THE SUBSTANCE MISUSE FIELD'S NO.1 MAGAZINE

Drink and DRUGS NEWS

www.drinkanddrugsnews.com
ISSN 1755-6236 September 2014

'The NHS is committed to treating people with other forms of addiction, but not gambling, and so the onus is on the third sector to provide the services necessary to support those who suffer ...'

UNFAIR ODDS.....

WHAT TREATMENT CHOICE FOR PROBLEM GAMBLERS?

addaction

www.addaction.org.uk

‘THE BIG AMBITION’

4th National Recovery Conference 2014

10th/11th November 2014

Glasgow

PEOPLE IN RECOVERY ATTEND FOR FREE*

Glasgow Marriott Hotel, 500 Argyle Street, Glasgow G3 8RR

BOOK NOW

www.recoveryconference.org.uk

*see website for more details

Registered office 67–69 Cowcross Street, London EC1M 6PU **Tel:** 020 7251 5860 **Fax:** 020 7251 5890 **E:** info@addaction.org.uk **www.addaction.org.uk**
Registered charity no. 1001957 Scottish charity no. SC040009 VAT no. 735842515 Company registration no. 2580377

Rad_016_0914

DDN Drink and Drugs News

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

Editor: Claire Brown
t: 01233 638 528
e: claire@cjwellings.com

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

Reporter: David Gilliver
e: david@cjwellings.com

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

Designer: Jez Tucker
e: jez@cjwellings.com

Publishing Assistant:
Annie Hobson
e: annie@cjwellings.com

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

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

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: inhauscreative iStock

Editorial – Claire Brown

Voices of reason

Are we ambitious enough for inclusion?

'The most effective way to overcome addiction and eliminate its costs is to help people to stop taking drugs and become fully abstinent,' says the Centre for Social Justice in its new report, *Ambitious for recovery* (page 4), adding that they would consider urging government to 'look at reducing welfare payments for claimants who continually refuse to address their addiction'. Such wide-sweeping ownership of the word recovery is not only dismissive of other routes to treating addiction, it's also a disservice to many of those trying to develop inclusive recovery communities.

In their article on page 14, Kingston RISE acknowledge the government's need to monitarise solutions, but refuse to see their community as just a problem to be solved. Their purpose (and inspiration) is rediscovering wellbeing – which by its very nature should be inclusive – and they highlight the aim of being 'as diverse and open minded as we can'. This month's profile adds to the case (page 16), with Sue Bandcroft reflecting on decades of change within our sector. Looking back to the 1980s she offers a timely reminder of the crucial role of harm reduction, with 'all partners working together'. She's still a firm believer in different approaches – 'not one particular dogmatic approach or the other'. Let's not let authentic voices of experience be drowned by the big splashes from the think tanks.

This issue

FEATURES

REGULARS

Keep in touch with us via Facebook and Twitter!
/DDNMagazine @DDNMagazine

NEWS IN BRIEF

SOUTH WEST STRATEGY

A pilot programme to help tackle hep C in the South West has been launched by Addaction Cornwall in partnership with the Hepatitis C Trust and pharma company AbbVie. The project includes staff training and peer-to-peer education and buddying, and is designed to reduce transmission rates and free up NHS resources. 'This is an exciting programme that we hope will maximise the opportunity for elimination of hepatitis C in the region and we are confident that where the South West leads, the rest of England will follow,' said Hepatitis C Trust chief executive Charles Gore.

THE WRITE STUFF

Adfam's annual writing competition for those affected by drug or alcohol use has been announced, with a main prize of £150 and two runner-up prizes of £100. *Adfam Voices 2014* is open until 31 October, and entries should be no more than 500 words. 'We are looking to get a record number of entries this year so please spread the word,' says Adfam.

Details at www.adfam.org.uk

ADD 'EM APP

A free iOS app to allow people to calculate alcohol units and calories has been launched by Drinkaware. It also provides personalised feedback as well as information on the health benefits of reducing consumption.

More information at www.drinkaware.co.uk

PATIENT POWER

Treatment providers Delphi Medical have joined with the Patients Know Best organisation to give clients secure online access to their health records. 'A patient recovering from a drug or alcohol addiction receives very fragmented care because none of the agencies dealing with them can access a single version of that person's medical record,' said Adelphi MD John Richmond. 'Putting the patient in control of their records solves this challenge at the click of a mouse.' Delphi plans to enhance the project with training material and video podcasts so that clients 'can quickly and easily understand why doctors are recommending certain treatment plans and courses of action.'

www.delphimedical.co.uk

THEY CALL IT MADNESS

European Commission funding has been announced for a research project on new psychoactive substances led by the University of Hertfordshire. EU-MADNESS (European-wide, Monitoring, Analysis and knowledge Dissemination on Novel/Emerging pSychoactiveS) is a two-year project to monitor, test and profile the types of substances emerging in Europe along with their 'associated characteristics and potential harms'.

www.eumadness.eu

Legal high deaths 'could' top heroin deaths, says CSJ

The rate of deaths linked to new psychoactive substances could be 'higher than heroin' within two years, according to a report from the Centre for Social Justice (CSJ) think tank.

Hospital admissions related to new psychoactive substances (NPS) rose by 56 per cent between 2009 and 2012, says *Ambitious for recovery*, while 97 people were found dead with NPS in their system in 2012, up from just 12 over the same period. 'Based on current trends NPS could be implicated in more deaths than heroin by 2016,' it says.

The report calls for measures similar to those in place in Ireland to make it easier for police and courts to close 'head shops' selling NPS. It also wants to see a 'treatment tax' added to the cost of alcohol to fund 'a new generation of treatment centres' and states that Public Health England and local councils 'risk giving up on many addicts', with the treatment sector mainly concerned with 'managing' people and the government's FRANK education programme 'shamefully inadequate'.

'Far too many' people are prescribed opiate substitutes, says the CSJ – which was set up eight years ago by Iain Duncan Smith – 'effectively replacing one addiction' with another. 'The most effective way to overcome addiction and eliminate its costs is to help people to stop taking drugs and become fully abstinent,' states the report. 'Yet as the CSJ has long argued, treatment services have continually failed to support abstinence-based recovery. Despite warm words in its *2010 drug strategy*, this government has failed to create the recovery revolution that it promised.'

A 'treatment tax' levy of 1p per unit could raise more than £1bn for abstinence-based treatment over five years, says the organisation, with the government urged to 'look at reducing welfare payments for claimants who continually refuse to address their addiction' once the additional treatment centres are up and running. It also suggests piloting a 'welfare card' scheme, where a proportion of benefits would have to be spent on essentials such as food and clothes. 'This would apply to alcohol or drug addicts with dependent children who refuse treatment and who have not been in work for a year,' it says.

'Addiction rips into families, makes communities less safe and entrenches poverty,' said CSJ director Christian Guy. 'For years full recovery has been the preserve of the wealthy – closed off to the poorest people and to those with problems who need to rely on a public system. We want to break this injustice wide open.'

Ambitious for recovery at www.centreforsocialjustice.org.uk

Scots drug-related deaths down from record highs

The number of drug-related deaths in Scotland fell by 9 per cent last year, according to figures from the Scottish Government, with deaths among under-25s the lowest since records began.

There were 526 drug-related deaths registered in Scotland in 2013, 68 per cent of which were among people aged 35 and over. The country recorded its highest ever number of drug deaths in 2011 (*DDN*, September 2012, page 4) when 584 people died, and just three fewer the following year (*DDN*, September 2103, page 5). Three quarters of the 2013 deaths were among men, and in more than 90 per cent of cases people had taken more than one drug.

The hope was that the increases in deaths in previous years had 'now come to an end', said community safety minister Roseanna Cunningham. 'These statistics are a product of a long legacy of drug misuse among older users. We are clear that one death is one too many, and that's why we are funding the Scottish Drugs Forum to work with older users and why almost 4,000 naloxone kits were issued through our prevention programme to people at risk of overdose in 2012-13, potentially saving more than 350 lives. We know we face a tough challenge, but there are signs our approach is working. Drug taking in the general adult population is falling, and far fewer young people are taking drugs than ever before.'

The number of deaths where new psychoactive substances (NPS) were present, however, rose from 47 in 2012 to 113, including 60 deaths where NPS were implicated – albeit along with other substances in all but five of the cases. The Scottish Government recently published its *New psychoactive substances – evidence review* and has committed to further research to address gaps in knowledge.

'NPS may be cheaper than known illegal drugs and we are aware of people using them across different age ranges and social groups,' said service delivery manager at Edinburgh-based Crew 2000, Emma Crawshaw. 'People who haven't used drugs before are at risk if they do not have experience or credible information.'

As DDN went to press, ONS figures revealed that the level of drug poisoning deaths – from both legal and illegal drugs – in England and Wales was 2,995 in 2013, the highest since 2001. Full details in October's issue.

Drug-related deaths in Scotland in 2013 at www.gro-scotland.gov.uk

New psychoactive substances – evidence review at www.scotland.gov.uk

Put health warnings on all alcohol, say MPs

Health warnings should be included on all alcohol labels, says the All Party Parliamentary Group (APPG) on Alcohol Misuse, to go alongside a new government-funded awareness campaign on alcohol harm.

The recommendations are among ten measures set out in the group's *Manifesto 2015*, along with stronger marketing regulations to protect the young, increased funding for treatment, making public health a core licensing objective and minimum unit pricing. 'Consumer information on alcohol products usually extends no further than the volume strength and unit content,' it says. 'In order to inform consumers about balanced risk, every alcohol label should include an evidence-based health warning as well as describing the product's nutritional, calorific and alcohol content.'

The document also wants to see alcohol harms made the responsibility of a single government minister with 'clear accountability', and mandatory training in parental substance misuse for all healthcare professionals and social workers. 'Alcohol abuse has become a national pandemic and needs to be treated as such,' it says, and the group is calling on all political parties to commit to the ten measures.

'Due to alcohol, one person is killed every hour and 1.2m people are admitted to hospital a year,' said the group's chair, Tracey Crouch MP. 'Getting political parties to seriously commit to these ten measures will be a massive step in tackling the huge public health issue that alcohol is.'

Political parties 'run for cover when they are confronted by the drinks industry and its immensely powerful lobby,' added vice-chair Lord Brook of Alvethorpe. 'These proposals give them another chance to consider whether they really have the guts to take a different line for the country's wellbeing in the future.'

All Party Parliamentary Group (APPG) on Alcohol Misuse manifesto 2015 at www.alcoholconcern.org.uk

Foil rules for services come into force

Legislation has come into force this month allowing services to provide aluminium foil 'for the purpose of smoking drugs', with a new briefing from Public Health England (PHE) explaining the new rules and providing advice on their implementation.

The aim of the legislation is to reduce injecting-related harms, with the condition that foil be supplied 'in the context of structured steps either to engage people in a treatment plan or as part of a treatment plan'.

The Advisory Council on the Misuse of Drugs (ACMD) previously advised the government that 'the balance of benefit' from providing foil favoured exempting it from Section 9A of the Misuse of Drugs Act – which relates to the prohibition of supply of 'articles for administering or preparing controlled drugs' – with the home secretary announcing last year that the government had accepted its advice (*DDN*, August 2013, page 4).

Provision of foil with be monitored via new fields added to the Needle Exchange Monitoring System (NEXMS), along with a series of interviews with service providers to be carried out next year. The PHE briefing urges services to make sure staff are 'aware of the respiratory complications of smoking from foil' and able to provide advice, as well as address concerns around issues such as 'drug smoking's lesser effectiveness and increased cost'.

Aluminium foil for smoking drugs: a briefing for commissioners and providers of services for people who use drugs at www.gov.uk

IN THE FRAME: current and former clients, their families and staff, gathered at Huntercombe Maidenhead Hospital, a specialist child and adolescent mental health facility, to help raise money for a local hospice. 'Everyone really looks forward to the annual fete,' said hospital manager Iris Cupido. 'It's a great way for our entire hospital community to come together.'

NEWS IN BRIEF

FAMILY FACTS

Adfam wants to hear from organisations providing support for families affected by drugs or alcohol for its *2014 health check* project. 'We want to know more about what's happening in the sector in terms of sustainability, funding, networks and partnerships,' says the organisation, which will publish a report based on the findings. Service managers can take the survey at *www.surveymonkey.com/s/9KYMHMH* until the end of September. *The annual Adfam/DDN Families First conference takes place in London on 23 October. Details at drinkanddrugsnews.com/2014-ddnadfam-families-first-conference*

SEARCH ME

The Home Office has published guidance for police forces on the implementation of the best use of stop and search scheme, which aims to create 'greater transparency, accountability and community involvement'. A report from Release last year found that black people are more than six times more likely to be stopped and search for drugs, and more than twice as likely to be charged if drugs are found (*DDN*, September 2013, page 4). *Best use of stop and search scheme at www.gov.uk*

MASS DEBATE

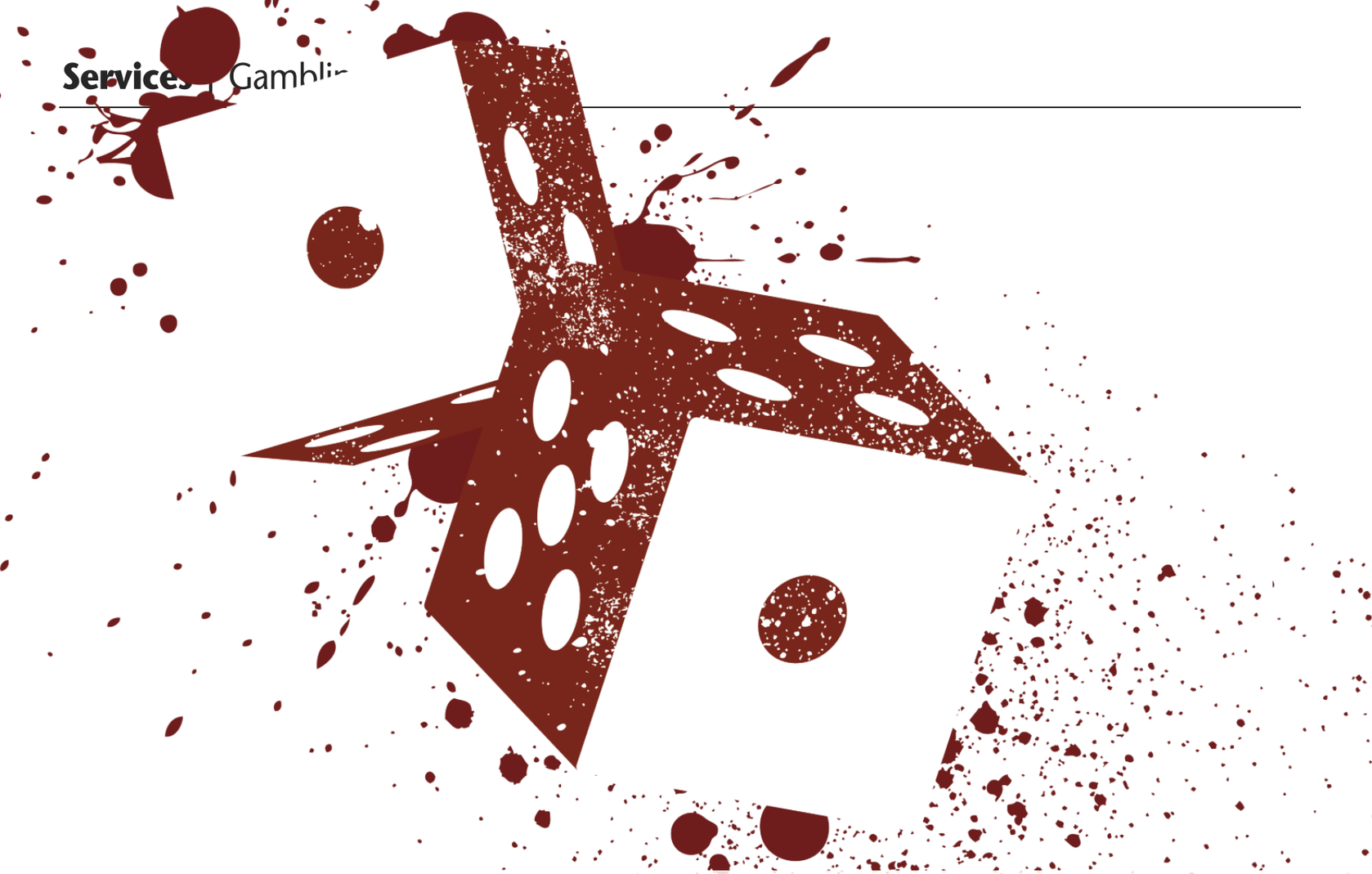
A guide to help people 'make the case for the legal regulation of drugs from a position of confidence and authority' has been produced by Transform. 'If someone tells you that legal regulation would mean a drugs "free-for-all", or that the war on drugs can be won if we simply fight harder, you'll be equipped to reply with short, clear and memorable counter-arguments,' it says. *Debating drugs at www.tdpf.org.uk*

E-CIG SAFETY

WHO is calling for a ban on the indoor use of e-cigarettes along with their marketing and sale to young people, as 'experimentation with e-cigarettes is increasing rapidly among adolescents'. There is also 'insufficient evidence to conclude that e-cigarettes help users quit smoking or not', it says. While the report was welcomed by the Faculty of Public Health, Professor Gerry Stimson of Imperial College, and co-director of Knowledge Action Change, said that WHO was 'exaggerating the risks of e-cigarettes while downplaying the huge potential of these non-combustible, low-risk nicotine products to end the epidemic of tobacco-related disease'. *Report on e-cigarettes to WHO Framework Convention on Tobacco Control at www.who.int*

BEREAVEMENT SUPPORT

DrugFAM's sixth annual conference, *Supporting the recovery of those bereaved by drugs and alcohol*, takes place in Birmingham on 4 October. *Full details at www.drugfam.co.uk*



LOADED DICE?

The estimated 450,000 people in the UK with a gambling problem are at a distinct disadvantage when it comes to getting access to treatment. *DDN* reports

Earlier this year no less an organisation than the Royal College of Psychiatrists (RPsych) called on the government to dramatically increase the level of support for people struggling with problem gambling (*DDN*, May, page 5), which it defines as 'gambling that disrupts or damages personal, family or recreational pursuits'.

'These adults deserve the same access to treatment services as those with alcohol and drug addictions,' said the college's Faculty of Addiction Psychiatry. It also pointed out that not only was current service provision 'under-developed, geographically "patchy" or simply nonexistent', it was also funded almost exclusively by the gambling industry itself.

For problem gamblers looking for support there's Central and North West London NHS Trust's (CNWL) National Problem Gambling Clinic, which offers one-to-one and group therapy, family services and referral to appropriate aftercare, as well as Gamblers Anonymous – which is holding events to mark its 50th birthday this month – and a network of just under 20 local services partnered with industry-funded support service GamCare.

As Broadway Lodge chief executive Brian Dudley told *DDN* last year, however, among the only residential centres offering treatment for gambling addiction are his organisation and the Gordon Moody Association, both GamCare-funded (*DDN*, November 2013, page 17). 'It's funded by the gambling industry because there's no other funding,' he said. 'The need is there, but the money doesn't follow it.'

RCPsych's report, *Gambling: the hidden addiction*, called for the government to 'recognise gambling disorder as a public health responsibility', to allow treatment to be provided by existing drug and alcohol services. Lack of government action, however, alongside the 'increasing availability and public visibility of gambling' would provide 'the perfect conditions for a new generation of problem gamblers – a future trend in addictions that we are ill-equipped to treat', said the report's co-author and consultant addiction psychiatrist, Dr Sanju George.

And that 'availability and public visibility' does seem to be increasing all the time, with an explosion in online gambling, gambling apps and more, much of it backed by well-funded advertising campaigns. Earlier this year there was a high-profile controversy around fixed odds betting terminals (FOBT) – frequently referred to as 'the crack cocaine of gambling' – installed in bookmakers, with MPs calling for a reduction in the maximum amount it was possible to gamble on them in one go, from £100 to £20.

There were 33,000 of these terminals in betting shops in the UK in 2013, accounting for more than half of the shops' net takings, according to regulator the Gambling Commission. The Campaign for Fairer Gambling, meanwhile, claimed that a staggering £1.6bn was lost on FOBTs last year – up £89m in 2012 – and that almost £500m of those losses occurred in 55 of England's most deprived boroughs. Even where money isn't at stake, however, as in the case of ordinary online gaming, there's real potential for addictive behaviour and negative consequences, with people becoming so obsessed that their health and relationships can suffer dramatically (*DDN*, February 2013, page 8).

As another RCPsych report in partnership with Alcohol Concern Cymru – *A losing bet? Alcohol and gambling* – illustrated, while there may be fewer people struggling with gambling problems than with alcohol, 'often people with alcohol problems participate in unhealthy gambling, and vice versa'. Both industries have seen the rules governing them in the UK liberalised in recent years, it points out, along with an expansion of female-targeted marketing. One in six of those interviewed for the report who had sought help for alcohol misuse also admitted to problems with gambling.

'There's a lot of comorbidity,' said Brian Dudley. 'Someone will come in with a drug or alcohol problem but when we actually start working with them we might well find their primary addiction is gambling, but they'd never have got funded.'

So is there a real role for the treatment sector here? 'Expert and experienced in

FROM BETS TO DEBTS

John explains how six years into recovering from drug and alcohol addiction, he stumbled into a gambling habit

IT STARTED THREE YEARS AGO with scratch cards, first £5 ones, then £10. Then I discovered roulette in the bookies – I'd only gone into the use the toilet and saw someone winning. The first time I played I won £2,500 and thought 'I could do that again'.

When the bookies wasn't open I'd buy scratch cards or go into pubs looking for the £500 jackpot machine. Then I began driving to motorway services to look for more machines. I won £28,000 in one day on roulette machines.

I'd have a ritual that gave me the same buzz as drug paraphernalia. I'd set out the scratch cards in order of value, and save scratching the amount off the winning boxes till last.

It was making me dishonest. I had £15,000 in the glove compartment of my car because I couldn't tell my wife. Then I couldn't sleep. I couldn't pay the rent – I couldn't even pay my mobile phone. I'd used my credit card to the limit and had two bank loans. My wife confronted me and I denied it – but she knew. I saw the pain in her eyes and thought, 'I really have to sort this out.'

As I was working at a treatment centre, I had access to one-to-one counselling. I also went to Gamblers Anonymous, using the 12 steps to make financial amends. I tackled my debts and used an app to block gambling sites on my computer. Up till then I'd gambled on the dogs, football, horses, roulette and scratch cards, but GA made me realise 'you win to lose'.

It's difficult to avoid because it's legal and people think 'it's only the lottery fund'.

The TV ads bombard you all the time – Barbara Windsor, Ray Winstone. It's hard to get away from it.

the medical treatment of addictions, these services could play an important role in tackling adult gambling disorder,' said the RCPsych report, with the basic service infrastructure and staff already in place. 'Incorporating gambling disorder within this structure provides a method to meet a critical and growing need, and one which not only needs to be seriously considered by the government, but also acted on.'

Derek Irwin, a psychotherapist and counselling services manager at GamCare, which currently offers counselling through a partnership with 18 local agencies, says his organisation would definitely 'support the same access for services related to gambling addiction' as for drugs and alcohol. 'Even though gambling as an addiction does not exhibit physical or health symptoms in the same way, the behavioural process is similar to other addictions and the consequences are often just as serious,' he tells *DDN*.

'The NHS is committed to treating people with other forms of addiction, but not gambling, and so the onus is on the third sector to provide the services necessary to support those who suffer as a consequence of their gambling behaviour,' says Marc Etches, chief executive of the Responsible Gambling Trust (RGT), a charity which exists to help 'minimise gambling-related harm' via voluntary donations from the gambling industry – around £6m per year.

From March 2013 to March 2014, 80 per cent of this money was spent on treatment, he points out, including the cost of running GamCare's National Gambling Helpline. However, there is 'scope to spend more on support for people with gambling problems and the RGT has plans to do so – but I've little doubt that nationwide provision of additional support through the NHS, including training for GPs on how to spot and treat gambling addiction, would greatly help problem gamblers', he states.

So could gambling be incorporated into the existing treatment sector, as RPsych's report advocates? 'Working with addictions in a treatment context would utilise similar skills, but training regarding gambling-related problems would be essential in order to deal with this specific problem,' says Irwin.

The report acknowledges additional resources would need to be identified – and ring-fenced – with the most significant cost likely to be training existing staff, and potentially employing more. Much could also be achieved by improving non-specialist care, however, with RCPsych calling for better screening for problem gambling by GPs and other professionals and the use of low-cost brief interventions to try to stop people moving from being 'at risk' to developing a full disorder, particularly with clients who are unsuited to – or unwilling to access – more intensive treatment.

Screening and brief interventions are indeed 'useful and important' says Irwin, as people 'would benefit from early intervention just like any other problem or condition'.

Meanwhile, the RGT's funding plan for 2014-15 has set aside £4.3m for the provision of services to treat problem gambling, stresses Etches. 'This includes £2.4m for GamCare to provide treatment services, either directly or via its network of partners, to gamblers and others adversely affected by gambling via free and confidential counselling, one-to-one or in groups, face-to-face and online.' The RGT has also made grants to CNWL to fund CBT-based counselling at the National Problem Gambling Clinic, he points out, as well as residential services at the Gordon Moody Association and GamCare's National Gambling Helpline. 'There is no national, publicly funded alternative to these services,' he states.

And what about RPsych's warning that without dramatically upscaled action now there could be a whole new generation of problem gamblers? 'It depends how you look at problems causally,' says Irwin. 'A parallel could be made with legislation, advertising and availability around alcohol. It is the case, we feel, that other problems and issues lead to addictive behaviours, so addressing these other issues would be our priority. Of course, legislation and advertising need always to be monitored, but it's not the solution.' **DDN**

Gambling: the hidden addiction at www.rcpsych.ac.uk

A losing bet? Alcohol and gambling: investigating parallels and shared solutions at www.alcoholconcern.org.uk

A major London conference on 13 November will look at the level of gambling-related problems in the UK, the links with drug and alcohol misuse, and opportunities for the treatment sector. For more information on Weighing up the odds, *or to book your place, visit www.drinkanddrugsnews.com*

'Often people with alcohol problems participate in unhealthy gambling, and vice versa... One in six of those interviewed for the report who had sought help for alcohol misuse also admitted to problems with gambling.'

WHAT STATE ARE WE IN?

A new, improved *State of the sector* report is underway and needs your input, says **Paul Anders**

LAST YEAR DrugScope, on behalf of the Recovery Partnership, undertook significant work to try to gauge the health and confidence of the adult community and residential parts of the drug and/or alcohol treatment system. The result was *State of the sector 2013*. Through a variety of means – an online questionnaire, regional events and telephone interviews – service managers and other stakeholders were encouraged to provide information about the condition of their services, how they'd coped with a period of significant change, how their partnership work was faring and what their outlook for the future was.

The resulting report gained significant traction. It received widespread coverage in both the specialist press like *DDN* and *Druglink*, but also in the broader voluntary and public service press, as well as being quoted by mainstream newspapers such as the *Independent*. It garnered ministerial interest through the Inter-Ministerial Group on Drugs, and Public Health England (PHE) took some of the key findings from the report as a mandate to prioritise housing and employment in its 2014-15 work plan.

The findings painted a picture of a sector in a state of flux. While there was little in the 2013 survey to cause particular alarm, many responses indicated that the process of change, driven both by changes to local authority funding and to the way that drug and alcohol services are commissioned, had only just started.

SOME KEY FINDINGS INCLUDED:

- *No clear evidence of widespread disinvestment in treatment. Many respondents reported an actual or anticipated decrease in funding, but others reported an increase, albeit sometimes as a result of gaining business due to local authorities rolling smaller contracts together.*
- *Many respondents indicated that they were engaging with features of the post-2013 commissioning landscape like Health and Wellbeing Boards and police and crime commissioners.*
- *Respondents indicated that they were having difficulty in supporting people to accrue 'recovery capital', with employment and housing particularly problematic but some problems also being experienced around access to mental health support.*
- *Many participants were concerned about the potentially harmful and disruptive effects of frequent recommissioning and retendering.*

Despite these challenges and more, most respondents were relatively positive about the future and some provided examples of how they'd changed their way of working to improve services, manage costs or improve partnerships.

LOOKING FORWARD

For 2014, *State of the sector* has been substantially revised, both to reflect the learning from 2013 and also to significantly broaden the scope of the work. While in 2013 we limited the survey to service managers from adult community and residential services, in 2014 we will be extending *State of the sector* to prison services and young people's services. DrugScope has consulted widely with service providers, government departments, PHE and other key stakeholders to ensure that the questionnaires accurately reflect the characteristics of each part of the sector and the issues that they face.

The adult community and residential questionnaire has also been developed from last year's, although changes have been kept to a minimum in the interests of being able to make comparisons with results from 12 months ago. By repeating the exercise, we aim to be able to learn – and say more about the pace of change and direction of travel, building on the baseline of *State of the sector 2013*.

However, while we were delighted with the response in 2013 when around 170 services responded, we would like to hear from even more this year, making the findings even more persuasive and useful to the policy-makers who in the end decide where to invest public funds.

We acknowledge that the questionnaires are quite lengthy, as we're keen to capture a wide range of treatment and non-treatment related activity. To make it easier to complete, you may find it useful to have details of the following to hand:

> 'While there was little in the 2013 survey to cause particular alarm, many responses indicated that the process of change... had only just started.'

- *The number of clients accessing your service*
- *Details of your funding and the length of your contract*
- *Your clients' support needs*
- *Any other services you work in partnership with, and*
- *To what extent your clients are able to access other specialist services.*

All responses are entirely confidential, and there is no editorialising. While DrugScope can't guarantee every comment a participant makes will be included in the final report, we take care to ensure that what is included is representative.

The State of the sector 2014 surveys will be launched in September. If you would like to discuss any aspect of the project, please contact Paul Anders at DrugScope – paul.anders@drugscope.org.uk. You can find the main and summary reports of State of the Sector 2013 here: http://www.drugscope.org.uk/POLICY+TOPICS/StateoftheSector2013

Paul Anders is senior policy officer at DrugScope

WEIGHING UP THE ODDS

13 November

NCVO Centre,
8 All Saints Street, London N1 9RL
(10 minute walk from Kings Cross)

GAMBLING IS AVAILABLE EVERYWHERE WE LOOK on the TV, the high street, online and on our mobile phones – with serious consequences for the many people becoming addicted.

The Royal College of Psychiatrists has now called for government to recognise that gambling is a public health issue.

How can we address the desperate lack of support for those experiencing gambling addiction? Should gambling be incorporated into existing treatment services? What does the gambling industry need to do?

Bringing together professionals from addiction treatment, public health and the gambling industry, this conference will open up constructive conversations and look at best practice to tackle policy, treatment options and safeguarding.

JOIN US IN CENTRAL LONDON FOR AN INFORMATIVE AND STIMULATING DAY OF DEBATE.

Places are £145 when booked through DDN.
Event organised by DDN and Esprit de Bois.

Book now at www.drinkanddrugsnews.com

JOIN US AT THE

RECOVERY STREET FILM FESTIVAL

SUMMER 2014

We'll be showcasing short films about people affected by addiction, living in recovery and meeting the challenges of finding a place in society over six locations during September.
www.recoverystreetfilmfestival.co.uk

Supporting organisations – Working Together to Celebrate Recovery

Alcohol Concern · addaction · CRI · Action on Addiction · Turning Point · Public Health England · Compass · DrugScope · Blenheim · Phoenix Futures

Registered charity no.284880

Recovery at its best

OUTSTANDING CONTRIBUTION TO RECOVERY
Presented by the NTA and voted for by service users

OUTSTANDING EMPLOYER OF THE YEAR
Awarded by the Suffolk Brokerage, May 2013

- Altered attitudes 12 Step Recovery Programme
- Primary (0-12 weeks), Secondary (12 – 24 weeks) and tertiary care (24 weeks+) (Foundation, Support and development packages)
- The UK's first 'Recovery Stuff' retail outlet
- Asset based Community Development
- CBT/NLP/Creative Workshops/Psychodrama, Adventurous activity, Family Intervention workshops
- Pathways to education, employment and housing
- Continuous aftercare – 12 step facilitation network

+44 (0)1502 587269
www.eastcoastrecovery.co.uk

RECOVERY
Releasing Your Potential

CQC registered eATA

Find us on Facebook at /eastcoastrecovery

ENGAGING WITH THE EXPERTS

Michael Gilbert talks to DDN about StreetRx.com, a new website that encourages the exchange of information between drug users while also promoting harm reduction

MEETING PEOPLE WHO USE DRUGS 'where they're at' is a core principle in the practice of harm reduction. Programmes are carefully designed to be culturally competent, respectful of dignity, and non-judgmental in their effort to reduce harms associated with drug use.

One of the challenges facing the harm reduction community is that health promotion information often comes in the form of media that are health-specific, and that rely upon their audience's interest and engagement in health-seeking behaviours. Billboards and bus stop ads have trouble finding their target audience, and even the most eye-catching pamphlet or clever infographic will only reach those who walk into the needle exchange or seek out health-related information online.

Research on stage-based models of behaviour change suggests that 80 per cent of people who use drugs are in re-contemplation or contemplation stages, while 20 per cent are in the preparation stage – and yet our communications strategies towards people who use drugs are predominantly focused upon those in the latter group. The discrepancy between the harm reduction community's communication strategies and the stage-based distribution of their audience presents an opportunity to reflect upon how we can 'meet people where they're at'.

An emerging approach to address this challenge is found in programmes that employ 'magnet content' strategies for distribution of harm reduction resources. These programmes use non-health-specific content to attract and engage their audience, while also providing links to health and wellness resources. The intent is to appeal to the social, economic and entertainment interests of drug users as a means to extend beyond those with active interest in health information, and to deliver health promoting resources as a complement to otherwise engaging media.

StreetRx.com is an example of this strategy – a website that gathers and presents information on the street prices of pharmaceutical drugs. After a strong debut in the United States, a group of epidemiologists, harm reductionists and informatics specialists have created an updated version of the website that asks UK visitors a simple question: did you get a good deal?

Visitors can view, post and rate prices in a format that offers price transparency in an otherwise opaque black market. All submissions are anonymous, localisation is set to the city level, and the feedback is shared via a simple price rating scale. This gives users access to information and assurance of privacy, while preventing the site from being used to make deals or set up stings.

The site appeals to the interests of people who buy and sell diverted prescription drugs, while also serving as a source of information on overdose prevention, emergency response and addiction recovery. Links to health and wellness information are subtle but frequently used, with the US version of the site making more than 10,000 referrals to external resources in the last year.

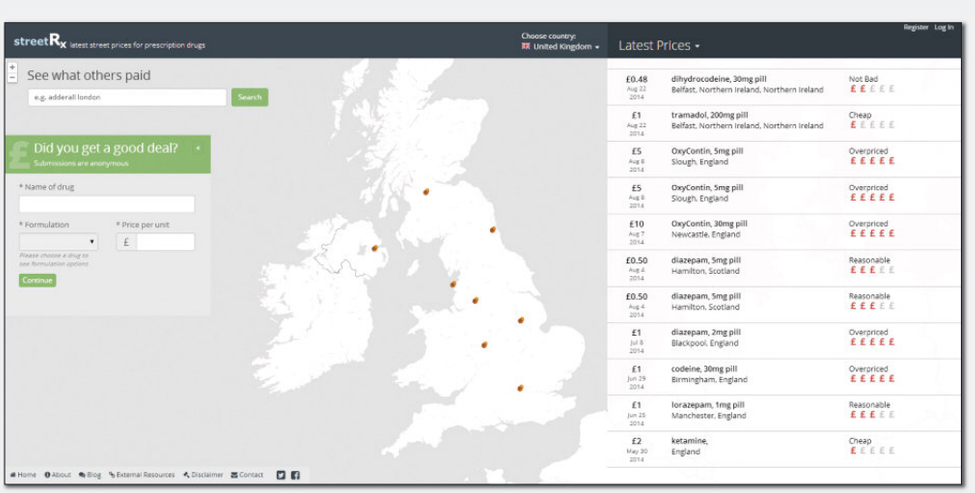
The appeal of this approach is that it establishes visitors as experts with valuable information and insights to share, and cultivates a frame of autonomy, competence and relatedness that the self-determination theory tells us will be conducive to engagement with health and information-seeking behaviours.

StreetRx also generates insights for harm reduction programmes and epidemiological research. Using the wisdom of the crowd, the site is able to identify differences in the appeal of conventional versus abuse-deterrent drug formulations, regional variances in diverted drug prices and changes in the localised price and availability of newly released products.

Information on populations' drug preferences helps harm reductionists to tailor outreach information to local needs, and assists epidemiologists and policy makers to understand the effects of pricing, prescribing and access rules on the diversion of prescription drugs.

In a 2013 paper, *Crowdsourcing black market prices for prescription opioids*, researchers found that StreetRx data was strongly correlated with conventional key informant sources and prices on the online Silk Road market.

These insights would not have been possible without the active participation of tens of thousands of site visitors. They are the result of engaging the curiosity and expert knowledge of people who use drugs without relying upon users' interest in health.



As harm reduction and addiction recovery professionals strive to reach a larger population of service users, we should look towards communication strategies that have appeal beyond health-specific interests.

By weighing up information-seeking behaviours focused on pursuit of entertainment, social engagement or economic interest, we can position health and wellness information as a natural complement to drug users' needs. These strategies are not alternatives to conventional health promotion and harm reduction messaging. Rather, they can expand our audience and create opportunities for wider engagement in an effort to generate and share information that serves the public's health.

Michael Gilbert is a research intern at Epidemico

LETTERS

MIND THE PREJUDICE

After reading the latest challenges and condemnations of the 12-step philosophy via Stanton Peele (*DDN*, April, page 8, and subsequent letters pages), I felt compelled to contribute as someone who has experienced a very positive influence from a 12-step programme.

I have many friends who are atheist and agnostic who attend meetings. Speaking with my counselling hat on, the 12 steps are a CBT programme of behaviour modification before CBT was invented. It's interesting that some professionals have such bitter reactions to it and my experience is that most professionals in the field have never attended an open meeting to gain their own perspective of the 12 steps. My experience in training professionals is that their biased judgements are either created from impressions and feedback from previous clients who have had a negative experience with a group or individual, or a prejudice they have that 12 steps is a religious cult or order.

Dispelling the myths of 12 steps is important for the sector. How can any professional give objective, non-biased opinions concerning 12-step groups if they have contempt for this approach? Let's not forget what a resource it is, with more than 200 meetings a week of NA in London from 7am to 11pm daily, 95 meetings a week of CA, almost 400 meetings a week of AA – not to mention all the others such as Marijuana Anonymous and Crystal Meth Anonymous. The fact is, meetings are free – no one pays, there's no commissioning involved, no staff needed and opening times are not restricted to nine to five.

Is the fact that 12-step fellowships are free one reason that they provoke such contempt in our field? Are they seen as a threat to professionals and services?

Mark Dempster, director, Mark Dempster Counselling

STRENGTH INSIDE

I am a first-time prisoner and, despite appealing my case, I have decided to use the time in prison as my rehabilitation. This is due to the fact that after many years in denial, I eventually admitted to myself that I am an alcoholic and had planned to go into a rehabilitation centre specialising in drying people out.

As that did not happen, my intention was to take full advantage of the help that the prison service would provide for alcoholics. Unfortunately, the prison system 'talks the talk' but does not 'walk the walk'.

When I had my induction in prison, I was delighted to hear all the in-prison support from RAPt (the Rehabilitation for Addicted Prisoners trust). This appeared to be a lot of empty promises, as all of the programmes that I wanted to do (ADTP, 12-steps, and Stepping Stones) have been cancelled due to budget cuts.

It has been difficult to receive books and literature associated with alcohol addiction, and when AA have sent me books, the prison will not let me have them as the justice secretary Chris Grayling does not allow books to be sent to prisoners.

There is no support from AA coming into prison due to the security issues, so despite occasional one-to-ones with a RAPt mentor, my rehabilitation has to be self-rehabilitation.

Through self determination, I am winning my battle and am today 200 days dry, but without my own will to win, I would think 'why bother? Nobody cares'. I am going to do this to prove myself, and be the man my fiancée Karen wants, but with little help from the prison system.

I hope other prison inmates reading this can keep the faith and beat the drink, do it on their own and stick two fingers up to a prison system that does not care.

Peter Mace, HMP Bure

TELL US HOW IT IS (WAS)!

DDN will be a whole decade old on 1 November and we want to hear from you, our faithful readers! Did you read our early issues? How has your job changed over the decade? What are your most significant working moments and how do you see the future for the drug and alcohol field? What do you want to see us covering in the future?

We'll be including contributions – memories, forecasts, whatever you want to share with us – in a special issue in November, so please get in touch with us by writing, emailing, Facebooking or Tweeting. We're waiting to hear from you!

Editor, claire@cjwellings.com, @ddnmagazine

We welcome your letters...

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

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

We do not want drug legalisation by the back door. But at the very least let's have the debate. Two years ago the PM rejected calls for a Royal Commission on drugs policy. It's high time for a rethink.
Sun editorial, 8 August

The *Sun* newspaper, which has in the past been a keen cheerleader and bootlicker for the Blair creature, the Iraq and Afghan Wars and for David Cameron, now wants a 'rethink' on drug laws. Well, you can't rethink till you've thought in the first place. Its pretext for this irresponsible tripe is an interview with Nick Clegg, in which he claims we're too tough on drug possession... The idea that this regime is too tough, and needs to be softened, could only find a home in the head of someone as dim as Nick Clegg.
Peter Hitchens, *Mail on Sunday*, 10 August

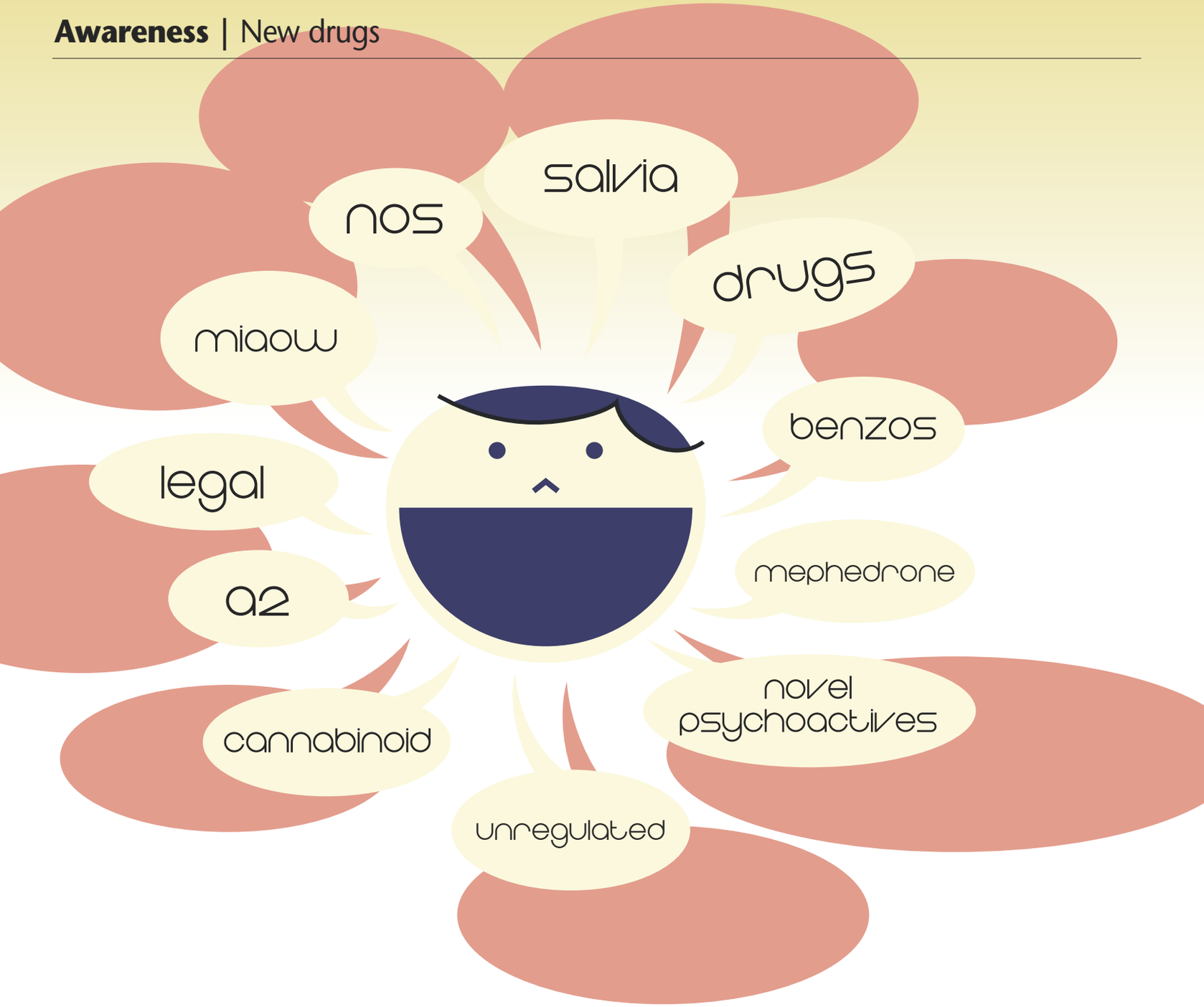
For many, an arrest for possession at a young age can start a chain reaction that leads first to drastically reduced employability and then to a higher likelihood of becoming engaged in the underground economy of drug distribution, often the only job available. Once this happens, it becomes almost a fait accompli that that person will spend a serious portion of his life rotating in and out of the system.
Eugene Jarecki, *Observer*, 3 August

Only poor people are weighed and measured by how much they cost the country. In fact, all of us, one way or another, represent a cost: whether by living too long or studying too much or mismanaging complex financial products. Each of us could have a price tag stuck on our heads that the rest of society could then resent us for. But for some reason this is not thought at all relevant unless you have cost the wrong kind of money.
Zoe Williams, *Guardian*, 18 August

The chief executive of the Scottish Prison Service says people who end up in jails like Barlinnie shouldn't be called 'convicts', 'criminals' or 'offenders' because it might stigmatise them and hamper their rehabilitation... Where do they find these people? I'm all for rehabilitation in jail. There's not enough of it. Most prisons are grim warehouses. But resorting to euphemism to describe prisoners is absurd. Before people can be rehabilitated they must face up to their crimes.
Richard Littlejohn, *Mail*, 26 August

Is it really such a good idea to ban the e-cigarette if it helps people to give up? You can't help but suspect that what is really going on here is that some people are so fanatical about not smoking that they refuse to tolerate something that looks like the real thing even though it isn't. I'm no friend of smoking these days but this just looks petty and vindictive.
Virginia Blackburn, *Express*, 28 August

An imposed period of sobriety may help people gain some insight into how much their alcohol use is damaging other aspects of their lives. Making such a discovery voluntarily is hard, because the pressure to drink in our culture is so vastly underestimated.
Deborah Orr, *Guardian*, 1 August



SEMANTIC CHALLENGE

The language of new drugs can be unhelpful at best and risky at worst. **Kevin Flemen** offers a guide

Our KFx training course Cats, Bees and Dragonflies explores the subject of newer, emerging drugs, and one of the issues we address very early on is the frame of reference. This inevitably brings up the vexed question of what collective terms to use about newer compounds.

For well-rehearsed reasons we should avoid the phrase 'legal highs'. Many of the compounds are no longer legal, and not all are stimulants. There is debate as to whether or not people equate legality with safety, but I am of the mind that 'legal' has connotations of being sanctioned or approved; it suggests legality via permission. As this is not the case, I prefer 'unregulated' as opposed to 'legal'.

The phrase that has become de rigueur among academics and policy experts is novel psychoactive compounds (or substances). It's the phrase of choice for the EU, and the EMCDDA defines it thus:

'A new narcotic or psychotropic drug, in pure form or in preparation, that is not controlled by the United Nations drug conventions, but which may pose a public health threat comparable to that posed by substances listed in these conventions.'

There are a number of problems with this definition, not least that some of the compounds are not that new. Nitrous oxide has been around since the latter half of the 19th century, 4-mmc was first synthesised in 1929 and a lot of the benzo-type drugs doing the rounds at the moment were first synthesised in the 1960s. It also creates the small problem that as soon as the drug is controlled by the UN drug conventions, it ceases to be a novel psychoactive compound (NPC).

More problematically for me, the term has little or no relevance to end users. A resource, service or awareness session referring to NPCs will not register with key target groups. Asking people, 'what NPCs have you used in the last month?' won't elicit the information that I am looking for. It's akin to when the language switched from talking about 'glue sniffing' to 'volatile substance abuse'. The language may be more accurate, but what it gains in accuracy it loses in comprehension.

The other thing that is interesting about all the widely used phrases – 'novel psychoactive compounds', 'legal highs', and 'research chemicals' is that the word 'drugs' is absent. According to Rick Bradley from KCA, presenting at a recent seminar, about 85 per cent of NPS users do not recognise themselves as drug users. The language we have all adopted contributes to the sense that these are somehow distinct from other drugs.

In turn, this linguistic sleight of hand has, to my mind, disempowered drugs workers. The recurrent theme from training sessions is a sense of not understanding this new world of NPS, and these are often experienced workers who can deal with the full spectrum of 'traditional' drugs. Reminding these workers that these are still drugs, much like ones they can and have worked with, does much to overcome this sense of disempowerment.

So, over time, I have tried to find a language that works to address these problems. I found that the phrase 'newer unregulated drugs' worked reasonably well – except when the law changes. What's important is that we have the discussion and explore the role language and terminology plays in constructing paradigms.

LANGUAGE OF ASSESSMENT

What we call our emerging drugs also has a bearing on the assessment process. If we don't ask and prompt about newer drugs, we may not get this information volunteered. And when it comes to newer drugs, this brings with it some very specific challenges.

1. *Not perceiving substances to be drugs*
   As highlighted earlier, there's some evidence that some people may not consider their 'legal' substances to be drugs, so if they are asked about other drugs they may not volunteer emergent drugs.
2. *Unfamiliar with collective terms*
   We want to try and avoid the term 'legal highs' for reasons mentioned, and use of phrases such as novel psychoactive compounds may not have a high recognition factor with young people.
3. *May not be familiar with drug families*
   Routinely we would ask people about (for example) their benzodiazepine use. But asking this doesn't automatically mean that the respondent will link their etizolam use to the use of benzos, and volunteer this as a response. Similarly, although we ask about cannabis use, the respondent may not volunteer that they are smoking synthetic cannabinoids.
4. *May not know what they have used or have misidentified it*
   The emergence of generic slang such as 'legals' could cover a wide range of drugs. Regionally, slang such as 'monkey dust' or 'bubble' could refer to a specific compound such as mephedrone or any unknown white powder. In turn 'mephedrone', once referring to 4-mmc, could now be used interchangeably for other white powder drugs. So assumptions both by user and worker as to what a person is actually using could be both misleading and dangerous.
5. *We don't want to give people a shopping list*
   Especially when working with younger, naïve users, it is important that the assessment process doesn't end up introducing the client to a whole list of substances with which they were unfamiliar. So while initially tempting, an assessment form that either lists or illustrates a wide range of different products is risky. It is still unlikely to be comprehensive – there are so many brands on the market now. But it also risks introducing substances to a client who was hitherto unaware of that compound or family of drugs. We need to prompt, but without exposing the respondent to still more compounds.

'...about 85 per cent of NPS users do not recognise themselves as drug users. The language we have all adopted contributes to the sense that these are somehow distinct from other drugs.'

PROMPTING, NOT PROMOTING

After a numerous training sessions and a number of false starts, a screening process emerged which addressed all my key concerns. It sits alongside an existing standard screen and looks specifically at newer drugs.

Rather than exploring specific substances it looks at types of compound and routes. So for example by asking about smoked substances it can elicit synthetic cannabinoids, kratom, or salvia without naming the substances. Even vague references to 'I smoked something, I'm not sure what it was…' can be incorporated.

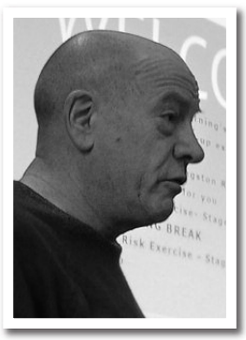
Likewise, by asking about 'white powders' we can explore all the different brands and unbranded substances again, without having to give names. Using the same format, the tool asks about pills and pellets, and other substances (swallowed, inhaled etc) to cover other drug groups.

Another key aspect of the assessment tool links back to the idea that we don't know what the person has used, and a lot of the time, neither do they. The respondent says that they have used 'mephedrone' but we can't be sure that this is the case. It is important to be able to hear their experience of what they used rather than imposing an assumption of how this substance should have felt.

In training we use the drug map to explore the relative location of different drugs. We can use it to explore potency, duration and effects. In the context of assessment it is left blank, so the respondent can describe how the substance affected them – strong stimulant effect, very hallucinogenic, drowsy and so on. This is useful, not least because it ensures that the client can articulate their experience of the substance. It can also highlight where there's a high chance they have used something other than their named substance – where the effects described are at variance with typical reports of that drug.

The assessment tool goes on to explore key issues stemming from use and develop an action plan, and can be downloaded free from the KFx website. (Feedback on its use is very welcome and will help me to revise it.) Ideally use of the tool will be combined with staff training to increase awareness and confidence in responding to newer unregulated drugs. **DDN**

Kevin Flemen runs KFx, offering drugs information and training. For more information and free resources visit www.kfx.org.uk



DOING F

Forget looking to government and corporations for answers to social problems. The answers lie in harnessing the strength within our recovery community, say **Tony Williams** and **Mario Sobczak** of Kingston RISE

We've had a recovery community in Kingston RISE (Recovery Initiative Social Enterprise) since 2011. It has touched about 200 people – some a little, some a lot – supported by two employees and half a dozen volunteers. Each year we've cost less to run than it costs to put one person through treatment.

So what does delivery look like for a recovery community? The bread and butter is our community café, where we meet regulars and new people. We check in together at the start of the week and check out at the end. We take care of each other. But we've done much more: we've acted in plays, played in a band, attended lots of festivals, and walked endlessly in the Surrey Hills. We've done yoga, mindfulness, three principles, and dug an allotment. We learned from each other at RISE College – and we've had fun.

People come and they go, but that's OK. We're not here to keep people locked into a service; we're here to help people get their lives back. Quite a few of them we don't see so much now because they've got jobs. We have measured our effectiveness using a tool by Martin Webber from the Institute of Psychiatry, which captures people's connectedness and their access to resources, before and after. The difference can be significant. But the real measure is in how people behave – they get lively again. It's in their faces, in their voices, when they spark with each other, and when they laugh. What are the ideas that have led us on this journey?

MODERNITY AND AUSTERITY

The modern world has brought us many benefits. We are, as a society, economically better off than the generations of our parents and grandparents. In general, life is easier. However, the modern world has brought us challenges not faced by previous generations, and the symptoms are evident almost everywhere. Obesity, malnutrition, mental illness, domestic violence and addiction are rife. The demise of extended families and the loss of a sense of community have left a significant proportion of society in desperate isolation. These symptoms can often strike together.

Today, faced with any kind of social problem, including the ones above, we typically look to government and corporations for answers. We cannot get those answers unless they are first monetarised, and 'solutions' competed and procured. Efficient processes, selection criteria and measurement become paramount; people secondary. Citizens have been repositioned as 'consumers', either in credit (as purchasers of products) or in deficit (as service users). A 'parent-child' relationship has been set up between those in authority and 'needy' consumers of services – with professionals sandwiched uneasily in between. It is possible today to believe that in the eyes of government, communities are problems to be solved.

Most recently, these issues have become worse because the funding for these 'top down' services has started to become scarce. Whether you believe in the austerity narrative or not, the reality for a substantial part of society – the most vulnerable – typically with a combination of issues such as homelessness, mental illness, addiction, poor physical health, and (underlying all) poverty, is that practical help is becoming harder and harder to find from traditional sources. For this section of community it's possible to see that 'everyone's in recovery from something'.

It's clear we need answers – and it's also clear the current paradigm doesn't deliver them. So what are we to do?

RESILIENT COMMUNITIES

In the recovery movement we are clear that the answers lie in each other, in community, so it is natural that we should look inside ourselves and to each other for answers. Answer number one is that the solution involves reinstating our notions of community. As Cormac Russell, of the Asset Based Community Development Institute, said: 'There are some things community is best placed to do; but we've forgotten how to do it. Government needs to get out of the way and let us do it. And for things community can't do; help them.'

Our notions of community will not, of course, spring into being at once after a 60-year lapse. We need to start by building communities that come together over pressing issues. Later, when we are strong, resilient and mobilised in a variety of ways, the chance will be there to join these communities together. Recovery communities have lessons for the community in general today, about how the cohesiveness we get from shared experience can translate into positive real outcomes that we achieve together. We are not passive, inert consumers of services; we can do things for ourselves. And that makes us, individually and collectively, stronger. We're collaborating with Martha Earley, head of Kingston Council's Equalities, Community and Engagement Team (ECET) to deliver community engagement and change, both within the council and to community groups using our approach and tools.

So how do we find the resources to deliver recovery today? Well, in a world where money is scarce, we use what is to hand that does not involve cash and profits. We are, all of us, endowed with an abundance of gifts – assets. These are the things we know how to do, or the things people we know can do. We've just forgotten to look for them, because we

T FOR OURSELVES

expect them to be provided for us. We need to look first at ourselves and our neighbourhoods for assets which we can make use of, rather than to look at our neighbourhoods as problems to be solved.

RECLAIMING OUR CITIZENSHIP

Next, we need to design our answers together, not have the answers given us from outside. To do this we need to organise ourselves without hierarchies, to be as diverse and open minded as we can – and we should make it fun. Most of all, we who experience the problem have the best understanding of the solution; and more, we need to be the solution. There is a power in recovery, as David Best says, and with this motivation we turn our deficits into assets. To do this involves our empowerment and a repositioning of the relationship between professionals, the deliverers of traditional services, and 'service users' – who in future must be part of the same, flat community. This is not natural for any of the participants and involves the biggest change of mindset. It does, however, work.

Finally, our solutions need to be designed beyond the soulless forms-driven answers that have come to dominate so much of the service delivery we have experienced in the past. We know, for example, that beneath all the symptoms is a loss of wellbeing, and that through community-led action our goal is to restore it. A good broad definition of a healthy life is the 'five ways to wellbeing' and our solutions need to embody those ideas. We believe that in any good answers, the scientific (true) must be balanced with the ethical (good) and aesthetic (beautiful). Today we have to recognise that it is just as important to lift people's hearts as it is to lift them out of poverty.

OUR JOURNEY TOGETHER

Where is this all going? The challenge today is to broaden the debate on these ideas and to use them practically. We are actively seeking your involvement in their development. Any products we create on this journey we intend to provide free to other community groups. We hope that you will do the same. The first step on the journey is a common understanding and a common terminology. To read more on the ideas in this article, see the references below. The next step is to talk to us, and to each other.

FURTHER READING:

Core Economy (Cahn, 2006); Asset Based Community Development (ABCD, McKnight, Building Communities from the Inside Out, 1993); Co-production (NEF, 2008); Five ways to wellbeing (NEF, 2008); Afternow; the Good, the Beautiful and the True (Hanlon, 2013); Recovery capital (Best, 2010).

'RISE is an excellent example of applying sound academic theory and emerging evidence-based practice in creating a caring and meaningful recovery community. The work they are doing is truly outstanding and should be an example of innovation in community development and co-production for and beyond the addiction recovery movement in the UK.'

DR DAVID BEST, ASSOCIATE PROFESSOR OF ADDICTION STUDIES AT TURNING POINT / MONASH UNIVERSITY

Recently retired substance misuse manager for Bristol City Council, Sue Bandcroft, reflects on decades of change in the sector. By **David Gilliver**

Spann

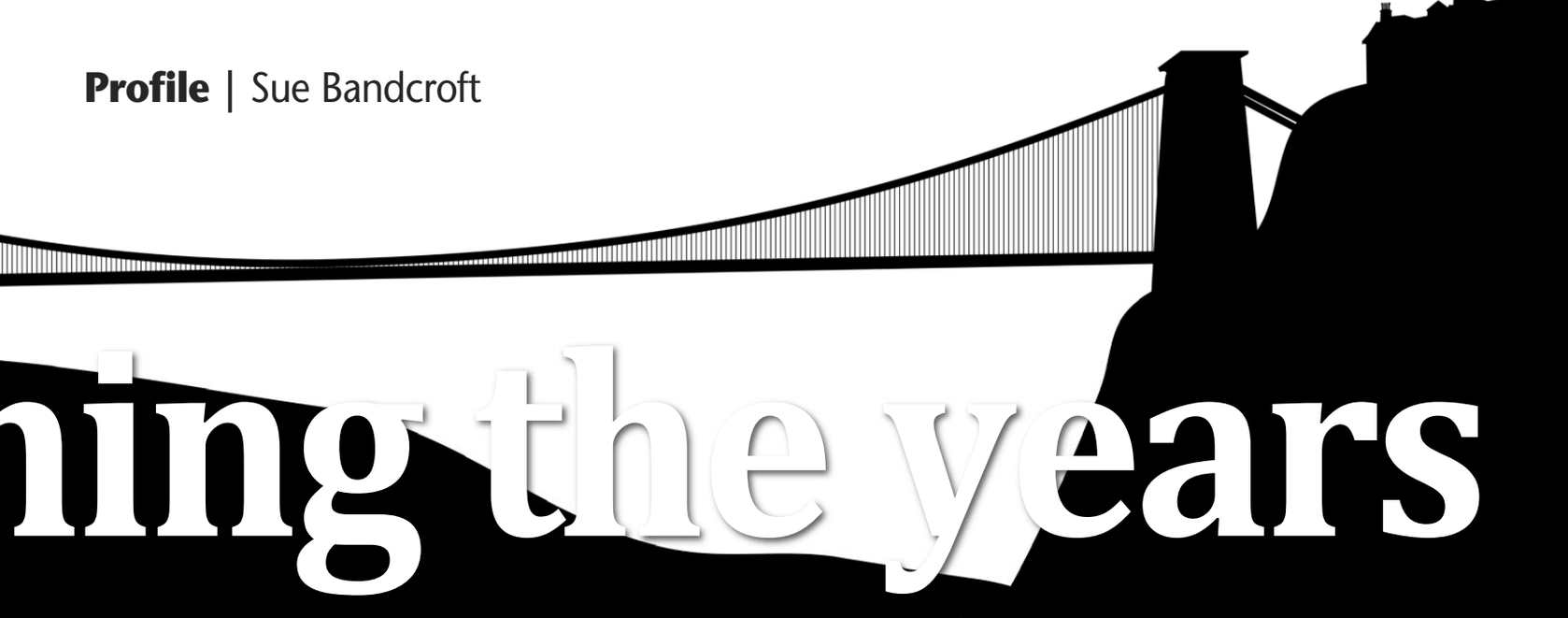
'There's nothing like the sun shining to make you think how nice it is not to have to worry about going into work, but I do miss it,' says Sue Bandcroft. 'So I'm starting to look around for something else to get involved in.'

Although she retired as substance misuse manager for Bristol City Council in May, she's been helping to finish off work around a framework for residential rehab services in the city. 'I'm still dabbling in there, as it were, but I'm trying to say, "I have to let them get on with it" now. I'm just looking at whether I should be still involved in the field, or are there other things I can get involved in? A bit like someone who's been a service user for a long time – you start to see that actually there are other things in life.'

It's a field she first came into in the 1980s, but it was while working as a nurse in London in the early '70s that she really became aware of the impact that drugs and alcohol could have. 'Even before that, at school, I had friends who'd had not pleasant experiences around drug use,' she says. 'So it had always been around.'

While nursing she became involved in health and sex education in schools, and later HIV prevention work. 'When I came to Bristol I was very much on the sexual health side, and in those days they had things called HIV prevention coordinators, so when the money came along I had responsibility for the drugs budget of that. One of the few things to thank Mrs Thatcher for was actually funding those sort of things.'

'There has to be a realism about the tight constraints, and workers do a disservice to their clients if they don't look at what's happening in the rest of the world with all the welfare reforms.'



ning the years

Her involvement in the sector then 'just went from there', she says. Before becoming substance misuse manager – a post she held for just under ten years – she'd worked in the PCT. 'I feel incredibly lucky to be able to have been in on the birth of something. When I was first involved it covered a much wider area of responsibility and [the budget] was less than half a million. When I left Bristol we had a budget of over £15m for drug services, so it's been a massive growth which has been wonderful to see. And now really we've got to consolidate and move forward together, rather than in this desperate way of everybody fighting each other.'

*****

It's well documented that the challenges facing the field are changing, with fewer people using heroin and crack and growing problems with newer substances. Bristol, however, was seeing acute problems with ketamine use long before it became a significant issue in many other places, partly connected to the city's well-established squatting scene. 'There's that, and also where it's placed geographically,' she says. 'Bristol is very much the gateway to the South West with very good links to lots of other places.

'When I was first involved, there was no voluntary sector drugs service,' she continues. 'I was involved in putting together the bid for the Department of Health for a very small sum of money to start what has become Bristol Drugs Project (BDP), which is now a massive voluntary organisation providing services. So we've always worked, if you like, bureaucrats and providers together, across the voluntary and statutory sectors, and core to that has been working with service users very much at the centre.'

There's also been a culture of 'trying to see what was coming next', she points out. 'So ketamine was about working with urologists, and we also had someone working in Bristol prison way before the days of a national prison drugs strategy. It was about all partners working together, getting early warnings about what's happening and then looking at developing responses. We had an integrated maternity service with social workers, specialist midwives and the voluntary sector very early on, and I personally visited virtually every GP surgery in what was then Avon and got about six GPs to start prescribing – now about 95 per cent of practices prescribe. So we always tried to look at what's coming and prepare for it, not wait for some directive from somebody like the NTA to tell us to do it. In fact sometimes they'd tell us not to do things.'

Did she take any notice? 'I'm not a person who does what I'm told unless I think there's plenty of evidence for it,' she says.

As someone responsible for commissioning services, obviously the last few years would have been to some extent defined by the squeeze on budgets and the austerity agenda. How much of an impact did that have on a day-to-day basis? 'I think I've been very lucky in that we were able to have what I believe was a truly joined-up budget, so that health put its money into the local authority, and NHS-type services were commissioned alongside housing, alongside money from the probation services, alongside money from the police, and also, sometimes, a bit from the prison service,' she says.

The result was a pooled budget that allowed the commissioning of genuinely joined-up services, she says. 'The budget grew, most of the time, and we always planned in terms of looking at what happened when that pot of money ended. I do think budget constraints mean that you do focus on what's core and what works, and make you look at re-designed services so you don't get complacent. I know it's really hard in terms of having to tender for services, but it also does sharpen up services an awful lot. There can be quite a bit of complacency about what's offered.'

A recurrent challenge, she states, was trying to 'break down some of the legislation that made it quite difficult to do things', despite that well-established culture of joint working. 'We worked very closely with the police and looked at how things could be done rather than why you couldn't do them – with the needle exchanges and things like that – and some of our biggest supporters were the police. So in some ways it's about finding the right person in the right place in some of the statutory organisations and then picking your way through the bureaucracy and the legislation. Rather than just going "oh no, you can't do it", it's about trying to find a win-win way. And, obviously, when you can't do anything, recognising that and moving on.'

Overall, what have been the most significant changes she's seen in the sector? 'Money's an easy one. But also, although it's still stigmatised, there's much more recognition of this being a health issue. And then there's also the recognition that one of the things that got us additional funding was the links to criminal activity, so actually this has been the shift – the joint working of organisations, rather than "us and them".'

All that has gone alongside a recognition of the value of harm reduction, she says, as well as 'looking much more at self-help and supporting people to make changes themselves, rather than telling them to make changes. It's a subtle shift but I think it's quite different. I hate the term "empowerment" but I think that is the thing. That's what my inspiration is, seeing people making changes and developing, and not being – or labelling themselves – a service user or drug user any more.'

*****

When Adfam published its report on OST and safeguarding children (*DDN*, May, page 4) she said that the sector often hadn't been very good at looking at people in terms of couples or relationships, let alone families (*DDN*, June, page 6). Does she think there's any sign of that starting to change?

'I think it is, but for a long time the view was of the service user just as an individual. You might look at what else was happening in their life, but there was almost a sense of dismissing families as part of the problem – and sometimes they are. There's a greater recognition of carer support, "significant others" – I hate these terminologies, but people who are close to people – and more joint working around those things. But I do think there's a long way to go in terms of really thinking about what children's experiences are.'

So is she optimistic about the sector's future? 'I'm optimistic if it doesn't get engaged in infighting and sitting in one camp or another. Individuals need lots of different approaches. I do think the growth of recovery communities is very positive and I'm really pleased to see initiatives like SMART being taken forward, so it's not one particular dogmatic approach or the other.'

Some of those divisions do seem to be finally breaking down now, though. 'I think it's quite slow, and I think there's quite a lot of language attached that's quite stigmatising,' she states. 'So I am optimistic but I do think there has to be a realism about the tight constraints, and workers do a disservice to their clients if they don't look at what's happening in the rest of the world with all the welfare reforms and so on. That's what daily living is going to be for people and we do need to get involved in those sorts of discussions.'

Her main message, however, would always be 'work together', she stresses. 'Don't fight each other, because this is a critical time. As with all public sector funding, this isn't about us and them. We've got to make the most of it, because it's the service users who'll lose out.' **DDN**

Now one of the oldest abstinence-based treatment centres in the UK, Broadway Lodge is celebrating 40 years of offering treatment for a variety of addictions. **Karen Kirby** shares the steps they have taken to adapt and thrive

STILL GOING STR

In 1974, Travis Cousins, then the director of the Bristol Council of Alcoholism, and Dr Dan Anderson, the principal of US treatment facility Hazelden, got together and came up with an idea to create a non-profit treatment centre that would offer support and counselling to individuals struggling with addiction.

Broadway Lodge opened its doors to eight clients in October 1974, with the objective of providing treatment for a number of different addictions, including everything from alcoholism and drug dependency to eating disorders, gambling and gaming.

Back then, treatment centres and therapeutic communities were only just beginning to develop in the UK, offering a new approach to support those struggling with addiction issues. The charity's approach to recovery was client-centred, based on a 12-step model with abstinence as its core. It was the first centre in the country to provide treatment based on the Minnesota model, and the organisation now has more experience than any other agency in the country at working with this programme.

Throughout the years, staff have developed an innovative approach to treatment, creating a 24-hour medical in-house team so we could take in service users with complex medical issues. Responding to clients' needs, we have developed units to support those in recovery throughout their journey, so the facilities include two single-sex units for those who need space away from a mixed-gender environment, and third-stage houses that aid recovery in the community.

Today, we employ more than 100 people and treat more than 500 people each year, and are proud of our reputation. Our CEO Brian Dudley says, 'It never ceases to amaze me that wherever I travel for conferences, both in this country and abroad, people approach me and say, "I went through the 'miracle mansion' 20 odd years ago".'

Our former clients are spread across the country, and we often receive updates on their lives and personal memories of their time in treatment. One such individual, who came to us in 1987, wrote that they were 'broken and desperate', and willing to try anything to combat their addiction.

'I had no understanding of addiction and no concept of "recovery" – I had never met anyone who had stopped using and rejoined society,' he told us. 'The people at Broadway Lodge seemed to know how to recover, so despite my incredulity at some of what they told me, I followed everything that was suggested.

'I did a most thorough step one, searching my wounded memory for examples of how I had been controlled and driven by the drugs and how my life had become completely unmanageable. I attribute, in part, the longevity of my recovery to the deep understanding this gave me about my relationship with drugs and the consequences of my using.

'Broadway Lodge gave me the solid foundation for a lifetime of recovery – full freedom and independence, and a rich and fulfilling life. The first five steps on which I worked during the five months in treatment gave me a platform for a life of self-discovery and growth.

'For me the gifts of recovery are manifold. There are numerous external signals of recovery; a passport and worldwide travel, an education, the ability to support rather than distress my family, respect in society and many more facets of a life that goes beyond any expectation I had when I was a slave to the addiction. But the most profound and rewarding transformation has been effected internally – an inside job.'

In 2012, we won the Independent Specialist Care Provider of the Year, which highlights good work and innovative thinking in the UK specialist care sector. Building strong partnerships with other organisations has been a key part of our ongoing innovative strategy. Keen to evolve effective aftercare, we set up the Recovery Centre with support from the Department of Health, and work alongside the Carlton Centre, Voluntary Action North Somerset (VANS), Weston Works and Alliance Homes to support clients with educational, training, employment, and housing needs. The centre provides a peer support and mentoring scheme, training volunteers who are in recovery and providing them with the skills to provide structured assistance to others. Our staff offer a number of activities, such as weekly football sessions that allow participants to get fit, have fun and meet others in recovery.

Diane Smith started at the Recovery Centre on the aftercare programme, then came back to the centre a year ago as a volunteer, helping on reception, becoming a support worker and taking on acupuncture sessions. 'I loved the support I received from clients and staff alike,' she told us. 'I lacked confidence and was always encouraged to keep pushing forward. I have gained so many valuable skills.'

Each and every one of Broadway Lodge's employees and clients has brought something different to the table, enabling us to constantly learn, evolve, and find new ways to help people.

Our ongoing aim to share knowledge and good practice has opened new opportunities for partnership working. We continue to run a schools programme that challenges stigma by tackling pre-conceived ideas about addiction. Clients and staff go into local schools and educate both students and teachers about the negative consequences of drug and alcohol misuse, as well as combating the stigma associated with those in recovery. Our staff also offer their expertise to local police and probation services, raising awareness and offering insight into the issues surrounding addiction.

ONG

'Each and every one of Broadway Lodge's employees and clients has brought some-thing different to the table...'

Other initiatives include the 'recovery renewal' programme, which encourages clients to participate in a number of therapy sessions and group activities that encourage personal development and reinforce recovery. A family programme works in conjunction with this, allowing family members and carers of those in recovery to come forward and share their experiences with others who understand what they are going through.

Our milestone anniversary has inspired us to create a programme of festivities, from a golf day and kayak race earlier in the year, to a reunion celebration and a black-tie evening with rugby union player Gareth Chilcott as a guest speaker.

Buoyed by all those who have made it a success, Broadway Lodge will continue to expand, evolving with its clients and offering specialist support where it's needed. Here's to the next 40 years! **DDN**

For more information on the events being held by Broadway Lodge to mark its anniversary, visit www.broadwaylodge.org.uk/events

'BY OUR SILENCE WE LET OTHERS DEFINE US'

In the run-up to the UK Recovery Walk this month, **Annemarie Ward** looks at how far the charity has come and where it's heading

THE UK RECOVERY WALK CHARITY exists to spread the message that 'prevention works, treatment is effective, and recovery is a lived reality in millions of people's lives'. Our primary purpose is to deliver these messages of hope to the cultures of addiction in our treatment systems and communities, and the charity's leaders are all people who are in long-term recovery from addiction. In order that we don't get diverted from our primary purpose we are not involved in mental health advocacy and wider social justice issues. We have no opinion on political and philosophical ideologies, different approaches to community development and public health, or whose truth is better and more beautiful than anyone else's.

Since our formation in April 2013 we have brought the film *The Anonymous People* to more than 40 locations throughout the UK to raise awareness of our mission, and so far we have been able to sign up nearly 700 members. We have also developed various resources to help mobilise, support and unify the UK recovery movement, all of which are free to download from our website, including *Advocacy with anonymity, using your story, top tips for media, and recovery community organisations' toolkit*.

During the past year we have co-produced the 2014 UK Recovery Walk with the Greater Manchester Recovery Federation and in addition we have:

- *Developed two training courses: 'Our stories have power' with accompanying Q&A booklet, and The 'UK Recovery Coach Manual', complete with training exercises. (These can all be downloaded free from our website.)*
- *Launched the Association of Community Recovery Organisations (ACRO), inspired by Faces and Voices of Recovery in the US.*
- *Launched The 'Give it back' campaign (every September) – a national and regional media campaign to showcase examples of individuals and groups in long-term recovery voluntarily giving something back to their local communities.*
- *Organised our sell-out conference, 'Advocacy in Action' (the day before the UK Recovery Walk) in partnership with Manchester Metropolitan University, which we hope will inform, inspire and guide our own movement.*

The UK Recovery Walk charity is the only organisation in the UK with an explicit mission to respond to the organisational and leadership development needs of grassroots addiction recovery community organisations, and to develop and unify addiction recovery advocacy in the UK. Why not visit our website at www.ukrecoverywalk.org and even join the charity (it's free!) and support our work for the next year, when our priorities will be:

- *Co-producing the 7th UK Recovery Walk in Durham in September 2015.*
- *Developing non-stigmatising, evidence-based narratives for the recovery advocacy movement to engage the public and policymakers.*
- *Advocating for the promotion of laws and social policies that reduce alcohol and other drug problems and support recovery for those suffering from addiction to them.*
- *Organising and supporting local and national advocacy campaigns.*
- *Further developing the Association of Recovery Community Organisations to support local action.*
- *Developing a leadership forum to increase leadership capacity and capability in the UK recovery movement.*

We look forward to seeing you at the 6th UK Recovery Walk in Manchester on 13 September to celebrate the achievements of individuals in recovery, and acknowledge the work of prevention, treatment, and recovery services.

Annemarie Ward is CEO of the UK Recovery Walk charity, www.ukrecoverywalk.org

EXPRESSIONS OF INTEREST

HARTLEPOOL BOROUGH COUNCIL

Adult and Young People's Substance Misuse Recovery Support Service

HBC Contract Reference Number: 754-14
NEPO Contract Reference Number: 9MNE-LYQDU7

Hartlepool Borough Council are seeking expressions of interest from suitably qualified, experienced and competent organisations to deliver a comprehensive range of recovery support services for substance misusing Adults and Young People within the Borough of Hartlepool.

The successful provider will be required to work alongside other organisations in a fully integrated, local treatment model and will be required to develop and deliver innovative practice that incorporates recommendations within NICE Guidelines and the Medications in Recovery Report to effect improvements in positive outcomes which are aligned to the Recovery and Reintegration agenda.

Initially the contract will be awarded for a period of 2 years, commencing April 1st 2015 and may be extended at the absolute discretion of the Council, for an additional 2 x one year extension periods, subject to future commissioning intentions, satisfactory performance and the availability of funding.

Services to be delivered, as a minimum but not wholly restricted to, will be as follows: Psychosocial Interventions, Recovery and Reintegration Support, Harm minimisation and Needle Exchange, Relapse Prevention, Education, Training and Employment Support, Housing Support, Family and Carer Support, Young People's Substance Misuse Services, Criminal Justice Interventions and Aftercare.

Full details relating to the service required will be provided in the Invitation To Tender (ITT) documentation. Organisations wishing to register interest and download tender documentation, which will go live on 8th September 2014, should apply via the North East Portal. www.qtegov.com.

If you require assistance with registering please email karen.burke@hartlepool.gov.uk

INVITATION TO TENDER

The Buckinghamshire Drug and Alcohol Action Team (DAAT) invite tenders for the provision of a

FAMILIES & CARERS SERVICE FOR THOSE AFFECTED BY SOMEONE ELSE'S SUBSTANCE MISUSE

(Ref: 9NDC-VUSXWQ)

The contract is offered, subject to annual review and ongoing funding, for a period of 2 years with a possible 1 year extension period.

The Council uses the South-East Business Portal to advertise tender opportunities and run its tender processes. In order to access these opportunities you will need to register on the portal. This is quick and free to do and will give you access to opportunities advertised by local authorities across the South-East region.

The website address is:
http://www.businessportal.southeastiep.gov.uk

The closing date for the receipt of tenders is 12.00pm on Friday, 26th September 2014.

Families First

The 3rd Adfam/DDN family conference

Adfam
Families, drugs and alcohol

DDN
Drink and Drugs News

Putting families at the centre of recovery

The essential diary date for family members affected by substance use and for all agencies and organisations who genuinely want to support them.

Early bird delegate rates for bookings before Friday 19 September

Family members – £80+VAT
Professionals – £135+VAT
Joint ticket special offer:
One family member plus one professional – £195+VAT (save £20)

Book at www.drinkanddrugsnews.com
e: conferences@cjwellings.com • t: 01233 633315

PROGRAMME

9.00 – 10.00AM **REGISTRATION, TEA AND COFFEE**

10.00 – 11.20AM **SESSION ONE**

VIVIENNE EVANS OBE, CEO ADFAM : A retrospective of the last 30 years of family support.

MICHAEL O'KANE, PUBLIC HEALTH ENGLAND – SUPPORT FOR CARERS: The importance of family members in recovery. What does the care bill mean for carers of those with drug and alcohol problems?

EMMA – A FAMILY MEMBER'S PERSPECTIVE: A daughter describes the impact of prescription drugs on her mother and the effect on their relationship.

11.20 – 11.40AM **TEA AND COFFEE**

11.40AM – 12.45PM **QUESTION TIME PANEL**
A lively interactive panel discussion chaired by Radio 4's **EDDIE MAIR**.

12.45 – 1.45PM **LUNCH AND NETWORKING**

1.45 – 3.00PM **SESSION TWO**

PROPS – FAMILY SUPPORT: A BRAVE NEW WORLD. Examining current challenges for family support providers, and looking at ways to meet clients' needs in a world of competitive commissioning, with **CLARE ROBINSON**.

CNWL – DRUG TRENDS. Looking at the use of legal highs and new psychoactives, and how to identify problematic use, with **ANNETTE DALE-PERERA**.

ONLINE SUPPORT: HOW TECHNOLOGY CAN HELP. A look at innovative ways that family members can gain advice and support in a virtual world.

3.00 – 3.20PM **TEA AND COFFEE**

3.20 – 4.00PM: **SESSION THREE**

LUCIANA BERGER, SHADOW MINISTER FOR PUBLIC HEALTH: How families can fit within the policy framework.

VIVIENNE EVANS OBE, CEO ADFAM: Close.

Adfam's photo exhibition, '30 faces from the other side of addiction', will be on display throughout the conference.

Thursday, 23 October 2014 – CENTRAL LONDON