THE FIFTH ANNUAL DDN/ALLIANCE CONFERENCE

DDN
Drink and Drugs News
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DDN Drink and Drugs News

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In it together!

Together We Stand was a sign of good health

Together We Stand (or 'together we run around' if you were on the *DDN* team on the day!) was a lively, fun, vibrant day in Birmingham – the gathering of a growing family from all areas of service user involvement. This year, as always, we witnessed diverse viewpoints being listened to with respect and areas of differing opinion being debated constructively. There were more group gatherings and special interest meetings than ever before – a sign that there's plenty of solidarity in the field of user involvement, both through traditional activism relating to user rights and in the newer recovery movement – and even a meeting on finding common ground.

There were lively sessions that could plant the seeds for change – a discussion that showed a wider naloxone roll-out could be getting closer, a constructive forum to change the doctor/patient relationship for the better, a call to respond to the needs of older users, and evidence of inspiring recovery groups. With these sessions, as with so many of the positive messages from the conference, the work needs to go beyond the event. Shout it loud – service user involvement is alive and well in all its many colours. We've reported on snapshots of many different elements in this special issue of *DDN*. Give us your feedback, tell us of anything we should have noticed, and be proud to have contributed to a movement that's an ongoing force to be reckoned with.

This issue

FEATURES

REGULARS

UK at alcohol death 'tipping point'

The UK has reached a 'potential tipping point' for tackling alcohol-related deaths, according to the Royal College of Physicians' special advisor on alcohol, Professor Sir Ian Gilmore. If current trends continue, the next 20 years will see 210,000 avoidable alcohol-related deaths – 70,000 from liver disease and the remainder from accidents, violence, suicide, cancers and chronic conditions like cardiovascular disease.

Alcohol-related liver deaths in England and Wales fell from 6,470 in 2008 to 6,230 the following year, but then rose again to 6,317 in 2010. In a comment piece for *The Lancet* co-authored with the University of Southampton's head of clinical hepatology, Dr Nick Sheron, Gilmore points out that the peak age for alcohol-related deaths is in people aged 45-65, and that alcohol is a factor in more than a quarter of deaths in men aged 16-24 – 'a shameful, preventable loss of life'.

A new report from the British Liver Trust, meanwhile, points out that alcohol-related deaths overall have doubled since the early 1990s and states that the 'current death toll from alcohol is equivalent to a passenger-filled jumbo jet crashing every 17 days'. Alcohol accounts for 80 per cent of deaths from liver disease, which is the fifth most common cause of death, it states, and prevalence of which could overtake stroke and coronary heart disease within ten to 20 years.

Prof Gilmore has long been an advocate of minimum pricing per unit of alcohol and there has been speculation that provision for some kind of minimum price could form part of the government's alcohol strategy, published later this month, although health secretary Andrew Lansley is known to be opposed to the idea and public health minister Anne Milton has questioned its legality.

The government has previously favoured banning the sale of 'below cost' alcohol – defined as the cost of duty plus VAT – which is due to be introduced next month, although Alcohol Concern said it would 'barely touch the sides' in terms of tackling problem drinking (*DDN*, February 2011, page 4). A recent study by researchers at Newcastle University found that a 'below cost' ban would affect fewer than 2 per cent of Newcastle's available alcohol promotions.

Portman Group chief executive Henry Ashworth, however, warned against 'Soviet Union style population controls' and said that 'doomsday scenarios' would not help to reduce alcohol misuse. 'The UK government will have to withstand powerful lobbying from the drinks industry, but the prize of reversing this tragic toll of alcohol-related deaths is there for the taking,' stated Prof Gilmore and Dr Sheron.

Meanwhile, a new report from Alcohol Concern urges the Welsh government to invest in local alcohol treatment services and make clear how much is spent on 'prevention and treatment of alcohol misuse, separately from spending on other drugs'. *Everyone's problem* also challenges the idea that alcohol misuse is the preserve of a small group of 'problem drinkers', and calls on policy makers to do more to tackle stigma.

'In reality, the line between sensible drinking and alcohol misuse is not always clear, and many of us cross it from time to time,' said manager of Alcohol Concern Cymru, Andrew Misell. 'Getting rid of the stigma around drink problems is not easy given the drinks industry's insistence that alcohol is a neutral product that only causes problems in the hands of irresponsible consumers – a so-called mindless minority.'

A new £1m fund for local communities to tackle 'binge and underage drinking' has also been announced by the Department for Communities and Local Government. The money will be allocated to ten local areas via a bid-based application process, and will be based on 'models of grassroots projects already delivering for their neighbourhoods'. 'We need direct, effective action on the ground to make a difference, and to make "sociable drinking" the acceptable norm,' said the government's 'champion for active safer communities' Baroness Newlove.

Prof Sir Ian Gilmore: Alcohol is a factor in more than a quarter of deaths in men aged 16-24, 'a shameful, preventable loss of life'.

See news focus page 6. *www.communities.gov.uk www.ncl.ac.uk Everybody's problem available at tinyurl.com/8246fuy*

Fewer young Scots using heroin – downward trend continues

The number of Scottish drug users aged under 25 who reported using heroin fell from 51 per cent in 2009-10 to 44 per cent in 2010-11, according to the latest figures from ISD Scotland and NHS Scotland. This confirms an overall downward trend since 2006-07, says *Drug misuse statistics Scotland 2011*.

In 2010-11, 10,813 'new' individuals sought treatment – down by almost 1,000 from the previous year – with their age profile continuing the 'ageing' trend of the last five years. In 2006-07, 51 per cent of clients were aged 30 and over, rising to 60 per cent in 2010/11. Among over-40s, meanwhile, the number of new clients receiving a specialist assessment rose from 15 per cent to 19 per cent over the same period.

Of the overall total of those who reported illicit drug use, 62 per cent reported using heroin, a fall of 5 per cent since the previous year. However the report points out that this figure has fluctuated since 2006/07, with a similar decrease between 2007-08 and 2008-09, followed by an increase in 2009-10. Heroin, however, was less commonly reported in the drugs profile of younger people, with 65 per cent of all age groups over 25 reporting using heroin compared to 23 per cent of 15 to 19-year-olds and 54 per cent of 20 to 24-year-olds.

'Significantly fewer young people are using illegal drugs and placing their health and lives at risk – however we are seeing a cohort of hard-to-reach individuals who have been using drugs for more than a decade,' said community safety minister Roseanna Cunningham. 'They are getting older and their risk of drug-related death is greater. But they are not lost to us. We have reformed Scotland's approach to tackling drug misuse – we now focus on the individual, not solely their addiction.'

A separate ISD Scotland/NHS Scotland report on drug-related deaths reveals 365 cases in 2010, 80 per cent of whom were male. The highest frequency of deaths was in the 25 to 34 age group at 35.9 per cent, followed by 35 to 44 at 32.3 per cent. More than 62 per cent had been in contact with drug treatment services at some point prior to their death.

NHS Greater Glasgow and Clyde's public health protection unit, meanwhile, is advising injecting drug users not to share needles or other equipment following six new diagnoses of HIV among people who inject drugs since the start of the year. People should 'take all the safety precautions necessary to protect themselves and others' said the unit's Eleanor Anderson. A list of free and confidential testing services in the region for anyone concerned is available at *www.nhsggc.org.uk*

Drug misuse statistics Scotland 2011 and National drug related deaths database (Scotland) report 2010 available at www.isdscotland.org

NTA sets out 'recovery-focused' budget allocations

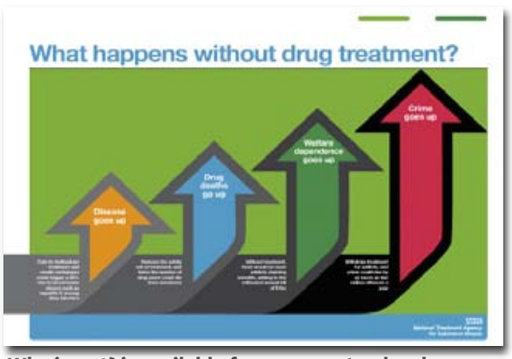
The NTA has informed local partnerships commissioning drug treatment services how much they will receive in 2012-13 from a 'total budget for community and prison services that continues to be worth about £570m', the agency has announced.

From next month, a proportion of the national contribution to local funding will reward areas 'on the basis of the number of individuals who successfully overcome addiction'. The revised funding distribution formula (*DDN*, March 2011, page 5) is 'in line with the government's plans to explore ways in which treatment providers can be paid for the results they obtain', says the NTA.

The core of the central government contribution remains the adult pooled treatment budget (PTB) – unchanged at £466.7m for 2012-13 – but 20 per cent of the allocation will be based on the number of people who complete treatment and do not return within six months, in anticipation of the national drugs outcome indicator (*DDN*, February, page 4) that will be measured by Public Health England when it takes over the NTA's functions from next year.

'At a time when all budgets are under pressure and many publicly funded programmes are being significantly reduced, the government continues to demonstrate its commitment to increasing the numbers recovering from drug dependency,' said NTA chief executive Paul Hayes. 'The government has maintained unchanged its contribution towards the cost of treatment services, so the onus is now on local authorities to ensure they continue to invest in services to support treatment and sustain recovery.'

The NTA will also shortly publish the responses to its *Building recovery in communities* consultation on a new service framework to replace *Models of care* (*DDN*, February 2011, page 5), and in the meantime has made available a range of support for partners 'developing effective locally owned systems'.



***Why invest?* is available from www.nta.nhs.uk**

These include materials for commissioners and strategic partners on the Joint Strategic Needs Assessment process, as well as a presentation, *'Why invest?'* (*DDN*, February, page 4), on how investing in local services 'benefits individuals, strengthens families and makes communities safer'. The presentation spells out the arguments for treatment and demonstrates what can happen without it, shows how an integrated treatment system works, and illustrates a drug user's steps to recovery.

Methodology for revised formula at www.nta.nhs.uk

Materials available to download from www.nta.nhs.uk or by emailing communications@nta-nhs.org.uk

Paul Hayes addresses service users at Together We Stand – see page 20

Police refute 'no go' drug areas claim

Claims in British newspapers that parts of some cities are now 'no go areas' comparable to areas of Brazil and Mexico have been refuted by the Association of Chief Police Officers (ACPO).

A number of papers ran stories that drug gangs were 'controlling parts of British cities' based on a section of the International Narcotics Control Board's (INCB) new annual report. *The Guardian*, however, stated that it had declined to run a story from the Press Association wire service headlined 'Drug gangs creating no go areas' as the quotes were a small part of a 'much bigger and not particularly important report' and 'did not justify the eye-catching headline'.

The paragraph seized upon by newspapers concerns community policing, and discusses how forces in cities such as Birmingham, Liverpool and Manchester 'like their colleagues in Brazil, have also sought to address the problem of incidents involving firearms by combining law enforcement responses to the problem with community policing initiatives aimed at building trust and mutual support with community members'. These include officers working closely with siblings of gang members who are at risk of being drawn into gang culture themselves.

'I simply do not recognise the reference to "no go" areas in the UK,' said ACPO lead on drugs, chief constable Tim Hollis. 'All police forces work closely with local authorities, criminal justice partners and local communities to tackle criminality in relation to drugs, acting on intelligence received and addressing problems robustly.'

The report also highlights the increasing use of 'designer precursor' chemicals for the manufacture of amphetamine-type stimulants and warns of 'illegal internet pharmacies' targeting young people via social media sites like Facebook.

The INCB is responsible for monitoring implementation of the international drug control conventions, and president Hamid Ghodse addressed concerns about the effectiveness of the conventions by stating that there is no better alternative 'foreseeable' to the present drug control system, and that many of the arguments presented for legalisation were 'deeply flawed'.

INCB annual report available at www.incb.org

News in Brief

BOWER BOWS OUT

Care Quality Commission (CQC) chief executive Cynthia Bower has announced her resignation from the organisation after four years. She will remain in post at the regulatory body, which has been dogged by controversy (*DDN*, February, page 15 and this issue, page 28), until the autumn to allow for 'an appropriate handover'. 'The process of setting up an entirely new system of regulation has been intensely challenging, but we have accomplished an enormous amount,' she said. 'We have merged three organisations, registered 40,000 provider locations and brought virtually the entire health and social care network under one set of standards, which focus on the needs of people who use services.' *To register for David Finney's DDN/FDAP workshop on the new inspection regime on 14 March email kayleigh@cjwellings.com*

FAMILY FACTS

A survey of frontline workers and their views of local responses to families affected by parental substance misuse has been launched by the NTA and the Children's Society. The survey covers issues like identification and assessment, workforce development and partnership working, with the findings used to help identify gaps in service provision. *Available at www.nta.nhs.uk until Friday 9 March*

HOMELESS HELP

Every homeless person should get the support they need for a healthier life, according to a new paper from charity Homeless Link. Services also need to work together to prevent people from ending up on the streets, says *Helping homeless people regain their health: our vision for a better NHS*, which includes recommendations and practical advice for commissioners and providers. 'By shutting them out of everyday services, many homeless people end up relying on expensive emergency services to meet their chronic health needs,' said head of policy Alice Evans. *Available at homeless.org.uk*

PROJECT PLAUDITS

Westminster Drug Project (WDP) has been named as one of the *Sunday Times* '100 best not-for-profit organisations to work for' for the second year running, based on employee surveys on areas like leadership, benefits and opportunities for personal growth. 'This recognition further cements the importance that we place on our people, and illustrates how essential their personal and professional growth is to both our organisation as a whole and the day-to-day work they do to help people recover from drug and alcohol dependency,' said WDP chair Yasmin Batliwala. The charity has also been awarded the 'Investing in Volunteers' good practice standard from the Volunteering England membership organisation

HERE WE GO AGAIN?

Could the government's forthcoming alcohol strategy finally include minimum pricing? And is even that enough on its own to tackle the country's drink problem, asks DDN

The UK is now at the 'tipping point' for tackling alcohol-related deaths, say past president of the Royal College of Physicians Professor Sir Ian Gilmore and liver disease expert Dr Nick Sheron (see news story, page 4), with a potential 200,000-plus alcohol-related deaths over the next two decades. The current death toll from alcohol is the equivalent of a fully occupied jumbo jet crashing every 17 days, adds the British Liver Trust.

With the government's much-anticipated alcohol strategy due later this month, is it really now or never in terms of tackling alcohol-related harm, or are these – as industry organisation The Portman Group would have it – simply unhelpful 'doomsday scenarios'?

A visit by prime minister David Cameron to a Newcastle hospital to deliver a statement about the cost of alcohol-related harm led to much speculation that the new strategy might include provision for minimum unit pricing, despite well-known antipathy to the idea from key government health figures.

While Scotland's attempt to introduce a minimum price has faced constant setbacks, many believe that last year's majority win for the SNP and a seeming change of heart on the issue by the Scottish Lib Dems (*DDN*, December 2011, page 6) mean the government will now get its Alcohol (Minimum Pricing) Bill through, and calls for a minimum price south of the border grow louder all the time.

Inevitably, both Cameron's speech and the *Lancet* comment by Gilmore and Sheron led to a blizzard of defensive press releases and statements from the industry. 'It is really important that we put this in context,' said Portman Group chief executive Henry Ashworth, who warned of the danger of 'Soviet-style population controls'. Both the Portman Group and the British Beer and Pub Association (BBPA) talked of the dangers of penalising or alienating 'the majority of drinkers' who use alcohol sensibly, with the BBPA even delivering a 'message in a bottle' to MPs calling for a freeze in beer duty in this month's budget, along with an end to the beer tax 'escalator' (*DDN*, 6 December 2010, page 5).

'I hope this grabs MPs' attention,' said BBPA chief executive Brigid Simmonds. 'As our message says, the British beer and pub sector supports around a million jobs in the UK.' And there, many health campaigners believe, lies the main problem. The British drinks industry is vast – Guinness and Smirnoff producer Diageo is the third biggest alcohol company in the world – and politicians are understandably wary of going up against this level of economic and lobbying might.

Both the Portman Group and BBPA stressed the importance of strong partnerships in tackling alcohol misuse, but it was the perception of the government's alcohol responsibility deal between the industry, retail and voluntary sectors as 'all carrot and no stick' for the industry that led the Royal College of Physicians, BMA, Alcohol Concern and The British Liver Trust to walk away from it.

The decision was down to the 'fundamental conflict of interest inherent in the deal', British Liver Trust chief executive Andrew Langford tells *DDN*. 'The alcohol industry has in the past, and still has, too much clout in formulating alcohol policy. The clear outcome – rising liver deaths – is ignored and disregarded. For more than ten years we have been persuaded to play the long game, sitting and watching the alcohol industry cultivate their relationship with the government. Now it must stop for the sake of the 100-plus families losing loved ones each week from alcohol-related liver disease.'

But what about the Portman Group's talk of 'unhelpful doomsday scenarios' and penalising sensible drinkers? 'The drinks industry are very good at influencing public opinion, due to the vast amount of money they spend on alcohol advertising and lobbying,' he says. 'What the public probably don't realise is that they are already being penalised through their taxes and are already paying for the collateral damage that alcohol causes, including the spiralling health and policing bills.'

The trust is encouraged by the positive noises about minimum pricing, he says, which follows government recognition of the relationship between price and alcohol when it announced its curb on below-cost selling (*DDN*, February 2011, page 4). 'While a poor and ineffective tactic, it did highlight that the government acknowledged the importance of price in tackling alcohol consumption issues,' he says.

But while keen on minimum pricing, the trust is also adamant that it would need to go hand in hand with a range of well-funded treatment options – 'it's vital that a comprehensive strategy is developed that tackles all aspects of alcohol consumption' he says. Public Health England will bring drug and alcohol treatment together for the first time, but as Paul Hayes pointed out at *Together We Stand* (see page 21), drug treatment has historically been much better funded. Is he optimistic that the new organisation could signal a positive change?

'In theory, yes, however we must be careful in how services are configured. We are already seeing signs of people who are not willing to access alcohol services due to its association with drugs. It's important to tailor services, however with alcohol-related conditions affecting more and more of the population each year we need to have services that are accessible, welcoming and suitable for the general population and the 'functioning' alcoholic-dependents who would not ordinarily seek help.' **DDN**

The British Beer and Pub Association's 'message in a bottle' – a call to MPs to freeze beer duty in this month's budget, as well as end the beer tax 'escalator'.

Post-its from Practice

Double check for dual diagnosis

Don't forget mental health in people who drink, says Dr Chris Ford

A VERY UPSET COLLEAGUE OF MINE, Ruth, was in my room saying, 'What have I done? How could this have happened when I did all they told me to do?' She had sent John, one of her patients, to see the psychiatrist, as he was getting more depressed and had marked suicidal ideation.

John was 56 years old, single, had worked all his life in the building trade, and had drunk between 60-100 units a week for most of the past 30 years. He had detoxed on a number of occasions, but had not 'felt right' when he wasn't drinking. He had been helped by fluoxetine for the past three years but his mood had deteriorated after the death of his mother several months ago. Ruth was reluctant to change his anti-depressants without specialist advice and had also wanted psychological support for John, but the local community IAPT (Improving Access to Psychological Therapies) service will not see people with drug or alcohol problems, so she could only access counselling through mental health services.

It had taken a few weeks to get John assessed by a psychiatrist, who said it was impossible to help him until he stopped drinking – and that if he did, his depression would probably go away. John got a place in detox quickly, because of a cancellation. Physically he coped well, but his mood got worse. On completion he was discharged back into the community.

John had been home for just four days when Ruth received a call from the local hospital to say he had been admitted the previous night. He had tried to hang himself and was going to be transferred under section to the psychiatric unit.

Ruth felt she had failed him, but she had treated John properly and had worked to her level of competence and confidence, with compassion. She had asked for help when she needed it, and this was when the mistakes started happening – it had taken weeks to get the appointment and there was no help until the patient stopped drinking.

We know that psychiatric illness can precipitate, as well as worsen, drug and/or alcohol problems, and that substance use can lead to psychiatric symptoms. Over the last 20 years we have recognised higher levels of dual diagnosis and there is now strong evidence to show the rate of substance misuse is substantially higher (35-60 per cent) in the mentally ill. These rates are even higher in inpatient and emergency settings.

Also, nearly three-quarters of the drug treatment population, and over 85 per cent of the alcohol treatment population, were found to have mental health problems – mostly depression and anxiety disorders, as well as psychosis.

Dual diagnosis should therefore be central to mental health care, and drug and alcohol interventions integrated or 'mainstreamed' into mental health services – not dismissed, as this psychiatrist seemed to do.

We will never know what would have happened if John had been given bereavement counselling, a change of antidepressant and ongoing help from the mental health services after his primary assessment, but I suspect he would be in a better state. And don't forget, even if linked to payment, never force people into a detox they don't feel they can do. Always be aware of patients' underlying mental health, and be ready for a problem that may emerge when reducing.

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

LEGAL LINE

CAN I SAVE MY SON FROM BEING EXPELLED FOR CANNABIS USE?

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

Reader's question:

My 15-year-old son has been temporarily excluded from school for possession of a small amount of cannabis and I'm really worried that he will be expelled completely. He took it in by mistake as it was left in his pocket from the weekend. I know it was a stupid thing to do but I don't want his education to be affected by this – he's got his GCSEs next year. Is there anything we can do?

Kirstie says:

Permanent exclusion from school should always be the last resort and generally occurs following a pattern of behaviour and failure of other measures. However, there are circumstances where one-off breaches of school policy will justify immediate and permanent exclusion – this may include alleged supply of drugs. There does not appear to be any issue of supply in your son's case though.

When a pupil breaks school rules as your son has, it is standard procedure for there to be a period of temporary exclusion while the matter is investigated and any action is considered. The headteacher will look at the circumstances of the incident, your son's explanation and previous behaviour record. Exclusion will normally be for a fixed term and you will be informed what the date of return will be, and work will be set to do at home. During the time that your son is excluded you must ensure that he is not in a public place during school hours, unless he has a reasonable excuse (*eg* a medical appointment).

If the headteacher decides that your son should not return to school, they must inform you of the decision, and give right to appeal, in writing. Any challenge to the exclusion will go before the school governors and will be an opportunity to put forward your views and any supporting evidence. The governors can either agree with the headteacher's decision or overturn it and allow a pupil to return to school. A negative governors' decision can be appealed to an Independent Appeal Panel (IAP) which has the same options open to them as the governors. However, they also have a further decision available to them – to advise that a pupil is taught elsewhere because there has been a breakdown in relationship between the family and school. This is not the same as approving of the exclusion.

The last possible route if the IAP upholds the original decision, is to take legal action. However, this will only be realistic in very limited circumstances and is unlikely to attract public funding.

The Department for Education publishes guidance on exclusion, which you should look at. Additionally, The Children's Legal Centre provides free legal advice and information to parents on education matters and can be contacted on 0808 802 0008.

Email your legal questions to claire@cjwellings.com and we will pass them to Kirstie to answer in a future issue of DDN. Contact the Release legal helpline on 0845 4500 215.

KNOWLEDGE IS P

'Quality hep C treatment is a right... don't let anyone tell you anything else. It's time to stand together and make a fuss.'

Magdalena Harris

'Substance use policies reflect power, politics and the perspectives of the times...There's no consistency in the past, and there's no consistency now.'

Professor Geof Rayner

'Knowledge is power – getting a diagnosis and finding out where you stand is empowering,' Magdalena Harris of the London School of Hygiene and Tropical Medicine told delegates in her opening session on the importance of early testing and treatment access for hepatitis C.

A desire to 'know how others coped with the problems I faced' had led her into the field of hepatitis C research, she said. She'd been diagnosed aged 24, but 'just put it to the back of my mind and carried on using.' By the time she was 29, however, she was facing a prison sentence and entered rehab 'because it would look good'. While there, a doctor urged her to start hepatitis C treatment and, although she was initially deterred by the side effects, she agreed. 'It felt like a ball and chain,' she said. 'I was incredibly tired all the time, but I decided it would be six months of hell in order to feel better for the rest of my life.'

She began doing research into hepatitis C at university, and then received a scholarship to do a PhD on the virus. One of the first things she'd learned was the importance of skilled, non-judgemental staff, she told the conference. 'What I noticed in doing research with service users is that the way the testing is offered can be a problem – it can be about ticking a box, and done in a cursory manner. That's often why people don't get tested.' Some service providers didn't want to talk about hepatitis C because 'they don't know that much about it themselves', she added, with the situation not helped by 'all the long, complex forms they have to fill in'.

However, more drug treatment providers were now offering hepatitis C treatment, partly in response to the fact that some service users found hospital treatment too rigid, and many were deterred from accessing hospital-based services because of previous bad experiences. 'But if they're going to implement hepatitis C treatment then service users need to be involved, to make sure it's done properly,' she stressed.

One of the chief benefits of testing was the simple fact of knowing your status, she told delegates. 'A lot of people assume they have it, when actually they don't. Having an illness can affect your self-concept, the way you feel about yourself.' Benefits of treatment, meanwhile, went beyond clearing the virus to encompass lifestyle change – as treatment could act as a 'turning point' – and a potentially 'huge boost for self-esteem'.

Another key issue was the way service users often viewed themselves, she said. 'I don't hear a language of entitlement – I hear a language of gratitude. People feel they're not worth it, or the barriers are just too great. The title of this conference is *Together We Stand*, but I don't see a lot of standing together among service users around hep C testing and treatment.'

It was important to combat the stereotypes of service users as apolitical and passive regarding their healthcare, she stressed, and peer support was also vital. 'Quality hep C treatment is a right, and should be advocated for as such. We need to think about what we can do to make a difference, and whether we're happy to be seen as a silent population. Current injectors are eligible for hep C treatment – don't let anyone tell you anything else. It's time to stand together and make a fuss.'

GARY TOPLEY OF THE FREE FROM ADDICTION PROJECT described a similar trajectory of being inspired to help others through his own experiences – in his case, with problem drinking. Put into the care system at the age of two, he went from a children's home to a foster family but struggled to find a bond with his adoptive mother. There were problems at school and trouble with the police, and the fact that his adoptive father was a professional darts player meant an early exposure to alcohol. 'I was being served in off-licences from the age of 13,' he said.

He was expelled from school then forced to leave a shared house because of his drinking, moving to a hostel where his alcohol intake increased and he began to self-harm. 'I hadn't dealt with the issues I had,' he said. 'I'd just run from them. I went totally off the rails. I was constantly drinking, getting arrested, and it seemed like wherever I moved I took my problems with me.'

He was arrested for stabbing his ex-girlfriend's new partner, his son was put up for adoption, and

OWER

The fifth annual DDN/Alliance conference, *Together We Stand*, began with inspiring presentations on setting up your own organisation, alcohol harm reduction, the importance of hepatitis C testing and putting the new public health landscape in context

any attempt at a fresh start was sabotaged by heavy alcohol use. Finally, following another fight, he received a custodial sentence. 'I felt useless and stupid. But it wasn't myself I blamed, it was the alcohol. I was released early, but guess what happened – I started drinking again, even more heavily than before.'

The catalyst, however, was having a daughter with a new partner. 'When she was three months old I asked myself if I really wanted her to be brought up in this environment. I decided I wasn't going to drink anymore, and I haven't. It's been tough, but I wanted to focus on doing what I wanted to do – helping others.'

He wrote to the local police explaining his aims, and they put him in touch with Derbyshire DAAT. 'It seemed strange to be sitting in meetings with the people I used to be against,' he said. When someone suggested he set up his own project it seemed too daunting a prospect, but he eventually established Free From Addiction in May 2010 and set about looking for funding. 'As you know, asking for money is no easy thing,' he told delegates.

From four members at the outset, the project regularly has 30-40 people attending its weekly meetings, and helps many more via email and social networking. It regularly contributes to alcohol awareness stories in the media and has already won several awards. 'I don't know what the future holds for the project, but I want to continue reaching out to support people who need help,' he told the conference. 'By working together we can make this country a better place for people who are in recovery.'

CONTINUING WITH THE ALCOHOL THEME, Daren Garratt of The Glebe Centre addressed the conference on the often-controversial area of alcohol harm minimisation. 'I'm not going to flower it up as being "harm reduction as a part of recovery", but as a systematic approach to maximise benefits for everyone – in terms of both health and budgets,' he said.

Alcohol harm reduction remained a hotly debated area, he told delegates. 'We've got a wet room at our service, and they're basically seen as drinking lounges in hostels. But if people want help and support, we provide it for them. We've got foreign street drinkers who use A&E like a GP's surgery because they're not registered with a doctor, at a cost of hundreds of pounds a time. So getting them registered with a GP – that's harm reduction. We can keep people off the streets, and we can keep them out of hospital.

'We are in a weird political climate,' he acknowledged. 'But you can seize the opportunity and do effective work if you don't see things as one-off interventions.'

CO-FOUNDER OF THE PUBLIC HEALTH ALLIANCE, Professor Geof Rayner, meanwhile, gave an overview of public health, putting harm reduction in its historical context as drug and alcohol treatment prepares to be taken over by Public Health England next year.

'When I started working in public health it was in local authorities,' he said. 'It was taken out in the '70s, and it's about to go back in, but it's always been about preventing harm and stopping the waste of lives. We need a model of public health that's about keeping people and families safe – we're talking about very long, intergenerational timescales.'

The last 200 years had seen vastly improved life expectancy, he said, but there were still a range of 'anti-health industries' to contend with. 'Some are illegal, and some are legal and approved, like tobacco, alcohol, gambling. I simply look at things in terms of the harm they cause – it's not a moral issue.'

The old models of public health were no longer able to address the complexity of today's society, he explained. 'The determinants of health are messy – there are no simple answers to solving anything.' It was also important to understand societal and philosophical questions – of biology and behaviour, and freedom and control, among others. 'Substance use policies reflect power, politics and the perspectives of the times – before the First World War you could buy cocaine in Harrods. There's no consistency in the past, and there's no consistency now. It may not even be possible to create a policy-consistent world.'

All policies had unintended consequences, he pointed out. 'The first national harm minimisation policy was giving out beer to stop people drinking gin – the Beer House Act of 1830. But then competition between beer companies led to stronger and stronger beers – unintended consequences. But what we know doesn't work is criminalisation.'

One in four US prisoners were incarcerated for drugs offences, he said. 'There are more young black and Latino people in prison in America than in higher education. It's a moralising policy which doesn't look at harm – it creates harm. At the same time, harm minimising strategies like syringe exchange and maintenance can be effective, but they also have unintended consequences. So we have to manage them carefully.' It was vital to build policies out of 'open-minded debate, admission of failures and involvement of the people affected', he stressed.

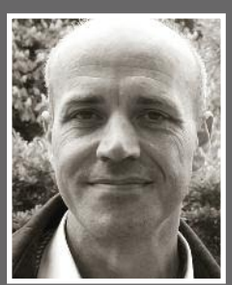
'It's back in local government now. But how well this works will be down to you making your case.' **DDN**

From top to bottom: Magdalena Harris, Daren Garratt, Gary Topley and Professor Geof Rayner

UK RECOVERY FEDERATION

VOICES OF RECOVERY

With the UKRF's regional recovery seminars underway, **Alistair Sinclair** reports back in the first of a series of columns



LAST NOVEMBER over 40 community members gathered on a rather chilly Monday evening in the Friend's Meeting House in Lancaster for the first North Lancashire UK Recovery Federation (UKRF) seminar. Other recovery seminars took place around the same time in Salford, Huddersfield and Norwich and many more are planned for 2012 across the UK. Bringing people together to explore their similarities, passions and strengths as human beings and focusing on the generation of asset-based community-led responses to community issues, the UKRF hopes to support people in recovery and recovering to identify, develop and sustain new, open and inclusive recovery networks.

One of the core aims of UKRF is to 'give a voice and face to recovering people and people in recovery'. *DDN* has offered us space over the next year to let people know how we are getting on within the diverse and inspiring recovery communities that are springing up all over the UK. We intend to use it to promote the many 'assets' out there in communities and to get some new voices heard. Here's Anthony:

'Survival 101: when you need to start a fire in the wilderness, one of the best and easiest ways is to use a "fire dog": a blackened, bubbled and blistered log or stick that has been in a fire before, has been put out, cooled and left to weather the rain, the wind and whatever else the great outdoors throws at it. Given time and opportunity to dry out, these fire dogs catch a spark easily and quickly ignite, giving enough heat and energy to bring swift flame to whatever tinder is thrown onto it.

'What I witnessed on Monday evening was an excellent lesson in what happens when we fire dogs – we who bear the marks of our time in our own fire – we who have weathered the storms of our own, usually self-created, wilderness and have been abandoned and left as clutter even perhaps by ourselves; we who could see no use and no purpose in our sorry, worn and broken state; we, even we, once dried out and given the spark of hope, burn more fiercely and brighter than ever.

'I saw people who believed hard, dreamed big and hoped tenaciously: passionate people of hope and character, imperfect but willing to fight for something, for people like themselves, for hope re-kindled. The road to recovery can feel like survival sometimes; a balancing act of what is expedient, what is safe and what is necessary, all in the midst of the sometimes overwhelming complications of living in the community.

'It can be wearing. Worn as I am, the unity of purpose, the acknowledge - ment of the skills already present in the recovering and the vision of those in the recovery community revealed on Monday evening was, to me, like a warm fire on a cold dark night. "Without vision, the people perish", so here's to the "fire dogs": fan the flames of your reignited hopes because they are brave, encouraging and, perhaps more importantly, infectious.' (Anthony Rei, after the first North Lancashire UKRF recovery seminar.)

We make the path as we walk it.

Alistair Sinclair is director of the UKRF

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Cameron has to face up to one historic fact: the British love drinking, and love drinking lots. The tactic he favours – making cheap drink less cheap – shows where his heart lies. It is the lower orders he has in his sights, and on the lines that 'an alcoholic is someone you don't like who drinks as much as you do', he has more or less declared that he does not like people at the bottom end of the social scale.

Nicholas Lezard, *The Guardian*, 15 February

Sorry, parents, if your children are going to take drugs, they'll take them, from herbal powders bought from the internet, to class As. For the most part, their complacency is tied up with being young and reckless, with delusions of invincibility. But what of the complacency of older generations: the worldly-wise who've 'been there, done that' with drugs (or think they have). People who can't resist opining on a drug culture which the vast majority of them probably haven't participated in for years? How much damage is being wrought by their complacency – or, more precisely, their ill-informed, outdated pseudo-liberal posturing?

Barbara Ellen, *The Observer*, 5 February

Killing yourself with drink and drugs costs society, *ie* law-abiding taxpayers who fund the police and NHS, a hell of a lot of money. It seems unfair that one group of bingers should be able to take more money from the state, to pay for their care, than I do.

Janet Street-Porter, *Independent on Sunday*, 19 February

Labour politicians, charities and the muesli-knitting classes in general have raised the spectre of the coalition's attempts to curb our ballooning welfare bill as an onslaught on the most vulnerable in society... Bunkum.

Kirsty Buchanan, *Sunday Express*, 5 February

Do the medical schools teach students *Alice in Wonderland*, in order to develop their ability to believe six impossible things before breakfast? Some people might suspect that if the idea of reducing the strength of alcoholic drinks were put into practice, people who were keen to get drunk could just drink a bit more... It would be a refreshing thing if the medical profession could return to giving us advice rather than demanding restrictive new laws. It would be a tonic if doctors would base their advice on genuine evidence and honest research rather than statistics invented by someone's PR office.

Steve Doughty, *Daily Mail*, 8 February

We need to de-glamourise alcohol – celebrities have a role to play as we know the influence they have. But we all need to be more responsible; teaching our children sensible limits and drinking responsibly ourselves. How many people reading think it is OK to drink a bottle of wine a night?

Nick Edwards, *The Independent*, 15 February

Much as women have been admonished to shop, and be tiny, we have been brainwashed into believing drinking to be part of a 'lifestyle choice'. The marketing has been blatant (Moet & Chandon ads in the glossies) and subliminal – a champagne flute in the hand in a fashion shot.

Liz Jones, *Daily Mail*, 18 February

VOX POPS

Throughout the day Paolo Sedazzari was in the DDN video booth, inviting delegates to share their views

Tony Birt, SevernSense
'We have been too interested in our own camps... to the point where activists are having meetings to decide if they can talk to each other... we need to remember the shared experience and commonality of stigma, discrimination and being outcast.'

Matthew Denham, The Small Business Consultancy (TSBC)
'The small business consultancy was created in 2009, and we have a vision to create a society where nothing holds people back from becoming successful. We do this by empowering people through enterprise.'

Chris Campbell, SMUG, to Gary Topley, Free From Addiction project
CC: 'You have faith in your own integrity, being who you are, being authentic and genuine.'
GT: 'Being real'
CC 'The integration is getting people back into the community'
GT: 'We've done that through diversionary activities, going biking together, gardening on our group allotment, film and video clubs... We've made things as diverse as possible to get people back into the community.'

Gary Topley, Free From Addiction project
'If people see this and think it's impossible to set up your own project, you've just got to believe in yourself and realise there are people out there that still need help, and what better help than help from their peers.'

A taste of therapy

Trainee therapists Llinos and Beccy offered delegates massage taster sessions, performing short treatments in reflexology and scalp massage. The students, who are doing their complementary therapy techniques diploma at Bridgend College, enjoyed their experience of helping delegates relax and improve their sense of wellbeing. *Voluntary contributions were donated to the charity Able Child Africa, http://ablechildafrica.org*

SPIRIT OF PARTNERSHIP

The National User Network (NUN) is building on achievements for another busy year

IN THE SPIRIT OF PARTNERSHIP WORKING, a model of good practice illustrated by and at *DDN*'s fifth annual service users' conference, The National Users' Network (NUN) held its annual general meeting at the event, *writes NUN co-chair Francis Cook*. Appropriately enough, several other users' groups and organisations met too, and a lively debate was organised and held during lunch by Neil Hunt, with selected invitees from the world of harm reduction. This included the better part of NUN's membership attending the conference, so it was felt that our agenda should be deferred until after the main business of the day was finished.

The eventual NUN meeting focused on the achievements of 2011, including the development of a more functional and attractive website, funded by Reckitt Benckiser and due to be launched shortly. This should draw together the current website, the Yahoo-hosted forum and the more recent and very successful Facebook page (*www.facebook.com/Nationalusersnetwork*) which has a current readership just short of four hundred and has touched some 146,800 people (according to the statistics provided). This includes 'friends of friends' but is a gratifying number and a source of satisfaction to members.

The current management team of Steve Freer and myself (co-chairing), April Wareham (secretary) and Alan Joyce (communications) was endorsed for another year in open elections, but the need for a treasurer to further funding streams and facilitate other projects was highlighted. It was noted that the use of social media by activists is turning into a very real means of influencing government policy, so we are well placed to pursue NUN's agenda online and beyond.

Many thanks to *DDN*, plus the many other people without whom the National Users' Network wouldn't exist. If you would like to find out more please go to the link above, and don't forget to check out *http://health.groups.yahoo.com/group/nationalusernetwork/* !

DOCTOR CAN YOU HEAR ME?

A relaxed and informal discussion between GPs and service users brought feedback that could radically alter the doctor/patient experience

'I'm very passionate about communications and how we can improve things,' said Dr Chris Ford, opening a breakout session on *Better communication with your GP.* Handing over to her co-chair Ossie Yemoh, she encouraged participants to be frank about contributing their experiences, while Dr Steve Brinksman, Birmingham GP and clinical lead for SMMGP, encouraged comments from the floor.

'Recovery is not Monday to Friday and I know if I'd had a rapport with my GP I'd have found recovery a lot earlier,' said Ossie, explaining how he had become an active service user representative in the London borough of Brent, because 'We recognised we needed to have a voice to make the change.'

His activism was borne of his own experience. 'Each time I went to my GP I couldn't find strength and the doors weren't open to ask for help,' he said. 'I felt stigma at the doctors and it made me run a mile. I'd go and find a corner that wasn't near another patient,' he said.

'So what helps or hinders you?' Dr Steve asked the group.

'My GP doesn't want to know,' responded one participant. Another said: 'What would affect me is to be treated as another bloody alcoholic who probably isn't telling the truth.'

Nathan, from Recovery Cymru, said: 'I can't get to see my doctor for ages – it's a massive hindrance. I don't want to make my problem an emergency.' He added that his previous rural doctor's knowledge was 'terrible' and his attitude remote, but by contrast his current doctor 'dresses down and makes me feel comfortable.'

Pat from Norfolk commented: 'I have a new GP who's good, but the first wasn't – he made me feel like dog shit. The second made me feel different so it was a totally different experience.'

'The most important thing is to be treated like a human being,' said Dr Chris, who added that treating patients with drugs and alcohol problems was 'the best work I do – it's the most rewarding and where I see the most change.' But the problem for many patients, as Dr Steve pointed out, was that GPs weren't contracted to work with drugs and alcohol. 'They have to want to, which doesn't help.'

Several participants gave accounts of staying with an unresponsive doctor for too long, not feeling confident enough to talk to the practice manager if they weren't happy.

Anyone could have a drug or alcohol problem, regardless of age, class or gender, said Dr Chris. 'At least 25 per cent of consultations relate to alcohol but people aren't being asked, and that's bad medicine.'

Many GPs seemed to lack specialist knowledge – an issue that Dr Steve said SMMGP was trying to address by campaigning for drug and alcohol knowledge to be included routinely in doctors' training. Stephen, from a Belfast service user group, wanted to know why this didn't already happen. 'There's the highest rate of benzo use in Northern Ireland because of the Troubles,' he said, and ignoring this made no sense.

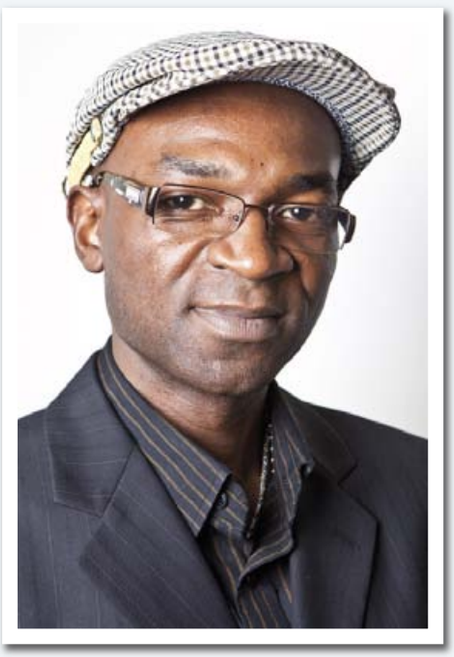
'Signposting' was also poor, with GPs not recognising that if they couldn't themselves help, there was a field of people who could. 'I have a good GP now but have had horrendous GPs in the past,' said John, a service user 12 years ago. 'One set back my recovery by a long time. He dismissed my drinking and put it down to a stressful job – he wanted to give me tranquilisers for stress. He didn't want to talk about alcohol and didn't know that alcohol services existed. I never went beyond him and I should have.'

People with learning disabilities were also ignored because they couldn't explain their problems easily, he pointed out. 'A big cultural shift needs to take place and GPs need to look at whether five or ten minutes is enough,' he said.

'For GPs involved in shared care, service users should be a big part of their training,' said Paul, who worked in service user involvement in Bristol. Ignorance could be devastating: 'I haven't had a hit for 20 years, but on the top of my medical notes it says "injecting drug user". Is that really me?'

Sunny from Wolverhampton wanted to see drug treatment move away from the medical model, so that 'ten per cent is about the drugs and the rest is about the person and what helps them get better.' Dr Steve stressed that the important thing about recovery – of which he was a big fan – was that it was voluntary, 'and if people don't want to recover – well as long as people have information, we can carry on supporting them.' He suggested a strong role for service user groups in developing two-way communication with GPs.

Summing up a lively discussion, Ossie said: 'We started this meeting with looking at communicating as a service user. We now realise we need to look at the medical side and the way to get GPs on board and explain to them the values. We have to keep knocking on the door.' **DDN**



'We now realise we need to look at the medical side and the way to get GPs on board and explain to them the values. We have to keep knocking on the door.'

Ossie Yemoh

Treating the **WHOLE** person

The role of GPs can be crucial to the recovery process, according to RSA research. Rebecca Daddow explains

GPS PLAY AN IMPORTANT ROLE IN THE RECOVERY PROCESS. They can be an effective catalyst to someone's recovery journey, knowledgeably informing a patient of their support options, signposting them to the correct services in their community and offering a listening ear. In some cases, GPs might be able to address problematic behaviour when a patient presents with a different issue, like a broken arm sustained from a drunken fall, simply by asking the question 'is there anything else troubling you?', helping to get the recovery process underway.

Unfortunately, this experience is not familiar to all. For some, the response of their GP has acted as an obstacle to support that was simply too much to get over, and can be significantly detrimental to a person's motivation to recover.

GPs are often the first port of call for those seeking help for problem drug and alcohol use. Just like everyone else, they look for reassurance that something can be done to help, they want to know the options for treatment or support, and they want to be treated fairly without prejudice and judgement.

Research from the RSA's Whole Person Recovery project demonstrates the variability of people's experiences of GPs. It brings to life the impact that ill-informed, prejudiced and inconsiderate responses from GPs have on a recovery journey compared to the results when they get it right.

Caring for drug users should be the concern of all GPs, not just the special interest of a few. After all, drug users have not forfeited their rights to treatment and support, and there is effective help available for those seeking it. The SMMGP and RCGP have been working to increase the training opportunities for those primary care workers interested in learning more about treating drug and alcohol users, but the reality is that there are still a significant number of GPs who are far from taking up these opportunities.

The role of GPs in the recovery process is an eight-minute film developed by the RSA, people in recovery from West Sussex, and a local GP. It is designed to raise awareness and remind GPs and other primary care workers of the impact that they can have on an individual's recovery journey. It is aimed at those practitioners that are disengaged from discussions on how to improve support for people seeking recovery and from the free training opportunities available through the RCGP.

There is a range of options for GPs in caring for patients with drug and alcohol problems, whether that is simply offering reassurance, signposting to specialist treatment centres or providing treatment in the practice itself. At the very least, all GPs should understand that with the right support, people can recover from addiction. And that for many, that support starts in the GP's office.

It is crucial that GPs are aware of the potential importance of their role in the recovery process: they are often the gateway to a much broader system of recovery support. How GPs act will have an impact on the rest of the system and how well it will operate.

Our hope is that the film helps many more people taking the first steps towards recovery to have a positive experience when engaging with their GP. It is freely available from the RSA website and the response has already been incredible. The film has been picked up and is being used by national treatment providers, numerous DAAT areas, the NSPCC and mental health teams. We are also delighted to note that it will be used as part of a training package being developed by an independent group in London that they will deliver in their local area. **DDN**

The film can be viewed and downloaded from www.theRSA.org/projects/recovery

Rebecca Daddow is senior researcher at the RSA and can be contacted on rebecca.daddow@rsa.org.uk or 020 7451 6833

'It is crucial that GPs are aware of the potential importance of their role in the recovery process: they are often the gateway to a much broader system of recovery support.'

Rebecca Daddow

'EVERYONE'S AN ASSET'

Top to bottom: Alistair Sinclair, 'Passions might be different but motivation and rewards are the same'; Darren Long, 'It's a great chat-up line to be able to say you're a yachtsman'; The LUF crew sit up front to hear Stuart Nevin.

Celebrating that recovery has an individual meaning for everyone was the main focus of a breakout session on recovery in the community

Everybody is an asset within their community, was the message of the *Recovery in the community* session led by Alistair Sinclair of the UK Recovery Federation (UKRF). Outlining that the UKRF supports many pathways into recovery, he said recovery should 'transcend, while embracing, harm reduction and abstinence-based approaches.' It was all about our connections to each other, but also about individual strengths.

Stuart Nevin of the Lancashire User Forum (LUF) shared his own motivation for getting involved with his recovery community. After 25 years of struggling with addiction, he went to a local service provider and was prompted to think about what his strengths were. 'I was always good at sports and working as part of a team,' he said. Feeling empowered by this, he was encouraged to give something back to his community.

He was pointed in the direction of LUF, where chair Peter Yarwood convinced him to focus on building on his strengths to help the community. He was inspired to set up a football group, and with subsequent funding from his local DAAT, its membership has now grown to 25 regular attendees. 'We don't talk about recovery,' says Stuart, 'we just go there and smash it in and have a top game of football.'

In Lancashire, LUF have created a 'level playing field', added Peter Yarwood. After being inspired himself last year at DDN/Alliance's *Seize the Day!* conference, by a speaker from the London User Forum, Peter brought back what he learned to Lancashire. From just three or four members, LUF now consists of up to 60 people. Its focus has been on building a group without a 'one size fits all' policy; instead, they encourage individual journeys to recovery.

Peter emphasised the importance of using 'asset-based community development', as well as nurturing a good relationship with local DAATs. 'Find out what's out there,' he advised, 'then map it and bring it together.'

Darren Long of the Island Trust – and formerly a service user with Phoenix Futures – followed with his own story. While struggling with a 12-step programme, he found out about a boat trip that the Island Trust ran annually for people who were dealing with their substance misuse problems. Abstinence was one of the requirements for taking part and, despite difficulties, Darren held onto the goal of being on the trip. In 2010, he went to sail on the Tectona — and afterwards went back to volunteer with the trust.

'I knew that sail training works as recovery because it worked for me when mainstream ideas didn't work', he said. When he came across a competition at Phoenix Futures to think of an innovative and a different approach to recovery, he put together a proposal to sail Tectona around Britain, using as many of the Phoenix Futures residential rehabs and community-based projects as possible to sail each individual leg.

The idea won the competition, and now trained as skipper of the Tectona, Darren says he has an amazing quality of life — 'it's a great chat-up line to be able to say you're a yachtsman'.

Alistair Sinclair concluded the session with a lesson aimed at showing that while everyone's passion might be different, the motivation and the rewards are ultimately the same. The UKRF point of view, he said, was that it was down to the individual to decide what recovery was. 'If someone is capable of realising their own assets and contributes to their community, then they are in recovery,' he said. **DDN**

ALL ABOARD THE VOYAGE OF RECOVERY!

As Phoenix Futures' service users prepare for the sailing adventure of a lifetime, James Armstrong describes how it all came about

PLANNING HAS STARTED FOR AN 1,800-MILE SAILING ADVENTURE around Britain's coastal waters. The 'Voyage of Recovery' will enable 160 people in Phoenix Futures' drug and alcohol addiction programme to experience sail training as a form of therapy.

The voyage will begin on 1 August 2012, sailing from Plymouth past Land's End and Liverpool to the west coast of Scotland and through the Caledonian Canal, coming back down along the east coast of England and finally arriving back ten to 12 weeks later.

The Voyage of Recovery was the winning idea in Phoenix Futures' 2012 Innovation Factor Award. The award encourages staff and service users to think about new ways of approaching the process of overcoming addiction. Previous winners include the Phoenix Forest, a project which aims to plant a tree for each service user who completes a structured treatment programme as part of their recovery from drug and alcohol problems. Recently, another 1,000 trees were added to the ever-growing forest.

This year's joint winners Stuart Plant and Darren Long came up with the Voyage of Recovery concept after experiencing sail training with The Tectona Trust, a charity dedicated to improving access to the world of sailing and now an organising partner in the voyage. Both Stuart and Darren are delighted to see that their dream is becoming a reality.

Stuart, a residential manager for Phoenix, believes that sail training offers an environment that can be genuinely helpful in overcoming addiction:

'Sailing is hard, physical work involving teamwork and a commitment to learning new skills. The service users will be involved in every aspect of running the ship, day and night, from planning and navigation to hoisting, trimming and reefing the sails; from keeping lookout and steering to hauling up the anchor.

'Sail training is proven to increase an individual's self-esteem and confidence, it also provides an arena for service users to gain awareness of one another and learn how to work as a team to achieve a common goal.'

Each of the 12 legs of the voyage will be a challenging five nights aboard the 80ft Gaff Ketch Tectona. The 15 members of the crew will have to work together to meet the diverse challenges ahead of them. On completing their leg of the voyage each service user will obtain a RYA competent crew certificate, which is a recognised qualification and a great starting point for anyone thinking about a career in sailing.

Darren, a former Phoenix Futures service user himself has found sail training to be more than just therapy. Sailing has now become a way of life for him: 'I went on a sail training trip with my service last year and now work as a volunteer on the same boat, it's been life changing in more ways than anyone could imagine.'

Participants will be engaged in intensive drug and alcohol rehabilitative treatment, and will have demonstrated a strong commitment to their goal of recovery. The voyage will give not just a goal to aim towards, but also offer an alternative form of therapy that will enhance their treatment.

Phoenix Futures, The Tectona Trust and Plymouth University will work together to study the impact of the voyage on those that take part. Evidence so far from the The Tectona Trust suggests that it will certainly be positive. Other Phoenix Futures programmes, such as the Conservation Therapy Programme, have increased service user retention (after 12 weeks of treatment) by 65 per cent. It's hoped the voyage can create similar results.

'The Voyage of Recovery is the latest of a series of innovations that we have championed,' says Phoenix Futures chief executive Karen Biggs. 'Our long history of delivering recovery services has shown us the importance of continuing to find new and imaginative ways to inspire people to take those important steps toward tackling their addiction. Those service users who take part in this voyage will have a once in a lifetime experience that will assist them in their recovery and they will also be great role models for those who think a life without addiction is an unachievable goal.'

The voyage will be funded by staff and supporters of Phoenix, along with their friends and family, pulling together to create a wide range of fundraising events over the next few months. Anyone who would like to support the voyage can go to *www.justgiving.com/voyageofrecovery* **DDN**

'Sailing is hard, physical work involving teamwork and a commitment to learning new skills. The service users will be involved in every aspect of running the ship, day and night...'

Stuart Plant

GOLDEN YEARS?

One of the morning's four lively concurrent sessions took a look at the problems faced by older users, and how services can best respond

'We all get old. But getting old is a double whammy for drug users... It's different for everyone, but with older users it's an ever-decreasing circle. Many don't have children, and your social networks shrink.'

Beryl Poole

'We knew that if we were going to help older people, we needed to be out there in the communities, rather than saying "come and see us".'

Simon Wakefield

'We all get old,' Beryl Poole told the breakout session on *Geriaddicts – the loneliness of the long-term drug user*. 'But getting old is a double whammy for drug users.' Problematic drug use could have negative impacts on health, quality of life, family relationships and social networks, she told delegates. 'And so can getting old.' Loneliness could be a huge issue, she said, worsened by social isolation and earlier-than-usual death of contemporaries. 'It's different for everyone, but with older users it's an ever-decreasing circle. Many don't have children, and your social networks shrink.'

There was also the ever-present issue of stigma. 'I saw a news story recently about an older drug user, and all of the comments underneath were incredibly hostile.' Life review was common among older users, along with regrets about ever having used drugs. 'But I don't regret using drugs – I've met the most amazing people,' she said.

Older people who continued to use drugs and require the support of services were an 'important, emerging population' with specific needs, she told the session, and Simon Wakefield of substance use charity NORCAS described how his organisation had established an outreach service for people aged 50 and above. 'We knew that if we were going to help older people, we needed to be out there in the communities, rather than saying "come and see us",' he said. 'We started with a blank piece of paper. Everything we have, we've built from scratch.'

NORCAS had noticed that more and more over-50s were accessing their services, and were also aware of the statistical evidence of rising rates of substance use in this age group. 'We recognised that people aren't "old" at 50,' he said. However, there were physiological changes, he pointed out. 'The body's capacity to tolerate the toxic effects of alcohol and drugs is reduced, and there can also be co-existing physical conditions, like heart disease or diabetes.' Bereavement and loneliness could be precursors to use, he said, and illness, retirement, boredom and isolation were all potentially significant issues. 'Pharmacists will deliver prescription drugs to your door, and supermarkets will deliver alcohol to your door. You don't even need to go out.'

Seventy per cent of NORCAS outreach clients were aged 50-59 and 25 per cent 60-69, he said, with an average age of 57 and an average age at first use of 18. 'We've got a 74-year-old client who started using heroin in his 40s, and has now decided he wants to do something about it.' The service offered counselling, support, motivational interviewing, signposting and advice, as well as free training for agencies. Advocacy services were also important, to support people who might be having problems with their GP or other services.

'A lot of older people don't realise there's a problem, or they ignore it, or they don't know we're there,' said his colleague Kate Lawrence. The organisation had developed excellent links with local agencies and health services, she said, and was now an established part of older people's forums. 'Partnership working keeps the service going. The other lessons we've learned are to evidence everything – we learned that the hard way – and the importance of getting feedback.'

It was also important to look for innovative approaches, she stressed. 'You don't just turn up and say, "are you taking drugs? Are you drinking?" You need new ways of engaging people and dealing with stigma.' These included providing services at venues like GP surgeries or libraries, rather than drug service premises. 'That way no one need know what you're there for.'

'It's important to make things fun and relaxed,' said Wakefield. 'And very important to be non-judgemental. We don't lecture.'

THE REAL **EMPLOYMENT** DEAL

The Small Business Consultancy (TSBC) brought a 'job shop' to *Together We Stand*, offering practical help in accessing employment. **Matthew Denham** gives feedback from the day

When do you get the opportunity to bring service users, commissioners and service providers together, at a national level?

The *DDN* conference that's when. We took the opportunity to meet service users and stakeholders from all around the country, and spent the day interviewing service users to get their opinion on their pursuit of abstinence and talk about their personal journeys. We raised questions around the stigma and the barriers they face gaining employment.

Ninety per cent of the service users we surveyed said their biggest barrier to employment was their offending history and lack of confidence as a result of being unemployed for over five years. The same people said they are ready and want to find employment, but just need the support and a boost in confidence through developing their core skills.

Drug-misusing offenders often describe their lives as a constant search for criminal opportunities. They shoplift, break into property, and steal from cars. They buy drugs, use them and are soon back on the streets looking for more opportunities to pay for the next hit. With drug dependency, their part-time offending becomes a full-time occupation.

So what options are there for people? Are they to be at home claiming benefits by choice and living the life that they have chosen, or should they rather settle for a similar life that is carved for them through public spending cuts?

These so-called work programme prime providers churn people in and out of unsustainable jobs, and are obviously ill equipped to inspire, support and incentivise people to make their own jobs or transition into sustainable employment .

To begin to address these needs right there and then we ran a mini 'job shop' with each service user who approached our stand. During the job shop the participants had the opportunity to have a one-to-one mentoring session with TSBC's CEO Amar Lodhia.

We used an anonymous case study of one of our past participants who had recovered from substance misuse and progressed into full-time employment, then worked his way up to a director position at the company.

The profile effectively demonstrates the necessary steps for other service users to do the same. Through customised interview sessions we were able to set professional and personal goals with each service user to help build their confidence and provide them with tools to actively look and apply for work in the future.

The job shop is just a small element of how we design and execute our 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.

Statistics show that the work programme is not supporting DAAT service users who are unemployed. The pursuit of abstinence in service users and unemployment needs our attention now. Our solution is using the same power demonstrated at the conference – the power of the collective. As part of our commitment to building and developing stronger, thriving local communities we will be launching TSBC Enterprise Hubs.

Working in partnership with local authorities, our Enterprise Hubs will work only with those furthest removed from the labour market, who have more complex needs which prime providers fail to address. Willing corporate partners will support the Enterprise Hubs through sponsorship and donations, and will showcase a powerful and change-making partnership between voluntary, private and public sector.

The Hub's aim is to pursue abstinence – abstinence from offending, abstinence from substance misuse and abstinence from long-term unemployment. The unique structure of this Enterprise Hub will engage with local businesses in a way that has not been explored before – through bringing the power of the collective together to create positive social change.

Matthew Denham is senior development manager, London Region, at The Small Business Consultancy CIC (TSBC)

'We used an anonymous case study of one of our past participants who had recovered from substance misuse and progressed into full-time employment, then worked his way up to a director position at the company.' Matthew Denham

GET THE KNOWLEDGE

A lively discussion on naloxone showed this life-saving intervention was becoming more accepted and gave hope for further roll-out in the UK

A breakout session on naloxone was 'a hearts and minds discussion' rather than technical training, according to Danny Morris, who ran the session with Neil Hunt. Its aim was to show how personal testimony resources had been developed to support a rollout of naloxone – the opioid antagonist drug, given by injection, to rapidly reverse the effects of an overdose long enough for medical support to arrive.

Once the immediate concerns of the group had been addressed, including that naloxone had no adverse side effects, the focus moved to getting users more directly involved in the process. Most overdoses were witnessed by others, making them entirely preventable, delegates heard.

Danny raised the issue that for any other group or community, whether or not to use a life-saving response wouldn't be an issue. 'We shouldn't be talking about this. It should be standard practice,' he said.

Legislative change to allow naloxone to be distributed had combined with strategic drive in certain areas of the UK, most notably in Wales and Scotland, whose governments had developed national programmes for naloxone distribution in the community and prisons. Progress was proving slower in England, where the localisation agenda left individual areas and services to determine whether or not take-home naloxone should be accepted strategy.

The very clear message that the law allows anyone to administer naloxone to save a life had filtered through and given momentum to the campaign to distribute the drug more widely. The main obstacles to distribution were proving to be stigma and discrimination, lack of knowledge about it among services, and lack of confidence among users and carers – which the session was helping to tackle.

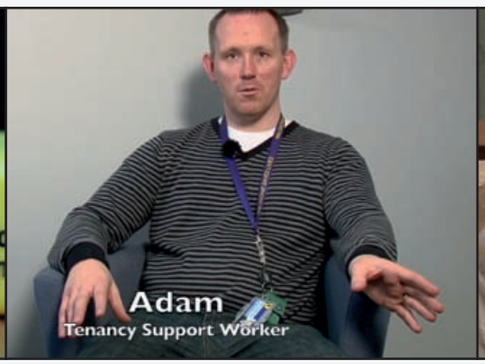
It was clear from evidence that as well as saving lives, naloxone was helping people to change their behaviour. 'They're managing their drug use better as they recognise the value of being involved, and they're also engaging more readily in treatment,' said Danny.

A brief presentation from Sally Kneath, a pharmacist in Swansea who worked closely with a local needle exchange, demonstrated the value of offering people 15-20 minutes naloxone training that ensured they were confident enough to leave with a take-home naloxone pack.

Buff Cameron and Chris Rintoul from U-Turn Training introduced their new smartphone app, designed to help reduce the risk of overdose and prevent loss of life if one occurs.

Central to the session was a showing of Jon Derricott's new film *I am the evidence* – powerful testimonies from people who have had their lives saved with naloxone, or who have saved the life of another.

I am the evidence will be available shortly on the Exchange Supplies YouTube channel



ENTER THE FILM LOUNGE

During lunchtime delegates watched several films submitted by user groups and services. Some of these can be viewed on YouTube.

WOBBLY STAN – THE BENZO MAN

Lifeline Publications' short animated film on the risks of benzodiazepine use. Wobbly Stan, an older benzo and heroin user, tries to explain to a young woman, Bee McCree, why he won't sell her any benzos. The story was devised with service users from Teesside and features the voice of actor Mark Benton.

LANCASHIRE USER FORUM (LUF)

An information film made by LUF, supported by Lancashire DAAT. Featuring LUF members and chair Peter Yarwood, the film explains how LUF members work with professionals to provide practical support for recovery, employment and wellbeing.

RECOVERY IS OUT THERE (RIOT)

A DVD made by RIOT, a committee of service users from the BAC O'Connor Centre in Staffordshire, whose recovery journey began in the local community. Every service user who completes the BAC O'Connor programme can become a recovery champion.

NALOXONE DRAMA WINS DDN FILM AWARD 2012

Jason Turner won this year's *DDN* film award for his film *Flat Out and Back*, a dramatisation of a real life situation. The film tells the story of Jonny's first score after leaving prison, his subsequent overdose and the lifesaving injection of naloxone he received.

Jason started iSore Media as a social enterprise after receiving film and media training while in recovery. As well as providing film-making services for both the commercial and private sectors, iSore also delivers media training workshops in treatment settings and prisons.

Flat Out and Back was originally commissioned through a social media project. It was funded by the service user involvement budget coordinated by Mark Spooner, founder of SUGAR, Birmingham's service user group umbrella organisation.

To find out more about iSore Media and how to obtain copies of Flat Out and Back visit www.isoremedia.org

Flat out, but worth it…

DDN film award winner Jason Turner, from iSore Media, received double the honours when he collected an award for excellence in involving hard to-reach groups. The award was presented by Sarah Feeley, team leader at Birmingham DAAT, at their annual awards held at Birmingham City football ground.

More than 200 people attended the DAAT's awards ceremony; with 127 nominations for seven different categories, they represent an opportunity to celebrate achievements from all areas of the treatment system as well as those of service users and carers.

BRAVE NEW WO

The closing panel debate saw vibrant – and sometimes heated – discussions around the implications of both the forthcoming treatment landscape and different interpretations of the recovery agenda

The afternoon's panel was made up of Alliance peer education coordinator Caroline Blackburn, SMMGP clinical lead Steve Brinksman, Release executive director Niamh Eastwood, NTA chief executive Paul Hayes and project coordinator of Southampton user group Morph, Si Parry. The first topic up for discussion was, 'How will drug and alcohol treatment fit within Public Health England?'

The treatment system had seen great improvements in recent years, said Paul Hayes, 'and the first thing we need to do is make sure that what's delivered under Public Health England is at least as good as it is now.'

Drug and alcohol treatment would be brought together for the first time under the new system, which meant 'huge advantages in terms of responding to people's needs instead of building an artificial wall'. Historically, however, drug treatment had been far better resourced than alcohol treatment. 'That means we must be very careful that we don't rob Peter to pay Paul,' he said.

Nonetheless, there was a real opportunity for Public Health England to be the next step change in the improvement of drug treatment, he continued. 'If we don't support people while they're in treatment, we won't get sustainable results. It's in everyone's interests to invest in services that promote recovery and sustain recovery.'

A key challenge would be that not every local councillor would see these issues as a priority, he warned. 'Every major political party is signed up to the localism agenda – but that means that people like me can't say, "thou shalt do this". Decisions will be made in every local authority area, and you are powerful enough when you come together to make a sound, solid political argument. Society benefits from investment in drug and alcohol services and locally this is an area that needs to continue to be invested in.' The localism agenda meant that it was 'over to us now', said Steve Brinksman. 'You can influence the decisions, but the downside is that if we don't, there will be disinvestment.'

It was a 'scary time coming up,' said Si Parry. 'To try to expect that local bigwigs and movers and shakers are going to listen to us doesn't seem to hang together really. I feel fearful for my peers. I know that people would rather give the money to donkey sanctuaries.'

The afternoon's other topic was, 'Is rise of the recovery movement narrowing patient choices, and how do we ensure that it's inclusive?' The recovery movement itself would not reduce choice, stressed Caroline Blackburn. 'What will is what people's view of recovery is. If you define recovery as one thing, that reduces choice.'

'It's how services and commissioners define recovery that's narrowing choices,' agreed Niamh Eastwood. One size fits all definitions were of no use, said Steve Brinksman. 'We want people to have the recovery journey that they want and need as individuals. Tell SMMGP if that's not happening,' he urged.

The 2010 Drug Strategy didn't actually talk about abstinence, Paul Hayes pointed out. 'A lot of the mood music before it did, but some commissioners and providers don't do nuance very well. They don't understand and have a knee-jerk reaction to the guidance. The drug strategy is actually much more demanding of commissioners.' Alex Boyt of Camden User Involvement Group, among others, challenged

'I feel fearful for my peers. I know that people would rather give the money to donkey sanctuaries.'
Si Parry

ORLD?

that. 'I worry that it's not just about interpretation – there are funding issues that are removing choice,' he said.

'We need to find common ground across the spectrum, from people using drugs to people who are completely abstinent and everything in between,' stressed Si Parry. 'We need to pull in the same direction, because otherwise we could pull each other apart. We need to keep chipping away and fighting for our rights to life.'

Responding to an audience question on the decommissioning of shared care, Hayes said, 'The issue for me is that I can't agree with the statement that shared care works all the time. There's an issue about moving contracts from one clinical setting to another, which we need to weigh up on a case-by-case basis.'

Ultimately, much depended on geography, commented one delegate. 'DAAT commissioners often get a tough time, but ours is very forward-thinking and has given us service users an opportunity to set up a project, and funded it quite substantially. There seems to be a total contrast of opportunity, depending on where you are.'

DAATs needed to look at the evidence base and provide services based on that, Blackburn told the conference. 'Rather than just counting numbers, they need to look at people's experience. Until they do, you won't get consistency of service.'

'We have to do this very carefully,' acknowledged Hayes. 'We have to take advice from expert groups of patients, and different patients have different needs.' **DDN**

FUTURE TENSE

Should service users be worried about the likelihood of being coerced into the wrong treatment? The NTA's chief executive Paul Hayes was a panellist at the conference and heard delegates' concerns. He gave DDN his thoughts after a lively debate

'It is not in anyone's interest to rush anyone out of treatment who is not ready or at risk of relapse.' **Paul Hayes**

I ALWAYS ENJOY THE OPPORTUNITY this conference gives me to engage with service users and hear their concerns at first hand. This year I was struck by the anxiety displayed by audience members about the future of substitute prescriptions, especially when local services are being retendered. I'd like to lay these fears to rest.

One of the challenges the sector has faced for some time now is that it doesn't do nuance very well. Some people prefer to inhabit a polarised universe in which complex subjects are portrayed in black-and-white terms. Perhaps as a bureaucrat I'm more comfortable with grey, but I hope that doesn't mean I am unable to make some things crystal clear.

The drug strategy does not say everyone should become abstinent, although it does set out an ambition for as many people as possible to overcome addiction and get off drugs for good. So we asked Prof John Strang to set up an expert group to look at prescribing guidelines. Its final report will be published shortly, and I won't be giving anything away if I say categorically that it will not be recommending that any time limit should be imposed on a methadone script.

Prof Strang's interim report last summer urged doctors to review their practice to ensure everyone on a script was given an opportunity to recover. This is all about enabling service users to make an informed choice. The outcome of any review has to be agreed between the provider and the service user. If he or she is not ready to come off a script, or doesn't want to take that step, then it should not happen.

On the other hand, we know that plenty of people come into treatment without any intention of staying on a script, yet find they are not actively encouraged to come off, and some even believe they have been actively discouraged from leaving it behind. This also should not happen.

The treatment system was never intended to drag large numbers of people in, script them, and keep them there indefinitely. Equally, we don't want people to be bounced out prematurely when it is not safe to do so. There has to be a balance that leaves the service user informed and supported to make a decision about their own life.

That calls for high level of skill on the part of drugs workers, a degree of humility among professionals that they don't necessarily know best, and, yes, the willingness of service users to make brave decisions and take risks.

The work of the expert group is part of a wider transformation to make the treatment system more recovery-oriented. For example, there is a financial incentive for partnerships to ensure more people complete treatment successfully. However, this is being introduced alongside existing rewards to get people in, and keep them there long enough for treatment to be effective. And the new incentive only kicks in if those who leave do not come back within six months. It is not in anyone's interest to rush anyone out of treatment who is not ready or at risk of relapse.

I hope this reassures service users that their interests remain at the heart of the treatment system. However, if people feel they are being put under undue pressure to come off a script, let us know. Tell your service user group, talk to the provider, tell the commissioner, or report it to the NTA. By the same token, if you are being discouraged from making progress towards abstinence, we need to know that as well. **DDN**

STANDING TOGETHER

This year's service user group exhibition was a vibrant hub of activity, full of enterprise, advice, networking and ideas

SUST – Service User Swindon Team

'I came with a group of service user reps and peer mentors and we all had a quality time,' says Anna Kyson from SUST Swindon. 'We had some business cards made up for the conference and were busy all day networking, meeting new people and sharing ideas.' SUST has some big plans for 2012, she explains, one of the most exciting things being the launch of Transition, a new evening support service, later this month.

The new venture is supported by Swindon and Wiltshire Alcohol and Drugs Services, who have provided premises and tea and coffee-making facilities, and Anna hopes it will provide somewhere for people to go when traditional services are closed, and where they can find non-judgmental support.

To find out more email annakyson@dhiswindon.org.uk

BADSUF – Bournemouth Alcohol and Drug Service User Forum

Margot Benjafield and Julia Dixon-Large were on the BADSUF stall, representing one of the oldest service user groups in the country. BADSUF has over 2,000 members and in the 17 years it has been running has built an influential role in the Bournemouth area, where it chairs the local DAAT. For the last ten years the BADSUF annual open day has attracted over 200 service users and providers, and is a major forum for feedback.

New manager Julia, who has taken over following the retirement of one of the founders, Frank Bond, hopes to build on his work and use her experience of commissioning and fundraising to expand the group still further and continue its work with treatment providers in the area.

Find out more at www.badsuf.com

Hope North East

Hope North East has recently achieved charitable status after previously working as a community interest company. Based in Middlesbrough, it runs arts groups, meditation sessions and job clubs, among other initiatives.

'It was great to meet The Small Business Consultancy [see TSBC's column, p.17] at the conference', says member Sharon Church. 'We were able to share some ideas on running and maintaining back-to-work support.'

The group is heavily involved in campaigning for better treatment in the north east, and sits on the boards of several local services. Among the group's longest running and most popular activities are the weekend nature walks – 'although at 12 miles, the Sunday walk is not for the faint hearted!' says Sharon.

Contact the group at www.hopenortheast.org.uk

SURF – North Somerset Service User Forum

'We all had a great time at *Together We Stand* – it's our "must go to" conference of the year,' says Mags Norman of SURF, a service user group in Somerset.

'Our membership has expanded greatly this year with over 100 members. Our advocacy service is up and running and our outreach programme will soon give us a presence in the town four days a week. We are now starting our plans to become a registered community group by 2013. We're already looking forward to next year's event!

Link up with SURF North Somerset on Facebook

SUGA – Service Users Giving Advice

SUGA is a fiercely independent group, open to all. 'Our remit is user involvement, pure and simple,' explains Hayley Zardin. 'We work with services and act as a kind of watchdog to campaign for good treatment for all.'

Since 2008 the group has provided support, given users access to training and held events, such as releasing balloons with a wish, a hope for recovery, or the memory of someone they had lost. The group produces a regular newsletter, with the next edition out in a couple of weeks.

'The conference showed how important it is for different groups from all over the country to be able to get together to share ideas and, in a way, be peer mentors to each other,' says Hayley. 'Our wish for 2012 is access to a permanent office base. We don't have funding and no one gets paid, but if we had somewhere to work from we could really move to the next level.'

If you can help with SUGA's search for a base contact hayley.suga@gmail.com

B3 – Brent

'We now provide advocacy, peer support, training and generally try to provide a voice for people who might not otherwise have one' says Ossie Yemoh from B3 in Brent – progress which he credits to the 'fantastic support' of his local DAAT.







One of the group's mottos is that 'addiction is not a 9 to 5, Monday to Friday business', which led them to set up Bsafe, a Saturday social club which 'provides a safe place at the weekend to talk to peers, get something to eat, get advice or even get a haircut!'

As well as providing peer support, B3 is out in the community talking to schools and young adults. The group also works closely with SMMGP to campaign for better shared care and try to get GPs in their area to engage with substance misuse patients.

Everyone is concerned about funding in the coming year and B3 have just had the green light to become a recognised service within Brent, which they hope will help them engage in contracts on an equal footing. But this isn't what motivates Ossie and the team. 'We are in the business of changing lives,' he says, 'and the passion to do that is there from when you wake up in the morning till when you go to bed at night.'

Find out more at www.b-3.org.uk

Tree of recovery

WDP service users' eye catching 'tree' grew leaves throughout the day, as delegates added their thoughts about what recovery meant to them.

'I saw a similar idea to these a few years ago when I was in college,' says Titania May, WDP's new service user involvement manager. 'They were asking people to hang up notes giving feedback, and I thought "what a brilliant idea".'

'Our tree symbolises recovery, in that the idea is already deeply rooted but it is constantly evolving and changing, and the more people that come together to be involved the bigger and healthier it will grow.'

Higher and higher!

High Designs, a social enterprise run by service users, joined the exhibition for the first time this year. It was an all-round positive experience that's continued the group's momentum, *says Mike Haj*.

At the end of 2010 an arts and crafts session was running in the stimulant service operated by Leicestershire Community Projects Trust (LCPT). At that time three service users who had come to the end of their treatment episodes with LCPT were attending the group.

Their talent was impressive and the work that they were producing was clearly integral to their ongoing recovery journey. Dave, in particular, was gathering a portfolio that he intended to use to try to gain permanent employment in a design role of some kind, and it was obvious to all concerned that there must be some way for these creative talents to become a viable business.

Around this time Santander advertised some available funds to groups in our region, so LCPT applied for them and secured £11,000 for the group to use. A competition for a name was launched among service users and the 'High Designs' brand was born, the name alluding to the 'high aspirations' of people recovering from a struggle with substances and their creative abilities.

High Designs is established as a social enterprise and is run by service users with interests in design and marketing. In the early days we linked up with De Montfort University so that students could train the designers to use the software needed to digitalise their artwork. When this was done we were able to produce the T-shirts and sell them.

All of the business activity is governed by a steering group of the service users with the support of LCPT for administration. For the original designers, Dave, Steve and Gary, the experience of seeing customers excited about their work, and actually buying it, gave them an incredible boost and appreciation of their true abilities, and Dave has now found full time work as a designer. On the first day of trading at the High Designs launch, they sold approximately £600 worth of T-shirts, which left everybody on a genuine high. Since then the group have attended various festivals and events and have had excited interest wherever they have been.

Attending *Together We Stand* at the NEC, however, was a special experience. There were some nerves in fact, because it was the first time that High Designs had gone before service users outside of Leicestershire. Both Helen and Gary, the most recent service users to join the group, were anxious that peers might not 'get' High Designs. They needn't have worried and the response to the stall was terrific!

'We had so many people wanting to get involved,' said Helen. 'The other service users have encouraged us so much, the feedback has been great, and they loved the shirts!,' said Gary. We left the conference excited about making stronger links with service user groups around the country and would be happy to hear from anybody with ideas about how they could get involved with High Designs.

You can contact High Designs through their website: www.lcp-trust.org.uk/?q=adults/high-designs **DDN**

NORTHERN LIGHT?

Iain 'Buff' Cameron's commitment to service user involvement in Northern Ireland didn't just require determination – it also meant taking very real risks. He talks to David Gilliver

From left: Buff Cameron; the new app; Chris Rintoul demonstrates on a dummy at *Together We Stand*

As well as the presentations, debates and networking opportunities on offer at *Together We Stand*, delegates also had the chance to see demonstrations of a new opiate overdose smartphone app. The app offers advice on emergency care including naloxone administration and life support, and has been launched by Belfast-based U-Turn Training, Consultancy and Empowerment.

U-Turn was founded by Chris Rintoul and Iain 'Buff' Cameron last year. A former chair of the Belfast User Group, Cameron also helped to develop Belfast's first drug outreach team back in 2003, and more recently was involved in setting up Northern Ireland's only homeless hostel provision for heroin users.

Like many of the best ideas, it's hard to believe that no one came up with the app concept before. 'We just stumbled on the idea really,' says Cameron. 'Both myself and Chris had been doing a lot of work with the Scottish Drugs Forum around naloxone, because we were involved in getting naloxone made available here in Northern Ireland. We were doing the 'train the trainer' naloxone courses, and as part of putting the training package together we wondered if there was an app available, because we thought it would be useful to get something like that widely distributed.'

Although there were some apps themed around drug use, as well as basic life support, there was nothing specific to overdose, they discovered. 'We decided to have a look at it and try to put something together,' he says. 'We met up with a company here in Belfast and they thought it was a great idea, so it went from there.'

The app is already available on the Android platform, with an iPhone version launching imminently. Although there's a small charge of £1.99 at the moment, the intention is that it the app will ultimately be available for free. Developing it, however, has been an expensive process, he explains.

'Neither myself or Chris had the technical expertise for building an app, so we had to pay for that, and it's cost us a considerable amount because we wanted to do it the best we could. Everything was done from scratch – illustrations, voiceovers – so there were substantial costs, as we didn't cut and paste anything from anywhere else. We're only intending to recoup our costs – we're not looking to make anything on it.'

So far the feedback has been excellent, and some organisations have already made donations towards the app's development. 'HIT have given us money, but more than that they've been really supportive. Pat O'Hare, Nigel Brunsdon and all of HIT have been fantastic in the support they've given us. I'm not sure we'd have been able to do it without them.'

Once the costs have been recouped, the aim is to follow up with a stimulant app, as well as to focus on further expanding U-Turn's crucial user involvement element. 'Both myself and Chris have been very involved in training and service user involvement, and all of the training courses we've developed have a very strong service user input – all of our programmes will have service user trainers delivering those courses alongside ourselves.

'The full name of the organisation is U-Turn Training, Consultancy and Empowerment, and the aim of the empowerment aspect is to try to bring service users through who want to go into this field and provide volunteer opportunities – but more importantly, paid opportunities – for them to gain skills and get work, so we also want to work with service providers to create volunteer placements.'

While user involvement is something that's now taken for granted across the UK, this certainly wasn't always the case in Northern Ireland. The country was very much a late developer when it came to harm reduction initiatives of any kind, and up until the millennium was characterised by an inflexible treatment regime, with no needle exchange or outreach work, and a generally very hostile culture as far as politicians and the media were concerned.

On top of all this, of course, was the ever-present risk of violence. Not only did the security forces often see drug users as potential targets to intimidate into becoming informers, there was also the constant threat of summary justice being meted out by the paramilitaries themselves.

'It wasn't even about dealing,' he says. 'If you were a heroin user you'd be shot dead, that was it. It was a death sentence. But even apart from that, you'd be shunned out of your community, so it was very difficult for anybody to get any

'Because harm reduction is so new to us, we remember what it was like before we had it. I think that maybe in places that have had it for a long time, people don't realise how bad it can get when you don't have those harm reduction strategies in place.'

sort of help or assistance. It meant that drug use stayed completely underground for a long, long time. But it has changed – it's not as dangerous any more, although there still are dangers.'

Isn't the irony that some paramilitaries were involved in dealing themselves? 'It was certainly rumoured, although I have no evidence to suggest any of them were involved in supplying heroin,' he says.

Harm reduction in Northern Ireland is now something that's firmly established, however. 'It's flourishing, given that it didn't really kick off here until 2000, which is obviously a lot later than other places,' he says. 'There's still quite a distance to go, but there are significant changes – we will have regional availability of naloxone across the whole of Northern Ireland, for example, our needle exchange programmes are expanding, and our drug outreach team is developing well. We are moving forward with things, but I don't think anyone ever gets it a hundred per cent right. There's still a lot to do.'

The 2005 International Harm Reduction Association (IHRA, now HRI) conference in Belfast also turned out to be a pivotal moment. 'I don't believe things happen by accident in the world of harm reduction, and I don't think it's any surprise that the IHRA conference was the same year that methadone was introduced here. I think we were probably going that way anyway, but the conference gave it an added impetus and maybe brought it about somewhat quicker.'

It also proved a dramatic boost to the development of user involvement, and was vital in terms of making connections and helping to bring services together, he explains. 'It certainly helped me individually and I know it helped us at the outreach team, through meeting people like Pat O'Hare, Mat Southwell and others who were very active in the harm reduction field, and who I could then rely on to help us out here. We got a lot of support from the conference.'

These days much of his day role is focused around the six-bed homeless hostel for active injecting users – again, a first in Northern Ireland – which he helped to set up at the end of 2010 and is managed by social exclusion charity Extern. Has he seen any impact from the recession on homelessness levels? 'Certainly we're seeing an increase,' he says. 'And we're probably set to see that rise further, given some of the new policies being brought in, particularly around things like housing benefit. So we're kind of bracing ourselves for that.'

What is cause for optimism, however, is the future of harm reduction in Northern Ireland, he says. 'I certainly don't have the same fear that I'm picking up in parts of England, Scotland and Wales around the recovery agenda. My personal belief is that because harm reduction is so new to us, we remember what it was like before we had it. I think that maybe in places that have had it for a long time, people don't realise how bad it can get when you don't have those harm reduction strategies in place.' **DDN**

www.u-turntraining.com

Living in exile

Now a counsellor and treatment practitioner, Nick Mercer spent years in active addiction. He gave delegates an entertaining and touching account of his personal journey

'I THINK MANY OF US FEEL LIKE EXILES – we always feel "outside",' stated counsellor and treatment practitioner Nick Mercer as he opened *Together We Stand*'s afternoon session. 'And we often condemn ourselves – often the greatest enemy of me is me.

'I'm going to nail my colours to the mast – I don't care what your persuasion is regarding recovery,' he said. 'I got clean and sober 23 years ago, after years of injecting in my groin, and I did become evangelical in the first few years.' There'd been times when he wanted to stop using drugs, he told the conference, but he 'didn't know how'. 'One thing I will say about all the "parked on methadone" arguments is that methadone saved my life.'

Problematic drug users responded to issues of low self-worth in two ways, he said. 'You can be deferential, or you can lash out. Like many of us, I was both. I've watched with great interest the growth of the various movements, and one thing I know is that it's better than it used to be when you had to jump through various hoops to get a methadone script, and were treated like shit.

'Whatever your persuasion, most of us would acknowledge that capacity to self-deceive,' he continued. 'But when we come together like this, when we wake up and focus, there's a strange power and energy. Sometimes we don't realise the significance of being here, in this room – the luxury of being able to analyse our situation, to unpick it, of breaking the cycle of that repetition. That's the beauty of coming together like this – we can start to explore who we are. There's something about this movement. We come from difficult places, difficult histories, but before we move on we need a safe environment to get that out.'

He'd worked in prisons for years, he told the conference. 'I've seen people cross that bridge and heal and become better, productive members of society, and I've seen their families heal as well. When we talk about being freed from the bondage of self and the bondage of addiction, if methadone is part of that then that's fine.'

He had watched the recovery movement develop and had come to feel rage at the way it had been 'transformed into nonsensical soundbites', he said. 'If recovery means sitting on methadone for the rest of our lives, then that's all right too. As soon as I start to tell you what to do, you will disengage. It has to be by consent.

'My sense with all of us is that the child within us remains – I've spent so much of my life in resentment, always feeling in exile,' he continued. 'That's the bit I feel is the injustice, that's the baggage.

It's easy to blame. I've done that all my life. As the years have passed, what I've learned is how little I know. Your story is your story.'

CONFERENCE QUOTES

A selection of soundbites from *Together We Stand*

'Nobody who looks at the figures thinks it's even possible for everyone to come off methadone. There will always be people who have a healthier and happier life on their script.'
Judith Yates, GP

'The 2010 Drug Strategy doesn't talk about abstinence. A lot of the mood music before it did, but some commissioners and providers don't do nuance very well. They don't understand, and have a knee-jerk reaction to the guidance. The drug strategy is actually much more demanding of commissioners.'
Paul Hayes, NTA

'Where is the problem anyway – is it the drug, the person, the crime? There's no consensus view of what the policies are. We're fighting over them all the time.'
Geof Rayner

'Recovery does not mean abstinence. I'm sick to death of the way it's being used by services to their own ends, when it's actually about funding and results.'
Beryl Poole

'People are getting coerced off their scripts. All we can do as service users is to speak up.'
Delegate

'We are in a weird political climate. But you can seize the opportunity and do effective work if you don't see things as one-off interventions.'
Daren Garratt, The Glebe Centre

'DAATs need to look at the evidence base and provide services based on that. Rather than just counting numbers, they need to look at people's experience. Until they do, you won't get consistency of service.'
Caroline Blackburn, The Alliance

'I know four people who've died since I've been in recovery. I'm grateful for all the money that's been spent on me, but the resources could be better allocated. Abstinence makes the heart grow fonder.'
Delegate

MY RECOVERY, MY CHOICE

With more than 166,000 people seeking treatment for opiate use, the need for quality information has never been greater. The My Recovery My Choice campaign has been devised to offer clear, useful information about dependence, support and recovery, as Jude Norton **explains**

A NEW CAMPAIGN, *My Recovery My Choice* was revealed for the first time at *Together We Stand*. The initiative aims to empower people affected by opioid drug addiction and was edited by the Alliance, in consultation with a number of other groups, from the European-wide *My Treatment My Choice* campaign for suitability to the UK.

The campaign is aimed at people who are touched by heroin use – whether directly, or as friends and family members – and offers non-judgemental support to help them decide what steps, if any, they might consider taking. It focuses on the belief that it's each person's right to decide if and when they want treatment, and provides a detailed overview of the treatment options available within the UK and how they can be accessed. It also recognises that different people want and need different approaches on their recovery journey, and includes information on psychological therapies, rehab, detox and complementary therapy.

The website is designed to be straightforward, user friendly and engaging, and is rich with genuine experiences, and there is also a printed booklet for those without internet access. Supporting materials are freely available for any organisation or group that works with drug users.

By providing tips on how to improve their chances of recovery success, as well as background information on how their work, benefits or childcare may be affected, the campaign seeks to manage expectations and provide confidence for each individual's journey. It describes a person's rights in treatment and what can be expected from health services.

There is also help for family and friends in the form of information on what dependence is, as well details of support groups where they can find help, and videos from patients and parents who have experienced the recovery process. Users are offered information on harm reduction and health risks associated with drug-taking behaviour and there are safety tips throughout, right down to reacting swiftly to an overdose.

My Recovery My Choice is an evolving initiative that has been created with the Alliance and with input from a number of UK user groups. If you are part of an organisation that would like to get involved, add your logo to the site, or suggest improvements – or if you would like to share your own story please get in touch by emailing mrmc@pcmscientific.com

The information on My Recovery My Choice is for educational purposes only and should not substitute for the advice of a medical professional. The website and related materials were produced by PCM Scientific (a medical education company) and the Alliance who redrafted a set of internationally available materials to make them suitable for the UK. Undertaken in consultation with other partners, this is an ongoing process. The creation of these materials was made possible through an educational grant from Reckitt Benckiser Pharmaceuticals.

www.myrecoverymychoice.co.uk

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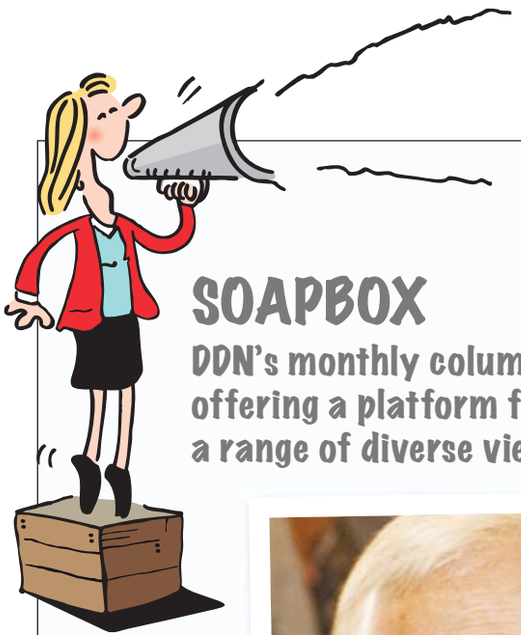
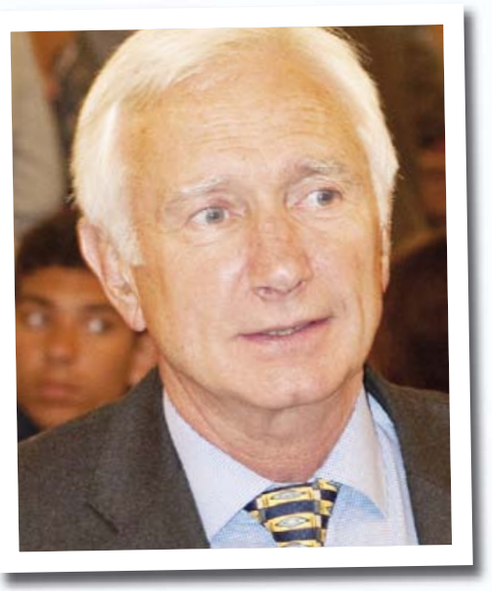
DDN would like to thank everyone whose support made ***Together We Stand***, the fifth national service user involvement conference, possible – The Alliance, NUN, UKRF, FDAP, all our volunteers, main sponsors The NTA, RBP, and Martindale Pharma, all our exhibitors, the speakers and workshop facilitators, the conference steering group, and most importantly all the delegates whose participation on the day made the conference the success it was.

Hope to see you all next year!



SOAPBOX

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



WHY DID CQC USE A SLEDGEHAMMER?

A punitive Care Quality Commission signalled the end of our well-respected rehab service, says John Jotcham

INDEPENDENT SOCIAL CARE CONSULTANT David Finney recently highlighted some major concerns about CQC inspections. These related to a toughening-up approach after recent negative publicity, including fallout from the Winterbourne View abuse scandal (*DDN*, February, page 15).

Walsingham House has experienced this tough touch with devastating and unnecessary consequences. St James Priory is a registered charity based in the centre of Bristol, providing quality services since 1996 through Walsingham House, a tier 4 rehab, and St James House, which is third-stage supported accommodation. Walsingham House opened originally as a pioneering drug and alcohol hostel for homeless people and evolved into a mainstream residential rehab provision, achieving block contracts and preferred provider status via tendering with a number of DATs, and providing an integrated dual diagnosis service from 2006.

It was forced to close in January 2012, and more than 15 years of dedicated, valuable and successful work with people struggling with a substance dependency were summarily ended, as a direct consequence of an intransigent and adversarial approach by CQC.

In October 2010, we achieved registration with CQC as a 15-bed 'accommodation for persons who require treatment for substance misuse', coinciding with our best year for referrals from April 2010 to March 2011. However, 2011 became our *annus horribilis*. A catalogue of staffing difficulties included long-term sickness of an experienced counsellor, retirement of a senior counsellor who was the bedrock of the team, disciplinary action and suspension of another staff member, temporary staff appointments, and the consequent disintegration of a very stable and experienced counselling team.

This came to a head in September, and in October CQC inspectors arrived to complete their annual inspection. They discovered, unsurprisingly in these circumstances, that there were standards with which Walsingham House had become non-compliant. We owned up to this immediately and emphasised that we wished to resolve all issues as soon as possible. Our belief was that clients were safe and systems were in place but that the evidence had not been recorded appropriately, partially at least as a consequence of major staffing problems.

There had been no complaints about the service from any quarter – clients, carers, commissioners, social workers or probation officers. We had developed very positive partnership relationships with a wide range of referral agencies and commissioners, and clients reported their gratitude for the services provided. We were aware that an inspection is regulatory but had assumed, erroneously, that the review would be a mutual process and our staff would all be involved in it. This was not the case, and the approach from CQC was punishing and judgemental, not collaborative or supportive.

Communication was poor – emails went astray and reports did not arrive on time. Warning notices (which were not required in our opinion) were issued based on a report that we had been unable to challenge for factual inaccuracies.

It was asserted that clients were not safe and yet all five clients in residence at the time were allowed to stay for the duration of their placement (eight weeks). We had positive feedback from all of them for the care and support they received during their stay, but CQC did not ask them for any feedback. As a consequence of the warning notices, our numbers were restricted and when the five clients completed their stay and were moved on successfully we were prevented from admitting new residents due to concerns about client safety!

Due to the warning notices, the local safeguarding team's excessive involvement, and delays in re-assessment by CQC, we had no clients referred to our service from October. For just about three months we had no residents at all – the first time this had ever happened. CQC had been informed at the beginning of November that we would only be financially viable in these circumstances until the end of December. Our financial tipping point was reached in early January.

While we readily accepted that there were areas of non-compliance with CQC standards at the time of the inspection, and willingly co-operated with all CQC requirements, there was no recognition by CQC of the positive context which framed the inspection. What the inspectors discovered was clearly not the norm, and a snapshot view did not provide a balanced assessment.

CQC literature states 'the CQC can be flexible about how and when to use enforcement powers' and 'any enforcement action we take will be proportionate to the risks posed to people who use services and the seriousness of any breach of the law'. We do not think that this happened.

As a consequence of CQC's inflexibility and overbearing approach, a valuable, established and respected service was forced to close with 18 redundancies. More importantly, a service that was generally held in very high regard by clients as a caring and effective resource for vulnerable people with a substance dependency has now ceased to operate.

This comment from a former resident is typical: 'When I got to Walsingham House I couldn't talk. I was traumatised and very damaged and did not trust anyone. I was cared for and given so much help and support in that place, and most of all I got hope that I could live without alcohol. The treatment I received was priceless for me and saved my life.'

John Jotcham is deputy chief executive of St James Priory

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DDN Drink and Drugs News **WORKSHOPS** fdap

Be Prepared – CQC compliance

14 March 2012, Central London

CQC have recently changed the way they inspect residential and community-based services. Following a pilot scheme, they are initially intending to focus on a small number of outcomes in their inspections, but will be doing so in more depth. Their new method of inspecting means that they will be spending more time speaking with or observing service users and their care and treatment. They will also be making all inspections unannounced!

So how can you be prepared for your next inspection? The course will show you how to look in depth at specific outcomes yourself; and how to ensure that you have the right evidence available to demonstrate your service's compliance to CQC. The course will also look at what to expect and how to respond on the day of the inspection.

For substance misuse services this will be the first inspection under the new registration criteria, and for many newly-registered services their first experience of being regulated. For this reason it is especially important to be well prepared.

David Finney is an independent social care consultant with a specialist interest in the regulation of substance misuse services. He has facilitated training events around the country. He was a senior manager with CSCI where he was the national lead for substance misuse services.

15% discount to FDAP members.

The course runs from 10.00 am – 4pm in central London, and includes lunch and refreshments. For more details about these workshops email Kayleigh@cjwellings.com or call 020 7384 1477. Or visit www.drinkanddrugsnews.com

If you are a trainer working in the drug and alcohol field and would like to discuss partnering with DDN on a training course, please contact us.

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Complexity is our speciality.

Working under a Recovery Management model the CBU provides recovery focussed solutions for the most complex and intractable addiction problems. Our clinical and therapeutic teams provide 24/7 support and service two single-sex wards offering 36 beds in total. Based in North Manchester (just off the M60) we have a national scope and take patients from all over the UK.

" My recovery really began at the Chapman-Barker Unit. Everyone else had written me off as a lost cause..."
Rebecca, ex-drug user

" You lot have done more for me in one week than anyone else has done in twenty years " -
John, ex-alcohol user

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We specialise in managing serious behavioural, mental and physical health problems that can be the consequence of chronic, long-term substance misuse

Contact us on 0161-772-3558 or at CBUadmin@gmw.nhs.uk. Find out out more on YouTube at **http://bit.ly/chapmanbarkerunit** or catch up with our bloggers on **www.wiredintorecovery.org**

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RESIDENTIAL WOMEN'S PROJECT

Open Day – Tuesday 3rd April 10am-2pm

Naomi Project, Highgate Hall, Hawkhurst, Kent

Flexible new programme addresses key issues for women in recovery including eating disorders. Come along to see the project, meet staff and hear testimonies. Event starts at 10.30 and includes lunch.

To book your place or for more information please email audrey.pie@kenwardtrust.org.uk or call 01622 816 084.

For the Naomi project please call 01580 752 179.

INVITATION TO TENDER

FOR THE PROVISION OF A FLEXIBLE INTEGRATED SUBSTANCE MISUSE SERVICE FOR ADULTS RESIDENT IN HARINGEY

Haringey Council

NHS North Central London

Restricted Tender Process

Haringey Council is seeking to provide a flexible and integrated substance misuse service that meets the needs of adult Haringey residents. Expressions of interest are invited from suitably qualified and experienced organisations /consortia for this provision.

It is anticipated that the Adult's Integrated Substance Misuse Service contract will commence in April 2013 and will be awarded for a period of three years with an option to extend for a further two-year period subject to funding confirmation. The contract value is circa £3.5m – £3.7m per annum, dependent on grant allocation.

Organisations are invited to complete a Pre-Qualification Questionnaire (PQQ). To access the PQQ you will need to register online with 'CompeteFor' by visiting www.competefor.com.

The PQQ must be submitted no later than 1pm Wednesday 11th April 2012 via the CompeteFor portal.

Any questions regarding the PQQ should be emailed to: **Cputenders@haringey.gov.uk** no later than **Wednesday 28th March 2012**. No further questions will be answered after this date. A clarification document answering all questions submitted by organisations will be made available to all potential providers via 'CompeteFor' on a weekly basis.

The subsequent tendering process will be completed using Haringey Council's Restricted Tender procedure through the online E-Tendering System.

The Council is committed to maximising diversity and welcomes applications from all sectors of the community, and is particularly keen to encourage consortia bids.

*A **'Meet the Buyer day'** for organisations interested in participating in this procurement process is to be held on **23 March 2012 at 12pm**, Committee room 1, Civic Centre, High Road, Wood Green, N22 8LE. Please contact Christiana Imoukhuede on 0208 489 6909 or email DAAT@haringey.gov.uk to book a place.*

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EXPRESSIONS OF INTEREST

NHS Kingston Clinical Commissioning Group

Royal Kingston

NHS Kingston

INNOVATIVE COMMUNITY WELLBEING SERVICE

NHS Kingston, Kingston Clinical Commissioning Group and the **Royal Borough of Kingston upon Thames Commissioners** are transforming their current IAPT and Substance Misuse Service provision into a combined Community Wellbeing Service, commissioned on the basis of outcomes.

Commissioners are looking from expressions of interest from suitably qualified and experienced providers to deliver a new and innovative service which will be underpinned by strong partnership working, community engagement, service user involvement and co-production.

In the interests of stimulating the market and encouraging participation and innovation from providers, an Industry Provider Day will be held on the 9th March 2012 at 10am. If you wish to attend you must first register your interest on the following website https://www.delta-esourcing.com/delta.

The information and/or documents for this opportunity are also available on **https://www.delta-esourcing.com/delta.** You must register on this site to respond, if you are already registered you will not need to register again, simply use your existing username and password. Suppliers must log in, go to your Response Manager and add the following Access Code: S9C6UE6YKT.

The deadline for submitting your PQQ response(s) is 19/03/2012 17:00.

If you experience any technical difficulties please contact the Delta eSourcing Helpdesk on call 0845 270 7050 or email helpdesk@delta-esourcing.com.

MY TURNING POINT

"It was when people started to focus on my recovery, not just my drinking."

Innovative thinking and the ability to respond to changing customer needs have always been fundamental to Turning Point's success. But they are perhaps more important today than ever before. In response to major changes in substance misuse commissioning, we are now creating a specialist directorate aimed at delivering greater focus and effectiveness in our provision of integrated substance misuse services. As a result, we are looking for number of sector specialists – like you – to help us achieve our ambitious growth and development strategies.

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TURNING POINT
turning lives around

Employment Opportunities in Lifeline's NEW Integrated Drug and Alcohol Recovery Service in York.

Lifeline is a national charity dedicated to supporting individuals, families and communities affected by drugs and alcohol. We have a range of exciting employment opportunities across our York based service, to deliver a new fully integrated recovery-orientated treatment service, that is forward-looking, innovative, and committed to the achievement of positive and sustainable outcomes for our service users.

Lifeline York will provide a full range of services to adults and young people, across community and criminal justice settings - including health improvement, assessment, integrated recovery planning, psychosocial and medically assisted recovery interventions – which aim to empower service users to develop their well-being, potential, and strengths. Our aim is to support and promote recovery and community integration, as well as provide essential engagement, advice and harm reduction services.

Key elements of the new service delivery will be asset-based working, co-production, personalisation, peer mentoring, partnerships, and the development of local recovery communities. Our service framework will be flexible, dynamic and creative in order to meet the needs of service users.

We are now seeking to recruit skilled, flexible, resourceful and experienced individuals for the following roles in a new integrated drug and alcohol service:

- Service Manager
- Team Leaders (Young People, Recovery Coordination, Health Improvement, and Reducing Re-offending)
- Peer Mentor and Volunteer Coordinator
- Young People's Practitioners
- Young People and Transitional Worker
- YOT Practitioner
- Recovery Coordinators
- Primary Care Coordinator (Nurse)
- Community Detox Coordinators (Nurse and Nurse Prescriber)
- Medical Recovery Coordinator (Nurse Prescriber)
- GP's with Special Interest (flexible hours)
- Health Improvement Nurse
- DRR & DIP Lead Workers
- Various volunteering and placement opportunities

For more information please visit:
www.lifeline.org.uk/work-for-lifeline

'Lifeline: Reducing Harm, Promoting Recovery, Challenging Inequalities'

Lifeline Project

The Lifeline Project - Helping Drug Users Since 1971
The Lifeline Project provides a range of services for people experiencing problems with drugs and/or alcohol.