INSIDE – TRAINING AND DEVELOPMENT DIRECTORY

DDN
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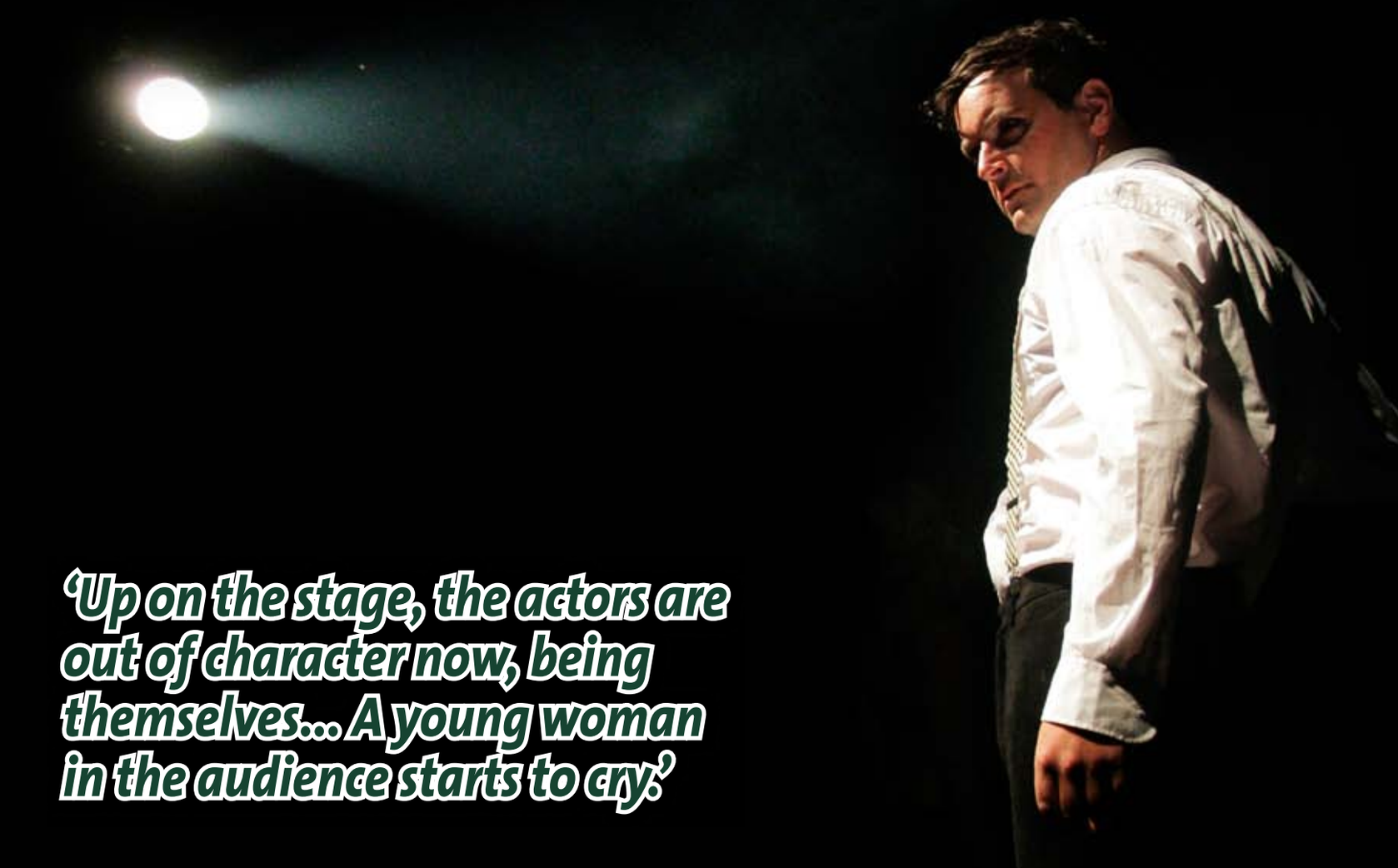
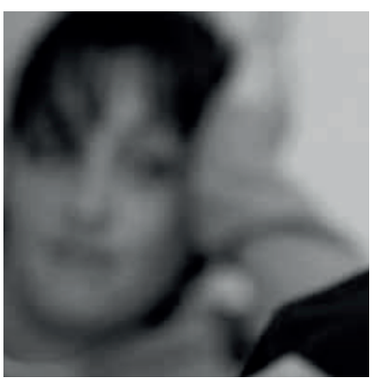


'Up on the stage, the actors are out of character now, being themselves... A young woman in the audience starts to cry.'

STAGE STRUCK

THE POWER OF THEATRE AND PERFORMANCE TO CHANGE LIVES

SUPPORTING YOU, SUPPORTING YOUR CHOICES



The NTA is committed to working with service users and to promoting a balanced treatment system that helps you on your road to recovery.

We are proud to support DDN's Together We Stand conference.

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DDN Drink and Drugs News

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Two-way street

Service user involvement gives a chance to engage

When a Bournemouth theatre looked at putting on an educational play about addiction, the director realised she needed the input of those who had 'been there'. The venture that emerged, Vita Nova (page 8), completely exceeded expectation, opening doors to engage not only with schoolchildren, but with police and local services. As well as making their mark on the difficult territory of young people's education, those involved in the group have also had chance to expand their own horizons with educational projects and creative learning – an inspiring example of two-way service user involvement that's life changing in many respects.

Mel had a very different experience of the personal and professional coming together when, as an addiction therapist, he found himself faced with the alcohol-related death of his brother (page 16). The usual family feelings of helplessness were further magnified by not being able to use his knowledge to stop the clock, and we thank him for sharing such a painful memory. Release's new executive director, Niamh Eastwood, is featured in our profile interview this month (page 18). You can meet Niamh, Dr Chris Ford (Post-it, page 11), Ken Stringer (page 12), Dr Steve Brinksman (Soapbox, page 23) and others with plenty to say about the vital role of service user involvement, at our conference in Birmingham on 16 February – hope to see you there!

This issue

FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: JOBS, COURSES, CONFERENCES AND TENDERS

News in Brief

GET BRIEFED

A new briefing paper on the 'issues and challenges for the delivery of drug interventions in the new public health system' has been published by UKDPC. *Illicit drugs and public health in 2012* is based on a workshop involving local directors of public health and representatives of central government. 'While some rebalancing of resources, particularly towards greater integration of treatment for alcohol and drug dependence, is likely to be of benefit, it is important that this is not done in such a way as to jeopardise the gains made in tackling drug problems,' it states. *Available at www.ukdpc.org.uk*

CABLE CALL

Alcohol Concern has written to business secretary Vince Cable calling for a specific policy on alcohol issues in the workplace to be included in the Corporate Governance Code, which sets out the responsibilities of companies listed in the UK. Alcohol-related absenteeism and lost productivity is estimated to cost the economy up to £6.4bn a year. 'Companies simply have to address attitudes to alcohol and drinking behaviours,' said chief executive Eric Appleby.

IT SUCKS

Suck & Blow alcoholic jelly tubes have been judged to breach three separate alcohol responsibility rules by the Portman Group's Independent Complaints Panel. It ruled that the product's name had clear connotations with sexual activity, that its bright packaging and 'childish font' would appeal to under-18s, and that its design – a tube designed to allow people to blow the contents into another person's mouth – encouraged rapid drinking. Another product, Crunk Juice, has been found to breach the responsibility code for encouraging excessive consumption and failing to make the alcoholic nature of the product clear on its packaging.

VOLUNTEERING VOICES

A new toolkit, *Real voices in volunteering*, has been produced by Adfam for use by volunteers, volunteer managers or anyone considering these roles. The toolkit brings together volunteering material, drug and alcohol information, and the experiences of service users and their families. *Available at www.adfam.org.uk*

Treatment to be 'key measure' of health improvement

'Successful completion of drug treatment' will be one of the 'desired outcomes' when Public Health England becomes operational next year. The measure is one of 66 national indicators included in the government's new *Public health outcomes for England*.

The measures are split into four domains of 'improving the wider determinants of health', 'health improvement', 'health protection' and 'healthcare, public health, and preventing premature mortality'. The drug treatment measure forms part of health improvement alongside 'alcohol-related admissions to hospital' and 'people entering prison with substance dependence issues who are previously not known to community treatment'.

The measures will be used by local authorities to track their progress in tackling key public health challenges, with Public Health England publishing data to monitor performance. From April 2013, councils will receive a ring-fenced budget – a share of around £5.2bn – and will be able to choose how they spend it 'according to the needs of their population', says the Department of Health, with those that make the most improvements receiving extra cash in the shape of a 'health premium'.

The drug treatment indicator will be based on the number leaving treatment 'free of their drug of dependency' and who do not re-present within a six-month period. The inclusion of the indicator was a welcome development that gave the treatment sector 'a national benchmark for measuring recovery for the first time', said NTA chief executive Paul Hayes.

'Every area of the country is different so councils will be able to decide what the most important public health concern is for them and spend the money appropriately,' said health secretary Andrew Lansley. However, at last year's DDN/Alliance conference in Birmingham, Paul Hayes acknowledged that drug and alcohol treatment would have to fight for its share of the cash against competing interests, with the possibility that it would not always be a priority. 'In straitened times is there a risk involved in moving money locally? You bet there is,' he told delegates. 'But we have to win these arguments.'

Agency chair Baroness Doreen Massey said in a statement that although Public Health England takes over the NTA's functions from next year, the agency was 'confident that the work we are doing now will secure the continued success and future of drug treatment and recovery services'. The NTA had been engaging with local authorities to make the case for treatment, she said, including using a new presentation, 'Why invest?' to show how treatment 'benefits individuals, strengthens families and makes communities safer'. The Faculty of Public health has also warned that the government needs to ensure that the health premium does not mean vulnerable groups, like homeless people, are 'penalised for being harder to reach'.

Why invest? available to download at www.nta.nhs.uk

Minimum pricing research questions 45p impact

An updated report from the University of Sheffield has suggested that a minimum price of 45p per unit of alcohol would have less of an impact than when researchers first reported on the issue in 2009, because of a slight increase in prices and slight decrease in drinking rates.

The Scottish Government named 45p as its minimum price in an amendment to its Alcohol (Scotland) Bill (*DDN*, 13 September 2010, page 4). However, new data sets show a 'slight reduction in mean alcohol consumption at the total population level' along with slight reductions in the proportion of the population classed as harmful or hazardous drinkers. At the same time, prices have risen, meaning the proportion of alcohol bought at less than 45p per unit fell from 72 per cent in 2009 to 69 per cent for beer/cider, 53 per cent to 48 per cent for wine, and 76 per cent to 72 per cent for spirits.

The revised report looks at a range of minimum prices – from 25p to 70p – with and without a corresponding ban on promotions. Even under the revised predictions, however, it found that a 45p minimum price combined with a promotions ban would see overall weekly consumption across the country fall by six per cent, with alcohol-related deaths falling by around 60 in the first year, up to around 300 a year after a decade. It predicts a fall in general hospital admissions of 1,660 in year one and 6,630 by year ten, along with 3,600 fewer offences per year.

While harmful drinkers would pay an extra £132 per year, moderate drinkers would pay just £9 more, it says. 'For all minimum price scenarios, with or without the presence of an off-trade discount ban, the majority of the health and healthcare benefits come from the harmful drinking group,' it states. The government will announce its new minimum pricing level in the spring.

'There is a clear link between the price of alcohol and consumption levels which is why we always intended to introduce a minimum price alongside the quantity discount ban,' said health secretary Nicola Sturgeon. 'The support in favour of minimum pricing is now overwhelming, and I hope that this time around Scotland's MSPs will do the right thing and back this policy.'

Meanwhile, new figures from the Office for National Statistics show a slight increase in alcohol-related deaths in the UK overall, rising from 8,664 in 2009 to 8,790 in 2010. Around 64 per cent were the result of alcoholic liver disease. Death rates in males aged 55-74 showed a 'sharp and statistically significant' increase from 41.8 per 100,000 population to 45.2. Although rates of alcohol consumption have been declining, it will take a number of years for any reduction in alcohol-related deaths to become apparent, says ONS, given the amount of time it takes alcoholic liver disease to develop.

The British Liver Trust has also launched a report stating that people with alcohol problems should not 'treated with a one size fits all abstinence approach'. Staff should work with clients to 'understand their preferences in setting goals to reduce their alcohol harm', it says.

www.sheffield.ac.uk/scharr/sections/ph/research/alpol/publications; www.ons.gov.uk; www.britishlivertrust.org.uk

More lenience for 'drug mules' in sentencing guidelines overhaul

People coerced into drug smuggling by organised criminals are likely to face shorter prison terms under new guidelines issued by the Sentencing Council.

The 'starting point' for sentences for drug mules, however, will still be six years, as opposed to the previously-recommended ten. People guilty of 'large-scale production', meanwhile, are likely to face longer sentences.

The guidelines are designed to help ensure 'consistent and proportionate' sentencing in English and Welsh courts – both magistrates' and Crown Court – and follow a major public consultation launched last year (*DDN*, April 2011, page 4). The council also carried out separate research into public attitudes, which found 'little support' for custodial sentences for possession or for 'substantial' sentencing for small-scale supply.

Under the guidelines, an offender's culpability should be determined by whether their role was 'leading' – defined as organising buying and selling on a commercial scale; 'significant', meaning an 'operational or management function within a chain', or 'lesser', meaning someone who was intimidated or naïve. The guidelines also set out four categories of harm, depending on the drug and the amount, and introduce an aggravating factor for supply offences so that those found guilty of dealing to people under 18 are treated more severely. The council was forced to issue a statement clarifying the definition of 'drug mule' after some newspapers ran 'drug dealers to escape jail' stories (*see news focus, page 6*).

'Where an offender profits from selling drugs, a prison sentence can be expected', the guidelines state. In terms of supply, however, they do make provision for drug users who may buy small amounts to share with friends – 'for example joint purchase for no profit, or sharing minimal quantity between peers on non-commercial basis' – in which case a community order could potentially apply. The council cites an example of two students who split the cost of 20 ecstasy tablets to share, and also recommends that medical use of cannabis for serious conditions should be a mitigating factor.

'Drug offending has to be taken seriously,' said the council's deputy chairman Lord Justice Hughes. 'Offending and offenders vary widely so we have developed this guideline to ensure there is effective guidance for sentencers and clear information for victims, witnesses and the public on how drug offenders are sentenced.'

DrugScope, which has campaigned for a review of sentencing for drug mules, said that while it remained concerned that sentences could still be lengthy, the guidelines were a 'positive step forward'. 'DrugScope has long had concerns about the numbers of women involved in low level supply and other offences as a result of violence and intimidation: far too many end up in the courts and in our prisons,' said chief executive Martin Barnes, adding that the organisation hoped that more judges would feel able to refer people for treatment. 'Good quality treatment is instrumental to breaking the cycle of drugs and crime which blight the lives of many individuals and communities.'

Release, meanwhile, stressed that the range of sentences available for non-violent drug offences remained 'disproportionately harsh'. 'The starting point for an importation offence for a medium amount of class A drugs is 11 years under these new guidelines, yet the offence of rape carries a starting point of five years and grievous bodily harm three years,' said executive director Niamh Eastwood. 'It is outrageous that a rapist will receive a significantly shorter sentence than someone who is a mid-level drug dealer.'

Full guidelines at sentencingcouncil.judiciary.gov.uk/guidelines/forthcoming-guidelines.htm

See page 18 for a profile of Release executive director Niamh Eastwood.

Afghan opium exports '15 per cent of GDP'

Potential export earnings from Afghan opium could be worth around US $2.4bn, equivalent to 15 per cent of Afghanistan's GDP, according to a report from the United Nations Office on Drugs and Crime (UNODC).

The full version of the *Afghan opium survey for 2011* shows a 133 per cent increase in the 'farm gate' value of opium, compared to the previous year. Sixty per cent of the farmers surveyed said their main motivation was the high value of poppy cultivation, with the gross income from opium now 11 times more than that from wheat.

A preliminary version of the report released last year showed a 7 per cent increase in cultivation compared to 2010 (*DDN*, November 2011, page 4). Much of the 2010 yield was wiped out by plant disease (*DDN*, 11 October 2010, page 4), and although higher prices were expected in 2011, the values 'far exceeded expectations', says UNODC. Around 90 per cent of the world's opium comes from Afghanistan. 'Opium is a significant part of the Afghan economy and provides considerable funding to the insurgency,' said UNODC executive director Yury Fedotov.

Poppy field in Kandahar: Opium poppy cultivation in Afghanistan increased by seven per cent and prices by 133 per cent, according to UNODC.
KeystoneUSA-ZUMA/Rex Features

News in Brief

TONGUE TRIAL

A new £1m addiction recovery clinic in Lambeth, south London, is to launch a three-year opiate treatment trial, the South London and Maudsley NHS Foundation Trust (SLaM) has announced. Six hundred people will be prescribed a buprenorphine-naloxone combination therapy, delivered in a small film to be dissolved under the tongue, alongside a range of psychological therapies. Research at SLaM also played a key role in the Department of Health's acknowledgement that injectable opioid treatment was a 'clinically effective second line treatment'.

HERTS AND MINDS

Westminster Drug Project (WDP) and domestic abuse charity Safer Places have been awarded £900,000 Big Lottery funding over three years for One Herts – One Family, a Hertfordshire-based project to provide early interventions to children under 11 and ensure joined-up support for families. 'We know when different service providers all come together to support a family in a coordinated and integrated way, it measurably improves the life chances for those children,' said WDP chief executive Yasmin Batliwala.

OVERDOSE APP

A new smartphone app that gives information and emergency advice about what to do in an overdose situation has been launched by U-Turn. *Available to download at www.u-turntraining.com/apps*

REPORT A CUT

Voluntary or community groups that have been told their statutory funding will be reduced are invited to share their story by filling in a simple form *voluntarysectorcuts.org.uk*, a collaborative project designed to map the cuts and their impact across the country. Contact details will not be made public.

ACCESS ALL AREAS

A new 'one-stop shop' for people with drug and alcohol issues has been opened in Edinburgh. The South East Recovery Hub brings together services provided by Edinburgh council, NHS Lothian and the voluntary sector in a single point of access. 'This new way of working also removes waiting times for appointments and makes the services much easier to access,' said Edinburgh Alcohol and Drug Partnership chair, Peter Gabbitas.

TOWARDS A FAIRER SYSTEM OF DRUGS SENTENCING?

New guidelines on sentencing people for drugs offences are intended to make the system fairer. **DDN** considers whether they do, and if the press has missed the point – again

'Soft justice on drugs' said the *Daily Mail*. Over at the *Telegraph*, meanwhile, it was 'Drug runners and dealers could avoid prison even if caught with heroin, cocaine or thousands of pounds worth of cannabis'.

Well, not quite. Once again it seems large sections of the press have either misunderstood – or wilfully misinterpreted – a story about drugs. The new Sentencing Council guidelines – for judges to follow when sentencing people for drugs offences – are designed to ensure proportionate and consistent sentencing throughout England and Wales (*see news story, page 5*), and are described as 'definitive' in that they bring together guidance for the courts for the first time.

The most significant point is that drug 'mules' will receive shorter sentences, and high level production offenders will get longer sentences, although to read some of the papers you'd think class A drugs had been legalised overnight.

Indeed, even when the Sentencing Council first announced it was holding a consultation on sentencing and intended to distinguish between those in 'leading' and 'lesser' roles (*DDN*, April 2011, page 4), the *Sun* called the plans 'barmy' while the *Express* said it was an attempt to 'bring about the de facto legalisation of drugs'.

'There has been very mixed media coverage of the guideline, with some suggestions that we are reducing sentences for supply offences and others that drug mules could receive community sentences,' a Sentencing Council spokesperson tells *DDN*. 'These suggestions are both incorrect. We are increasing sentences for those convicted of industrial scale production of drugs, while naïve and coerced drug mules will receive slightly reduced sentences. There's no "getting soft on drug dealers" – there's no change on that front.'

Indeed, the council had to issue a statement explaining exactly what a drug mule was, after some media outlets suggested that people would receive community sentences for smuggling drugs like ketamine.

'A drug mule is typically used to import significant amounts of class A drugs, but some reports have suggested that mules would smuggle small amounts of class C drugs, and therefore would not be jailed if convicted,' says the spokesperson. 'The council cannot envisage a scenario whereby an organised gang would coerce and pay for an individual to fly into the UK with small quantities of class C drugs, as it would make no commercial sense.'

Although drug mules are usually vulnerable people, they are recruited to smuggle significant quantities of class A drugs, which is why the council suggests the offences are likely to fall within category two of its four categories of harm, where the starting point is 1kg of heroin or cocaine and sentences range from five to seven years, with a starting point of six.

The media focus, says the council, has been to draw conclusions about the sentence someone would receive based on the offender's role and quantity of drugs, but regardless of other factors that could be present. 'A judge takes into account the full details of any case and only then can decide what category is appropriate in that specific case, and consequently what sentence should be passed', the spokesperson says.

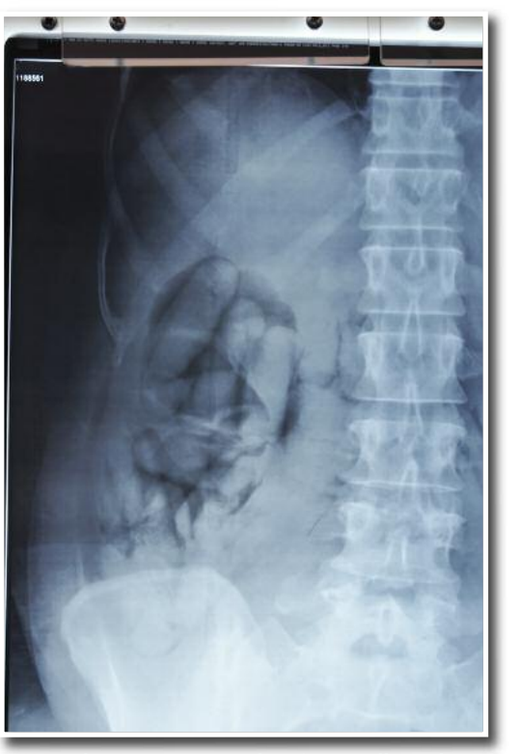
In some ways the council is, inevitably, in a no-win situation. At the same time as being castigated for going soft on drugs, it has faced disapproval from liberal broadsheet columnists. Responding to deputy chairman Lord Justice Hughes' statement that 'drug abuse underlies a huge volume of acquisitive and violent crime, and dealing can blight communities', Leo Benedictus wrote in the *Guardian*, somewhat bizarrely, that 'you might as well say that nice houses blight communities just because some people commit crimes to pay for them'.

The guidelines come into effect on February 27. How binding are they – how closely will judges and magistrates have to follow them? 'The guidelines must be followed, unless it's in the interests of justice not to do so,' says the spokesperson.

'There may be some exceptional cases where a judge can ignore the guidelines. If there was an exceptionally serious case, the judge could sentence outside the guideline and up to the statutory maximum – for supply, for example, they could go up to life.'

As DrugScope said in its response to the guidelines' publication, the revising down of sentencing for 'mule' offences is at least a positive step forward.

However, given that many drug mules – who tend to be women – are vulnerable, often desperate, people living in poverty, and who may well have been threatened with violence towards themselves or their families, six years is still a very long sentence. Especially, as Release points out, when the starting point for rape sentencing is five years and grievous bodily harm three.



UK Border Agency x-ray showing swallowed packets inside a person's body: 'Many drug mules – who tend to be women – are vulnerable, often desperate, people living in poverty, and who may well have been threatened with violence.'
Geoff Moore/Rex Features

While one reason is the way the sentences are calculated – drug mules have a lesser role, but the amount of drugs involved means the offences fall into the higher categories of harm – another is that the scope for the council to impose major change is limited, as ultimately they have to work within what is on the statute.

'We work within the current legislation and have no powers to change the law,' says the spokesperson. 'If legislation changes, then sentencing guidelines are amended as necessary.' **DDN**

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Of course, somewhere in a drug addict's fuddled mind they will want to keep their children. But the fact is, a heroin addict stumbles through each day shoplifting or working as a prostitute to feed their habit. Making enough money for drugs is their first priority – not their child... When are we going to realise allowing drug addict parents to keep their children just doesn't work? It will never work. A drug addict will sell everything to get their next fix. They will steal from their parents, sell the furniture – they will sell their child if it comes to it.
Anna Smith, *Daily Mail*, 13 January

As a lowly parliamentarian, David Cameron was part of a committee that recommended that the government begin a discussion within the UN on 'the possibility of legalisation and regulation' of drugs. As prime minister, he keeps quiet. In opposition his deputy, Nick Clegg, declared: 'the so-called war on drugs is failing.' Yet on a visit to Mexico last year he had only praise for the 'courageous' battle, which has produced a murder rate over 15 times Britain's. Doubtless he will be forthright in his memoirs.
Economist editorial, 21 January

It took 14 years for America's leaders to repeal prohibition. After 50 years of the failed drug war, it is time for today's leaders to find the courage to speak out.
Richard Branson, *The Telegraph*, 23 January

This week it was disclosed that there are at least 190 families nationwide with ten or more children living on state benefits to the tune of £61,183, tax- free. To take that home in the real world, you would need to be making about £100,000 and seeing as most of these lazy losers struggle to get their considerable backsides off the sofa to reach for another cut-price lager, it's highly unlikely they will ever waddle off to work.
Nick Ferrari, *Daily Express*, 15 January

For most of us, Mexico is reduced several times a week to a sickening barrage of horror flick headlines. Thirty-five bodies left on the freeway during rush hour in a major tourist city. A person's face sewn onto a soccer ball. Bodies found stuffed in barrels of acid. Heads sent rolling onto busy nightclub dance floors. What could explain such savagery? Traffickers don't have a political or religious ideology like al Qaeda. The answer, some experts say, is a number. Something like $39bn. That's the top estimated amount Mexican and Colombian drug trafficking organisations make in wholesale profits annually.
Ashley Frantz, *cnn.com*, 15 January

Most youth justice resources are concentrated on the incarceration stage but, when released, children – often returning to neglectful, chaotic or addicted families – frequently revert to old behaviours because of a lack of support.
Mark Johnson, *The Guardian*, 17 January

Where is the 'quality evidence base' for alcoholics to justify treating them with alcohol? Does it exist? Of course not. But doling out heroin on the state is dressed up to be different. It is the last ditch and desperate investment in a treatment approach that doesn't work. It's the latest expensive scheme to avoid admission that 'harm reduction' – giving opiates to addicts – doesn't work; that our national health policy makers have been barking up the wrong tree for years now.
Kathy Gyngell, *Daily Mail*, 2 February

LEGAL LINE

WILL MY CANNABIS PLANTS LAND ME IN JAIL?

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

Reader's question:
I use cannabis for medicinal purposes and sometimes grow a few plants so I can be more certain about the quality of what I smoke. It's all for personal use – I never give or sell any to anyone else. I've heard that there are new sentencing guidelines coming into force and wonder, how will this affect me if I get caught?

Kirstie says:
The Sentencing Council has produced comprehensive guidelines for drugs offences, which will come into force from 27 February 2012. They will apply to anyone sentenced for a drug offence after that date, regardless of the offence date.

For a cultivation/production offence (which is what your conduct would amount to) the guidelines look at the role of the offender, and the amount of plants grown (the scale of the operation) to reach a starting point for sentence, within a specified range. This can then be increased or decreased by aggravating and mitigating factors.

As someone growing solely for yourself, you would be considered to be in a lesser role as long as the circumstances support this. Additionally, if growing up to nine plants you would be placed in the lowest category of harm (the more plants the higher the category). As such, the starting point for sentence would be a 'band C' fine, which is equivalent to 150 per cent of weekly income, and may be paid in instalments. The sentencing range extends from a discharge (no punishment as long as a further offence is not committed within a particular period) through to a medium level community order. This could incorporate various requirements including supervision by the probation service, treatment through a Drug Rehabilitation Requirement and unpaid work. This is not too different from the current magistrates' court guidelines – the range of sentence at each end is just slightly extended.

The court will also take into consideration any factors which make the offence more or less serious and move up or down from the starting point accordingly. Unfortunately medicinal use of cannabis is not a mitigating factor for a cultivation/production offence, though it can be for simple possession matters. The sentence starting point for possession of cannabis will be a 'band B' fine (equivalent to 100 per cent of weekly income) – this is no change from current practice. Please note that it is possible to be prosecuted for cultivation/production for any plants found and a separate offence of possession for any dried amount.

It is important to remember that even though prosecution for cultivation/production of cannabis may not result in a particularly harsh sentence, it is still a criminal offence and can result in a criminal record. It is therefore always advisable to seek legal advice if arrested.

Email your legal questions to claire@cjwellings.com.
We will pass them to Kirstie to answer in a future issue of DDN.
For more information about benefits and incapacity to work through substance misuse please contact the Release legal helpline on 0845 4500 215.

STAGE STRU

The curtains open. The lights come up. On a bare stage two men are whooping and cheering. It becomes evident they are watching a football match. They order drinks at an imaginary bar. Ah, they're in a pub. The action freezes and we cut to another character sitting alone in a pool of light, centre stage. He's looking at Facebook and waiting for his dad to come home from the pub.

Back in the pub, dad is vaguely trying to get away but his friend plies him with drinks. Eventually, when the match is over he leaves, comes home drunk and creates uproar with mum in front of the child, then collapses on the floor. The action freezes.

The audience is made up of 14 to 15-year-olds from two schools in Hampshire, and they are here to learn about alcohol and risk-taking behaviour. The show continues, and the scene is replayed using members of the audience standing in for the original characters. The young people are excited by the sight of their friends up there on the stage, under the lights. The actors explore the scene and try out different strategies, different endings.

They are watching Vita Nova – 'new life' in Latin – which began as an idea in the minds of a group of newly recovering addicts and alcoholics in Bournemouth. They had undergone 'treatment' and were writing a sketch about the experience. Well, that was the idea at the beginning, but somehow they got hooked up with Bournemouth Theatre in Education – Sharon Muiruri, co-director, was looking to put together an educational play about addiction, and who better to approach than those who had 'been there'?

The play, *Scratchin' the Surface*, told the story of Jay, a nice guy from a good family who gets involved with nightclub culture, party drugs and 'the raven', a Faustian embodiment of addiction. Sharon's training and background in applied theatre, coupled with the breathtaking choreography of Junior Jones – at one point the raven flies Jay around the performing space, illustrating the exhilaration of drug intoxication – made for a genuinely thrilling and thought provoking production.

After the fledgling theatre company had undergone necessary vetting procedures, the play toured secondary schools throughout Dorset. The production was always accompanied by a 'share' session at the end – an opportunity for students to ask direct questions of the performers. The Q&A was carried out anonymously, with questions written out on slips of paper. What the students wanted to know was, 'Why do people get involved with drugs? How much money did you spend? Did you go to jail? What did your mum and dad think?' – to mention a few.

Up on the stage, the Vita Nova actors are sitting on a row of chairs. They are out of character now, being themselves. Jane is talking about her daughter and the fact that she hasn't seen her for the past five years. A young woman in the audience starts to cry. After the show, the young people mix with the members of Vita Nova, and one young man confides that his father has a long-term drink problem and has been in and out of rehab.

'We'd been going about three years when we first started calling it the "authentic voice",' says Simon Bull, chief executive of Vita Nova, and one of the original founder members. 'I can't remember who coined the term. It's the idea that kids take it more seriously if it's coming from the horse's mouth, rather than from a copper, a probation officer or a doctor. I suppose it had become clear to us that we were doing more than just prevention work with the schools. Going in there with the play was having an effect on our members, the volunteers who were acting in the play – OK, they were being given the opportunity to "put something back", maybe to make some kind of restitution, but it was more than that. Little by little they seemed to be growing in confidence. Being part of Vita Nova was having a profound effect on their own lives.

'Of course you don't realise these things all at once,' he continues. 'Vita Nova started out as a one trick pony, really. We had the play, the share session and that was it. I don't think we'd thought much about where it was going, or how it would impact upon us as people.'

After the first couple of years with *Scratchin' the Surface*, Vita Nova became a registered charity. 'It became apparent that there was work to be done,' says Simon. The work in the schools was going very well and Vita Nova had started work on some other devised theatre pieces. Sharon helped them to make a play called *The Mule* – about drugs trafficking globally and locally – and a version of *A Midsummer Night's Dream* involving recovering addicts, children and the local police.

'That was fantastic! You know what addicts and the police can be like – it really broke down some barriers,' says Simon. 'And it was very visible in Boscombe.' Vita Nova is based very near to Boscombe, one of the most deprived wards in the south of England. Access to employment, education, housing and healthcare is restricted, and there is an exceptionally high incidence of alcohol and drugs misuse. 'And all of the things that go with that,' comments Simon.

UCK

Started by a group of ex service users, Vita Nova has performed plays and delivered workshops to more than 100,000 people in schools, youth centres and treatment facilities. Ignatius Harling **sets the scene**

'It was partly in recognition of this that we started to diversify our input into the schools,' he says. 'Vita Nova was becoming quite experienced in workshop facilitation and we rolled out themed workshops, tailor made to the school's requirements, on subjects like bullying, domestic violence and knife crime. We also started to look further at initiatives which would enhance the lives and opportunities of our service users.'

Vita Nova has worked with around 700 service users since 1999, with many members going back into full-time education, and several gaining degrees. Largely reliant on grant funding, it runs drama workshops that are 'open access' for newly abstinent people and also engages with those on substitute prescriptions. Although based in the South of England, we can deliver educational projects nationally and we have now performed to more than 100,000 people.

It was in 2006 that Vita Nova contracted to work with Nell Leyshon, well-known playwright and novelist, who remains Vita Nova's writer in residence to this day. 'Nell has developed a way of working with writers – based upon starting where people are and nurturing with constructive feedback – which has spread into Vita Nova's core work,' says Simon. 'We now have prospects of running creative writing workshops in prisons and mental health settings, as well as appearances as arts and literary festivals throughout the country.'

Simon sees this input from arts professionals as having a mentoring function and as an inevitable development for Vita Nova. 'We started out wanting to make a play and slowly we are being shown how to do this for ourselves.'

The creative writing groups are now embedded as part of Vita Nova's 'offer' to the recovering community in Bournemouth. Many participants are getting involved in 'slam poetry' events locally and further afield, and last year Vita Nova published its first anthology of members' poems and creative writing, *Clean*.

'That was really something,' says Simon. 'We put on an event at the Winchester – an arts venue in Bournemouth – and invited the great and the good of the literary and arts establishment. Feedback was amazing. You'll find a copy on Amazon.'

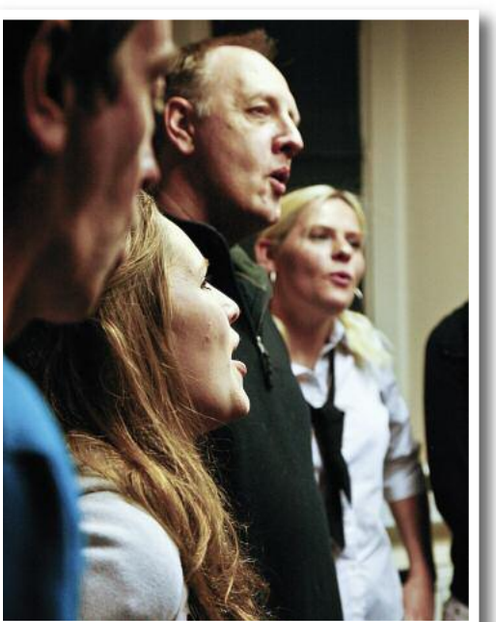
Vita Nova's latest 'arts coup' has been the engagement of Jessica Swale, an exceptionally talented young professional theatre director. The intention is to mirror the mentoring process that has already taken place with the writing.

'We're going to Arvon – the Arvon Foundation, a registered charity offering high quality writing workshops delivered by professional writers – for the third time. There's 16 of us in total and we're really looking forward to it. Jessica has agreed to teach, alongside Nell. It's a dream ticket. We're very fortunate.'

The show is over and Vita Nova's actors have climbed into their minibus and driven away into the night. The auditorium is empty apart from the girl who was crying during the 'share' part of the show.

'You know, I think they're really brave to do all that,' she says. 'To come up here and tell us about themselves. I mean they don't even get paid for it. I reckon if they manage to turn even one person's life around they'll feel it's been worth it.' **DDN**

Ignatius Harling was a volunteer with Vita Nova from 2001-2003 and went on to train as an actor. He is now employed by Vita Nova as coordinator. www.vitanova.co.uk



COMPUTER WORLD

Highly controversial at the time, **Martin Blakebrough** looks back at 20 years of computerised onsite dispensing at Kaleidoscope's headquarters

ON 19 DECEMBER 1991, in the reception of a red brick hostel in Kingston-upon-Thames, something revolutionary was about to happen. The first computerised onsite methadone dispensing system in the UK was set to go live.

John Lipscomb and Ulrich Kohler of Kaleidoscope, who had painstakingly put the system together, switched it on with considerable trepidation as Home Office inspectors looked on. The Home Office – which would determine if Kaleidoscope would be given a licence for this controversial approach to onsite methadone dispensing – had a good working relationship with Kaleidoscope, one of the only voluntary sector providers for medical treatment at the time. This positive relationship was crucial for Kaleidoscope, in the light of hostility from other NHS bodies and the police.

So why did Kaleidoscope opt for computerised onsite dispensing? Firstly the increasing numbers attending our services – 300 a day by 1990. Because of the difficulty in accessing treatment in south London, Kaleidoscope provided services to a far wider client base than Kingston residents and, unusually for the time, refused to have a waiting list for treatment. As numbers grew it became necessary to look at new models for ensuring we gave medication safely.

Kaleidoscope staff went to New York to look at how they did things there, and it was after seeing the Beth Israel Medical Center's computerised methadone dispensing system in operation that we sought out the software company to set up a similar system in Kingston.

'It was very rare to give methadone on the site of a treatment agency,' says John Lipscomb, who still manages Kaleidoscope methadone dispensing systems in Wales and England. 'Even in hospitals it was not possible. I remember working with my colleague Ulrich Kohler on ensuring the software supplied by Johnsons Computers, Oregon, properly linked with the pump. The ability for accurately dispensing methadone was vital, although having a system that is just a computerised pouring system is not that helpful. The main point of computerised systems is to maximise interaction with a client and to integrate medical and care plans, and the companies we work with continue to develop further the integration of care and medical plans.'

Kaleidoscope has always been committed to harm reduction, but the emphasis has been on service, which means more than just giving out a condom, methadone or a needle. Kaleidoscope founder Eric Blakebrough said, 'methadone is the carrot into service and our task then is to provide a menu for people to make their own life choices'.

Uli Kohler went from Kaleidoscope to work for the European Commission and then to a German drug agency developing services across the world, but we continued to work alongside him with agencies across South East Asia, setting up the first onsite computerised methadone system in Asia – in Kathmandu, Nepal – with his support.

John Lipscomb is surprised there aren't more agencies offering onsite systems in the UK. 'When you manually dispense methadone, all your concentration is on the transfer of the medication, from the bottle to the cup,' he says. 'But when you dispense via the computerised system, you have time to meet a client eye to eye.' The importance of such programmes is to enhance the clients' treatment experience, he stresses – a computerised system is safer, more accurate, provides better time with the client and proper records where there is information sharing.

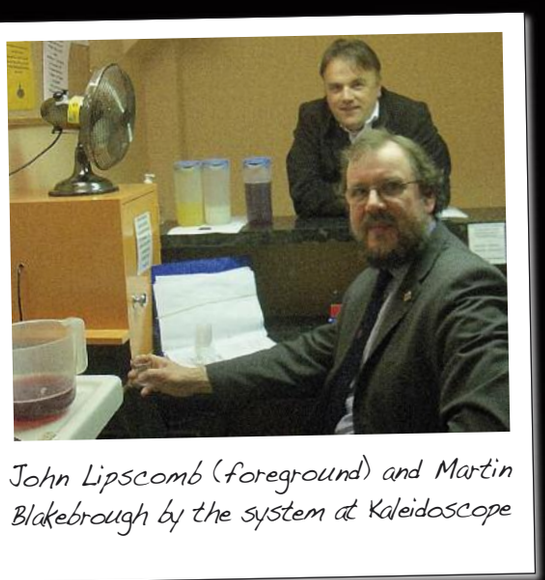
'What is crucial today is to further develop better case management systems,' he says. 'There are systems that in effect purely dispense as pouring systems. The problem with such systems is that you cannot plan detox, or message a client or put basic notes on the system. In reality any onsite system must add to client care. I believe the whole idea of onsite dispensing is to provide case management with dispensing. Onsite dispensing means workers can deal with a client's crisis immediately. A good computerised dispensing system means key workers and nurses share information, and case management is properly integrated.'

The other development in computerised systems is enhanced security, he says. 'To be honest this development is great for commissioners but actually does not achieve an awful lot for the money. The amount of dispensing to the wrong people through photo ID was never a problem in the first place and when you compare the photo system with the biometric system there is minimal, if any, difference in terms of errors.'

Looking back over 20 years, John says that the biggest critics of onsite dispensing were the public health services. 'I think they always felt that they had exclusivity when it came to medical issues. The reason why health services have sometimes struggled to deliver good quality drug services is because they are an illness service. The consequence of such services is that they look at the illness rather than the whole person.

'Having worked for over 20 years in this field I recognise that a drug service needs to offer medication but that is just a small part of care. I believe care must include housing, education, training, employment opportunity, counselling, spirituality and, above all, human interaction.'

Martin Blakebrough is chief executive of Kaleidoscope



John Lipscomb (foreground) and Martin Blakebrough by the system at Kaleidoscope

LETTERS

CONSPIRACY AT WORK?

I read with some concern – as is often the case – the letter by Elisabeth Reichert, school head (*DDN*, January, page 11).

Her idea of applying the (in itself questionable) 75 per cent success rate cited for the 'addiction recovery training programmes' she mentions to the general population of 'dependents' sounds implausible. Is she or anyone else able to provide references for appropriately conducted trials published in a respected journal or is there a liberal, secular, psychomedical conspiracy at work as, it seems, is so often the case?

I ask this as there can be bias and methodological problems with the 'research' and information (as well as the anecdotal evidence) employed by people to support their position. For example the 'intention to treat' must be considered as in the following example:

If I were to claim that people with substance use problems need to move town, run ten miles prior to attending a meeting every day and not use drugs or alcohol for three years for them to be 'cured', those prepared to enter my 'treatment' would be self-selecting and unlikely to be representative of most 'dependents', as many would not be prepared to subject themselves to it for a number of very good reasons.

If I were to not count the people who dropped out (or were thrown out) of my arduous regime for the purpose of analysis and only considered those who had successfully completed my miracle cure, one year later when I wanted to look at the success of my intervention most fair-minded observers would say that, whatever the percentage of (for example) abstinence in the completers (or even those happy to be starters), it does not represent a clear endorsement of my intervention.

The paranoid position people and organisations choose to adopt when faced with the choice between 'I am wrong' and 'the world is wrong and in a big conspiracy against me' is well illustrated in the substance use field.

As well as being shown to work, interventions must be ethical and acceptable to those they affect. Any system for people with substance use problems needs to try to include those who don't simply do what you think they should.

Perhaps researchers worldwide, the NTA, NICE and most other people concerned with the treatment of substance use problems are involved in a conspiracy, but it is one I am happier to relate to than those that come out of evidence-defying, prejudice-embracing people and regimes such as those in Russia, many places in Asia and a number affiliated to certain religious bodies that shall remain nameless.

Niall Scott, Rochdale

NALOXONE RESPONSE

Following the flurry of letters in response to my 'Soapbox' piece (*DDN*, December 2011, p.24), I have written to a number of respondents, some of whom have got back to me, and this correspondence has been illuminating and useful. In particular I wanted to expand on the potential issues relating to the unfortunate legal cases of Evans and Townsend. These cases are concerned with manslaughter on the grounds of gross negligence, especially to do with acts of omission in relation to overdose, and have implications in terms of the duty of care for both professionals and concerned others.

On the one hand it seems clear to me that there is a lack of awareness of this case and the potential implications thereof. On the other, following these discussions I recognise and acknowledge that some of the wording in the original piece could have been more judicious and obscured the argument. The standfirst in the soapbox piece was not my words and I would not have chosen them.

I have taken the gist of the letter that I wrote to others, and have posted this as a blog on my website so that those who want to explore the issue further can do so there. I would like to thank *DDN* for maintaining an open and inclusive editorial policy, and all those who have entered in to correspondence and discussion, both supportive and otherwise.

Kevin Flemen, KFx, www.kfx.org.uk

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.

Post-its from Practice

People above policies

Cost savings must never undermine quality of care, says Dr Chris Ford

I WAS PLEASED TO BE INVITED, but very sorry to go, to the leaving party of our locality manager Teresa. She had come into the area when the local specialist service was in disarray, was mainly staffed by agency staff and had a poor reputation with people who needed treatment and local GPs.

Over the next year or so this slowly changed. The staff morale improved with increasing numbers of permanent staff, the medical lead was good and the atmosphere in the service became one of 'how can I help you' rather than 'what do you want'. Teresa was kind, effective and supported staff. She was also able to look outwards and form good partnership working.

There had also been many improvements in the area in the preceding years, with commissioners and DAAT managers who understood drug treatment and avoided the destruction of re-tendering instead supporting services to improve. They also 'understood' and valued primary care drug treatment.

The area partnerships have been and continue to be, strengthened by a monthly 'shared care quality group' when the managers of all services, including me and the primary care shared care manager, come together to discuss quality and joint working. This meeting helps us learn and improves moving people who need treatment to the most appropriate service.

With a joint philosophy of care in an area and people like these on the job, it breeds respect for each other, which filters through to users of the services. People presenting are not seen as 'bad', but as individual people with complex needs who are asking for help.

During all the years I have done this job, it's been all about people, not policies, for me. We need guidelines and policies but more importantly we need people with humanity, who care; we need open-minded Teresas rather than 'Ms Buttoned Up'. Even more so at this time, when all the talk is about changing policies, it is easy to forget that the more important issue in drug treatment is care and supporting people to be who they want to be and get where they want to get to. And we can be the facilitators, or the inhibitors, of people's journeys.

I thanked my lucky stars that I work where I do, when after an hour of phone calls I still hadn't been able to get help for a patient who had moved to south London. Almost every conversation started with 'no', or 'we can't do that, it's not in our policy'. I will continue to try, somewhat saddened by the knowledge that those staff can't possibly be getting job satisfaction.

I miss Teresa who was an important cog in the relatively healthy local drug treatment system. We are fortunate because things look good with her replacement. I'm an optimist, but I'm aware we face changing times ahead with an emphasis on policies, with cost being more important than quality, and where staff and the people who need treatment are often treated poorly. Care for staff so we can care for others.

Dr Chris Ford is a GP at Lonsdale Medical Centre, clinical director for IDHDP and a member of the board of SMMGP, www.smmgp.org.uk

The Alliance has reviewed its structure and purpose in light of a new 'era of recovery'. Chief executive **Ken Stringer** gives the thought behind the organisation's recent changes and looks to the future

Adapt to su

The Alliance was born as The Methadone Alliance almost 13 years ago – in a time of optimism and of hope. The drug field was filled with energy, creativity, imagination – and money. With a commitment to stand up for people's rights to make choices regarding their own treatment, the Alliance focused on some clear objectives – to improve service users' experience of drug treatment and other services, to lobby for improvements in access to services for all, and to improve the information service users have about treatment and treatment options.

Since then we have helped and supported over 10,000 people through difficult times. We continue to run an online forum and a helpline, we have been responsible for setting up specific local projects to develop peer education and local support groups and continue to deliver hands-on advocacy work. We have helped people to access substitute prescribing and helped others to find reduction programmes, detoxes and abstinence pathways. We train people in harm reduction approaches and relapse prevention. All of this is geared towards supporting people to become informed and to make choices, to gain control over their lives and be in a position to determine their own future, their own recovery.

During this time we have seen many changes in the way drug treatment is delivered. No one waits more than four weeks for assessment and treatment anymore in England (when we started out, three- or four-month waiting lists were not unusual). We have widespread agreement to a range of evidence-based reliable treatments that should be available to everyone who needs them. This is ratified by NICE, meaning that for the first time people in the UK have a right to substitute prescribing, harm reduction services and psychosocial interventions.

Given these advances, The Alliance needed to take stock this year of where we were, what was happening across the drugs field, and what the need was for an organisation like ours in the new era of recovery.

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Recovery is the focus of this government's approach to drugs and we were keen to understand what impact this was having on the ground – what it meant for the people who use our services. So this year we spent some time talking about this with our stakeholders. We did this through a structured survey, brief analysis of our helpline calls and advocacy cases, small focus groups and discussions, and internet forums. We also drew on the experiences of our board members and correspondence with workers and service users.

We know that recovery is fundamentally about self-determination – about choice. It is not about simply getting what you are given, doing as you are told and accepting someone else's choice about what your options are. Given this, recovery should be changing the way services are delivered, improving their quality, making sure that individuals get a better deal – not just in terms of drug treatment but across the range of things that build recovery capital, like housing, social care and employment. And The Alliance should be out of a job.

In our survey, 80 per cent of our group told us that substitute prescribing – and for many, long-term maintenance – was hugely important for their recovery. We heard from people who had not had a job in 20 or more years for whom a reliable, regular script had given them the stability to become a 'long-term taxpayer'.

Sounds like recovery? Yet we have received more reports than ever from people concerned about being coerced into abstinence. A number of service users have reported being told by their provider that as newcomers to the service they can only have a script for six months. Disturbingly, people who believe they are in recovery have told us that they are being tapered off their medication because they are now stable.

Some service users have spoken to us about the difficulties of quasi-compulsory 'self-help' groups, with users threatened with the withdrawal of their script if they do not attend recovery meetings. We have also had a number of calls about unnecessarily intrusive and 'bullying' regimes, including mandatory home visits to inspect storage facilities for medication, excessive inappropriate screening, refusal to move stable users off supervised consumption and the reinstitution of daily pickup for users who have been stable and picking up weekly – in once case this was threatening a service user's continued employment.

More than half of the people who responded to our survey said that they had felt pressurised by their key worker or doctor to make changes to their prescription they didn't want, and a further 13 per cent said they were worried this might happen.

A worker contacted us to tell us that they had been receiving explicit instructions to move people to reduction and abstinence – particularly those who are most stable. Despite their fears that these people would become less stable and even start using again when their scripts were reduced or stopped, the worker was told that it was a critical issue and that without doing this, the service would be shut down as this was government and NTA policy. This is not true – but this experience it seems is not unique and other workers have sought our advice about whistleblowing around similar concerns.

Alongside all these changes there also seems to be an increasing stigmatisation of those people on scripts. Echoing many others, one service user told us: 'There is

rvive

an anti-medication movement... Users are often frightened to admit they are on methadone or are quick to say "I'm coming off". The stigma is very unhelpful.'

In the absence of clear government guidance, in a number of areas across the country providers and commissioners seem to be struggling to interpret 'the recovery agenda' as anything other than service rationing, coerced reduction and detoxification and a new reliance on unfunded self-help groups to provide post detox support. We do know there are still a significant number of high quality services where the evidence of what is effective and why it must be followed is understood and supported. However given the impact of a new performance management indicator, cuts in funding both for drugs and across the public sector, and increasing demand for substance use – particularly alcohol service – we think they will find it hard to keep to those standards, particularly without the support of organisations like The Alliance.

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There is without doubt an increased demand and need for the services of The Alliance. But we have lost funding over the past two years, and we have recently had no choice but to make valued staff redundant – the only other option was to shut down. However we know this is not a situation unique to The Alliance – many charities and voluntary sector organisations have found themselves in the same position over the past few months. We have done the same as them – made cuts, and worked on a plan to help us survive the difficulties, achieve a stable base and then increase our capacity. Essentially we have to change how we use the limited resources available to us if we are to deliver the support we believe is essential to a growing number of fearful and disempowered people.

The Alliance must become a true alliance, supporting and developing local groups, transferring resources to where they are needed – with service users, rather than maintaining expensive premises and a salary structure. We will need to work with volunteers – from both the drugs field and the user movement, making the most of scarce resources to continue to deliver our helpline and advocacy work. In future editions of *DDN* we hope to be able to come to you with specific requests for your input – as we will need your help.

The past 12 months have been a difficult time for us but we have fought and will continue to fight to meet the need for advocacy, brokerage and information for those getting the rather grubbier end of the recovery stick. I'm confident it's a fight we can win. Because there is a very clear role for The Alliance in the age of recovery – after all we have been advocating for it for years. **DDN**

'In a number of areas across the country providers and commissioners seem to be struggling to interpret 'the recovery agenda' as anything other than service rationing, coerced reduction and detoxification...'

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Hepatitis B Surface Antigen
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GAME CHANGER

The Care Quality Commission has had its share of bad press recently, and is toughening its approach as a result. But, says **David Finney**, that shouldn't be cause for despair

THERE HAS BEEN MUCH CRITICISM RECENTLY OF THE CARE QUALITY COMMISSION (CQC) in the press, on TV, in government circles and in health and social care journals. The question is, what implications will this have for the substance misuse sector?

Those who watched the BBC's *Panorama* as it investigated the Winterbourne View hospital for people with learning disabilities couldn't help but be shocked by the abuse of vulnerable people. In the aftermath, CQC and the local authority came in for criticism as they were seen to have delayed their response to the whistle blower, and questions were asked about an inspection regime that could allow a three-year gap between visits.

The National Audit Office published a report in December 2011 in which it outlined that fewer than half of the CQC's planned reviews were completed in the six months to April 2011. It also highlighted that by September 2011, 14 per cent of all CQC posts were unfilled, with a high proportion in registration and inspection activity.

In September 2011 the Health Select Committee pointed out that 'the bias of the work of the CQC away from its core function of inspection and towards the essentially administrative task of registration represented a significant distortion of priorities'. This partly explained why inspection activity was low initially, and then in December 2011 the public enquiry into the Mid Staffordshire NHS Trust heard evidence from a CQC board member, Kay Sheldon, in which she criticised the leadership and culture of the organisation.

A recent policy initiative, *Recognising excellence in adult social care*, whereby outside contractors were to be appointed to award excellence ratings has also been dropped after criticism from provider associations concerned about the cost and lack of objectivity of the scheme. Public pronouncements from CQC have indicated that they are progressing with the appointment of new inspectors and a revamped inspection regime, and thereby hope to increase the number of inspections, or reviews, undertaken this year.

A recent consultation document highlighted changes that CQC intends to introduce including:

- *Inspection visits once a year, all unannounced.*
- *Targeted inspections, focused on a smaller number of outcomes*
- *Reports that focus only on areas of 'non-compliance'*
- *An enforcement regime that offers no extension of timescales*
- *No reference to a provider's previous track record*
- *No encouragement of improvement without enforcement action.*

In response to concerns about perceived unresponsiveness to whistleblowing, CQC has also published a document entitled *Raising a concern with CQC – a quick guide for health and care staff about whistle blowing*. This raises the profile of CQC as a public body concerned about safeguarding issues in regulated services with the expectation that it will take action.

On the ground, the experience of providers is that CQC is now quick to undertake inspection visits if concerns have been raised with them by staff members, relatives, professionals or other members of the public. Behind the scenes, providers are also aware that commissioners are being informed of perceived failures in services and contracts are being affected as a result of this information sharing.

Glancing at the CQC website will often reveal information about enforcement action being taken against care homes or reports of the failures of NHS trusts, and there are also regular updates about how CQC is progressing in its urgent review of all learning disability services following the Winterbourne View investigation. It will not be surprising if CQC is now more robust in its inspection style.

So what are the implications for substance misuse service providers? My view is that treatment services for substance misuse registered with CQC will need to be vigilant rather than complacent in the light of the trends highlighted. Some of the implications may be:

- *Delayed inspections due to the slippage in the CQC timetable and focus on learning disability services*
- *New inspectors who may not be familiar with the substance misuse field*
- *No prior warning of a CQC inspection*
- *No opportunity to send completed provider compliance assessments to CQC before an inspection visit*
- *Highlighted concerns may be communicated to commissioners*
- *An emphasis on safeguarding and safe recruitment procedures*
- *A much tougher approach to enforcement, even if you've been a good provider*

On the positive side, however, experience has shown that CQC inspectors spend a good deal of time listening to people using services on their visits.

On the positive side, however, experience has shown that CQC inspectors spend a good deal of time listening to people using services on their visits. This is in line with their 'observational tools for inspectors' documents which suggest that 50 per cent of their time should be spent with service users, and an examination of inspection reports shows that many people using services are saying very positive things about the treatment they are receiving, especially in residential services. It appears that this then guides the inspectors' thinking as they write their reports.

So, whilst it may be tricky dealing with CQC, an experience akin to dancing on ice, when one slip could be disastrous, it is possible to succeed and have a positive inspection report placed in the public domain.

David Finney was the policy lead for substance misuse services in the Commission for Social Care Inspection (CSCI) and is now an independent social care consultant specialising in the inspection of substance misuse services.

DDN/FDAP are holding a workshop on 14 March in London looking at the new inspection regime and how you can be prepared for your next inspection. For more details email kayleigh@cjwellings.com or call 020 7463 2085.

Mel Ashton's role as an addiction therapist couldn't prepare him for the alcohol-related death of his brother. He describes what happens when the personal meets the professional

Too close to h

In the early afternoon of 14 July 2003, I took a call on my mobile phone from my younger sister. It was unusual for her to ring me at work and in the moments before I answered it, I knew it had to be important. It was. Before I heard the words I will never forget, I heard her sobbing. My sister simply said, 'he's gone, Melvyn'. Of course, I instantly knew who she meant. She was referring to my younger brother, who was then aged 42, no age at all. But then, Paul (not his real name), had been dependent upon alcohol for all of his adult life and, while I objectively knew that early mortality, and certainly chronic morbidity, were likely to be visited upon him sooner rather than later, it took me several moments to absorb the hard, cruel reality that he had actually died.

In fact, Paul had died in hospital. My sister told me that the cause of death was two-fold – first, an oesophageal bleed, and second, a serious fit, or as I knew it, an alcohol seizure.

I remember not knowing what to say. After we ended that call, I sobbed in the office, where one or two of my colleagues stood motionless as they too absorbed the reality. They comforted me as best they could in the circumstances. On one hand, I couldn't quite believe it – not my brother. On the other, why not? It was not the first time that he had been hospitalised for alcohol-related problems or detoxified in the three decades that this 'ambiguous molecule' – as Griffith Edwards calls it in his book of the same name – had dominated his life.

I also knew from my professional role, which included teaching addictions at higher education level, that – according to Alcohol Concern – the number of alcohol-related deaths in the UK has 'consistently increased since the early 1990s, rising from the lowest figure of 4,023 in 1992 to the highest of 9,031 in 2008. Sobering statistics, perhaps. But they were real people with real families, partners and friends. Paul had been added to the prevalence data for the year 2003-4.

I left my office shortly afterwards, still in deep shock at the news, and I tried to leave behind my role as a senior addiction therapist and tutor. The former called for me to work with harmful and dependent drinkers as a matter of course, and I always found this a humbling experience, respectful of the size and nature of the problem and clients' efforts to rid themselves of it. The latter simply confirmed what I already knew – that alcohol dependence and its related mortality can happen to anyone. It did not select its victims according to their social, economic or ethnic status.

However, during the period of coming to terms with our profound loss, I at times also found it difficult to let go of my professional role and identity and simply grieve as a son and brother. I vividly recall visiting the hospital mortuary, where my brother lay, cold, stiff and yet, I hoped, 'at peace'.

I spent some time alone with him. At one stage, I apologised to him for not being able to help him as an addictions professional and his kin. I tried to explain why – not for the first time in his history – especially to my parents and two sisters. At the same time, I felt a sense of guilt, not so much borne of that difficulty, but of the personal distance I had sometimes put between me and Paul. In truth, I had not given him the support that he needed, as a brother. I used the fact that we – me and my own family – lived over 30 miles away and had busy lives to justify this to myself. Importantly, I also told myself and others that 'you can't social work your own brother – you're too close to it'. I still think that, for good reasons.

But, if I'm honest, I also felt a sense of disappointment, even anger, towards Paul, especially for the worry that his problem had visited upon our now elderly parents. 'Why,' they asked with good reason, 'can't Paul stay off the alcohol?' A very pertinent question for all who deal with, or are affected by, this significant problem. I recall the words of a colleague, a former advisor on alcohol to the chief medical officer, who commented with absolute sincerity that this was as 'serious as it gets'.

As I stood and stroked my brother's lifeless forehead, I made him a promise that, at the time, I was determined to do my best to keep – that I would do all I could, in my professional role, to prevent others from meeting the same fate. I have tried to fulfil this promise since, but not necessarily with a less fateful and final outcome.

At one stage in my bereavement leave, I visited the treatment agency that had known and worked with Paul. The worker – ironically, a former neighbour of mine – was not available for me to speak to and for reasons of confidentiality, I was not told anything more than they had sought to treat him as best they could. Paul was, as I already knew, drinking in excess of a bottle of vodka per day and his living conditions caused a lump in my throat. It was not untypical, as I well knew, for dependent drinkers to find themselves socially isolated and often unable to care for themselves properly, their lives turned upside down by alcohol. This was also true of Paul.

My eulogy, on the day of the funeral, also reflected upon the battle that he had had in overcoming his alcohol dependence. Again, there were moments when it occurred to me if those assembled wondered if I was speaking as his brother or in my professional capacity. My apparent and unashamed grief hopefully answered this question.

So, how has this all impacted upon me and my professional role? What sense have I been able to make of it? Clearly, there have been many occasions when his death and its circumstances have caused me to experience 'psychological pangs' of grief, especially on or close to anniversaries. Moreover, the sense I make of the power of addiction is of a very complicated phenomenon. Definitions and explanations of substance dependence have varied over decades, some locating it in a disease model, others emphasising the role of social learning in its development.

I understand why it makes sense to explain dependence (or in that context, 'addiction') as a disease, over which the individual has lost power or control, but nevertheless, I prefer Orford's 2001 description in *Addiction* that 'by long usage, an activity that was originally pleasurable has become a "necessity"; that a strong craving is part of the experience; and that despite the many harms that it has

brought, neither the exercise of reason nor encouragement from others have been sufficient to bring about control'.

Thirdly, my own personal experience has cemented my belief in the value of social support for change (even though, to my shame, I was unable to provide this to my own brother). Thus, I am a strong advocate of social approaches such as Social Behaviour and Network Therapy (Copello *et al.* 2002; 2009), for which there is good evidence of effectiveness.

Fourthly, my experience, and the time that has elapsed since Paul's death, has not diminished my determination to do all I can professionally for those who want or need my help, or that of an addiction or allied service.

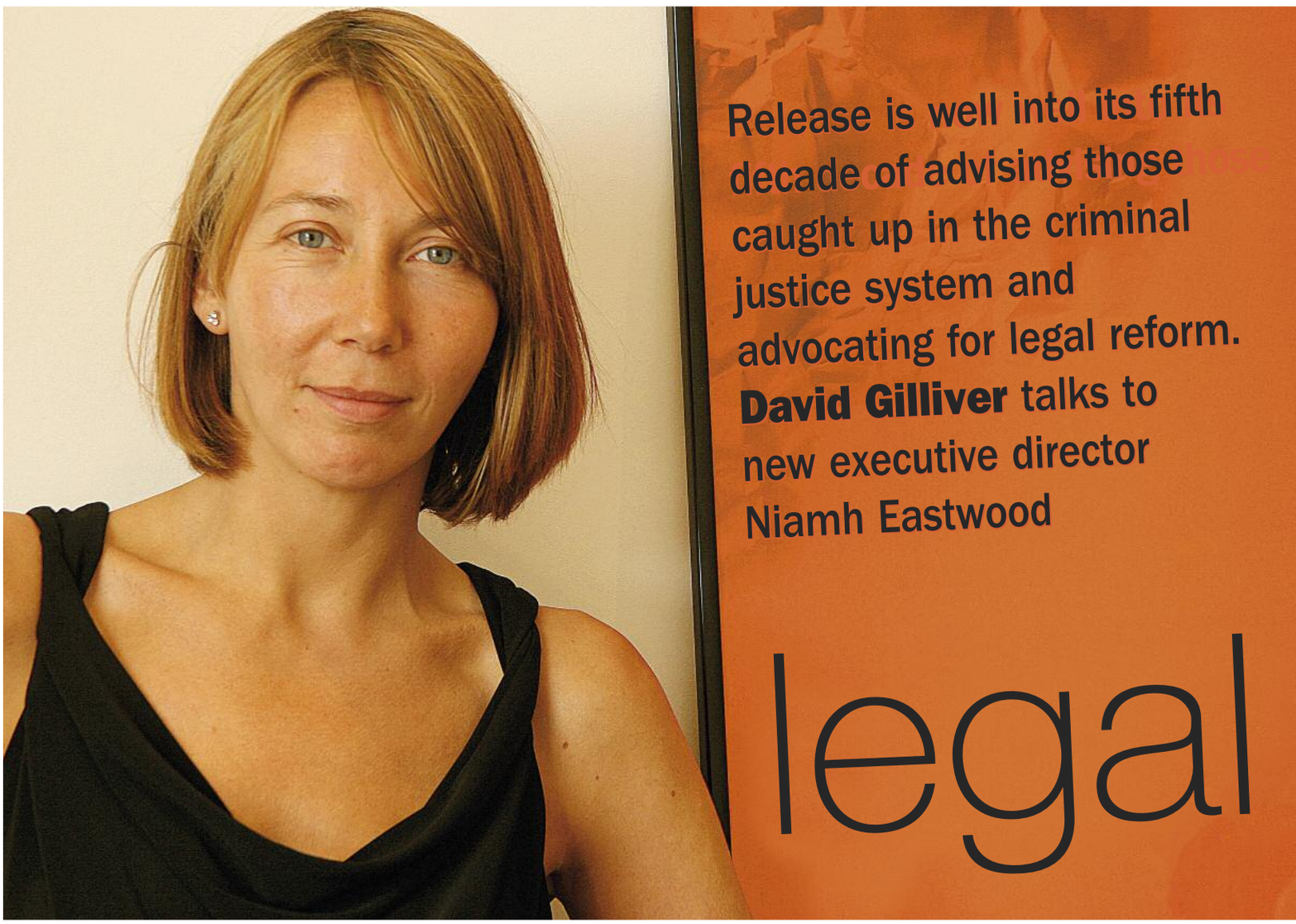
Lastly, there have been a number of occasions where a client and/or their family has suggested that I do not understand how the problem of alcohol dependence affects significant others, as my role is purely as a professional. I have always resisted any temptation to disclose my own personal experience, as this is not, in my view, consistent with my role or good practice. Whilst I cannot claim to know what it is like to be in their specific situation, I do seek to empathise with genuine cause and intent. There have also been occasions when clients' experiences have touched an emotional nerve in me because they remind me of Paul. However, I have tried my best not to leak this, if at all possible.

So, why am I writing this article, eight years after Paul's death? Another good question, for which there is no neat answer. That said, I recognise that self-disclosure is present here and there is also an element of personal catharsis in my motivation. If that is in any way self-indulgent, please forgive me.

However, there is more to it. I think the matter of where the personal can meet the professional, and how we respond to this, is a worthy subject for discussion. I have described my own experience, not as the correct way, but one way. As I continue to work in the addictions field, it is something of which I have to be aware in my practice. It would be interesting to hear of the experiences of others in this profession. **DDN**

Mel Ashton is a senior addiction therapist

'There have been a number of occasions where a client and/or their family has suggested that I do not understand how the problem of alcohol dependence affects significant others, as my role is purely as a professional. I have always resisted any temptation to disclose my own personal experience.'



Release is well into its fifth decade of advising those caught up in the criminal justice system and advocating for legal reform. David Gilliver talks to new executive director Niamh Eastwood

Release has been providing vital legal advice on drugs issues, as well as campaigning for reform of the drugs laws, since the late 1960s. Last month saw Niamh Eastwood take over from Sebastian Saville as executive director, ten years after joining the organisation as a legal adviser. She had initially trained as a barrister but took time out to decide if that was what she really wanted to do, and was teaching at a university when the position at Release came up. 'I was always quite political and I was interested in working for an NGO and campaigning,' she says. 'I'd studied law in order to try to help people who were vulnerable, or who'd been treated unjustly in some way.'

Growing up in Northern Ireland, she'd seen people 'caught by the police for very minor drug offences and it having a hugely negative impact on their lives', while at the same time realising that the drug laws provided little deterrent to people actually taking drugs. 'I was always aware that the current drug system was an absolute failure,' she says.

However, it was when she started to deliver Release legal surgeries in treatment centres in London that she began to feel a much more powerful sense of injustice. 'I saw the people who were really impacted upon as a result of the whole policy, people who were incredibly vulnerable and who in the majority of cases had been traumatised in some way – through childhood experiences, sexual abuse, physical abuse, neglect. It was very clear that you were dealing with people who often were taking drugs to self-medicate, and criminalising them meant creating a system that punished them further.'

What they needed instead was to be treated in a way that was 'non-judgemental and gave respect and support to improve their lives', she says, support that could come through relatively small things such as helping to improve their housing or resolving legal issues, in order to provide some level of stability. 'For me it was a real social justice issue.'

She was appointed head of legal services in 2007, and became Release's deputy director the following year. What does she consider the most significant developments she's seen in her time at the organisation? 'Certainly what we've welcomed over the last ten years has been the increase in investment in drug treatment services, but coupled with that has been this really intensive approach to diverting people from the criminal justice system into treatment through coercion – court orders, arrest referral schemes and so on. Again, I would have thought that just creates a greater stigma for people affected by problematic drug use.'

On a wider policy scale, however, she's excited by the growing support for legal reform. 'It really feels that there's a sea change, and we're hopefully getting to a point in the next few years where politicians will feel they can discuss this issue and start to properly evaluate it,' she says. 'There's a real change in how we're

discussing policy – we're not seeing any practice implementation, but at least some politicians, and a larger proportion of the media, are addressing the issue.'

From a campaigning point of view, decriminalisation is 'very much the policy reform that we see as attainable within a short period of time,' she says. 'For politicians, it's much easier for them to advocate for policies that still make the supply of drugs illegal but the possession and use not illegal, or dealt with through a civil system. But as the next step we will be doing more research around models of regulation, and promoting the government to experiment with regulation of certain drugs.'

One of the organisation's main policy concerns at the moment, however, is the ongoing programme of welfare reform, and the effect it will have on the people Release is there to help. 'In terms our legal services, the vast majority of our clients are in receipt of benefits and there are a number of things they're concerned about. Housing benefit reforms are going to particularly impact on those who live in London and are dependent on private rented accommodation, and it really can't be overstated how much damage these reforms can cause to individuals.'

Many are at risk of being uprooted and separated from all of their support networks, she stresses. 'You're talking about people who've lived in the same areas since they were born – 20, 30, 40 years living where their families are, their doctors, their drug treatment services. To wrench them out of those communities could mean significant damage to their health, and we are likely to see an increase in problematic drug use as a result.'

The lack of detail is also a source of real concern, she says. 'You're seeing a piece of primary legislation being processed through Parliament and yet we're still not quite sure how it's going to impact on vulnerable people – that's what's really worrying. Until we see the final regulations we won't know how much damage it will cause.'

'We want to promote evidence that shows that the model of enforcement you have has very little impact on levels of drug use within a society, and therefore why pursue a harsh law enforcement approach that causes significant damage to those caught up in it, as well as being expensive to the state?'

challenger

All of this anxiety means more calls to the Release helpline, one of the charity's most crucial – and widely admired – services. The Home Office stopped its funding for the helpline in 2005, despite the fact that many callers to the government's £5m-a-year Talk to Frank line end up being referred to Release anyway (*DDN*, February 2011, page 8). Soon after came the recession, and the consequent drop in private and corporate donations, and things were starting to look shaky for a while. Are finances on more of a sure footing now?

'In all the years I've been here, it's certainly been a rollercoaster in terms of funding,' she laughs. 'But I'm pleased to say that for the next year there's sustainable funding, and we've got plans to make sure that the services and campaigning work can continue. One of the things we're going to look at this year is how we can maybe be a bit more innovative in the way we man the helplines.'

This will include looking at recruiting volunteers – drug workers or lawyers in the field – to help out, so that the service can be expanded, she says. 'At the moment it just runs during the day, so it would be good to have a couple of evenings a week where people could get expert legal advice or drugs advice.'

So what will be her other priorities as executive director? 'The core of Release is the services we deliver,' she says. 'Currently we have ten legal surgeries operating in the London area, seeing about 2,000 people a year. We've had funding from the Lloyds TSB Foundation to run some more pilot services so that will expand the programme over the next 12 months and that's really exciting. We hope to be operating in three or four new boroughs within the next 12-18 months.'

And it's the experience of delivering those services that convinces Release that it needs to continue to campaign for legal reform, she says. 'We're going to continue our 'Drugs – it's time for better laws' campaign (*DDN*, June 2011, page 4) and one of the next steps is to publish a paper on decriminalisation, looking at jurisdictions and states across the world and their experience of decriminalisation. We want to promote evidence that shows that the model of enforcement you have has very little impact on levels of drug use within a society, and therefore why pursue a harsh law enforcement approach that causes significant damage to those caught up in it, as well as being expensive to the state?'

Just how expensive it is in the UK – and Release estimates it as anything up to £5bn – is something the charity will try to establish with a forthcoming economic analysis, and it will also be carrying out research on disproportionate policing and prosecution of drugs offences.

'The evidence is that it's not all of society that's affected by drug laws,' she says. 'It tends to be young black men and young people living in areas of deprivation, so we're doing a freedom of information request to the police to build on the evidence that there is a disproportionate impact on these groups. What's happening is we're punishing people who are already living in difficult circumstances, and that's not a just approach within a society.'

Another aim is to extend beyond London, she says, and establish offices in the north and Scotland. 'We get a high volume of calls from those areas and we see a real need for services to be delivered there.'

This will mean expanding the current, highly committed ten-strong workforce. 'Release is the sum of all of its parts, and that's very much the result of the dedication of the staff,' she says. 'We've got an amazing team.'

www.release.org.uk

You can follow Niamh on Twitter: @niamhrelease

David Best considers what a genuinely recovery-oriented system of care should look like

New land

In my new book on the recovery movement, *Addiction Recovery,* I set out a theory for recovery that is based on around 1,000 recovery interviews and completed questionnaires collated in the last five years. Basically, the model is that people achieve stable and lasting recovery as a developmental process of growth, where their personal and social resources (recovery capital) are sufficient that they are in a position to take advantage of a 'window of opportunity for change'. This may be involve formal treatment, but will almost certainly involve engagement with at least one person or group who is the catalyst, the inspiration and the role model for the initial steps to recovery.

One of the big challenges for researchers interested in recovery is the question not only of who is likely to recover and under what circumstances, but who the 'recovery champions' are who will inspire and sustain the recovery journey. While the 1,000 stories suggest that everyone recovers in incredibly diverse and personal ways, the one 'rule' would appear to be that nobody does it alone.

So who are these people who champion recovery? The majority of people who are the catalysts and carers for the recovery journey are themselves in recovery, but this is not a rule and there are numerous occasions on which family members, specialist addiction workers and other professionals are cited as the 'turning point'.

What these individuals tend to have in common is the ability to transmit hope and the positive expectation that recovery is possible, proving their commitment by 'going the extra mile' and being there to support and encourage. With peers this is what Moos (2011) has referred to as 'social control' and 'social learning', where individuals early in their recovery journey can observe and learn how people do their own recovery. We still have no satisfactory research into what the characteristics of the champion are, or whether more is better, although we do have a good idea that more time spent with people in recovery is a good predictor of quality of life (Best et al, 2011).

Another key finding from the body of research I've been involved in, discussed in the book, is that there are broadly two phases of recovery journeys. In the first are the basic enablers that allow for the personal growth that evolves into recovery capital. In this first phase, the key tasks are to help individuals resolve acute crises around health, housing, and the practical barriers to change. This is something that is consistent with mental health recovery journeys (Rethink, 2008). But these are enablers in the sense that they create the conditions from which quality of life and enduring change emerge.

For people to make the leap from the first area (the domain of specialist treatment services and their acute linkage equivalents) to the second, it appears that champions act as the bridge that plants the seeds of hope and the support and techniques to nurture the early shoots of recovery. And for this to happen, the champions have to be visible and accessible.

Critical to the model outlined in *Addiction Recovery* is the idea that social capital is a contagion from one person to another, and while champions do not have to be in recovery, they will almost always provide links and supports to individuals and groups who are. But for this to work, there have to be groups or champions to access, and some knowledge or awareness of them.

While this will often involve mutual aid groups, there can be two problems – one is the lack of visibility to people starting their recovery journeys (in and out of treatment) and another is the off-putting myths and rumours that are often perpetuated by professionals who have little contact with, or experience of, recovery groups, or indeed with wider community assets and champions.

Thus, the success of SHARP and Parkview in Liverpool, of the Basement in Halifax and of LEAP in Edinburgh, is partly about the charisma and strength of their champions, but also because they create strong and supportive bridges from 'treatment' to role models and support structures for recovery. Where recovery is invisible (or exclusively anonymous) there is a structural barrier to recovery contagion.

What this also means is that recovery is easier to achieve in some areas than in others – where there are accessible, visible and attractive champions who are well known in the community and recognised as such in specialist services, the bridge to recovery is both easier to find and easier to cross. And what this means for addiction specialist services is that they have three crucial roles to play in a recovery journey.

First, the therapeutic alliance builds hope and trust and generates a shared belief that recovery is possible. Second, that the specialist service and its links to partner agencies such as housing and primary care enable the person to grow well and safe enough to make recovery choices, and third, that the bridges are in place from treatment to champions and groups of recovery. The research cited in the book on areas that have created successful bridges – Liverpool, the Wirral, Edinburgh to name only a few – suggests that the building of bridges and networks of champions creates the conditions to allow recovery contagion to take place at a community level.

But the contagion is not merely among service users and people later in their recovery journeys. It also crucially takes place in families and communities and, to date, our ability to harness the strengths and resources of the families has been limited. And then there is another critical group – the professionals and their commissioners – whose belief about recovery and their tacit models of change

and wellbeing are critical in strengthening and supporting recovery pathways.

Thus, recovery contagion can be spread and can be role-modelled through workers and teams in exactly the same way that it can with peers, and it seems clear that the worker who believes that their clients can and will recover will do more and will engage better than workers who are jaded, burnt out and sceptical

'While the 1,000 stories suggest that everyone recovers in incredibly diverse and personal ways, the one "rule" would appear to be that nobody does it alone.'

about recovery and its prospects. But while this seems obvious, it is not well understood or well measured in identifying recovery-ready teams and services.

And this brings me to my last point. Recovery-oriented systems of care are a fundamental paradigm shift in what treatment looks like, who delivers it and when. It means a transition in working relationships from expert-patient to partnership; a shift in location of recovery from the specialist clinic to the community; it means a growing role for peers and families and a more circumscribed role for professionals; and it means a system where the assets should reside in the community.

What makes a recovery system includes how good treatment services are, but relies much more heavily on the resources that exist in the local community at three levels – individuals who inspire; groups that support and sustain; and organisations and institutions that adapt to provide the foundations for recovery and to allow the key things – training, housing, health and wellbeing – that enable quality of life to grow in communities that recover and change.

Addiction Recovery is published by Pavilion

David Best is associate professor of addiction studies at Turning Point Alcohol and Drug Centre/Monash University, Australia

ENTERPRISE CORNER

THE ESSENTIAL HAND UP

How can we give job opportunities to those furthest removed from the labour market, asks **Amar Lodhia**

We all know the barriers that problematic drug and alcohol users face gaining employment – lack of education and skills, poor health, stigma and lack of support – and hear the staggering statistics and the costs attached to them every day.

Our united mission is to get service users to successfully complete treatment and transition into employment or self-employment. This is accompanied by increased government pressure to do the same. Add into the mix economic downturn and throw in an increasingly competitive job market, and what do we get? A complete mismatch between policy, labour and the market. It is essential that we not only continue to generate conversation and engage with all stakeholders involved, but that we develop and implement effective solutions together to align policy, labour and the market.

Recently TSBC attended two events where we began taking steps in doing just that. TSBC is part of the London Drug and Alcohol Network's Routes to Employment Advisory Group, whose main focus is to effectively break down the barriers for drug and alcohol agencies and third sector organisations. They aim to ensure they are provided with more guidance and are able to develop or source effective employment training education programmes which can provide consistent and effective advice and access routes into employment for service users.

I attended the Royal Society of Arts (RSA)'s jobs summit last week where panellists including former CBI (Confederation of Business Industry) head Sir Richard Lambert and David Miliband MP discussed how to mobilise the labour market. I asked the following question: 'Where is the incentive for labour market gatekeepers like prime providers and employment agencies to support those furthest removed from the labour market? Should these populations just create their own jobs?'

This is TSBC's Year of Innovation and we have developed a new adult 'Progress to Success' programme. This uses unique tools to support service users to break down barriers and stigma, and gain self-realisation through an employability skills programme that inspires them to apply their skills and career ambitions to the labour market. The aim is to give service users practical skills to actively look for and secure employment.

The LDAN project will be running employer forums as well as workshops in current business forums to develop awareness, training and support resources for employers. Over 99 per cent of the private sector in the UK are small businesses. They account for 50 per cent of our jobs and 60 per cent of our country's GDP. Surely, whether service users set up their own business or are looking for work, small and medium-sized businesses should be a key focus.

Our 'Breaking the Cycle' initiative involves matching the capacity needs of small businesses to those on our programmes, and we help them identify gaps within their organisation – for example if their business is expanding an operation, launching a new product and they need sales and business development support. This initiative is perfectly suited to support their business and help those who are furthest removed from the labour market.

Amar Lodhia is chief executive of The Small Business Consultancy (TSBC), tsbccic.org.uk

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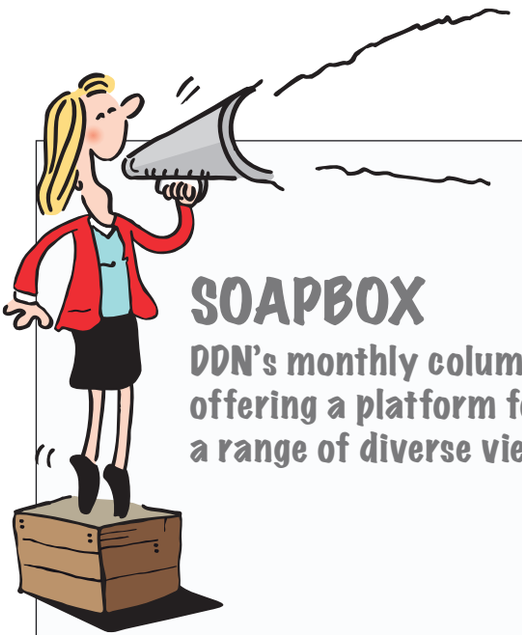

SOAPBOX

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

SHARED CARE – STIRRED, BUT NOT SHAKEN

The skills of GPs are more important than ever to the vision of truly integrated healthcare, says Steve Brinksman

There has been a lot of recent activity on the SMMGP website forums in response to a post from a GP who has been informed that the shared care service in his region is to be decommissioned before the entire service is put out to tender, on the grounds that it isn't cost effective and doesn't fit in with the recovery agenda.

We hope that this is an anomaly, because it seems perverse that after ten years of encouraging primary care to become involved, some would now like us to return full circle to when GPs were actively discouraged from working with substance misusers. Those who trumpet abstinence for all as the only mantra, may see shared care as synonymous with long term methadone maintenance and primary care as full of people 'parked on a script', when in reality many primary care schemes offer a fully integrated system incorporating harm reduction through to recovery and beyond.

The NHS is changing and this will no doubt have a huge impact on drug and alcohol services. Two key messages are consistent: 'moving care closer to home' and 'no treatment about me without me' and it is hard to envisage how these could be delivered for those using drugs and alcohol problematically without significant input from GPs and other primary care practitioners. The aims of the current drug strategy also fit into a strong and robust primary care system, albeit that any system where the GP is simply a 'script robot' will need to be redefined.

Recent figures from the NTA show a decline in the numbers of those entering treatment, but an increase in the average age of those who do access help. We are also seeing an ageing of the population in treatment. This highlights the problems of working with people with co-existing medical problems, and the complexities this brings make the holistic general medical skills of GPs more important than ever.

Transferring of commissioning to local authorities as set out in the *Liberating the NHS* white paper could be seen as moving away from primary care services – however the links between the GP-led clinical commissioning groups and directors of public health will be essential if the vision of a truly integrated service is to be delivered, especially with the increased focus on incorporating alcohol treatment. The scale of the alcohol problem facing this country is immense and if GPs who are prepared to work with substance users in current shared care schemes are disenfranchised, it is hard to see how commissioners will persuade others to become involved. By the same token the increased recent focus on addressing the importance of 'addiction to medicines' – especially opiate-based analgesics and tranquilisers – emphasises the need for GP skills to work with a group who would not necessarily perceive themselves as 'addicts'.

Obviously not all shared care schemes deliver the high quality, effective integrated services that are possible in primary care, but where that isn't happening the answer is to work with all the relevant stakeholders including the local clinicians to redesign services to deliver these outcomes. Services that reflect best practice should be used as exemplars to facilitate service redesign in other areas; the move to localism doesn't preclude learning from others.

At a recent event looking at redesigning primary care services, I was struck by a comment from a service user that 'recovery should begin and end in the community'. GP practices represent the unique local communities that surround them and primary care based drug services are therefore easily accessible. There is huge value in the normality people feel in sitting in a waiting room with other patients as opposed to the stigma of attending a 'drug clinic'.

Primary care should be the hub that services link into, the default position for people to be seen. This doesn't decry the specialist work that goes on, it doesn't prevent those who need residential rehab from going, but it does need key workers to see patients in that setting, to work with GPs to promote abstinent recovery as an achievable aim for many and to be something to aspire to for those who are not yet ready for that step.

I fervently believe that out of the shifting sands on which shared care currently finds itself, we can create an innovative and inspiring primary care based system that solidly integrates the best evidence from harm reduction, medically assisted recovery and sustained abstinence, helping individuals to achieve and maintain their own recovery goals.

Dr Steve Brinksman is SMMGP clinical director. www.smmgp.org.uk

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Coventry Partnership
Towards a safer, more confident city
Coventry Community Safety Partnership

TENDER

for the provision of drug and alcohol user and parent-carer involvement services in Coventry

The Coventry Community Safety Partnership is seeking to tender for the provision of a drug and alcohol service user and parent/carer involvement service. The main element of the service will be to provide user involvement services including peer-led research and consultation. The provider will also offer independent advocacy to support service users dealing with a specific issue in relation to their drug or alcohol treatment.

The contract will be for 2 years and the contract value per annum will not exceed £70,000.

The closing date for the submission of proposals is 4pm on Friday 2 March 2012.

Further details and the tender pack is available from ***www.coventry.gov.uk/tendering*** *citing ref 1658.*

ADDICTIONS COUNSELLOR

35 hours per week including some weekends
Clouds House, Wiltshire

We are seeking to recruit an addictions counsellor to join our multi-disciplinary treatment team at Clouds House. You will have relevant counselling experience working in a residential treatment setting as well as knowledge of 12-step facilitation. You will also hold an addictions counselling qualification at level 3 or equivalent.

For a copy of the job description and information about how to apply please email the HR team on ***human.resources@actiononaddiction.org.uk*** *or call us for a chat about the role on* ***01747 832027****.*

Closing date: Monday 20 February 2012

The post is exempt from the Rehabilitation of Offenders Act 1974 and is subject to a Criminal Record Bureau disclosure check. Action on Addiction is an equal opportunities employer and welcomes applications from all sections of the community.

For more information about Action on Addiction, visit our website

Action on Addiction

www.actiononaddiction.org.uk

Action on Addiction is the only UK charity working across the addiction field in research, prevention, treatment, professional education and family support. Charity No. 1117988.

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EXPRESSIONS OF INTEREST

Substance Misuse Services at HMP Kingston

Portsmouth City Council, on behalf of the **Safer Portsmouth Partnership**, is inviting expressions of interest from suitably qualified and experienced provider organisations or consortia interested in being invited to tender for the provision of integrated, recovery focused substance misuse services at HMP Kingston, Portsmouth. HMP Kingston is a Category C Training prison for Indeterminate Sentenced Prisoners.

The contract is expected to be awarded by the end of May 2012, would commence on 1st October 2012 for a duration of 36 months.

Closing date for expressions of interest will be Friday 2nd March 2012.

Expressions of Interest will be via the completion of a Pre-Qualification Questionnaire which can be obtained from our online tendering website In-Tend: ***http://www.portsmouth.gov.uk/procurement/102 70.html***

The process for these Services would follow a restricted model, but organisations should note that they are part B services as described by the Public Contracts Regulations 2006.

safer portsmouth partnership

HM PRISON SERVICE
Public Sector Prisons

HMP Kingston

Expressions of interest for the provision of a recovery focused substance service in HMP, Isle of Wight

The Isle of Wight Drug and Alcohol Action Team is seeking expressions of interest from suitably qualified organisations, that can demonstrate the knowledge, innovation and ability to deliver substance misuse services in a secure environment, and to meet the needs of a diverse population.

The contract is for a period of three years from 1 October 2012 to 30 September 2015, with the option to extend for up to a period of two years from October 2015 to September 2017.

A more detailed notice has been published on the council's website which can be viewed at: *www.iwight.com/council/procurement*

Expressions of interest can be submitted by completing a pre-qualification questionnaire, which should be returned no later than 2pm on the 27 February 2012.

The questionnaire can be obtained by phoning: (01983) 821000 extension 6343, or emailing: *andrew.pye@iow.gov.uk*

ISLE of WIGHT COUNCIL

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

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INVITATION TO TENDER

The Buckinghamshire Drug and Alcohol Action Team (DAAT) is seeking a provider to deliver its Open Access Substance Misuse service

The contract will deliver an Open Access Substance Misuse Treatment Service which includes the following elements:

- ***Open Access***
- ***Housing Related Support***
- ***Care Co – ordination***
- ***Harm Reduction***
- ***Criminal Justice services***
- ***Service User Involvement***

The contract will be for a period of three years with an option to extend for a further two years subject to annual review and ongoing funding.

Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) may apply to this contract.

The Council uses the South East Business Portal to advertise tender opportunities and run its tender processes.

Tender documents will be available at *https://www.businessportal.southeastiep.gov.uk/* from the 13th February 2012. You will need to register on the portal to access this opportunity.

The closing date for receipt of tenders is midday on the 26th March 2012

BUCKINGHAMSHIRE COUNTY COUNCIL

TOGETHER WE STAND

The fifth national service user conference

Join us in Birmingham for the unmissable event of the year, where service users, treatment providers and politicians debate what's working and what needs to change!

CONFERENCE PROGRAMME AND TIMINGS

9.00 – 10.00 Registration and coffee

10.00 – 11.15 Opening session

Hepatitis C: *Magdalena Harris*, London School of Hygiene and Tropical Medicine. The importance of early testing and improved treatment access.

Alcohol harm minimisation: *Daren Garratt*, The Glebe Centre Wet Room. Establishing a safe environment to encourage engagement.

Alcohol service user groups: *Gary Topley*, The Free From Addiction Project. Overcoming personal difficulties to establish a sustainable grass roots alcohol support group.

Public Health: *Professor Geof Rayner*, Public health guru, co-founder of the Public Health Alliance and the first chair of the UK Public Health Association. Coming home – why drug and alcohol treatment belongs within public health.

11.15 – 11.45 Coffee and networking

11.45 – 1.00 Concurrent sessions

I'm the evidence. Naloxone works: Developing UK personal testimony resources to support naloxone roll-out and reduce overdose deaths. *Neil Hunt and Danny Morris*

Older users: Looking at improved specialist treatment and the issues and stigma faced by older people. *Beryl Poole* and *Simon Wakefield*

Recovery in the community: Inspiration from groups that are establishing practical ongoing recovery communities at a local level. *Alistair Sinclair and friends*

Effective GP communications: How to establish and maintain a partnership relationship with your GP. *Dr Chris Ford and colleagues*

1.00 – 2.30 Lunch and networking

An opportunity for delegates to meet the service user groups from around the UK along with treatment and service providers in the exhibition area, visit the practical demonstration areas and watch service user films shortlisted for the DDN film awards.

2.30 – 4.00 Afternoon session

My story: *Nick Mercer*, counsellor and treatment practitioner. Nick describes his own poignant and often amusing journey of recovery.

The panel debate: Back by popular demand, this session provides an opportunity for delegates to debate and consult on key issues. Chaired by *Neil Hunt*, with panel members including NTA chief executive *Paul Hayes*, Alliance chief executive *Ken Stringer* and Release executive director *Niamh Eastwood*. This is your chance to have your say.

Also including: Video booths, smartphone app launches, recovery choir, essential service user consultations, alternative therapies and massage, NUN and Alliance updates, and much more.

DDN Drink and Drugs News

The Alliance – Taking treatment forward

The Atrium Gallery, NEC, Birmingham

16 February 2012

Full session details, speaker biogs and up-to-date conference information at: www.drinkanddrugsnews.com

Naloxone works: Have you had experience of naloxone that you would be prepared to talk about on film? As part of the launch of this new online resource, we need to hear from people who have either administered naloxone or had it administered to them. If you have a personal experience that you would be prepared to discuss please contact us now

t: 020 7463 2081 e: ian@cjwellings.com

Final online delegate booking still available!
www.drinkanddrugsnews.com