NEW-LOOK SUMMER 2014 TRAINING AND DEVELOPMENT DIRECTORY

DDN
Drink and Drugs News

www.drinkanddrugsnews.com
ISSN 1755-6236 June 2014

'Around three quarters of employers have admitted that they discriminate against applicants who have a criminal record...'

CAUTION – EMPLOYMENT AHEAD

BACK TO WORK?
BREAKING DOWN BARRIERS TO EMPLOYMENT

DDN
Drink and Drugs News

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Website:
www.drinkanddrugsnews.com
Website maintained by
wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: Kali Nine LLC

DDN is an independent publication, entirely funded by advertising.

PUBLISHERS:

CJ Wellings

PARTNER ORGANISATIONS:

fdap
Federation of Drug and Alcohol Professionals

SUPPORTING ORGANISATIONS:

Adfam
Alcohol Concern
The Alliance
ANSA
drugsandalcohol today
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Mentor
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Editorial – Claire Brown

Reading the signs

Let's keep navigating towards fairer chances

Things aren't easy for our sector at the moment. The signs are everywhere, from the slow pace of the recruitment market to the many-tiered bureaucracy that's throttling seemingly simple and straightforward policy decisions. So maybe it's time to shake ourselves a little and not lose sight of our ideals. Helping to organise the Recovery Festival (1-2 July) has been a stark reminder of the fight needed to set clients on a level playing field. The purpose of this event is to create dialogue with the housing and employment sectors, in the hope of breaking down barriers to both, as well as tackling very real and pervasive stigma. All kinds of issues have emerged, and we're highlighting the 'Ban the Box' initiative on page 8 to showcase some of the vital activism out there.

Elsewhere in this issue we give commissioning practice a good airing (pages 16 and 18). Gordon Morse's perspective is particularly interesting as an employee of one of the dominant players in the recommissioning game, as he questions the practice of radical change in the place of subtle continuity. And we haven't finished with the debate started in April's issue by Stanton Peele, with more interesting comment on page 10. There's plenty to think about in this issue, so please give us your reaction. This sector may have its struggles, but was never known for its silence!

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NEWS IN BRIEF

LENGTHY PROCESS

The Scottish Government's plans to introduce a minimum unit price for alcohol have been referred to the EU's Court of Justice in the wake the Scotch Whisky Association's legal challenge, with a judgement unlikely to be received until well into the second half of 2015. 'We are confident of our case and look forward to presenting it in the European Court of Justice,' said health secretary Alex Neil. 'While it is regrettable that this means we will not be able to implement minimum unit pricing sooner, we will continue our ongoing and productive dialogue with EU officials.'

WHEN THE KHAT'S AWAY

The sidelining of 'expert views' in the UK's ban on khat reveals 'a troubling approach to law making and one which is all too familiar in drug policy', says a report from Swansea University. The government announced that khat was to be controlled as a class C drug last year (*DDN*, July 2013, page 5), despite a recommendation from the ACMD that it not be banned. 'The UK ban is an unwelcome development that lacks an evidence base and harm mitigating measures,' says *European policy on khat: drug policy lessons not learned*. Report at www.swansea.ac.uk

GENEVA CONSUMPTION

A new documentary has been produced by the Independent Consortium on Drug Consumption Rooms (ICDCR) (*DDN*, October 2013, page 16). The ICDCR visited the Quai 9 facility in Geneva to hear from staff, service users and local residents. 'Watch it and tell me that DCRs are controversial, not a vote winner and encourage people to inject,' said ICDCR founder Philippe Bonnet. *Watch at http://youtu.be/iMTdwF7T0y8*

FIRM FOUNDATIONS

A new charity, Foundation for Change, has been launched to continue the work of the NEXT project, which aims to build self-esteem and help people reintegrate into society. Of the people accessing the project between 2008 and 2013, 83 per cent went on to voluntary placements, 65 per cent went on to further education and 39 per cent are now in full-time employment. *www.foundationforchange.org.uk*

New era for Europe's 'complex, damaging' drug problem

Europe's drug problem is becoming increasingly complex and potentially more damaging, according to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Positive trends in relation to established drugs are again 'counter-balanced by new threats' posed by synthetic drugs, says *European drug report 2014*.

People accessing treatment for heroin for the first time fell from 59,000 to 31,000 across the continent between 2007 and 2012, although there are still an estimated 1.3m opioid users in Europe, says the document. While falling rates of HIV infection as a result of improved coverage of treatment and harm reduction services have been stalled by outbreaks in Greece, Romania and elsewhere, total drug overdose deaths were down to 6,100 in 2012 from 6,500 the previous year and more than 7,000 in 2009.

The rise in the amount and variety of new drugs, however, is showing 'no signs of abating', with 81 new substances notified to the EU's early warning system last year and a total of nearly 250 over the last four years.

Cocaine is still the most commonly used illicit stimulant, although reported use is falling even in countries with high prevalence rates, such as Spain and the UK, while methamphetamine use – previously confined mainly to the Czech Republic and Slovakia – appears to be spreading to countries such as Germany. 'Europe's current methamphetamine problem has no single face and appropriate responses will need to be adapted, developed and tailored to the local patterns of use and problems observed,' says the agency. The report also highlights the trend for combining injecting drug use with risky sexual practices in parts of the gay scene (*DDN*, April 2013, page 6) as a 'behaviour of growing concern', and calls for close monitoring of the issue as a 'public health priority'.

'Looking at the big picture, we see that progress has been made in Europe on some of the major health policy objectives of the past,' said EMCDDA director Wolfgang Götz. 'But the European perspective can obscure some important national differences. Our latest data show how encouraging overall EU trends on overdose deaths and drug-related HIV infections, for example, sit in sharp contrast to worrying developments in a few member states'.

Meanwhile, figures from Public Health England (PHE) show a continued fall in opiate and crack use, with the number of adults entering treatment falling from more than 64,000 in 2005-06 to just under 46,000 in 2012-13. Injecting rates for these drugs also fell from just under 93,500 in 2010-11 to just over 87,300 in 2011-12. There was 'no room for complacency', however, said the agency's director of alcohol and drugs, Rosanna O'Connor. 'Alongside this encouraging evidence, we remain vigilant to the major substance misuse challenges – such as reaching an ageing population of entrenched opiate users, and protecting younger people from the harms of newer substances.'

A status report on new and club drugs has also been produced by DrugScope, including their health impacts and related harm reduction initiatives, while a new report from UNODC also highlights the 'ever-greater share' of the drugs market being taken by synthetic drugs. 'There is a dynamic and unprecedented global expansion of the synthetic drugs market both in scope and variety' said UNODC's director of policy and analysis, Jean-Luc Lemahieu.

European drug report 2014 at www.emcdda.europa.eu

Estimates of the prevalence of opiate use and/or crack cocaine use, 2011/12 at www.gov.uk

Business as usual? A status report on new psychoactive substances (NPS) and 'club drugs' in the UK at www.drugscope.org.uk

Global synthetic drugs assessment at www.unodc.org

EXECUTIVE DROP IN: New NHS chief executive Simon Stevens (left) made a surprise visit to the Hepatitis C Trust's testing van at the Harlequin medical practice in Birmingham. Trust outreach officer Jim Conneely (*DDN*, January, page 6) was testing clients when the NHS boss arrived for an official visit at the centre, which is jointly run by Swanswell and a local GP practice. 'He was more than willing to engage with me,' said Conneely. 'He was enthusiastic and friendly and hopefully left with a good impression about the van and the trust's work.' Meanwhile, the trust has appointed a new peer educator, Archie Christian, to work in drug services and homeless shelters. 'Hopefully by dispelling the myths that surround this virus we can help to prevent unnecessary transmission, and in the case of those already with a positive diagnosis, we can encourage and support them into treatment,' he said.

Council alcohol funding fears

Local authority areas with a high level of alcohol-related harm are the least likely to expect increased funding to tackle the problem, according to a new report from Alcohol Concern.

While most local authorities expect funding for alcohol services to stay the same or increase over the next three years, nearly a third of treatment providers report that they've seen funding decrease over the previous financial year, says *A measure of change: an evaluation of the impact of the public health transfer to local authorities on alcohol*. Most also expect it to fall over the next three years.

The report's findings are based on questionnaires sent to local authorities and clinical commissioning groups. 'It was hoped that the transfer of responsibility to local authorities would lead to greater responsiveness to local need, and local authorities appear have taken on board the scale of alcohol harms and given the issue due priority,' says the document. However, those in areas experiencing high levels of alcohol harm are 'more fearful' about future funding. Areas with higher levels of harm are more likely to be deprived and have competing pressures on their public health budgets, with some of the poorest boroughs facing 'disproportionate cuts'.

'It is a real concern for the future that those local authority areas battling against the worst levels of alcohol-related harm are the least likely to expect increased funding for alcohol,' said Alcohol Concern's policy programme manager Tom Smith. 'Both treatment and prevention services need to be given clear prioritisation and responsibility must not be allowed to fall between the gaps of local bodies and service's remits.'

Meanwhile, the cost of drugs to treat alcohol dependence topped £3m last year, according to figures from the Health and Social Care Information Centre (HSCIC). Alcohol dependence drugs cost the NHS £3.13m, up nearly 7 per cent on the previous year. Nearly 184,000 drugs were dispensed in 2013, up almost 80 per cent on a decade ago.

Alcohol-related deaths are continuing to fall, however, according to the latest Local Alcohol Profiles for England (LAPE). National figures for alcohol-related mortality for men are down 1.9 per cent since 2012 and more than 7 per cent over the last five years, while for women the figures have fallen by 1.4 per cent and 6.8 per cent respectively. Stark regional variations continue, however, with around 150 local authority areas seeing an increase in deaths since 2012.

A measure of change at www.alcoholconcern.org.uk
Statistics on alcohol – England, 2014 at www.hscic.gov.uk
Mortality figures at www.lape.org.uk

Time to change direction on drugs

The pursuit of a 'militarised and enforcement-led' global drugs strategy has resulted in 'enormous negative outcomes and collateral damage', according to a report from the London School of Economics and Political Science (LSE).

Among these are worldwide human rights abuses, widespread violence in Latin America, Russia's HIV epidemic, corruption and political destabilisation in Afghanistan and West Africa and 'mass incarceration' in the US, says *Ending the drug wars*. The document includes a call from five Nobel Prize economists for resources to be redirected towards 'effective, evidence-based policies underpinned by rigorous economic analysis.'

Proven public health and harm reduction policies should be prioritised, it says, with states allowed to pursue new initiatives to determine what works and 'rigorously monitored' policy and regulatory experiments encouraged. The document calls on the UN to take the lead in advocating a 'new cooperative international framework based on the fundamental acceptance that different policies will work for different countries and regions.'

Among the report's other signatories are ministers from the governments of Guatemala and Colombia and UK deputy prime minister Nick Clegg. 'The drug war's failure has been recognised by public health professionals, security experts, human rights authorities and now some of the world's most respected economists,' said the report's editor, John Collins. The most immediate task is ensuring a sound economic basis for the policies, and then to reallocate international resources accordingly.'

Ending the drug wars at www.lse.ac.uk

Stop and search reform pledged

Police stop and search powers are to be overhauled, home secretary Theresa May has announced, with the Police and Criminal Evidence Act code of practice revised to 'make clear what constitutes "reasonable grounds for suspicion".'

Last year, a report from Release and the London School of Economics and Political Science (LSE) found that black people were more than six times more likely to be stopped and searched for drugs than white people (*DDN*, September 2013, page 4). They were also more than twice as likely to be charged if drugs were found and more than five times more likely to face immediate jail if found guilty of possession.

Under the revised code, officers using their powers improperly will be subject to 'formal performance or disciplinary proceedings'. While stop and search is 'undoubtedly an important police power', if misused it can be counter-productive and damaging to community relations, the home office stated.

National training for stop and search is to be reviewed, with assessments of officers' fitness to use the powers introduced, while the government will also bring forward legislation to make public access to stop and search records a statutory requirement if forces fail to allow it voluntarily.

Nationally, only around 10 per cent of stop and searches result in an arrest, while HM Inspectorate of Constabulary found that nearly 30 per cent of the stop and search records they examined 'did not contain reasonable grounds' for a search. 'Nobody wins when stop and search is misapplied,' said Theresa May. 'It is a waste of police time. It is unfair, especially to young black men. It is bad for public confidence in the police.'

NEWS IN BRIEF

THE BALLARD OF ALCOHOL CONCERN

Alcohol Concern has announced that Jackie Ballard will take over as chief executive from next month, having previously headed up RSPCA, Action on Hearing Loss and Womankind Worldwide. She replaces Eric Appleby (*DDN*, June 2013, page 16), who has been acting in an interim capacity. 'There is an uneven battle between the global drinks industry, which deploys massive resources to promote its products and influence behaviour, and those, including Alcohol Concern, who are campaigning for a change in drinking culture,' she said. 'It makes this a challenging but crucial role and it is one that I am looking forward to taking on.'

PRISON PROBLEMS

Britain's prisons are ineffective at tackling alcohol-related criminal behaviour, according to a survey commissioned by Addaction. Despite the fact that 70 per cent of prisoners questioned for *The Alcohol and Crime Commission report* had been drinking when they'd committed their offence, the report found little evidence of either support on release or to help them understand the role of alcohol in their offending. The commission wants to see improved training for prison staff and for alcohol treatment to form a key part of prison rehabilitation, including ongoing support in the community. 'A staggering number of prisoners committed a crime while drinking, but unless they're alcohol dependent the system doesn't properly recognise them as problem drinkers,' said Addaction chief executive Simon Antrobus. 'This means that people are leaving prison without the support they need.'

PROJECT APPOINTMENT

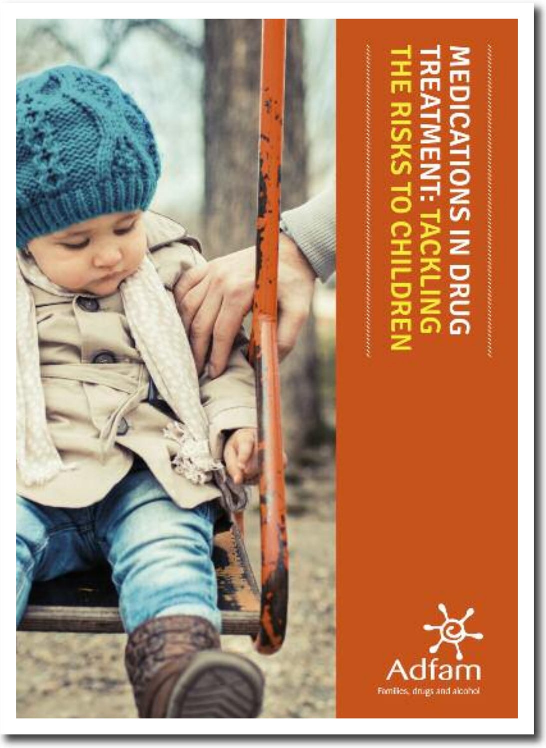
Sue Clements is the new CEO of Westminster Drug Project (WDP), the organisation has announced. She previously led development of health and justice services at Care UK.

PART OF THE PICTURE

Five new briefings have been published as part of the Lesbian and Gay Foundation and University of Central Lancashire's *Part of the picture* research project into drug and alcohol use in the LGBT community. The documents contain recommendations for service providers, policy makers, commissioners, GPs and researchers. *Briefings at www.lgf.org.uk*

SAVE THE CHILDREN

Adfam's recent report on the ingestion of drug treatment medications by children makes worrying reading. ***DDN*** looks at what could be done to reduce the risks



'OST is an extremely valuable tool in the fight against drug addiction... However, we also must recognise that the drugs used – especially methadone – are toxic, powerful and a clear danger to children when stored or used incorrectly by their parents and carers.' ADFAM

'OST is an extremely valuable tool in the fight against drug addiction, and we are clear that the evidence base supports its part in our treatment system,' says Adfam's *Medications in drug treatment: tackling the risks to children* report (*DDN*, May, page 4). 'However,' it adds, 'we also must recognise that the drugs used – especially methadone – are toxic, powerful and a clear danger to children when stored or used incorrectly by their parents and carers.'

Alongside interviews and a review of existing guidance and research, the report studies 20 serious case reviews from the last decade involving the ingestion of OST medication by children, and concludes that children's safety is not being prioritised by treatment professionals. It calls for better training and improved national data collection, and says that far too little is even being learned from the findings of the serious case reviews themselves.

'I do think that's true,' says Sue Bandcroft, who retired from her post as substance misuse manager for Bristol City Council last month and was involved in a serious case review in the city. 'There's always – and always should be – a lot of local learning, but that's not always brought together and, because there's no requirement to publish them in full, you often get reports that are very redacted, so it can be quite hard to find the messages.'

One of the consequences of this is an ongoing wide variation in practice across the country, says Birmingham GP and drug policy advocate Dr Judith Yates. 'What we're doing varies from place to place depending on whether we've had any of these tragedies in our area or not, and it seems a bit poor that we seem to be learning after each individual tragedy rather than having any central collation of it all. It needs to be national guidance, rather than waiting for some poor child to die and then learning from that, which is what we did here.'

A child whose family her practice was involved with died from an accidental ingestion in 2008, since which time 'we've had safe storage boxes given to everybody,' she says. 'Some services around the country do that, and some don't.'

A new study as part of the *Keeping children safe at home* project is now hoping to go some way to addressing these variations in practice. A multi-centre case control study of all children aged up to four who go to A&E as a result of poisoning – not just by OST – it aims to be largest ever to look at the modifiable risk factors for poisoning in young children, with its findings hopefully used to develop better prevention strategies.

As well as better data collection and improved analysis of serious case reviews, however, Adfam's report is also calling for a 're-emphasis' of the importance of safeguarding children when making decisions about OST in line with existing NICE guidance, and for improved training for drug workers, GPs, pharmacies, social workers and others to make sure they're fully on top of child protection issues.

'What looking at case reports clearly indicates again and again is just the importance of coordination and cooperation and communication between all the different agencies,' says Yates. 'So it's not only drug workers who should be looking at where the methadone – and not just methadone, but all medication – is being stored in the house, but health visitors and everyone else. They look at stair gates and all the other hazards in the house, and they need to be particularly aware when parents are on particularly dangerous medication. When social workers make home visits they should be asking "where's the medication? Show me".'

In terms of challenging the parents they come into contact with, however,

‘We've changed our leaflet to include explicit warnings such as... “babies and small children have died after tiny amounts of methadone have been given”.’

DR JUDITH YATES

I think that... quite often we don't ask ourselves the question “what's the child's everyday life experience of this?”.’

SUE BANDCROFT

another finding from the serious case reviews studied in the document was that practitioners often ‘missed or minimised’ risk factors during the family’s contact with services, taking an ‘overly optimistic’ view of progress on the part of parents who were ‘able to manipulate or deceive’ services into believing they were making positive changes. The report calls for professionals to be more ‘robust’ in their work with families, with some cases described as ‘an accident waiting to happen’.

So, are drug workers open to manipulation by parents? ‘I think manipulation’s quite a hard word to use – it’s a very judgmental word,’ says Bandcroft. ‘Maybe “optimistic” about changes in clients. One of the things that we’ve certainly observed is that people would make plans with people, set them goals, and they wouldn’t reach them, so they’d make some more. Now that may be fine when you’re dealing with an individual adult drug user, but I think that when there’s children involved quite often we don’t ask ourselves the question “what’s the child’s everyday life experience of this?”

‘In the drugs world, the client’s needs and setting the client goals and being optimistic about their future has always been to the fore, but I think that very often we haven’t looked at people even in terms of couples or relationships,’ she continues. ‘In a partnership you need to make sure that if both are engaged in treatment then they have the same regimes, and that you also think about what your experience of it would be if you were the 18-month-old baby in this family.’

‘This is a constant message that we learn from all the safeguarding training – to have professional concern,’ says Yates. ‘It’s always difficult to make that judgment because you’re wanting people to do well and you’re trying to encourage people, and yet you have to keep your eyes open for the possibilities you could only know about if you’ve been properly trained. It’s an element of the training – to be aware that these cases happen.’

Sue Bandcroft did find her involvement with serious case reviews – she also chaired a case review sub-group on safeguarding children with substance-misusing parents – encouraging in some ways, however. ‘One of the positives that I found for the drugs world – which is actually in the recommendations of the Adfam report – is having somebody on the serious case review sub-groups, or however the local authority does it, who’s from a substance misuse background. I was a commissioner of services so I was able to know what services were available and what would be suitable.’

Disturbingly, however, though ingestion of OST medications by children is often the result of unsafe storage, there are also the ‘rare but real’ cases where methadone is deliberately given to children to pacify them, as had happened in five of the cases studied by the report. ‘In several more cases the practice was suspected, or how the child ingested the drugs is unclear,’ states the document. ‘It was clear from the serious case reviews that professionals working with these families had not accounted for this possibility, and this was mirrored by the interviewees in this research.’

‘That was another important message that came from the review I was involved in,’ says Bandcroft. ‘Nearly all drugs workers with someone on a methadone script talk about lockable cupboards, lockable boxes – a whole emphasis on ensuring the person has a locked box – but little is ever discussed about not giving the methadone to a child. You can have as many locked boxes as you like, but – to think the unthinkable – if somebody is actually giving it to a child it doesn’t matter that it’s locked away.’

Even among experienced practitioners who are fully aware of the dangers of children accessing OST drugs, the ‘practice of administering drugs to children was difficult to accept or address’ says the report. The answer, says Bandcroft, is for this to become part of a forceful generalised message, ‘rather than it looking as if you’re focusing on the individual. If there’s children involved then the message has to include “never give the methadone to a child”.’

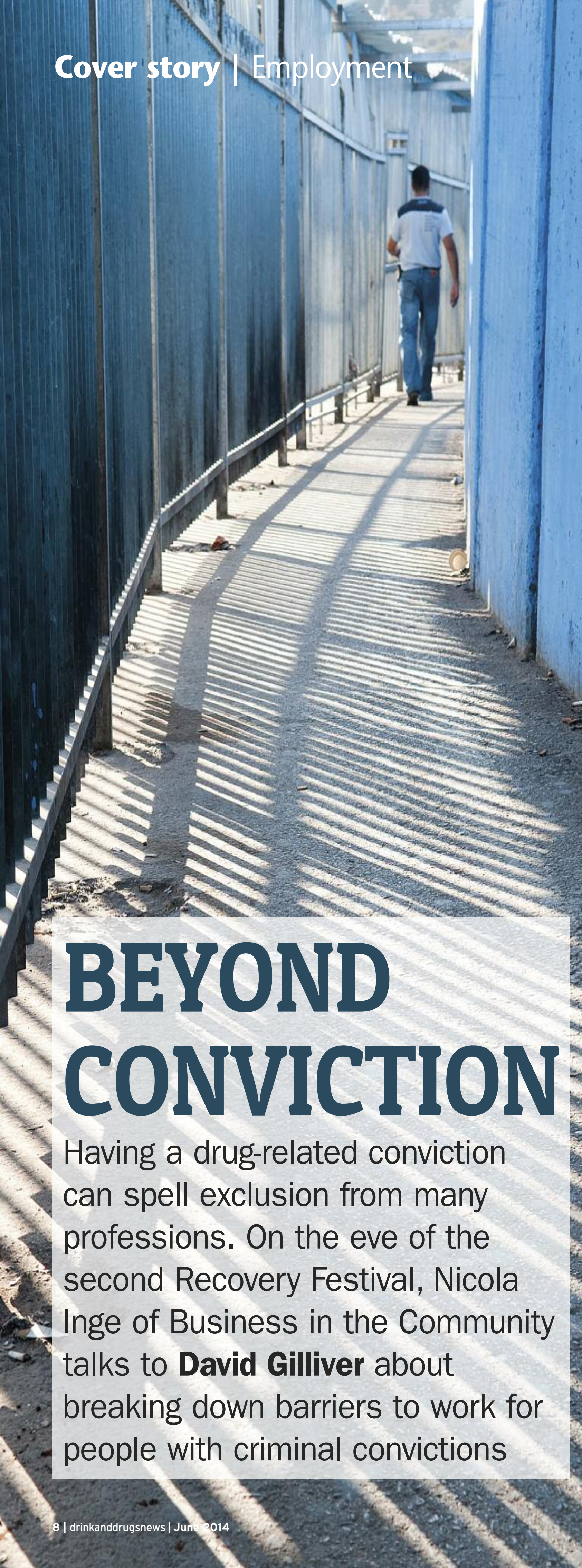
In fact, Judith Yates’ local service in Birmingham has now done exactly that, as a direct result of Adfam’s findings. ‘When you read through any report like this you think “yes, I knew that” and “yes, we need to do that” and then you look for something which you’re not quite expecting, and I suppose the idea that methadone might be used as a soother or pacifier was a surprise to me,’ she says.

‘They found cases where there were signs that opiates had been given to the babies regularly, and one parent saying that it was sort of normal, accepted practice in their area. On the back of that we’ve changed our leaflet to include explicit warnings such as “never give your baby or child even a tiny amount of methadone or other opiate for any reason” and “babies and small children have died after tiny amounts of methadone have been given”.’

But if the key to addressing these disturbing issues is effective communication, then there’s also another message that has to be put over clearly, she believes. ‘Social workers and health visitors and everyone who isn’t a drug treatment worker needs to be firmly informed that parents being on opiate substitute treatment is the most important thing for the safekeeping of the children. If the parents are not on opiate substitute treatment, but are using illicit drugs, then that’s when the children are at most risk. Anything that threatens the ongoing engagement in treatment is increasing risk to the children.

‘Most social workers now accept that, but it’s ongoing education – particularly I think for health visitors and midwives sometimes – that OST is a good thing, not a bad thing,’ she says. ‘Clearly, the vast majority of parents on opiate substitution who’ve got children are taking their medication properly and safely. And keeping it away from their kids.’

Report available at www.adfam.org.uk



BEYOND CONVICTION

Having a drug-related conviction can spell exclusion from many professions. On the eve of the second Recovery Festival, Nicola Inge of Business in the Community talks to **David Gilliver** about breaking down barriers to work for people with criminal convictions

Around three quarters of employers have admitted that they discriminate against applicants who have a criminal record. This, says the business-led charity Business in the Community (BITC), is their loss, as it means that they're missing out on a vast pool of skills and talent.

One of the main means of exclusion is the tick box on job application forms that asks about previous convictions – a 'blunt instrument', according to BITC. It's this that led the organisation to launch the Ban the Box campaign last year, calling for people to be judged on their ability to do the job and with the disclosure of convictions delayed until a later stage of the recruitment process.

The initial inspiration came from a US campaign with the same name, launched by an organisation called the National Employment Law Project. 'It had the same principles as ours but it was taking a legislative approach based on equal opportunities, and saying that people from certain minority ethnic groups were being disproportionately affected because they were over-represented in the prison population,' says BITC's work inclusion campaign manager Nicola Inge.

BITC followed the US campaign's progress and a couple of years ago began working with a group of companies led by Alliance Boots to look at the issues around increasing employment opportunities for ex-offenders in the UK. 'One of the things they all agreed that they could do – and that was within their control and would make a positive impact – was to remove the tick box from their application forms and move it further down the process,' she says.

BITC began a dialogue with other organisations involved in supporting offenders back into work, such as Nacro, Unlock, the St Giles Trust and Recruit with Conviction, to find out whether it was something they would support and then took the idea to the business community itself, holding discussions during Responsible Business Week. After a good response from both, the campaign was worked up for its launch last October.

'A really big part of it for us is sensitising people to the campaign, and getting employers to change their practices,' she says, and so far the response has been positive, with 15 employers – who collectively employ 150,000 people – signed up. 'We're very pleased with the reception, and we've learned a lot.'

One of the main lessons has been how much depends on the sector, she stresses. 'Either the sector they're in or they're working with being regulated or having particularly strict security measures, and that actually there's a lot of lack of understanding among the business community about what they can and can't ask. That's the stuff that we've really been developing as the campaign's being going on – resources to help them understand the regulatory environment and take some of the fear out of it.'

Much of this fear is 'based on it being a very complex issue', she acknowledges, often exacerbated by misrepresentations in the media. 'But what I find is that once you actually take people into a prison and introduce them to people who've got convictions – once they can tangibly grab hold of it and get their head around it – that fear goes and they realise that it's actually not as difficult as they thought.'

However, it's not necessarily just fear on the part of the employers, she explains. 'They have concerns about safeguarding their employees, their customers, their clients, so it's almost a fear on behalf of what they think their employees, customers or clients would think. It has so many layers that we need to tackle, which is why we've been really grateful for the support we've received from organisations who've endorsed the campaign, because alone we can't change the perceptions of every employer in the country – much as we'd like to. We've really relied heavily on the businesses that have signed up and the organisations that have endorsed us.'

One of these is Freshfields Bruckhaus Deringer, the first law firm to sign up and an organisation that's had a long-standing involvement with BITC's Ready for Work programme, which helps people overcome disadvantage and move into employment. 'About a third of the people we support through Ready for Work have unspent convictions and Freshfields, to their huge credit, have been very forward-thinking and brave in focusing their involvement on offering placements and employment to some of our Ready for Work clients.'

So far they've offered around 250 paid placements, with 25 people even going on to full-time employment at the firm. 'The reason they were so quick to adopt Ban the Box is that they'd already been working with and employing ex-offenders,' she says. 'They'd explored some of the stuff around risk and management support and broken down a lot of those barriers, which meant that when Ban the Box came out there was a really strong precedent within the organisation. One of the other themes that emerged really strongly from the campaign was leadership, and we were very lucky that one of their partners was a really strong, powerful advocate for the campaign internally. I think once you've got that commitment at that level of seniority it reassures the people who are going to be implementing the changes and helps in setting a bit of momentum and pace.'

So, turning it around for a moment, what would her advice be to someone with a criminal record who's looking for a job – how can they best present themselves in a positive light? 'I think probably the first, and arguably most important, piece of advice is find out exactly what your criminal record is. There's an awful lot of people out there who don't necessarily know the extent of their record and don't know what's spent or unspent, and that can trip people up. So that's what we always say – find out exactly what it is, what you'd have to declare, what are your unspent convictions.'

'With this whole concept of recruiting for attitude and training for skills... that determination and grit that some people have if they've overcome particularly challenging life experiences are arguably greater than in some other candidates.'

Nicola Inge

It's also about building up an 'evidence base' to show to employers, she stresses. 'Building skills, building experience – so many employers that we speak to say that they recruit for attitude and then train for skills. So when someone comes to an interview and presents a really positive attitude towards that employer – they've done their research, they're really motivated and passionate about learning the job – that stands for an awful lot. The challenge for people with convictions is that often they don't get the opportunity to get to that point because they get screened out, which is what Ban the Box is trying to tackle.'

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So what would BITC say to an employer who was reluctant to hire someone with a drug-related conviction? 'My first port of call would be trying to understand whether that's borne out of personal fear or misconceptions, or whether there's a genuine operational barrier,' she says. 'I would always try to get an employer in front of someone who had unspent convictions who could actually make them understand that they're a job seeker, they're talented, they have their own skills and experience that they could offer, and break down some of that fear and stigma.'

While clearly there are some people with convictions that mean they'll never be able to work in specific industries or roles, they're the minority, she stresses. 'With most people, if they're able to tell their own personal story in a way that helps the employer understand that they're not going to be a risk to the business or customers, then there are actually very few operational barriers to employers taking them on.'

There's also a strong argument that people who've overcome things like a substance problem or prison sentence would bring a strength of character – and be extremely loyal – to any employer that gave them a chance. 'What we're absolutely not advocating for is positive discrimination,' she states. 'We're saying that different life experiences develop their own specific qualities in an individual, and I think employers, more and more, are having to look in different places to find the qualities they need in an employee. With this whole concept of recruiting for attitude and training for skills – particularly in terms of some of the entry level jobs – the qualities and the positive attitude, and that determination and grit that some people have if they've overcome particularly challenging life experiences are arguably greater than in some other candidates.'

The organisation is now also involved in some EU-funded research into health inequalities in childhood, welfare and employment. The data is still being analysed but among the preliminary findings are that people facing multiple barriers to work 'really value the personalised, accessible support' provided by specialist agencies such as drug or homeless charities, and that a wide network of support is also vital, with many clients engaging with three or four agencies when looking for work. 'It was also interesting that for people with substance and alcohol misuse issues, their sustainment rates for jobs were actually higher than some of the other groups we support,' she says.

And in terms of BITC's extensive dealings with employers, does she feel that stigmatising attitudes towards people who've had drug problems are still entrenched, or are they starting to soften a little? 'From the way employers are talking to us, I think it has developed a little bit,' she says. 'Really, what they're saying is "give us the right people for the job". It's less about them needing to understand everyone's background and experience and more about wanting to understand what that person can offer to the organisation. In that respect it has developed. We certainly don't take the approach of selling in our Ready for Work graduates because of the experiences they've overcome – it's more about "look what this person can do, look what they can bring to your business". I think that's kind of the shift in narrative.'

What's ultimately vital is supporting people to tell their story in the most positive light to employers, she stresses. 'So in terms of disclosing convictions, it's about practising what that disclosure statement might be, and how you can explain to the employer that the experience you've overcome – or your previous conviction – isn't going to present a risk to them. And also being very confident about what it is that you can bring as an employee.'

The Recovery Festival 2014 takes place on 1-2 July. Full details at www.recoveryfestival.org.uk

www.bitc.org.uk

ENTERPRISE CORNER

WORKFORCE CHALLENGE

Amar Lodhia experiences a day in the life of a local enterprise and employability service (LEES) worker

SPEAKING AT AN EVENT last week on how entrepreneurship can help ex-offenders re-integrate into society and reduce reoffending rates, it struck me how important our frontline workers are to everything we do at TSBC. They're the face of TSBC with all our participants and delivery partners on the ground, as well as the driving force behind our successes. So, I'd like to devote this month's column to giving you a bit more of an insight into our LEES workers, what they do and why they do it.

I spent a day with Vicky Scott, our worker in the London Borough of Merton. She only joined us about eight weeks ago and is based at the MACs project, which provides recovery and support service within the Merton drug and alcohol treatment system.

Vicky starts her day contacting service users to remind them of their sessions with herself and/or meetings with potential employers, interviews, attending open days at colleges etc – they sometimes need a little nudge.

Then the rest of the morning is generally given over to preparing for her individual sessions with service users. As TSBC provides a unique service that is tailored to each participant and their action plan, the preparation and research ahead of each session can range from making contact with local employers to meetings with services such as housing support. She also tries to arrange for them to meet local people and inspiring role models.

The afternoon is the most client-facing part of her day, where Vicky actually delivers sessions with service users. The content, which she's developed in the mornings, and key objectives of the sessions depend on the progress each service user has made against their actions. For example, if it's the first introductory session, they agree the action plan and what the service user wants to get out of their engagement. Vicky helps them to plan their 'journey' by setting SMART goals that they will work together to achieve, throughout their engagement with TSBC.

Like every job, there is some admin, and Vicky will admit to leaving this to the end of the day (or end of the week, if she can!). But TSBC does allow her to maximise client-facing time and our project support officer at head office is on hand to help when she's 'super busy'. She also contacts referrals received at the end of the day, and books appointments with clients.

'What I love about the role is being able to be such a key part of a client's recovery,' says Vicky. 'Being directly involved with the participants and allowing me to share my first-hand experiences, and to see the positive effects of my efforts and planning with the clients – seeing them engaging in the programmes is so inspiring.'

'I believe the uniquely designed programmes that are delivered in such a personalised manner allow participants to progress at their own pace, depending on their level of recovery,' continues Vicky. 'Not every participant will complete the programme with a job or even enrol into college but they WILL have at least progressed in their life's journey. They *will* have gained relevant and essential skills or tools along the way, which, I feel, can be carried with them throughout their lives.'

TSBC are actively recruiting LEES workers across the Midlands and London. For more information contact Vanessa Bucknor-Scott, head of people development and resourcing on vanessa@tsbccic.org.uk and follow me our daily updates and industry news on Twitter by following @tsbclondon don't forget to use the #tag DDNews when tweeting.

LETTERS

'Right now, broadly speaking, 12-step rehab continues on a rough rule of thirds - some clients get it, some don't, and some might if we went at it differently...'

BOLD QUESTIONING

I was pleased to see some support, in among the hornets' nest of letters and tweets, for the inclusion of Stanton Peele's take on recovery (*DDN*, April, page 8). It is easy to believe in the effectiveness of a 12-step model when surrounded by people who describe themselves as in recovery – as might be the case if you go to lots of fellowship meetings or work in a treatment centre, or indeed both. Can it be helpful to question beliefs and practices which seem to support so many people making positive changes?

Richard Craven's letter (*DDN*, May, page 16) helpfully refers to the shameful and shaming practices sometimes to be found in 12-step based residential approaches in the 1980s. Take for example the instruction 'shape up or ship out' – encapsulating the belief that snags and difficulties in treatment were always the responsibility of the client and never the organisation.

Steps 2 and 3 neatly embedded the necessity of handing over one's will to a power greater than oneself and who would that be, in the case of fresh-off-the-street addicts who'd been burning their bridges, if it wasn't the counsellor or the group? Fine if it worked, but for many rehab quitters this was surgical removal of any surviving vestiges of dignity and self-belief. Years were to pass before 'vulnerable adults' entered the treatment discourse.

Twelve-step rehab has been on a long, let us hope continuing, journey since that time, in the direction of recognising the needs, resources, qualities and circumstances of the individual. When an agency has been especially smug and self-satisfied – in other words, resistant to change – the journey has been especially painful, not infrequently ending in liquidation.

Let's hope the journey into the light continues, but let's also recognise the inherent resistance of many

We welcome your letters...

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organisational cultures. Right now, broadly speaking, 12-step rehab continues on a rough rule of thirds – some clients get it, some don't, and some might if we went at it differently. Why is that, and what do we need to consider here? Long may we have outspoken commentators like Stanton Peele to raise questions which frighten us.

Paul Taylor, couns.super@gmail.com

EACH TO THEIR OWN

Further to last month's debate, I also believe there is a great deal of lack of understanding of 12-step programmes. Addiction is a life-threatening problem, and if something is helping people to recover their lives without a substance dictating their days, why would anyone disagree with that?

I believe there are other ways to recover. Harm reduction is vital to begin with, but does it make sense to spend a life on a substance like methadone and many other so called solutions?

AA in particular has had a huge success rate for many years – if it works, don't fix it. I have never witnessed anyone being kidnapped to go to a programme, it is their own choice. If one chooses to go another path why does 12-step have to be their problem? Would it not be a good idea to just get on with their own solutions and leave others to get on with theirs?

A final point: 12-step programmes are free and self funding; would that be a reason? Or maybe it is the choice of individuals not to be abstinent, or they confuse 12 steps with orders not suggestions – I could go on and on. Surely the best thing is to choose your own solution and stop criticising. It seems that this debate is looking for what is wrong and not at what works for many, though (obviously) not all.

Rita Matthews NCS (Acc), MBACP, AHPP certified reality therapist, FDAP, associate member of the Royal Society of Medicine

COMMENT

EXPORTING THE DISEASE

Lise Reckee brings a Scandinavian perspective to the debate about the 12-step model

I AM WRITING IN SUPPORT of Stanton Peele's exceptional wisdom and freedom In rejecting the punishment/treatment dichotomy (*DDN*, April, page 8). Strange as it may seem to English speakers, Stanton Peele´s views on addiction and recovery are not under debate in Scandinavia. Frankly it can be quite confusing to understand the fuss and the controversy so openly expressed in the US and UK.

Long ago when living in Denmark, I used heroin – extensively and often combined with other drugs. I almost died from it. Methadone was available from the general practitioner, who prescribed it to me for almost 15 years – even though no one ever labelled my condition as a disease, or told me what I had was a chronic condition. My physician simply followed the Hippocratic oath, prescribing an opioid and consoling and soothing me. This was not a common attitude among all Danish physicians, but every general practitioner was allowed to decide for themselves whether they wanted to treat addicts or not. No counselling was offered, nor any demands of me changing my lifestyle.

We looked at opiate addictions as bad habits that you were supposed to outgrow. And it may be a surprise for the Americans, but many – including me – did outgrow their addiction. Sadly this was not reflected in scientific reports, as the Danes never really took the issue of 'recovery' that seriously. On the other hand, what you would call harm reduction measures were from early on introduced and maintained in Denmark.

Many Danes, once seriously addicted to drugs, are in good job positions today, as we grew up as was expected. This was not a road followed by all of those addicted to drugs, and some were left behind, like everywhere else. Often this was because they were denied the prescription of methadone or other opioids. The Danish perspective changed in the 1990s, when the 12-step movement started to colonise Scandinavia through private entrepreneurs in the form of professional addicts opening private treatment institutions. They claimed that the Danish treatment model had proved to be a failure and pointed out the missing communities of recovering addicts as proof.

At the time I was enrolled at university finishing my masters degree in psychology, and had left my drug and methadone taking days long behind me. Actually I rarely thought or spoke about drugs, but with the fuss in the media from the new 'recovering addicts', I became curious and went to a newly established 12-step meeting. There for the first time ever, I learned that I had a chronic disease, and that relapse was to be expected. I did not know the word relapse, and I had certainly never thought of having one. But after a few meetings I started waking up in the middle of the night with panic attacks and the phrase 'relapse' on my mind. What if I woke up experiencing an uncontrolled relapse? I reconsidered my desire to attend 12-step meetings because, furthermore, I was told that my ability to control my drinking alcohol proved I did not have 'the disease'. Not having a deadly disease has given me freedom to do whatever I like for the rest of my life, including using recreational drugs, drinking alcohol, using pain medications for serious pains, hanging out with whomever I like and pursuing a carrier of my own free choice.

The 'traditional' view on addiction and recovery is still alive and well in Scandinavia, where most people and many social workers still see drug addiction as a passing phase in life that you can and should outgrow. However, we now struggle with the two disease models imported from the US. The NIDA model embraced mostly by Norwegian physicians results in patients receiving methadone or buprenorphine, and they are told that their medical treatment is permanent – that they will never be able to quit. Some patients have objected and filed cases against the health authorities protesting that they have been denied detox or tapering of their medications, with some even being coerced into taking huge doses of methadone they do not want.

Non-judgmental treatment in Denmark was available in many forms from the '60s, even though the Danes had no working concept of 'disease', but rather defined treatment in the context of social customs or prescribing opioids as a kind of traditional maintenance. Neither concept of 'addiction as disease' (AA's or Nora Volkow's) has improved treatment quality or rates of success, which have been documented by the national addiction research centre. On the contrary, the disease models have introduced a range of troublesome concepts including the chronic and incurable addict. Harm reduction does NOT depend on a disease theory – quite the opposite, in most cases.

Lise Reckee is a Danish social worker/addiction counsellor, now working in Norway

> **'The Danish perspective changed in the 1990s, when the 12-step movement started to colonise Scandinavia through private entrepreneurs in the form of professional addicts opening private treatment institutions...'**

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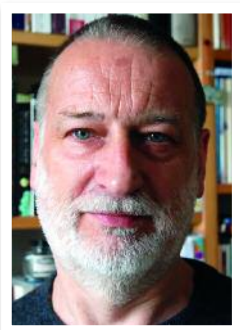
Danish Lessons



Denmark's initiatives to tackle drug-related deaths could give valuable pointers to reshaping drug policy in the UK, says **Blaine Stothard**

As part of his programme of international visits looking at drug policy, Home Office minister Norman Baker visited Copenhagen in February 2014. This visit, one of many from the UK, included a roundtable discussion at the British Embassy and trips to the Danish Drug Users Union, a building-based drug consumption room, and the Christiania cannabis market near the centre of Copenhagen. At the time of writing (May 2014) we don't know what impressions the minister brought back. But there has been sufficient recent activity in Denmark to consider what might be coming our way.

Denmark's population of 5.6m includes an estimated 17,000 injecting drug users, principally using opiates but with an increasing use of cocaine. National statistics for drug-related deaths, collected by the police since 1970, and by the health service since 1995, show that since 2000 there have been around 250 annual drug-related deaths (DRDs), falling to 210 in 2012. Reducing this high death rate has long been the aim of campaigning groups, including BrugerForening (Danish Drug Users Union) and Gadejuristen (Street Lawyers: slogan 'hard-core harm reduction').

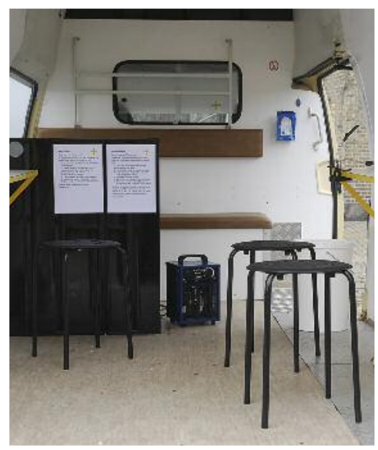
In 2004 Anders Fogh-Rasmussen's Conservative-led government acted on its zero tolerance policy on drugs. Against police, Copenhagen City Council and others' advice, the illegal but tolerated cannabis market in Christiana ('Pusher Street') was closed down. As predicted, this resulted in the displacement of the market elsewhere and its integration into existing illegal drugs markets mainly controlled by rocker and biker gangs. Challenges by other criminal organisations led to violent turf wars and shootings, predicted by those questioning the clampdown.

The negative consequences of the closure of Pusher Street resulted in a detailed proposal by Copenhagen City Council for the regulation of cannabis on a trial basis. The proposals envisage a state or local authority controlled and regulated cannabis market – cultivation (a stage in the cycle not included in most similar proposals elsewhere), distribution and retail. Sale to the public would be through dedicated outlets, with staff present to advise purchasers on concerns they might have. The results would be monitored and evaluated to assess impact. The proposals, which have extensive cross-party support from Copenhagen City Council (and majority public support) have, so far, been rejected by governments, most recently in 2012. But they remain 'live' following the November 2013 local elections and the formation of a new city council.

An open cannabis market has been re-established in Christiania. Booths sell cannabis behind curtained entrances, a stark contrast to the pre-2004 market, where tables groaned under the weight of bricks of resin. The existence of these booths seems to have given some UK visitors the impression that cannabis is freely available in Denmark: signs – in Danish, English, Spanish and German – mark entry to the Green Light District, request that there is no photography, and emphasise that the cannabis trade remains illegal in Denmark.

In 2007, Fogh-Rasmussen's government introduced medically prescribed heroin, with clinics in four cities, including Copenhagen. A result of parliamentary pressure and a media campaign, this programme has contributed to stabilising the health of its clients, mostly older, formerly chaotic, injecting heroin users, and to reducing crime and associated nuisance. Users attending the programme are required to inject, not smoke – a harm-reduction behaviour adopted by some long-term users the programme was intended to attract who have, as a result, declined to register. About 250 users are registered. Thrice-daily attendance at clinics is required for prescriptions to be issued and injected, making it difficult for users to maintain family commitments, employment, or education and training. The programme is expensive, employing health and medical staff on high salaries and using pharmaceutical products which could be obtained at a fraction of the cost from alternative suppliers. Commentators conclude that the programme was well intended but poorly thought through.

At an October 2013 local election meeting in Copenhagen's Vesterbro district, home to several agencies working with socially excluded groups and the city's principal illegal drugs market, the majority of the candidates who spoke endorsed the activities and spending of the city council which responded to the needs and situations of socially excluded groups, including injecting drug users. Five of the candidates specifically referred to the need to maintain a floor of taxation levels if such programmes were to continue, and warned against parties and politicians who promised tax reductions.



BrugerForeningen is one example of the environment in Denmark, or at least Copenhagen. Housed in a building in the Nørrebro district of Copenhagen whose other occupants include a youth centre, a library and a nursery (British nimbies please note), BF provides a morning drop-in service for injecting drug users; harm-reduction sessions for existing users; a 'clean-up' team of users who regularly clear discarded paraphernalia from areas used by injecting drug users, and organises courses and seminars for relevant professional bodies – police, social workers and health professionals. Copenhagen City Council provides some funding. Lessons here include the ability of long-term heroin users to plan, organise, manage and campaign, in collaboration with residents and social agencies, when able to use in safe and sterile conditions.

Together with the NGOs Gadejuristen and Antidote, BF campaigns for the increased availability of naloxone (a team of BF members has been trained and licensed to administer naloxone, the first non-health personnel in Denmark to be permitted to do so); for the provision of foil as part of harm-reduction and needle-exchange work, and the provision of drug consumption rooms. Current health service guidance emphasises the health risks of smoking, used as an argument against allowing those on medically prescribed heroin programmes to smoke rather than inject. Health service guidance also refers to the health risks of using foil in smoking heroin, obstinately failing to distinguish between plain foil and foil coated or treated for the catering trade, the coatings and their carcinogenic fumes representing the risks. The 2010 ACMD report on foil is being used in this campaign.

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The opening of consumption rooms has the 'best' lesson for the UK. As part of their aim to reduce drug-related deaths, Danish campaigners had long argued for drug consumption rooms. Part of their case was the evidence of lives saved, emerging from studies where DCRs operate. While still in opposition, the parties now in government (since September 2011) undertook to introduce legislation enabling DCRs to be established. The new government introduced its bill to permit DCRs, enable local authorities to commission and operate them, and provide for their funding. The law came into force on 1 July 2012 after gaining parliamentary approval.

Two building-based drug consumption rooms have since opened in Vesterbro, one in the premises of Mændenes Hjem (The Men's Home), a project for homeless people which, despite its name, works with all who are homeless and responds to their needs. This room (Skyen: The Cloud) has two sections, for injecting and for smoking, separated by a transparent, air-tight partition. When I visited in October 2013, all 14 places were occupied, mostly by men, some Swedish. Users check in with the medical staff present. Pseudonyms may be used, if constant, and the drug/s used noted – on my visit, cocaine was the principal drug used.

In January 2014 the Home Office stated that drug consumption rooms were not in prospect for the UK, being in breach of domestic legislation and international conventions. Lesson from Denmark: always seek a second legal opinion when governments say 'it breaches national law and international conventions' – national governments have the power to change domestic law if the political will exists.

The provision of sterile and safe injecting facilities was catalysed by the establishment of a mobile DCR by a citizens' initiative in Vesterbro. This converted ambulance, Fixelance (Fixerum (consumption room) + ambulance), took to the streets on 11 September 2011 – before the election and the subsequent change in the law. Staffed by volunteers, including medical professionals and social workers, and funded by individual and small-business donations, Fixelance initially operated on tenterhooks, with legal teams from Gadejuristen on call in case of challenge or interventions by the authorities. There were none. Shortly after Fixelance 1 started operating, a second was donated by the national emergency service, Falck. Once the legislation was passed, Copenhagen City Council took over the running and funding of the two Fixelance. The citizens' initiative was dissolved. Its originator, Michael Lodberg Olsen, now campaigns, as Antidote, with BrugerForening for improved access to naloxone. Fixelance 1 has since been replaced by a purpose-built vehicle.

The Fixelance initiative was started by local residents in Vesterbro, where many injecting drug users and other marginalised social groups congregate. They were concerned at the poor health, living and social conditions of those groups, and rather than trying to exclude or displace them, developed positive responses, an ongoing, decades-long task. The focus has been to restore a sense of dignity and worth to the lives of injecting drug users at the same time as reducing the impact their lifestyles have on local residents. (Moves to set up a DCR in Birmingham are based on similar principles.) The results have included less discarded injecting equipment; increasing use of the mobile and building-based consumption rooms, rather than playgrounds, backyards and stairwells, to inject; an absence of DRDs in the consumption rooms, and significant changes in public opinion. Here is a further potential lesson for the UK – process, public support, pragmatism.

Campaigners expect the consumption rooms to contribute to a further reduction in drug-related deaths (DRDs). While the significant 2012 fall in DRDs, recorded in the 2013 EMCDDA *Focal point report*, is welcomed, all involved express caution in attributing the fall to the DCRs and Fixelance. The statistics covered the whole of 2012: the building-based DCRs had only been operating for two months – and there was an increase (from 32 to 37) in Copenhagen DRDs. The 2013 statistics are awaited with great anticipation.

As part of their aim to reduce drug-related deaths, Danish campaigners had long argued for drug consumption rooms. Part of their case was the evidence of lives saved, emerging from studies where DCRs operate.

The Danish National Museum, curators of the Viking exhibition currently at the British Museum, has added Fixelance 1 to its collection, using it to illustrate themes in contemporary Danish history. It was formally 'unveiled' at the museum in April, in a courtyard next to one of the museum's ancient runic stones, with the spire of Christiansborg, the parliament building, in the background. Maybe there is a further lesson here about acknowledging social issues and challenges and the individuals affected rather than denying, dismissing or demonising them. They exist and are part of contemporary society, and are better responded to when understood, not subjected to scorn, misrepresentation and stigma.

Blaine Stothard is an independent consultant in health education, www.healthed.org.uk

Catch them early

This year's SMMGP and RCGP conference brought GPs, frontline workers, commissioners and service users together to explore the topics of prevention and early intervention in the new public health environment. **Kayleigh Hutchins** reports

EARLY INTERVENTION WAS THE THEME at SMMGP and RCGP's 19th national conference on managing drug and alcohol problems in primary care, promoting an idea of 'working with the system' to engage vulnerable people and stop problems before they had a chance to develop. With the backdrop of a changing sector and funding cuts, delegates heard examples of what was happening up and down the country to meet the needs of those affected by drug and alcohol problems, as well as bringing into sharp focus several barriers – both political and social – to taking early action.

The DrugAware model, introduced by programme lead Anna Power, showed education as a means of reaching young people in schools and academies across Nottingham. Power pointed out that young people were seven times more likely to become a drug user if one of their parents were, and so the scheme was aimed at identifying those vulnerable children and engaging with them before problems could take root. It included young people in the development of the in-school programmes, taking the emphasis away from punishment and focusing on engagement. The programme had proved successful, she said, with 80 per cent of schools across Nottingham now DrugAware schools.

'Change the late intervention culture' urged Graham Allen, MP for Nottingham North. It was of utmost importance to break the cycle of intergenerational use – and the most effective way of doing this, he said, was by making sure that services and programmes 'meshed together', ensuring commissioners and practitioners shared a common goal. Giving children social and emotional support would set them up to have a better standard of life – and early intervention would create an 'emotional bedrock' for them.

Allen also pointed out the importance of having a strong evidence base in order to 'monetise outcomes to get funding'. The best way to appeal to the government and policymakers, he said, was to emphasise the 'massive cost of failure', which would inevitably cause more money to be dedicated to drug and alcohol misuse programmes and social welfare.

Duncan Selbie told delegates that preparing children for life was a target for PHE – as it should be for the nation as a whole – not only by dealing with drug and alcohol problems, but also issues like obesity, domestic violence and tobacco. There were 'three people in the early intervention relationship' he said – government, local services and the public – and there needed to be a conversation as a nation on how best to tackle these issues.

When answering questions from the floor, Selbie denied being 'too cosy' with the drinks industry, reiterating that PHE was clear in wanting minimum unit pricing and plain tobacco packaging, and saying that 'being independent isn't about being loud, it's about winning.'

Concerns were raised about the state of commissioning, and the effect it was having on delivering a good service. Selbie said that local government 'understandably wanted the most they could get out of their spending'. He urged services to 'have the courage and patience to work with that process' by showing local government that their way of doing things would be the best and give the most value for money.

The effect of the commissioning process on early intervention was touched upon again in a workshop held by Turning Point's Selina Douglas. She highlighted the challenge that substance misuse services had, more than any other, to make sure they met performance expectations, while under the pressure of 'having to do more for less' and keeping service users 'at the heart of any change'.

Discussion among the workshop participants revealed that the process of tendering and retendering was putting stress on frontline workers, who questioned whether those who were making the changes really understood what it was like, both for them and their service users. The performance focus changed too frequently, said an attendee – where it was once 'get [service users] in and keep them in', the focus was now 'get them out and keep them out'.

Another delegate questioned how the targets that had been set for treatment services were being monitored for long-term effects, and what impact they would have on early intervention and on society ten years down the line. Douglas said that early intervention had been difficult in the past because of a lack of evidence, but that the evidence base was now stronger, which would make it easier in the future.

Di Wright, of the commissioned services for Kent County Council, said that commissioners were looking at commissioning different services together 'so that it enhances both sides and gets a better service for clients,' to which Douglas added 'a substance misuse service cannot exist in isolation – it has to exist in a network of services.'

Stigma and mental health issues also posed obstacles to identifying problems early. Alcohol misuse was an issue that was often overlooked, said consultant liaison psychiatrist Dr Peter Byrne, and many people were reluctant to admit that they were struggling with alcohol for a variety of reasons. Not only was there social stigma, but people with alcohol problems were often seen as 'the patients that doctors dislike', said Byrne, and fear that their doctor would treat them differently often prevented people from seeking help. This 'failure to disclose' meant problems were not being identified early enough, and community-specific services – such as LGBT and Muslim alcohol services – were needed to help engage with those who were reticent to seek help.

'Interventions are critical,' said health improvement lead Lee Knifton, 'but without relieving social stigma, they won't be as effective as they can be.' He told delegates that in Scotland, and in particular Glasgow, overall public health was 'as bad as it gets', and had been declining systematically since the '50s, with health inequalities having accelerated since the '80s. Almost all of the inequalities, he said, had to do with 'addiction, mental health, violence and suicide' and working with these interlinked areas of public health should be a priority.

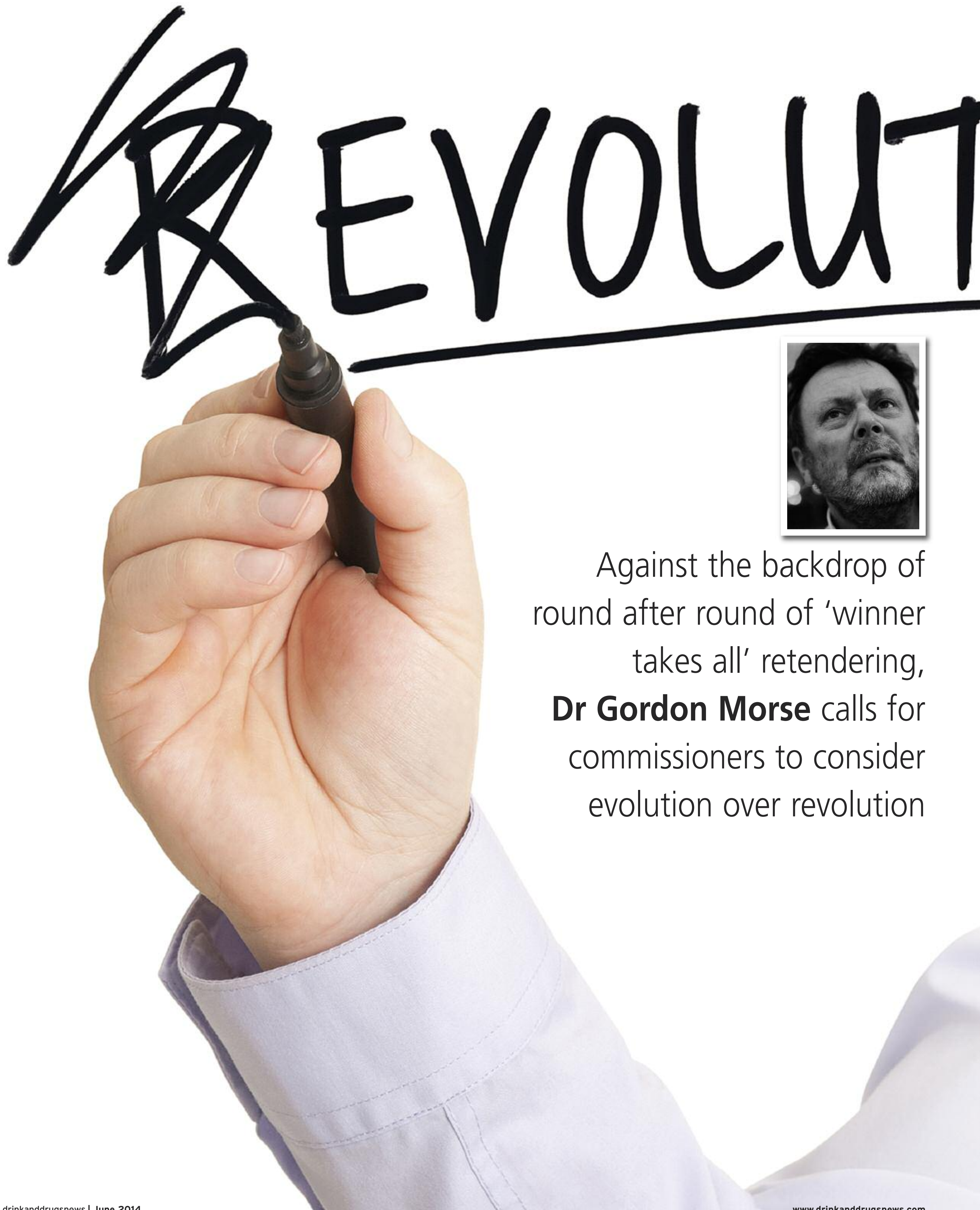
Stigma was a complex social phenomenon that 'dehumanised and separated', he said, compounded by things like religion, personal experience and the media, and it would take more than just giving people 'the right information in the right ways' to tackle it. Ten years ago, Knifton and colleagues in Glasgow mental health services made a 'city alliance' with the government and regeneration agencies, which undertook participatory research studies with marginalised communities who had experienced stigma and discrimination. It aimed to generate practical solutions and brought together a community of organisations alongside service users to understand the nature of stigma and mental health, identifying issues such as a high degree of 'recovery pessimism' among practitioners.

> **'Giving children social and emotional support would set them up to have a better standard of life – and early intervention would create an "emotional bedrock" for them.'**

As a result of this research, the Scottish Mental Health Arts Festival – now in its eighth year with 200 partner organisations – was created as a means of 'challenging stigma and perceptions of people experiencing mental health problems' and engaging harder to reach members of the community, such as the poor and ethnic minorities, through music, art and comedy. The events aimed to start the right sort of discussion about mental health and addiction, with a view to relieving stigma and helping identify problems early.

Changing opinions about early intervention was crucial, added Dr Peter Byrne during a Q&A session, and as a lot of media coverage of mental health and addiction was negative, it was important to publicise stories that would 'capture the media's attention'. Among frustrations with the changing commissioning landscape, minimum unit pricing and plain tobacco packaging, it was incredibly difficult to get health into the political debate, but 'as physicians we need to get the right stories out there,' he said.

For conference reports and presentations, visit www.smmgp.org.uk/html/reports.php



Against the backdrop of round after round of 'winner takes all' retendering, **Dr Gordon Morse** calls for commissioners to consider evolution over revolution

'Addiction treatment already provides outstanding value for money – uniquely as a medical treatment, it returns its costs many times over.'

There can't be too many commissioners of community drug and alcohol services who are lying in their baths thinking, 'If I had a clean sheet of paper and could completely redesign my treatment system, it would look exactly like the one I've got.' Equally there can't be many service users who are similarly thinking, 'If we could completely redesign an addiction treatment service that works for us, it would look exactly like the one we have.'

Commissioners work very hard to deliver treatment systems that are safe, deliver what the evidence and guidance says works, meet targets, and come in at a price that the local health economy can afford. The good commissioners will also be listening to what their service users want as well, which isn't always the same thing.

Most legacy treatment systems are the product of an evolutionary process, with some local services just springing up, some mandated by statute, and others added over time as situations dictate and resources allow – an abstinence service here, an alcohol service there, a street agency, DIP, NHS mental health service, some GP-run services, etc, etc – and each one (usually) with its own information system, buildings, management structures and gate-keeping criteria. None of them talk much to each other, not many understand who is responsible for what, and service users bounce around this patchwork system getting a bit of this, a bit of that. Some find that they just don't seem to fit any of the criteria for any service, and give up.

Rationalising all of this makes abundantly good and obvious sense. Get one provider to be responsible for everything – one management structure and one set of buildings to pay for, one cohesive team of personnel that can absorb fluctuations in staffing without falling over, everyone talking to each other in one information system. And just one place for service users to turn up to, where they can get help at whatever stage they are at in their addiction 'journey' – from drop-in needle exchange and advice, through specialist prescribing and psychosocial interventions, to detox, relapse-preventing aftercare, family and carer support, and links to employment, housing and so forth. Everyone works to shared protocols and practices, at one place, with pathways to everything that is needed. There is one treatment system that can encompass more than one treatment philosophy, with just one phone number to call.

Such systems are true 'integrated' treatment systems. There are many that claim to be integrated, but are in fact one building that houses several different services, or integrated in that you get most things but still have to go somewhere else for, say, your DIP worker. Others look as if they are integrated because there is just one name for the service, but then you find that it is a confederation of providers with disparate approaches.

All of these may work to a greater or lesser extent – there are some excellent examples of multiple providers working well together and some which struggle, but if you build fault lines into a system, the chances are that tensions can turn these fault lines into fractures. And inevitably, to try to pre-empt fracturing and to make it all work, there are a million more weekly meetings to get all parties around the one table to thrash it all out.

With so much to gain, full integration seems to be a 'no-brainer', and indeed many treatment systems have been recommissioned in this way in recent years – but what are the risks? What is there to lose?

Well the obvious risk is that 'all of your eggs are in one basket'. Can the provider really deliver all that they promised in their glossy tender document? Do they understand clinical risk, and are their governance structures sound? Do they have financial stability and have they done this before? Do they have the relevant local expertise to provide what's needed?

The past decade has seen a shortlist of rapidly growing not-for-profit providers emerge as 'the usual suspects' in these big recommissioning exercises – they have amply demonstrated their safety, strength and skills in whole systems change, as well as delivering greatly improved cost effectiveness in the presence of squeezed budgets.

So the outcomes of contracting whole system change have in the main vindicated the theory behind integration – but they come at a high price. Aside from financial cost, these revolutionary events are enormously destabilising and demoralising for existing providers. To not win a tender to retain your service feels like everything you have done before has not been good enough – all the relationships with service users and surrounding agencies that have taken so long to build up will be torn apart.

Rumours and myths abound about the incomers, senior staff leave, taking their skills and experience with them, and while all the professionals are worried about their jobs, the users of the service are frequently forgotten – and they have real concerns too. However, in the main, incoming providers recognise these concerns and work hard to mitigate their effects by retaining current service staff and recruiting locally, thereby maintaining existing relationships and local knowledge.

So where massive change is needed revolution can be painful, but change happens quickly. But what then? After revolution comes a need for stable evolution – it's a delusion to think that you can keep on getting better and better value, round after commissioning round, by cyclical 'winner takes all' retendering which risks providers being forced every three years to offer more for less. Addiction treatment already provides outstanding value for money – uniquely as a medical treatment, it returns its costs many times over. Isn't it time to add to recommissioning strategies some subtle fine-tuning to support quality and stability, rather than just the 'big bang' option?

Of course services that are demonstrably failing need transformation, but what the great majority of decent functional services – and those who use them – need is stability. When the system is right and services are adequately resourced then staff with the right skills will stay in post, and will be able to deliver evidence-based effective interventions, which take time to train and perfect.

This last point about training has been one of the unforeseen casualties of short-term commissioning, and has the potential to profoundly erode the skills base in addiction medicine in the future: the NHS has been the bedrock of treatment provision and training for the past 60 years. The rapid move away from NHS-provided addiction services has dislocated the traditional provider of training from the workplace where experience can be provided.

In the new treatment landscape, the independent sector has the workplace experience, the skills and the willing to take on the training role – but the training of clinicians and indeed of generic workers who are specialising in addiction work takes the sort of time that short-cycle commissioning makes almost impossible.

As someone who works for one of the above mentioned 'usual suspects', this might appear to be a self-serving argument – but the essential point is unarguable: good integrated services need to be well designed, but they also need to be nurtured, as do the clients that they serve and the workforce they employ. Commissioning needs to be radical when big change is needed, but subtle when it is not.

Gordon Morse is the medical director of health and social care organisation Turning Point, www.turning-point.co.uk

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Unless you have a young male family member who is repeatedly stopped and searched, it is difficult to appreciate the bitterness it causes... The striking thing is that some policemen, and their apologists, remain so invested in non-evidence-based stop-and-search when they know that only 9 per cent of such stops result in arrests (mostly for small amounts of cannabis), and they also know how damaging it is for police-community relationships.
Diane Abbott, *Guardian*, 2 May

If [Peaches Geldof's] post mortem had discovered a fatal heart condition or cancer, we would be entitled to our sadness. But when the lethal blow is dealt by the more insidious hand of heroin, then the deceased is judged to be unworthy of our compassion. It's a heartless position, wholly devoid of human empathy.
Lucy Hunter Johnson, *Independent*, 2 May

When I read in the papers about what Peaches did – or indeed anyone in the grip of this foul disease – the thing I'm always careful to remember is that it's not them. It's the addiction. Somehow the Addiction God kidnaps their ability to think or behave rationally.
James McConnel, *London Evening Standard*, 2 May

All of us who are sober today had to fall down – often many times and before anguished eyes. We had to hit the ground hard enough to be willing to stand up. And for all that pain, we were the lucky ones. Philip Seymour Hoffman, Cory Monteith and everyone who dies each day from alcoholism and addiction remind us just how lethal this disease is.
Bill Clegg, *Guardian*, 9 May

Drug addiction is a terrible thing, but it is not a disease.
Jan Moir, *Mail*, 2 May

If the argument that e-cigarettes will ultimately lure kids into smoking seems specious, I suspect that's largely because the one thing that smoking an e-cigarette definitely doesn't do is make you look good... If an aura of cool has somehow clung to cigarettes despite the best efforts of anti-smoking campaigners – despite the fact that the most visible pro-smoking campaigner in Britain is currently Nigel Farage, a man with all the insouciant cool of a toddler on a bouncy castle – then the opposite seems to be true of e-cigarettes.
Alexis Petridis, *Guardian*, 5 May

In an imperfect world, but one where the effects of smoking comprise a large threat to the health of the nation, we should act on the balance of probabilities – which is that e-cigarettes cut smoking. Like health education, the ban in pubs and high taxation, e-cigarettes are part of the answer.
Independent editorial, 20 May

Three out of four serious offenders are now walking out of court saddled only with community orders, fines or suspended sentences... The liberals whose malign influence still dominates our criminal justice system spew out all sorts of nonsense about why prison is such a terrible idea, but the facts are clear.
Stephen Pollard, *Express*, 17 May

CAPTURED ON CAMERA

A roving Recovery Street Film Festival aims to change public perceptions of addiction, as the organising team explains

THIS SUMMER will see the launch of the inaugural Recovery Street Film Festival. Organised by a consortium of treatment providers including Phoenix Futures, Turning Point, CRI, Blenheim and Action on Addiction, supported by Public Health England (PHE) and DrugScope, the festival aims to celebrate and promote recovery from substance dependency.

The festival will hit the streets in September, starting in London and moving to several major cities in the UK, and will be hosted online at www.recoverystreetfilmfestival.co.uk. The festival is now open for submissions and we are encouraging anyone directly or indirectly affected by addiction to make a short film (maximum of three minutes) about aspects of addiction and, more specifically, recovery.

Statistics from PHE show that 29,025 people successfully completed their treatment programme in 2012-2013. That is 29,025 people on their recovery journey, and the festival organisers are encouraging all past and present service users, their friends and families and drug and alcohol service staff to take a full and active part in Recovery Street. Working in the substance misuse field we know that there are many misconceptions about substance misuse and that a lot of stigma still exists. Recovery Street is an opportunity to take a closer look at recovery, express the issues involved in substance dependency and celebrate and promote individual stories of recovery.

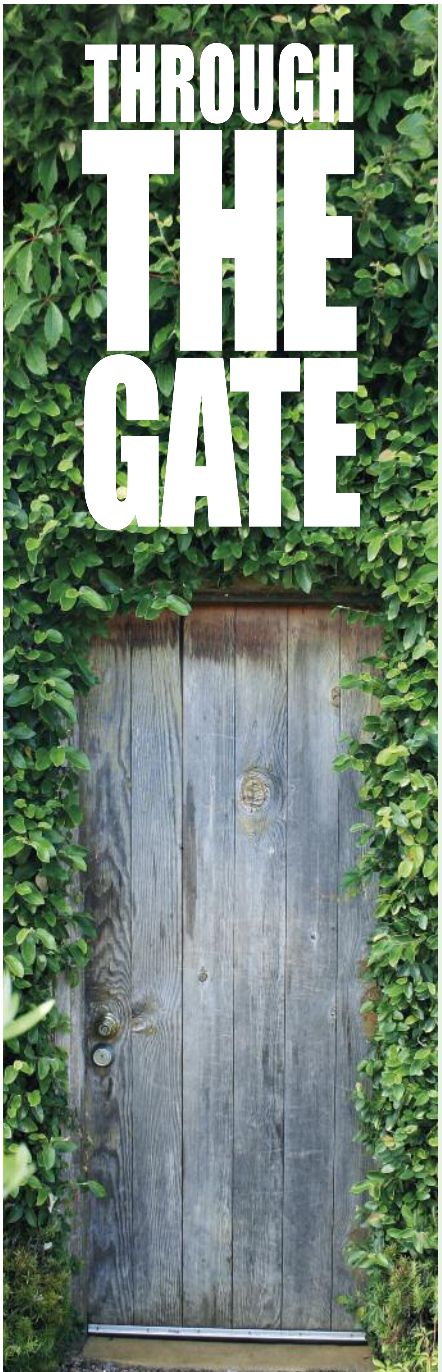
At the heart of the Recovery Street Film Festival is the desire to challenge and change public perceptions about substance misuse. Its theme, 'Deserving a Future', focuses on those living in recovery and meeting the challenge of finding a place in society. We want to demonstrate through the medium of film the diverse issues that are faced by people overcoming addiction and how those around them can be affected. We would like the three-minute films to make an immediate impact on the audience and as such, apart from the need to focus on recovery, there are no restrictions on creativity. Films can be short dramatic plays using actors, drawn or stop-frame animation, documentary-style pieces, or simply personal stories. We want the films to show a different side to the story of addiction – one that shows a true picture of the determination, commitment and courage that is required to face the challenge of starting life afresh.

A panel of film professionals will select the official festival films, including Sylvia Harvey, founding member of the Sheffield International Documentary Festival and visiting professor at the Institute of Communications Studies, University of Leeds, and David Cohen, psychologist, writer and documentary filmmaker. These will be shown at a 'pop-up' Recovery Street cinema in a number of major UK cities during September.

Members of the public will be invited to stop and view one or more of the films and encouraged to seek out more films online. As well as a panel award for the most original and imaginative approaches to telling stories of addiction and recovery, there will be a public vote award to determine the winners and highly commended films.

Film submissions not shown as part of the festival will be hosted online, alongside the official festival films, to create a library of insight and education around addiction and recovery.

You can find out more about the Recovery Street Film Festival on our website http://www.recoverystreetfilmfestival.co.uk/ or you can follow the action on Twitter at #RecoveryStreet



THROUGH THE GATE

Sue Reynolds, the clinical lead of substance misuse at HMP Littlehey, tells DDN about joining the growing number of prisons to introduce a life-saving take-home naloxone programme for prisoners upon release

HMP/YOUNG OFFENDER INSTITUTE (YOI) LITTLEHEY is a purpose-built category C prison which holds convicted and sentenced adults and young adults. The average number of patients engaged in substance misuse treatment is typically around ten to 15.

The treatment regime for substance misuse was based on a recovery-focused approach and risks at release for these patients were high due to social and economic pressures, including their home situation, family support and employment. The highest risk was that they would have developed a low or zero tolerance to opiates/substances as a result of having been stabilised during custody, and so would be at an increased risk of overdose when released.

The local service provider had initiated a take-home naloxone programme, and so there was already support for these patients as they returned to the community. For these reasons, we wanted to initiate a programme within the prison.

The task was to gain agreement from the governor of HMP/YOI Littlehey and other senior staff for a take-home naloxone programme to be introduced, allowing for patient training to be undertaken and naloxone to be available 'at the gate' upon release back into the community.

Initially the idea of implementing the programme was made a reality by free training provided by Nina Bilbie, a Prenoxad representative. The appointment was set up by myself, with the full support of Dr Ruth Bastable, GPwSI prescriber for substance misuse treatment. Follow up meetings between myself, Nina and Ruth were key to identifying and overcoming the barriers to implementation. It turned aspiration into reality.

A needs assessment, which allowed objectives to be clearly defined, and a working plan to ensure that all boxes were ticked, needed to be in place. The Prenoxad protocol was adapted to reflect what HMP/YOI Littlehey would be delivering, and due to the small numbers, it was agreed that a patient group directive (PGD) would not be required and each prescription would be generated to the named patient on an FP10 prescription.

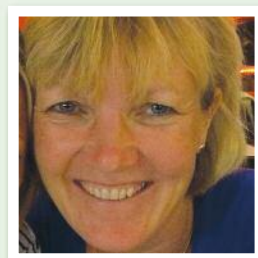
A business plan proposal was put together, using the support and information provided by Prenoxad, and presented at the drugs and therapeutics/medicines management meeting to the governor and other senior staff, including the lead chief pharmacist managing the prison. They were very supportive and due to the small numbers involved, the costs were minimal, which contributed to the positive outcome of the idea.

Training was delivered both to the clinical healthcare staff and non-clinical, psychosocial drug and alcohol recovery team (DART) workers in the prison, and a prison training package for patients was also developed. A DVD and sample syringes, needles, algorithm and instruction packs were supplied by Prenoxad. Training was provided by the substance misuse lead on a one-to-one basis with the prisoner, as well as a training evaluation checklist.

It was important to ensure there was a pathway in place for purchasing and accessing the naloxone. The source supply is as and when required for a prisoner's release on an FP10 prescription, and the local pharmacist supplies it. The naloxone is given at reception upon release, and signed for by the prisoner and the nurse dispensing it. A letter is also presented at the gate, asking the prisoner to send it in if the naloxone is used and providing information on the circumstances.

The plan has been successful due to the large amount of people offering positive support and having the motivation to take it forward. The key factor was that shared expertise was available and easily accessible. The same commissioners (the DAAT) who provide the Inclusion programme both within the prison and the local community also commission and provide the clinical substance misuse treatment services in the prison. The GPwSI working within the prison also provides for the local community, and all key players involved were in agreement for the plan to be implemented. This was running concurrently with the community service providers who were initiating the same implementation plan.

There were no huge obstacles or barriers to overcome, as the support was there from the head of healthcare, the governor and the chief pharmacist. The materials provided by Prenoxad were excellent and enabled things to happen very quickly, while the protocol was easily adapted to reflect local practice.



'There were no huge obstacles or barriers to overcome, as the support was there from the head of healthcare, the governor and the chief pharmacist.'

SUE REYNOLDS

The patients thought it was an excellent idea – they were very keen and appreciative that this was available to them and it made them feel empowered and supported. It has been included in the programme delivered on the drug recovery wing as part of the first aid and overdose session, and the prisoners who have had training have felt it has boosted their confidence in being able to manage an opioid overdose situation.

To be able to have naloxone injections available for prisoners being released is a huge breakthrough for drug treatment intervention in the prison setting. It takes away some of the worry of releasing vulnerable people into the community with a high risk of overdose. It has been a fantastic achievement and I was provided with tremendous support from colleagues. I hope this initiative continues to spread nationwide with little resistance – if it is available in the community, it can be made available within secure settings too.

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Invitation

OXFORDSHIRE COUNTY COUNCIL

NEW INTEGRATED DRUG AND ALCOHOL SERVICES IN OXFORDSHIRE

INVITATION TO A MARKET PLACE DEVELOPMENT DAY – FRIDAY 20TH JUNE –

10.00am-12.30pm – followed by lunch and optional visits to services in the afternoon

At: The Kings Centre, Osney Mead, Oxford. OX2 OES

Oxfordshire County Council Public Health Directorate would like to invite potential providers and interested parties to a market place development day on the 20th June 2014. The day will provide you with an over view of Oxfordshire, our challenges, our needs and our vision.

Our vision is to integrate drug and alcohol services in Oxfordshire and have one prime provider to take the contract lead working with a variety of other providers to build and develop asset based treatment services and a robust recovery community.

The contract will be high value in the region of £5 million per annum.

The service will provide clinical and non-clinical treatment for drug and alcohol addiction, advice, information, early intervention, wrap around services, family services and meet the challenge of new psychoactive substances and deliver differential services across a large rural county

We don't want a 'one hat fits all' approach to drug and alcohol misuse and addiction, but want to work with innovative forward thinking providers to co design and develop world class service provision.

You will able to meet a wide variety of providers large and small, from housing to education training and employment, mental health and drugs and alcohol sectors. It will be an opportunity to network and make connections and visit current services.

For further details and to register your attendance please contact Anne Johnson on 01865 328607 or email anne.johnson@oxfordshire.gov.uk.
Early registration is encouraged.

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As part of our new North West Through The Gate Pilot we require:

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Providing support for the project, including the coordination of prison releases and pick ups, date collection and reporting and office admin.

NETWORK COACH

Full-time, £20,000 – £23,256 pa
The post holder will be responsible for overseeing a team of recovery coaches and telephone support volunteers.

For more information or to apply email shahroo@emerginghorizons.org