GET IN SHAPE – SUMMER TRAINING DIRECTORY INSIDE

DDN
Drink and Drugs News
www.drinkanddrugsnews.com
ISSN 1755-6236 May 2013

'The researcher exploring NPCs can get swept along in the novelty, uncertainty and confusion... chasing the illusory white rabbit in numerous forum threads.'

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DDN Drink and Drugs News

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

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: Andrew Howe/iStock

Editorial – Claire Brown

The right support

From training to campaigning

How often do we worry about trying to keep up with every new danger drug to hit the headlines? The age of fast news has us googling at every tweet and risking missing far more important elements of the job. In this month's cover story, Kevin Flemen offers a reassuring guide to staying ahead of novel psychoactive compounds, using existing skills to respond calmly and effectively.

There's a varied alcohol theme running through this issue, as minimum pricing arguments continue to rage. Alcohol Concern's conference tackled parental alcohol misuse (page 6), Adfam look at why families often struggle for so long without seeking help (page 14) and Joss Smith asks what we can do to make support groups more relevant to men (page 13). In this month's Soapbox (page 21), Andy Stonard waves a burning torch at our hypocritical attitude to booze.

Adding our voice to the *Support. Don't punish* campaign (page 20) was a no-brainer. The global campaign, endorsed by many high-profile figures, aims to highlight the harms caused by criminalising and stigmatising people who use drugs, and show humane policy alternatives. Visit the website – www.supportdontpunish.org – to add your support and reinforce the message that stigma and repression should never be tolerated.

This issue

FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES AND TENDERS
CENTRE PAGES: SPRING TRAINING DIRECTORY

NEWS IN BRIEF

POLICY SHIFT

The Obama administration has published its *2013 national drug control strategy*, which includes a commitment to reform the country's criminal justice system through alternatives to jail for non-violent drug offenders. Other key aims are to prevent drug use through education, expand access to treatment and 'support Americans in recovery'. 'There are no easy answers to the drug problem, but experience has shown us that by breaking down silos and collaborating across disciplines, we can make a real and lasting change,' said director of national drug control policy Gil Kerlikowske. *www.whitehouse.gov*

MINORITY REPORT

A new report on developing prevention services targeted at minority groups has been launched by EMCDDA. The study analyses interventions in nearly 30 European countries, and offers guidance on how to choose and adapt programmes and select the workforce implementing them. *Drug prevention interventions targeting minority ethnic populations at www.emcdda.europa.eu*

PRIORITY REPORT

Public Health England has launched a document setting out its priorities for 2013-14, including to 'improve recovery rates from drug dependency, recognising this as the core purpose of drug treatment'. The organisation 'can and will make important progress in our first year by focusing on a small number of key actions with the greatest potential to make a difference to health and wellbeing in England,' states the publication. *Our priorities for 2013/14 at www.gov.uk/government/organisations/public-health-england*

RADIO WAVES

UK Recovery Radio (*DDN*, March, page 17) has recorded its first podcast, featuring interviews with people in recovery and professionals from across the addictions field. *Listen at recoveryradio.blogspot.co.uk/p/the.html*

BLEAK ADMISSION

One in 11 hospital admissions for liver disease in England resulted in a hospital death last year, compared to one in 72 admissions overall, according to the Health and Social Care Information Centre (HSCIC). Nearly half of all liver disease admissions are for alcoholic liver disease. *Report at www.hscic.gov.uk*

Alcohol minimum unit pricing still on the cards

Minimum unit pricing (MUP) is 'not dead and buried', chair of the All-Party Parliamentary Group on Alcohol Misuse, Tracey Crouch MP, told Alcohol Concern's recent *Happy families?* conference (see news focus, page 6). However, it 'will be delayed'.

'I'm extremely disappointed that government is likely to delay its implementation,' she told the event, but stressed that there was still 'considerable' support within government. 'I'm pressing, along with colleagues, for its implementation. It's a shame that we had a secretary of state who wasn't committed to it, because we'd be a lot further along with it now if that hadn't been the case.'

Public health minister Anna Soubry has also stated that MUP was 'still official policy' in an interview with *Total Politics* magazine, and that she was now convinced of its merits, having previously expressed concerns about the potential impact on lower-income responsible drinkers. 'You have to get the balance right, especially with public health, so that you take the measures that benefit the public's health but without causing people to resent you,' she told the publication.

Meanwhile, a study by researchers from the London School of Hygiene and Tropical Medicine and the University of York has concluded that the alcohol industry 'ignored, misrepresented and undermined' scientific evidence in submissions to the Scottish Government's 2008 consultation on minimum pricing and other measures.

Researchers studied nearly 30 submissions to the *Changing Scotland's relationship with alcohol* consultation, including those from the Portman Group, Tesco, ASDA and the Wine and Spirit Trade Association. Submissions raised 'concerns' over the industry's 'ongoing involvement with policy making', says the study, which is published in the peer-reviewed journal *PLOS Medicine*.

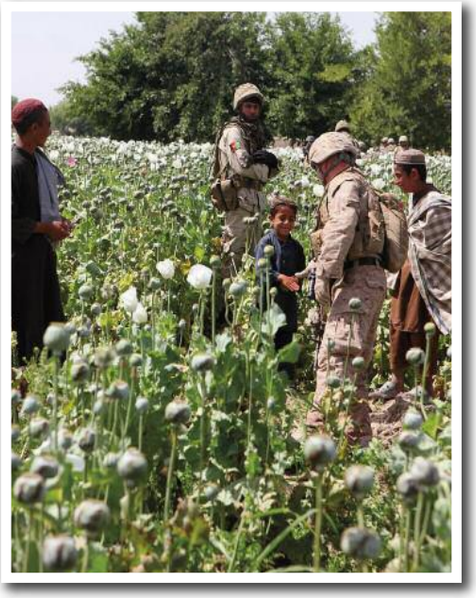
'There is a broad consensus internationally among researchers that the most effective measures to control problems caused by alcohol are to raise the price, control availability and restrict marketing activities,' said lead researcher Dr Jim McCambridge. 'However, our study shows that key players in the alcohol industry constructed doubt about this wealth of scientific evidence and instead chose to promote weak survey-based evidence as well as making unsubstantiated claims to their advantage.'

The tactics meant it was harder for governments to make evidence-based policy where the industry was involved, he added. 'The public interest is not served by the alcohol industry's misinterpretation of research evidence and we must consider to what extent we should allow the health of the population to be compromised by these commercial interests.'

The BMA has also called on MEPs to consider the public health impact of alcohol in response to the legal challenge to the Alcohol Minimum Pricing (Scotland) Act mounted by the Scotch Whisky Association and other bodies on the grounds that it breaches European trade rules.

'Evidence clearly demonstrates the link between alcohol price and consumption and that is why doctors in the UK and internationally recognise the importance of introducing pricing mechanisms to reduce alcohol-related health harm,' said BMA Scottish council deputy chair Charles Saunders. 'Those who have opposed minimum pricing have dismissed such evidence and instead have presented opinion as evidence in a crude attempt to protect profits and business interests. I hope that MEPs will consider in full the public health impact as this issue is debated in Europe.'

Industry use of evidence to influence alcohol policy: a case study of submissions to the 2008 Scottish Government consultation at www.plosmedicine.org



Cultivating a problem? Twelve Afghan provinces are likely to show an increase in opium cultivation this year, according to UNODC's *Afghanistan opium risk assessment 2013*, with cultivation also expected in provinces previously considered poppy-free. The findings point to a 'worrying situation', says the report, with high prices making cultivation an attractive option. There also remains a 'strong association between insecurity, lack of agricultural assistance and opium cultivation', with villages that had not received assistance in the previous year significantly more likely to grow opium. UNODC recently announced its intention to promote grassroots development in poor communities dependent on drug crops, in association with the United Nations Industrial Development Organization (UNIDO). Meanwhile, a UNODC study on organised crime in East Asia and the Pacific found that more than $16bn worth of heroin was trafficked in the region in 2011, two thirds of which was produced in Myanmar. *Reports at www.unodc.org*

Three quarters of Scots drugs death victims 'not on prescription'

The majority of drug-related deaths in Scotland in 2011 were among people not in receipt of a substitute prescription, according to a new report by ISD Scotland and NHS Scotland.

The year saw the highest number of drug-related deaths ever registered in Scotland (*DDN*, September 2012, page 4), with methadone 'implicated in or potentially contributing to' 47 per cent of them, leading to a government review of substitute prescribing. However, according to analysis of 438 of the deaths in the *National drug-related deaths database (Scotland) report 2011*, 74 per cent of those who died were not receiving a substitute prescription at the time of their death, and nearly 60 per cent of those where methadone was implicated were not in receipt of a methadone prescription.

The figures 'helped to contextualise' the 2011 statistics, said the Scottish Drugs Forum (SDF). According to the document, the high levels of overall deaths involving methadone could have been the result of a number of factors, including users seeking different drugs during the 2010/11 heroin 'drought' and high levels of poly drug use, with 97 per cent of fatalities having more than one drug present in their system.

In terms of the 'significant number' of deaths involving people who were on a methadone programme, however, the report points to potential factors such as poor dosing regimes, poly drug use, lack of access to prescribing support, older age and poor overall health.

'There is a huge body of evidence around the protective nature of substitute therapy for drug users,' said SDF director David Liddell. 'What is clear from the statistics is that most people who died had dropped out of treatment for a range of reasons and this is clearly worrying.'

Failure to frame opioid replacement therapy (ORT) in the context of a range of interventions was too often 'an unfortunate feature' of public debate, he stated, with 'simplistic arguments around whether or not we should have ORT. The debate must move on from this narrow lens and focus on the wider issues of how to respond effectively and holistically to the needs of the 60,000 people with drug problems.'

National drug-related deaths database (Scotland) report 2011 at www.isdscotland.org

Brighton considers 'consumption rooms'

The provision of drug consumption rooms is being considered by Brighton and Hove's Safe in the City partnership and health and wellbeing board.

The proposal is one of a number in a report from the Independent Drugs Commission for Brighton and Hove, which was commissioned by the city council.

Among the other recommended measures are more training in naloxone administration and improved data collection on drug use patterns and supply routes. The report also calls for a more creative use of social media as part of education and support services for younger people, and urges that young people's services be kept separate, so that younger users 'don't have to mix with older, more established users'.

The proposals were discussed at a meeting of Brighton and Hove Safe in the City partnership board at the end of April, and will be followed by any feasibility studies considered necessary before recommendations are made for committee politicians to vote on. There was 'no set timeline other than that around the commission coming back to look at what has been taken up in 12 months time,' a council spokesperson told *DDN*.

There are around 2,000 problem heroin and cocaine users in the city, according to the commission, with almost 1,500 people attending drug treatment services in Brighton in 2011-12. 'We have a relatively high number of drug users in the city, and in the past we have had high numbers of drug-related deaths,' said Brighton and Hove director of public health, Tom Scanlon. 'We have come a long way from the peak in 2000 when 67 Brighton and Hove residents died from drug use. While this has fallen to 20 deaths, each of these still represents a personal tragedy for the person concerned and for families and friends.'

Vulnerable young choose high profile brands

Heavily advertised brands and cheap, strong alcohol are the drinks most consumed by vulnerable young people involved with treatment services, according to an Alcohol Concern survey.

According to the study – which surveyed more than 380 11 to 17-year-olds across 14 treatment services in England and Wales – Foster's lager was the most commonly consumed drink, followed by generic or own-brand vodka, Smirnoff vodka, Frosty Jack's cider and Glen's vodka.

The frequency of spirit consumption has almost doubled among 11 to 15-year-olds since 1990, and has risen by 95 per cent among girls. Vodka was most widely consumed by the girls who took part in the survey, while strong cider was popular with both sexes and beer tended to be drunk by boys. The results echo the findings of a report from the Boston University School of Public Health and Center on Alcohol Marketing and Youth (*DDN*, March, page 4), which found youth alcohol consumption in the US to be far more dominated by a 'relatively small number of brands' than consumption among adults.

Research by Alcohol Concern also found that the 'Dan and Brad' characters from Fosters TV advertising were more familiar to 10 and 11-year-olds than characters from leading confectionary and crisp brand adverts. 'Alcohol advertising is linked to consumption, particularly in those under 18 years old, and it's time we introduced robust measures which protect this group from exposure to it,' said Alcohol Concern policy programme manager, Tom Smith.

NEWS IN BRIEF

CARTELS EYE EUROPE

EU law enforcement agency Europol says that it has gathered intelligence that Mexican criminal gangs are 'attempting to establish themselves as key players in the European drugs market'. Although moves by the Sinaloa cartel to establish themselves in Europe were averted by a 'timely, intelligence-led law enforcement operation', Mexican groups continue to expand their roles 'along the supply chain towards Europe' to increase profits, says the agency. 'We do not want the level of violence and brutality which we see in Mexico mirrored in Europe,' said agency director Rob Wainwright.

HEAVY HITTERS

Research has been published by Sheffield Hallam University showing the impact of welfare reforms across the UK. The report provides information for every local authority district, with the worst affected areas facing losses of twice the national average. 'As a general rule, the more deprived the local authority, the greater the financial hit,' it says. *Hitting the poorest places hardest at www.shu.ac.uk*

HIGH IMPACT

New psychoactive substances could 'impact disproportionately on young people with difficult lives' – such as those leaving local authority care or who have pre-existing mental health issues – in the same way as heroin, the Scottish Drugs Federation (SDF) has warned. It was vital not to simply focus on supply, stressed chief executive David Liddel. 'We also need to look – as we should do with all drug use – at why people are using these new substances and the impact they have on individuals.' This would help services to respond more effectively and inform approaches to prevention, he said. The forum has also developed a new set of information materials for Scotland's community-based naloxone programme, including posters, leaflets and booklets. *Available at www.sdf.org.uk*

RYAN CHAIR

Ryan Campbell has been appointed as chief executive of KCA (UK). Previously development director at RAPt, he is also chair of mental health charity Mind. KCA was 'unique in being able to meet the needs of people of all ages who are experiencing substance misuse, mental health problems and other complex issues, in a passionate, outcome driven and human approach', he said.

KEEPING IT IN THE FAMILY

How can workers be best equipped to identify and address parental alcohol misuse? DDN reports from Alcohol Concern's recent conference

Up to 1.3m children were affected by parental alcohol misuse, Adfam chief executive Vivienne Evans told Alcohol Concern's *Happy families? Equipping practitioners to tackle alcohol issues in families* event. 'And those are just the ones we know about, who come to the attention of social services. There are a hell of a lot more that we don't know about.'

When her organisation had run training on parental substance misuse in partnership with Alcohol Concern and Addaction it had been struck by 'how many different people from different professional backgrounds and services wanted to access it – proof that it's everybody's business', she said. One of the greatest challenges, however, was identifying parental alcohol misuse, she stressed. 'Many families are dealing with alcohol use that the user doesn't think is a problem.'

HIDDEN HARM

While parental substance use was often linked with mental health issues, poverty and domestic violence, and was a key factor in children being taken into care, the message of *Hidden harm* – that services could protect and improve the health and wellbeing of affected children by working together – was still key, she said.

'Practitioners, if supported and managed and trained, can intervene to help children. But we still hear of people working in children's services saying "I don't want to get involved with drugs and alcohol – it's too tricky, too complicated", and at the same time you have people in drug and alcohol services who just want to focus on the service user and not the family.'

One of the main lessons to emerge from the practitioner training was the importance of working with managers, she told delegates, as practitioners needed support in the workplace. However, at a time when workforce development was critical, services were finding it harder and harder to access money for training, while another funding challenge was the loss of focus on universal services, she added. 'This is an issue for teachers, youth workers, all of us.'

Although the prevalence of alcohol misuse was 'particularly pronounced in deprived families', there were also significant issues with, for example, middle-aged, middle-class women, chair of the All-Party Parliamentary Group on Alcohol Misuse, and Conservative MP, Tracey Crouch, told the conference. 'They don't fit the bill of the "troubled family" so perhaps they're less likely to receive support.'

REFORMS

It would take time for the government's health service reforms to properly bed in, but the shift of responsibility to local level presented considerable opportunities for dealing with parental substance use, she said. 'If you have GPs who recognise the need for services they will be feeding that up to the commissioners', although GPs still had problems identifying people when the problem was not immediately obvious. The government's alcohol strategy, however – which had been 'broadly well received by public health groups' – had made a clear commitment to identifying people at risk.

NEGLECT

Alcohol was both a 'contributor and symptom' of neglect, director of public policy at Action for Children, Helen Donohoe, told the conference. 'But we're absolutely passionate that it doesn't have to be that way.'

Child neglect was 'notoriously difficult to define', she said. 'A child deserves a safe home, healthcare when it's needed, emotional engagement and love, as well as stimulation, guidance and boundaries. As a society we have a very stiff attitude towards talking about things like emotional warmth.' Neglect was serious, however, she stated. 'It can kill, it can destroy a childhood and go on to destroy an adulthood as well. In the UK, it's the most common form of child abuse, but services often feel powerless to intervene if there's no physical abuse going on.'

Her organisation estimated that up to one in ten British children experienced neglect, she said. 'You can't simplify the causes, because it's incredibly complex, but you can identify some circumstances.' These included deprivation – 'although that doesn't mean that if you're poor, you're neglecting your children' – poor housing, inter-generational neglect of the parents themselves, disability, mental health, domestic abuse and substance misuse. 'ChildLine tell us they get around 100 calls a week from children worried about their parents' drinking,' she added.

Action for Children was campaigning vigorously to change the law around neglect, she stressed, while better inter-agency working and early intervention were crucial. 'We also want all social care professionals to be thinking about the child at home when dealing with adults.'

Of all the disadvantages affecting families, alcohol was the most common across all classes, said senior research fellow at the University of Oxford's education and social policy departments, Naomi Eisenstadt.

'In better-off families it's easier to hide – the house is bigger and the kids have got somewhere to do their homework. If you're living in poverty you're likely to be in contact with services – for your housing, your benefits – so any problems you have will be more visible.'

UNDERSTANDING

One of the things the government could do to help was reduce pressure on parents, she said, through things like paid maternity leave, encouraging flexible working and provision of universal benefits 'with no stigma or massive bureaucracy' attached. 'One problem with policy making is an absolute lack of understanding of the problems that poverty brings,' she stated. 'The government wants to enhance the capabilities of families, but you have a much better chance of doing that if you reduce the pressure on them. The problem with the current government is

'In better-off families it's easier to hide... If you're living in poverty you're likely to be in contact with services... so any problems you have will be more visible.'

NAOMI EISENSTADT

'Practitioners, if supported and managed and trained, can intervene to help children. But we still hear of people working in children's services saying "I don't want to get involved with drugs and alcohol..."'

VIVIENNE EVANS

that they don't understand that.'

The situation was likely to worsen, she warned, with rising unemployment – particularly among women – and changes to tax credits, housing benefit and the introduction of an overall benefit cap that would inevitably hit bigger families particularly hard. The removal of ring fences also made it difficult to track the reductions in funding for vital services.

'In our society, when it comes to alcohol, we have huge mixed messages,' said children and families substance misuse consultant Wendy Robinson. 'There's the heavy promotion of alcohol at one end, and at the other end of the spectrum if you do have an alcohol problem then it's something to be ashamed of.'

ENTRENCHED PATTERNS

Fixed and entrenched patterns could develop in families, she said, and what was necessary was 'evidence-based practice and practice-based evidence – let's learn from the services we're lucky enough to have'.

When engaging with families it was vital to remember that 'reluctance and ambivalence' were not the same as 'denial', she stressed, and that, for children, 'resilience is not the same thing as coping. Our work is to ensure that the child has a voice, a presence and a primary influence, and to work to ensure that the parent works to protect the child, and not the other way around.'

On that subject, child psychotherapist and family worker at BDP Casa Family Service Islington, Retta Bowen, told delegates that 'we often encounter children who are parenting their parent. They'll say things to them things like "please don't drink too much" and "when are you coming home?" It's important to remember that, as well as the child we're working with, the parent has usually been through those same traumas and is using alcohol to manage unmanageable feelings.'

It was vital to build trusting relationships, and help parents to 'regulate, self-soothe and recognise that they're traumatised by their experiences', she said.

Services also needed to be explicit about their mission, FDAP chief executive Carole Sharma told the conference, and ensure that those values were shared by the entire workforce.

RECOVERY

Any service was a learning environment for both practitioners and service users, she said, and although 'recovery' was a word that was often misused, there were ways to determine if a workforce was 'recovery-orientated'. 'Are they optimistic for the service users, do they establish partnerships with service users and their networks, and facilitate mutual aid? Also, have a look around where you work and take down all the posters with rules and regulations and images of death,' she urged. 'We need to professionalise ourselves – not just say we're working with others, but show that and make sure our clients know that.'

Independent consultant Esme Madill shared the results of Comic Relief's alcohol hidden harm project, which had funded five projects using a range of different interventions over a five-year period, to look at what worked best for the children of substance-misusing parents.

'Broadly, what we found to be most effective were services that were child-centred, whole-family orientated, therapeutic and evidence or experience-based,' she told the event – particularly those child-centered services that gave children places to go and things to do. 'Some of them told me it was the highlight of their week,' she said.

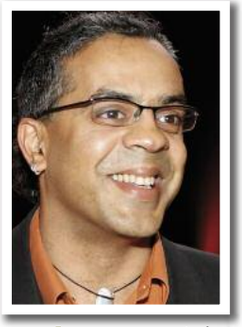
GROUP WORK

In terms of the older children interviewed for the project, many said that while important changes had often taken place during one-to-one work, group work had been hugely important as it had made them feel less isolated. 'They'd say things like "it made me realise I wasn't the only one going through this, and that was a huge relief".'

Almost all the projects had said they needed longer-term interventions, she stressed – 'not less than five to six months, and able to extend that support later according to client need'. Full involvement of universal services was vital, she said, with primary school teachers in particular ideally placed for recognising when things start to go wrong. 'You need strong leadership, you need to invest in partnership, and you need to evaluate the work and act on the findings,' she told delegates.

'We only have one asset, and that's our workforce,' said Carole Sharma. 'It's all we've got.'

Psychoactive cha



Knowing enough about each novel psychoactive compound that emerges in time to help clients can feel like an impossible task. **Kevin Flemen** gives a pragmatic approach to staying ahead

Anyone trying to keep abreast of novel psychoactive compounds (NPCs) will know what a daunting task this can be. My inbox is constantly refilling with bulletins informing me of new compounds, alongside emails from frontline workers asking about substances that their clients are experimenting with. As with any new development, a flurry of new responses emerges. In an echo of the period after the crack strategy was published, some agencies are creating 'NPC worker' posts. Elsewhere, commentators are using use the emergence of NPCs as evidence for stricter laws or as proof of the failure of prohibition, according to their ideology.

Closer to the coalface, one can spend thankless hours reading through forum accounts of people's latest psychedelic experiments, while their peers, with varying levels of knowledge, discuss the finer points of pharmacology.

In much the same way that an incautious worker can get drawn in to the chaotic presentation of their client, so the researcher exploring NPCs can get so swept along in the novelty, uncertainty and confusion that they lose sight of some pragmatic responses. I've found myself in this situation, chasing the illusory white rabbit in numerous forum threads. Over the past few months in training sessions, another set of responses has started to emerge, which can offer a useful approach:

1. Acknowledge ignorance

We need to be very cautious about thinking we know more than we do. From the lab that thinks it is making drug X, to the end user who believes they have bought a specific drug, there are layers of uncertainty. The lab, the web retailer, the head shop and the end user cannot be certain what they are making, selling or using.

Even if they could be certain, it doesn't help us that much because we don't know enough about how most NPCs will work in the short, medium and long term.

The snag for most people involved in this fast-moving scene is that we tend to crave facts. Whether posting to a website, writing a leaflet or offering training, we want to proffer knowledge. We then run the risk of creating an illusory sense of knowledge, when actually what we largely offer is conjecture and speculation.

The primary message to everyone contemplating use or who is already using is the extent of the 'unknowns'. It is not a failing not to know; it is a failing to not acknowledge that we don't know.

2. Work symptomatically

Given the colossal uncertainty as to what an individual has taken (or what combinations they have used) and how little we know about specific compounds, trying to ascertain what a person has used, or thinks they have used, may not be that helpful. Instead, a primary question should be 'how do you feel?' rather than 'what have you taken?'

If, for example, a person presents to club outreach workers saying that they have just used AMT, how do they know that's what they have had? Is this based on what the website/head shop/dealer/mate said? Without previous experience to compare it to, or an objective reference point, how can they know that this is what AMT feels like? And even if it is AMT, what else have they had?

Alongside this uncertainty, we may struggle to gain any objective evidence of what has been used. Newer drugs may not show up in tests or may give misleading positive results.

So it is much more useful – and important – to lead with an exploration of symptoms. Management of panic, high pulse rate, elevated temperature, delusion, blood pressure – these will be much more important in the short term than trying to identify exactly what the person has used.

3. Share knowledge

Having successfully managed a presenting situation (*eg* in a crisis) it is then wholly appropriate to try to identify what was used. It will be useful to ascertain the name of the substance, its appearance, packaging, route, dose and other substances used. But until confirmed by analysis, the identity of the substance should be treated as uncertain.

Without toxicology we can cascade what we know – that substance sold or bought as X, which looked like this and was taken like this, possibly caused these effects.

If we have toxicology results and it says that the

A primary question should be 'how do you feel?' rather than 'what have you taken?'

substance in question wasn't X but contained Y, then we can also brief the field to say that the substance sold and packaged as X was found to contain Y and had these effects.

If tests do show that substance X did, in truth contain X, then we now know a bit more about X than we did before – that it may be linked to these side effects.

Importantly, all such information cascades must be clear as to the evidence underpinning assertions, mindful that they may be of limited geographic relevance, and that they are time limited and can become obsolete.

4. Cluster drugs...

A model that I have found useful in training sessions has been to provide a detailed framework of drug families, so that people can locate newer drugs against more familiar comparisons. If we then at least start from the basis that our new drug shares the same risks as its nearest neighbours, we can start to engage with the substance and refine the information as more knowledge emerges. So by locating newer compounds such as etizolam or ethylphenidate alongside more familiar compounds such as diazepam or amphetamine, you can provide common sense advice on tolerance, overdose, mixing and withdrawal.

5. ...but use caution

Having extolled the virtues of clustering by drug families, there are of course limits to it. This includes the dramatic differences in dose range between older, adulterated drugs and newer drugs that may be stronger and purer. It can only provide a foundation. Newer drugs may turn out to be safer, or more hazardous and this should be acknowledged. A key area where a 'clustering' approach works less well is general drugs education literature. Saying, for example, that '6-APB is similar to ecstasy' is something of a double-edged sword. While it could inform useful harm reduction, it also runs the risk of popularising and effectively advertising a new drug.

6. Keep sight of skill sets

One of the key benefits of locating newer compounds within a comprehensible framework is that it allows workers to see how their existing knowledge and skills can be applied. In the face of a flurry of new drugs, some people seem paralysed by abbreviations and slang names. But those same workers were skilled at working with people who had cravings, were bingeing on cocaine, or who were experiencing bad ecstasy-related comedowns. Reinforcing that their skills are transferable to newer compounds can leave workers empowered and more confident in engaging with them.

7. Review popularity

Not everything becomes popular. It is certainly the case that there's been a veritable slew of new drugs coming to market as reported by international and European monitoring, but very few of those drugs will ever appear on the UK market and fewer still will gain popularity. So time and energy can be wasted researching and preparing for some NPCs that will never become an issue.

Throughout the distractions of the new, the less new is becoming more and more popular. Mephedrone has become a fixture of some regional drug markets, but elsewhere the most widely reported newer compounds have been gabapentin and pregabalin. So amid the coverage of NPCs, we need to be aware of less high profile compounds that are gaining ground.

8. Keep sight of fundamentals

It's important not to lose sight of some fundamentals here. NPC use rose in part and peaked because the 'right drug', 4-MMC, arrived at the right time – pre-austerity, with a market typified by poor quality cocaine and MDMA.

We don't have a good evidence base in relation to use, but there is some evidence that while a small number of people are dabbling with NPCs, the majority, given a choice, will gravitate back towards the 'classics' of cocaine, MDMA, cannabis and speed.

Those who are experiencing the biggest problems and need targeted interventions are:

- multiply vulnerable people, including young people for whom NPCs are just the latest, most available ways to be altered
- young naive users who are able to source potent compounds with little information or skills for harm reduction.

9. Get tech savvy

The internet plays a critical role in the emergence of NPCs and in changes to existing drug markets. It is therefore essential that workers keep their knowledge of evolving technologies as up-to-date as their awareness of new drugs. This includes being confident and familiar with undertaking primary research online in a number of arenas (such as drug discussion forums), and able to critically assess the value of the information.

It is no longer enough to rely on one or two authoritative sources of information as they are all too often woefully behind the curve. In turn, the need to be able to roam the web means that organisations that restrict access to websites based on catch-all search terms (such as 'drugs') must review and change their policy. Expecting workers to stay abreast of NPCs while restricting net access is akin to expecting someone to navigate from London to Glasgow with only a sextant and a mappa mundi.

Beyond pragmatism

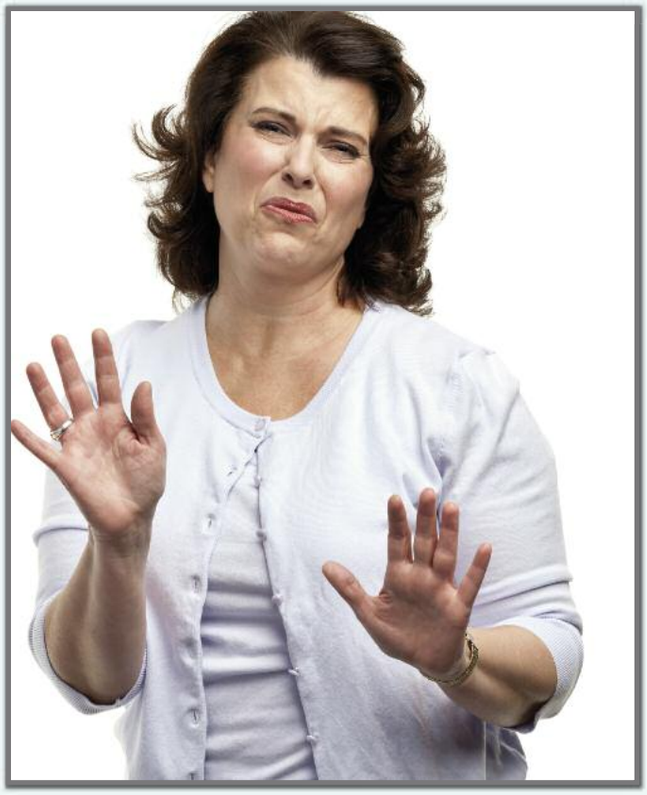
There are of course many interventions beyond these pragmatic suggestions that need to be explored in relation to NPCs. The way substances are analysed and tested and how this information is shared with the wider field and end users is a significant challenge and the legislative framework and regulation of sale needs wholesale review. Retaining outreach, educative and harm-reduction interventions for people using NPCs is essential, even while other parts of service align themselves with delivering recovery-orientated services.

While these greater systemic issues will get addressed slowly, there is much that we can do now, with what we do know and the skills we do have. **DDN**

Kevin Flemen runs KFx, a drugs information and training services and has delivered training sessions about NPCs around the UK. For more information and resources go to www.kfx.org.uk

LETTERS

'The general air of hostility, suspicion and barely concealed contempt usually starts with the reception staff, very often continues with the GP and almost always continues in the pharmacy afterwards.'



UTOPIAN VIEWS

Much as I'm sure that Post-its columnist Dr Steve Brinksman is an excellent and committed GP, I can't help feeling that many of his observations about NHS primary care are perhaps a little rose-tinted and utopian. They certainly don't bear much resemblance to my own experiences.

In February's column (page 7) he talks about one of the privileges of being a GP as 'the opportunity to follow through the "cradle to grave" ethos that the NHS was founded on', knowing his patients from a young age onwards throughout their lives. I can't remember the last time I saw the same GP twice at my practice. Perhaps what he's describing is normal in small towns or predominantly rural communities, but in inner city practices – such as the one in Birmingham where he works – surely this is the exception rather than the norm?

Then in the write-up of the service user conference (*DDN*, March, page 8) he describes general practice as an environment that 'aims to be' non-stigmatising. I'm glad he felt the need to qualify that. I've no doubt that there are GP practices that are like this, but it strikes me that they must still be fairly few and far-between. I've certainly never experienced one. The general air of hostility, suspicion and barely concealed contempt usually starts with the reception staff, very often continues with the GP and almost always continues in the pharmacy afterwards.

I think the experiences detailed by participants in the conference's *Right to treatment* workshop (*DDN*, March, page 10) are probably much more representative of general practice as a whole, with people describing attitudes of 'you've brought it on yourself' or how medical professionals hate to have their opinions challenged.

I know the NHS is facing great challenges in terms of funding and resources, and I know its staff are often over-worked and over-stressed. I also know that attitudes are probably slowly improving. But I do think we've got a very long way to go before most people get to experience anything like what Dr Brinksman describes at his own practice.

Name and address supplied

ELECTRO REVOLUTION

Professor Howard Parker acknowledges the harm reduction benefits of e-cigarettes (*DDN*, April, page 18), but also says they do not have a scientific clean bill of health.

E-cigarettes deliver nicotine in aerosol form without the hazards of tobacco smoking. As nicotine has minimal health impacts, they can dramatically reduce harm to smokers. With the rapid growth of the e-cigarette market, we are seeing a consumer-led health revolution that requires no NHS resources.

However, the UK government, along with the US and others in Europe, is gearing up to classify e-cigarettes as medicines, which would bring heavy regulatory burdens, costs and restrictions. It would be appalling if, in the name of safety, regulators smothered the e-cigarette market in red tape, tipping the balance back in favour of smoking cigarettes.

Gerry Stimson, emeritus professor, Imperial College London

Professor Stimson will be writing about e-cigarettes in the June issue of DDN.

CLOSE TO HOME

Your last issue touched on issues that are very close to me. Going to prison for a drug offence took me away from my children and broke up our family (*DDN*, April, page 8). My two children were taken into care and my daughter still does not forgive me.

I attempted suicide twice and did things I am very ashamed of. I still find it hard to live with myself and my children will never forgive me for the pain I made them go through. I am not in touch with their father any more.

I now volunteer as a women's support worker and it gave me some hope to learn that the Prison Reform Trust are working with these other organisations to make sure that women who are not violent have the chance of getting support to reform and stay with their families. The only time I was violent was to myself.

If I had had the support your authors talked about, my life would be very different.

Name and address supplied

We welcome your letters...

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

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Some people will always need 'welfare'. What is now commonly imagined, though, is that those who most need help should be punished for needing it. This is real emotional austerity. Cold, hard, crossing over the other side of the street stuff to avoid the poor.
Suzanne Moore, *Guardian*, 2 April

It's hard to imagine a more repulsive creature than Mick Philpott, the lowlife benefits scrounger convicted of killing six of his children in a fire. And who paid for his disgusting lifestyle? We did. Philpott may be the dregs of humanity. But the welfare system helped him every step of the way.
Sun editorial, 3 April

His house, his booze, his drugs, his women and his 17 children were paid for by a benefits system meant to be a safety net for the truly needy... Indeed, Philpott never even attempted to find a job. The children owed their existence to his desire to milk the welfare system.
A N Wilson, *Mail*, 2 April

The roll out of the government's latest benefit cuts binge has begun in four London boroughs, ushering in a policy marked by that special form of stupidity so prized by the Thatcherite right. Economic honesty, long-term social cost and any attempt by the politicians responsible to imagine what life might be like for people different from themselves have all been sacrificed in deference to the cheap politics of ignorance, resentment and spite.
Dave Hill, *Guardian*, 17 April

Shipbuilding, steel and coal were sacrificed on the altar of Thatcherism. The 1984-85 pit strike for jobs ended in victory for her. And a terrible defeat for villages and towns now plagued by despair, joblessness and drugs. Never forget, never forgive.
Kevin Maguire, *Mirror*, 8 April

Certainly, arresting cannabis users involves more paperwork than it should. But isn't the main reason why drug abuse wrecks so many lives that the police won't even attempt to tackle it?
Mail editorial, 1 April

Until we have the guts, as a country, to recognise the catastrophe of our drugs policy, and challenge the hysteria and immaturity that consigns millions of people to needless misery, innovations like [consumption rooms] in Brighton will be welcome but small distractions, a bunch of needles in a giant, international haystack of our own making.
Amol Rajan, *Independent*, 18 April

Brighton, already reeling from its drug problem, would instantly become a magnet for drug users and dealers alike. Shooting galleries are also public health hazards, with increased rates of HIV and hepatitis.
Melanie Phillips, *Mail*, 18 April

It will not be long before your home town has special places where drug abusers can poke or snort poison into their bodies. These will be legal and paid for by you and me. It is a stupid idea, of course. People who take such drugs are selfish parasites in need of deterrence, not patients in need of treatment. The nicer we are to them, the more of them there will be, as we have proved conclusively over the past four decades.
Peter Hitchens, *Mail on Sunday*, 21 April

POLICY SCOPE

What will happen when drug and alcohol services are at the mercy of local decision-makers, asks Marcus Roberts

LOCALISM MATTERS

THERE HAS BEEN PLENTY OF DISCUSSION about the implications of the results of the local election on 2 May for national politics, as a barometer of the performance of the national parties and their leaders. It is easy to forget that these elections are important outside of the 'Westminster bubble' too, because of their implications for local services. The elections of councillors in these upper-tier and unitary authorities will help to determine the composition of health and wellbeing boards and police and crime panels for example, local bodies that are making critical decisions about drug and alcohol services.

The enhanced role of local authorities also emerges as a theme for the Public Health England (PHE) statement *Our priorities for 2013/14*, published at the end of April (see page 4). While PHE is the 'expert national public health agency', in reality its influence will depend on its powers of persuasion and the quality of its 'evidence-based professional, scientific and delivery expertise and advice'.

PHE will be important for the future of drug and alcohol services, having absorbed the former National Treatment Agency (NTA) in April. PHE includes 'improve recovery rates from drug dependency' among its priorities, and has inherited the personnel, expertise and infrastructure from the NTA to drive this forward – yet it remains to be seen what it can do, if anything, should some local authorities disinvest in drug services. The PHE 'priorities' document clearly states that 'improvement in the public's health has to be led from within communities, rather than directed centrally' and that 'PHE will not performance manage local authorities'.

A related question concerns the status of the *Drug strategy 2010* and *Alcohol strategy 2012* in a localist environment. For example, DrugScope argued that Department of Health guidance for health and wellbeing boards on local needs assessments and health and wellbeing strategies should include a list of key national documents to inform local plans. This recommendation was rejected when the guidance was published in March. So what weight will these national strategies carry with the people responsible for service design locally?

There has been a lot of debate about the likely impact of both the abolition of the NTA and philosophy of localism on drug and alcohol services, ranging from out and out doom-mongery to a 'seen it all before' nonchalance ('plus ça change, plus c'est la même chose', as the French have it), with most plumping for the 'risks and opportunities' mantra. We are now at the business end of the current policy cycle, so we will soon start to see what happens for real.

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

FAMILY MATTERS

IT'S A MAN THING

How can we encourage men to access support groups, says **Joss Smith**

ADFAM WAS SET UP BY THE MOTHER OF A DRUG USER who was in search of support but unfortunately could not find any. This situation has been repeated over the last 29 years across the country and today there are many community family support groups set up by family members who have themselves experienced the impacts of drug and alcohol use on the family.

In the large majority of these communities the groups are set up, facilitated and attended by women, with men significantly under represented. Adfam launched its Including Diverse Families project in 2007 and included 'men' as a diverse group to try and address this issue. However, across the country, men are still not accessing the support groups, one-to-one sessions and services family support offers.

'It is Men's Health Week from 10-16 June – perhaps this is an opportunity for family services to review their provision...'

Men – brothers, fathers, sons and partners – can be just as profoundly and adversely affected by drug or alcohol use in their family as women, but often respond in different ways. It is often the mother or female partner of a drug or alcohol user that will initially look for and access support. Male family members often either resist support or feel existing support provision is not appropriate for them, which leaves them feeling isolated.

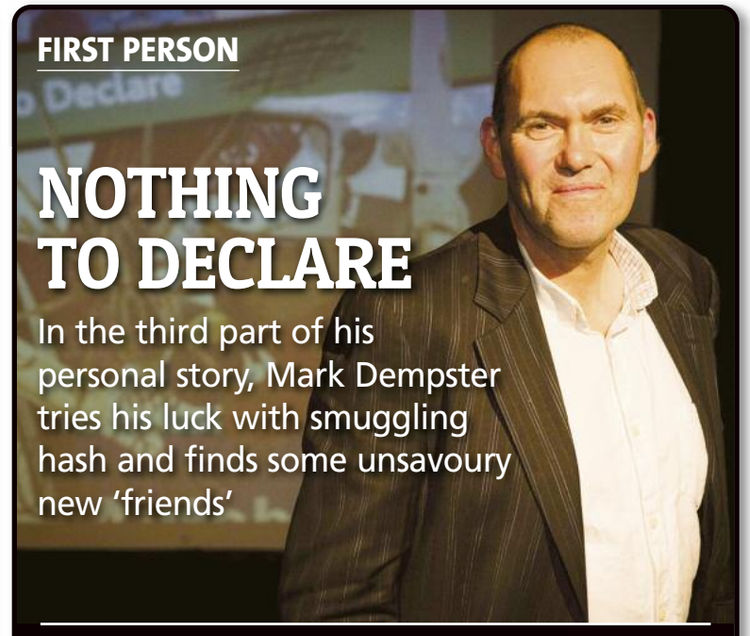
Many services experience difficulty in encouraging male family members to seek and access support. The family support sector is often perceived by men as being for women (and children) only. The disproportionate representation of women among staff and clients can lead men to think that support services will have a feminine atmosphere, or provide only a 'tea and sympathy' environment. Some services do have an overtly female focus and culture among staff and service users, and the term 'carer' is often seen as applying only to women and not to men.

Cultural and social norms, expectations of masculinity and an adherence to dominant notions of male independence, self-reliance and strength also have an impact. There is reluctance among men to admit to problems and seek help – men often feel that they have to fix the problem and do not want to be seen as not coping. Some support staff admitted that when supporting the mother they often 'forgot' to ask about the father and how they were coping. Sometimes the mother's negative opinion of the father is unchallenged by staff, unaware of the family's history, and others reported being discouraged to offer their support to men for fear of antagonising female service users.

Perhaps in light of all of the above, men are still fairly consistently under-represented and their needs regularly go unaddressed. It is Men's Health Week from 10–16 June – perhaps this is an opportunity for family services to review their provision to respond better to the distress, shame and pain men feel, living with a drug or alcohol using loved one.

Joss Smith is director or policy and regional development at Adfam.
Funding family support *can be found on Adfam's website, www.adfam.org.uk*

FIRST PERSON



NOTHING TO DECLARE

In the third part of his personal story, Mark Dempster tries his luck with smuggling hash and finds some unsavoury new 'friends'

TERRORIST BRIAN HAD BEEN RIGHT about the cheque cashing charges – I pleaded guilty and accepted a slap on the wrist and another fine. I was lucky and I celebrated with a trip to India with my girlfriend. I was in the back of a hut in Goa when I first tried opium – I loved it and couldn't stop taking it the entire time we were there. All she wanted to do was see the sights and do 'couple' stuff. By the end of the trip she made me promise not to use drugs anymore and stopped me smuggling some hash back to London – I broke up with her when we got back.

Seeing how easy it could have been to smuggle hash, I convinced a friend that we should go back and get a few kilos of hash from Malana – we could sell it for thousands in London. We trekked through mountains to get to the village – we could have frozen to death in the Himalayas or been killed by angry villagers because we didn't know the local customs. But with a guide and a lot of luck we got our hash through the airport at Delhi and would have got back to London if it hadn't been for a detour through France. We had decided that I would be the hippy decoy and my friend would dress smart and carry the hash. It didn't work. We lost the hash and he ended up doing several years in a French prison. I got away with less cash than I started.

Back in London I used the contact with Brian to get a supply set up. Nick was helping, but got locked up for possession. At the time Brian was producing most of the speed in London and I was building a big business selling thousands of pounds of drugs a day. I needed help to run things so I brought in some friends – Walshy was my man who dealt with the customers. We had been friends since childhood and it felt good having him around. Besides, it gave me somebody to get high with.

With the drug business a 24-hour job and the pressure of dealing with the chaos of Terrorist Brian and his psycho henchmen, I took more drugs to cope. I had gone from opium to smoking heroin and was drinking from the moment I woke up until I passed out at night. I couldn't get up in the morning without downing a can and chasing the dragon. Walshy was a speed freak and Brian a cokehead. I wanted to get away from Brian, but I was locked in; he would kill me if I left.

The business was getting dangerous too – the Hells Angels tried to murder Nick because they couldn't find me to make me pay for a drug deal gone bad. Things weren't going well. I thought that I just needed to get my own supply, and then things would be better. That was my new plan.

Mark Dempster is author of *Nothing to Declare: Confessions of an Unsuccessful Drug Smuggler, Dealer and Addict*, available now on Amazon.
Next issue: Life takes a more dangerous turn when Mark is taken prisoner in Morocco

STAYING SILENT

Adfam share new research that reveals why families often struggle for a long time before seeking help with a problem drinker

Drugs and alcohol are often grouped together in discussions of substance misuse. Although there are many crossovers, there are also some crucial differences, including the impacts on the family and how relatives go about accessing support. Family members interviewed for Adfam's research often struggled for a long time before accessing help – many over five years, some over 20, and some never at all. The reasons behind this were numerous and complex, but at the heart of it was a difficulty in identifying what constituted an 'alcohol problem'. This could be linked to the seeking of help by the problem drinker themselves, many of whom wait 12 years longer to access treatment than drug users. This could in turn limit their family members from accessing support too.

Although they may face their own delays in seeking support – not least because of stigma and shame – families who find out a loved one is using drugs may be quick to identify this as a problem, as an illegal activity associated with a number of health and social harms.

By contrast, the legality of alcohol, its widespread use and the societal ambivalence towards (or even celebration of) heavy drinking all mean that concerned others can struggle to classify a family member's alcohol use as a drinking problem. This was tied up with assumptions and stereotypes of what an 'alcoholic' is, and an inability to match this up with their own family member.

Drinking problems can also develop gradually over time, without an obvious tipping point into dependency or alcoholism. This could be exacerbated if the drinker was able to conceal their consumption (one family member recalled finding a stash of empty cans in the attic as a moment of realisation), or if they were able more generally to maintain the pillars of a 'normal life' like holding down a job. 'Tipping points' were hard to identify, but families said that only when the drinker was unwilling or unable to cut down that the problem really came into focus.

Binge drinking was a topic of interest for families, as it represented a pattern of alcohol use that was not classed as 'dependent' but which could still have significant negative impacts on family life and relationships. However, according to the research, GPs and specialist services usually didn't deem this 'serious enough' to warrant official intervention, and families could feel even worse for having broached the topic as it could provide support to the drinker's claims that there was no problem with their consumption.

Even when trying to open up to friends, families could find themselves in a catch-22: if they focused on the level of consumption alone, then they struggled to get their point across as to how serious things had become; but if they focused on the behaviours associated with their loved one's drinking – arguments, fights, car crashes, incontinence – then they risked horror, incomprehension and stigma from those around them.

Some family members also showed a lack of awareness of their own needs, and many assumed that getting help for the drinker was the only issue at hand. Even for those who did feel they needed support, they often didn't know it was available or were doubtful that it would do any good; families were again quite critical of GPs and specialist services, and examples of being signposted towards support were few and far between. These were crucial missed opportunities not just to engage families, but to engage drinkers too.

For the families interviewed who did access support, feedback was generally very positive – they viewed it as a 'lifeline' and a 'godsend', and valued the opportunity to explore their problems in a non-judgmental environment. However, the range of support tended to be limited to self-help groups, where not all families felt comfortable, or more focused on drug use than alcohol.

Overall, this research shows that families affected by a loved one's drinking seem beset on all sides by barriers which prevent them from accessing support. They may not have the knowledge to identify a drinking problem in the first place; they don't always recognise the impact it has on them, and their own consequent needs; they're often unaware of the existence of family support, or sceptical of the benefits it could bring; and their first step in reaching out may not be a positive one and knock them back even further.

As well as improving the reactions of professionals to families' queries, there is also a need for families themselves to increase their comprehension of problematic alcohol use so they feel confident and motivated to seek support when they feel that they need it. Perhaps the government's current focus on the widespread, cheap availability of alcohol may make people confront how much they drink in ways we haven't seen before, although this remains to be seen; but either way, there is a clear need for expansion and improvement in the number and quality of services which support people struggling with the day-to-day impact of alcohol use in their family.

***Out of focus: how families are affected by problem drinking, and how they seek support* available from www.adfam.org.uk.**

This article is from the latest issue of Families UpFront, Adfam's quarterly magazine for professionals working with families affected by drug and alcohol use, which covers important policy developments, the latest good practice news and key issues in family support. For online and print subscriptions visit www.adfam.org.uk or email publications@adfam.org.uk.

TRAINING AT THE BAR

As the Swanswell Inn opens for business on a Monday morning in Birmingham, it becomes obvious that this is no ordinary pub. The mobile mock-up has been created as a training facility for businesses to understand how alcohol and drugs can affect people in the workplace, and how they can tackle problems effectively.

'Recent statistics suggest that work stress is now the biggest factor driving people in Britain to alcohol and drugs,' says Swanswell's talent development manager, Sharon Smyth. 'Just over half of adults polled by charity Mind said they drank after work, with one in seven admitting to drinking in the day, so it's not surprising that sickness absence caused by alcohol misuse is costing UK businesses around £6.4bn a year.'

The charity's training gives anyone with a responsibility for workforce welfare an opportunity to learn skills and ask questions so they can apply their knowledge to real life situations.

'Employers often have problems identifying potential substance misuse and knowing how to support team members affected by it,' says Smyth. 'Initial conversations can be tough to start, so it's important such situations are approached sensitively and backed up with facts.'

www.swanswell.org

Keeping it REAL

Lucy Seymour-Smith recently attended Aquarius's service user conference as a new recruit to the alcohol charity's team. Here she shares her first impressions of the event

This year is my first service user conference. Being based in head office means that I don't get to see many service users, and so I'm really looking forward to this as an opportunity to see the people that Aquarius is all about.

Everyone's looking really friendly as they start to arrive. A few people seem to have come not knowing anyone else but next time I've looked up they're chatting away happily. One of the things I read about last year's SU conference was that it was good for people to meet up with other people in the same situation as them, and I can certainly see that 'common ground' factor.

I'm surprised to not see that many older people here – the vast majority are young or middle aged. Alcohol misuse in older people is so under-reported. As we get ready to start, Aquarius staff are chatting away to service users – I can see a lot of good and obviously developed relationships. Chief executive Annette Fleming makes a very thoughtful and down to earth speech about the importance of events such as this to celebrate what service users have achieved so far, as well as bringing hope by seeing what others have done.

Three service users give their stories on struggles with alcohol, gambling and drugs. I knew this stuff happens, but to see people bravely struggling through the pain of reliving their past is something else. Tears held back by deep, controlled breaths; an obviously painful experience that is visibly a great milestone for each speaker.

Powerful poetry and strong statements are used by the speakers to express themselves and their feelings – it's remarkable to see creativity crafted so eloquently to put into words years of despair.

Some of their quotes stuck with me:

'Alcohol can lead to dark places, but we can overcome this for a better life.'

'My doctor saved my life several times, and never gave up on me – even though he probably should have several times.'

'After the first year, not drinking gets easier and easier – I can assure everyone here.'

'Before, when I was drinking, at times I didn't know who I was or where I was.'

'There are doors in the mind that are just too painful to open.'

'Stopping drinking is hard, but not as hard as keeping on drinking.'

Later Shaheen Choudry gives a great talk on BME communities that weren't accessing alcohol services and Nita, a community champion, helps to identify what events are going on so people can see Aquarius there.

During question time someone asks about the biggest changes at Aquarius over the past few years. David Millard, chair of trustees, talks about the new environment of tendering, which is very competitive – we've gained and lost projects. Service user meetings have become an important part of forming partnerships – clients can teach us. He says that there's always another step to the journey and that's what we're here for.

Annette Fleming says the organisation has grown because we've got a more diverse range of skills and experience. She says it's important that people know that if they feel they need to come back to Aquarius, they can. We want to always be welcoming – it's as simple as that.

Lucy Seymour-Smith is communications officer at Aquarius, www.aquarius.org.uk

Staying ahead of THE INSP

The Care Quality Commission is once again changing the way it inspects and rates substance misuse services. Make sure you are prepared, says **David Finney**

The Care Quality Commission has released a new strategy, *Raising standards, putting people first – our strategy for 2013–2016*, **and it could have major implications for the substance misuse sector**.

Recent reports from Mid Staffordshire, Winterbourne View and the Health Select Committee have all been critical of CQC and its operations. Internally, CQC has commissioned two reports which have also set challenges, such as the restoring of 'star ratings' and an overhaul of its methodology. So what are the changes we should look out for?

CQC now seems to have ended its generic approach to regulation. The commission says that there will be new 'fundamental' care standards, differentiated by sector, with specialist teams to inspect hospitals and social care services. The health secretary, Jeremy Hunt, has announced that CQC will also reintroduce 'performance ratings' so that the general public will have good information on which to base their choices of services. CQC also says that it will inspect services according to risks posed to people who use the service – an 'about turn', after recently committing themselves to annual inspections.

Other significant changes will be the appointment of a chief inspector for hospitals, as well as chief inspectors of social care and primary care. CQC has been quite open about its priorities, saying that 'the changes will come into effect in NHS hospitals and mental health trusts first, because we recognise that there is an urgent need for more effective inspection and regulation of these services.' It goes on to say that 'we will extend and adapt our approaches to other sectors in 2014 and 2015.'

The immediate questions for the substance misuse sector regarding this 'direction of travel' are:

- How specialised will the inspection approach be, *ie* will substance misuse be seen as a 'stand alone' sector?
- The substance misuse sector is comparatively small, so how can it be heard in the consultation process on the new standards and the new methodologies?
- Will there be an opportunity to contribute to the training of inspectors in the particular knowledge and skills necessary to inspect the substance misuse sector?
- What will the performance ratings look like, and will they reflect how excellence is perceived in the substance misuse sector?

My view is that the 'big players' in the sector and the representative bodies need to ensure that they are in communication with CQC at an early stage so that their voice is heard. There is also no harm in single providers making representations to be included in the consultation process, because CQC says that it is committed to working with partners in the health and social care system.

Another interesting strand to the CQC strategy is the desire to listen to people who use services. CQC says that it will focus on gathering the views of people in the most vulnerable circumstances. There is also a specific point under the heading of 'Involving people in our work', which says that: 'We will set up a panel of people who use services to inform all aspects of our work and improve how we gather the views of the people who use services.' CQC also says that it 'will improve how we involve small and diverse community groups in our work.'

These seem to me to be great opportunities for service user representative groups to get in touch directly with CQC and raise issues on behalf of people who use substance misuse services. And remember this includes many community services which are registered with CQC as well as residential services.

The next and most immediate question is: what can we expect in the coming year?

The public statements of CQC are that it will be 'business as usual' for the social care sector. This means that the approach outlined in *Improving the way we regulate*, (a document published in February 2012), still applies. This means that you will be inspected on at least five outcomes, one from each of the chapter headings in the 'Essential standards'. The intention of CQC was to cover all 16 outcomes in a three-year period, so it is likely that the outcomes inspected will be different this time around.

A reading of inspection reports shows that CQC tended to look at the following outcomes most often during the last round of inspections in 2012-13:

- Respecting and involving people who use services – 1
- Care and welfare – 4
- Safeguarding – 7
- Supporting workers (supervision and training) – 14
- Monitoring of quality – 16

So for the forthcoming year, as providers, you need to look at your last inspection report and check if these outcomes have been inspected. If any haven't, then make sure you are up to speed and prepared for them. If they were inspected, then you need to look and see what CQC might prioritise next. In its documents CQC says that it will inspect according to information received, so if there have been any safeguarding issues raised or complaints passed onto CQC then these outcomes will be the first to be inspected. Also, CQC says that it tailors its inspections according to the services you provide, so the next priority may be other key components of the treatment you deliver. My suggestion is that the following might be high on CQC's priorities if they haven't been inspected already:

- Consent – outcome 2
- Medicine management – outcome 9
- Staffing – outcome 13
- Complaints – outcome 17

There has also been a growing tendency for CQC to ask about any people in your services who might temporarily lose capacity to make decisions where the requirements of the Mental Capacity Act 2005 become relevant.

The preparing of evidence for your inspection is important and needs to be

PECTOR

well thought through. This will involve ensuring that relevant policies are up to date and that the approach you are taking matches that outlined in CQC's 'Essential standards'. It could also be crucial to prepare your staff, and people using your services, for any discussions they may have with the inspector, so they know what to expect and can answer the questions as openly as possible. Some providers have found an external audit very useful, both from the information gained and also the experience of being inspected on outcomes, with which they may not have been familiar.

'CQC... says that it will inspect services according to risks posed to people who use the service...'

My recommendations are that you get involved, be well prepared, don't leave it to others, and ensure that service users are right at the heart of what you do.

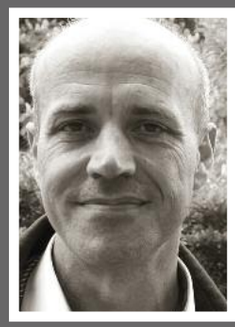
David Finney is an independent social care consultant with a specialist interest in the regulation of substance misuse services and was formerly national lead for substance misuse services with CSCI.

He will be running a one-day course in partnership with DDN, on Tuesday 18 June, to look at the changes in detail. CQC compliance - whatever next? is at The Malmaison Hotel, Birmingham; email kayleigh@cjwellings.com or call 01233 636 188 for details.

VOICES OF RECOVERY

TAKING OVER THE ASYLUM

Are we ready to embrace truly service user led services, asks **Alistair Sinclair**



I WAS BACK ON TRAINS IN APRIL, which gave me the opportunity to hear from a lot of people about their approach to 'co-production', a word and concept, championed by public health, that's slowly entering into the mainstream. I was in Norwich on the 17th, facilitating a UKRF asset-mapping recovery seminar for (mostly) service users and 'peer supporters'. The next day at the London User Forum (LUF) in Barking I heard about some great user-led stuff going on in London, and a week or so later I was in Widnes at a recovery event doing a bit more community asset mapping and hearing about a different LUF, the Lancashire User Forum. A couple days after that I was in Rickmansworth in Hertfordshire delivering another UKRF seminar, this time focused on assets in the 'Three Rivers' area.

Tim Sampey, the CEO of 'Build on Belief' (BoB) a charity established in 2012 (having grown from SUDRG in Notting Hill, West London) to run peer-led activities and services for people with substance issues, spoke at the Barking LUF. In an eloquent, passionate and 'off the cuff' speech, this stood out for me: 'There's something going on... a revolution... service users are becoming a major part of the delivery of services... this is going to get bigger and bigger... we need to connect with each other across London and learn and grow together.' I've been reflecting on Tim's words, on what I've seen in the last month, the willingness of many service users, practitioners and community members to share their assets, get involved, 'co-produce', and thought a little bit of recovery history might be interesting.

Larry Davidson in his book *The Roots of the Recovery Movement in Psychiatry* (Wiley-Blackwell, 2010), traces the beginnings of 'recovery' as an orientation back to the work of a chief physician, Phillipe Pinel, and Jean-Baptiste Pussin, who worked together in Paris at the Bicêtre Asylum from 1793. Pussin, the superintendent of the asylum (working alongside his wife) had himself been an 'inmate' at the Bicêtre in 1771.

So what did they do to dramatically improve 'recovery' within the asylum? In a nutshell, they imposed a zero tolerance policy on abuse – nearly all the staff were eventually sacked and replaced by 'former and recovered inmates'. They supported a community-learning environment and, most significantly, they gave meaningful work to the 'inmates'.

'We will find, perhaps surprisingly, that recognition of the value of hiring people in recovery to provide care to others – what is currently called "peer support" – can be traced back to this era, when Jean-Baptiste Pussin... was not only the first to remove the inmates' chains but also the first to use the strategy of hiring convalescing patients to provide *traitement moral* to the patients of the asylum.'

I'll leave you with a couple of questions. If, as Duncan Selbie from Public Health England says, homes, jobs and social connections lie at the heart of wellbeing and health, and if 'co-production' is key to the development of 'healthy' services and communities, how ready and willing are we to let the 'inmates' run the 'asylum'? Are we prepared to remove all the chains?

Alistair Sinclair is a director of the UK Recovery Federation, www.ukrf.org.uk

NEW DIR

'It's clear that the global consensus on prohibition is breaking...'

ANN FORDHAM

'It's clear that the global consensus on prohibition is breaking,' says International Drug Policy Consortium (IDPC) executive director Ann Fordham. 'But that doesn't mean there's going to be a new consensus.' IDPC is a global network of nearly 100 NGOs and other organisations that aims to encourage debate and promote more humane and effective policies across the spectrum of drug control. 'If we look at the global drug policy debate there's been some significant shifts in the last few years, with more and more countries looking at the option of the removal of criminal sanctions for drug use and possession for personal use,' she says.

The Organization of American States (OAS), for example, has been leading a review of Latin American policy, and is expected to launch two reports later this month – an analysis of the current situation as well as a 'scenarios' document on what might happen if countries were to adopt approaches not necessarily based in strict prohibition.

Looking at those discussions, it's clear that 'there's been a massive shift', she states, but that doesn't mean that all countries are moving in the same direction. 'Russia is absolutely entrenched in complete rejection of any kind of harm reduction, for example,' she says. 'Human rights NGOs are being shut down on a daily basis, and last year they asked USAID and other multi-lateral bodies to leave the country. They're positioning themselves as a donor for the Central Asia/Eastern Europe region, and that's a scary thought – what kind of conditionality will be tied to Russian funding, given that they don't accept needle and syringe programming? In Russia, 50 per cent of people who inject drugs are living with HIV. That's a million people.'

Is there any effective way to exert pressure? 'It is the challenge, and it's why we do what we do,' she says. 'There are two lines of advocacy, and one is to show them as increasingly isolationist. They look like they're on the outside now because so many countries are discussing more pragmatic and public health-based approaches to drug control. The other option that is still really important is to find lines of constructive engagement where possible, and that's extremely difficult.'

Was it any easier in the days before Putin? 'They've always been fairly hard line,' she says. 'The difference is that the US used to be the global enforcers of a very prohibition-led approach, but they're moving away from being the hardliners and Russia is moving into that space. It is a challenge, but we need to keep putting pressure where we can, using relationships with other donor agencies and institutions like UNODC, and reminding the European Commission that they need to focus on Russia because of the neighbouring countries and the rising HIV epidemic.'

There was a fear that Yuri Fedotov taking over as UNODC executive director would signal a tougher approach (*DDN*, 19 July 2010, page 5), but it seems that may have been unfounded – does IDPC share that view? 'That was a concern

David Gilliver talks to International Drug Policy Consortium executive director Ann Fordham about raising awareness and the changing course of the global drug policy debate

ECTIONS

and we did a lot of advocacy work with a strong focus on UNODC because they're the global lead on HIV among people who inject drugs,' she says. 'Mr Fedotov, for a long time, did not come out and make any strong statements about harm reduction or how a punitive approach fuelled the HIV epidemic, but we do think that's shifting.'

While he made 'some quite supportive statements' at the Commission on Narcotic Drugs (CND) this year it's important to remember that it was 'on the back of sustained advocacy from civil society, and some very concerned donor governments saying that UNODC had to show political leadership on this issue and that Mr Fedotov must not be swayed by the Russian government,' she states.

*****

IDPC recently published a well-received report in partnership with Chatham House and the International Institute for Strategic Studies (IISS) on different approaches that law enforcement agencies could take in managing drug markets – shifting the emphasis from arresting users to problems like violence, corruption and HIV. 'It sits alongside the drug policy reform work, but it's also about what we can do today to understand where resources can be best spent and where we've perhaps been pursuing wasteful strategies that have actually created more harm,' she says.

IDPC is also coordinating the *Support. Don't Punish* campaign (see next page), which aims to highlight how criminalisation of people who inject drugs increases risks around HIV/Aids and other blood-borne viruses, part of a project to boost harm reduction services in Africa and Asia. 'The idea is that to scale up harm reduction services you have to address the policy and legal environment in which those services operate,' she says.

As well as raising awareness, the campaign is calling for more money for 'grossly underfunded' harm reduction services. 'Globally, people who inject drugs have access to an average of two needles each per year, which is absolutely appalling coverage, so this is a call on donor governments to make a strong commitment. That's the 'support' aspect, and the 'don't punish' element is about removing the criminal sanctions associated with drug use. People are stigmatised and put in prison, where they're extremely vulnerable to HIV infection because there's even less coverage of needle and syringe exchange and opiate substitution therapy.'

IDPC's network of member organisations gives it global coverage, but there are still regions where it feels it needs to reach out to more members, such as Africa, where issues around drug use and trafficking are becoming increasingly important and the response 'is still quite nascent,' she says.

With a steering group made up of representatives from across ten regions, how easy is it all to coordinate? 'It is a challenge, but IDPC is first and foremost a network, and we really believe in the value of having a global coalition of organisations working together. As with any network, there's a challenge in terms of communications and coordination but we're living in the age of very good social media and other communications, and there is usually a regional lead to coordinate.'

One key role is to develop advocacy tools for use by partners and members, and regular requests for advocacy training have led to the creation of a toolkit that will be launched at the Harm Reduction International (HRI) conference next month – 'a set of tools that you can take off the shelf and develop your own advocacy training,' she says – and IDPC also collaborates with partners to mount drug policy seminars. 'Local civil society organisations get to sit at the table with the key decision makers in their country. It's a very important way to ensure that dialogue happens, because it can be difficult for civil society to get in the room with the right people.'

In addition to all this, IDPC actively disseminates the work of its member organisations, helping to increase visibility and build capacity, as drug policy debates have 'traditionally been quite opaque and complex', she says. 'One of IDPC's key mandates is to try to support to our members and other civil society partners to be able to engage effectively in drug policy advocacy in some of those more complex debates.'

She's been executive director since 2011, having joined the organisation three years earlier from the International HIV/AIDS Alliance, where she did policy work around injecting drug use and HIV at the same time as studying for a master's in human rights at Sussex University.

'It was the confluence of the two that got me interested in the drugs issue,' she says. 'I wanted to write my final dissertation on a really pertinent human rights issue when it came to the HIV/Aids epidemic – understanding the issue of injecting drug use as a human rights issue as much as anything else.'

After learning about IDPC at IHRA's 2008 conference in Barcelona, a job came up as coordinator and although she was the only staff member for the first year, the organisation has now grown from a network of 30 members to 97, with five full-time and two part-time staff. 'It was incredibly fast-paced and rewarding, but it has been a total rollercoaster,' she says.

So what are her ambitions for IDPC now? 'In addition to the very important aspects of the networking and civil society visibility, we're already focusing on 2016 and the next UN General Assembly special session on drugs. We want to increase our reach and our influence in terms of the global debate, because we feel that coming out of 2016 there will definitely be some governments who will clearly have made a break with the current regime.

'We want to be able to play a constructive role in those discussions, and support the member states that are moving quickly towards more serious reform.' **DDN**

Spread THE WORD

It's time for a new approach to drug policy, writes **Jamie Bridge**

This year, a global advocacy campaign is being launched to raise awareness of the need for widespread drug policy reform. *Support. Don't Punish* aims to highlight the harms caused by the criminalisation and stigmatisation of people who use drugs, while also promoting policy alternatives grounded in public health, social inclusion and human rights.

The global 'war on drugs' is fuelling HIV and hepatitis epidemics among people who use drugs, as well as a wide range of other health, social and economic harms. People who inject drugs now account for a third of all HIV infections outside of sub-Saharan Africa, and up to 80 per cent of infections in Eastern Europe and Central Asia. Repressive drug laws, policies and practices aim to stifle drug markets but have failed to reduce levels of drug use around the world and have instead created a policy environment that condones mass incarceration, torture, execution, abuse and discrimination.

The campaign will be officially launched through a prominent 'day of action' on 26 June – the UN's 'international day against drug abuse and illicit trafficking'. The day has been used by some governments for public executions of drug offenders and a celebration of the repressive approaches that we know are causing so much harm, but *Support. Don't Punish* is our chance to take ownership of this day and change the global rhetoric on drug policy – promoting reform, alternatives and more humane responses.

Paradoxically, 26 June is also the UN's 'international day in support of victims of torture' – a coincidence that takes on added significance following a recent report from the UN special rapporteur on torture, Juan E Méndez, in which he stated that the systematic maltreatment of people who use drugs in health settings, such as forced detoxification or denial of services, may cross a threshold equivalent to torture or punishment.

So we're asking supporters to engage in a 'day of action' – changing their profile pictures on Facebook and Twitter and taking to the streets in selected cities as part of a high profile coordinated effort to raise global media and public awareness of the issues. *www.supportdontpunish.org* contains all the information you need to participate, including the campaign statement, factsheets, briefings, videos, logos and t-shirt and mask designs.

Please visit the website to register your support for the campaign statement, and spread the message to colleagues and friends. You can use the Twitter hashtag #supportdontpunish for news, links or reports, and an interactive photo project has been launched for people to express their support.

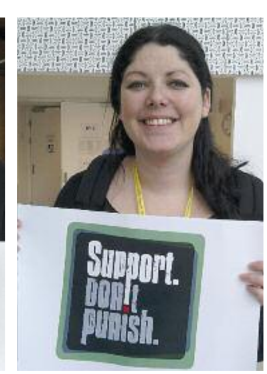
The campaign's bold and independent branding can be freely adopted by any organisation or individual who supports its aims, and it's hoped that this will become an 'umbrella' under which groups from around the world can identify.

NGOs, charities, activists, advocates and networks of people who use drugs can freely download all of the campaign materials to use in their own way to influence governments, donors, policy makers, the media and the general public.

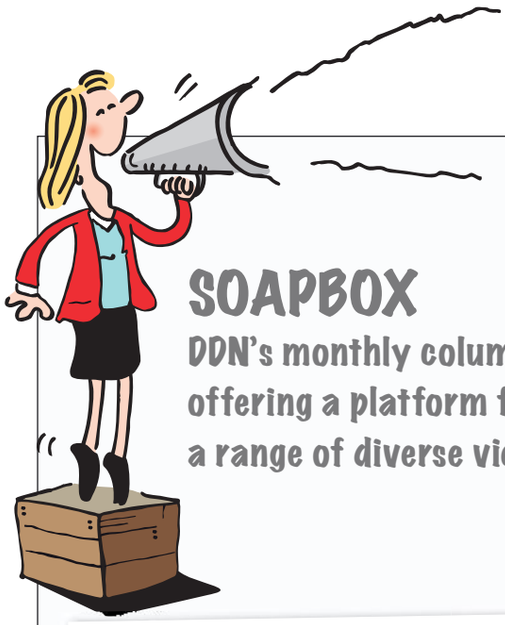
Support. Don't Punish is part of the Community Action on Harm Reduction project (*www.cahrproject.org*), an ambitious, four-year project which aims to expand HIV and harm reduction services to more than 180,000 people who inject drugs in China, India, Indonesia, Kenya and Malaysia. The campaign is being led by the International Drug Policy Consortium (IDPC) alongside the International Network of People who Use Drugs (INPUD), Harm Reduction International (HRI) and the International HIV/AIDS Alliance.

Jamie Bridge is senior policy and operations manager at IDPC

supportdontpunish.org

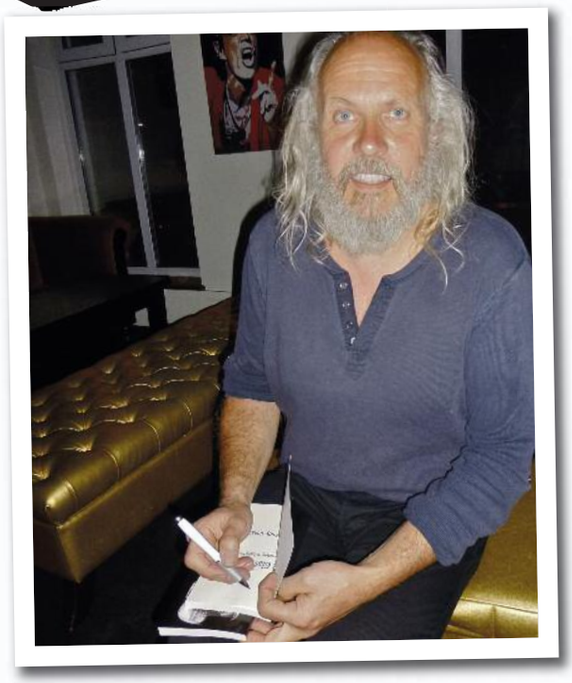


Left to right: Eliot Albers, INPUD; Ann Fordham, IDPC; Ruth Dreifuss, Global Commission on Drug Policy; Michel Kazatchkine, GCDP; Mara Nakagawa-Harwood, International AIDS Society; João Goulão, national drug and alcohol coordinator, Portugal; Maria Phelan, HRI



SOAPBOX

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



QUALITY NOT QUANTITY

The drink debate has become stuck on quantity. Why can't we acknowledge that booze is a part of our lives and have an intelligent discussion about harm reduction, asks Andy Stonard

Drinking alcohol in Britain has again become a perilous pastime. There have been periods in history when the people have drunk more – much more, in fact – and there have been periods of time when drinking levels have fallen because of laws or circumstance, such as the 1914-18 Great War.

Our overall consumption has decreased slightly in recent years, but alcohol-related ill health is climbing alarmingly. So there is something seriously wrong.

We need to consider the drinking of alcohol in relation to individual drinking patterns, our behaviour, our culture and our attitudes. We cannot just talk about quantity and arrange our policies and public education around quantity. It's about discussing Alcohol UK – how its people consume alcohol, how alcohol relates to ill health, social disorder and violence, child care and domestic violence. Our social and moral frameworks are all framed within our drinking and how we drink.

Drinking for some is an occasional pleasure. For many it forms a significant part of their social and personal lifestyle. Then for a large number of people it has become an essential aspect of life – drinking as an integral daily activity.

For up to two million people it is a daily occupation, often from the moment of waking until the end of the day, encompassing psychological and physical dependence. For this group and some of the above, drinking and alcohol-related problems sweep through and affect loved ones and family, neighbours and friends, work colleagues, as well as strangers on streets and in bars.

Alcohol consumption is a significant factor in domestic violence and child abuse, in violent incidents and in accidents on the roads, in the workplace and in the home. The NHS services (especially A&E), GP surgeries, the police service and the courts are often overwhelmed with drunkenness and the accompanying chaos. We know all this of course. Such statistics appear regularly in our newspapers and other media.

Against this reality we have a range of political and economic commentaries on how best to tackle this from the government, but with no action and never anything concrete. The drinks industry advertises and promotes brands and sells alcoholic beverages very successfully. The supermarkets sell vast amounts of discounted lager and wines as part of their marketing strategies. Local corner shops have to have a licence to sell alcohol or go out of business.

On the other hand, the British Medical Association (BMA) and health lobby, the police and local authorities all caution against the wave of alcohol-related ill health and harm. Our hospital services are overrun, while whole city centres are drunk, with serious disorders and violence, often on the brink of major confrontations and disaster.

And what about our politicians? Our members of parliament have historically offered nothing coherent and their views and opinions usually divide equally into three. One third will stand up for freedom of choice for the consumer and free trade for the industry – because it suits them as shareholders, or directors, or as members of parliament of a constituency with brewing and distilling interests as donators to party funds and so forth. Another third will be talking about public health because of their interests; and the third will ignore the debate.

Why change the status quo? For the aforementioned combatants, it is a good living working for either side; for the government it is a massive earner and, anyway, the people of the UK like a drink and getting drunk. No one forces anyone to drink. We all have free will.

No one wakes up one morning and decides to have a drink problem, to be an alcoholic. For many it is a slow journey over years. For others it is an unfortunate accident or incident. For some, alcohol covers up anxiety; a drink makes socialising easier and for many of us it becomes a daily habit – a bottle of wine at home, a weekend drinking with friends, the pub after work. It builds, it wanes, it builds again.

How do we even try to address such a widespread issue? My starting point is that I have yet to meet or hear a politician prepared to do anything about it, so we all need to look to ourselves and one another. We need to understand our own attitudes to drinking alcohol, what these attitudes are, how they have been formed and how others' beliefs and attitudes impact on each of us.

Unless there is a cultural shift across our entire society and its institutions and, most importantly, its people and our attitudes and beliefs, then all the tampering of pricing policy, licensing and moral panics will continue to be like pissing in the wind.

Andy Stonard has spent most of his career in alcohol treatment and charities and is former chief executive of Rugby House. His new book, A Glass Half Full: Alcohol Harm Reduction, is available on Amazon

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Closing date: Friday 17th May 2013

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East Sussex
County Council

Tender for the provision of Drug and Alcohol Recovery Services ASC 071-13

Notice calling for Expressions of Interest

East Sussex County Council invites expressions of interest from organisations interested in tendering for the provision of non-residential community drug and alcohol recovery services.

The organisations shortlisted to Tender will, in the first instance, be able to demonstrate:

- A proven track record of delivering similar services.
- Demonstrable technical expertise and capacity to be able to deliver the service
- Effective quality monitoring processes

It is intended that the contract will be for an initial duration of three years with the option for the Council to exercise two subsequent twelve monthly extensions. The value of the contract will be in the region of £15m (that is £5m for each of the three years).

Award criteria will be based on a combination of both technical & commercial capability and best value, detailed criteria will be provided within the Invitation to Tender. Organisations applying should note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 may apply.

To express your interest and obtain a Pre-Qualification Questionnaire, please register via the South East Business Portal (www.businessportal.southeastiep.gov.uk). If you are unable to access this service, please call 01323 463284 for assistance.

Expressions of Interest must be received no later than 12.00 noon on the 18th June 2013.

The deadline for the return of the Pre-Qualification Questionnaire is 12.00 noon on the 19th June 2013.

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- ***Psychosocial Support***
- ***Recovery Support***

The contract will be awarded for an initial period of 4 years with the option to extend it further by up to 3 years, dependent on performance and ongoing Central Government funding.

The Council is of the opinion that Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) may apply to this contract.

The Council uses the South East Business Portal (the Portal) to advertise tender opportunities and run its tender processes. In order to access details about this tender you will need to register on the Portal at the following address:

https://www.businessportal.southeastiep.gov.uk.

Registration is free and it will give you access to opportunities advertised by Local Authorities across the South East region. All communication referring to the tender must be submitted via the Portal.

The closing date for receipt of tender submissions is 8th July 2013.