SIMPLY THE BEST... BETTER THAN ALL THE REST...

DDN
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*'The British recovery movement has a vital role to play in looking for "the good, the true and the beautiful" in our deficit-based society...'*

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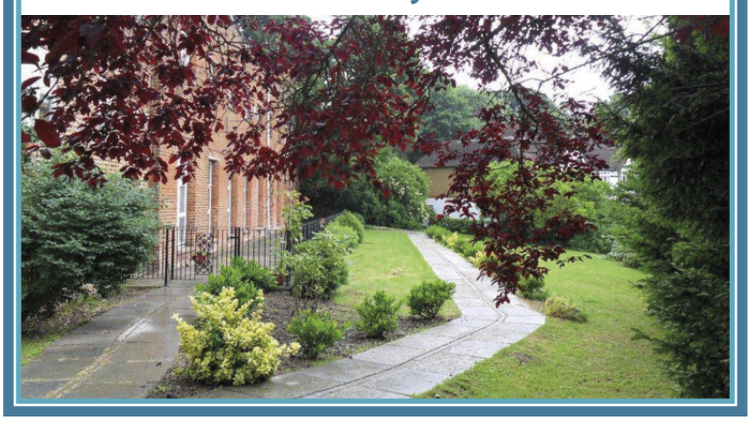

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*Presented by the NTA and voted for by service users*

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*Awarded by the Suffolk Brokerage, May 2013*

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**Editorial – Claire Brown**

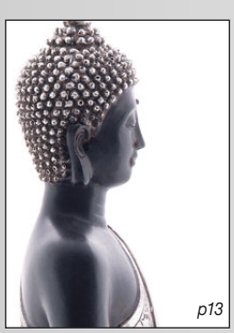
# Mind over matter

## Take time to live in the moment

**Mindfulness** is a word that's started to appear more regularly in a treatment context, so it was helpful to have Dr Paramabandhu Groves' explanation of how it can be used to help avoid relapse and improve wellbeing (page 13). Apart from the therapeutic components, we can learn much from the Buddhist practice of 'paying deliberate attention to our experience as it unfolds moment by moment, with an attitude of friendliness and curiosity'. It's a mindset that might at first seem to fit more readily with a 'recovery' approach – Alistair Sinclair explores new integrative methods that are 'creative, ecological, ethical and beautiful' on page 8, while looking at the suggestion that we need a 'fifth wave of public health' to challenge our culture of 'rampant individualistic consumerism'. Yet interestingly, the Kaleidoscope conference (page 14) links mindfulness to harm reduction, helping people to understand themselves better, and opening channels to reflect, contemplate and meditate.

Sadly, this issue contains tributes to two special individuals who left us too young, but made their mark on so many of those who knew them (page 10). Their work and outlook on life are a reminder to be passionate about our beliefs, as they were, while treasuring our diverse friendships – and the importance of living in the moment.

# This issue



### FEATURES



### REGULARS

## NEWS IN BRIEF

### AGONISING STATISTICS

Almost 18m people died 'in unnecessary pain' in 2012 as a result of inadequate access to painkillers like morphine, says the Worldwide Palliative Care Alliance, with huge discrepancies in provision worldwide. 'This is a public health emergency and an intolerable situation,' said senior fellow at the alliance, Dr Stephen Connor. 'Barriers to adequate pain treatment worldwide include overly-restrictive laws and regulation, over-exaggerated fears of addiction and a lack of understanding of the issues among governments and health professionals. Attitudes need to change.'

### SITUATION STABLE

The prevalence of drug use is now stable around the world, according to UNODC's *World drug report 2014*. Around 5 per cent of the global population used an illicit drug in 2012, it says, while the number of problem drug users stood at around 27m. However, in recent years 'only one in six drug users globally has had access to or received drug dependence treatment services each year', said UNODC executive director Yury Fedotov. *Report at www.unodc.org*

### A FRIENDLY WORD

A new report on how treatment services could be improved for the LGBT community has been issued by the charity London Friend. *Out of your mind* draws on interviews with both service users and commissioners, and includes practical toolkits as well as recommendations. 'Our research has found very poor representation of LGBT treatment need in local needs assessment, and our clients have told us treatment services don't always understand the drugs they are using, or how they're being used,' said London Friend chief executive Monty Moncrieff. 'It feels like LGBT issues are literally out of people's minds when they plan and deliver drug and alcohol services.' *Report at londonfriend.org.uk*

### PICK A PRIORITY

A new interactive map showing the priorities of health and wellbeing boards across England has been produced by the Local Government Association (LGA). Users can either select a specific area to see a summary of local priorities or choose a theme to find out which areas are focusing on it. The aim is to support the boards and stimulate collaboration, says the LGA. *Tool at www.local.gov.uk*

### RESEARCH CASH

Alcohol Research UK has announced its 2014 small grants scheme to support research projects, pilot studies or relevant conferences. *More information at: alcoholresearchuk.org/grants/small-grants/Application deadline is 16 July.*

# Drug policy reform calls gather momentum

**Last month saw demonstrations in 100 cities as part of the *Support. Don't Punish* campaign for 'more effective and humane' approaches to drug policy, according to campaign organisers.**

The demonstrations – in cities including London, Paris, Moscow, New York, Bogota and Mexico City – took place on 26 June, the United Nations' International Day against Drug Abuse and Illicit Trafficking, which has been used by some governments to justify violent punishments for drug offenders, including public execution. The campaign is not calling for new money but rather a diversion of 'a small fraction' of drug law enforcement budgets for investment in services based on public health and human rights, it says.

'The momentum for a change in global drug policy is rapidly gathering pace,' said executive director of the International Drug Policy Consortium (IDPC) Ann Fordham. 'Criminalising people for using drugs is wasteful, ineffective and damaging and all around the world communities of people are rising up to say "enough is enough".'


*Members of Pussy Riot join the 'Support. Don't Punish' demonstrations in Moscow*

As part of the global day of action, an open letter to David Cameron calling for a review of UK drug policy was signed by more than 80 high-profile people and organisations. The letter wants to see the end of criminal sanctions for drug possession and – with more than 1.5m people criminalised over the last 15 years for possession offences – details the 'social and economic costs' of a criminal justice approach and its impact on BME communities and the employment prospects of young people. UK drugs laws had resulted in 'mostly the young, black and poor' being the focus of enforcement, it says.

The letter also urges the prime minister to lend his support to those governments in South America that are moving towards reform. 'We must support them to end the cycle of brutality and destruction that results from the current drug control framework,' it says. Among the signatories are the Prison Governors Association, the National Black Police Association, the Howard League for Penal Reform, the International HIV/Aids Alliance, the National Aids Trust, the Terrence Higgins Trust, Michael Mansfield QC, Julie Christie, Will Self, Russell Brand and Sting.

The UK should be at the forefront of the drug policy reform debate, said Release executive director Niamh Eastwood. 'In 2002 when the prime minister was a member of the Home Affairs Select Committee he supported the recommendation that the UN consider alternatives to the status quo,' she said. 'We are asking him to stand by that commitment and recognise the damage that has been done, both nationally and internationally, by repressive drug policies.'

The protests took place two days after the government's ban on khat came into force, with the substance now a class C drug despite the Advisory Council on the Misuse of Drugs (ACMD) concluding that 'the evidence of harms associated with the use of khat is insufficient to justify control' (*DDN*, February 2013, page 4). The ban would 'serve to create a new income stream for organised crime', said head of external affairs at Transform, Danny Kushlick.

The ACMD has also recommended that the entire tryptamine family of compounds – which includes the hallucinogens AMT and 5-MeO-DALT – should be controlled as class A substances, along with synthetic opiate AH-7291. Although some tryptamines are already controlled, the UK was 'leading the way by using generic definitions to ban groups of similar compounds to ensure we keep pace with the fast-moving marketplace for these drugs', said ACMD chair Professor Sir Les Iversen. The government's permanent ban on NBOMe and benzofurans – previously placed under a 12-month temporary banning order – has also now come into force, along with the upgrading of ketamine from a class C substance to class B (*DDN*, March, page 5).

# West Africa 'should decriminalise' low-level drug offences

**West Africa should consider decriminalising low-level and non-violent drug offences, according to a report from the West Africa Commission on Drugs. The drug trade in the region is now not only a threat to public health but is undermining institutions and damaging development efforts, says *Not just in transit: drugs, the state and society in West Africa*.**

Although the region has been experiencing a period of optimism, with growing economies, increased democracy and fewer civil wars, this is at risk from the 'destructive new threat' of the drug trade, the commission states. 'With local collusion, international drug cartels are undermining our countries and communities and devastating lives.'

The area is no longer simply a transit zone for drugs bound for Europe, it says, but a 'significant zone of consumption and production' in its own right. At an estimated $1.25bn, the scale of the cocaine trade alone 'dwarfs the combined state budgets' of many countries in the region, it adds, and while the region has a long history of cannabis production, mainly for local consumption, it is now also becoming a producer and exporter of synthetic drugs.

'The drugs trade is currently valued at hundreds of millions of dollars in West Africa, a region where the majority of the countries are still among the poorest in the world,' the document states. 'The growth in drug trafficking comes as the region is emerging from years of political conflict and, in some countries, prolonged violence.' The legacy of this instability is state institutions and criminal justice systems that are vulnerable to infiltration and corruption by organised crime, it says.

Drug use needs to be regarded 'primarily as a public health problem', argues the report, which is the result of 18 months of collaboration with regional, national and international organisations including the United Nations Office on Drugs and Crime (UNODC), the African Union (AU) and the Economic Community of West African States (ECOWAS). Although traffickers and their accomplices should face the 'full force of the law', drug users themselves need help rather than punishment, it argues. 'We believe that the consumption and possession for personal use of drugs should not be criminalised,' it states. 'The law should not be applied disproportionately to the poor, the uneducated and the vulnerable, while the powerful and well-connected slip through the enforcement net.'

**'State institutions and criminal justice systems... are vulnerable to infiltration and corruption by organised crime.'**

**WEST AFRICA COMMISSION ON DRUGS**

'Most governments' reaction to simply criminalise drug use without thinking about prevention or access to treatment has not just led to overcrowded jails, but also worsened health and social problems,' said ex UN secretary-general Kofi Annan, who initiated the commission.

*Full report at www.wacommissionondrugs.org*

# PHE: Increase hep C treatment or face liver cancer time bomb

**England will see 1,650 annual cases of hepatitis C-related end-stage liver disease and cancer by 2035 if the current low levels of treatment are maintained, according to Public Health England (PHE).**

Although around 160,000 people are infected with hepatitis C in England, just 3 per cent access treatment each year. However, the burden of healthcare costs associated with untreated hep C means that increasing this coverage to 100 per cent over the next 10-15 years would only mean a 31 per cent increase in spending, says PHE. The agency is calling for services to be made more easily accessible – including expansion into drug treatment, primary care and prison settings – as well as better monitoring and reporting of treatment outcomes.

'While there would be a financial cost to rapidly increasing treatment rates, the increase is not as great as you might think because the costs of managing undiagnosed and untreated hepatitis C are so high,' said PHE hepatitis expert Dr Helen Harris. 'Currently, we are paying a very high price in terms of lives lost and burden placed on future healthcare resources.'

'Hepatitis C is a curable disease and to have so few people being offered the chance to rid themselves of the virus is simply not acceptable,' added Hepatitis C Trust chief executive Charles Gore. 'If more people are diagnosed and treated, we could rid ourselves of this virus within the next 15 years, a unique opportunity. The alternative is ever more people dying entirely preventable deaths.'

Meanwhile, new figures from the Office for National Statistics (ONS) show that the incidence of liver cancer rose by 70 per cent for men and 60 per cent for women between 2003 and 2012, making it the 18th most common cancer in England.

*PHE study at www.journal-of-hepatology.eu*

*Cancer registration statistics, England, 2012 at www.ons.gov.uk*

## NEWS IN BRIEF

### ROAD TO RUIN

Around 28,000 people die annually and 1.34m are injured on Europe's roads as a result of accidents caused by people driving under the influence of a psychoactive substance – primarily alcohol – according to a report from EMCDDA. 'As drug consumption patterns change, particular concerns arise,' said EMCDDA director Wolfgang Götz. 'These include an ever-expanding range of psychoactive substances and medicinal products as well as context-specific risks such as those posed by young people driving home from nightlife venues after consuming a mix of alcohol and drugs.' *Drug use, impaired driving and traffic accidents at www.emcdda.europa.eu*

### STIGMA STRUGGLE

A series of October events is being planned by Adfam to celebrate its 30th birthday, with a focus on campaigning against 'the stigma that affects so many families'. A campaign pack is available from the Adfam website, and the organisation is encouraging local groups and services to hold their own awareness-raising events. *Resources at www.adfam.org.uk*

### BMA BAN CALL

The sale of cigarettes should be banned to anyone born after the year 2000, the British Medical Association (BMA) has stated, after delegates at its annual conference voted to support the motion. The move would 'help create the first tobacco-free generation', it says. 'The level of harm caused by smoking is unconscionable,' said research assistant in academic public health, Tim Crocker-Buqué. The policy would 'not instantly prevent all people from smoking', he said, but rather 'de-normalise' it.

### ROI REPORTS

An alcohol 'return on investment tool' to inform local decision making has been developed by NICE. The tool helps to model the economic returns that can be expected for different interventions, and comes with a range of support materials. Users can mix and match interventions to see which package provides the best value for money. *Free download at beta.nice.org.uk*

### PEOPLE POWER

Westminster Drug Project (WDP) has been awarded the Investors in People Standard, which demonstrates an organisation's commitment to staff development. 'We strive on a daily basis to make sure that each and every one of our employees reaches their full potential,' said WDP chair Yasmin Batliwala.

### SOUTHMEAD CELEBRATION

Bristol's Southmead Project is holding its 20-year celebration event on 20 September, featuring presentations, discussions, drama and music. *http://southmeadproject.org.uk*

# BREAKING BONDS

Research findings about mothers having multiple babies removed by the family courts hit the headlines recently. *DDN* hears about some of the issues the newspapers overlooked

**'There are some mums who require some kind of adult protection response – they're highly vulnerable, with serious mental health problems and learning difficulties, probably in sexually exploitative relationships with no control over their lives, and then there are other mums who are desperately trying to get themselves out...'**

**DR KAREN BROADHURST**

**A NEW STUDY** by the universities of Manchester and Brunel, funded by the Nuffield Foundation, has been looking at the incidence of recurrent care proceedings in family courts and found that approximately one in three care applications concerns a mother who 'can be described as a repeat client'. Problematic drug and alcohol use – and associated chaotic lifestyles – is a major contributory factor, researchers say.

The research team studied records held by the Child and Family Court Advisory and Support Service (Cafcass) – the only centrally stored source of data linking children, mothers and care proceedings – covering the period from 2007 to 2013, and concentrated on completed cases of recurrent care proceedings issued under section 31 of the Children Act 1989. Its conclusions were that recurrence was a 'sizeable problem' for family courts in England.

Local authorities issue care proceedings when concerns are such that compulsory legal intervention is thought necessary to ensure the safety and wellbeing of a child. While the high volume of annual care applications has led to members of the judiciary raising concerns about 'repeat clients' who go on to lose their children to care or adoption, no one has really known the extent of the problem until now.

During the period covered by the study, 7,143 birth mothers appeared in 15,645 recurrent care applications regarding 22,790 children. Was the team surprised by the findings? 'No, I think we've underestimated the problem,' Dr Karen Broadhurst of the University of Manchester tells *DDN*. 'We can only capture recurrent care proceedings, but children can come into care through other routes – via a section 20 agreement with a parent, or they can bypass care proceedings and relatives can apply for a private law order or residence order, for example. There are more children in care linked to other children in care than we've identified.'

The team has now applied for funding for another two years to undertake a large mixed-method study, and it also carried out a pilot study of qualitative interviews with 25 birth mothers, sponsored by one local authority with a high recurrence rate. It has also started in-depth research into a randomly selected sample to look at points of engagement with services and opportunities for prevention.

The initial findings, however, were picked up by several national newspapers, most of which focused on the extreme examples of women having several children – into double figures, in some cases – removed. 'One of the things the media's slightly misrepresented is that there's a difference between cases of multiple recurrences – one after another after another – and mums who might have a baby, then another one and stop and grow up a bit and come back and keep a child,' Broadhurst says.

'There's a lot of variation behind the big figure, which is quite important in terms of prognosis for change. There are some mums who require some kind of adult protection response – they're highly vulnerable, with serious mental health problems and learning difficulties, probably in sexually exploitative relationships with no control over their lives, and then there are other mums who are desperately trying to get themselves out and have the wherewithal to do that.'

Around 25 per cent of all children in care proceedings are linked to recurrent cases, the team found, with the average interval between the start of the first and second set of

proceedings 93 weeks, suggesting that women were often 'pregnant again during proceedings or shortly after'. With mothers who had more than two applications, however, the intervals were even shorter, indicating that 'the highest risk parents had the least time to change'. It's essential to address this, say the authors, to give vulnerable mothers the chance to 'exit this cycle'.

What's also striking is the age of the mothers. Half of those involved in a cycle of repeat proceedings were 24 or under at the time of the first care application, with 19 per cent aged between 14 and 19. Nearly 60 per cent of recurrent care applications related to infants under 12 months, and 42 per cent of all applications were made within a month of birth.

How much of a role did drink and drugs play in the cases they studied? 'Major, major,' says Broadhurst. 'What we're seeing with the interviews we've done with women is early adolescent drug and alcohol use, usually as a coping mechanism in response to childhood sexual and physical assault and trauma and abandonment – early onset drug and alcohol use from the age of around 12, 13, 14. That tends to then result in adolescence being really quite troubled – homelessness, rough sleeping, maybe sex working, unstable care histories – in a high percentage of cases.'

As the women don't have time to turn their lives around, or even to properly engage with services, access to treatment is 'a really key issue,' she says. 'There are differences across the country and some very good practice, but one of the problems in some areas is that when mothers are referred to the local authority, the local authority won't respond early in the pregnancy – it waits until they deem the foetus to be viable and the baby likely to be born. They leave the intervention really late in the pregnancy – say 30, 32 weeks – so essentially the baby's born before any work's been done with the mother. So the default position then is removal, issuing care proceedings at birth, or in better cases mother and baby placement in foster care or residential placement.'

It's vital to work with drug and alcohol-using mothers early in pregnancy, as this can be a 'window for change', she stresses, a 'time when women think "right, I've really got to get my life in order". Because a lot of local authorities don't do that there is no window for change, and we're seeing women generally in these cases with short interval pregnancies.'

This means that another issue that drug and alcohol services should be thinking about is access to contraception, she points out. 'That's a long-standing finding, actually, in relation to mums with problems of drug addiction – that women will not prioritise their reproductive healthcare needs. They're thinking about "how can I survive and manage my drug habit?" They either think they can't get pregnant, or it's secondary, so drug and alcohol workers need to help them space their pregnancies and access contraception, make it more of a priority. If women do space their pregnancies they've got much more chance of keeping their next child.'

Is there anything else that treatment services could be doing to reach out to this population? 'Obviously, an outreach community-based or home-visiting, proactive approach would be good, because from what we know of these mums they sometimes struggle to leave the house, particularly if they've had a child removed. They'll take to their beds and they can't function in society at all – they're desperately suicidal, bereft. They're not out accessing anything.'

What's also needed is longer-term support, she says, citing the example of the US-based PCap (parent-child assistance) program, a recovery-focused service that offers support for three years and tries to keep mother and baby together. 'The view is that if you can do that in as many cases as you can, that mum won't have another baby,' she says. 'It's an incentive not to get pregnant again in the short term.'

One issue, of course, is that in the UK funding for many wraparound services and family support is being cut. 'Vulnerable parents are really up against it in terms of getting help, and people are less sympathetic towards them – there's been a punitive shift,' she states. 'A lot the basic infrastructure for family life is being so cut back – housing, community services, everything. But it's not a cheap option to put people in care, and the outcomes are not guaranteed.'

Is there anything else that the family courts themselves could be doing? 'A lot of these mothers are very young – 24 or under, or 14-19 in the case of 19 per cent of them – and I just think a lot of them will find the court a completely alien place. I also think the quality of legal help they get is very variable. The problem-solving approach to court is much better. The FDAC [Family Drug and Alcohol Court] model guarantees – or goes as far as it can to ensure – a coordinated approach to treatment at the start of proceedings, whereas what generally happens is that recommendations can come part-way through or late.'

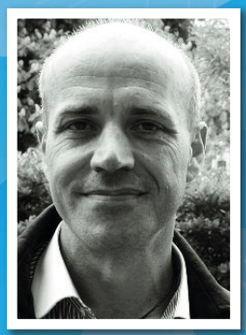
What's more, new timescales of a 26-week deadline for care proceedings introduced under the Children and Families Act 2014 could make things worse, she says. 'It will be really hard for these parents to turn their lives around in six months, particularly if they don't get help from the outset of legal proceedings, and with the standard court model that's not guaranteed. They can be referred for help, go on a waiting list – they're queuing.'

It amounts to 'a breach of social justice', she believes. 'The treatment recommendations that are made at the final hearing will often be something like 18 months psychotherapy, because the mother has borderline personality disorder, and no one wants to pay for that. We've seen mothers who are paying for the treatment themselves, they do ten weeks psychotherapy and the court says, "I'm sorry, that wasn't enough." Often the parents in our sample fell below the thresholds for disability and mental health services, so the court makes recommendations – says "you must do this" – and the parent can't access that help. That seems very unfair.'

The team now hopes to produce as many rich-detail qualitative findings as possible over the next two years to inform frontline practice, she says, particularly around what could help facilitate change. 'Obviously we shouldn't be naïve and think we can fix everyone, because we can't. But these young parents have got a lot of scope to grow up and change.'

**'What we're seeing with the interviews we've done with women is early adolescent drug and alcohol use, usually as a coping mechanism in response to childhood sexual and physical assault and trauma and abandonment...'**

# Catching the wo



The British recovery movement has a vital role to play in looking for 'the good, the true and the beautiful' in our deficit-based society, says **Alistair Sinclair**

**'While we have been encouraged to focus on the "canaries in the mine", those who are the first visible casualties of a sick society, fixing them and returning them to productive life, we have been discouraged, interestingly, from looking at the mine itself...'**

**'A people are as healthy and confident as the stories they tell themselves. Sick storytellers can make their nations sick. And sick nations make for sick storytellers.'**

***Ben Okri, Birds of Heaven.***

This was a quote I threw into the room when I presented to DDN's national service user conference in Birmingham in February – because I believe we live in a sick nation, full to the brim with sick storytellers who dominate our mainstream media and political discourse.

It's a reflection of the deficit world we live in. A world of needs and gaps and experts that is increasingly apportioning blame to the other, the alien, the vulnerable, the undeserving poor, whether that be the Muslim, the immigrant, the benefit scrounger, the homeless or the drug user.

We live in times of great fear and anxiety, times of austerity, and this narrative, this story, now permeates every aspect of our lives. The wealthy and privileged, rather interestingly, have got richer during these times as they've retreated even further into their gilded gated communities. Meanwhile the poor have got poorer and the 'squeezed middle', those hard-working families, anxiously scrabble to hold on in this era of zero-hour contracts, flexible working and creeping neo-liberal privatisation.

We live in interesting times, and in Birmingham I offered a perspective that I'm sharing with you now. It's a perspective that seeks to place 'recovery' within a historical context, and position the future British 'recovery movement' as something with the potential to be positive, inclusive and, rooted in the promotion of social justice, truly transformative.

I'll start with a little recovery history. There are many who recognise recovery as a term within the 12-step movement going back 79 years, and others who think it popped into treatment land with the drug strategy in 2010. As Larry Davidson from Yale University illustrates in *The Roots of the Recovery Movement in Psychiatry* (2010), recovery's roots as a service orientation (putting aside recovery within communities for hundreds of years) can be traced back to 1793 and the groundbreaking work of Philippe Pinel and Jean-Baptiste Pussin.

In recognising the importance of mutual aid and a meaningful life, giving jobs to the inmates of a Paris asylum, Pinel and Pussin lay the foundations of the peer support we see today. In the US, Dorothea Dix (1840), a tireless advocate for the mentally ill within prisons and Jane Addams (1889), the founder of the resettlement movement, were instrumental in advancing the notion that healthy environments promote health, and their work emphasised the key importance of 'living with' and 'doing with' in communities as opposed to the usual default


deficit setting of 'doing to'.

The psychiatrist Adolf Meyer (1900) went on to make a number of significant observations which at the time – and perhaps still today, in some quarters – were regarded as radical. People can and do recover; even those in the midst of illness possess valuable strengths and it's our interactions in the social world, in the everyday, that are key to recovery.

The founding of AA in 1935, with its emphasis on mutual aid and self-help, has major significance in this recovery history, as does the civil rights movement of the 1960s and the consumer/survivors/ex-patient movement of the late 1980s and early 1990s. Phil Hanlon, professor of public health at the University of Glasgow, outlines another kind of history in his book *The Future Public Health* (2012), which I believe also has deep significance for the British recovery movement. He suggests that there have been four waves of public health, which have brought significant improvement to health over the last 184 years.

Each new wave begins while the previous wave is at its peak. The first wave of public health (1830-1900) saw the rise of 'classical public health interventions' – a recognition, before the science caught up, of the importance of clean water and sanitation. In this period we see the growth of municipal power and influence, and the beginnings of the rise of the 'expert'. The second wave (1890-1950) sees the continued ascendency of the expert, the flowering of 'scientific rationalism', expansion of hospitals, health visitors and the germ theory of disease. The third wave (1940-1980), born of a deep demand for change and a post-war consensus, sees new forms of social solidarity and collective responsibility leading to the creation of the NHS, the welfare state and social housing. While the fourth wave (1960-2000), which also sees the rise of neo-liberalism (perhaps a partial response to the third wave?), focuses on individual risk factors and lifestyle issues.

These four waves have had a significant impact on health and continue to do so. However Hanlon is very clear, as are many others in the fields of public health, economics, environmentalism and politics (to name a few), that we are now, all of us, in an age of crisis, staring into the abyss and facing the 'challenges of modernity'. Across the developed world and increasingly in the 'majority world', people are getting sicker in increasing numbers. As communities continue to fragment and social ties fray (something Bruce Alexander describes eloquently in his book *The Globalization of Addiction: A study in poverty of the spirit,* 2008), levels of unhealthy dependency – drugs being just one among many – and mental distress are rising dramatically.

Needs are rising and resources are dwindling. Hanlon contends that current interventions are failing to address societal issues because they are grounded in an acceptance of cultural norms that are fundamentally part of the problem: 'economism (the belief that money will sort things out), individualism, consumerism and materialism' – all of these driven and sustained by the deficit world we live in. Modern society is unequal, inequitable and unsustainable, says Phil Hanlon in *The Future Public Health*.

It's not all doom and gloom and this, I believe, is why the British recovery movement, if it learns from its history and puts social justice at its heart, has a major role to play in the response to this crisis of modernity. Hanlon suggests there is a need for a 'fifth wave of public health' which will challenge the rampant individualistic consumerism that underpins a dominant economic model based on endless growth – a model that is taking us, as I commented in Birmingham, 'to hell in a hand basket'. While we have been encouraged to focus on the 'canaries in the mine', those who are the first visible casualties of a sick society, fixing them and returning them to productive life, we have been discouraged, interestingly, from looking at the mine itself. So while we rebrand and tinker at the margins, all of us 'users' within a dysfunctional system, we remain silent as to the really destructive addictions.

As George Monbiot put it in the *Guardian* on 27 May, this issue is 'the great taboo of our age – and the inability to discuss the pursuit of perpetual growth will prove humanity's undoing... The inescapable failure of a society built upon growth and its destruction of the Earth's living systems are the overwhelming facts of our existence. As a result, they are mentioned almost nowhere. They are the 21st century's great taboo, the subjects guaranteed to alienate your friends and neighbours.'

Hanlon believes that our current system, with its acceptance of modernity's 'norms' and overriding emphasis on the objective (evidence and science) at the expense of the subjective (the many meanings found within the 'I' and the 'we') is failing. He calls for new 'integrative' approaches that will bring the subjective and objective together on equal terms, valuing the stories and wisdom found within families, neighbourhoods and communities. He suggests that we need new approaches that are 'creative, ecological, ethical and beautiful', which will reintegrate 'the good, the true and the beautiful' – grand language that needs to be turned into reality within communities, which is where I believe the British recovery movement comes in.

In positioning 'recovery' as the 'remaking of meaning', and a shift from a deficit-based world to new strength-based ways of being, it is possible to see the movement as central to the search for the 'good, the true and the beautiful'. Where else would you start if not with those who still struggle in this deficit world, with the people who are trying to recover, with the 'canaries' and with the people who have managed to 'remake' themselves? Where else will we find the wisdom and the learning that will enable us all to deal with our damaging dependencies?

Which is why the UKRF is promoting a recovery month in September that supports movement toward a strength-based world founded on community resilience and potential; a month that will write new hopeful stories. And it's why we're gathering in Leicester on 26 September at an event entitled 'Creating Narratives for the recovery movement: the good, the true and the beautiful'. We believe we will make the path by walking it. So we'll do a little walking together. I hope some of you can join us.

***Alistair Sinclair is UKRF director. The UKRF's event, 'Creating narratives for the recovery movement: the good the true and the beautiful' is on 26 September in Leicester. Details at www.ukrf.org.uk***

OBITUARY

# CAROLINE BLACKBURN

## 26 JULY 1977 – 7 JUNE 2014

**It is with great sadness and shock that we are looking back on the life of Caroline Blackburn, a woman so full of energy and who had such a joy for participating that her recent death will no doubt have stopped many of us in our tracks.**

Caroline worked for the Alliance, running the Kirklees peer advocacy team after spending a number of years studying to be a fully qualified and experienced counsellor. She had recently returned to university once more to continue her studies – Caroline had a thirst for knowledge that her friends and family noted from her early years.

She gave her role in Kirklees everything, as she did with all aspects of her life. She fought tirelessly for better services for drug and alcohol users and gave many the opportunity for training and volunteering, helping with their transition away from chaotic use and supporting people to believe in themselves once more. Caroline steered the service user scene towards a level of professionalism that had at times been previously lacking.

Many will remember Caroline from the annual *DDN*/Alliance service user conference, hearing *that* laugh and seeing *that* smile. She has left a daughter, of whom she was immensely proud, and a host of friends and family that will hold her dear in their memories.

Caroline – you will be sorely missed.

*Maddy, Jules, Peter, Beryl, Ursula, Daren, Tony, Lee, Dave (former Alliance colleagues) and those that worked closely with Caroline over the years.*

**'Rather than just counting numbers, DAATs need to look at people's experience. Until they do, you won't get consistency of service.'**

As part of a panel discussion at the fifth DDN/Alliance conference in 2012, Caroline spoke out passionately for fair treatment.

# LETTERS

## APPLYING WITH CONVICTION

I'm writing in response to Nicola Inge's article *Beyond conviction* (*DDN*, June, page 8). The 'Ban the Box' campaign is an excellent idea and fully supported by online magazine *theRecord* and our partners at Unlock. The principle behind the Rehabilitation of Offenders Act was to break the cycle of offending and re-offending by enabling people with convictions to gain employment, and led to the concept of a spent conviction.

Sadly, with the inception of the CRB, now DBS, this principle suffered a massive setback, and asking about previous convictions at the application stage became commonplace, particularly in health, social care and education – the very services that espouse a progressive approach to rehabilitation. This, in turn, led to people with convictions not even applying for jobs that require a disclosure at the application stage.

The US approach based on the equal opps agenda and its accompanying legislation is well worth emulating in the UK, for all the reasons set out in the article. And, following Gandhi's famous dictum, it would serve people with convictions, the recovery industry and the wider society well if drug and alcohol treatment services were to 'be the change they want to see in the world.'

If recovery services were truly committed to equal opps, they would never expect candidates to discuss their offences at interview because this never gives people with convictions the opportunity to present themselves as equal to those without convictions. This differentially discriminates against those from minorities, as mentioned above, and male applicants – often under-represented among the recovery workforce – because they are seven times more likely to have a conviction than females.

There are only three reasons employers ask about convictions on application forms: because they think they ought to, because they intend to use that information to discriminate or because they are just plain nosy. The simple fact is that an employer only needs to know about the criminal record of people they will employ, *i.e.* the person who emerges as the leading candidate, after the interview stage is complete. There is no need for any employer to elicit or, more seriously, retain information about a person's criminal record if they are not going to employ them. It is only the successful candidate who ever needs to be asked. The other candidates should be able to exit the recruitment process with their privacy intact. Sadly, this is not the case with any of the treatment service recruitment processes that *theRecord* is aware of.

Often, employers are also labouring under the illusion that screening for convictions at the application stage is a form of risk assessment. It is not. The absence of a conviction tells you nothing about a person's honesty or safe conduct, it only tells you that they have never been caught and convicted.

A person with a history of, say, violence or fraud, but who was never

**'If recovery services were truly committed to equal opps, they would never expect candidates to discuss their offences at interview because this never gives people with convictions the opportunity to present themselves as equal...'**

caught, can sail through the process untested, while the poor sod convicted of possessing a few grams of weed or stealing a car 20 years ago gets grilled by complete strangers in a powerful position in a non-therapeutic setting. Any therapist will tell you that this can be devastating, even relapse-inducing. Both Unlock and *theRecord* regularly receive mail and calls from people who've been treated in this way only to be told that a stronger candidate got the job, so there was never any need to put them through that part of the interview because their record was never actually relevant to the employer. And even when they are successful, they are often then faced with working alongside people to whom they have disclosed their convictions – the people who interviewed them. It might be better if such disclosures are only ever made to HR and passed to senior management, not colleagues, because you never get a second chance to make a first impression.

So, if recovery employers want to offer an equal opportunity and run a safe and legal service, there are just three things they need to do. Firstly, ask only the prime candidate about previous convictions. Secondly, follow that up with the appropriate level of DBS check and, thirdly, risk assess that candidate regardless of whether they have a conviction or not. There are several psychometric tests that can be used for this in consultation with a suitably qualified psychologist. If their favourite candidate proves risky, then move on to the next. It would also be very helpful if employers would state at the application stage which level of DBS check is required for that specific post. This would give the candidate an informed choice whether to proceed with an application or not.

**Richard, editor, www.the-record.org.uk**

## ONCE REMOVED

I totally agree that commissioning needs to change dramatically in order to provide a better service (*DDN*, June, page 18). The work done to help people is extremely undervalued and underrated, the service user suffers and the high pressure of more responsibility puts stress levels up. This can cause sickness and puts many workers at risk for their own mental wellbeing. Erm hello, is anyone actually concerned, or are they so far removed from the problem they have no idea?

**Rachael Almond, by email**

## GETTING PERSPECTIVE

I am currently studying at the BRIT School and am in the process of producing a news show for FM and internet broadcasting through 'BRIT FM'.

I am producing a five-minute package about a common issue in our society. I see how drugs are very incorporated into young people's lives and how drugs surround our youth culture heavily.

I wish to gather a few interviews to gain a professional perspective on the issue – the effect of certain drugs on performance or health, or why people turn to drugs (both legal and illegal) habitually. You can contact me at frazerleonfoster@gmail.com

**Frazer Foster, by email**

## BANANA SPLITS

I went to a few of the big debates on abstinence versus harm reduction in London in 2008 and 2009 and listened to a lot of fear coming from the floor, and anger. Paul Hayes, chief executive of the NTA, when the question about spirituality came up said, 'I don't do spirituality'. Nearly all the people there cheered and clapped and I heard the person behind me say, 'what do the 12-step lot think about that?' When I looked around the person who had made the remark was a drug worker and was laughing to three service users from the area I come from, who, by the way, are still in the tier 3 system.

Harm reduction should be the first port of call for the addict who suffers – and I say suffers because people do not turn up at services if everything is alright in their life. Everyone has an opinion, and that's all Stanton Peele has (*DDN*, April, page 8). Oh, and a book to promote.

This government has it right when they say people can recover and live fulfilled and productive lives by turning up to 12-step meetings without ever stepping into the UK's tier system. Twelve-step meetings are where they meet others of their kind who have a solution which they give freely. Public Health England are promoting that drug services should take service users to meetings, yet they are still telling people that they must first do their groups or consider applying for detox and rehab funding.

The word recovery is not new, though it's thrown about and being defined to death. Let's hope next we will get some expert saying 'Bananas' is the new buzz word –someone might even write a book about it.

**Martin Territt, by email**

## COMPETITION UPDATE

The first ever Global Drug Survey drugs meter minutes video competition (DDN, April, page 14) has extended its entrance deadline. You now have until 14 February 2015 to submit a harm reduction and drug education related video – for more information, email adam@globaldrugsurvey.com.

www.globaldrugsurvey.com; www.drugsmeter.com

**Adam Winstock, consultant psychiatrist and addiction medicine specialist, and founder of the Global Drug Survey**

**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.

# WHAT YOU'RE SAYING

From the DDN website, www.drinkanddrugsnews.com

### *On Stanton Peele's article, 'Mind the steps?', DDN, April, page 8...*

ALL RECOVERY GROUPS are about the people that attend them. I tried AA for a couple of months as I didn't know of anywhere else to go. The first thing that shocked me were people at the group who had not touched alcohol for many years (*eg* 20), so they said. Why were they still attending AA? To keep them sober, apparently. The fact is there is no discussion allowed, only listening to someone else telling you the same old story about what they did when they were drunk. You can't challenge anything anyone says (no cross sharing). It is all religious dogma founded in 1930s America. I have not had a drink for three years, so I have got power over alcohol.

Many GPs for example don't realise it's a quasi-religious organisation. 'Humbly asked God to remove my shortcomings' – why did he give them to me in the first place then? I told them I did not believe in the 12 steps so was asked to leave – in fact AA state the only criteria for joining is a desire to stop drinking. No, it's a religion in my opinion and they try and convert you. It's all about God, although they deny that. Count how many times alcohol is mentioned in the 12 steps then count how many times God is mentioned. I formed my own SMART Recovery group. If AA works for some people great, but treatment providers should be aware of other self-help groups in their area and most aren't.

***Stephen Keane***

ONE ONLY HAS TO READ STANTON'S BLOGS to understand why he is critical of AA, and an interpretation of the 12 steps as has been made known to him. The abuses that he has heard about in AA and has written of do occur in AA meetings, and among AA patrons outside of the meetings. That these abuses occur has been acknowledged in AA circles, down to and including conference level, however, beyond acknowledgement little has been achieved by way of effective action. The lack of action is possibly due, in part, to members' vulnerability (especially in early recovery) being taken advantage of, and particularly in the UK, to confusing anonymity with secrecy. There is also the wider societal and cultural reluctance (professional and lay) to address, let alone deal effectively with, abuse.

12-step philosophy is open to interpretation, as is any philosophy (and I use the word 'philosophy' as a coverall for all approaches to thought, including theology). There are those that distort (intentionally or thoughtlessly) a philosophy to rationalise their behaviour, hence some religious adherents engage in various forms of abuse. AA and 12-step philosophy is not immune to being abused, especially when proponents of such interpret 'powerless over addiction' to mean 'powerless, period'. I find Stanton's criticism of this interpretation of the 12-steps as reinforcing victimhood valid. Personally, I admit I am powerless over addiction, mine and others, however, I interpret that in an empowering way in that, I will do all that I can to stay sober (and staying sober is more than just not drinking.)

My own journey with the 12 steps has been a solitary one. Having been rendered a victim by a brutal religious regime in a life pre-addiction, my personality is now such that I will not accept a code of conduct without challenging it. I do not prescribe to the fundamentalist religious view of 'my way is the only way', as quasi-religious types in AA do. As such, my challenges offend those over-inflated egos attracted to AA, and their cliques.

I have spent over two sober decades poring over various approaches to life and living. I cherry-pick, and accept responsibility for that which I have chosen, and that which I have discarded. I may just take a Stanton cherry, though it will be one that appeals to me now, at some tomorrow I may return for more. Am I prepared to accept Stanton's valid perception as the only way? Of course not, 'He's not the Messiah, he's just a(nother) naughty boy'.

***Trevor H***

**OBITUARY**

# PHIL FOX

## 8 JUNE 1959 – 16 JUNE 2014

**It is with greatest sadness that we break the news of the passing of Phil Fox, our founder and creative director. He passed over on Monday night, 16 June.**

Everyone will remember him as a truly inspirational person who founded Outside Edge Theatre Company, as well as a friend and mentor to so many. Being involved in theatre saved his life in 1999; through founding Outside Edge, he was able to share that love of theatre and challenge and engage us all to support his work so that he could help others through their own recovery.

Our deepest sympathy and heartfelt consolations go to his family and to everyone whose life he has touched. We are ourselves coming to terms with this very sad and sudden loss. We will, as soon as we are able, share further information about how we can remember and celebrate his life and the gifts which he was able to share through his work. The company will continue to operate as normally as possible which is what Phil would have wanted.

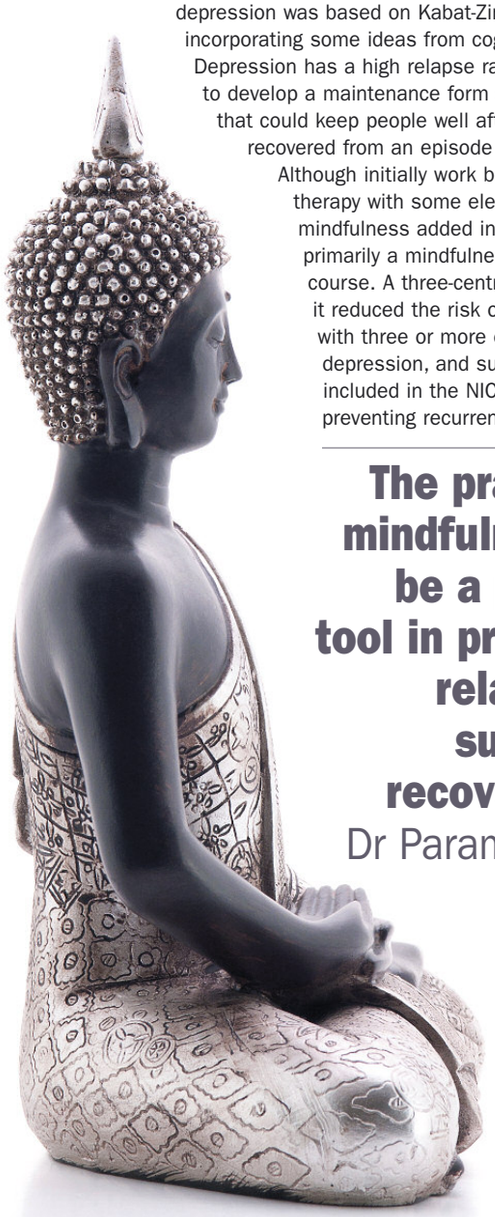
*Jim, John, Patricia, Shereen, Yvonne, Cathy, Siva and Annamaria, Outside Edge Theatre*

# THE BUDDHIST WAY

**MINDFULNESS** has been a cornerstone of Buddhist practice for about two and a half thousand years. The essence of mindfulness is paying deliberate attention to our experience as it unfolds moment by moment, with an attitude of friendliness and curiosity.

In the late 1970s Jon Kabat-Zinn in Massachusetts started using mindfulness as a therapeutic modality, especially for people with chronic pain, but also for people with anxiety and stress. He developed an eight-week course called mindfulness-based stress reduction (MBSR) using mindfulness meditation and simple yoga. His work showed that about two thirds of people with chronic pain benefited, and benefits were maintained at four-year follow-up. In particular, people benefited if they continued to practise mindfulness, even if only informally (as oppose to formal sitting meditation).

Mindfulness-based cognitive therapy (MBCT) for depression was based on Kabat-Zinn's work, incorporating some ideas from cognitive therapy. Depression has a high relapse rate, and the aim was to develop a maintenance form of cognitive therapy that could keep people well after they had recovered from an episode of depression. Although initially work began as cognitive therapy with some elements of mindfulness added in, it ended up being primarily a mindfulness meditation course. A three-centre trial showed that it reduced the risk of relapse in those with three or more episodes of depression, and subsequently it was included in the NICE guidelines for preventing recurrent depression.



**The practice of mindfulness can be a powerful tool in preventing relapse and supporting recovery, says** Dr Paramabandhu Groves

MBSR and MBCT have generated a wide interest in using mindfulness for a range of conditions. A review in 2013 reported that there had been 209 randomised controlled trials involving mindfulness. Given the relapsing nature of addiction, the work on MBCT suggested mindfulness might also be helpful for use in addiction. Mindfulness-based relapse prevention (MBRP) is an adaptation of MBCT for preventing relapse into addictive behaviour.

## RELAPSE PREVENTION

The key components of MBRP are threefold (in a handy ABC). The first part is developing awareness. This is done through sitting meditation, a body scan, mindfulness of everyday activities such as walking or eating, and a 'breathing space' – a mini-meditation that can be done anytime during the day. Bringing awareness to simple activities like eating, we start to recognise that frequently our mind is not fully attending to what we are doing. Often our minds are caught up in worrying about the future or going over the past, rerunning arguments or playing out fantasies – a condition referred to as automatic pilot.

The sitting meditations provide an opportunity for watching the mind in more depth. For example, in the mindfulness of breathing meditation the breath is used as a focus. Inevitably the mind frequently wanders off from the breath, and in acknowledging where the mind has gone we can develop awareness of habitual thoughts and emotions. By recognising what is going on, we step out of automatic pilot, with its danger of running off down relapse-predisposing mental habits. Triggers and unhelpful mental patterns are recognised earlier, when it is easier to choose something other than an addictive behaviour. The second stage is learning to 'be' with experience. The emphasis is to not push away unwanted experiences, but instead find a way of letting them be. This helps to avoid suppression or unhelpful habitual reaction. It can also lead to a change in perspective so that thoughts and emotions are not over-identified with: thoughts are just thoughts, not (necessarily) facts.

The third stage is making skilful choices. On the basis of greater awareness and when not acting out of habitual reactions, it is possible to make wiser decisions about how best to act.

## IS MINDFULNESS EFFECTIVE?

Preliminary work suggests that MBRP may be helpful in preventing relapse into substance use. To date there have been eight randomised controlled trials. Two showed no difference from controls, but the others showed reduced substance use. Some studies also showed improvements in other areas, such as enhanced psychological and social adjustment, and reduced craving.

Mindfulness is being used with other therapeutic modalities. In developing dialectical behaviour therapy (DBT) for borderline personality disorder, Marsha Linehan included mindfulness as part of the package. Mindfulness is used to encourage acceptance and to extinguish automatic avoidance of emotions, and DBT has been adapted for substance misuse treatment.

Acceptance and commitment therapy (ACT) emphasises accepting difficult thoughts and emotions in the service of moving towards goals that are in line with a person's values. Although ACT was not developed from the mindfulness tradition, mindfulness practices are now often used to enable the acceptance part of ACT. It has been used to help with a wide variety of disorders including substance misuse, for which there is a growing interest in its application.

Mindfulness appears to be helpful for a range of psychological disorders, as well as improving well-being and psychological functioning. For the future, rather than focusing just on relapse prevention (MBRP), mindfulness courses – referred to as mindfulness-based addiction recovery (MBAR) – may be seen as a support to the broader journey of recovery.

**Dr Paramabandhu Groves is an NHS consultant psychiatrist at Camden and Islington NHS Foundation Trust, specialising in addictions, and clinical director of Breathing Space, www.breathingspacelondon.org.uk**

**This year's Kaleidoscope Conference looked at how spiritual practices, such as mindfulness, could link to harm reduction to improve the treatment landscape.** Martin Blakebrough **reports**

# MIND OVER MATTER

**Mat Southwell opened the 2014 Kaleidoscope Conference** by linking harm reduction to mindfulness: 'I find injecting ketamine helps me with mindfulness.' The challenge he gave delegates was that governments may define recovery as one without drugs, but as a service user he wanted to set his own agenda. The challenge of harm reduction has always been one where the service user sets their agenda for change.

The need for harm reduction is as true now as it ever has been in that we need to keep people safe, so naloxone and needle and syringe exchanges are focused on doing this. Mat talked about a time when he was using drugs chaotically, which badly impacted on his life. He sought to change, but that change led him to consider what drugs he could take and what drugs he was not able to live with. The problem today is that many commissioners are focused on recovery, which they see as primarily moving a person to being abstinent from drugs. The harm reduction message is being disinvested in, which means many services are not being empowered.

Harm reduction, according to Dr Julia Lewis, is like Marmite – you seem to either love it or loathe it. Its importance must not be minimalised, however. It is an evidence-based approach that has saved millions of people – a principle that originates from the UK and is now globally accepted. The development of needle and syringe exchanges alongside substitute prescribing has made a real difference to people. Yet many people find it a difficult concept as it seems that one is condoning behaviours that many feel are immoral and destructive to society, as well as to the individual.

The use of drugs among drugs workers is a topical issue. Should staff not set an example and advocate the perceived ideal of a drug-free lifestyle? If workers talk about their own safe using does this not cause problems for someone who is chaotically using drugs? The experience I have had does not bear this out. One of the most successful programmes Kaleidoscope has run, Simplyworks, included a staff member on a methadone programme, and that person had the best engagement and outcomes of any of our staff.

In Wales, drug agencies have come together and established a peer mentoring project, which has included substance users and has achieved staggering results; Kaleidoscope in Cardiff found more than 200 permanent jobs for service users. In India, one agency has active drug users providing needle syringe exchange and substitute prescribing and again meets the needs of that drug-using community. When we look at naloxone, it works best when we empower service users and I would argue that we also give the dealers clean needles so at least people injecting for the first time do so as safely as possible. Harm reduction is not an ideology, it simply is based on what works – and that was the key message of this conference.

Service user empowerment is a fundamental part of harm reduction and in Gwent Kaleidoscope has been delighted to work closely with The Voice, a proactive service user group that has just opened its own Newport service, called the Hub. What is critical to them is ensuring people receiving services are able to challenge treatment providers and commissioners in designing the right services for their needs. The service again is not driven by one theme, such as recovery, but looks practically to support the user in the changes they wish to make. It has also managed to reach out to an open prison, developing a very strong link with HMP Prescoed, where some prisoners have volunteered to support the Hub with their unique skills and at the same time address their own issues through peer support. The workshop they ran at the conference gave space for service users to talk about their own personal journeys and was one of the highlights of the day.

# 'Harm reduction is like Marmite – you seem to either love it or loathe it.'

**DR JULIA LEWIS**

Workshops enabled proactive debate as well, from looking at the place of alcohol in society to how service providers can be more effective when they provide integrated services with the service users' needs placed at the centre.

Many of the pioneering drug takers took drugs to look for profound mind-altering experiences. Psychonauts are people seeking to push the boundaries of mindful experience and certainly Mat Southwell would consider himself in this category. The desire to push human mind experience is in many ways part of the human tradition, be that through taking substances, or by travelling, or even excessive sport.

The problem for treatment providers is that this dash for experience is often forgotten, so treatment focuses on the medical aspects of addiction. It may help someone deal with a traumatic experience, but in a dash for secularism has forgotten that, for many, drug use is about finding the meaning of life – a profound experience.

So where is the place for the spiritual element – is it religious or can meaning be found through other means? Mindfulness is becoming a major force, not just in drug treatment but as a tool when working with any group of people, from education to boxing. To enable people to experience mindfulness, we provided a workshop run by Eluned Gold, head of personal and professional programmes at Bangor University.

Eluned was also one of our main speakers on the subject of mindfulness, looking at support for parents and carers, while Dr Paramabandhu Groves, consultant psychiatrist at Camden and Islington NHS Trust (see page 13), looked at mindfulness for addiction recovery.

Dr Groves reminded us that the concept comes from a Buddhist tradition but is not one that requires a person to be an adherent of a religious perspective. Mindfulness creates time to reflect, to contemplate or meditate, enabling a person to understand issues in a different way. For some they may experience a spiritual enlightenment, for others it may be a better understanding of the self. The importance of the metaphysical, however, is a vital component of our human nature.

The day ended in style, with a panel discussing the place of spirituality or faith in the recovery journey. The meeting was chaired by the former chief executive of Newport City Council, Chris Freegard and included Dr Groves from the Buddhist tradition, Bishop John Davies of Brecon and Swansea, Roderick Lawford from the humanists in Cardiff, Tazlim Hussain from a mosque in Newport, and the founder of Kaleidoscope, former Baptist minister, and my father, Eric Blakebrough, who made the case passionately for harm reduction from a theological perspective.

**Martin Blakebrough is chief executive of Kaleidoscope, kaleidoscopeproject.org.uk**

**POST-ITS FROM PRACTICE**

# Challenging behaviour

## **Although primary care is an ideal place for treating substance problems, sometimes extra support is needed, says** Dr Steve Brinksman

**IT IS MY FIRM BELIEF** that the majority of people with drug and alcohol problems can be managed in primary care, albeit with the proviso that appropriate access to psychosocial treatments are in place. I was initially therefore fairly downbeat about having to refer Bill back to our local secondary care provider.

He and his brother Jack are both registered at our practice and have been for a number of years. Now in their late forties, they each have a long history of chaotic IV polydrug use and alcohol dependency, punctuated by numerous prison sentences. Over the years their lifestyle has taken its toll and they both have a number of physical health problems, mainly related to alcohol use, and previous encounters with mental health services.

Jack, the older of the two, was being treated by the secondary care drug service for a number of years when we were approached to see if his care could transfer to our practice as, due to some of his other problems, attending treatment was becoming more difficult. In the three years since then there have been spells when he has lapsed into more problematic drug and alcohol use, but with a lot of input from his keyworker at our surgery we have succeeded in integrating his care into our practice. This is also testament to the skill of our receptionists who have managed to build a good rapport with him that on the whole nullifies his occasional outbursts.

Perhaps feeling flushed with success we then agreed that his brother Bill's opioid prescribing could also be transferred from the secondary care provider. Despite trying the same approach, this has been much less successful. Three local pharmacies have barred him due to abusive language and he would regularly cancel or not attend key worker or doctor appointments. His alcohol use escalated and he was verbally offensive to the receptionists on several occasions.

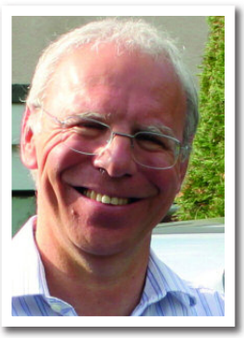
We have a policy of discussing patients with any conditions whom we are struggling to manage either clinically or behaviourally at our weekly practice clinical meeting. As a result of one of these discussions it was decided to transfer Bill's care back to the secondary care drug service.

This was a difficult decision and made me realise that whilst we may be fortunate to have the clinical and case management skills available to support less stable people, the roles of other staff and colleagues are equally important. Primary care is a fantastic place to deliver care to those using drugs and alcohol problematically, but some will need extra support and care and I am grateful that additional services are available.

Bill still comes to see me and we are now starting to address some of his physical and mental health issues. I hope that at some point he may again receive all of his care at the practice but for now transferring his opioid substitution treatment out has meant he has remained a patient at the practice. For all concerned, a positive outcome.

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

# ALL CHANGE



The Care Quality Commission is about to unveil new plans for inspecting substance misuse treatment services, as **David Finney** explains

**THINGS ARE CHANGING FAST** at the Care Quality Commission (CQC) this summer. In the light of previous negative publicity there is a new structure and a new approach developing. CQC say that by October there will be a new inspection methodology in place, so inspectors will be looking for different things and writing different reports.

The big news for the substance misuse sector is that all treatment services, whether residential or community services, will be based within the hospital directorate; more specifically within the section of this directorate that deals with 'community-based services for people with mental health needs'. This means that there should be a similarity of approach to community drug and alcohol services and residential rehabilitation services. We wait to see whether this means that the methodology being developed will be more similar to clinical treatment services than adult social care. For a long while residential services battled to be thought of as 'treatment services' rather than 'care homes', so maybe this will lead to a more realistic and 'joined-up' approach to inspection?

Another piece of good news is that CQC has appointed a 'national professional advisor and policy manager for substance misuse'. Her name is Violeta Ainslie and she used to work as treatment provider with Cranstoun Drug Services until very recently. I am personally very encouraged on two counts. Firstly, this is a full-time post dedicated to this sector. In my previous role, the substance misuse sector was only a small part of my job; now there is someone dedicated to the sector, who can join up all the dots within CQC and be a point of reference for external agencies. Secondly, as someone who was recently working within the sector, she is well placed to understand the unique characteristics of substance misuse treatment.

Part of the national advisor's role will be to set up an 'expert group', which will be a reference point for the development of the new methodology for this sector. At the time of writing, this group was due to begin its deliberations at the beginning of July. The next step will be publishing a 'signposting' document which will chart the way forward and explain when the new methodology is likely to be implemented. So, while the adult social care sector is planning to implement in October 2014, the substance misuse sector may have to wait a while. The message is, 'watch this space!'

Having completed the first consultation phase on 4 June, in which CQC tested various elements of the new methodology in hospitals and care homes, CQC will now no doubt use some of the feedback and incorporate it in the new approach to the substance misuse treatment sector.

**'...now there is someone dedicated to this sector, who can join up all the dots within CQC and be a point of reference for external agencies.'**

**NEW METHODOLOGY**

There is no doubt that the new methodology will focus on the 'five questions', which are: Is the service safe, effective, caring, responsive and well led?

You may have seen the provider handbooks and appendices on the CQC website, which set out the proposed framework. There are some key features which mark a change from the previous approach:

- ***The 'provider information return' will be sent out to services before the inspection, so that they can self-assess against the five questions.***
- ***There will be 'key lines of enquiry', which will act as prompts to inspectors as they look at how the five questions are worked out in the service.***
- ***There will be 'ratings' which will be published and will determine inspection frequency. These ratings extend from 'outstanding' to 'good', then 'requires improvement' and finally 'inadequate'. There are complicated rules which determine how these rating are arrived at – however there are also helpful guidelines that tell you what each rating might look like for each question.***
- ***There will be a greater reliance on 'experts by experience' to provide the service user perspective.***
- ***There will be an emphasis on 'intelligence monitoring', which means gathering information from a range of stakeholders.***
- ***Finally, although the Care Act 2014 has been granted Royal Assent, the new draft 'fundamental standards of care' and 'regulated activity regulations' are now awaiting parliamentary approval so cannot be enforced until that is achieved. It is expected that this will happen by October 2014 so that the new approach is fully grounded in law.***

Meanwhile, between now and October 2014 CQC will continue to undertake routine inspections, so if you have an unannounced inspection this will be according to the existing methodology. There will be one difference and that is that the summary at the beginning of the report will focus on the 'five questions' as a taster of what is to come. The possible reasons for an inspection before October are: that your last inspection occurred between April and October 2013; there are outstanding compliance actions; there have been complaints made to CQC which they may be following up in terms of compliance; or you have changed registered manager in the last 12 months.

When looking forward to the new approach, some of the most recently published inspection reports give clues as to what may be asked. However it is worth waiting to see exactly what is proposed for the substance misuse sector and, where possible, contribute to the debate through routes such as FDAP and your representatives on the 'expert group'.

As CQC publish more information, such as the 'signposting' document with an outline of their new approach, it will be possible to look at the implications for your service more fully. To help this process there will be courses which will focus on the substance misuse sector this autumn, organised through DDN.

**David Finney is an independent social care consultant. His course on everything you need to know about the new structure is on 11 September in central London – details at www.drinkanddrugsnews.com**

# MEDIA SAVVY

## WHO'S BEEN SAYING WHAT..?

I'm wholly on the side of senior nurses who, at their annual conference in Liverpool, called for those with drink-related injuries to be turned away from A&E and directed instead to 'drunk tanks'... It's not just that these idiotic individuals cost money we can ill afford (£3.5bn a year is spent on treating patients for the effects of alcohol; at weekends, up to 70 per cent of A&E admissions are alcohol-related); it's also that patching up these fools diverts precious resources from other areas of the NHS. Areas such as care for the elderly, that are manifestly more deserving than some silly girl who's drunk her own weight in Bacardi Breezers and who is slumped unconscious in a pool of her own bodily fluids.
Sarah Vine, *Mail*, 18 June

The next time you hear someone complaining about the 'nanny state' or the right of individuals to drink as they see fit, spare a thought for the people around the drinker. In particular, consider whether our children and young people have the right to grow up in an environment that protects them from the harm that alcohol causes.
Dr Evelyn Gillan, *Scotsman*, 5 June

The elephant in the room is the truth that it's pleasure that drives drug use – guidelines that fail to acknowledge this will mean people will not pay attention to them.
Adam Winstock, *Observer*, 22 June

E-cigarettes are either going to save millions of lives by helping people to quit smoking or they are going to destroy millions of lives by luring children and young people into the habit. It is very hard for the onlooker to know what to believe, when the rhetoric is flying in both directions from very eminent people who all have a passionate commitment to public health.
Sarah Boseley, *Guardian*, 16 June

The wildly contradictory reports on the health effects of the e-cigarette mean the only certainty I have about them is that no one knows what sucking in clouds of liquid nicotine really does to the human body... it's not all that long ago that cigarettes were warmly welcomed into society – and millions suffered and still suffer the cancers to show for it. Well before e-cigs become just as entrenched, we need more research to discover how they work.
Lucy Tobin, *London Evening Standard*, 13 June

Sending drug users to jail is usually an expensive waste of time. But decriminalisation's flaw is that it does nothing to undermine the criminal monopoly on the multi-billion-dollar drugs industry. The decriminalised cocaine consumed without criminal consequences in Portugal is still supplied by the gangs who cut off heads in Colombia. Only legalisation takes the business out of the hands of the mafia.
*Economist*, 18 June

Tony Blair was absolutely right to make the link between opium production in southern Afghanistan and heroin use in Britain. But it is clear now that he and others were wrong to think this link could be broken through military action internationally and police enforcement domestically.
William Patey, *Guardian*, 25 June

# Prima

Dr Judith Yates talks to **David Gilliver** about swapping the GP surgery for the international policy arena, and the vital role of primary care


'I do believe that the best care for people who use drugs and alcohol is in their own GP surgeries where possible,' says Dr Judith Yates, who – although retired from her GP practice since 2010 – is far from retired from the drugs field.

She'd wanted to go into medicine since childhood but dropped out halfway through medical school to 'explore the world and myself a bit', an experience that helped her decide that it was being a GP – as opposed to other areas of medicine – that would provide the most interesting challenge. As a young trainee in the late 1970s, and her practice's only female GP, she soon discovered that the only way to see male patients was though consultations with those who had drink and drug problems. 'At that time the psychiatric addiction services were struggling to find their way and the heroin was flooding in, and by the '80s the waiting lists for treatment by the psychiatrists were rapidly building up,' she says. 'People were falling out of their care and turning up on my doorstep.'

Her other discovery, however, was just how rewarding helping this client group could be. 'It just seemed to be something that I could easily do. The rest of general practice – which I was doing as well, of course – often involves the long-term care of physical ailments, some of which are quite gloomy, whereas these were young people with lots of potential who'd struck upon hard times and with a helping hand could get on with their lives. The transformations could be quite rapid.'

She went on to spend three decades as a Birmingham GP, working in the city's first community drug team in the early '90s at the same time, and after a while the group of patients at her surgery who used drugs numbered around a hundred. Clearly, not all practices were – or are – as accommodating. Does she feel that the stigmatising attitudes of some GPs are starting to change?

'I think it's very patchy and postcode-y,' she says. 'In Birmingham we were lucky in that when all the crime money came in with the NTA all the GPs working in this field – only about four or five of us – joined the newly formed shared care monitoring group and managed to use that money to set up probably one of the biggest primary care-based drug treatment services in the country. It's been very effectively organised and managed in that drug workers go out into GP services as opposed to sitting in a centre somewhere waiting for patients to come to them. Around half the people who are scripted in Birmingham are treated in primary care, which is good but it does need proper focus. GPs on their own can't do it – they need properly organised key workers coming in because there just isn't the time in ordinary primary care.'

She still does a weekly clinical session with the community drug team and also helped to plan and set up a new residential detox and rehab clinic, working there for two 'enormously enjoyable' years after retiring from her surgery. But it's policy work that's been taking up most of her time lately.

'I had a bit more time to pick my head up from the coalface and look around so I started to look at ways to reduce drug-related deaths in Birmingham and work on our take-home naloxone project,' she says. 'I thought I'd be able to just put on a couple of training the trainer sessions and then someone else would take over and it would run itself, but that didn't happen. I discovered that you have to chip and chip away at all these little tiny local barriers that prevent any change.'

It was through the naloxone project that she met Philippe Bonnet (*DDN*, October 2013, page 16) and started investigating the growing international evidence base for consumption rooms. Is she confident that the Independent Consortium on Drug Consumption Rooms (ICDCR) can achieve its aim of establishing a facility in Birmingham?

'We've been waiting for the Birmingham re-commissioning to finish because – quite rightly and reasonably – we were asked to not take our plans forward in any concrete way while all the services were going through this enormously time-

# ry position

consuming recommissioning round, and we didn't know who was going to be running treatment services anyway. So we've been collecting information and improving our understanding of what could be done and what would be cost-effective. We've spoken to some people among the police and the local authority who are cautiously interested, but we obviously need the clinical arm.'

The city's main clinical provider is likely to be announced this month and ICDCR is confident that they'll be interested if it can be shown that consumption rooms are both necessary and value for money. 'I think we can prove that it's cost-effective if we don't have grandiose ideas. The Vancouver and Sydney ones are big, all-singing, all-dancing versions but we see a Birmingham version as being part of the existing needle and syringe and outreach programme – there'd be no new staff or new budget. If we could find a backroom associated with the existing services, with a few sinks for people to wash their hands and a kettle to offer people a cup of tea and a listening ear, that would be fine. It's not a high-tech answer to anything – it's not like heroin-assisted treatment, which is very expensive.'

What about the legal status of consumption rooms – how much of a barrier could that be? 'In parts of Europe allowing your premises to be used for taking drugs is still against the law but there are local accords with the police, and we see that as the way it could happen in the UK, although we'd obviously like to change the law eventually,' she states. 'If you think about needle and syringe programmes, the police don't arrest everyone going into those, which they could because they know they've got heroin on them. The same would apply to consumption rooms – they'd know they were people who used drugs but they're not the big dealers, they're people with a dependency who are street injectors.'

The international evidence also shows that people 'tend to up their game' once they start using consumption rooms, she says. 'The staff wax lyrical about the transformation in their behaviour, and they carry on those learned habits when they're not in the centre – their health improves, they no longer attend A&E and they begin to re-engage with society.'

Being able to provide the service without a new budget could clearly go some way towards making it more attractive in today's environment – how optimistic is she about the state of the sector overall? 'There's no doubt that the money is tight and not ring-fenced any more, so we have to be smarter with it,' she says. 'Obviously the more resources you have the more quality you can offer but there isn't any choice about it, I suppose. But in terms of human beings I tend to be an optimist and I'm hoping that we're still learning.'

Indeed the whole of her involvement with the sector has been a learning curve, she states. 'It has been for all of us – before the 1980s there wasn't a big heroin-using population in the UK. It was small numbers of people, mostly dependent on pharmaceuticals – they'd blag their GPs for Diconal and all those things. So the huge flood of heroin that came into the country and the huge increase in people using it involved us initially working out how to keep people alive and help them with substitution treatment.'

As has been widely documented, that heroin-using population is now growing older, and so far the indications are that it's not being replaced by a significant younger one. 'I do hope that's a societal change and gradually people will not get into this dependency on opiates, because it's such a long-term trap,' she says. 'Some of the stimulants and novel psychoactives have their own problems but – even with cocaine – they're things that you can walk away from a bit more easily than an opiate habit. So I'm hoping that we won't be seeing families affected quite so much, and the policies have kind of followed that learning curve in a way. We're kind of all learning together.'

She'd long been part of SMMGP (Substance Misuse Management in General Practice) and when SMMGP's Chris Ford set up IDHDP (International Doctors for Healthier Drug Policies) she was asked to become a director. This year has seen her visit the Commission on Narcotic Drugs (CND) in Vienna, representing IDHDP's rapidly growing membership of almost 600 doctors from more than 70 countries who 'believe we need health-based rather than criminal justice based drug policies', she says.

**'Liver specialists are now very excited, saying... that the new treatments mean that we could eliminate hepatitis C within 15 years.'**

And it's in arenas like this that real change can be brought about, she believes. 'I've always supported the test-and-treat approach to hepatitis C and HIV, for example, but while you've got to do it on a one-to-one basis you do also need to have it as national and international policy to make a real difference. If you can get people into treatment you can also defeat the disease, because even if they're not immediately completely cured their virus count goes down so they're not so likely to pass on the infection, and it's the same with HIV. The liver specialists are now very excited, saying that we're on the "cusp of a new dawn" and that the new treatments mean that we could eliminate hepatitis C within 15 years.'

She praises the Scottish plan to treat more people for hep C each year than are becoming infected with it as a way to ultimately eradicate the virus. 'Also you don't end up bankrupted by the exponential growth of cirrhosis and liver failure,' she says. 'And they've got a national naloxone programme of course – if they vote to opt out of the UK, we should all vote to join Scotland!'

While there's 'no simple step' to eradicating drug-related deaths or harm it's essential to be part of the 'international conversation', she stresses. 'Take-home naloxone has been shown to reduce drug-related deaths in parts of the US by up to 50 per cent, and I hope there'll be new regulations to allow its even wider provision in the UK.' It was also announced at the Vienna CND that forthcoming WHO guidelines will state that everybody who could potentially be at the scene of an opiate overdose should have access to naloxone, she adds.

'I believe that it may come to be seen as negligent to prescribe methadone without also prescribing a take-home naloxone kit. Drug consumption rooms have also been shown to be a cost-effective step as part of existing treatment services around the world, and I believe we should look seriously at small pilots in parts of the UK where there's a need. Applying a criminal penalties to drug use has never made any drug safer, and the sky hasn't fallen in on countries like Portugal and the Czech Republic where steps towards decriminalisation have been in place for many years.

'These are all areas where policy and central guidance and leadership are needed to drive change. I see my pension as a government grant that allows me time to apply my past clinical experience to these broader areas, where policy change can make such a difference to the wellbeing, not just of individuals, but of populations.'

*www.idhdp.com*

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**- Professor Peter Anderson**

**Themes:**

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|---|---|---|
| Pain, analgesia and addiction | E-treatment | Contingency management |
| Alcohol, public health and what we think we know | | E-cigarettes |

**Speakers:**

| | |
|---|---|
| Dr Rebecca Lawrence | Pain and dependency – Better together |
| Dr Cathy Stannard | Pain, analgesia & addiction *(working title)* |
| Dr James Bell | Pain and addiction - Managing patients who aren't managing |
| Dr Heleen Riper | The clinical & cost-effectiveness of e-prevention & treatment for alcohol misuse |
| Dr Bridgette Bewick | How are individuals processing the information we provide?: Using verbal protocols to explore the user experience of brief personalised e-interventions for alcohol use |
| Prof Kathy Carroll | The brave new world of computerized interventions for addictions |
| Ildiko Tombor | Development and evaluation of SmokeFree Baby: A smoking cessation smartphone app for pregnant smokers |
| Mike Ashton | Base of the evidence base for addiction treatment |
| Dr Frances Kay-Lambkin | Improving the management of co-morbid addictive and mental disorders through the use of technology |
| Dr Tim Weaver | The acceptability and feasibility of implementing contingency management in routine practice *(working title)* |
| Dr Nicola Metrebian | Do monetary incentives increase completion of HBV vaccination amongst people in opiate treatment? |
| James Nicholls | Alcohol licensing and public health: Bringing research and practice together |
| Prof David Foxcroft | On the accuracy of brief alcohol questionnaires in UK primary care |
| Dr Lynne Dawkins | Electronic cigarettes: Nicotine and non-nicotine components of vaping |
| Prof Ann McNeill | E-cigarettes: Policy, availability and use *(working title)* |
| Dr Jamie Brown | E-cigarettes: Latest trends from the Smoking Toolkit Study |

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***David Finney has been specialising in the regulation of the substance misuse sector as an independent consultant since 2009. Previously he was the national policy lead on substance misuse services with CSCI.***

***£145 per person (15% discount for FDAP members), includes lunch and refreshments.***

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Essex County Council

ESSEX DAP drug & alcohol partnership

## Specialist Treatment and Recovery Service (Substance Misuse) – Previously Specialist Prescribing Services.

Essex County Council (in particular the Public Health Commissioners) is looking to procure a Specialist Treatment and Recovery Service (Substance Misuse).

The service will be predominantly prescribing for recovery, which includes reduction/detoxification as a default approach and promotes freedom from drugs of dependence (including Alcohol). It will operate as an element of the greater Essex substance misuse recovery system.

The value for this contract is expected to fall between £5.5 million and £6.3 million per annum. It is anticipated that the contract will run for a maximum term of seven years (five years with two one year possible extensions). It is likely that TUPE will apply and it is anticipated that the contract will commence on 1 April 2015.

If you are interested in bidding for this contract please ensure that you register on Ariba, details below:

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To register go to *http://ecc.supplier.ariba.com/ad/register/ssoactions?type=full and follow instructions*

Or to *Essex.gov.uk* and follow the links through business and supplying the council.

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Send an e mail with your organisation name in the title field to the workspace link below. This needs to include:

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***ARIBA HELP DESK FOR TECHNICAL SUPPORT: 0800 3583556***

*All procurement related queries must be emailed to the Event Message board once you have been Invited to Participate.*

North Somerset Council

Safer and Stronger North Somerset

## North Somerset Council is looking to procure a recovery-focussed substance misuse treatment service, integrating the existing drug and alcohol services under one contract.

This service will be available to adults, living in North Somerset or registered with a GP in North Somerset experiencing drug and/or alcohol use problems. It will include: structured and un-structured treatment programmes; one to one and group psycho-social programmes; pharmacological treatments including arrangement for community and inpatient detoxification; harm reduction initiatives, including specialist needle exchange and initiatives to address factors which are hindering an individual's ability to achieve their desired substance use goals, e.g. isolation, family problems, mental health issues, physical health issues, education, employment.

North Somerset Council will accept bids from single providers, partnerships and consortia; and, subject to approval, will accept bids based on sub-contracting arrangements. The Council will be particularly interested in receiving bids in which the delivery arrangements will provide increased and measureable social value.

**It is likely that TUPE will apply.**

The value for this contract is expected to fall between £1.8 million to £2.5 million per annum. (Note: in response to available budgets the annual cost of this service will be subject to change.)

It is anticipated that the contract will run for a maximum term of 5 years (3 years plus the option to extend for a further 2 years in 1 year increments). It is anticipated that the contract will commence on 1 April 2015.

***Stakeholder consultations have already begun and as part of this process the Council will be holding a provider's awareness and networking event for organisations interested in bidding. This will be held on 23 July 2014 between 11.30 and 13.45 at the Campus, Highlands Lane, Weston-super-Mare BS24 7DX (http://www.the-campus.org.uk/about/location/)***

***To register your attendance at the awareness raising and networking event please contact Jacqui Cuthbert (jacqui.cuthbert@vansmail.org.uk)***

It is anticipated that the pre-qualification questionnaire (PQQ) stage will commence in early August 2014, with the invitation to tender (ITT) stage commencing in early October2014.

All procurement documents will be published on supplyingthesouthwest.org.uk.

***Additional information related to this project will be made available on http://www.northsomersetpartnership.co.uk/whoweare/people%2Band%2Bcommunities%2Bboard/substance+misuse+commissioning1.asp***

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*Compass is a national charity providing services to tackle problem substance misuse. Our mission is to help people to solve the problems of drug and alcohol use, creating healthier lives and safer communities, and last year we supported 15,000 people on their recovery journey. The Harrow community drug and alcohol service is recruiting for the following roles.*

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*Tel: 01204 540824*

*For an application pack for the Leeds or Hull vacancies please contact Emma Haigh,*
*Email: ehaigh@nhs.net*
*Tel: 0113 2444102*

**Current closing date for applications is 9am Thursday 31st July 2014**

*Expressions of interest are welcomed at any time.*

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## London Borough of Merton invite expressions of interest for the provision of an integrated young people's substance misuse, detached youth and sexual health promotion service for young people aged 24 and under and their families.

Merton Council is seeking to invite suitably experienced providers, to submit tenders to deliver integrated substance misuse prevention and treatment, detached youth work and sexual health promotion. The required service will provide a full range of preventive activities and specialist interventions for young people to address risk and build resilience.

The council is looking for an organisation or consortia with a proven track record in delivering services for young people and achieving positive outcomes.

The tender process is being conducted via the London Procurement e-tendering system www.londontenders.org/procontract/user

The closing date for expressions of interest will be 12 noon on Friday 25 July 2014.

For further information please contact:
Michael Balamwezi
Contracts and Procurement Manager,
Children, Schools and Families
London Borough of Merton, 10th Floor Civic Centre,
London Road, Morden SM4 5DX

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bdp
Independence from drugs and alcohol

Are you passionate about helping people gain independence from drugs and alcohol? We are. **BDP** is an experienced resourceful organisation working with over 3,000 individuals a year delivering key elements of Bristol's **Recovery Orientated Drug and Alcohol Service (ROADS)**. We are seeking exceptional people to join us:

## SHARED CARE WORKERS

*(Full Time, Permanent )*

Delivering opioid substitution therapy within primary care in partnership with 90% of Bristol's GPs.
**Closing date**: Mid-day Tuesday 22nd July 2014
**Interview date**: Thursday 31st July 2014

## ASSESSMENT ENGAGEMENT WORKER

*(Full Time, Permanent )*

As the first point of contact with ROADS you have a vital role in assessing need and inspiring change.
**Closing date**: Mid-day Tuesday 22nd July 2014
**Interview date**: Wednesday 30th July 2014

**Salary**: £18,992 progressing to £25,848
**Hours**: Full Time Equivalent 37.5 hours per week

**Please contact Angelo Curtis, quoting the job reference, for an application pack: BDP, 11 Brunswick Square, Bristol BS2 8PE**
**Tel: (0117) 987 6004, E-mail: recruitment@bdp.org.uk**

*We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation and we want to provide the best possible service to all of Bristol's communities.*

BRISTOL CITY COUNCIL

Registered Charity No: 291714 Company Limited by Guarantee: 1902326

OXFORDSHIRE COUNTY COUNCIL

www.oxfordshire.gov.uk

*Oxfordshire County Council – Public Health*

# Contract for an Integrated Adult Drug and Alcohol Treatment Service

*Invitation to Submit an Expression of Interest – CPU 861*

Oxfordshire County Council Public Health Directorate is seeking a Prime Provider to deliver an integrated adult drug and alcohol treatment service for Oxfordshire.

The aim of the service is to provide comprehensive and integrated treatment and care for any adult in Oxfordshire who is experiencing problems with their drug and alcohol use at all levels.

As Oxfordshire's premier drug and alcohol service we are looking for a Service Provider who will lead clinically, be the centre of excellence, offer a comprehensive public facing service and inspire recovery. This includes providing advice and information, harm reduction, brief interventions, medical treatment, recovery programmes and support with housing, health, education and employment. The Service Provider will be expected to develop recovery communities in Oxfordshire utilising asset based approaches and mutual aid to sustain recovery. The Service Provider will support Shared Care and work closely with GPs to ensure their patients are able to access the full range of services.

The Service Provider will be required to evidence a proven track record in the delivery of high quality services of the same nature as a Prime Provider and must be able to demonstrate excellent, innovative and pro-active skills in working with adults with substance misuse problems and managing sub - contractual relationships.

**This is a 3 year contract with the option to extend for a further 2 years in aggregate. The Service will commence from 1st April 2015.**

**The maximum value for the three year contract will not exceed £16 million; the maximum value for five years will not exceed £26 million.**

- *To Express an Interest follow the link: www.businessportal.southeastiep.gov.uk and click on Opportunities and then Oxfordshire on the drop down menu.*
- *The Invitation to Tender including specification will be published on the 8th July 2014. Providers that have Expressed an Interest will be sent a link to the Invitation to Tender documents.*
- *The Expression of Interest and Invitation to Tender will close on the 30th July 2014.*

**The closing date for submission of bids is the 1st September 2014.**

**If you have any questions regarding the tender process please contact: Carol Rogan, Strategic Procurement Officer**
**Email: carol.rogan@oxfordshire.gov.uk**
**Telephone: 01865 323731.**