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# DDN
## Drink and Drugs News

**AROUND THE REGIONS:**
Welsh service users get by with a little help, while Manchester looks at the true meaning of recovery

**'Part of the problem lies in the misconception that the armed forces continue to provide holistic support for members after they have left... but many leave with no support whatsoever.'**

# WHEN JOHNNY COMES MARCHING HOME
## ADDRESSING EX-MILITARY SUBSTANCE MISUSE

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Recovery Conference

# ADDICTION: THE CASE FOR RECOVERY IN A CHANGING WORLD

Recovery

## 17 November 2010, Congress Centre, London

**Chair: Mark Gillyon,** *NTA Head of Delivery for the North*

**Special Early Bird Booking Rate till 30 Sept. 2010!**

### Speakers & Topics:

**Prof. David Best** - Recovery capital: an individual and group phenomenon
*University of the West of Scotland and Chairman of the UK Recovery Academy*

**Mark Gilman** - Asset Based, Visible Contagious Recovery
*National Treatment Agency for Substance Misuse in England (NTA)*

**Christian Guy** - The policy context
*Senior Policy Specialist, Centre for Social Justice*

**Dr. Ed Day** - Bringing 2 worlds together
*Senior Lecturer & Honorary Consultant in Addiction Psychiatry, University of Birmingham.*

**Noreen Oliver MBE** - Bringing recovery home
*Founder & Chief Executive Officer, The BAC (Burton Addiction Centre) and the O'Connor Centre in Staffordshire*

**Dr. David McCartney** - LEAP evaluating outcomes – recovery communities
*Clinical Lead at Lothians & Edinburgh Abstinence Programme (LEAP)*

**Dr. Alison Battersby** - The Psychiatrist and The Third Sector Provider: Effective Bedfellows?
*Consultant Psychiatrist in Substance Misuse, NHS Plymouth*

### Objectives:

Leaders in the field will discuss the evidence base for drug and alcohol recovery models and what the implications are for therapeutic interventions including the economic argument for including realistic recovery options within the treatment 'toolkit'. Using examples of best practice we will explore how drug treatment systems can gear up for the increased demand for recovery options from the public; the political support for recovery options and how to make this possible within the current economic climate.

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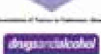

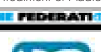

**Editorial – Claire Brown**

# Inspiration fix

## Don't curb your enthusiasm!

**The enthusiasm at the Welsh service users' conference** (page 12) was infectious and refreshing, particularly in this climate of real and impending cuts. It was a reminder of what's working for many people – and that includes some economically sound decisions on best treatment options. Chris Campbell, founder of the user group SMUG, could have taken the prize for sheer exuberance, encouraging people to be proud of their progress and applaud peers for life-changing achievements, and it was a reminder of the valuable momentum service user networks can build up. Just as impressive was the central role the Welsh Assembly Government played, invited by the service users who put together the programme. They were willing to talk about difficult issues such as waiting times and took part in the entire day, answering whatever thorny questions were thrown at them. And there was plenty of practical advice, particularly for families and carers on contributing to recovery. Adfam's Oliver French examines other ways to capitalise on family support on page 11.

From groups with a growing profile, to a population that has little visibility away from the frontline. Tony Wright (page 6) gives insight into the massive changes faced by ex-service personnel when they try to readjust to civilian life. That veterans should become homeless rough sleepers or end up in prison is a depressing enough fact – add a layer of drug and alcohol problems and you have a toxic mix of trauma and depression that makes them highly unlikely to contact services of their own volition. We owe much to these members of our community to make sure they can engage with the right support services.

And on the subject of appropriate support, Ursula Brown uses evidence from the Alliance's helpline (page 10) to highlight the need for us all to take a stand against the discrimination that all too many people with a script, or a substance misuse problem in their history, experience when trying to enter the world of paid employment.

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Giving proper support to families can help them offer valuable 'recovery capital' to their loved ones. Let's not miss out on the opportunity says Oliver French.

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Peer mentoring, family support and the growing recovery movement featured strongly at the second annual All Wales Substance Service User Conference. DDN took part in a lively day.

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## News in Brief

**Raising the stakes**
A series of playing cards featuring anti-drugs messages has been launched by the London Drugs Policy Forum (LDPF). The cards, aimed at 13 to 15-year-olds, will be distributed to young people across the capital. 'This is a creative, but serious, attempt to get across anti-drug messages to young people who would probably not be receptive to accepting advice in a more formal way,' said LDPF chair Hugh Morris.

**Hair today**
Drug and alcohol test provider Concateno has launched a campaign to raise awareness of the role of hair testing for parental drug and alcohol misuse in child protection cases. 'Child protection work involves challenging cases where there can be a scarcity of objective evidence and often unreliable witnesses, but where tough decisions are required on difficult cases such as whether to take a child into care,' said Kevina Murray of the company's child protection division. Hair testing can demonstrate patterns of drug use over longer periods than other biological tests and can also help prove abstinence, states Concateno.

**Two more anthrax cases**
The number of confirmed anthrax cases in Scotland has risen to 45, with new cases in the Greater Glasgow and Clyde and Tayside NHS board areas. Thirteen Scottish drug users have died as a result of the outbreak.

**Euro round-up**
The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has published its *General report of activities 2009*, describing action in each area of its work programme. *Available at www.emcdda.europa.eu*

**CHAMP has chosen**
The 12 finalists in the 2010 Mentor UK CHAMP awards have been announced. Shortlisted entries in the 'communities' section are Project Taboo (Blackburn and Darwen), Sub 21 (Tyne and Wear), Changing Tracks (Shrewsbury) and Offbeat (West Lothian). Shortlisted in the 'schools' section are Bottle It (Derby), We're not all the same (Denny), the Smashed touring theatre company and ALCOPOPS (Borehamwood), while those selected in the 'young people's involvement' category are Just for a Laugh (County Durham), The Amazing Dr Sober (Manchester), Core Spirits (Blairgowrie) and On the Wagon – Off the Flagon (Merthyr Tydfil). The awards recognise projects to prevent alcohol misuse in young people, with the winners announced in November.

# Coalition ditches welfare drug assessment pilots

**Plans for pilot projects requiring welfare claimants to attend drug-related assessments have been dropped by the coalition government.**

The Social Security Advisory Committee (SSAC) had consulted on the introduction of two year 'welfare reform drugs recovery' pilot schemes that would have meant claimants having to report for a two-part 'substance-related assessment' (SRA), with those failing to attend two SRAs being made to undergo a drugs test (*DDN*, 29 March, page 4).

Pilots were planned for Birmingham, London, Cumbria, Lancashire, Yorkshire and Merseyside. However, in response to a report from the SSAC, ministers had decided 'not to take forward' the proposals, states the Department for Work and Pensions (DWP). The department will instead 'look at how government departments can work together to provide the help and support people need to overcome drug and alcohol dependency and get back to work' – including a focus on issues like mental health and housing.

Under the original proposals people would have had to undergo the assessments where there was 'reasonable grounds to suspect that they are dependent on, or have a propensity to misuse, a proscribed drug', and the scheme would also have allowed for the sharing of data between agencies to identify problem drug users. The SSAC report, however, states that the 'pilot is unlikely to be effective, contains a number of significant flaws and is unlikely to produce robust results. If implemented, we believe the pilot runs a high risk of causing significant harm' – including moving drug users away from treatment, disengaging them from the welfare to work system and damaging relationships between advisers and claimants.

'Under the current system, over 80 per cent of problem drug users are estimated to receive benefits, often for many years, and with no real chance of recovering or getting back to work,' said minister for disabled people, Maria Miller. 'Those with drug and alcohol problems often face other difficulties in finding work, and we will now focus on addressing substance misuse in the wider context of other barriers to employment such as housing and mental health issues. We are determined to reform the welfare system so that drug and alcohol users receive the help and support they need to overcome their dependency and get back to work.'

DrugScope, which said in its consultation response that the proposals risked further stigmatising and marginalising drug users, welcomed the decision not to go ahead. 'Despite important concessions by the previous government, concerns remained about the balance of support and compulsion in the pilots, including new powers for job centre staff to require, on a suspicion, someone to answer questions about possible drug use and the introduction of drug testing.' Release said it was 'delighted' that the provisions had been dropped.

The DWP has also published the findings of research into the experiences of problem drug users in looking for work and claiming benefits. Many of the 75 drug users interviewed for *Problem drugs users' experiences of employment and the benefits system* felt they were stigmatised by Jobcentre Plus staff, and most experienced problems around housing, education, skills and mental health.

*Social Security Advisory Committee report available at www.ssac.org.uk*

*Problem drugs users' experiences of employment and the benefits system available at www.dwp.gov.uk*

# UNICEF speaks out on Cambodian detention

**UNICEF has issued a statement on the care and protection of children in Cambodian institutions, following a Human Rights Watch report that detailed beatings and torture in compulsory drug treatment centres (*DDN*, 1 February, page 5).**

One of the institutions described in *Skin on the cable – the illegal arrest, arbitrary detention and torture of people who use drugs in Cambodia* is Choam Chao, an establishment in receipt of UNICEF support (*DDN*, 10 May, page 11).

The Human Rights Watch report contains accounts of drug users – including children – sex workers and the homeless being arrested, often at the request of relatives or in large-scale 'round-ups', and compulsorily detained in centres where beatings, rapes and torture take place. UNICEF states that it has taken the allegations 'very seriously' and has met with Human Rights Watch representatives several times to discuss the situation.

'UNICEF was very concerned about the findings of the HRW report,' says the statement. 'No child should ever be subjected to physical or emotional violence, and the state has a clear duty to safeguard the wellbeing of children in its care.' UNICEF had provided 'limited funding' to Choam Chao through the Ministry of Social Affairs, Veterans and Youth Rehabilitation, it states, adding that the facility was 'not a centre for drug rehabilitation but a temporary welfare facility for children who are at risk, including children who occasionally use drugs'.

UNICEF had supported the centre since 2006 as part of a 'wider strategy on juvenile justice reform' and had immediately brought the report to the attention of the ministry, it said, while its own investigations had revealed that abuse had occurred at the centre in the past but ceased with the centre's reorganisation in 2006. UNICEF states that it advocates the closing of compulsory detention centres, to be replaced with community-based treatment, and has called for the immediate release of all children from the centres.

# Blow for Scottish minimum pricing

**The Scottish government's plans to introduce a minimum price per unit of alcohol have suffered a setback with both Labour and Conservative MSPs voting against the proposal in the stage one parliamentary debate on the Alcohol (Scotland) Bill.**

An amendment calling for minimum pricing to be removed from the bill was backed by Labour and the Conservatives and opposed by SNP, Green and independent MSPs, with the Liberal Democrats abstaining. Although the vote was not legally binding, it has been seen as indicative of the extent of opposition to the proposals. All of the provisions of the bill will now proceed to the more detailed scrutiny of the stage two debate.

'The amendment that was passed has absolutely no legal effect and it is noticeable that fewer than half of all MSPs voted for it,' said health secretary Nicola Sturgeon. 'The Scottish government will, at stage two, continue to seek to persuade members to support minimum pricing, which is backed by a huge range of experts in Scotland. The public health of Scotland is more important than party politics and, as the bill progresses, I hope that all parties will listen to the evidence and put the national interest first.'

Although not a 'magic bullet', minimum pricing would effectively target the high strength, low cost alcohol favoured by problem drinkers, said Ms Sturgeon, 'in a way which neither tinkering with alcohol duty nor adopting a "below cost" policy would do.' The Scottish government estimates the total cost of alcohol misuse in Scotland at around £3.56bn, or £900 for every adult, with an average of 115 alcohol-related hospital admissions each day. It has called the bill a 'once in a generation chance' to tackle the country's alcohol problems (*DDN*, 30 November 2009, page 4).

# Government halts vetting and barring registration

**Registration for the controversial vetting and barring scheme, which many in the field feared could have potentially damaging effects on the employment prospects of ex-service users (*DDN*, 7 September 2009, page 6), has been halted to allow it to be remodelled to 'proportionate, common sense levels' the government has announced.**

Voluntary registration with the scheme for new employees or volunteers, and those moving jobs, was due to begin next month but has now been stopped as 'many businesses, community groups and individuals see the current scheme as disproportionate and overly burdensome, and that it unduly infringes on civil liberties', the government states. The remodelling process will be carried out by the Home Office in partnership with the Department of Health and Department for Education.

The scheme was instigated in response to the Bichard Inquiry, which looked at the way background checks are carried out following the murders committed by Ian Huntley, who was able to get a job as a school caretaker despite being known to the authorities. The intention is that no one who poses a threat to either children or vulnerable adults is allowed to work with them in a paid or unpaid capacity – however, Independent Safeguarding Authority (ISA) guidance lists convictions and cautions that 'relate to addictive behaviour and persistent offending' among those classed as relevant. The ISA will continue to maintain lists of those barred from working with children and vulnerable adults, and Criminal Records Bureau (CRB) checks will remain in place, while NHS staff will also continue to be covered by the barring arrangements

'Protecting the most vulnerable people in society is a basic duty of any government,' said care services minister Paul Burstow. 'While we must be confident that the systems we have in place are up to the job, we must also be sure that they are proportionate. We will look in detail at what should be done to ensure that the scheme meets both these tests.'

It was vital that the government took a 'measured approach' said home secretary Theresa May. 'We've listened to the criticisms and will respond with a scheme that has been fundamentally remodelled. Vulnerable groups must be properly protected in a way that is proportionate and sensible. This redrawing of the vetting and barring scheme will ensure this happens.'

**BACK IN THE DAY:** the Greater Manchester hepatitis C strategy has enlisted the help of local rock band Hell to Pay to help raise awareness of the virus. The band accompanied the campaign to local towns as part of *Back in the day did you take a risk?* which is aimed at people who have injected drugs in the past. The campaign, mounted by Greater Manchester West Mental Health NHS Foundation Trust's alcohol and drugs directorate, also partnered with local radio station Rock Radio as well as distributing text and freephone numbers for people to access advice.

# Drink drive overhaul may save hundreds of lives

**Cutting the blood alcohol limit for drivers from 80 to 50mg of alcohol per 100ml of blood would save 168 lives in the first year, according to a new study by the National Institute for Health and Clinical Excellence (NICE).**

The report, commissioned by the Department for Transport, recommends that the limit be reduced in line with other countries.

The introduction of the 50mg blood alcohol concentration (BAC) rate in 15 European countries collectively led to 11.5 per cent fewer alcohol-related driving deaths among 18 to 25-year-olds, the group most likely to have an accident, says *Report of the review of drink and drug driving law*. Cutting the limit in the UK would prevent around 168 deaths and 16,000 injuries in the first year, states the report, the first major review of drink driving law since 1976.

'Overall, the international evidence indicates that lowering the BAC limit from 80mg to 50mg could reduce the number of alcohol-related deaths and injuries in the UK,' said NICE's director of public health excellence, Dr Mike Kelly. 'Not only could it have a positive impact on those who regularly drink well above the current limit before driving, but it also has the potential to make everyone think twice about having a drink before they decide to drive somewhere.'

'The ideal level of alcohol consumption before driving is none at all,' said Alcohol Concern chief executive Don Shenker. 'However, the recommendations of the report present an improved response to the significant rise in mortality rates as blood alcohol levels increase. Reducing acceptable levels of alcohol consumption before driving will decrease the risk of accident and injury to both drivers and bystanders. Compared to driving with no alcohol in the blood, the level of risk triples between 20mg and 50mg whereas the risk of death from drink driving increases six times between 50mg and current limits.'

*Report available at northreview.independent.gov.uk*

# FORCE for change

Ex-services personnel can often face huge challenges readjusting to civilian life, and substance misuse and homelessness are common. It's time this population stopped being overlooked, says **Tony Wright**

Each year between 8,000-16,000 people leave the armed forces and return to live and work in the civilian community. For many the transition is seamless, yet for a significant number the journey brings with it an inability to re-establish themselves and settle back into in a society they no longer identify with. This can lead to relationship difficulties, alcohol and drug misuse, unemployment, homelessness, involvement with the criminal justice system, and – for those suffering from diagnosed or undiagnosed post traumatic stress disorder (PTSD) – self-imposed isolation, self harm or suicide. Many may find themselves marginalised, disenfranchised from mainstream services, and experience chronic social exclusion.

Last summer I worked as a development manager for an organisation providing substitute prescribing. During the assessment process it became clear that many of the people accessing support had been in the forces, reporting that their problematic alcohol or drug use began during service life and became worse when they left.

In many ways I could identify with this, as I'd served in the armed forces in the late '70s and remembered the difficulties I faced trying to readjust. When I'd reinvented myself as a registered social worker and probation officer I was alarmed at the number of ex-forces men and women I encountered in my working day. Many had seen their basic needs bypassed by both statutory and third sector providers and had fallen through the net. A great number had become homeless or were rough sleeping, with all the physical and mental health problems that go with that lifestyle, while others were involved in the criminal justice system or holding down menial, low paid positions that reflected neither their ability or potential, or offered any long-term prospects.

Research by the National Association of Probation Officers (NAPO) in 2008 found that up to 8,500 veterans were in prison and another 3,000 on parole, while there were 'likely to be thousands on community supervision'. Most had seen recent active service, it said, and 'a large, but unknown' number had symptoms of PTSD. In response I established a not-for-profit social enterprise called About Turn CIC, but while looking for funding I was constantly asked to prove the need and demand. NAPO recognised that something was amiss and conducted a survey of its members, asking them to identify offenders with an ex-forces background being supervised in custodial or community settings – the common themes were shocking, but proving that a 'need' existed remained harder than I expected.

In desperation I made a freedom of information request to all local authorities in the north east asking them to tell me how many ex-forces veterans were accessing support from mental health, drug and alcohol, A&E, probation and social services, as well as the homeless sector. It transpired that only 16 ex-forces personnel had accessed support across the whole region. The north east has a population of 2.6m and, according to the Ministry of Defence, is 'one of the UK's top recruiting areas for the three armed forces and is home to tens of thousands of service personnel and their families'.

Almost all services fail to ask the basic question 'have you served in the armed forces?' which effectively means services cannot be commissioned to meet need. I approached Kevan Jones, MP for Durham North and at the time the veterans minister, and asked if he could do something. Some weeks later I was told that a research project was about to be commissioned to look at 12 regional authorities collaborating for the first time to assess the healthcare and social welfare needs of the ex-forces population in the north east, with findings available at the end of 2010.

In June 2009 I started running peer-led support groups for ex-forces men and women outside office hours, as no other service existed that facilitated face-to-face contact to physically connect this community. The group is now legally constituted and we regularly have a core group of ten to 13 people attending on a weekly basis. Members have developed a group identity that is all about using the skills they acquired during their time in the military to do good deeds in the community. If any member has issues then peers and committee members can help them access mainstream or specialist services, an approach that's proved to be extremely successful as it allows group members to advocate and broker services based on personal recommendation. We now have groups running in Sunderland, Newcastle, a north east prison and north Wales and we plan to expand the service further.

The civilian community and indeed many service providers have difficulty understanding the unique needs of the ex-forces community. Part of the problem lies in the misconception that the armed forces continue to provide holistic support for members after they have left, and there is also a misconception that everyone who leaves the forces has a sound knowledge base of what is available. Even if this were true, many would not ask for charity. Pensions are available for those that serve full terms but many leave the employ of the services with no support whatsoever.

There are many reasons for discharge from the armed forces, including completion of service time, medical discharge or dishonourable discharge, while many soldiers exercise the right to buy themselves out after a minimum of four years. It can be argued that those serving for a long time may become

institutionalised, struggle with a loss of identity and find themselves in a civilian community alien to them, while those that are medically discharged must cope with the restrictions their impairment has on future employment opportunities and their ability to function in a civilian community.

Those who complete four years service or less should in many ways be more able to reintegrate into the community, but there is growing evidence to suggest that many end up in a life categorised by failure and disappointment. Large numbers are recruited into the armed forces from areas of multiple deprivation and join as a way to escape poverty and improve their limited life chances, and failing to make it in the army is viewed negatively by both family members and society.

Dishonourable discharge brings with it an impact on life chances that can only be described as catastrophic – the ex-soldier needs to adapt to his or her status within the civilian community as 'soiled goods' and the real or perceived disadvantage this brings. If we add to the equation the lack of specific services to meet the needs of the ex-forces community, then the negativity becomes toxic and it becomes extremely difficult for people to re-establish themselves in civilian life or the job market.

In the north east, homeless ex-forces personnel are 'begging for change' in more ways than one. Several members of the Forces for Good group are technically homeless and excluded from local authority housing provision either by default or by choice – many are homeless at the point of exit from the armed forces and not prioritised for accommodation, ending up sofa surfing or sleeping rough. We have several Forces for Good members who have lived in trenches or constructed elaborate 'bashas' in inner city woodland areas rather than sleep rough in public view. Some describe being redirected to the homeless sector and told by well-meaning housing workers that the only available housing is within the temporary accommodation sector, more often than not multi-occupancy dwellings. As one ex-soldier said, 'you go in clean but come out with a drug habit, in a box or in handcuffs after battering a resident'.

The hidden population of ex-forces personnel has no political voice and no vehicle to channel dissatisfaction with the services on offer, and it will be interesting to see how long it takes for the government to realise it has a duty of care to look after those that have made such sacrifices on behalf of their country.

The complexity of the issues facing ex-forces personnel returning to live in the civilian world is only going to increase as our involvement in wars and peacekeeping duties places huge pressure soldiers and their families. It is my view that the answer to this ongoing problem will be driven by the ex-service community themselves. They understand the issues their comrades face when they slip through the net and fail to engage with mainstream services, and they also know how to re-engage them when it does. They continue to look after their own – in our experience if the support is provided by former soldiers at the right time and in the right place then it is accepted without prejudice. The civilian community's greatest asset is its ex-forces community – the problem is nobody has made either party aware of this fact.

*Tony Wright is MD of About Turn CIC and founder of the Forces for Good network.*

# POST CARD FROM Gwynedd

I decided to start a service user group for Gwynedd about a year and a half ago. My husband was in full agreement with the idea, having been a service user himself for 20 years and coming to the end of his treatment. We went ahead and found volunteers, and the issues, it seems, started from there.

The first step was trying to get agencies to take us seriously, which after a year we think they now do. The second difficult step was obtaining funding, which we managed after about ten months. I'm really thankful that now all service users living within Gwynedd have their thoughts, ideas and opinions taken to our substance misuse action team and community safety team. We have also managed to gain seats on the area planning board for Betsi Cadwaladr University Health Board, and we try to obtain seats on any commissioning body, steering or task group relating to substance misuse that we can.

After all this time we are now looked on as a reliable group of volunteers. We hope we are bringing service users compassion, and in some small way, empowerment. We struggle with funding and with volunteers, but at the end of the day this group is doing all that it set out to do, even through all the ups and downs and normal daily trivia that pops up.

I am proud of this group, but I am even more proud of the volunteers that we have and the hard work they put in – whether that's for service users who phone at 2am, or the work they do with the task groups. I can say hand on heart if it were not for them this group would not be where it is now.

The struggle with funding will always be there, but this group will also always be there. It's not easy – the political red tape is difficult to struggle through, but we take it one step at a time.

If service users wish to get a group going, arm yourself with as much knowledge as possible and break down all barriers that stand in the way. If we can do it then I feel almost anyone can. All it takes is willpower and belief.

**Denise from REAL, the service user group for Gwynedd**

## Post-its from Practice

# Help the ageing

## Don't forget the needs of older people, says Dr Chris Ford

**ONE OF THE OTHER PARTNERS** at the surgery asked me to see one of her patients. Angie was 54 years old and had been happily stable on 80mg of methadone mixture. She had always worked and had brought up her two children who had long left home, but she frequently saw and enjoyed caring for her two grandchildren. She had tried several times to become drug free, but always felt unwell and odd, so had decided to continue maintenance indefinitely.

Angie usually saw her GP every month for a review of her dependence, her blood pressure (which was raised) and her wellbeing. For the last four to five months she had been coming in more frequently complaining of tiredness, lack of sleep, night sweats and irritability and we knew she was hepatitis C and HIV negative.

After doing a full screen of blood tests which were all normal, Angie's GP wondered if she was becoming tolerant, and increased her methadone. The increase failed to help, so my colleague wondered if Angie was becoming depressed. After a full psychological assessment she agreed to try antidepressants, but these seemed to make the situation worse. Having run out of ideas, my colleague asked me to see Angie.

I reviewed Angie's history and then it occurred to me – what do 54-year-old women frequently present with? The menopause! Angie had used an IUS (intrauterine system) so had not had a period for years. She therefore presumed she had finished the menopause, but upon further questioning, it became obvious her night sweats were clearly flushes, and her irritability was definitely hormonal.

With the increasing age of some people on long-term maintenance we have to remember that not only are they at risk of all of the usual conditions associated with ageing, but they are also at increased risk of other conditions. National data shows rising numbers of older problem drug users in contact with drug treatment services.

Some physical health problems can result from prolonged smoking, alcohol and/or drug use alongside any of the diseases common in older patients, such as hypertension, diabetes, and chronic airways disease – not forgetting liver damage and mental health problems.

Angie and I discussed the menopause and the possible options. She decided that now that she knew what was happening she didn't want to take any more drugs, such as hormone replacement therapy, and we had great fun learning 'imaging cold' to manage her flushes.

We need to remember to think about the whole person, who may use drugs but is always so much more, and who may have high levels of both physical and mental morbidity. Sometimes they are in poor health and may have low expectations of healthcare after years of being neglected and poorly treated. They will almost certainly have lost friends and may be isolated.

Meeting all the needs of older people who use drugs is a challenge that we must address. General practice is the perfect place from which to take it on.

*Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP. To become a member of SMMGP, receive bi-monthly clinical and policy updates and be consulted on important topics in the field visit www.smmgp.org.uk*

# LETTERS

**'Alcohol-specific commissioners... tend to be an exception and so this level of attention, expertise and investment is often displaced by the drugs agenda.'**

## Alcohol academy

In response to Max Vaughan's article *In commission* (*DDN*, 24 May, p12) outlining his experiences and ambitions for developing alcohol treatment in Birmingham, I would firstly like to congratulate him for outlining a clear ambition of provision for 15 per cent of the in-need population across all tiers.

Ensuring alcohol treatment (and early intervention) across tiers within integrated pathways is a challenging but important ambition for commissioners. However alcohol-specific commissioners such as Max tend to be an exception and so this level of attention, expertise and investment is often displaced by the drugs agenda.

Last year the AERC Alcohol Academy was established as a not-for-profit organisation aiming to support the development of high standards of practice, learning and development within the alcohol field. Max identified he we would welcome input from others in trying to achieve his aims, so I would like to highlight the academy's alcohol leads e-forum which can be found by visiting www.alcoholacademy.net. There are also specific subject discussion forums available at the comprehensive www.alcohollearningcentre.org.uk.

**James Morris,**
**AERC Alcohol Academy**

## Same old story

I am responding to David Casellas's poorly thought out argument (*DDN*, 7 June, page 8). His letter is in favour of talking cures and swift detoxes as the only option rather than one of a range of options, from diamorphine prescribing, methadone maintenance treatment and other quality opiate substitution therapies through to well-supported detox and rehab for those wishing to travel down this route. It seems typical of the woolly thinking displayed by some professionals who are employed to deliver evidence-based treatment.

David appears not to know that after the collapse of diamorphine prescribing in the early seventies for all but a few, drug treatment did indeed move towards a swift, punitive detox as the only option for those that could not afford private treatment. In fact Alan Joyce refers to this himself and explains that the only way he could maintain any quality of life was by moving his treatment into the private sector (*DDN,* 24 May, p10). As a result we had the endless revolving door of detox, relapse and all the health risks, aquisitive crime, BBVs and death that often accompany dependency on street heroin.

David is right in stating that many users would prefer heroin rather than methadone, but I believe he draws the wrong conclusions from this. Supporting his theories on the basis of a rapper who to my knowledge has not suffered with a long-term opiate dependency is laughable I'm afraid.

There is no 'magic bullet' to deal with addiction, just different treatments that suit different people. As a result we need quality services that cater for a range of needs and are supported by evidence.

**William Lee, peer advocate, by email**

## One last time

I read Tim Sampey's article on the London Service User Forum with great interest (*DDN*, 7 June, p13). As someone who has been involved with two service user led organisations, FIRM (Fun in Recovery Management) and Outside Edge Theatre Company, a drama company working with ex-users, I know how isolated user led groups can become. Often they are so focused on their own services that they don't have the time or resources to learn about, or network with, other service user led organisations.

I also know, having attended the service user drug reference groups' day conference in Kensington and Chelsea, how successful service user led organisations can be if given fairly minimal support and encouragement by professionals. It would seem a great pity if the NTA could not organise one last forum so that the London Service User Forum can be assisted in planning its own future.

If, as suggested, London DAATs were prepared to offer fairly minimal assistance, provision of a venue and refreshments to facilitate quarterly meetings, then the development of a useful forum could be maintained and DAATs could directly benefit by their increased awareness of the variety of service user led provision across London. This in turn could stimulate existing networking and possible new local initiatives.

Hopefully Tim's article will initiate some response both from professionals and service user led organisations.

**John Gordon-Smith, by email**

## CALLING ALL SERVICE USER GROUPS

**DDN will be putting together our first ever Service User Group Directory in July, and we want all service user group coordinators to contact us so that you can be listed. The directory will cover the entire UK, and will list information on your meetings and campaigns, designed to be accessible to everyone interested in accessing group services.**

This is an opportunity to promote your group to those who may not know about the services you offer. We've already heard some great stories from groups across the country, with schemes such as allotments, newsletters, radio shows and outdoor activities to bring their members together into a real community.

The importance of service user groups sometimes goes unnoticed, and your views can get lost along the way. Make sure your voice is heard and establish your group as a key place for service users to get involved, and on the road to recovery.

Email me at lexy@cjwellings.com and I'll let you know what information we need for your group listing. I look forward to hearing from you!

**Lexy Barber, DDN**

## 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. Visit our forum at www.drinkanddrugsnews.com**

# Nothing to declare?

## With employment discrimination rife against people who are stable on maintenance scripts, we need to work harder to open channels for our jobseekers, says **Ursula Brown**

**THE ALLIANCE HELPLINE** recently received a call from a man running a small business who had discovered that one of his staff receives a methadone prescription. He wanted to find out more about what it meant and how he could support his staff member through a reduction programme. We were amazed and heartened by the employer's attitude. He could easily have decided that he no longer wanted to employ this member of staff, but instead chose to engage with him as a person and to offer help and support. It's fairly easy to guess which course of action would have a better effect on his employee's journey through treatment.

Minister for Employment Chris Grayling recently said that it is a priority for the coalition government to get the poorest and most vulnerable members of our society back into work. At the same time there has been talk about making receipt of out-of-work benefits conditional on willingness to work. Within the substance misuse field, employment is rightly considered a vital component of reintegration, and many service users actively want to find work as a part of their recovery journey.

But for people who are stable on methadone or buprenorphine maintenance scripts who want to get back to work, there's a Catch 22 that comes up over and over again. When you apply for a job, most application processes ask you to disclose any medications that you're on, either on the application form or as part of a medical disclosure. Probably rightly, many people on maintenance prescriptions believe that disclosing their status in applications will preclude them being offered the job they're applying for. But if they don't disclose their status and are offered the post, they run the risk of losing their job for providing false information on their application form if they're ever found out.

The Alliance regularly receives helpline calls from people who have lost their jobs, or are at risk of losing them, because their employer has discovered they are in receipt of a maintenance prescription. This often happens because a co-worker has been at the chemist while the caller has had supervised consumption, because someone has seen their medication in their bag, or because the constraints of their prescribing regime mean that they have to take time out of work to pick up their medication. We always ask why the caller didn't tell their employers about their situation when they applied for the role, and invariably the response is that they wouldn't have been offered the job if their employers knew.

For the most part, these callers say that they haven't had difficulties in their work and have received good appraisals until the time when their employers found out about their prescription. Sadly, for most of them doing their work well isn't enough to overcome the stigma of drug dependence and they lose their jobs, with no recourse on appeal because they have lied in their application.

Not coincidentally, most people we hear from with this problem are working outside the drug and alcohol treatment field. Within the field, there has long been an acceptance that offering training, volunteering and employment opportunities to service users is part of the process of reintegration. More and more organisations accept that stably maintained workers can be a valuable asset.

However in the wider workforce, it's unusual to find organisations that will willingly take on staff who admit to having had substance misuse problems. It's even harder to find employers who understand that a methadone or buprenorphine script does not automatically mean that someone will be unable to perform the duties of a given role, or that they are inherently untrustworthy.

If the government is trying to encourage people off benefits, and if we accept that employment is an important step in many people's recovery and reintegration, then drug and alcohol agencies need to work harder to make sure that the stigma of a maintenance prescription or a former substance misuse problem isn't an insurmountable hurdle to finding work outside the substance misuse field. We must also continue to lead by example as employers, developing models of good policy and practice for employing and supporting staff in this situation, and making it clear that these employees have much to contribute.

The Time to Change project, set up by Mind and Rethink, is currently campaigning successfully on the subject of employment discrimination against people with mental health problems. Similarly, we need to educate employers and the general public to dispel the fear and stigma around employing and working with people who are on maintenance prescriptions or who have recently achieved abstinence.

If the decency and compassion of the employer who called the Alliance helpline were the norm rather than a remarkable exception, one of the biggest barriers to employment for current and former service users would disappear. The thorny problem remains though: how do we make this happen?

*Ursula Brown is chief executive of The Alliance*

# Family ties

## Giving proper support to families can help them offer valuable 'recovery capital' to their loved ones. Let's not miss out on the opportunity says **Oliver French**

**DESPITE INCREASING RECOGNITION** in recent years, the successful involvement of families in drug and alcohol treatment remains in a curious limbo – while people are becoming more aware of the positive impact it can have, there is little knowledge or consensus about how it is best applied in practice.

By harnessing the recovery capital that families provide, outcomes can be improved for all parties – so why do poor relationships persist between treatment agencies, families and family support services? Why do many treatment workers remain focused on the individual, and what is preventing a truly family-friendly treatment system from flourishing?

Treatment centres often represent the first port of call for concerned families, and it is vital that this opportunity for engagement is not lost in a haze of mutual suspicion, fear and lack of understanding.

The first problem is that much discussion – and disagreement – surrounding family support can hinge on definitions: what does the term even mean? How does 'Think Family' manifest itself? Depending on outlook, organisation, history and – undeniably – where the money is, family support can mean working with the whole family or with children of drug using parents, specific interventions like behavioural couples therapy, the 'traditional' model of independent peer support for families who provide a listening ear for each other, and everything in between. Family support means different things to different people, and this leads to patchy service provision across the country.

Treatment staff whose areas of expertise are being pushed into ever-expanding horizons are commonly overworked, and families cannot be treated as a simple add-on. Engaging with families isn't easy, and assuming treatment staff can add it to their repertoire without any guidance actually devalues families and the people who have become experts in working with their particular needs.

It's a question of training and leadership. Drug workers cannot be expected to work effectively with families without adequate supervision and support, and it is this practical guidance and direction that is currently lacking. Difficult issues such as safeguarding, risk assessments, appropriate boundaries, confidentiality, conflict and trust are not small obstacles to overcome.

Arguments about service level agreements, targets and job descriptions – 'it's not my job to work with families, and my service isn't paid for it' – assume that users' and families' needs are diametrically opposed, and this false dichotomy hampers progress. This should be replaced with a culture in which the appropriate involvement of families is both sought and celebrated.

Most families want the best for their loved ones, and this ambition should be acknowledged and used productively. What we need is a system which, at all levels, recognises families' needs in their own right but also the positive contributions they can make when properly supported in this role. Families are at the forefront of addiction, and they should be at the forefront of recovery too.

There needs to be greater recognition of the 'recovery capital' that can be offered by families. As referenced in the Adfam/DrugScope briefing Recovery and drug dependency: a new deal for families, families can be an invaluable source of support, inspiration and ambition when it comes to recovery and reintegration, and working with them throughout these processes can reap huge benefits.

Family involvement in treatment can never replace a full menu of support for families in their own right, and any successes on this front should not be put forward as evidence that families' needs are being properly met – this risks impinging on the work of independent, dedicated family support services and diverting valuable funds to treatment services claiming to offer 'family support' at a knockdown price.

But for too long the relationship between families and treatment services has been fractious and characterised by mutual suspicion. Rather than this culture of criticism we are looking towards a future where strengths, weaknesses and areas for improvement and partnership – both in 'the system' and within the workforce – are recognised and addressed, rather than assumed and left to ferment.

There is no one definition of family support, and flag-planting about whose work is 'the' way forward is not a productive route to take. Each approach has its benefits for different families and situations – the problem is identifying the right kinds of support and involvement, when they are (and aren't) appropriate, and how to deliver them. There is a skilled and dedicated workforce already in place, and tapping into this existing infrastructure presents a real chance of improving the system as a whole, and the lives of families.

*Adfam is holding a consultation event for service managers/operational leads to unpick the issues explored above, and we will be producing a free resource based on the findings which, we hope, will at least provide some introductory learning. This is the least that is required if we are to consolidate the disparate fields of family support. To sign up for the event (22 July, London) or to discuss Adfam's work further, please contact Joss Smith on j.smith@adfam.org.uk. Recovery and drug dependency: a new deal for families is available from www.adfam.org.uk.*

*Oliver French is policy and communications coordinator at Adfam*

Peer mentoring, family support and the growing recovery movement featured strongly at the second annual All Wales Substance Misuse Service User Conference. **DDN** took part in a day of lively debate

# GETTING BY WITH A LITTLE HELP

'Our priority is to make sure people have a nice clean safe environment for treatment and that they are treated with dignity and respect,' Karen Eveleigh from the Welsh Assembly Government told delegates from all over Wales. Treatment needed to come at the right time, she said, and take account of an individual's needs during their journey. This meant 'a whole package of support – from the day treatment begins to a day, hopefully, when they can put their past behind them and move on.'

With £23m capital investment and £52m spent on services, she wanted to know that service users were getting value for money. 'Ask for your care plan if you haven't got one,' she urged. 'You need to understand what your care plan is and have the opportunity to discuss it and agree it.'

The government would continue to support service user involvement, both locally and nationally, she said, and called for the continued growth of service user groups throughout Wales:

'Nobody can be certain quality is being improved if they don't ask people who do and don't use services.'

One aspect of service user involvement that was found to be working very successfully was peer mentoring. At an energetic session chaired by Chris Campbell, founder and director of SMUG – Substance Misuse Users Group – delegates fed back their experiences. Many had received support as a result of the ESF Peer Mentoring Project, a four-year initiative funded by European Structural Funds that offered help to service users in moving on when they finished treatment. Peer mentors usually had experience of substance misuse themselves and were able to give friendship and guidance in developing new skills and self-confidence and avoiding relapse.

'We felt there was a gap, a reservoir of people who've been through experiences and can give something back,' said Mike Hardy of the Welsh Assembly Government. With the £9m funding from Europe the peer mentoring programme was now operating throughout Wales and had created 60 jobs, many for people who had criminal records.

'I passionately believe that anyone who's been through this journey has something to give,' he said, urging delegates to get in touch and join the scheme.

Dan from Kaleidoscope described his experiences of peer mentoring from both sides. When addicted to drugs and alcohol, he had spent ten years on the streets of Exeter, 'doing anything to keep me warm and prevent me from feeling threatened'. Eventually he deliberately got caught selling drugs so he could receive help in prison. He became a peer mentor as he 'wanted to give something back'. He now supports a caseload of six clients, including helping them to consolidate debts.

Many others emphasised how important peer support had been to them, whether connected to services or through their local service user group.

'I haven't had a drink for a year and nine days,' said Robin from Newport. 'But I couldn't have done it on my own – I don't know how anyone does.'

'The hardest part for anybody trying to give up is getting the support. You need it when you come out of detox or rehab, when you're on your own,' said Mike who had started up an alcohol support group in Deeside. He now had around 30 members and met once a week – but the group had been fighting for funding for two years, he added.

'The peer mentoring is fabulous but it's a shame that health services aren't

## STRENGTH IN NUMBERS

Sharing success stories was a major feature of the Welsh service user conference as delegates in all stages of recovery relished recognising the significance of their progress

***'I put the drink down and started growing up'***

Last time I was stood like this I was in court! said Marie. I'm a recovering alcoholic – my first experience of a drink was at eight years old. I was sexually abused by my stepbrother and I didn't feel I could share this with my 'under the carpet' family. I was abused by my grandfather who also abused my young cousins – and at that point I spoke up and broke the cycle.

As a teenager I was raped, and called a slag by my partner, so I went on to drugs – amphetamines and the club scene. Loud music and chaos meant I didn't have to deal with it. I got pregnant and was still getting abused by my second partner, so I went back to my family – but they wouldn't take me in so I had to sleep in the car. I went back to drink, had my baby, and my drinking kept getting worse. I was a crap mother – all I could see was this needy bundle. I feel sorry for my kids; I have two beautiful girls.

I was given two months to live in 2004. I had liver cirrhosis and it shocked me. I thought I had to give up drinking for the kids, so I put the drink down. But I was a 'dry drunk' – I had all these issues I hadn't dealt with.

I took to wine for five years and would drink six bottles a day. My final wake-up call was when the kids came back from a few days at their dad's and interrupted my drinking. I was so angry – it's such a selfish illness. My mum came to fetch the kids so I took a hammer to her car and smashed all the windows, then came at her. I woke up in cells in the morning to be faced with pictures that showed me what I'd done – I'd been in blackout.

The kids were taken off me, which gave me the strength to ask for help. I went to rehab for six months and was allowed to be a child again, I was able to grow. I'm still fighting for my youngest daughter, but I feel like I'm growing up at the same rate as my eldest – we're close as it feels as if we are both ten.

The illness is consuming and I have to keep a constant check on my sobriety. I have to check for alcohol in everything, even in mouthwash.

***'I never thought I'd do a doctorate'***

I got into gear at 15 and used for 25 years, said Mark

**Partners in improvement: Chris Campbell of SMUG, Karen Eveleigh of the Welsh Assembly Government and Glenn Abbott of Word on the Street, who chaired the conference**

doing it,' said Ben Pagget from Channel, a service user group in Conwy County. His group had been going for six years and was one of the first groups to receive stable funding, with Ben's the first paid post.

'Direct health services, CDAT [the community drug and alcohol team], should be providing these services, not just saying "piss in a pot, see you next week",' he said. 'It's about two things, drug use and lifestyle, and the two go together.'

Channel members made it their business to visit the hotspots where service users go, such as clinics, he said. 'We go along whether we're invited or not and ask them how the service is, and we feed that back.' It was part of the group's role to be objective and critical of services, Ben explained, but he wanted better partnerships in creating improvements.

'I don't want users to run services, I want a mix of both,' he said. Staff should be made up of 'half who've done it themselves and half who've learnt it.'

In another session, Gareth Hewitt, head of substance misuse, strategy and finance had to tackle the thorny issue of waiting times. Reiterating the increased spend on treatment places and crediting the Substance Misuse Treatment Framework (Welsh version of Models of Care) and TOPS (the Treatment Outcomes Profile that monitors client outcomes), he said that having the substance misuse agenda back in the health portfolio was 'not a bad thing' in the face of cuts.

He felt that progress had been made in establishing key performance indicators (KPIs) that stated that referral to assessment should take place within ten days, and assessment to treatment within another ten days.

His colleague Conrad Eydmann, South Wales substance misuse regional advisor for the Welsh Assembly Government, said a lot of work had **continued →**

Whiteley. I was involved in the music scene in London and drugs were a big part of the bohemian lifestyle.

Working with a flexible drugs team who understood my needs and developed my recovery gave me the opportunity to be where I am now.

I never thought I'd be doing a doctorate – I thought I'd be pushing up daisies by now. I did 12 rehabs, 20 detoxes and private clinics. What worked for me was that flexible team. Without them I wouldn't have done a degree, a masters and a PhD – I've even got a book deal. It just shows the progress I've been able to make.

***'Recovery is now a daily choice'***

No one wants to be an addict, said Alan Andrews. Things in my life set me up to be an addict – I had physical and sexual abuse.

I got involved in crime, was sent to a detention centre, then an approved school at 14, borstal at 17, and ended up in prison till the age of 29. 'Your son is going to be in trouble for the rest of his life' my headmaster had told my mother.

When I started taking drugs I was happy because it hid what I felt. I committed crime just to get money for drugs, but then I saw psychiatrists, drug workers and doctors in prison – I wanted to change. I went to the Ley Community for 13 months. It's an intense rehab and it turned my hair grey.

Recovery is now a daily choice for me. I started Choose Life in 1996 because I wanted people to remember there's a person behind those problems and we need to convince them that recovery is possible. That people believe in you is part of recovery. You can make a 180 degree turn in life – I firmly believe that if I can do it, you can do it.

**Choose Life: (clockwise from left) Karen Craven, Justin Norris, Julie Perkins, Wayne Jenkins and Alan Andrews**

Continued from page 7
been done to bring down waiting times using existing resources.

This had involved identifying good and bad practice, 'going out and finding places that are doing it right and turning it into guidance'.

'But there is no room for complacency,' he said. 'We're looking at a "whole systems" approach. If you do all you can, you know that if there are still waiting times it's a genuine deficit.'

Attendance figures were found to be poor compared to other parts of the UK, including England.

'We need to make sure services are flexible enough,' he said. People not turning up represented 'the biggest waste of resources', whereas adjusting opening times to include a couple of evenings and half a day at the weekend to take account of people wanting to go back to education, training or employment would make a big difference.

'We're acknowledging chaotic behaviour, but we're not reflecting that in the way services are delivered,' he said. It was services' job to become more responsive through working better with other agencies to cover support relating to all areas of life. This wraparound support was vital: 'Ninety per cent of service users' needs are not clinical,' he pointed out.

Last speaker, but definitely not least judging by the audience's reaction, was David Best, reader in criminal justice at the University of the West of Scotland. Dr Best had come to talk about the recovery agenda and began by raising the question 'why are we making a big deal about something we've always done?'

The new ideas were about building evidence around recovery and a system that supported it, he said. 'Millions are spent on getting people prepared for recovery, then deserting them. Aftercare and ongoing recovery gets nothing.'

The message of 'if you're not using then don't come back' was creating a model for failure, he said. The recovery agenda was about trying to create balance between quality of life, sobriety and citizenship.

'The point of recovery is quality of life,' he said. 'It doesn't matter about whether you're still using or not – we get held up by these arguments. Quality of life is the important part. In a recovery model you decide when you recover... it's not down to a professional to tell you you're in recovery.

'Arguments about abstinence being an absolute priority are trivial,' he added.

Basic principles of recovery were that is was self-directed and empowering, he said. There were holistic and cultural dimensions that differed according to personality, but it was essentially social, involving peers, allies and families, and it was about rebuilding.

Most importantly, said Dr Best, the outlook was far more hopeful than the standard definition of addiction as a chronic relapsing condition. 'Fifty-eight per cent of people with substance misuse problems will recover.'

**'The point of recovery is quality of life. It doesn't matter about whether you're still using or not – we get held up by these arguments. Quality of life is the important part.'**

Dr David Best

A study of drinkers had shown that recovery went well beyond five years, but there was further inspiration to be drawn from the research. The study had shown that people who recovered had a better quality of life than people who had never been addicted.

'It's about recovery as growth, an ongoing personal journey,' said Dr Best. In the early stages of change people had retarded growth, but then it changed over. 'It's a message of hope for people who make it beyond five years of recovery – they become "better than well".'

How could we make this happen for more people? He suggested that the key was in helping people to 'give things back', 'but we've created a system that doesn't enable people to do that.'

Doing meaningful activities in the community, such as getting involved in peer support, had been shown to improve self-esteem and reinforce a positive sense of identity. The emergence of recovery champions and communities had shown that recovery was not a pipe dream but proof that one person's progress could be another's inspiration to change.

The language of recovery had now filtered through to government all over the UK and was beginning to underpin policy. Karen Eveleigh reinforced the Welsh Assembly Government's commitment by saying during the final question and answer session: 'Service users, give yourself power, ask for your recovery plan. It's not about Welsh Assembly Government and service providers and commissioners doing this to you – it's about you doing it to yourself.'

## EMPOWERING FAMILIES

Harnessing the positive energy of families and avoiding conflict

**'It's all about shifting the energy to something useful and away from nagging or shouting,'** family intervention worker Charlotte Waite tells family members who come to CRAFT (Community reinforcement and family training) in Cardiff looking for support. She shared her techniques with delegates at a session on support for families and carers.

'Family members can encourage people into treatment and help them make the change but they are often angry and can be antagonistic,' she said. So CRAFT uses a programme that coaches family members by teaching them the importance of confidence, motivational techniques, and how to avoid reinforcing negative behaviour.

The system was started by American psychologist Dr Bob Myers to help his mother deal with his father's drinking, and is based on cognitive behavioural therapy. It aims to reduce the drug or alcohol use and get the loved one into treatment.

'We do a full risk assessment to avoid creating conflict, but we encourage family members to allow the user to understand the consequences of their actions and to avoid always clearing up for them,' she said. 'We point out that if your words are that you won't support their use but your actions are the opposite, what message does that send?'

All aspects of the family's interaction with the user are discussed and they are encouraged to study body language and look for triggers. 'Often it's as simple as pausing before speaking, and avoiding repeating negative behaviour,' she said.

She explained how one of her clients has a son who always went straight upstairs on his return from his work in a garage to use heroin, so she encouraged the father to greet his son on his return and offer him a cup of tea before he went upstairs. The cups of tea turned into conversations about how their days had been, but always avoiding discussing heroin and lapsing into confrontational exchanges. The new routine of engagement between the father and son eventually saw them buy a car together to practise mechanics, allowed the son to open up about his issues, and he has since accessed treatment.

The power of positive reinforcement was helping many desperate families to avoid falling into previous negative patterns, she said. While stressing that family members should not feel guilt and must encourage users to see the consequences, she also emphasised the value of rewarding changing behaviour, telling delegates 'you catch more flies with honey than with vinegar.'

**Claire Watson** reports from a Manchester conference that saw service users and professionals gather to debate the way forward and the true meaning of recovery

# RECOVERING OPTIMISM

**EARLIER THIS YEAR THE ALCOHOL AND DRUGS DIRECTORATE** (A&DD) of Greater Manchester West (GMW) Mental Health NHS Foundation Trust held a conference to both try to define recovery and work out how the NHS can best provide services that promote and aid recovery among substance misusers.

The day succeeded in reminding us all why we are here and that, while we do inspiring work, there are still things we could do better. It's easy for those who are genuine about working with people in recovery to become demoralised in the face of the one-dimensional portrayal of our services as methadone-dispensing agencies but this event saw service users and professionals challenge that portrayal on all fronts – looking at the diversity of approaches and services within the NHS as well as strengthening partnerships beyond, not least with self help and mutual aid organisations like SMART Recovery, NA and home grown peer support and volunteering programmes.

NTA's north west regional manager Mark Gilman (pictured, top left) set the scene but what was truly inspirational, and extremely humbling, were the service user accounts that showed us, the professionals, that recovery is very personal – it's whatever an individual says it is. For one speaker recovery was maintenance on a methadone script, which had enabled her to lead a stable life and support herself and her family, while for another it was total abstinence. Throughout the morning it became clear that recovery is a subjective term and that all services need to work together to support individuals and their families in their journey.

All the service users had a common goal, which was to give something back – whether by facilitating SMART recovery groups, acting as a volunteer, representing A&DD on the trust's service user and carer forum or attending one of the many support groups. What was also clear was that a paradigm shift was taking place in the relationship between services and service users. While GMW has a long history of involving current and former service users – whether as user advocates, peer supporters, volunteers or paid staff at all levels of the organisation – the recovery agenda and economic climate has given this a renewed impetus.

GMW recognises that a greater equality in the balance between professionals and recovering users is needed for the sector to move forward, and it is developing a range of initiatives and partnerships to address this – as it was agreed that all of us, and none of us, are 'experts' in recovery. The growth in partnership working with some of the north west's leading non statutory recovery services and, importantly, the plethora of SMART, NA, peer mentoring and non aligned recovery groups supported by NHS services has been extremely heartening.

A&DD's Dr Louise Sell, detective sergeant in the Lancashire Police Duncan Whitehead, and former service user and NTA advisor Stephen Bamber (pictured bottom left) all spoke about the physical, psychological, social, and spiritual needs of service users and their families. Louise described the ways in which services have been restructured to incorporate recovery coaches and recovery centres, while Duncan spoke of his work with volunteers to challenge police stereotypes of substance misusers. This had led to police officers recognising the importance of listening to new ideas and ways of working beyond the traditional methods, he said. Stephen, meanwhile, described the role of faith and spirituality and we were fortunate to have one of the trust's chaplains at the event who has been instrumental in working with inpatient services to create a 'haven' where service users can reflect, pray or meditate.

What became abundantly clear is that the NHS can provide recovery-oriented services, but not on its own, and family interventions work is underway throughout the directorate. It should also be noted that the whole day was run by current service users, ex-service users, volunteers and peer supporters who did a superb job of chairing the event and making sure it ran smoothly. They have experienced the system and now volunteer their time to effect change and improve quality and choice, for which we extremely grateful.

Among the day's conclusions were that we need to maintain a belief in the ethics and principles of the NHS and that the NHS was founded on a moral vision. Partnership working and the role of volunteers and peer supporters are essential, and we also need to think about interpreting recovery outcomes in the form of hard targets as sometimes we, the professionals, put obstacles in the way of recovery. It was agreed that recovery could perhaps be defined as 'the flourishing of the individual' and, crucially, that it's time to replace pessimism with 'recovery optimism'.

*Claire Watson is workforce development manager at A&DD. Tel 0161 772 3782.*

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# Professional Training for Drug & Alcohol Practitioners

## Part-time courses from Autumn 2010

- Accredited, modular courses incorporating the "Models of Care" framework, DANOS competencies and QuADS benchmarks
- Recognised qualifications for all practitioners in areas including healthcare, criminal justice and social care
- Taught in five-day blocks
- Ideal for those new to or returning to study

### Certificate in Substance Misuse Management (Stage 1)

This entry level Certificate is recognised as an accredited qualification that provides introductory training for all professionals working with problem substance users. The 18 month programme starts in September and runs in Canterbury and across the UK where there are cohorts of 10 or more.

### Diploma in Substance Misuse Management (Stage 2)

The Diploma provides a framework for understanding the biological, psychological and social perspectives of problem substance use within the context of service provision. The programme aims to develop therapeutic understanding and client specific interventions against the backdrop of current research and thinking in the field. The 2 year programme starts in October and runs in Canterbury.

### BSc in Substance Misuse Management (Stage 3)

This provides in-depth study of the psychological, environmental and biological aspects of addictive behaviours including ethics, research methods and a small research project. You will develop a detailed understanding of client assessment and outcome monitoring, skills required by project workers, managers and commissioners. The 2 year programme starts in November and runs in Canterbury.

Postgraduate research opportunities are also available.

**For further information and to apply, please contact:**
General Office
T: 01227 823072 E: socio-office@kent.ac.uk
www.kent.ac.uk/CHSS/

University of Kent

UNIVERSITY OF BIRMINGHAM

College of Medical and Dental Sciences

www.mds.bham.ac.uk

# Forensic Mental Health Studies

## MSc/PGDip/PGCert

Do you work with mentally disordered offenders or those individuals who require a similar spectrum of care? Are you interested in updating and expanding your knowledge of theory and practice?

If so, this course provides you with an excellent opportunity to increase your skills and knowledge alongside other experienced professionals from a range of backgrounds.

You will study subjects including:

- The history of forensic mental health service provision
- Mentally disordered offenders and the law
- The treatment of mentally disordered offenders
- Substance misuse
- Risk assessment and management
- Research in practice

This course will benefit you by updating your knowledge and improving your promotional prospects within your current profession. It will also help you to realise your potential in new areas and give you the tools and incentive to do your own research into an area of interest within forensic mental health.

**Duration**

You are able to study the programme on a full-time basis over 1 year (two afternoons per week), or a part-time basis over 2 years (one afternoon per week). You can also choose to study some of the modules on a stand alone basis.

**Entry requirements**

A good relevant degree or an appropriate professional qualification at sub degree level plus experience of working with mentally disordered clients.

**Learn more**

For more information including details of individual modules and how to apply and to watch a video of our students talking about the course please visit our website www.mds.bham.ac.uk/forensic or contact Angela Oakley on 0121 678 3088 or email forensic@contacts.bham.ac.uk

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- Detox facilitated
- 12 Step and holistic therapy
- EATA member
- Weekly reporting to NDTMS
- Block contracts available
- Client weekly reports

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- EATA member
- Weekly reporting to NDTMS
- Block contracts available
- Client weekly reports

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## DAAT Senior Commissioning Manager

**Band 8b £46,870 - £57,561 p.a. inc**

The Surrey Drug and Alcohol Action Team (DAAT) has successfully developed a range of drug/alcohol treatment services to meet the needs of drug/alcohol users in Surrey and to reduce the harm to individuals, their families and the wider community.

You'll be working for Adult & Young People's Drug/Alcohol Treatment Services to build upon existing achievements and further improve outcomes for service users and carers.

You'll need to demonstrate experience and understanding of commissioning and performance management of services, have excellent knowledge of strategic and budget management and of partnership working and a commitment to improving outcomes for service users.

The Surrey DAAT is hosted by NHS Surrey

For more information, please contact Huseyin Djemil on 01372 205790 email: huseyin.djemil@surreydat.nhs.uk

**To apply for this post go to www.jobs.nhs.uk and search for vacancy number: 750-CC-9049.**

**Closing date for applications: 9 July 2010.**

We are an equal opportunities employer and the Trust provides a smoke-free environment for all staff, patients and visitors.

**Visit our website on: www.surreyhealth.nhs.uk**

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## Sheffield Young People's Substance Misuse Service

CRI works to create safer and healthier communities. We help people to break free from harmful patterns of behaviour by delivering innovative services which have a measurable impact on both health and community safety issues. Our services are hallmarked by an emphasis on quality, a responsiveness to local priorities, and an outstanding record of achieving targets.

An exciting opportunity has arisen for three motivated and enthusiastic individuals to join CRI in providing young people's substance misuse provision as part of Sheffield's young people's substance misuse service. The posts will offer structured individual support, group work and training to professionals. One of these posts will be seconded to the Youth Offending Service in Sheffield and will be based within the YOS offering targeted and specialist interventions.

### Young Person's Substance Misuse Worker (x2) *(Ref NM417)*

**£21,621 to £24,571 per annum • Permanent – 37.5 hours per week**

The post holder will join our team in the Young People's Substance Misuse Service offering brief and specialist interventions. They will provide one to one treatment and support to vulnerable young people who are experiencing problems with drugs and/or alcohol. The successful candidate will also provide group work sessions to young people and training for professionals.

### Youth Offending Substance Misuse Worker

*(Ref NM416)*

**£21,621 to £24,571 per annum • Permanent – 37.5 hours per week**

The post holder will work with young offenders to meet their substance misuse needs as part of a holistic package of care. Consequently, they will be able to demonstrate a working understanding of the youth justice system and the needs of young people.

These are exciting opportunities for motivated individuals to join our dynamic team. The successful candidates for both roles will have experience of engaging young people with multiple needs and the provision of substance misuse interventions. They will also show commitment to working in partnership with allied professions.
For these posts, professionalism, dedication and a commitment to partnership work with young people and their families are essential. In return CRI will offer excellent terms and conditions, a comprehensive career development plan and the training and support needed to really make a difference to the lives of young people, their families, and the community.

**Closing Date: Monday 5th July 2010**

**Only electronic applications will be accepted via www.cri.org.uk**

**The successful candidate will be subject to a Criminal Records Bureau check at enhanced level.**

**In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.**

Committed to anti-discriminatory practice, CRI aims to be an equal opportunities employer.
Crime Reduction Initiatives is a registered charity in England and Wales (1079327) and in Scotland (SC039861), Company Registration Number: 3861209 (England and Wales).

*safer communities, healthier lives*

## DDN/FDAP WORKSHOPS

**15 JULY**

### Beyond mephedrone - The continued rise of new psychoactive "internet" drugs.

As mephedrone joins the legion of illegal drugs, drug users who don't wish to break the law are moving further into unknown territory than ever before. A vast array of RCs (research chemicals) are being sold and bought over the internet. Move over m-cat, here comes naphyrone (NRG-1), 5-IAI, sub-coca dragon 3, Benzo-fury (6-APDB), AMT, MDAI and of course NRG-2! Discover more about the effects and consequences of taking this ever expanding new range of mind altering substances.

The course is run by Ren Massetti, training co-ordinator for Suffolk DAAT and freelance trainer. Cost £115 + vat

Come and hear one of the people who predicted the mephedrone phenomenon as we look into the future of drug use in the UK.

***15% discount to FDAP members.*** All courses run from 10am – 4pm in central London, and include lunch and refreshments. For more details about these workshops email ian@cjwellings.com or telephone 020 7463 2081. Or visit: **www.drinkanddrugsnews.com**

DDN'S first **SERVICE USER GROUP DIRECTORY** will be a pull out and keep section in **19 JULY**'s DDN – your regional guide to the service user groups and campaigns in your local area, alongside best practice from all over the UK.

**DON'T MISS OUT**

on this opportunity to tell us what your group's been up to. Contact ***Lexy Barber*** on 020 7384 1477 or email lexy@cjwellings.com

To enquire about advertising in the directory please contact ***Faye Liddle*** on 020 7463 2205 or email faye@cjwellings.com

**THE NEWHAM SUBSTANCE MISUSE PARTNERSHIP INVITES EXPRESSIONS OF INTEREST TO TENDER FOR THE MOVING ON SERVICE**

The Newham Substance Misuse Partnership is proud to offer a real opportunity for a suitably qualified and experienced organisation to deliver the Tier 2-3 Moving On Service.

The Newham Substance Misuse Partnership on behalf of NHS Newham and the London Borough of Newham are redesigning their drug and alcohol treatment system in line with the personalisation agenda, with a focus on treatment effectiveness and recovery. Newham is also currently developing high quality and productive services comprising a selection of innovative and exciting 'Hub & Spokes' which aims to improve health and well-being to the people of Newham.

The successful organisation will offer a service which will act as a gateway to permanent accommodation, support people to lead healthier drug and alcohol free lives and facilitate independent living. The service will provide individual living skills such as life skills, advice, relapse prevention, financial management; and access to education, employment and housing. The service will work in collaboration with the Drug and Alcohol Care Management Team and other relevant partners to deliver sustainable and holistic aftercare packages addressing service users housing, education, training and employment needs.

It is anticipated that the contract will be let for 3 years commencing 01 April 2011.

For further information, and/or to express an interest, please contact: Steve Frost, Senior Procurement Manager, NHS Newham, Warehouse K, Unit 8, 2 Western Gateway, Royal Victoria Dock, London E16 1DQ or email: steve.frost@newhampct.nhs.uk

The closing date for expressions of interest is 12 noon on Wednesday 07 July 2010. Late expressions of interest will not be accepted. The Newham Substance Misuse Partnership reserves the right not to make an award.

## Development Officer: Alcohol; Young People

**£21, 519 - £ 24,646 per annum**

**Ref: 4059**

Closing date 12 noon: 9 July 2009

**For more information, please visit www.bury.gov.uk/jobsandcareers**

Forest YMCA is a large community organisation based in Walthamstow and a Registered Social Landlord, regulated by the TSA. We provide accommodation and support for young people along with move-on accommodation and housing for refugees. We have a newly refurbished restaurant and internet café, as well as a weights gym and spa suite. The Association also provides out of school care in the local borough and a youth club at our main site.

## Supported Housing Officer (Drug and Alcohol)

Salary: £22,000 pa • 37.5 hours per week • Ref: HR392

Managing your own caseload of residents you will be able to draw upon your past experience as a support worker in a low-medium needs hostel. You will provide advice and support on a 1-2-1 basis to clients on education and training, welfare benefits and resettlement.

You will draw upon your counseling qualification to provide either CBT or 12-step based counseling to individuals and groups regarding the affects of alcohol and drugs, along with preparing individuals for submission to CDAT and other addiction agencies. You should be able to prepare and distribute relevant literature to residents and provide education programs where requested.

You will also be able to undertake assessments and support plans and have a basic knowledge of Supporting People and the QAF framework having had significant previous experience of providing 1-2-1 support to clients.

For more information on Forest YMCA please go to www.forestymca.org.uk

Closing date for applications is Friday 9th July 2010.

For an application pack please email ymca@pennatcs.com or call 0845 055 0261 quoting the reference HR392.

*Forest YMCA is an equal opportunities employer.*
*Registered charity no. 803442*

**THE NEWHAM SUBSTANCE MISUSE PARTNERSHIP INVITES EXPRESSIONS OF INTEREST TO TENDER FOR THE DRUG AND ALCOHOL ASSESSMENT AND CARE MANAGEMENT TEAM SERVICE**

The Newham Substance Misuse Partnership is proud to offer a real opportunity for a suitably qualified and experienced organisation to deliver the Tier 3 Drug and Alcohol Assessment and Care Management Team Service.

The Newham Substance Misuse Partnership on behalf of NHS Newham and the London Borough of Newham are redesigning their drug and alcohol treatment system in line with the personalisation agenda, with a focus on treatment effectiveness and recovery. Newham is also currently developing high quality and productive services comprising a selection of innovative and exciting 'Hub & Spokes' which aims to improve health and well-being to the people of Newham.

The successful organisation will offer an open access service which will deliver social and crisis support, care co-ordination and management for service users with drug, alcohol, drug/alcohol and mental health issues. The service will also act as a gateway to other relevant services as well as providing on-going care planning for those service users engaged within the community prescribing service.

It is anticipated that the contract will be let for 3 years commencing 01 April 2011.

For further information, and/or to express an interest, please contact: Steve Frost, Senior Procurement Manager, NHS Newham, Warehouse K, Unit 8, 2 Western Gateway, Royal Victoria Dock, London E16 1DQ or email: steve.frost@newhampct.nhs.uk

The closing date for expressions of interest is 12 noon on Wednesday 07 July 2010. Late expressions of interest will not be accepted. The Newham Substance Misuse Partnership reserves the right not to make an award.

# OPEN ROAD

*Open Road values and respects the diversity and individual differences of our service users, staff, including contracted consultants who work for us, and our volunteers. Open Road is the largest charity in Essex providing drug and alcohol treatment services and has been reducing the harmful impact of drugs and alcohol on users, their families, partners and society. Open Road has been awarded funding from the Big Lottery Fund, to deliver two new exciting and innovative projects.*

## 2 X FAMILY SUPPORT WORKERS required for Basildon & Colchester

**18 hours per week £20,000 — £24,000 pro rata**

An opportunity has arisen for two self-motivated individuals to be part of a unique service providing support to clients and families that are affected by drug or alcohol abuse. The role will involve working in the community, offering a package of interventions aimed at addressing the needs of the 'whole' family. You will work as part of a multidisciplinary team, providing assessments, 1-1 support and effective care plans. The role may require you to work some evenings and weekends.

## PROJECT WORKER required in Tendring – fixed term 3 year contract

**12 hours per week £8,000—£10,000 per annum**

An exciting opportunity has arisen for a self motivated individual to be part of a unique project supporting the delivery of a Conservation Training Programme. You will work to engage client in the programme as well as undertake regular risk assessment and crisis intervention when appropriate, as well as building strong links with treatment providers. You will also be responsible for the recruitment and retention of volunteers to help support the delivery of the project as well as collection and evaluation of statistical information.

***The project is being delivered in conjunction with the Green Light Trust who provide structured actives linked with conservation and woodland management***

**For an application pack please visit our website at www.openroad.org.uk, or contact Caroline Warwick on 01206 369782 or email Caroline.warwick@openroad.org.uk. Closing date for applications is Wednesday 30th June with interviews being held on the 7th & 9th July**

*Open Road values and respects the diversity and individual differences of our service users, staff, including contracted consultants who work for us, and our volunteers. Registered Charity No. 1019915 Registered in England No. 2806113*

Compass is a rapidly expanding independent sector organisation providing services to help communities cope with problem drug and alcohol use. Due to the expansion of our services in Yorkshire, we now have the following exciting opportunities available:

## Practice Nurse x2

**37 hours per week | £20,352 - £26,470+ 7% nursing supplement. p.a. | Ref 184**

The post is based at Criminal Justice Specialist Prescribing Service in Hull undertaking work with a team of clinicians to assess, plan, implement and evaluate planned care for problem drug users. The role involves the provision of a direct, specialist nursing service to clients and includes responsibility for caseload management.

As the clinic prescribes for Service users involved in the Criminal Justice System this post calls for close co-operation with Probation, Drug Intervention Programme and Crossover Day Programme in addition to other drug treatment and rehabilitation agencies in the community.

## Senior Practioner

**37 hours per week | £24,422 - £26,284 p.a.**

**For registered nurses - £27,212 - £29,314 + 7% nursing supplement p.a | Ref 185**

An exciting opportunity is available to join our busy and exciting Criminal Justice Specialist prescribing service in Hull as Senior Practioner. We are looking for a creative, dynamic and experienced individual who has a passion for working with a broad range of service users involved with the criminal justice system and has a particular interest in quality and clinical governance.

Working closely with the Nurse Team Manager, you will be involved in the development and delivery of specialist substance misuse provision, leading on multi-disciplinary working, providing guidance and support to the existing team, including taking a clinical lead on service delivery.

We are interested in receiving applications from a broad range of disciplines, including RMN's, RGN's, social care, psychology and psychiatry. Knowledge and experience of Tier 3 interventions and specialist prescribing is essential.

## Day Programme Worker

**22 hours per week. | £20,454 - £24,201 p.a. pro rata | Ref 186**

The East Riding of Yorkshire DRR Programme operates in Goole and Bridlington. All service users accessing the service have consented to being subject to a Drug Rehabilitation Requirement of a Community Court Order. The Structured Day Programmes are for those on a Medium or High level order. The programmes provides group work, individual keywork support and vocational, educational and recreational activities aimed at supporting clients to address their drug use and achievable sustainable change in line with their own personal goals.

The post is based within the Day Programme Team in Goole

- Providing group work to address drug use, health, lifeskills and achieving change.
- Offering a range of educational, vocational and recreational activities and skills.
- Giving 1 to 1 advice and support and interventions to holistically address needs.

The post calls for close co-operation with other drug treatment and rehabilitation agencies in the criminal justice system and the community.

**We believe that a healthy work/life balance is key to a successful and rewarding career so we are proud to be able to offer:**

- 27 days annual leave per year + 8 Bank Holidays
- Free Employee Assistance Programme
- Compass Group Personal Pension Scheme
- Childcare Voucher Scheme
- Excellent Training Opportunities

**All posts may require some evening/weekend/bank holiday work.**

**For more information and details of how to apply, visit www.compass-uk.org**

**The closing date for all of the above roles is 30th June 2010..**

All Compass posts are subject to an Enhanced CRB disclosure.

**www.Compass-uk.org**

Charity registration No: 518048

## Can you help overcome the harms caused by alcohol, drugs and gambling?

Last year over 10,000 people contacted our services for help. We are passionate about what we do and are looking for positive, skilled and enthusiastic people to join us.

- **Service Manager** – **Birmingham Tier 3 Services Ref: B/10/21**
  **£28,636 – £34,549 per annum (under review) • 37 hours per week**
- **Service Manager** – **Birmingham Tier 2 Services Ref: B/10/22**
  **£28,636 – £34,549 per annum (under review) • 37 hours per week**
- **Participation Workers Ref: B/10/23**
  **£19,621 – £22,958 per annum, pro rata**
  **1 x 37 hours per week, based in Birmingham and Solihull**
  **1 x 37 hours per week, based in the Black Country**
  **1 x 18.5 hours per week, based in Northamptonshire**
- **Practitioner** – **Birmingham Tier 2 Hospital Service Ref: B/10/24**
  **£19,621 – £22,958 per annum • 37 hours per week**

For further information, the opportunity to download an application pack and full details of our current vacancies, please visit www.aquarius.org.uk

Alternatively, email: recruitment@aquarius.org.uk or write to Human Resources, 2nd Floor, 16 Kent Street, Birmingham B5 6RD quoting the relevant reference number.

Closing date: noon on Friday, 25th June 2010.

*Successful candidates will be subject to an enhanced CRB check.*

*Aquarius – actively working towards equality in employment and service delivery*

*Aquarius Action Projects is a Registered Charity No 1014305.*

*AVA is a small national second tier organisation working to end violence against women in the UK. We are recruiting two posts to further develop our work on issues relating to violence against women and problematic substance use. Both posts are based in London.*

**STELLA PROJECT**

### MENTAL HEALTH INITIATIVE COORDINATOR,

**full time, £32,532 inc ILW**

This post will coordinate a new three year project to develop partnerships between substance misuse, mental health and violence against women organisations in order to improve responses to women experiencing these overlapping issues.

**STELLA PROJECT**

### LONDON COORDINATOR,

**17.5 hours per week, £32,532 inc ILW (pro rata)**

Our work in London is focused on managing change processes and facilitating effective partnership working to improve services to survivors and perpetrators of domestic and sexual violence affected by problematic substance use. This is done through the delivery of training, consultancy, events, information and good practice guidance.

*Application packs from: www.avaproject.org.uk*

*Enquiries: Karen.Bailey@avaproject.org.uk, 0207 785 3862*

*Closing date: 4 July; interviews scheduled for 20 and 22 July.*

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