available for tackling this chronic disease[1]. Heroin addiction remains at large, affecting 81 per cent of adults seeking treatment for drug dependency in England between 2011 and 2012[2].

My Recovery My Choice is a growing awareness campaign that was launched in 2012 to offer opioid users and their family members meaningful support through clear and relevant information. *My Recovery My Choice* aims to help opioid users make an informed choice regarding their treatment, should they wish to tackle this complex medical condition and take steps towards their own recovery. Widely accessible through an engaging, highly visual, user-friendly website, a printed booklet and additional supporting materials are also available to download at http://www.myrecoverymychoice.co.uk.

The focus of the *My Recovery My Choice* campaign has evolved from the belief that it is a person's right to decide if and when they want treatment. From discussing how to spot the signs of dependence and what dependence is, to tips on maximising the chances of treatment success, *My Recovery My Choice* hopes to help people develop a greater understanding of dependence as well as the associated harms to health. This year sees *My Recovery My Choice* being enriched with additional information on the health risks associated with drug-taking behaviour and sharing practical tips on staying healthy. How to minimise harm and reduce the risks of commonplace comorbidities, such as blood-borne diseases, will be covered. A recent news article reports that just 3 per cent of hepatitis C infected people are treated each year, despite it being a curable disease, highlighting the urgent need to raise public awareness of this virus, which affects around half of all injecting drug users[3]. As such, the detailed focus will be on hepatitis C, developed under the guidance of Charles Gore, the chief executive of the Hepatitis C Trust. Upon completion, the campaign hopes to gain endorsement from this prominent organisation, bringing information and support to a wider number of beneficiaries.

My Recovery My Choice seeks to empower people and provide confidence for each individual's journey by providing meaningful knowledge regarding the types of treatment available in the UK. The need for individualised recovery, as influenced by the wants and needs of the patient, is identified and information on both medically assisted and non-medically assisted options is provided. The campaign also recognises that it is not only the drug user who is affected by heroin or opioid use, as friends and family members often struggle with the knowledge that their loved one is dependent. On the website, they can find advice, details of support groups, and videos from patients and parents who have experienced the recovery process.

This past year has seen *My Recovery My Choice* strengthened by endorsement from the Kenward Trust, UK Recovery Walk, Phoenix Futures, Delphi Medical and Cranstoun, increasing the current campaign endorsement to 20 national drug support organisations. Additionally, *My Recovery My Choice* has featured at four conferences across the UK in 2013, serving to engage local user groups and share campaign assets, and more than 86,000 materials have been distributed, including informative booklets and attention-grabbing posters, postcards, leaflets and wallet cards.

Encouragingly, two thirds of website visitors who have submitted feedback have felt better informed about opioid dependence and more confident in their decisions around tackling it. Overall, to date, the campaign has been credited with outstanding feedback:

'The most important drug resource in the UK today.'

'Great resource for people with concerns about their own or a friend/family member's addiction, and great advice for those looking to enter drug treatment.'

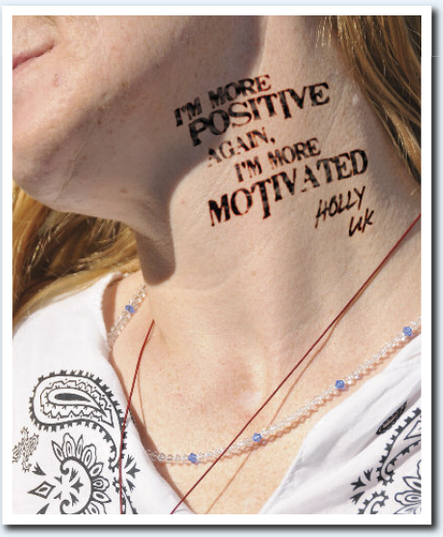
'Good to see such a balanced approach.'

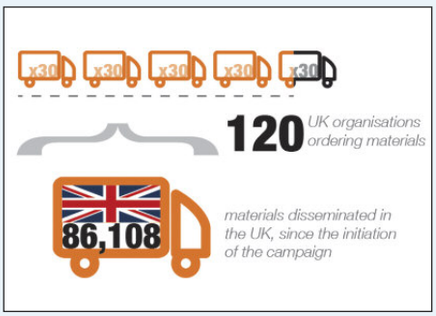
My Recovery My Choice is an evolving initiative and we are always looking to develop and improve the campaign. If you have any suggestions on improvements that can be made to the site or have a story that you would like to share, we would love to hear from you.

If you are part of a community drug organisation and would like to represent *My Recovery My Choice* at a conference in England, Wales and or Scotland, please get in touch. Similarly, if you would like to endorse the campaign with a logo or backlink to the website, please email mrmc@pcmscientific.com

The information on *My Recovery My Choice* is for educational purposes only and should not be a substitute for the advice of a medical professional. The website and related materials were produced by PCM Scientific (a medical education company) and the Alliance, who redrafted a set of internationally available materials to make them suitable for the UK. Undertaken in consultation with other partners, this is an ongoing process. The creation of these materials was made possible through an educational grant from RB Pharmaceuticals Ltd.

www.myrecoverymychoice.co.uk





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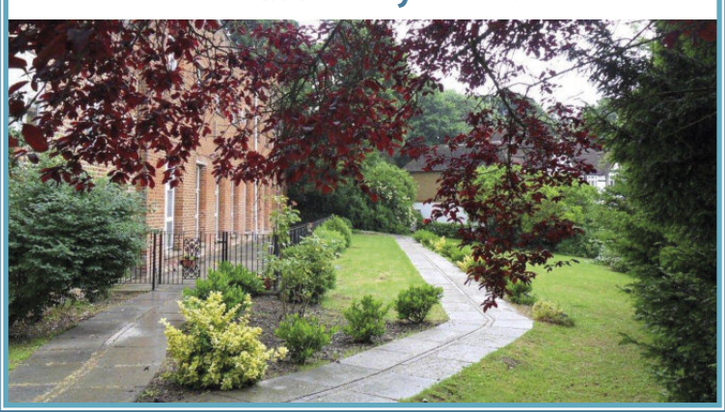

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Broadway Lodge is the oldest 12 step provider in the UK.

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THE TREATMENT CENTRE FOR ADDICTION

Surrey and Borders Partnership NHS
NHS Foundation Trust

ALCOHOL: NEW DIRECTIONS

Surrey and Borders Partnership NHS Foundation Trust are delighted to announce their first National Alcohol Conference on the 14th May 2014. We will be offering an innovative view into the treatment of alcohol use disorders with emphasis on the future.

The Conference will provide a unique opportunity to explore challenges and changes from both physical and psychological perspectives. We will promote an exciting and interactive experience for delegates by exploring advanced approaches in alcohol research and treatment applications:

Firstly, ***Professor Alex Copello*** will offer insight into the significant and stressful ways the family unit is affected. However families can also provide important positive influences in the process of change. The session will review the evidence for some of these interventions and suggest a way forward in terms of clinical implementation and future research.

Dr Katrina Scior explores the problems associated with alcohol misuse which are increasingly prevalent in those with learning disabilities due to readily accessible alcohol associated with community living. NICE recommend Brief Intervention (BI) prior to receiving any more specialist interventions. This presentation examines whether BI available to adults can be delivered to those with mild to moderate learning disabilities.

Each year an estimated 1 million people attend A & E departments in the UK following Traumatic Brain Injury (TBI). Alcohol related head trauma in particular is recognised as a major public health problem and a large contributor to the incidence and cost of TBI. ***Dr Vanessa Raymont*** suggests that Initial diagnosis of severity of TBI is not a reliable indicator of long-term problems and thus underlines the necessity to develop long term follow up services.

Repeated alcohol detoxifications can lead to an inability to perform a task that captures two of the basic features of addictive behaviour – cue induced motivation to seek a reward and failure to inhibit such motivation when reward seeking is inappropriate. The data presented by ***Professor Theodora Duka*** in this session will add to our understanding of alcoholism and may have implications as to how alcoholic detoxification is carried out.

There is strong consensus for those experiencing medically assisted withdrawal from alcohol it should be part of a structured treatment package. ***Dr Christos Kouimtsidis*** discusses the interventions which are based on CBT. Key components range from identifying high risk situations to coping skills facilitating overall lifestyle changes compatible with an abstinent way of living. The presentation will examine the experience of the Preparation for Alcohol Detoxification Groups established in 2009 from both qualitative and quantitative perspectives.

Foetal alcohol syndrome is recognised as one of the most common causes of intellectual disability. ***Dr Raja Mukherjee*** will include an overview as to the complexity of the diagnosis together with findings to better understand the subtleties of individual presentation covering cognitive, sensory, communication and wider neurodevelopmental overlaps caused by prenatal alcohol exposure.

As discussed, alcohol consumption has a high impact on many lifestyle and risk factors for disease and death in the UK. ***Hayley Bath*** of the East Surrey Clinical Commissioning Group will present their "Alcohol in Safer Hands" Project which involves the scoping and integrated commissioning of a new alcohol service specification pathway across the whole health and social care economy in East surrey. It aims to set East Surrey as a beacon for Integrated Service Specifications for Alcohol as a case study to help other CCGs reduce the harm caused by alcohol.

Wednesday 14 May 2014
Holiday Inn, Victoria Way, Woking, Surrey GU21 8EW
£125 including parking, lunch and refreshments
Reductions for NHS and Charitable Organisations
Online booking: www.sabp.nhs.uk
Email: georgina.lambie@sabp.nhs.uk

THE CONFERENCE PROGRAMME

09:00-09:30	Registration
09:30-09:40	Chief Executive Opening Address – *Fiona Edwards, CEO, SABP NHS Foundation Trust*
09:40-09:50	Introduction and Welcome – *Dr Marian De Ruiter, Lead Consultant, SABP NHS Foundation Trust*
09:50-10:30	Family Interventions in Alcohol Disorders – *Prof. Alex Copello, University of Birmingham*
10:30-10:50	Refreshments
10:50-11:30	AUD in Learning Disabilities Population – *Dr Katrina Scior, Senior Lecturer in Clinical Psychology, University College London*
11:30-12:10	Traumatic Brain Injury and AUD – *Dr Vanessa Raymont, Consultant Psychiatrist & Senior Researcher, Imperial College*
12:10-13:00	Lunch
13:00-13:40	The Effects of Repeated Detoxes on the Brain – *Prof. Theodora Duka, Sussex University*
13:40-14:20	Structured Preparation for Abstinence from Alcohol – *Dr Christos Kouimtsidis, Consultant, SABP NHS Foundation Trust*
14:20-14:40	Refreshments
14:40-15:20	Alcohol Use in Pregnancy: Foetal Alcohol Syndrome – *Dr Raja Mukherjee, Consultant Psychiatrist, SABP NHS Foundation Trust*
15:20-16:00	Alcohol in Safer Hands Projects – Hayley Bath, East Surrey Clinical Commissioning Group
16:00-16:20	Summary – *Mark Prunty, Consultant, SABP NHS Foundation Trust*
16:20-16:30	Close – *Dr Christos Kouimtsidis, Consultant, SABP NHS Foundation Trust*

Full programme – www.sabp.nhs.uk

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- ✓ Complementary therapies
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www.wdp-drugs.org.uk
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Salary: pro-rata £18,500- £25,000 for 22.5 hours.
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Closing date for applicants: 24th March 2014
Information: Peter J Davies 01483 533300
www.addictioncare.co.uk

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Change and be happy

Swanswell is a national recovery charity which wants to achieve a society free from problem alcohol and drug use.

With over **four decades** of experience, we help thousands of people make a positive difference to their lives every year.

Don't just take our word for it - see our website for inspiring stories of recovery.

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www.swanswell.org

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Full time, £31,902 – £38,270 pro rate D.O.E, permanent.

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Closing date: 25 March 2014

For further information and to download an application pack please visit www.hagam.com Alternatively, you can call us on 01895 207 788 or email help@hagam.org.uk

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RAPt Drug & Alcohol Treatment Service

Senior Drug and Alcohol Practitioner

RAPt
THE REHABILITATION FOR ADDICTED PRISONERS TRUST
stopping addiction. stopping crime.

Hours: 35 hours p/w with some flexibility required
Location: London Prisons
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We currently have an exciting opportunity for an experienced 12-Step recovery professional to work across our London Prison teams managing a caseload of clients, running workshops, both CBT and 12-Step based, and referring to our partner organisations. You will be responsible for overseeing the quality of the Interventions delivered by the substance misuse working in your team. Working directly with the Deputy Service Manager you will ensure that agreed performance targets are met. In conjunction with your team you will provide a range of interventions to our clients.

All applications will need to be made with a RAPt application form, which you can download from our website: www.rapt.org.uk. We are unable to accept CV's.
Closing date for applications: 14th March 2014 (10 am)

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NOW OPENING IN LEICESTER...

SENIOR COUNSELLOR
£Neg – LEICESTER

Due to the opening of the Midlands centre, we are seeking an addiction counsellor qualified or part qualified with good knowledge of the 12-step treatment program. Experience of group and 1-2-1 therapy, good communication skills.

COUNSELLOR
£Neg – LEICESTER

We currently have two positions available at our new centre for those training or thinking about training as a counsellor. Essentially you will have sound knowledge of the 12 steps or be in personal recovery from addiction.

ADMISSIONS COORDINATOR
£Neg – LEICESTER

Our new Midlands centre is looking to recruit an individual with a good understanding of addiction to greet new clients at the centre, conduct initial risk assessment, liaise with medical staff and personnel from PCP Head Office. Various other ad hoc tasks, bright and bubbly personality.

LIVE IN SUPPORT WORK
£Neg – LEICESTER

A truly important part of our team, we are seeking someone with knowledge of health & social care or addiction, to live full time on site and be available between 4pm and 9am Monday to Friday. Week ends and day times are off duty. Good communication and personal skills will be required.

SENIOR COUNSELLOR
£Neg – CHELMSFORD (Essex)

We opened this centre in 2009 and are seeking an addiction counsellor, qualified or part-qualified, with good knowledge of the 12-step treatment program. Experience of group and 1-2-1 therapy, good communication skills.

COUNSELLOR
£Neg – CHELMSFORD (Essex)

We currently have a position available at our Essex centre for those training or thinking about training as a counsellor. Essentially you will have sound knowledge of the 12 steps or be in personal recovery from addiction.

Please contact Perry Clayman or James Peacock on 01582 730113 or email your CV to info@pcpluton.com

www.rehabtoday.com