TRAINING AND DEVELOPMENT DIRECTORY INSIDE

DDN
Drink and Drugs News
www.drinkanddrugsnews.com
ISSN 1755-6236 October 2012

G.I. BLUES

US INITIATIVES TO SUPPORT MILITARY VETERANS

NEWS FOCUS
Will Public Health England and a new ministerial team help to refocus drug and alcohol policy? p6

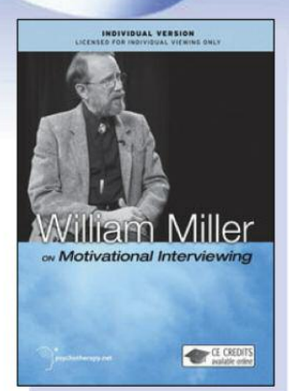
HOT TOPICS
'Meeting people where they're at' – the vital essence of harm reduction p16

PROFILE
The head of Philadelphia's addiction services on seamless support for the vulnerable p18

Motivational Interviewing

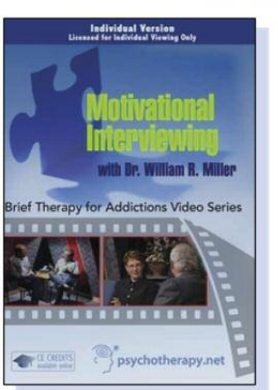
Save £10

Learn from the Founder!

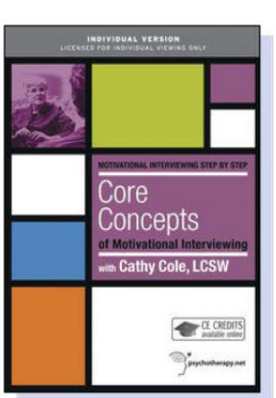


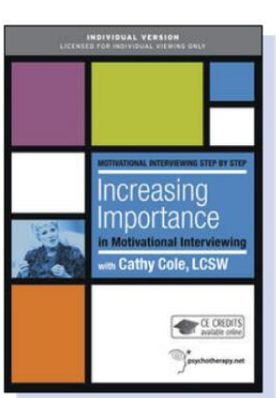
PsychotherapyDVDs.com
is proud to present a brand new release:
William Miller on Motivational Interviewing

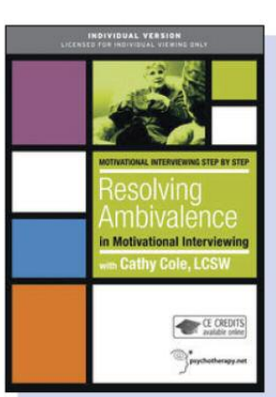
Also by William Miller:
Motivational Interviewing in Brief Therapy for Addictions Video Series

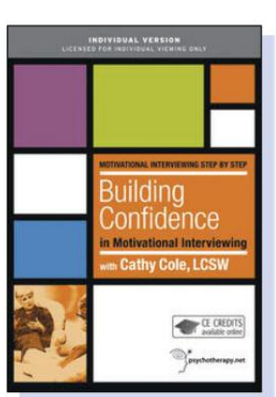


Brand new 4 DVD set: **The most detailed video training on Motivational Interviewing to date!**
Best seller in USA – now available in UK for the first time:









Readers of "Drink & Drug News" can **save £10** on **ALL** their orders during the month of October 2012.

Simply use the coupon code DDN1012 on the checkout.

www.psychotherapydvds.com

DDN Drink and Drugs News

Published by CJ Wellings Ltd,
57 High Street, Ashford,
Kent TN24 8SG

Editor: Claire Brown
t: 01233 637 359
e: claire@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Advertising Manager:
Ian Ralph
t: 01233 636 188
e: ian@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Publishing Assistant:
Kayleigh Hutchins
t: 01233 633 315
e: kayleigh@cjwellings.com

Subscriptions:
t: 01233 633 315
e: subs@cjwellings.com

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

Printed on environmentally friendly paper by the Manson Group Ltd

Cover montage: JelliPics

Editorial – Claire Brown

Frontline support

Uniting to find the hidden harmed

Many services commissioned by local authorities failed to ask if the individual accessing them had served within the armed forces. This comment from Tony Wright (cover story, page 8) is striking in its simplicity and revealing in its explanation of why so many veterans find themselves struggling alone to adapt to life back in the civilian community. It's an issue that comes up regularly in Parliamentary circles; maybe our case study from the US veterans court can inspire a different – and more humane – approach that reflects respect and gratitude as well as service provision.

In this month's profile (page 18), Roland Lamb shares another vision of supporting vulnerable people. 'One in every 100 Americans is incarcerated... we have broken families... a lot of fragmentation all over the place.' Once again tackling this starts with communication, getting substance and mental health services to integrate so they can reach out effectively. It's a cohesive ethos that many UK services are doing their best to foster in an attempt to reach society's most vulnerable. Adfam has addressed the difficult area of child to parent abuse through a new report (page12, 13) and Cinzia Altobelli (page 15) looks at ways to support clients who are victims of all kinds of domestic abuse. By tackling taboos together, the hidden harmed stand half a chance.

This issue

FEATURES

6 **NEWS FOCUS**
Will Public Health England and a new ministerial team help to refocus drug and alcohol policy, or are they empty exercises in rebranding? DDN reports.

8 **A VETERAN PERFORMANCE – *COVER STORY***
Tony Wright visits an inspiring US initiative to divert military veterans with substance issues away from the criminal justice system, and contrasts the lack of support here.

11 **NEW ERA**
A lot has changed since the advent of the CQC and there are more changes on the way. David Finney explains what services can expect in the coming months and years.

12 **THE LAST TABOO**
More support is needed for victims of abuse perpetrated by their children, says Oliver Standing.

15 **JOINING FORCES**
New partnership-led training aims to help victims of domestic abuse incidents where substances are an issue, says Cinzia Altobelli.

16 **IT'S WHERE YOU'RE AT**
Harm reduction should be about 'meeting people where they're at', according to the recent HIT *Hot topics* conference. Jamie Bridge reports.

18 **LIBERTY TO CHANGE**
Philadelphia is integrating its substance and mental health services to provide seamless support for vulnerable people. David Gilliver talks to its director of addiction services, Roland Lamb.

20 **SPREADING THE EVIDENCE**
Grace Ball reports back from the UK Recovery Academy's recent Manchester conference.

REGULARS

4 **NEWS ROUND-UP**: North West tops alcohol-related liver deaths • Scots hit treatment wait targets early • fall in Bolivian coca cultivation • Second fatal anthrax case in Blackpool • News in brief.

7 **POST-ITS FROM PRACTICE**: Recovery should only be defined by the individual, says Dr Steve Brinksman.

7 **MEDIA SAVVY**: Who's been saying what..?

10 **LEGAL LINE**: release solicitor Kirstie Douse answers your questions. This issue: should old convictions count?

10 **LETTERS**: New rules could reinvigorate the public consultation process, says Marcus Roberts.

13 **ENTERPRISE CORNER**: Recovery must reach every member of the family, says Amar Lodhia.

13 **FAMILY MATTERS**: How do we respond appropriately to child to parent violence, asks Joss Smith.

17 **POLICY SCOPE**: The mantra of drug policy failure is drowning out our successes, says Marcus Roberts.

21 **VOICES OF RECOVERY**: Harnessing the strengths of individuals shows the power of community-led recovery, says Alistair Sinclair.

22 **MY JOURNEY OF SELF-RECOVERY**: In the second part of her story, Marie Tolman finds herself falling deeper into addiction and has her first brush with the law.

23 **SOAPBOX:** We must learn to balance risk and freedom, says John Ashton.

THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES AND TENDERS

CENTRE PAGES: AUTUMN TRAINING DIRECTORY

NEWS IN BRIEF

CRISIS TALKS

Harm Reduction International's (HRI) 23rd international conference will be held in Vilnius, Lithuania, on 9-12 June 2013. The event – which is being organised in partnership with the Eurasian Harm Reduction Network – will look at the urgent need for political and financial support to address the HIV epidemic being driven by injecting drug use in many parts of the world, as well as 'the ethical basis of the harm reduction philosophy'. *Visit www.ihra.net/conference for more information.*

OPEN DOOR POLICY

Alcoholics Anonymous is inviting treatment staff, doctors and other medical professionals to attend its open meetings throughout November, with the aim of providing a greater understanding of how the fellowship works. *Open meetings are listed at www.alcoholics-anonymous.org.uk – to attend call 020 7833 0022 or the national helpline on 0845 769 7555.*

FAMILIAL EXPRESSION

Adfam has launched its annual writing competition for families affected by substance use. Entries for Family Voices 2012 – which should be a maximum of 500 words – can be emailed to familyvoices@adfam.org.uk or posted to Adfam, 25 Corsham Street, London N1 6DR. The winner will receive £150, two runners up will receive £100 each and all will be able to see their winning entries presented by a celebrity guest at the Adfam carol concert in December.

BENEFIT BOOST

Action on Addiction has been awarded a three-year grant by international risk specialist and employee benefits consultant group Jardine Lloyd Thompson (JLT). The money will be invested across the organisation's treatment and family support services and will also help fund training. JLT will also work alongside Action on Addiction to pilot workplace awareness schemes and look at how businesses can support employees affected by addiction. 'The workplace is an important, but currently under-utilised, channel for addressing misunderstandings about addiction and providing people with information and support,' said Action on Addiction chief executive Nick Barton. Action on Addiction has also launched the annual Merseyside Recovery Awards, to be held at flagship social enterprise and 'dry' bar, The Brink (*DDN*, December 2011, page 12) on 27 October. *www.recoveryawards.co.uk thebrinkliverpool.com*

QUESTION THE COUNCIL

The Advisory Council on the Misuse of Drugs (ACMD) is holding an open meeting in London on 11 October, with attendees able to put their own questions. *Places will be allocated on a first come, first served basis – registration forms at www.homeoffice.gov.uk/agencies-public-bodies/acmd*

North West tops alcohol-related liver deaths table

Rates of premature death from liver disease are higher in the North West than anywhere else in England and are also increasing at a faster rate, according to a report from the North West Public Health Observatory. Rates of premature mortality from liver disease in the region in 2010 were nearly double those in 1995, says *Burden of liver disease and inequalities in the North West of England*.

The peak ages of liver disease death in the North West are 55-64 years for both men and women, with alcohol-related liver disease accounting for the greatest proportion. Death rates from alcohol-related liver disease were also highest in the region's most deprived local authority areas.

Prevalence of hepatitis C among injecting drug users also remains higher in the North West, with hospital admissions for hepatitis C increasing from less than 3,000 in 2005 to almost 5,000 in 2010. Admission rates among males were double those among females, with 75 per cent of all cases the result of sharing contaminated injecting equipment.

The report is also unlikely to do justice to the 'full burden' of liver disease in the region, it adds, as hospital admission data 'represent the most severe cases of liver disease and do not include people treated in primary care or outpatient departments where the majority of people with liver disease are treated'.

'The premature and avoidable mortality' caused by liver disease as well as the gap between the North West and the rest of England 'indicate the scale and urgency of the problem,' the report concludes, calling for liver disease action to be made a priority for the region's commissioners. It also wants to see better strategies for early diagnosis, improved surveillance to address information gaps and better use of local intelligence to target the populations most at risk. Prevention efforts should also target groups 'whose current behaviours put them at risk of progression to chronic liver disease', such as young women, it states.

Meanwhile, a new report from the Children's Commissioner states that more than 2.5m children in the UK are living with a hazardous drinker and more than 700,000 with a dependent drinker. Just over 950,000 children live with at least two binge drinkers, says *Silent voices: supporting children and young people affected by parental alcohol misuse*, while just under 460,000 live with a lone parent who is a binge drinker.

Children living with parental alcohol misuse come to the attention of services later than children living with parental drug misuse, says the report, and the true size of the problem 'remains unknown'. The document calls for more policy focus on 'the wide group of children in need of support as a result of parental alcohol misuse' rather than just those in need of protection, as well as policies and strategies that 'take into account the impact on children who may be affected by a range of levels of parental alcohol consumption and not just dependent drinkers'.

The links between parental alcohol misuse and domestic violence also need to be taken into account in policy development at local and national level, it says, while the new health and wellbeing boards must make sure that parental alcohol misuse is well understood in their area.

'Children living with parental alcohol misuse come to the attention of services later than children living with parental drug misuse, and the true size of the problem "remains unknown".'

The report signalled 'a growing awareness amongst policy advisors that you don't have to be addicted to a substance to suffer from alcohol or drug misuse', said Action on Addiction chief executive Nick Barton, while Turning Point said it highlighted the need for better information. 'We are aware that the provision of services for families for alcohol misuse is patchy and we know that this needs to change,' said director of substance misuse services Jackie Kennedy. 'For us the key lies in replicating services that have already proved effective; focusing on family focused substance misuse services, partnership working and home-based services for families. We need more services to meet the needs of parents to prevent a new generation of children at risk of poor mental health, drug and alcohol addictions, truancy and worse.'

Burden of liver disease at www.nwph.net/nwpho
Silent voices at www.childrenscommissioner.gov.uk

Scots hit three-week treatment wait targets early

Ninety per cent of people in Scotland who start treatment for a drug or alcohol problem are waiting three weeks or less, according to figures from IDS Scotland. The Scottish Government's deadline for achieving the three-week target under the HEAT (Health improvement, Efficiency, Access to services and Treatment) initiative was March 2013.

The statistics, which relate to people who started their first treatment between April and June this year, were 'a tribute to the work done by alcohol and drugs partnerships, health boards, charitable organisations, volunteers, families, and many others', said community safety minister Roseanna Cunningham. 'In 2007 we inherited waiting times of over a year and have turned that into a maximum three-week wait, nine months ahead of our target.'

The figures represented 'a great achievement by services in ensuring that access to help is available as early as possible,' said Scottish Drugs Forum (SDF) director David Liddell. 'We know that often levels of motivation to seek help among problem drug users can fluctuate, and it is therefore crucial that if people do come forward for help it is available straight away. We also know that this is only the start of a recovery journey which can be long and very challenging. So we not only need services which are easily accessible but also services which can build a long-term therapeutic relationship and respond to people as individuals – the challenge is to ensure quality and accessibility.'

However there was 'still more that can and will be done,' said Cunningham. Recent figures recorded more drug-related deaths for Scotland in 2011 than in any previous year, and an increase of 20 per cent on the previous year (*DDN*, September, page 4). Methadone was 'implicated in, or potentially contributed to' 47 per cent of the deaths, which – although it was unclear how many of those who died had actually been prescribed the substitute medication – has led to stories and editorials in parts of the Scottish press critical of substitute prescribing (see *Media Savvy*, page 7) as well as calls for a parliamentary inquiry.

Quarterly drug and alcohol treatment waiting times figures for April to June 2012 available at www.isdscotland.org

'Significant fall' in Bolivian coca cultivation

Coca bush cultivation in Bolivia has fallen by around 12 per cent, according to a monitoring survey by the United Nations Office on Drugs and Crime (UNODC) and the Bolivian government.

The area under cultivation for coca plants – which yield the leaf used to produce cocaine – fell from 31,000 hectares in 2010 to around 27,000 in 2011, with coca leaf prices rising sharply as a result.

Bolivia and Peru supply most of the cocaine sold in Europe, while Colombia primarily supplies the US. Earlier this year, UNODC reported that the total world area under coca bush cultivation fell by 18 per cent in the three years to 2010, mainly as a result of declining production in Columbia (*DDN*, July, page 4). Opium production in Afghanistan, meanwhile, had 'rebounded' to its previously high levels following almost half of the 2010 crop being wiped out by plant disease, with prices rising as a result.

'Higher prices are making coca more attractive, but farmers need viable long-term alternatives if we are to curb illicit crop-growing,' said UNODC representative in Bolivia, Cesar Guedes.

2011 national coca monitoring survey at www.unodc.org

Second fatal anthrax case in Blackpool as Wales confirms new infection

A person who injected heroin has died in hospital in Blackpool from anthrax infection, the Health Protection Agency (HPA) has confirmed. The death occurred three weeks after another fatal anthrax case in the town (*DDN*, September, page 5), and public Health Wales also confirmed that a Gwynedd drug user has been hospitalised with an anthrax infection.

There have been ten confirmed cases across Europe since June – three in Germany, two each in England and Denmark and one each in France, Scotland and Wales, although only the English cases have been fatal. The HPA is continuing to monitor the situation, but says it remains 'unclear' whether the UK cases are linked to those in mainland Europe.

Emergency departments and walk-in clinics have been alerted by the Department of Health about the possibility of people presenting with anthrax symptoms, and the NTA has been circulating posters and leaflets to treatment centres and other organisations in touch with drug users, such as needle exchanges, community pharmacies, housing departments, hostels and benefits offices.

'It's likely that further cases among people who inject heroin will be identified as part of the ongoing outbreak in EU countries,' said expert in blood-borne viruses at the HPA, Dr Fortune Ncube. 'The HPA is warning people who use heroin that they could be risking anthrax infection. We urge all heroin users to seek urgent medical advice if they experience signs of infection such as redness or excessive swelling at or near an injection site, or other symptoms of general illness such a high temperature, chills, severe headaches or breathing difficulties. Early treatment with antibiotics is essential for a successful recovery.'

NEWS IN BRIEF

HOMELESS HELP

Funding to help people facing 'the real and frightening prospect' of homelessness will continue until the end of the current Parliament, housing minister Grant Shapps has confirmed, with councils across the country receiving a share of £160m in homelessness prevention grants over the next two years. The government's *Making every contact count – a joint approach to preventing homelessness* document drew criticism recently from homelessness organisations in the light of ongoing welfare reforms (*DDN*, September, page 6). A new website and phone line to provide help for people sleeping on the streets will also be operative by Christmas, said Shapps. In the meantime, Homeless Link has relaunched its website offering information and links to services for people at risk of homelessness in the capital. 'Our research has shown that almost half of those who sleep rough will not have had any contact with services before they end up on the street,' said Homeless Link chief executive Rick Henderson. *www.homelesslondon.org*

GUIDING LIGHT

New guidance from the Royal College of General Practitioners and the Royal College of Psychiatrists sets out the medical competencies necessary for doctors working with people with drug and alcohol issues. Services need to make sure they employ teams with the right mix of clinical expertise and skills, says *Delivering quality care for drug and alcohol users: the roles and competencies of doctors*. The guide identifies levels of competency for addiction psychiatrists, GPs with special interests or extended roles, and doctors and GPs in emergency departments. *Available at www.rcpsych.ac.uk*

VIRTUAL TREATMENT

Swanswell has partnered with the University of Reading to develop virtual reality software to encourage behaviour change in people with substance use problems. Clients use a virtual reality headset to access computer-generated scenes, each of which allows them to make different decisions. The aim of the technology – showcased at a recent conference in France – is to identify triggers for alcohol or drug use and help people develop coping skills. 'Swanswell believes that virtual therapies such as this can play a big part in the treatment and recovery of many more of those affected by substance misuse in the future, so we're really excited about using more of this technology,' said project lead Liam North.

IS A GENUINE PUBLIC HEALTH FOCUS FOR DRUGS AND ALCOHOL ON THE HORIZON?

Will Public Health England and a new ministerial team help to refocus drug and alcohol policy, or are they empty exercises in rebranding? ***DDN*** reports

Amid the gasps that greeted the news that David Cameron had used his cabinet reshuffle to appoint Jeremy Hunt as health secretary – 'Wow,' said the *Independent*'s Matthew Norman, 'that's somethin' else' – few noticed that Anna Soubry had replaced Anne Milton as parliamentary under secretary of state. At least that was the case until her comments about assisted suicide led to her being branded a 'train wreck' and the knives coming out in the press.

The *Daily Mail*'s Melanie Phillips, however, chose a different line of attack. She branded Soubry a 'drugs policy liberaliser', based on comments made to a group of sixth formers six years ago – before Soubry was even an MP – that in an open debate the students would likely conclude that 'certain types of cannabis are less harmful than alcohol and tobacco' – an 'idiotic and dangerous view', said the *Mail*.

When the column was published it was undecided which minister would be given the drugs brief, although Phillips stated that, if those were still Soubry's views, giving her any health brief would signal 'a truly dire absence of due diligence'. In fact – after a few days when it looked as thought the brief would go to Dan Poulter – it was confirmed that Soubry's portfolio does include drugs and alcohol.

Some in the sector had been hopeful about Poulter's potential appointment, as he had done work on behalf of disadvantaged populations in his capacity as a GP. Whether Soubry does turn out to be a 'liberaliser' remains to be seen but as her brief also includes 'relationship with Public Health England, [the] public health system and finance', could we be looking at a new era characterised by a genuine public health approach to substance issues, or is the switch to Public Health England nothing more than a change of name?

'I am optimistic,' says Gerry Stimson, former Harm Reduction International (HRI) executive director and now programme director for *City health 2012*, a conference organised by the London Drug and Alcohol Policy Forum (LDAPF) to be held later this month. 'To have a body called Public Health England sends a strong message that drugs, alcohol and related issues need to be dealt with in a cross-cutting way. It's all still shaping up, but certainly the intent is there – that you need to join up the health, welfare and social responses – and that's good.'

The conference will provide an opportunity to question Public Health England chief executive Duncan Selbie, while its overall aim is a broadening of approach, says Stimson. 'The way things are beginning to shape up with Public Health England, it's interesting to look at health issues in a cross-cutting way. The conference aims to explore a lot of the good things in the public health arena that are done at a city level, often *despite* what's going on at a national level.'

One example is around housing, he says. 'There is growing evidence that if you can sort out people's housing needs then the drug and alcohol aspects sort of fall into place, so initiatives like Housing First are interesting. Obviously it's a long way off yet, and it's a bit optimistic because there's such a shortage of housing in this country, but it's a step in the right direction. Alcohol is also an interesting example – you can argue for taxes to go up, or for laws to change, but what do you do now on a day-to-day basis at a city level to reduce nuisance and harm?'

Alcohol treatment has historically been seen as the poor relation to drugs, and while NTA chief executive Paul Hayes told delegates at *DDN*'s *Seize the day* conference that the move to Public Health England offered the chance to 'right this historic wrong' (*DDN*, 7 March 2011, page 10), others worry that the shift – when combined with spending cuts and changes in commissioning – just adds to overall uncertainty about the future of service delivery. There are also concerns, as Hayes himself conceded, that not all directors of public health will see drug and alcohol treatment as a priority for their area.

Despite treatment funds no longer being ring-fenced, expectations for service delivery will remain, which will 'add some uncertainty', says Stimson. 'It's like saying "you can do what you like with the money but you still have to deliver X". We need to keep the right balance between public health and treatment needs. We need to ensure that public health protection continues – needle exchange, HIV testing, hepatitis C testing, overdose prevention – we need the mixed package. That's the message that's got to come through, and there will be a steep learning curve at local authority level. It's keeping the balance of public health protection and individual treatment needs.'

Ultimately, however, the fact that Public Health England will be around at time when the rest of the health service is undergoing such a dramatic overhaul can only be a good thing, he believes. 'I hope it keeps a public health vision alive and prominent. In a way it's going back to a much earlier version of public health, when it was the municipal authorities who had the responsibility rather than the health authorities.'

Yui Mok/PA Wire

'Few noticed that "drugs policy liberaliser" Anna Soubry has replaced Anne Milton as parliamentary under secretary of state.'

As co-founder of the Public Health Alliance Geof Rayner told *DDN*'s *Together we stand* conference earlier this year (*DDN*, March, page 9), 'It's back in local government now. How well this works will be down to you making your case.'

City Health takes place in London on 22-23 October www.cityhealth.org.uk

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

As for Jeremy Hunt's promotion to Health Secretary, all you can really do with that bombshell is borrow from the late Sidney Vicious, and indeed the even later Eddie Cochran, and mutter an awed, 'Wow. That's somethin' else.'
Matthew Norman, *Independent*, 5 September

As Jeremy Hunt has not proved to be a particularly adept minister, and such plaudits as he might try to claim have been overshadowed by the BSkyB fiasco, the question is why he should be put in charge of a huge and unfamiliar department. There he will have to push though complex and controversial reforms introduced by his predecessor Andrew Lansley, who, whatever his shortcomings, had at least studied the NHS for seven years. It's all mystifying... No minister in recent times has behaved so badly in office and survived, and I am including in that judgment several New Labour scoundrels.
Stephen Glover, *Daily Mail*, 5 September

Drug addicts are selling NHS methadone to buy the heroin it's meant to wean them off. Hundreds have died taking methadone sold by addicts in a taxpayer-funded cycle of misery. Victims include angel-faced Danielle Scott, 17, who was fed the heroin substitute by a dealer who got gallons of it on prescription.
Daily Record news story, 4 September

Successive governments knew that when they poked at the nasty little methadone problem, the stench would be overwhelming. This is a story of short-termism, apathy and concealing the truth of what has been a strategic blunder. In every war there are profiteers, and the war against addiction is no different. Chemists, doctors and drug companies got fat as the addicts got skinny.
Annie Brown, *Daily Record*, 7 September

Breaking the link between benefits and living standards would be no less than breaking the link with decency. In hard times the values of a civilised society must ensure the most vulnerable families are protected.
Alison Garnham, *Guardian*, 18 September

Prohibition is a relatively recent social experiment, an extremely dangerous failure, and should be dismantled as soon as possible.
Howard Marks, *Guardian*, 1 September

The 40-year publicity campaign for dope, provided gratis by dozens of rock stars (who can flourish however stupid they are), has been so effective that 13-year-olds who smoke it do not even think it is a drug. And untold numbers of criminal parasites make a tidy living by running chains of hydroponic cannabis farms in the attics of suburban houses. In fact, it is one of Britain's few agricultural success stories of modern times.
Peter Hitchens, *Mail on Sunday*, 2 September

Music festival casualties rub cheek by jowl with middle class girls who have ditched their smart clothing and opted for car boot sale chic in order to catch the eye of edgy musicians. These girls who will have friends, fathers, brothers – boyfriends even – in the armed forces and so inevitably will be or have already served in Afghanistan declare themselves 'starstruck' by these heroin addict music 'stars'. Heroin addiction helps fund the Taliban. It helps fund people who kill and maim our troops.
Annabelle Fuller, *Daily Mail*, 11 September

Post-its from Practice

The three Rs

It's all about the right treatment, at the right place, and the right time, says Dr Steve Brinksman

There are many things I love about being a GP but above all I value the long-term relationships I have with my patients. The other night while doing a routine surgery session, I recognised the name of a man on my list who was booked in to have a minor cyst removed.

Dave and his partner Sarah had been using heroin for a number of years when they first joined our practice a while ago now, because they had heard we treated substance misuse in primary care. In fact at the time they joined us we had the slightly bizarre situation that the practice was only accepting new patients if they used heroin!

They engaged well in treatment and both managed to stop using heroin on top of their script, and that was as far as it went for a couple of years. They had a daughter who was about eight at the time when Dave and Sarah came in to see me together one day. They had decided that they wanted to be not only heroin free but also off prescribed opiates. We discussed the various options and it was obvious that they felt a residential rehab programme incorporating a detoxification was the right way forward. Sarah's mother lived locally and would provide childcare, so through our primary care based key worker all the paperwork was done and a place was arranged for them.

They had a date to go in and all was in place, scripts cancelled, no further appointments with the drug worker or me till they returned. Two weeks later Sarah came in for an emergency appointment. She had been unable to cope with being apart from her daughter and had discharged herself, although Dave had decided to stay. She was still determined to become opiate free but had realised that what she thought was the right option to pursue this goal would not work for her. We restarted her methadone prescription and devised a slow reduction programme. She found this worked for her and was proud of her ability to cope with both caring for her daughter and reducing her prescribed medication.

Dave found the support offered by the rehab facility invaluable and stayed for the full six months. By the time he returned Sarah was on 8mls of methadone daily and a month later she had stopped all prescribed opiates.

The family remain patients on our list and Dave and Sarah remain drug free. Dave has been promoted at work and their daughter does her GCSEs this year. For me the joy of treating people in primary care is that not only could we find an option that suited each of them, but also unless patients move away, I will in all probability see them again.

Recovery happens in primary care, sometimes with patients who stay with us, sometimes with those who go away to other treatment systems. We should be proud of these patients – as I am of Dave and Sarah – and yet accept each person is different.

We're equally as proud of the progress that Dave's brother, who remains on a methadone prescription, has made. Rehab didn't work for him and he felt safer with a longer term prescription. I haven't given up on regularly discussing options for change with him, but he doesn't feel ready yet; that is his decision to make, not mine. If he decides it's time for a change again, I and the rest of the practice will help him, but till then we will keep him as safe as we can.

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

A VETERAN performance

Tony Wright visits an inspiring US initiative to divert military veterans with substance issues away from the criminal justice system, and contrasts the lack of support here

In 2011 I was lucky enough to be the recipient of a Winston Churchill Memorial Trust travelling fellowship, which enabled me to travel to the USA for a six-week period to study services available to ex-service personnel who had slipped through the welfare safety net. I wanted to learn from the veteran-centric support services that developed following the Vietnam War, when the experience of veterans brought post-traumatic stress to the attention of the medical community and the nation. The medical fraternity initially had trouble understanding the psychological difficulties that veterans faced when they returned to the civilian community, however, and as a result many failed to engage with mainstream health services, dropping out of the system and experiencing chronic social exclusion as a result. To this day Vietnam veterans continue to number among America's destitute and homeless.

I visited veteran-orientated organisations in 14 states, as I wanted to learn how the services engaged with, and supported, veterans living chaotic lives. One of the most interesting projects I visited, and a scheme that could be easily replicated in the UK, was the Buffalo Veterans Treatment Court, a specialist hybrid drug and mental health court that diverts veterans struggling with addiction and/or mental illness from the traditional criminal justice system.

The court is a collaborative effort between veterans' agencies, the police and the criminal court, pre-trial, outreach and treatment sectors. Veterans voluntarily participate in a judicially supervised treatment plan developed by a team of court staff, healthcare and mental health professionals and peer mentors, with the full involvement of the individual.

My experience of the court was like nothing I'd seen in 29 years as a social worker or probation officer. I was impressed by the professionalism and the way all agencies, from the voluntary to the statutory, worked together to meet the needs of veterans. Judge Robert T. Russell, the presiding judge, welcomed me to his court and allowed me to observe proceedings.

A veteran was escorted in, handcuffed, by an armed court official. He looked like any other problematic drug user after a night in the cells – on the verge of 'a rattle', as we say in the UK. He stood in front of the bench and bowed his head as he answered the judge's questions about his addiction to drugs, his offending and service history, accepting that he needed help as his life had spiralled out of control after several combat tours in Vietnam. His elderly mother was called to the bench and said he had gone into self-destruct mode since his return to the civilian community 30 years ago.

With the aid of the veteran's military records it was confirmed that he had taken part in several offensives during the Vietnam conflict. As if to emphasise the long-term damage this man had experienced, he physically flinched at the flash from a recently appointed court photographer's camera. There was a murmur of disapproval from the courtroom – I later found out that the room was filled entirely with veterans and their families. Judge Russell politely pointed out that it was not court etiquette to use flash photography and personally apologised to the veteran.

He asked if the veteran had ever accessed medical help in relation to post-traumatic stress and he said he had not. He then quietly and respectfully questioned the man for a few more minutes, asking if he would accept the support of the court. When he said he would, the judge instructed the court guard to remove the handcuffs. As the veteran rubbed his wrists the judge addressed the courtroom: 'Ladies and gentlemen, I would like to introduce you to this man. He served in the Vietnam War, I have confirmed his status as a veteran and his service history. He is here today for the first time. He has agreed to accept our help and support. Please give him a warm Buffalo Veterans Court welcome.'

The courtroom erupted into applause, with both staff and visitors cheering their

ABOVE: Tony Wright (centre) at the Buffalo Veterans Treatment Court.
FACING PAGE: Veterans' demo

support. The defendant seemed stunned. 'We very much thank you for your service to this country, but you've got a lot of work to do,' the judge told him, adding that he now had the support of the court, its staff and its volunteer mentors. He told the defendant to 'faithfully attend treatment sessions' and stay away from 'the people, places and things that are temptations'.

He was then introduced to his mentor, who had served in the same division in Vietnam, to formulate a plan of action. They were told to report back in 15 minutes and again in two weeks to report on initial progress. 'I also want the court welfare and social work team to give all the financial support and assistance it can to your mother so that she can keep in touch with you and support you both now and in the foreseeable future,' the judge said.

The veteran was marched out to more applause, returning 15 minutes later with the mentor, who reported that supported accommodation had been secured and that a medically supervised drug and alcohol detox was available for later that day. The mentor said that he would escort the veteran to appointments and meet him every day until the next court date. Interventions and support packages can last 36 months or more, depending upon need, and before the veteran left the court, Judge Russell made it clear with that since the programme had been established in 2008 no one had reoffended, and he advised him not to be the first.

I can confirm that, almost a year later, he hasn't reoffended and is making great progress addressing all his issues with the help of the court mentors, medical and social work staff. Those who have been through the programme are also given the opportunity to become mentors themselves, thus reinvigorating the recovery process through real examples of success.

*****

In the UK we already have the infrastructure to pilot and establish veterans courts, yet there is a reluctance to accept the true numbers of veterans that have involvement in the UK criminal justice system, or even that the problems are attributable to military service. Until we can come to a consensus on the numbers within the criminal justice system and accept that real and effective alternatives to custody can be put in place, veterans will continue to be over-represented within the system and excluded from real opportunities to address the multiple and complex issues that impact on their everyday lives and ability to assimilate with a society that owes them so much.

Here, the Royal British Legion proudly promotes the millions it spends on financial and welfare support, but the fact that it has to gives a real insight into the levels of deprivation and need that exist in the former service population. Add this to the money paid out by Combat Stress, Help for Heroes, SSAFA and the other veteran-specific charitable organisations, and it is the generosity of the British public and charitable trusts that pay for most, if not all, services.

During my social work career I noticed that increasing numbers of former service personnel were becoming visible within the homeless sector or mental health support services, suffering from diagnosed or undiagnosed post-traumatic stress disorder, with many more presenting at A&E departments, GP surgeries, substitute prescribing services and AA or NA meetings.

In 2009 I founded About Turn CIC (*DDN*, 21 June 2010, page 6), but the journey to establish a truly 'needs led' service that was fit for purpose has been difficult and slow. The economic downturn, a change of government and lack of understanding within both the charitable funding community and military benevolent organisations – and widespread denial that veterans exist within the UK criminal justice system – has led to limited opportunities to acquire core funding to develop a much needed service.

We found, by initiating a freedom of information request, that many services commissioned by local authorities failed to ask if the individual accessing their services had served within the armed forces. This fundamental omission – at first point of contact, assessment stage or during the writing of a pre-sentence report – can lead to a missed opportunity to understand the root cause of complex issues.

Organisations then try to shoehorn veterans into existing provision that is neither appropriate nor relevant to their individual needs, and veterans are also notoriously bad at asking for help. Some may view survival 'on the streets' – or when experiencing acute adversity – as a continuation of the exercises or missions they took part in while on active service. Couple this with a highly developed sense of pride and a determination not to be viewed as a burden on society and it's not surprising that civilian-orientated support services find it difficult to maintain a meaningful relationship with ex-forces personnel.

'In the UK... there is a reluctance to accept the true numbers of veterans that have involvement in the UK criminal justice system, or even that the problems are attributable to military service.'

Many veterans continue to feel a deep sense of dislocation within the civilian community long after discharge, and the common misconception that the military 'take care of their own' has also stood in the way of developing appropriate services. Short sighted and 'top down' solutions that look for quick fix results via brief therapeutic interventions, or adopt a 'refer on' approach, will inevitably result in failure and long-term damage.

The introduction of the Armed Forces Covenant and locally driven armed forces forums will go some way to ensuring organisations, at the very least, sit around the same table to look at how the needs of veterans can be collectively met. However there appears to be a reluctance to share practice or information, and referral of veterans to other organisations is limited. It is essential that a process be developed by which localised 'grass roots' statistical data can be collected, shared and acted upon to address unmet needs.

This will require much closer partnership working. Specially designed service delivery models with integrated pathways to specialised support need to be developed and, if supported by targeted funding, could significantly increase engagement with services for marginalised veterans and their families, reducing both social isolation and the risk of reoffending.

Tony Wright is founder and MD of About Turn CIC.
www.aboutturncic.co.uk tony@aboutturncic.co.uk
www.buffaloveteranscourt.org

LEGAL LINE

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

SHOULD AN OLD CONVICTION COUNT AGAINST MY CRIMINAL INJURIES APPLICATION?

READER'S QUESTION:

Last year I was violently attacked on my way home from work. I had to have a number of operations on my face and still have visible scars. I am also psychologically affected – I can't work, only leave the house if I have to, and suffer from nightmares. I made a criminal injuries application but have been refused because I have criminal convictions. It doesn't seem fair that I can't get any compensation because of things I've done in my past.

KIRSTIE SAYS:

This must have been a very distressing experience, and obviously continues to be so. You were right to make an application to the Criminal Injuries Compensation Authority (CICA).

In assessing a claim, CICA consider a number of different factors about the incident itself and the person applying for compensation. Unfortunately one of the things they are able to take into account is the character of the applicant, with reference to previous criminal convictions. This does not seem fair, and CICA do not offer any explanation about why they do this. Legal challenges to this have failed in the past. However, they cannot simply make a blanket refusal based on the fact that someone has criminal convictions, and they can only have regard to unspent convictions. Each case must be looked at on its own merits.

CICA operate a penalty point system which allocates a specified number of points to a conviction according to what sentence was given and the time that has passed between the date of sentence and the date of the application. The total number of penalty points is then used to reduce an award by between 10 per cent (1 point) and 100 per cent (10 points). Sentences of 30 months or more in prison will never become spent and attract 10 points. Tactically it is sometimes possible to delay an application to minimise the reduction applied, especially as there is a two-year period to apply from the incident date.

You should check the guidance in relation to this – at bit.ly/SlUNuT – and make sure that the calculations have been made correctly. If not, then you should request a review of the decision not to make any award because it was reached incorrectly. Even if the calculation is correct, you can still request a review on the basis that there are exceptional circumstances present in your case and discretion should be exercised to make an award (even if that is reduced in some way). If you are still unhappy with the decision after review, you can appeal the decision to the Tribunal Service – they are completely independent of CICA. Unfortunately it is often difficult to find free representation for these sorts of cases, though you may be able to get some assistance from a local law centre or Citizens Advice Bureau.

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

For more information about this issue please contact the Release legal helpline on 0845 4500 215.

LETTERS

CLEAR SIGHTED

I was very heartened to read the interview with Alliance founder Bill Nelles (*DDN*, September, p10). The story of setting up The Alliance is an inspiring one of genuine user activism, and of making a huge difference and saving lives. For the past few years we have had a good system in this country with medication available, and I think it can be sometimes forgotten that this was not always the case.

There is much talk of patient choice and the oft-heard discussion of 'an individual recovery journey'. However in the current climate individuals on a script are often left feeling stigmatised and in constant fear of having their medication removed. The situation in the UK 30 years ago, and the current lack of methadone prescribing in parts of Canada, provide a stark reminder of how many lives have been lost by the blinkered pursuit of abstinence as the sole treatment option

Despite this, Nelles states how open he is to abstinence and how he 'wants people to get the treatment they want' and sees his role to protect people's choices. Coming from him, talk of 'individual recovery journeys' does not sound hollow at all.

Someone with a vast knowledge of the UK treatment system gained through professional and personal experience, coupled with his current situation as someone removed, have given Nelles a unique perspective. I look forward to hearing more from him.

Colin Reed, by email

MEDICATIONS IN RECOVERY

Professor Strang tells us that overcoming drug dependence is often difficult, and reports that not everyone who comes into treatment will succeed (*DDN*, August, p14).

As he indicates, research and experience demonstrate that opioid substitution therapy (OST) succeeds in helping bring heroin addicts to abstinence (but only in 3 per cent of cases).

We also know that 12-steps succeeds in 20 to 30 per cent of cases and that, while other recovery programmes have consistently brought 55 to 70 per cent of addicts on various substances to lasting abstinence, there are still 25 to 30 per cent who, for well-known reasons, are fundamentally incurable and for whom therefore OST or the prescribing of diamorphine appears a realistic management of their addiction.

That leaves 70-plus per cent who have not quit, who have tried hard to do so on numerous occasions (often daily), who have failed just as often, but who still want to escape their addiction – including wanting to quit their methadone dependency.

In other words, the essential difference between the 'incurables' and the 70 to 75 per cent who still want to escape their addiction is willingness, with the larger group unfortunately lacking in knowledge of how to get themselves back into the natural state of abstinence into which 99 per cent of them were born, and the smaller group utterly resistant to quitting.

So why for one moment consider putting the majority of heroin addicts on OST, when the majority are both able and willing to quit, and have not done so only because they have not been offered the opportunity to be trained in the effective addiction recovery techniques which are currently practised at 169 centres (including prison units) in 49 countries and which have been helping hundreds of thousands of addicts of all types to cure themselves since 1966.

Regrettably, it appears that effective self-help training in do-it-for-yourself addiction recovery techniques is ignored and/or defamed because it does not entail the daily usage at any stage of psycho-pharmaceutical medications.

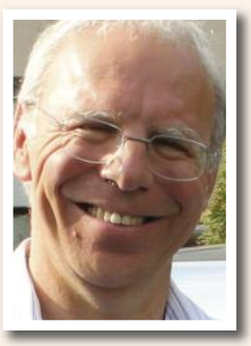
Along with addiction prevention training, the government's goal of reduced demand is achieved by recovering existing addicts to relaxed lasting abstinence, without prescribing any other addictive substances.

Kenneth Eckersley, CEO, Addiction Recovery Training Services (ARTS)

We welcome your letters...

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

NEW ERA



A lot has changed since the advent of the CQC and there are more changes on the way. **David Finney** explains what services can expect in the coming months and years

IT'S BEEN THREE AND A HALF YEARS SINCE THE FORMATION OF THE CQC, this monolithic government body to regulate health and social care, so what has been the impact on the substance misuse sector and what are the implications of the CQC's change in direction?

To date, I think that our experience has been mixed. Some services have actually had an inspection that gave them a positive report while others have not been so lucky, and services previously rated 'excellent' have struggled to make themselves understood to CQC. Others are still awaiting an inspection and unsure what to expect, while Walsingham House was closed as a result of its inspection. So what can we expect in the future?

The national context is interesting, as CQC has been roundly criticised by the press, provider associations and, most significantly, the government's own health select committee. The criticisms have led to changes in the way CQC operates, with the most significant change being the resignation of chief executive Cynthia Bower and her replacement by David Behan, former director of social care at the Department of Health.

I view this as a positive step, having worked for David Behan at the Commission for Social Care Inspection (CSCI). My experience then was that he was a man of vision and clear thinking and had a passion for quality. For the substance misuse sector it's also reassuring to know that he has been chair of a DAT – there's reason to believe that he will 'get it' in relation to this sector. Furthermore, CQC chair Dame Jo Williams has also recently resigned, leaving more scope for change.

WHAT IS CQC UP TO AT PRESENT?

Among other things, it is:

- **Focusing on registering GP surgeries – it's possible that GPs will have to declare in their statement of purpose whether or not they have staff who are substance misuse specialists.**
- **Implementing the document *Improving the way we regulate*, which means annual unannounced inspections for all providers and a focus on looking for non-compliance rather than good practice.**
- **Responding to whistle-blowing as a priority, in the wake of Winterbourne View.**
- **Recruiting 255 extra inspectors – while this will result in extra staff, there will still be delays in inspections given the necessary induction period, and perhaps less likelihood that your inspector will have experience of inspecting substance misuse services.**
- **Launching a consultation on its strategy for 2013-16. This includes a risk-based approach to inspection, which means visits according to assessed risk rather than on a routine basis. CQC will also be relying on information from local authority commissioners and Public Health England as well as complaints and notifications. This is a change from the current system, so please visit the CQC website and respond to the consultation if you have strong views.**
- **Commissioning research into ways to improve regulation, in conjunction with Manchester Business School. This is a long-term project but one to watch in case new thinking emerges.**

WHAT ARE THE IMMEDIATE ISSUES FOR THE SUBSTANCE MISUSE SECTOR?

- **For the rest of this inspection cycle – until March 2013 – the methodology of looking at a few outcomes on a visit still applies. You can expect inspectors to focus on involvement of people in the running of the service, care planning, safeguarding, staff development and quality monitoring. Much of the evidence will be gained through talking with service users and staff as well as looking at your record keeping.**
- **If you run a residential service expect some puzzlement from inspectors if they see that your service type is 'care home' but you don't deliver 'personal care' in terms of practical caring tasks. If this is the case you could ask to be re-designated as a 'residential substance misuse service', where the focus is on psychosocial treatment and the need to share rooms can be therapeutically justified.**
- **Tougher enforcement – CQC has developed a 'regulatory escalator' which moves providers much more quickly to statutory warning notices, and just one major concern can trigger this action. There is also the power to publicise the action – and the local press do tend to be interested – so there could be serious consequences for the commissioning of services, as Walsingham House found out to its cost. Advice giving by inspectors is a thing of the past – the emphasis now is on assessing compliance.**
- **Next year, expect a whole different raft of outcomes to be inspected. CQC says that from April 2013 it will look at one outcome from each heading in the 'essential standards' so, for example, they could assess consent under the Mental Capacity Act, nutrition, medication, staff recruitment or complaints, or any outcomes not previously assessed.**

MY ADVICE, therefore, is don't leave anything to chance and undertake a thorough audit of your service according to the CQC outcomes. You should also be prepared to explain to an inspector exactly what your service does, as they may have no prior experience of the sector (the document *Preparing for CQC inspection* on the CQC website offers practical tips). You also need to ensure that staff are fully aware of whistle-blowing arrangements and the role of CQC in safeguarding and complaints management. And finally, keep providing a quality service that thoroughly meets the needs of your service users and fully involves them in the treatment they receive.

David Finney is an independent social care consultant with a specialist interest in the regulation of substance misuse services. His next DDN/FDAP workshop, CQC compliance… whatever next? *is in London on 17 October. Book at www.drinkanddrugsnews.com*

More support – and understanding – is needed for victims of violence and abuse perpetrated by their children, says **Oliver Standing**

The last taboo

In the last quarter of 2011 I travelled around England with the director of domestic violence agency AVA, Davina James-Hanman, meeting parents whose children had drug and alcohol problems. This in itself was not unusual – many of Adfam's projects are based on focus groups and consulting families affected by substance use. What made this project different, however, was that these parents were victims of domestic abuse perpetrated by their children.

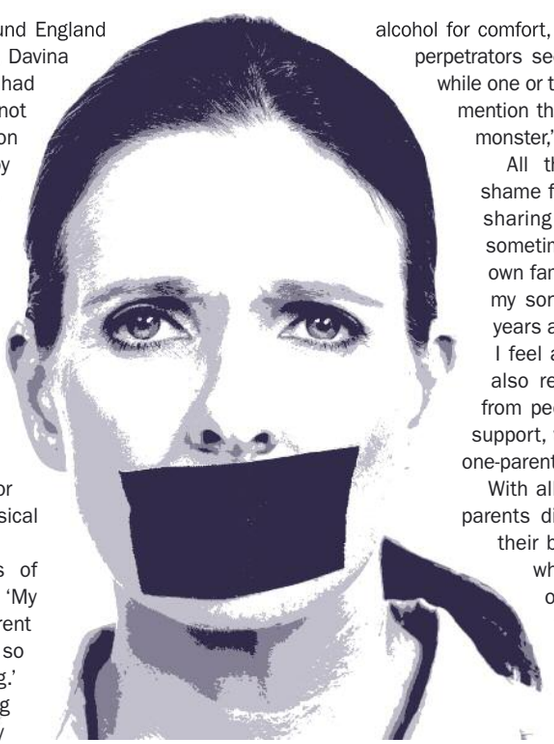
'I've had knives at my throat off him,' one mother told us. 'He said to me, "you better move now 'cos I'll use it", so I said, "do me a favour and do it because I can't take it anymore, you're destroying me".' Like victims of intimate partner violence (IPV), though, victims of child-parent violence (CPV) suffer more than acts of physical violence – domestic violence is usually manifest as a process of coercive control where the perpetrator uses emotional, psychological and sometimes physical abuse to exert power and control over a victim.

Perhaps unsurprisingly, then, the experiences of victims of CPV mirrors those of IPV in their breadth. 'My experience is… to do with mental harm,' another parent told us. 'He has just damaged me so much, I am so tired that I wonder sometimes how I can keep going.' Many parents reported a common theme of being worn down by their children, bullied, deliberately targeted when at their weakest and financially exploited. 'I've had text messages saying he'll have his legs broken if we don't pay £500 by this Friday, and we've got ourselves into serious debt,' one parent told us.

For anyone to deal with this is, of course, immensely hard, but consider the two extra factors at work here. Firstly, the perpetrator of the abuse is the child of the victim. This reversal of the normal power relationship touches on a major taboo in most societies, which generally assume that the parent has control over the actions of the child and that any behavioural issues are the result of lax or inefficient parenting.

Even if a parental victim reaches a point where he or she attempts to sever ties with the perpetrator, they are still a parent responsible for their child in the eyes of society, the law and, often, themselves. One mother we spoke to regretted the firm stance she'd taken – 'I wish I hadn't thrown my son out… that goes against the grain… a mother to chuck her son out'.

Secondly, drugs and alcohol complicate the picture even more. The relationship between substances and domestic violence can be very complicated, reflected in the variety of stories shared with us. Some parents had themselves turned to alcohol for comfort, while others couldn't stand the sight of it. Some perpetrators seemed to enter rages fuelled by drugs or alcohol, while one or two were described as even worse when sober. 'You mention the word monster… that's what I call my son – the monster,' a mother said.



'My twin sister doesn't know my son is a drug addict – he's been an addict for 20 years and she doesn't know. I want to tell her but I don't…'

All these factors contributed towards a profound shame felt by many parents who did not feel comfortable sharing their experiences with professionals, and sometimes even friends and family. 'You can't talk to your own family – I get too upset. My twin sister doesn't know my son is a drug addict – he's been an addict for 20 years and she doesn't know. I want to tell her but I don't, I feel ashamed.' This sense of shame and stigma was also reinforced by some of the reactions parents got from people who should have been potential sources of support, with one mother being told 'it's because you're a one-parent family' by one of her friends.

With all this stigma to face, it's unsurprising that many parents didn't immediately ask for help, but instead did their best to deal with the situation themselves. Even when help was available they were often not aware of the network of excellent family support groups that exist around England for families affected by drugs and alcohol. 'I didn't know there was support for us… I was talking to a friend and the friend told me that there was support out there for me, which I knew nothing about,' a parent reported.

Unfortunately, when parents did make that step and ask for help, many of the responses they received were not satisfactory. A mother told us that there 'seemed to be a problem with social services when it's the parent or family requiring help, rather than the child. There seems to be some sort of mental block where they can't understand, or don't want to understand, that possibly the family are not able to deal with the child.'

We summarised everything parents told us in the report *Between a rock and a hard place* and made a series of recommendations for policy makers which we believe can improve recognition of CPV and, crucially, the support available for parents. You can read more of the moving, but often inspiring, stories the parents shared at *www.adfam.org.uk/news/265* and if you'd like to know more about the project email me at o.standing@adfam.org.uk or call 020 7553 7656.

Oliver Standing is policy and projects coordinator at Adfam

Adfam and DDN are holding a 'Families First' conference for family members and professionals on 15 November in Birmingham. Details at www.drinkanddrugsnews.com

ENTERPRISE CORNER

SILENT VOICES

Recovery must reach every member of the family, says **Amar Lodhia**

For a long time at TSBC we have advocated that the key to sustained recovery lies in our four core values – inspiration and aspiration, positive role models, incentives and a stable environment.

In a family situation, this is even more important when you take the young child who has grown up with a substance-abusing parent. Critically, they are given a false start in life right from the get-go, with a distinct lack of positive role models, no one to inspire or incentivise them and anything but a stable home environment.

Working with participants across the age spectrum, we have found entrepreneurship and a lever into the world of business and employment to have been the common feature that has pulled them through treatment for good. It seems logical to apply the same rationale to a family situation and break the destructive cycle that substance misuse can have upon young people growing up in these environments.

'We are actively seeking examples of how work being done with parent and child together is carried out.'

Recent research from the Children's Commissioner found that a shocking one in three children in the UK live with at least one parent who is a binge drinker (see news story, page 4). With an additional 350,000 children of problem drug users in the UK today, there are over a million young people whose wellbeing and personal development has been severely compromised. Future public health reforms must show a focus towards ensuring that the levels of treatment available to substance misusers are on par with that available to their children.

There has been recognition among childcare professionals that more must be done around the whole family intervention process. This requires a more holistic approach to recovery, recovery for all those within the family affected by the impact of substance abuse. For us it makes sense that parents struggling through treatment with substance misuse cannot be seen in isolation. At home, there will be a young child, struggling through their own issues, with no treatment on standby to help them. Of course this is easier said than done.

When we met Louise Casey, the prime minister's tsar on tackling troubled families across the UK, we discussed how we could use enterprise, business and initiatives like *Breaking the cycle* to bring a positive purpose to a family and instil our values to enable both parents and children to progress together. We are actively seeking examples of how work being done with parent and child together is carried out as well as case studies.

I'd be interested in hearing your examples, case studies and views on this. Email me personally at ceo@tsbccic.org.uk and follow us on Twitter @TSBCLondon using the #tag DDNews

Amar Lodhia is chief executive of The Small Business Consultancy CIC (TSBC)

FAMILY MATTERS

A GOOD START...

The government has acknowledged that child to parent violence exists – now the real work begins, says **Joss Smith**

THIS WEEK THE GOVERNMENT ANNOUNCED A CHANGE TO THE DOMESTIC VIOLENCE DEFINITION TO RECOGNISE THAT 16 TO 17-YEAR-OLDS CAN BE VICTIMS OF ABUSIVE BEHAVIOUR.

Many organisations, including Adfam, lobbied for this change in our response to the consultation in March. It's a really great start to wider understanding of the complex nature of domestic violence that can affect people at different ages and, crucially for Adfam, within different relationships. However that is what it must be viewed as... a start.

In partnership with AVA we recently released our new report *Between a rock and a hard place* considering the often significant impact of child to parent violence. Under the previous definition, a 17-year-old physically abusing their parents or grandparents was not considered to be perpetrating domestic violence. Our research indicates that it's more likely to be considered a child protection issue, anti-social behaviour or conduct problem and service responses to child to parent violence are not as developed as those towards partner violence. This group of parents also did not recognise the actions of their children – which ran the full range from physical assaults with weapons and death threats to coercive control including extreme behaviour, blackmail, emotional abuse and financial exploitation – as domestic abuse.

Domestic violence services are unlikely to be in touch with these parents (who typically look for help regarding their child's substance use and not the abuse they suffer) and may not be used to characterising these experiences as domestic violence if they normally work on intimate partner violence. Parents are generally unwilling to disclose the abuse due to the 'double stigma' and shame that surrounds both having a child using substances and being abused by your own child.

The new definition opens the door for further discussions on 16 to 17-year-olds being both victims and perpetrators of child to parent violence. However we must not assume that the widening of the definition will neatly result in an increase in the safety of parents or an improvement in the response of services to their situation. Many services are vastly over-stretched and underfunded and the hidden nature of child to parent violence means that it often goes unrecognised. Practitioners need training and support to work with this different client group, whose experience of violence has many similarities to intimate partner violence but also unique characteristics, which require a specialist understanding.

This change definition is a good start and we are pleased that Adfam's and many other organisations' views have been listened to, but we are still faced with the struggle of what to call the violence parents suffer, how to respond appropriately to both the perpetrator and victim, and where this sits within government policy. As Dr Sarah Galvani concludes at the end of our report, for these parents, 'what is clear is that we need to do better'.

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

Families First

The first Adfam/DDN family conference



Thursday, 15 November 2012 – BIRMINGHAM

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

This conference will bring together family members – many of whom are providing support networks around the country – along with policy-makers and professionals. This is a must-attend event for family members affected by substance use and for all agencies and organisations who genuinely want to support them

Early bird delegate rates for bookings before Friday 14 September
Family members £80 + vat
Professionals £135 + vat
(An additional £10 will be added to bookings made after this date)

Full programme and online booking on
www.drinkanddrugsnews.com
e: conferences@cjwellings.com *t: 020 7463 2081*

Adfam
Families, drugs and alcohol

DDN
Drink and Drugs News

Putting families at the centre of recovery

CONFERENCE PROGRAMME

9.30–10.30am **Coffee and registration**

10:30am **Opening session**
Chaired by Adfam chief executive **Viv Evans**, the session will include a national overview from NTA chief executive **Paul Hayes**, and **Christine Tebano**, founder of Parent Support Link, will give her personal perspective of setting up a family support service.

11:30am **Coffee break**

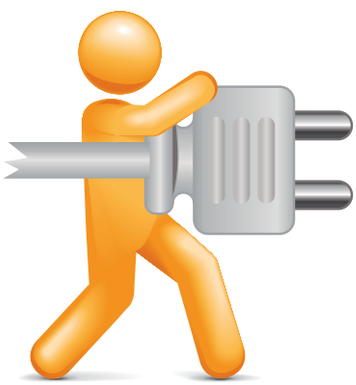
11:50am **Session two**
Alex Copello, consultant clinical psychologist at University of Birmingham, will present research on coping strategies for families and **Niamh Eastwood**, director of Release, provides advice on families, legal rights around bail, arrest, search warrants, and access to treatment.

12:30pm **Lunch**
Including relaxation therapy and the family groups' exhibition area.

1:45pm **Workshops**
Small practical workshops including help with criminal justice, practical coping strategies, boundary setting and the impact of alcohol

2:45pm **Afternoon session**
Dr Steve Brinksman, chair of SMMGP, will provide a GP's perspective on families affected by drug and alcohol issues and **Karen Biggs**, chief executive of Phoenix House, will examine how treatment services provide support for families.

4pm **Finish**



JOINING FORCES

New partnership-led training aims to help victims of domestic abuse incidents where substances are an issue, says **Cinzia Altobelli**

DOMESTIC ABUSE VICTIMS WITH SUBSTANCE MISUSE ISSUES ARE AMONG THE MOST VULNERABLE, ISOLATED AND CHALLENGING TO ENGAGE. They suffer from severe and frequent abuse, and receiving the right support from skilled and experienced professionals can help to make a real difference to their lives.

According to research by Quigley and Leonard in 2000, and White and Chen in 2002, substance misuse is a factor in more than half of high-risk domestic abuse cases, with alcohol likely to contribute to 'intimate partner violence' in a variety of ways. Levels of consumption affect the likelihood and severity of violence, and alcohol appears to be 'particularly important in escalating conflict'.

This increased level of risk to domestic abuse victims when there is an underlying drug or alcohol problem – and current lack of services and practitioners properly equipped to support them – has led to the development of an innovative new training course for professionals. Families Plus (a division of Action on Addiction) and Co-ordinated Action Against Domestic Abuse (CAADA), two leading national charities tackling addiction and domestic abuse, have combined their expertise to develop and deliver a training course for professionals entitled *Substance use and domestic violence: providing a risk-led response*.

The new joint training looks in depth at key issues faced by practitioners from both sectors, and encourages learners to explore possible differences in agency approach. The substance misuse sector traditionally favours a counselling, talking therapy approach, while the domestic abuse sector supports clients with skills that are more likely to be based on risk identification and advocacy. Space is provided for learners to reflect on their practice and consider new ways of assessing and offering support to their clients, while opportunity to connect with professionals from both fields adds to the learning environment, with facilitators encouraging participants to share difficulties and best practice.

Substance use and domestic violence uses a systemic approach to help practitioners support clients. This encourages practitioners to realise that individuals cannot be understood in isolation from one another, and that to effectively engage a client all elements of their situation should be taken into consideration, and theories and techniques give professionals the skills to see their clients as interconnected and interdependent individuals who are more fully understood in the context of their 'system'.

The course includes time to look at the relationship between the user and his or her substance misuse, and how the effects of addiction impact the non-using members of the family. The struggle faced by significant others who are non-users is often overlooked in the treatment of substance misuse and Families Plus has long used the phrase, 'You don't have to misuse alcohol or drugs to suffer from alcohol or drug misuse'.

Systemic thinking is particularly important when substance misuse is an issue for the victim, the perpetrator, or both. The relationship with drugs or alcohol will have a significant impact on the relationship between couples and other family members, as the dynamic can be complicated and the risk to a victim increased. Apart from the higher levels of violence reported, opportunities for control and manipulation are increased if a victim is drug or alcohol dependent. Levels of secrecy and shame can also increase, and these become powerful barriers to asking for help and support. These issues also need to be understood in the context of cultural diversity.

Substance use and domestic abuse constitute two of the three major risk factors for child abuse and neglect, as identified by the Munro review of child protection in 2011. In acknowledgement of this, the training also supports practitioners to identify the impact and risks for children who may be living in the household.

'According to research... substance misuse is a factor in more than half of high-risk domestic abuse cases.'

Practitioners have identified that one of the key issues they face when confronted with substance misuse and domestic abuse is 'where do I start?' It is often the case that drug and alcohol services will not work with clients who are victims of domestic abuse, and domestic abuse agencies, particularly refuges, feel they do not have the facilities to support substance misusing victims. The need for joined-up working has never been greater and this joint initiative will help practitioners find the best way to support clients in this situation.

The course has been accredited by the University of Bath at Level 4 and consists of four days of teaching. The training provides practical information alongside the theoretical approach and includes the most up-to-date evidence-based learning. Learners to date have reported a decrease in levels of anxiety following the course and increased confidence in supporting these vulnerable clients.

For more information or to sign up visit http://www.caada.org.uk/learning_development/CPD-Substance-Use-about-the-course.html

Cinzia Altobelli is leader of therapeutic services at Action on Addiction's Families Plus service

It's where you'

Harm reduction should be about 'meeting people where they're at', according to the recent HIT *Hot topics* conference. Jamie Bridge reports

Last month HIT hosted their second *Hot topics* conference in Liverpool, sponsored by Martindale Pharma. This national harm reduction event attracted 140 delegates from across the country and beyond, with a multi-themed programme making for an engaging day but a challenge in terms of summarising proceedings here! As rapporteur for the event, I tried to draw on one key message that came across strongly – that harm reduction is about 'meeting people where they are at'.

The morning presentations demonstrated that 'where people are at' is changing, however. Dr Adam Winstock drew on data from the Global Drug Survey and Drugs Meter (*DDN*, July, page 12) to show the increasing use of new drugs and growth of the internet as a 'drug market without borders'. As we learn more about these drugs, their effects and potential harms, we need to adapt our messages, services and approaches accordingly. Concerns have been raised about dependence levels perceived by those using mephedrone, for example, as well as the severity of comedown after use and the impact of banning the substance in terms of diverting people to other drugs or leaving them in the hands of an illegal street market.

The presentation confirmed that 'the UK is still a powder-loving country' and that a fifth of 18-22 year-olds admitted using an unknown white powder in the past twelve months. Basic harm reduction messages are not always reaching these groups, a point developed further by Matt Gleeson from UnitingCare ReGen in Australia, who made the case for 'web 2.0-enabled harm reduction services' that can take full advantage of social media and other new technologies.

The web allows for two-way communication with people who use drugs, advocacy and mobilisation, learning and sharing information, myth busting and facilitating peer support, yet this work continues to go unfunded in most cases and is often seen as a 'productivity killer' by bosses. Adapting the way we think about this work is a core cultural challenge for services.

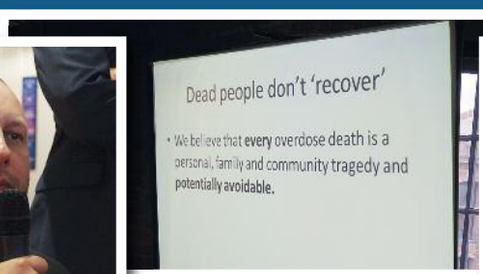
Stephen Heller-Murphy from Healthcare Improvement Scotland then outlined the work being done in Scotland to provide harm reduction in prisons, and the frustrations encountered, particularly with the continued absence of prison needle and syringe programmes. Foil is also proving hard to come by for prisoners looking to smoke their drugs – with foil-wrapped biscuits being banned in some prisons – leading to even higher rates of injection.

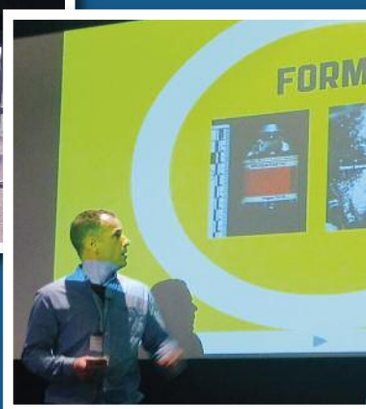
Mat Southwell from the Gold Standard Team then provided a fascinating account of the dynamics of ketamine use, the varied profile of users, and the emerging risks. Again, simple harm reduction advice – around hydration, safe use environments and the development of tolerance – is often failing to reach these individuals.

Later in the day, delegates heard presentations from Martin Chandler of Liverpool John Moores University and Dave Crosland on the widespread use of performance and image enhancing drugs, which now account for up to 80 per cent of the clientele in some local needle and syringe programmes. While the body building community continues to be comparatively well self-policed, emerging patterns of use among relatively naive gym-goers – particularly young people and those going through 'mid-life crises' – is a big concern.

While these presentations pointed to unmet needs and unreached groups, the afternoon session highlighted the ongoing needs of the more 'traditional' harm reduction clients – particularly those injecting heroin and crack cocaine. Nigel Brunsdon from HIT provided insight into the deeply ingrained rituals – or 'foreplay' – of drug preparation and why these can be so hard to challenge and change. John Campbell from Glasgow Addiction Services presented on the provision of injecting equipment kits, which reach around 13,000 clients through 74 outlets in the city. The kits now include plastic 2ml ampoules of sterile water for injection – a newly available harm reduction product – and have been very well received in service evaluations.

Dean Linzey from Reading DAAT then presented on efforts to improve and expand HIV and HCV testing, using rapid oral swab tests that can be easily





Delegates at *Hot topics* debate key harm reductions issues

?re at.....

administered by key workers on the ground. Faced with low testing uptake and a medical model that was like 'speaking in tongues' to clients, these services have overhauled themselves to deliver a much more flexible approach that met people's needs.

Sara McGrail gave an impassioned presentation on the government's recent *Putting full recovery first* document, pointing out that although the document has been criticised by many of the signatory agencies in private, none has stepped back from it publicly, and it remains both an influence for commissioning and a yardstick of the current government's outlook.

Delegates also heard that whereas the term 'recovery' has been a source of empowerment and strength in the mental health field, it has been hijacked in the drugs field in a 'victory of moral determinism, greed and self-righteousness over evidence'. Instead of the language of recovery being used to empower people who use drugs to determine their own goals and improve the range and quality of services they receive – especially given widespread unhappiness at a one-size-fits-all treatment system that had developed under the NTA – this government's idea of recovery has come to embody one imposed goal for all: total abstinence from all drugs.

According to McGrail, this hijacking of recovery language is down to three related factors – the broader push for austerity and funding cuts, the development of 'big business' treatment charities focused less on individuals in their care and more on tenders, contracts and profit, and several years of highly efficient political lobbying from residential treatment providers and the conservative Christian right. Together they have created a 'hierarchy of worthiness' – with abstinence placed above all other successful treatment outcomes – which has been translated into a system that 'measures the success of drug treatment by the absence of people in drug treatment'.

McGrail predicted that deaths, infections and stigma would increase as a result of this shift, and called on delegates to recognise the weaknesses of the previous treatment systems and maintain their focus on reducing harm. 'We are needed now more than ever,' she said, emphasising the need to meet people where they're at, rather than where we are being told they should be.

Jamie Bridge is senior policy and operations manager at the International Drug Policy Consortium.

POLICY SCOPE

The popular mantra of drug policy failure is drowning out our successes, says Marcus Roberts

CHANGE THE RECORD

The idea that drug policy is 'failing' appears to have wide currency among MPs and journalists. On 8 September, a headline in The *Observer* proclaimed 'Drug laws are not working, believe 75 per cent of MPs', while noting that the poll commissioned by the UK Drug Policy Commission found 'little consensus on changing existing laws' among MPs. The *Observer* piece concluded with a quote from one David Cameron MP, who had said back in 2002 as a member of the Home Affairs Select Committee that Britain's drug policy 'has been failing for decades', explaining that 'drug abuse has increased massively, the number of drug-related deaths has risen substantially and drug-related crime accounts for up to half of all acquisitive crime'.

Now, if I was an MP or journalist or local politician with no specialist interest in drug policy lending an ear to the 'mood music', I think one of the dominant themes I would pick out was that 'drug policy is failing'. It is a slogan that unites those left-wing liberals (and right-wing libertarians) who lobby for reform of drug laws with those social conservatives who attack the legacy of our drug treatment system – although, of course, they have opposing views of what is failing and why.

Is it true? Not really. As Roger Howard, chief executive of the UK Drug Policy Commission, commented in The *Observer*, 'drug policy in the UK has had some good achievements, like keeping HIV rates low among drug users and getting more people into treatment', adding 'but it's now clear to many people that we need some fresh thinking'. Fresh thinking is a good thing, but that doesn't mean a fresh start.

Consider David Cameron's charge sheet from 2002. Is drug abuse 'increasing massively'? On the contrary, the evidence says that drug abuse is now falling. According to the 2010-11 *British crime survey*, last-year use of any illicit drug fell from 11.1 per cent in 1996 to 8.8 per cent in 2010-11, and among 16 to 24-year-olds from 29.7 per cent in 1996 to 20.4 per cent in 2010-11. In 2010-11 there was also a fall of nearly 10,000 in the number of heroin and crack users coming into treatment over a two-year period.

Are drug-related deaths rising? The Office for National Statistics says there was a fall of 3.5 per cent in England and Wales in 2011 compared to the previous year, the third consecutive year that the numbers were down. What about acquisitive crime? It's falling, and there is overwhelming evidence that drug treatment reduces offending and reoffending (see the NTA's *Treat addiction, cut crime* for chapter and verse).

Now not everyone will accept all of these figures at face value and there are no grounds for complacency, but this is far from the picture of policy failure that is getting across to many politicians. At a time when we need to be making the case for investment in drug and alcohol services in tough financial times, we need to be talking about our successes too. At the moment they can sometimes seem to be 'hidden in plain view'.

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

Liberty to CHAN

Philadelphia is aiming to live up to its 'city of brotherly love' motto by fully integrating its substance and mental health services to provide seamless support for vulnerable people. **David Gilliver** talks to its director of addiction services, Roland Lamb

Roland Lamb, who was one of the speakers at the second national *Recovery in the Community* conference in Sheffield last month (*DDN*, September, page 5), has used his five years as director of the Office of Addiction Services at the Philadelphia Department of Behavioural Health to help to oversee the introduction of 'recovery-orientated systems of care' across the board.

The City of Philadelphia's drug and alcohol treatment and mental health services are integrated into one comprehensive system, working via a network of agencies and collaborating closely with criminal justice, education and child welfare departments. The city's philosophy is that the 'central role of individuals and families in responding to, managing, and overcoming' substance and mental health problems should be 'an organising point for the entire system'. Its vision is one of 'recovery, resilience, and self-determination' with professional treatment viewed as one aspect among many to support people in managing their own conditions while 'building their own recovery resources'.

Although it had always been proficient at dealing with immediate crises, transformation was needed to shift the department's focus to the long-term, says Lamb. 'We had a very good acute care system, a very good crisis-oriented system. We did a very good job of taking people in, treating them and sending them home, but then you have a person who finds themselves coming out of a treatment programme and going back into the very community in which they struggled and survived their initial addiction.'

As a result, that acute care level had become characterised by the 'recycling' of people, he states, and it was this – coupled with wider issues – that convinced the department that something needed to change. 'They'd go into our detoxes and our residential treatment programmes and in less than six months they'd be back. And then there were the collateral issues, like increases in the prison population because of our preoccupation with the drug war. One out of every 100 Americans is incarcerated – we're filling up our prisons, we have broken families and we have the disconnect between professional help and community support, families and therapists. A lot of fragmentation all over the place.'

It's this disconnect that the city aims to address, and his vision is one of aligning and integrating departments throughout the local government structure to ensure that professionals 'coordinate our dollars' to provide ongoing support. Everyone wins as a result, he maintains. 'It's to the prisons' benefit to keep folks in the community and functioning well and it's to the child welfare department's benefit to keep families intact and functioning well.'

*****

On a wider level, the aim is for far more 'functional involvement' with the clinical healthcare system, something that's being partly facilitated by the Affordable Healthcare Act, which is pushing both sides to work more closely, he explains. 'So ideally we'd have a system where no matter where I presented, if I had these other issues on board those services could be brought to me in one place. We're talking about the creation of managed care hubs and healthcare navigators – people who can help others navigate the system, an excellent role for how we use peers.'

Fully achieving this vision won't be easy, he acknowledges, not least because of the economic situation. 'These last few years of really having a recovery focus have positioned us well, but we've received a number of cuts in our drug and alcohol area – we just got hit this July with a $1m cut.' And while greater integration does allow the city to manage its money better, some of the biggest obstacles to change have come from within both the departmental structure and the recovery community itself.

'The resistance comes from all directions. It comes from people in recovery who've been used to a system where people tell them what to do and what they are and what they're not. We're a stigma-driven society, so you have people who don't have a high opinion of their worthiness for care and, for that reason, in many cases don't even access it. Then you have the treatment providers, who are used to one particular way of doing things, and then you have the administrators and the recovery advocates. When you propose a system transformation you propose that all those folks are going to have to change their position and be something different.'

He compares the system's previous incarnation to 'rich parents', throwing resources at a problem unaware of how little long-term effect it has, and says the department is 'still not over the hump' in getting everyone on board. 'Like any other transformational model you have your early adopters, your late adopters, and you spend a lot of energy trying to convince everybody in the middle. People want to be in control, and I often tell people that the most insidious of all addictions is the addiction to power, and it's also the greatest illusion. People think that they're going to lose something that they never really had – "I'm not going to have the power do decide how these dollars get spent".'

Although he's been at the helm in Philadelphia for five years, he's spent the whole of his 37-year working life in the addictions field, with his interest stemming partly from personal experience. 'As a young man I got into drugs and enjoyed it maybe to the point where it was a problem. It didn't keep me from going through school and graduating from college, but it kept me from doing a lot of other things. Then I became interested in wanting to work with young people, mainly in the area of addiction, and I've been doing that ever since.'

There's no shortage of need for that work, as Philadelphia continues to struggle with challenging social problems, particularly around drug-related violence, although crime rates have fallen from their high five years ago. 'We also have a homeless issue and we were bringing down our incarceration numbers but because of the cutbacks and so on those things are going back up again. But we need to maintain activity in our city system as far as continuing to move folks towards recovery – the longer people stay in the community in their recovery they are outside of that recycling and we're just dealing with new faces in that cycle. We need to continue to keep people in the community.'

*****

Recovery-orientated systems of care are more developed in the US than the UK – is there anything that people here might find surprising in the way Philadelphia is doing things? 'For us, everything begins with the people who are in recovery,' he says. 'Solutions, collaborations and partnerships begin in the community, and there's no exclusion. We're all accountable for recovery and we are all citizens of a larger community of recovery, and for that reason we began in the community – we had meetings in churches and different community venues, forming boards and inviting input from all over the place.

'We're still looking for new ways to connect to groups who hold anonymity as their calling card, for example – you can remain anonymous but we want to support you too,' he continues. 'We need to create a free flow of traffic so you have your professional side – the licensed treatment programmes – but then you have all the riches of the community with people creating all kinds of activities. They need to be a part of professional care, and professional care needs to be accessible to those folks in the community.'

Definitions of recovery can be a tricky issue in the UK, but Philadelphia has come up with 'an evolving definition' of their approach, seeing recovery as 'the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced' and involving the 'continued enhancement of a positive identity and personally meaningful connections and roles in one's community'.

Is Philadelphia fairly unique or is this becoming a more common model? 'It's a struggle,' he says. 'When I travel around the country, I see it mostly being done on a state level. We have an advantage, being a city of 1.4m people having access to the dollars that we do for behavioural health, and we're still sort of an anomaly. A lot of the efforts that you see around recovery are state efforts and they're a lot slower because you're talking about trying to move this concept across geographically separated counties, whereas we're all in one place.'

Ultimately, it all comes back to that focus on the long-term, he says. 'It's a lot like the soldiers coming back from overseas to a community – they don't know where they are, don't know their place, don't know how to function, and we're seeing suicides. In some ways a post-traumatic reaction to an addictive career is not too much unlike that. It's very much about long-term support.' **DDN**

Above: Roland Lamb at the 2011 America Honours Recovery event. Courtesy of Faces and Voices of Recovery.

'They'd go into our detoxes and our residential treatment programmes and in less than six months they'd be back.'

Roland Lamb

SPREADING THE EVI

Grace Ball discusses how the UK recovery movement is continuing to evolve, and reports back from the UK Recovery Academy's recent Manchester conference

These are turbulent times in the addiction field, with some ill-conceived government initiatives and outspoken comments from some recovery advocates leaving many in mainstream addiction treatment feeling resentful and even distrustful of the 'new recovery agenda'. Not only that, but there have been disputes and arguments within the recovery movement itself, which has led to frustration and confusion across professional groups and people trying to achieve that bridge between active addiction and active recovery.

In some respects, ideological and territorial disputes are inevitable in a fluid new movement containing a variety of beliefs, philosophies and views on the nature of recovery. It's true that the UK recovery movement looks far more cohesive than its US counterpart, but this seems to be partly because that movement is largely dominated by the 12-step fellowship and has a different social context (an insurance-led market rather than NHS provision, and fewer social safety nets). It has also existed for longer there.

That's not to say that we should simply accept the rancour as inevitable. But we should recognise it for what it is and work towards its elimination, because we all have a vested interest in maintaining cohesion and defending everyone's right to recovery, not our individual subjective orthodoxy or personal doctrine.

An important aspect of achieving understanding of the recovery landscape is transparency regarding the roles and remits of various component organisations.

The Recovery Academy set out a clear mission statement back in 2009, the key element being to help develop the evidence base and bring it to a wider audience, and to encourage the practitioner community to develop its own evaluative skills to demonstrate, and report, what works.

With welfare reform and health and social care policy changes, there's more scrutiny for positive outcomes and responsibility to the public purse, but above all a focus on what can be done to improve the chances of initiating and sustaining an individual's recovery journey within their community. The objective understanding and application of the recovery evidence base becomes paramount within a framework of limited funds and challenging decision making.

The evidence underpinning rhetoric should not be underestimated, although rhetoric can have negative connotations. It's often thought to refer to speech that, if it isn't wholly untrue, is at least misleading or perhaps simply vacuous – at times some people within the recovery movement have been critical of 'empty rhetoric'. However, rhetoric should not just be empty words or dramatic presentations – recovery rhetoric has a place in the study and art of writing and speaking well about recovery, being persuasive and knowing how to transmit logical objective arguments. Rhetoric should be a fundamental building block of recovery education and workforce development.

The Recovery Academy conferences reflect on communal dimensions of recovery, highlighting the importance of proactively nurturing recovery cultures in order to reap the full social benefits of recovery success. These are not vacuous intellectual exercises – the intention has always been to demonstrate living, material expressions of the diversity and richness of UK recovery cultures.

The academy focused exclusively on the nature of evidence as the theme for its 2012 conference, held in Manchester. We believe in the importance of highlighting what is currently known in order to make a space for what is emerging, new and innovative, and we welcomed more than 15 presenters and workshop facilitators to support and develop the thinking of a full house of delegates. The academic approach helped to define and evidence recovery within different settings, with presentations scoping out how to measure and evidence change and outlining the challenges.

Ian Wardle talked about the uncertainty, defensiveness and rhetoric of a multitude of small recovery organisations representing various interests and viewpoints, a multi-million pound treatment industry that has learned to speak the language of recovery and devolved commissioning with no master template. He also discussed how the threat of disinvestment prompts worthy, but defensive, lowest-common denominator lobbying, the unimaginative approach to the scale of challenges facing our industry and persistent strategic isolation and insularity.

Delegates were encouraged to consider an individual's recovery through strength-based case management focussing on the client/patient's strengths, personalisation of care and improvement of the therapeutic relationship, and using the community as a resource – assertively reaching out to people and maintaining contact.

Themes of care and treatment converged with a focus on recovery in the community. Dr David Best highlighted recovery to mean a sense of hope, purpose and belonging, and a sense of identity and pride within three levels – a personal recovery journey, recovery as a social contagion and recovery as a social movement where people experience connectedness, meaning and empowerment. Mark Gilman developed the evidence for recovery as an asset in

community development and Andy Perkins led a workshop in tools for building recovery orientated community capacity.

The translation of objective rhetoric to operational commissioning was highlighted as challenging, but not impossible, and delegates reported greater confidence in their operational practice with the broadening of their knowledge base. With this in mind we look towards the future role of the academy – we're in the process of extending our board directorship and look forward to the variety of experience, knowledge and skills this will bring to the Recovery Academy table.

We will continue to produce bulletins and plan for our conference in 2013, which addresses the challenges of 'what now' – how do people take the rhetoric and make operational change that makes a difference? We want to support people demonstrating viable and visible actions – whatever system of treatment and community they are in – because significant change is only going to come from consensus and flexibility, where treatment compliments a range of opportunity and support garnered from the community.

We will be using the skills and knowledge of our directors and wider networks to identify and report areas of good practice, and support where we can the development of the evidence base. We would strongly encourage anyone who is interested in the principles, ethos and philosophy of the Recovery Academy to get in touch with us.

Grace Ball is a Recovery Academy director and treasurer.

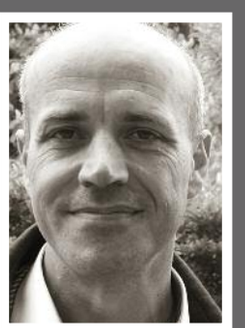
Please contact Grace or Linda Swift on recovery.academy@hotmail.co.uk for further information, or if you want to become part of the Recovery Academy wider network

'These are turbulent times in the addiction field, with some ill-conceived government initiatives and outspoken comments from some recovery advocates leaving many in mainstream addiction treatment feeling resentful and even distrustful of the "new recovery agenda".'

VOICES OF RECOVERY

VITAL CORE

Harnessing the passions, strengths and skills of individuals shows the power of community-led recovery, says **Alistair Sinclair**



SEPTEMBER SAW A LOT OF RECOVERY ACTIVITY. There were recovery walks in Trafford, Ireland, Weston-super-Mare, a recovery festival in Leeds, rather a lot of recovery-themed conferences and, of course, the big one – the fourth UK Recovery Walk in Brighton on 29 September. We're going to see a lot more community-led recovery activity in 2013 so I thought it would be good to hear from Brian Morgan, my fellow UKRF director and UK Recovery Walk planning group member on the 'abundance' and assets that are starting to become more visible in communities:

'We decided to hold the UK Recovery Walk for 2012 in Brighton and Hove because of the emerging strength of recovery communities in the South East. I had started to develop a network in the region, affiliated to the UKRF, and there was lots of energy and enthusiasm for recovery evident in the Brighton area. Brighton is well known for its proliferation of community activists, its liberal mindedness, and, more negatively, for being the 'drug death capital of the UK' – a perfect place therefore, we felt, to use Asset Based Community Development (ABCD) approaches to deliver the walk, rather than have an 'outside agency' deliver it for us. We wanted to focus on Brighton's strengths rather than its weaknesses, and one of its major strengths is its people in recovery.

'In August 2011 I met with a small group of people who had come together to learn how SMART groups were facilitated. We met at the local MIND offices, which set the tone because after that we rarely set foot inside traditional substance misuse settings again. I talked about the previous UK walks and then we got right into it, doing a 'hearts, hands and heads' exercise to map out our individual passions, strengths and skills. We left the room aware that we had the ability to deliver this UK event and that together we could do this – either because we had the assets or we knew somebody else who had them within the community.

'We went on to map associations within the community, starting to make the 'abundance' visible, and identified the institutional assets that could be accessed in the local area. This was our way of beginning to explore the 'recovery capital' that we had as individuals – both what we had as a group and what was out there in the community.

This ABCD approach is a process that takes time. But the group got it and got it quickly. I've found that most people in recovery communities do – the lights go on! This isn't always the case with agencies. They are often slower on the uptake. There's a bit of suspicion, a little condescension perhaps. Systems creak. But we did it.

'The Recovery Walk took place last week – planned, organised and delivered by a core of people who are all in recovery, dreamed and lived. This group stuck together for over a year and made it happen. They showed the world a bit of the 'abundance' that's out there in communities and did it by embracing asset-based approaches grounded in notions of 'belonging' within communities. Roll on 2013.'

Alistair Sinclair and Brian Morgan are UK Recovery Foundation (UKRF) directors. www.ukrf.org.uk

In the second part of her story, **Marie Tolman** finds herself falling deeper into addiction and has her first brush with the law

My journey of self-discovery

AT 16 I WAS A REGISTERED HEROIN ADDICT. Smack became my security blanket, comforting my troubled soul, providing me with a place to hide from myself. And then she would turn on me, making me suffer unimaginable withdrawals – not just physical but also emotional. I was incomplete without her presence.

My boyfriend at the time had acquired some peach Palfium. He was already an IV user, but up until now that was one thing I said I wouldn't do, purely because I was frightened of needles. He was furious and said I must inject them. I had tears streaming down my face, terrified, as Kevin placed the torque around my arm.

With my heightened senses I could feel every movement he made, every breath I breathed, the feel of the belt tightly wrapped around my arm, the sound of my skin piercing, then the release of the tourniquet. I felt euphoric – this was so intense, so overwhelming. I was comfortably numb, silencing the constant chatter in my head and blissfully at one with myself.

By the following day I was expert at injecting. Sad as it seems, I was actually proud that I had moved up a notch in the hierarchy of drug taking. My criminality stepped up to feed my ever-increasing habit. At 16 I had been arrested twice for shoplifting and was feeling quite proud of myself – I was a real criminal now. We used to steal cars to go and score.

One night, things went very wrong and we were arrested. They found me hiding under a van a few roads away, and my mate Sean in bush. It was a Friday evening and the following day we would go before Saturday morning court. Sean was remanded in custody and I was granted conditional bail, but my parents didn't have a phone, so together we went in a sweatbox to grizzly Risely [remand centre]. I was sort of excited that this would buy me creditability, but at the same time I was frightened – a little girl trying to be a big girl, and way out of my depth.

Up to this point I had only done a few hours withdrawal and nothing prepared me for the events to come. On arrival, I was horrified that you had to take all your clothes off and bend down to touch your toes. I had never really been sexually active – I was always one of the lads – so this was the worst experience ever, made worse by the fact that male officers were present too. Then my name was called out and I was taken to a room that looked like something from a horror movie, with an old hospital bed.

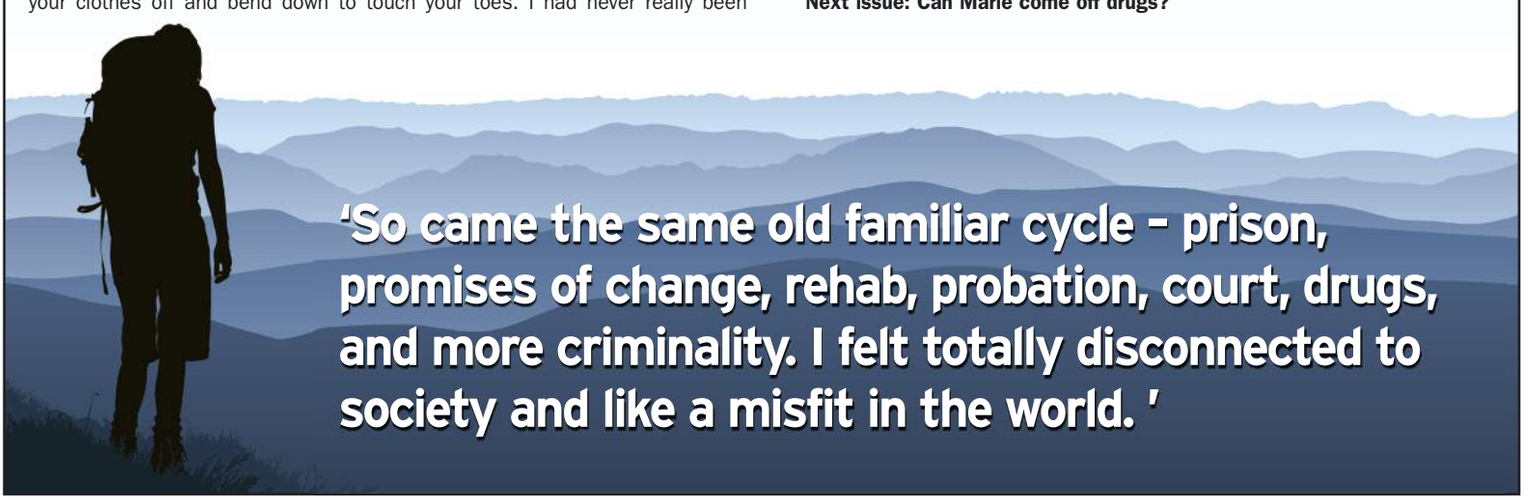
I was asked to remove my underwear, and as I lay on the bed, I freaked out. The details of what happened next scared me for a very long time, as I was forced to have an internal examination. Even now, I find to it hard to understand such unnecessary abuse. I sat in the bath feeling disgusted and contaminated, completely invaded. My body was the only thing that truly belonged to me. These feelings were exacerbated by the increasing intensity of my withdrawals.

I was only there for nine days, but that was enough. My mum was at court waiting for me, tears running down her face, but she was greeted with a mouth full of abuse for leaving me there. I can only imagine how distraught my parents must have been. Nobody had contacted them to let them know where I was, and it was only through a reception letter that they knew.

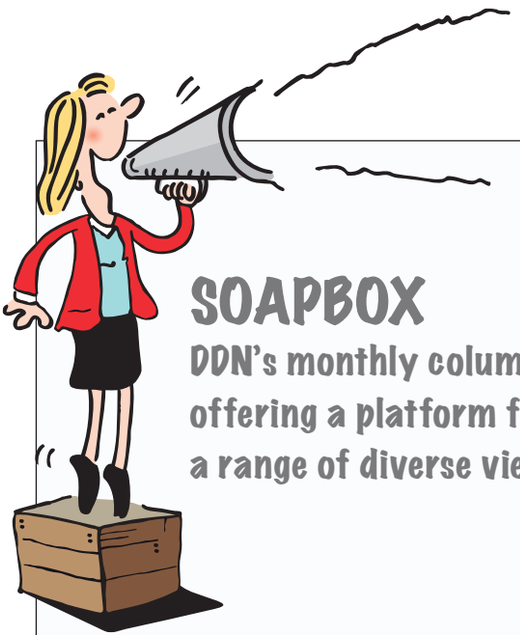
Pandora's box was well and truly open, and the pain and hurt were unleashed on my family and friends. I was an addict with a conscience but the only way I knew how to cope was by dulling the pain of my guilt with more drugs, especially opioids and barbiturates. So came the same old familiar cycle – prison, promises of change, rehab, probation, court, drugs, and more criminality. I felt totally disconnected to society and like a misfit in the world. While I was in rehab, my dad told me of the pain of witnessing me go through this every day, not knowing if I was going to come home, or if they'd find me in my bedroom with a needle in my arm, dead, or hear that I had been raped or murdered.

He said, 'At least when Pauline was killed, it was over and done with and I knew she had gone. This is torture, Marie, please stop – it's making your mum and me ill.' These words should have given me strength, but instead I was unable to cope. I so wanted to stop, but I just couldn't work out the pathway to do it.

Next issue: Can Marie come off drugs?



'So came the same old familiar cycle – prison, promises of change, rehab, probation, court, drugs, and more criminality. I felt totally disconnected to society and like a misfit in the world. '



SOAPBOX

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

CITY CHALLENGE

We must learn to balance risk and freedom, says **John Ashton**

MOST OF US ENJOY A LOVE-HATE RELATIONSHIP WITH OUR CITIES.

We expect them to provide for a wide range of our needs and expectations, yet sometimes they overwhelm us and we seek the open horizons of the fells or shoreline. We yearn to re-establish a connection with nature and the seasons, which can seem elusive when surrounded by bricks and mortar and a night sky devoid of stars because of light pollution. From biblical times people have sought refuge in cities and escape from the narrow parochialism of the village, where bigotry can rear its head and xenophobia is a close cousin of intolerance of difference. Strength in numbers can be a big pull if your lifestyle falls outside accepted norms.

Yet the notion of city as nirvana has never gone unchallenged. The pull and push factors that generate rapid urbanisation have always brought public health challenges in their train. We know from public health academics such as the late Thomas McKeown of Birmingham that disease occurs in populations when they migrate or their habitat and adapted way of living is changed. Cholera flourished in the teeming slums of Victorian England and it took the galvanised efforts of civic leaders (the church, the press, the business community and early health professionals) acting through the Health of Towns Association to achieve sanitary reform. That reform gave them the legislative and financial tools to tackle the urgent issues of the day – safe water and sewerage, paved streets and refuse collection, housing standards, food hygiene and a subsequent plethora of local authority provided public services.

The work of these early pioneers was driven by the so-called sanitary idea, much espoused by president of the Board of Health, Edwin Chadwick. At its heart was the need to separate human and animal waste from food and water. The responses were typically Victorian, rather mechanistic but very determined. For Chadwick this took the form of the egg shaped, brick lined sewer pipe – and his obsession with finding the right way of doing something and then doing that everywhere. The town of Liverpool under its triumvirate of Duncan (medical officer), Fresh (sanitary inspector) and Newlands (borough engineer) put in 20 miles of such sewers in 20 years and the country followed over the next couple of decades.

The impact of such measures was significant. As the nature of infectious disease came to be better understood, and the Pasteurs revealed the germ theory of infection, prevention and personal hygiene took their place alongside environmental action. Town planning joined the party and model towns and cities began to separate out living areas from the industrial and recreational. Salubrity was embraced as a core municipal function and local authorities began developing a wide range of public services encompassing housing, parks and gardens, swimming baths, social services, schools, abattoirs, tramways and gasworks and much beside.

Over 100 years later much has changed but urbanisation has gathered pace. A majority of the world's population now lives in large towns and cities, some of them huge. Many accommodate vast slum areas where to the traditional problems of infectious diseases have been added the modern scourges of non-infectious and degenerative disease associated with populations that have begun to live for life spans undreamed of by our great great grandparents. Then there are the lifestyle diseases associated with the existential dilemmas of a post religious age where each of us must find our own path, negotiating the rules and ethics of a much more fluid social contract. This contract is both more liberating and more daunting than when churchgoing was the norm, everybody knew their place, and the state acted as enforcer of the status quo.

Cities of today are expected to meet even more of our personal ambitions. They must simultaneously be places to grow people in, to offer them the optimal amount of test and challenge, rites of passage, opportunities and support in sickness and in health. We have begun to redefine how we understand them, as ecological habitats and as building blocks of society. The challenges in developed countries are no longer the cholera and drains but issues such as depression, drugs and alcohol and dementia. We are no longer subservient to handed-down rules, but autonomous beings seeking to negotiate paths towards our dreams, and if the questions of health and wellbeing are about anything, they are about co-production and co-maintenance. The freedom to take and manage risk is a genie that is out of the bottle. The search for a common game board for the modern city has barely begun.

So in taking stock in 2012, over 150 years after the first Public Health Act, there are many questions to ask – ethical and political ones to do with power and control, governance and autonomy, and freedoms of the individual and the collective. Such things come into prominence when we focus on behavioural issues such as alcohol, drugs, violence and sexual expression. One thing is certain: the city is here to stay and there is much to be said and done if the dreams of liveable, aspirational and sustainable cities are to be available to all those who seek their joys and frustrations.

Professor John Ashton CBE is regional director of public health for the North West. He will be delivering the Alison Chesney & Eddie Killoran Memorial Lecture on 22 October in London. Visit www.kachange.eu to reserve a place.

3 SIMPLE STEPS TO SECURE AND EFFICIENT METHADONE DISPENSING

Use biometrics to identify patients quickly and securely

DRX Dispense integrates with the latest iris cameras and fingerprint readers to identify patients beyond any doubt.

And with identification typically taking less than **0.3 seconds**, there's absolutely no compromise on efficiency.

Reduce dispensing time to less than 20 seconds

Computerised dispensing speeds up the dispensing process and ensures a dosing **accuracy of up to 99.95%**.

Faster processing allows operators to dispense to more patients, more quickly and frees up time for patient care.

Improve information quality and cut data entry times

DRX takes care of every aspect of your data, from patient records and CDRs to stock control.

Web-based software allows **immediate access** to patient information across multiple locations, providing both operators and commissioners with accurate, **real-time data**.

To find out how your organisation can benefit from automated methadone dispensing, please call us on **01865 989 470**
email us on **info@drxsystems.com**
or visit our website at **www.drxsystems.com**

DRX DISPENSE

UK and European distributors: Argus Global UK, 5 Meadow Court, Witney, Oxon, OX28 6ER

DDN Drink and Drugs News

fdap

DDN/FDAP WORKSHOPS

We are pleased to offer the following workshop:

17 OCTOBER 2012

CQC compliance... ...whatever next?

This course is designed to keep you up-to-date with the latest changes in CQC regulation:

- **CQC have recently announced that all inspections will be annual and unannounced. So you are never far from your next inspection, and you won't know it's coming!**
- **Your service may be newly registered by CQC, which means you will be unfamiliar with inspection and won't know what to expect when the inspector calls.**
- **The level of CQC enforcement activity has increased across the board, so you need to be aware what may happen if you are not compliant and how you can rectify the situation.**
- **This year, CQC say that they will be focusing on a select number of outcomes in their inspections, but doing so in more depth. Their new method of inspecting means they will be spending more time speaking to, or observing, service users and their care and treatment.**

SO HOW CAN YOU BE PREPARED FOR YOUR NEXT INSPECTION?

The course will show you how to look in depth at specific outcomes yourself, and how to ensure that you have the right evidence available to demonstrate your service's compliance with CQC. The course will also look at what to expect and how to respond on the day of the inspection.

For those of you who have been inspected you may wish to learn how to develop action plans which meet CQC requirements, so there will be an element of "master class" action planning built in to the day. All participants will be able to learn from this.

David Finney is an independent social care consultant with a specialist interest in the regulation of substance misuse services. He has facilitated training events around the country and provided consultancy in relation to CQC regulation for a variety of treatment services. He was a senior manager with CSCI where he was the national lead for substance misuse services.

Places are only £135 + VAT. 15% discount to FDAP members.
All courses run from 10.00 am – 4pm in central London, and include lunch and refreshments.

For more details email kayleigh@cjwellings.com
or call 020 7463 2205
or visit www.drinkanddrugsnews.com

DDN training is run as a partnership between DDN magazine and independent training providers. DDN offers trainers promotion, advertising and marketing resources, a central London venue, and admin support. If you are a trainer working in the drug and alcohol field and would like to discuss partnering with DDN on a training course, please contact us.

UK RECOVERY FEDERATION

we make the path by walking it

RECOVERY, WELLBEING & US

A UKRF Community Conference

Wed 5th December 2013

9.30am-5.00pm, The Gujarat Centre, Preston, Lancashire

WORKSHOPS

• Asset-based Recovery • Social Enterprise • 12 Step Facilitation • Making Recovery Visible • Families & Recovery • Recovery-orientated Standards • Co-production in action • Community Organising & more...

Lots of discussion, connecting, learning, giving and a bit of music

Sponsored spaces available for UKRF Associate Members.
Limited number of £50 places available for professionals.
Contact alistair@ukrf.org.uk for details & booking

WE MAKE THE PATH AS WE WALK IT – TOGETHER

www.ukrf.org.uk

Residential Drug and Alcohol Rehabilitation

Yeldall MANOR

- **CQC Registered**
- **Detoxification from Drugs and/or Alcohol**
- **1st Stage Rehabilitation Programme (3-6 months)**
  Includes group work, counselling, work experiences, IT training and recreation.
- **2nd Stage Resettlement Programme (3-5 months)**
  Semi-independent living on the Yeldall estate. Includes voluntary work placements, counselling, group work and individual support plans with a key worker.
- **Aftercare**
  Included free of charge.

www.yeldall.org.uk • admissions@yeldall.org.uk • 0118 940 4413

"A community of like-minded men determined to turn their lives around."

ADULT SUBSTANCE MISUSE SERVICES IN LEICESTER, LEICESTERSHIRE AND RUTLAND

Leicester City Council, on behalf of the Safer Leicester Partnership is seeking Expressions of Interest from suitably experienced organisations to deliver specialist Substance misuse services to adults in Leicester, Leicestershire and Rutland. These services exist in 2 Lots:

LOT 1. Leicester: Adult community based substance misuse services that will support users into recovery including open access provision, specialist harm reduction services, prescribing services, psycho-social interventions and aftercare services. Primary Care services will also be a part of this Lot. The likely contract value is in the region of £3.7 million p.a.

LOT 2. Leicester, Leicestershire and Rutland: Criminal Justice substance misuse services (on behalf of Leicester, Leicestershire and Rutland County Councils) that provide fully integrated and comprehensive criminal justice substance misuse services including those within HMP Leicester. The likely contract value is in the region of £3.3 million p.a.

It is anticipated that each contract will be awarded for 3 years with an option to extend for up to 1+1 further years subject to funding and performance, with a start date of 1st July 2013.It is likely that TUPE will apply. Prospective providers are invited to tender for either or both of the services. Consortia tenders will also be considered.

A TWO STAGE RESTRICTED TENDER PROCESS IS BEING UNDERTAKEN FOR THE CONTRACTS.

Stage 1 - Completion and submission of Pre-Qualification Questionnaire (PQQ); and Stage 2 – Invitation to Tender. Only those applicants successful at Stage 1 will be invited to tender at Stage 2. A bidder information session will be held on Wednesday 17th October 2012. All interested parties are encouraged to attend the event. Details will be supplied in the PQQ documentation.

Suppliers must read through this set of instructions and follow the process to respond to this opportunity.

*The information and/or documents for this opportunity are available on https://www.delta-esourcing.com/delta. You must register on this site to respond, if you are already registered you will not need to register again, simply use your existing username and password. Please note there is a password reminder link on the homepage. Suppliers must log in, go to your Response Manager and add the following Access Code: UKX377752N. Please ensure you follow any instruction provided to you here. The deadline for submitting your response(s) to stage 1 is **3.00p.m. Friday 2nd November 2012.** Please ensure that you allow yourself plenty of time when responding to this invite prior to the closing date and time, especially if you have been asked to upload documents. If you experience any technical difficulties please contact the Delta eSourcing Helpdesk on call 0845 270 7050 or email helpdesk@delta-esourcing.com.*

Leicester City Council reserves the right to not make an award for any of the above contracts. Contract values are indicative and may be subject to change.

Leicestershire County Council · Rutland County Council · Leicester City Council

Commissioning a Recovery Orientated Substance Misuse Treatment System for Bristol

– Provider Day/Tender Opportunity

Bristol City Council (on behalf of Safer Bristol Partnership) would like to offer potential providers the opportunity to attend a provider day, where plans to re-commission a Bristol wide recovery orientated substance misuse treatment system will be outlined.

The events will be held at
The Council House, College Green, Bristol BS1 5TR on
Friday 12th October OR Tuesday 16th October 2012 9.45am - 12 noon.

This event is an opportunity to inform providers of our competitive tendering intentions and answer questions. More details of the procurement model and scope of contracts will be given at the event.

To confirm your attendance by completing a booking form, please send an email containing your contact details to procurement.support@bristol.gov.uk

Applicants wishing to express an interest in the Tender will be required to complete a Pre-Qualification Questionnaire (PQQ). The PQQ stage will go live on the Bristol online procurement system on **7th November 2012**.

The intention is to establish contracts with either a sole provider, lead provider or consortium. If providers are intending to form a consortium all members will need to complete the PQQ stage and have a draft consortium agreement in place which will need to be submitted as part of the PQQ process.

BRISTOL CITY COUNCIL

More jobs online at: www.drinkanddrugsnews.com

ADDICTIONS COUNSELLOR

Full time, 5 days per week

As our service is growing and workload increasing, Rhoserchan is looking for an enthusiastic and dynamic person to join our treatment team. The ideal candidate will have a good understanding of abstinence-based treatment and the 12-Step programme in addition to extensive experience of working with clients who suffer from chemical dependency.

All Rhoserchan counsellors are required to be qualified to Diploma level.

The successful applicant will be based in the First Stage building but may be required to work at times in Second Stage. A willingness to be flexible and to work as part of a team committed to providing a service of excellence to all Rhoserchan clients is necessary. A full driving licence is necessary, and the ability to work with residents in Welsh is desirable.

Please send a full CV to: Anette Rumble, CEO, Rhoserchan, Blaencastell, Penrhyncoch, Aberystwyth, Ceredigion SY23 3EX

Email: a.rumble@rhoserchan.org.uk

CHAIR AND HEALTH-PRIMARY CARE AND YOUTH SERVICE MEMBERS OF THE ADVISORY PANEL ON SUBSTANCE MISUSE (APOSM)

Time Commitment

Chair - Minimum of 6 days per annum

Members – Minimum of 3 days per annum

Un-remunerated but reasonable expenses will be met

The Advisory Panel on Substance Misuse (APoSM) advises the Welsh Government on the delivery of the Welsh Substance Misuse Strategy and other drug and alcohol misuse issues.

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

The closing date for applications is 26 October 2012. Applications received after this date will not be considered. It is expected to hold interviews early December 2012.

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

Llywodraeth Cymru
Welsh Government

www.cymru.gov.uk

Regulated by The Commissioner for Public Appointments

INVESTORS IN PEOPLE

Take part in a Virtual Rehab Experience

Our unique free training days are designed to give care managers, social workers and any potential referrers a better understanding of a service user's rehab experience.

Join us and be prepared to participate and experience for yourself what it is like to be a member of one of our Therapeutic Communities.

Upcoming 2012 Virtual Rehab dates

Hampshire Residential Service	Wirral Residential Service
24 October	15 November
13 December	

Events are free – lunch and refreshments provided

To book your free place
www.phoenix-futures.org.uk/events

Phoenix Futures
Ending dependency, transforming lives

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

KINESIS LOCUM
Specialist Recruitment

- Total Recruitment for the Drug and Alcohol field. (DAAT, Nurses, Commissioning. NHS. Criminal Justice...and more)
- The Trusted Drug and Alcohol Professionals.

You call Kinesis, we do the rest!

www.kinesislocum.com

0207 637 1039

Substance Misuse Personnel

Permanent • Temporary • Consultancy

Supplying experienced, trained staff:

- Commissioning
- Service Reviews
- DIP Management
- DAT Co-ordination
- Needs Assessments
- Project Management
- Group & 1-1 drug workers
- Prison & Community drug workers
- Nurses (detox, therapeutic, managers)
- many more roles...

Call today: 020 8987 6061

Register online:
www.SamRecruitment.org.uk

Solutions Action Management
Still No.1 for Recruitment and Consultancy

Society for the Study of Addiction

Annual Symposium, 2012

Thursday 8 – Friday 9 November at the Park Inn, York

Themes: *Emerging challenges in addiction psychiatry* | *Recovery* | *Alcohol harms, interventions and policy* | *The research base for policy*

Dr Bruce Ritson will give the Society Lecture:
Alcohol problems in Scotland – An historical perspective

Leeds Addiction Unit
19 Springfield Mount
Leeds, LS2 9NG, UK
Tel/Fax: +44 (0) 113 295 2787

Speakers

Dr John Roche | Prof Val Curran | *Dr Fiona Measham* | Dr Adam Winstock
Dr Richard Cooper | Dr Betsy Thom | *Dr Rachel Herring* | Dr Richard de Visser
Dr Petra Meier | Dr Jane Marshall | *Dr Duncan Raistrick* | Dr John Kelly
Mr Tim Leighton | Dr Lymarie Rodriguez

Presentations: *New drugs, new problems? Responding to club drugs in Leeds* | Ketamine: an overview of its long-term effects on mental and physical health | *Changing trends in mephedrone and novel psychoactive substances* | New drug trends and unmet treatment need - Findings from the Global Drug Survey, 2011-12 | *Respectable 'addicts'? Identity and over-the-counter medicine abuse* | Delivering alcohol policy: the role of partnerships | *How do we judge the 'value' of alcohol interventions?* | 'I have more negative reactions to really drunk women': working with & against gender double-standards for drinking & drunkenness in interventions with young people | *Alcohol price and availability: the evidence base* | Where now, UK alcohol policy? | *Implementing alcohol policy in the general hospital* | Mobilizers, mechanisms and moderators of addiction recovery | *Recovery: is this a new agenda or not? – What has been the impact of changes in the government-imposed treatment agenda over the past 15 years?* | Time and change: A developmental model of young men's recovery

CALL FOR PAPERS: Delegates' abstracts for consideration for poster presentation are welcome. Any addictions subject considered. See 'INSTRUCTIONS FOR AUTHORS' in 'SYMPOSIUM & CONFERENCES' menu on our website. **£500 SSA prize for best poster.**

Closing date: 12 Oct (poster). **Send to:** graham.hunt@nhs.net

PLUS - Fred Yates 2011 prize-winner, Dr Bridgette Bewick:
Using brief electronic personalised feedback to reduce use of alcohol and other drugs

Early bird delegate discount available! Payment deadline – 5th October!

Register & pay online: **www.addiction-ssa.org/ssa_10.htm**

ESSEX DAP
drug & alcohol *partnership*

The Essex Drug and Alcohol Partnership (EDAP) are seeking to procure an independent Support, Advice and Mentoring service.

This is an excellent opportunity for organisations to work alongside the Essex Integrated Recovery System.

The service will be expected to be staffed predominantly by a volunteer workforce and requires the capacity and competence to work with adults, young people and families affected by substance misuse in order to support them to achieve long term recovery.

EDAP are inviting organisations to attend a two hour Supplier Workshop. This workshop will provide interested organisations the opportunity to find out more about the Essex Integrated Recovery System and the proposed role of an independent Support, Advice and Mentoring service in contributing to the long term recovery for our clients, their families/carers and the wider community. The Supplier Workshop will also provide potential suppliers with the opportunity to discover more about the procurement process and meet EDAP commissioners.

Date: 24th October 2012. Time: 10 am – 12pm.
Venue: Central Chelmsford location to be confirmed
To book a place at the Supplier Workshop please email: *essexdat@essex.gov.uk*
by 16th October 2012. *Places are limited to two people per organisation.*

Following the workshop it is EDAP's intention to competitively tender the above provision in accordance with Essex County Council (ECC) procurement process throughout Autumn/Winter 2012 with a forecasted contract start date of 1st April 2013.

Organisations are asked to register with ECC's supplier portal Ariba **www.essex.gov.uk/Business-Partners/Supplying-Council**. Ariba is free to register and, following registration, potential supplier organisations can respond to the ECC's tendering opportunities online.

BE THE CHANGE

We are planning the sixth national service user involvement conference and we want your input.

What vital issues should be on the programme?
Who do you want to see speaking?
What messages do we need to take forward to politicians and decision-makers?

Most importantly, we need you to share inspiring examples of user involvement, recovery and genuine activism in your area that have made a difference.

This is your conference – please get in touch.
To be involved in the consultation and to suggest speakers, visit the DDN conferences page of the new look **www.drinkanddrugsnews.com**

14 FEBRUARY 2013

The National Motorcycle Museum Birmingham

DDN Drink and Drugs News

THE SIXTH NATIONAL SERVICE USER INVOLVEMENT CONFERENCE