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DDN
Drink and Drugs News

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LIFE-SAVING STUFF

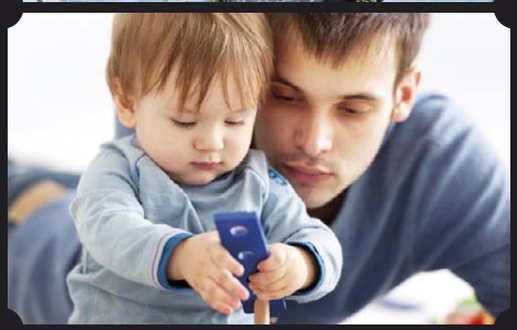
SO WHY IS NALOXONE STILL DIFFICULT TO GET?

Families First

The first Adfam/DDN family conference








While addiction can tear families apart, family support can be a huge factor in driving the successful recovery of both the individual and the whole family.

This conference will bring together family members – many of whom are providing support networks around the country – along with policy-makers and professionals.

The aim of the event is to demonstrate to family members that they are not alone, and there is support available. It will also reenergise individuals involved in the daily stresses of dealing with the consequences of a loved one's drug and alcohol problems, and offer hope and inspiration by showcasing the work of family support groups around the country.

This one-day event will allow agencies to hear from some of the most inspirational advocates for better treatment and support, and will encourage working partnerships between family members and treatment providers to help whole families' recovery journeys.

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Early bird delegate rates for bookings before Friday 14 September
Family members £80 + vat
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Thursday, 15 November 2012 – BIRMINGHAM

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Revival plan

Is there any reason to delay naloxone provision?

Nearly 3,500 naloxone take-home kits have been issued in Scotland over the past year, giving the chance of emergency treatment for overdose that has proved to be life-saving (page 4). Since the early pilots nearly three years ago, progress has been slow in following the evidence of success with UK-wide distribution.

Back in November 2008, David Best and colleagues rounded up the evidence from pilot projects all over the country and argued that the biggest barriers to implementation were ambivalence, lack of policy direction and concerns about legislation. The ACMD's recommendation to the public health minister in June that this WHO-approved medicine should be more widely available was a motivated step towards distribution, but our cover story (page 8) shows there is still a way to go.

The NTA's training programme for families and carers of drug users across England proved an effective exercise in principle, yet naloxone remains prescription only and not commonplace in environments where an overdose is most likely to happen. CRI services in Sefton and Brighton have demonstrated that service users can be effectively equipped with take-home kits alongside their prescriptions, but it's surely now time for the law to catch up with practice and make it routinely available so it can it fulfil its life-saving potential.

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FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES AND TENDERS

Cover Graphic: Nigel Brunsdon – http://injectingadvice.com

NEWS IN BRIEF

STATISTICALLY SPEAKING

The proportion of 11 to 15-year-olds who have ever taken drugs has fallen from 29 per cent in 2001 to 17 per cent in 2011, according to the NHS Information Centre. Rates of last-year and last-month drug use have also fallen, while the proportion who have never drunk alcohol has risen from 39 per cent in 2003 to 55 per cent. Meanwhile, according to the Home Office, last-year use of any illicit drug among adults has fallen from 11.1 per cent to 8.9 per cent between 1996 and 2011/12, although this was 'due in large part to a notable decline in cannabis use' with the long-term trend in Class A use showing 'no statistically significant difference'. *Smoking, drinking and drug use among young people in England at www.ic.nhs.uk; Drug misuse declared: findings from the 2011/12 crime survey for England and Wales at www.homeoffice.gov.uk/*

REVOLUTIONARY TIMES

A report on countries that have adopted some form of decriminalisation for drug possession has been published by Release *to support its Drugs – it's time for better laws* campaign (*DDN*, June 2011, page 4). The aim was to look at existing research to establish whether the adoption of decriminalisation policies led to significant increases in drug use – 'the simple answer is that it did not,' says the charity. Further reports into disproportionate policing and prosecution of possession offences in the UK and the associated costs will follow later this year and in early 2013. *Available at www.release.org.uk*

SETTING STANDARDS

Coordinated, well-led interventions involving all relevant community services are necessary to improve the psychosocial development and wellbeing of young people with substance misuse problems, according to new practice standards published by the Royal College of Psychiatrists. The standards were developed in partnership with DrugScope, whose director of policy – and *DDN* columnist – Marcus Roberts was on the expert advisory panel. *Available at www.rcpsych.ac.uk*

BEREAVEMENT CONFERENCE

The fourth DrugFAM annual *Bereaved by addiction* conference takes place on 6 October in High Wycombe. DrugFAM was established by Elizabeth Burton Phillips following her son's drug-related death (*DDN*, October 2011, page 20). *To request a place email bereavement@drugfam.co.uk*

Anthrax case in Scotland

NHS Lanarkshire has issued a public health alert following a confirmed case of anthrax in an injecting drug user, who is described as being in a 'critical but stable' condition.

The European Center for Disease Prevention and Control (ECDC) has also reported two new cases among injecting drug users in Denmark and France, as well as three cases in Germany.

The Lanarkshire case was confirmed late last month, with the onset of the European cases thought to have been between early June and early July. The anthrax outbreak of 2009-10 saw nearly 50 confirmed cases in Scotland – 13 of them fatal – along with a further 72 'probable' or 'possible' cases, and was the UK's largest single 'common source' outbreak of anthrax in humans for 50 years (*DDN*, January, page 6).

'It is possible that heroin contaminated with anthrax may be circulating in Lanarkshire and potentially other parts of Scotland,' said consultant in public health medicine at NHS Lanarkshire, Dr David Cromie. 'Clinicians and microbiologist are on alert to the possibility of anthrax in heroin users who present with appropriate signs and symptoms. Injecting drug users known to Lanarkshire addiction services are being contacted to raise their awareness.'

NHS Lanarkshire's advice to drug users was to avoid all heroin use, which it recognised 'may be very difficult' to follow, he said. 'Muscle-popping, skin-popping and injecting when a vein has been missed are particularly dangerous. Smoking heroin carries much less risk than injecting it. If there is any pain or swelling around an injection site drug users should seek urgent medical attention.'

An updated anthrax guide for frontline drug workers has been produced by the Scottish Drugs Forum (SDF) and Health Protection Scotland, along with anthrax alert information for drug users.

SDF materials at www.sdf.org.uk

Risk assessment: anthrax cases among injecting drug users Germany, June-July 2012 at www.ecdc.europa.eu

Interview with SDF chief executive David Liddell on page 18

Eastern Europe bucks declining HIV trend

The number of people worldwide who were newly infected with HIV fell by 100,000 between 2010 and 2011 to 2.5m, according to a report from the Joint United Nations Programme on HIV/Aids (UNAIDS).

This represents a 20 per cent reduction since 2001 and continues the trend reported in 2010 that at least 56 countries have either stabilised or achieved significant declines in their rates of new infection, says *Together we will end Aids*.

However, there is 'no sign' that the epidemics in Eastern Europe and Central Asia are slowing down, says the report. There are 1.5m people living with HIV in Eastern Europe, with an estimated 170,000 new infections in 2011. The use of contaminated injecting equipment remains the main route of transmission in this region, it states. In the Russian Federation, newly reported HIV cases almost doubled between 2005 and 2010.

In the countries for which data was available – Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan and Ukraine – injecting drug users living with HIV were less than half as likely to be receiving HIV treatment as people who did not inject drugs, says the document. Laws and policies that discriminate against drug users and sex workers and lack of services to meet their needs are 'important barriers to increasing access to treatment', it states.

Meanwhile, Harm Reduction International (HRI) has launched the 2012 edition of its *Global state of harm reduction* report, which points out that almost one in three HIV infections outside of sub Saharan Africa is attributed to unsafe injecting practices. Failure to address injecting drug use threatens the global AIDS response, states HRI, with falling levels of donor support and severe lack of coverage for services. The number of needle exchange programmes in Russia fell from 70 in 2010 to six in 2012, it points out.

'The reluctance of governments to fund an adequate response to HIV and injecting drug use stands in stark contrast to the seemingly limitless budgets for ineffective and punitive law enforcement responses,' said executive director Rick Lines. 'Governments care more about fighting a losing war on drugs than they do about winning the fight against HIV.'

Together we will end Aids at www.unaids.org

Global State of Harm Reduction at www.ihra.net

Scots give out nearly 3,500 naloxone kits

There were 3,445 naloxone kits issued across Scotland in 2011/12, according to figures from ISD Scotland and NHS Scotland.

The opioid antagonist can temporarily reverse the effects of an overdose to allow more time for the emergency services to arrive (see feature, page 8).

Scotland's national naloxone programme – the first in the world – is funded by the Scottish Government, with a national coordinator based at the Scottish Drugs Forum (SDF), and includes extensive training. Just over 2,700 of the 'take home' kits were issued in the community, with the remainder issued by prisons. Almost 90 per cent of the community kits were given to people at risk of overdose, with the rest issued to service staff and friends and family, with the person's written consent. There has been some criticism of the programme, with one MSP telling the BBC that it gave drug users a 'get out clause'.

'Naloxone offers the chance to save a life, and sends a clear message to individuals that their lives matter,' said community safety minister Roseanna Cunningham. 'It is not the solution to drug-related deaths, but it is an important intervention, within a range of available treatment and support, which can help reduce harm, encourage engagement with drug services and support people towards recovery.'

National naloxone programme Scotland monitoring report – naloxone kits issued in 2011/12 available at www.isdscotland.org

See page 18 for a profile of SDF chief executive David Liddell

Focus alcohol policy on health

Government alcohol policy risks overlooking vital health issues in its focus on public order, the House of Commons health committee has warned.

In its *Government's alcohol strategy* report, the committee states that while public order issues are important, the health impact of alcohol misuse is 'more insidious and pervasive'.

The report also calls for rules on alcohol advertising to be 're-examined' to reduce the likelihood of marketing being directed at, or seen by, under-18s and for the industry – if it genuinely wants to be seen as a 'committed partner' in the controversial alcohol responsibility deal (*DDN* April 2011, page 4) – to acknowledge that its advertising messages 'do have an effect' on attitudes and consumption levels. 'If this were not the case it is not clear why shareholders should be content for their companies' resources to be spent in this way,' states the report. Although the document acknowledges the importance of corporate social responsibility, the deal is 'not a substitute for government policy', it says.

The committee also supports the government's commitment to minimum pricing, but states that it needs to make sure price levels are monitored and evidence based.

The report's conclusions have been largely welcomed by organisations across the treatment sector, with Alcohol Concern calling for a review of the responsibility deal and Turning Point stating that the strategy was 'big on binge drinking' without properly considering the 'time bomb of health consequences that is already beginning to explode.

The Local Government Association (LGA), however, stated that it was important to understand that issues and solutions were 'unique in each community', while Mentor chief executive Paul Tuohy said the committee had 'missed a golden opportunity to press the government to turn their rhetoric about preventing problems into solid reality'. Industry body the Portman Group stated that the committee had 'failed to understand' the significance of the responsibility deal's unit reduction pledge.

See news focus, page 6

Substitute prescriptions 'must be regularly reviewed', says expert group

Service users should not be 'parked indefinitely' on substitute medication and all prescribing treatments need to be regularly reviewed, according to the final report from the expert group chaired by Professor John Strang of the National Addiction Centre.

However the group has rejected the idea of time limits for treatment, warning that this could increase rates of overdose, crime and blood-borne virus transmission as well as damage people's chances of recovery.

The cross-sectoral group, which delivered its interim report last year (*DDN*, August 2011, page 5) includes chief executives Viv Evans, Karen Biggs, Noreen Oliver and Ian Wardle, service user representatives Peter McDermott and Jason Gough, GPs Gordon Morse and Roy Robertson, and academics David Best, Neil McKeganey and Alex Copello, as well as psychologists, nurses, commissioners, service directors and others.

Although clearly stating that opioid substitution therapy is effective, *Medications in recovery: re-orienting drug dependence treatment* says that there needs to be immediate action to ensure it is 'always delivered in line with clinical guidance'.

Professionals should review their patients to 'ensure they are working to achieve abstinence from problem drugs', it says, as well as integrate services with mutual aid groups, employment, housing and other support agencies and make sure that treatment programmes are dynamic and 'support recovery'.

The report acknowledges that behaviour change depends on a 'range of internal and external resources' that many people may not have, but says that there is a culture of commissioning and practice that does not 'give sufficient priority to the desire of individuals to overcome their dependence on drugs,' said Professor Strang.

'Substitute prescribing has an important contribution to make to recovery-orientated drug treatment, but it is not an end in itself', said Strang.

Report at www.nta.nhs.uk

A GROWING MOVEMENT: service users in Doncaster get ready to celebrate National Allotments Week this week (6-12 August). Rotherham, Doncaster and South Humber NHS Foundation Trust runs allotment projects at a number of its Doncaster services which, as well as giving service users the chance to cook their own produce, helps to 'improve their health and wellbeing, learn new skills and bring them together with other people,' says professional lead occupational therapist Wendy Ferguson.

NEWS IN BRIEF

SIX OF THE BEST

A third of people who entered treatment for the first time in the last three years went on to complete it and did not return, according to the NTA. The agency has issued a new report analysing the six years' worth of treatment data that was released last year (*DDN*, November 2011, page 4), and shows how the treatment system performed over a sustained period rather than 'the conventional 12-month snapshot of annual statistics'. The NTA has also announced that it intends to step up its engagement with the residential rehab sector in order to 'challenge commissioners who inappropriately restrict access and help under-performing providers' – those with high drop-out rates and low levels of discharge from the system. *From access to recovery: analysing six years of drug treatment data and The role of residential rehab in an integrated drug treatment system at www.nta.nhs.uk*

WHO GUIDANCE

New guidance on the prevention of hepatitis B and C among drug users has been published by the World Health Organization (WHO), with recommendations including peer interventions and the offer of incentives to increase uptake of vaccination programmes. *Guidance on prevention of viral hepatitis B and C among people who inject drugs at www.who.int*

ANCHORS AWEIGH

Phoenix Futures' three-month 'Voyage of Recovery' (*DDN*, March, page 15) had its launch last week. The project, in partnership with sailing charity Tectona Trust, will see more than 100 people in treatment for drug or alcohol problems sail around the coast of Britain on the Gaff Ketch Tectona before arriving in Plymouth in October. 'It really has brought people of all ages and backgrounds together to support recovery from addiction and help transform individuals and their communities around the country,' said voyage project manager Adele Duncan. *Follow the voyage at www.phoenix-futures.org.uk*

SURVIVOR STRENGTH

Survivors Manchester, the support organisation for male survivors of sexual abuse (*DDN*, 19 October 2009, page 6) has launched a new website and e-newsletter. Research has found that males typically take around 20 years to disclose their experiences – '20 years of unhealthy and maladaptive coping mechanisms', says the organisation. *www.survivorsmanchester.org.uk*

DOES A PREOCCUPATION WITH BINGE DRINKING MEAN THE HEALTH ASPECTS OF ALCOHOL ARE BEING OVERLOOKED?

The health select committee recently reported that government alcohol policy should move beyond public order in town centres and increase its focus on health. ***DDN*** reports

The press loves a good 'binge Britain' story, especially if its moralising tone can be accompanied by pictures of young women in various states of undress on a night out. But, when it comes to policy, is there a risk that the public order aspects of our alcohol culture are in danger of eclipsing public health?

The House of Commons health committee thinks so, with its report (see news, page 5) on the government's alcohol strategy (*DDN*, April, page 4) stating that, while its attempt to bring a coherent approach to tackling the issues is welcome, the strategy's focus on public order 'overshadows the health issues'. Although binge drinking and related public disorder and anti-social behaviour are certainly important, said committee chair Stephen Dorrell MP, 'the health impact of chronic alcohol misuse is in our view also significant and greater emphasis needs to be placed on addressing that impact'.

As well as calling for a 're-examining' of alcohol advertising regulations, including the possibility of a version of the French 'Loi Evin'– which is designed to restrict children's exposure to alcohol advertising, including viral marketing (*DDN*, June 2011, page 21) – the committee wants to see a central role in developing policy objectives given to Public Health England, adding that the controversial 'responsibility deal' (*DDN* April 2011, page 4) is 'not a substitute for government policy'.

Many treatment organisations have issued statements agreeing with the committee's findings, with Addaction and Turning Point both calling for more investment in early intervention and specialist treatment. The Royal College of Psychiatrists stated that it expected the Department of Health's planned guidance on the development of alcohol services to 'highlight the strong evidence base supporting screening and brief intervention', particularly in primary care, but it also wants to see separate guidance issued on the capacity of services.

'The health committee described the state of alcohol services in England as "dire" in 2010 and we see no evidence that this situation has changed,' said a joint statement from chair of the college's faculty of addiction psychiatry, Dr Owen Bowden-Jones, and Scottish chair Dr Peter Rice.

What liver disease charity the British Liver Trust wants to see to address this situation is far more investment in alcohol specialist nurses, with the one-million-plus annual alcohol-related hospital admissions meaning that 70 per cent of all alcohol costs to the NHS are incurred in hospital. Existing good practice models could easily be translated into routine care for alcohol-related conditions, the trust believes.

Given the intense cost pressures on the NHS, however – £20bn of 'efficiency savings' needed by 2015 and even more expected to be announced after that – how likely is it that the government will actually take the message on board and employ more specialist nurses?

'The government has committed itself to delivering an effective alcohol strategy, and with respect to specialist alcohol nurses the figures speak for themselves,' the trust's chief executive Andrew Langford told *DDN*.

'So far, they have been bold with minimum pricing so I am hopeful they'll take on board the evidence. We know that alcohol treatment services have been the poor relation when compared to the investment in drug services – a specialist alcohol nurse would go some way in bridging that gap.'

Employing specialist staff would save money in the long run, but presumably that means policies need to be fundamentally reformulated to bring more of a focus on long-term strategy? 'With regards to addressing preventable liver conditions as a whole, yes they do,' he says. 'Alcohol is a public health issue which requires a long-term attitude and a consistent approach. We have spent decades making alcohol cheaper, more available, allowing it to become a normal part of everyday living – to reverse that and to inform a generation who are used to such a relaxed approach to alcohol will take time.'

The trust has repeatedly stated that the impact of chronic alcohol misuse isn't given the prominence it deserves, citing data from Liverpool PCT that almost all (90 per cent) of its hospital admissions related to alcohol are actually for chronic conditions.

'There is no denying that binge drinking has preoccupied the media, however it's the chronic and habitual drinking, often in the home, that is our biggest problem,' says Langford. 'I still don't believe that people are able to make an informed decision on how much they drink and, importantly, the health impact it might be having, which is why measures such as health information on packaging should be better. We are also faced with an often-symptomless condition, with the liver not showing signs of complaint until late on in disease progression. Sadly, and probably the most difficult message to drive home, is that preventative action is the way to protect yourself from a preventable liver condition.' **DDN**

The press loves a good 'binge Britain' story, especially if its moralising tone can be accompanied by pictures of young women in various states of undress on a night out.

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

A *Sun* YouGov poll showed six out of ten Brits want to see drug users escape prosecution and receive better medical treatment instead. Of course, this type of change only applies to possession and does not amount to full legalisation, as dealers and traffickers would still be hunted and jailed by cops. But in the *Sun* poll, 56 per cent of people did say they would like to see the idea of complete legalisation reviewed – along with other policy options.
Sun news story, 11 July

Having failed to understand that drug policy was failing because of the fundamentally flawed division it created between soft and hard drugs, users and dealers, Britain under the Labour government increasingly abandoned law enforcement and set out instead to manage the ill effects of drug use. But under this strategy of 'harm reduction' – a Trojan horse for legalisation – drug use has rocketed skywards. The legalisers' arguments are wrong-headed, historically false and often absurd.
Melanie Phillips, *Mail on Sunday*, 8 July

The *Times* and now even the *Telegraph* have joined with the *Independent* and *Guardian* in giving over column inches to 'open minded' but misguided libertarians. These writers would have us believe that the normalisation and legalisation of drugs is a solution to the ghastly addiction that [Eva and Hans Rausing] fell into without check. It is not.
Kathy Gyngell, *Daily Mail*, 13 July

I don't think charities should take money from people they know are still using. The message that it sends to the vulnerable is that with enough cash you can buy your way out of anything.
Janet Street-Porter, *Independent on Sunday*, 15 July

There's a fine line between mutually supportive drug users and mutually supportive recovering addicts. The same person can enable a friend to put down or pick up: flip-flopping between the two is far more common than 12-step groups would like to admit. I don't believe that addiction is a 'disease', but once hard drugs are in your life there's a good chance that they'll keep you busy for years – taking them, staying away from them, or alternating miserably between the two.
Damien Thompson, *Telegraph*, 11 July

The big question is advertising. It is nearly three years since the BMA called for a total ban – on sponsorship too – as part of a strategy to curb drinking. The industry says there's no evidence that it encourages drinking, a surprising assertion when it has an £800m-a-year budget.
Guardian editorial, 18 July

Who saw Louise Mensch on *Question Time*, refusing to say which class A drug once 'messed with' her head because she didn't want to 'glorify' drugs? It was a wonderful, surreal moment. One could just picture all the future addicts, lying on dirty mattresses, saying: 'Yeah, Louise Mensch, Conservative MP for Corby, got me started – when she talked about her past drug use on *Question Time*, she just made it all seem so cool.' In a way, it's touching that Mensch believes that she exerts such influence over the nation. Did I say touching? Sorry, I meant risible.
Barbara Ellen, *Observer*, 8 July

POLICY SCOPE

Substance misuse is being blamed for child poverty ahead of the true causes of inequality, says Marcus Roberts

FOOD FOR STIGMA

One in five people (19 per cent) believe that parental drug and alcohol problems are the main cause of child poverty in Britain, according to the latest *British attitudes survey* (and 75 per cent identify them as a cause of child poverty). This puts substance misuse at the top of the league table of 'main causes' of child poverty for the 3,000 respondents to this survey. It comes ahead of 'their parents do not want to work' (15 per cent), 'their parents lack education' (10 per cent), 'their parents' work doesn't pay enough' (9 per cent), 'because of inequalities in society' (5 per cent), parental illness or disability (3 per cent), experience of discrimination (1 per cent) and lack of access to affordable housing (1 per cent).

Parental substance misuse can have a serious negative impact on children, and can contribute to child poverty. But the main reason for poverty? The latest figure for the number of children living in relative poverty in the UK is 2.3m (the Institute for Fiscal Studies warns that this number may increase by 400,000 by 2015). The 2003 *Hidden harm* report concluded that there were 250,000 to 350,000 children of problem drug users, while observing that 'problem drug use prospers in circumstances of poverty and disadvantage, from which the children of problem drug users are by no means the only ones to suffer'.

Amongst the mishmash of individual and structural factors included in the *British attitudes survey*, it is genuinely shocking that substance misuse problems are seen as more fundamental to – and more causally primary for – poverty compared to things like poor education, lack of opportunity, low pay, unemployment and inequality, by such a large section of the public.

This is not the place to consider the reasons and significance of all this in any detail, but two thoughts spring to mind. First, the increasing focus on 'addiction' as an issue for the Department of Work and Pensions may be working at a more subterranean level to shift public perception of the causes and dynamics of poverty in Britain. Second, that laying the blame for child poverty at the door of parental addiction will tend to feed the stigma and discrimination that can keep families locked in poverty.

On the subject of statistics, I was at a meeting recently when a powerpoint came up that said 'Every ten addicts not in treatment in 2010-11 committed: 13 robberies and bag snatches, 23 burglaries, 21 car thefts and more than 380 shoplifting thefts'. These figures are being promoted by the NTA as a means of influencing local commissioners to part with scarce resources. I have no problems with the promotion of the crime reduction dividends from treatment to incentivise investment, but is it really helpful to imply that every 'addict' not in treatment is committing a load of crime? The aggregate figures from which these are derived would be impactful enough, a fairer reflection of the reality and less likely to reinforce stereotypes and feed stigma.

The British attitudes survey 28 available on the NatCen Social Research site at www.britsocat.com

Marcus Roberts is director of policy and membership at DrugScope, www.drugscope.org.uk

HARM REDUCTI SAVED MY LIFE

'Every single one of our hostel residents... has been trained and issued with naloxone mini-jets, and drug-related deaths in the city are down significantly'

'His modesty means that he plays it down, but actually he's a local hero,' says CRI project manager at Sefton Integrated Recovery Treatment Service, Alan McGee. He's talking about Paul (not his real name), a participant in the service's take-home naloxone programme and one of more than 100 service users, carers, volunteers and staff to go through naloxone training at the service since last year.

'It was only about a week and a half – two weeks at the most – after I'd been given the naloxone that I actually used it,' says Paul, a drug user for almost 30 years. 'A lad came to my house and said he had something to leave for a friend of mine. I'd known him since he was a kid – I'm older than him – so I let him in, and he talked me into letting him have a hit there. He fixed up, then said he was going to the toilet. I heard a thud, and when I went and opened the door he was on the floor. He'd stopped breathing and his heart had stopped as well, so I had to do CPR. I gave him half of the naloxone at first, waited a few minutes, but nothing happened so I gave him the other half. A few minutes later he came to.'

The ambulance he'd called turned up just after the overdose victim had come round, Paul continues. 'They were asking me all sorts of questions about the naloxone, like did I have permission to use it and was I trained to use it. The lad didn't want to go in the ambulance at first but I talked him into doing it. The ambulance people told him that he'd actually stopped breathing and all that, and that I'd brought him back from it. He couldn't thank me enough, but I didn't think it was that much of a big deal.'

*****

The Advisory Council on the Misuse of Drugs (ACMD) recommended in a recent report that the government should ease restrictions on who can be supplied with naloxone – which can reverse the effects of an overdose to allow people to get further medical help –

An incomplete pres

ION

The ACMD regards naloxone as an evidence-based intervention that saves lives – yet it remains prescription only. **David Gilliver** hears from a service that's calling for provision to be rolled out. Graphics (including cover) by **Nigel Brunsdon**

and increase its availability (*DDN*, June, page 5).

Successful pilot programmes have led to naloxone being made more widely available in Scotland and Wales, and Scottish lawmakers have also ruled that the drug can be provided to some services for use without prescription in an emergency. However, while naloxone has been provided locally to service users and carers in England for years – and the NTA has run a naloxone and overdose programme which saw families and carers of drug users across England trained in how to administer it (*DDN*, 13 July 2009, page 4) – no comparable roll-out has followed.

The ACMD's letter to public health minister Anne Milton accompanying its *Consideration of naloxone* report stated that, while provision of naloxone reduced rates of drug-related death, the maximum impact would only be achieved if the World Health Organization-approved medicine was 'given to people with the greatest opportunity to use it, and to those who can best engage with heroin users'. At the moment, however, it remains prescription-only, which means that, in the words of the ACMD, 'non-medical services which may experience frequent opiate-related overdoses are not able to legally hold stocks of naloxone to use in an emergency'.

The council's report, however, acknowledges that wider provision alone would not be enough to significantly bring down drug-related death rates, and the ACMD aligns itself with 'UK and worldwide research that indicates that training service users, peers and carers in all aspects of how to respond to an overdose' is essential.

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At CRI's Sefton service, all service users issued with take-home prescriptions of methadone or other substitute medication are trained to administer naloxone, usually via a mini-jet, while the organisation's service in Brighton and Hove, as well training all of its service users has so far trained around 80 family members and carers. 'Anecdotally, they feel much more confident and empowered,' says CRI's director of operations Mike Pattinson. 'There's always that kind of fear of, "Do I have to call an ambulance, have I got time to call an ambulance?" They feel much more confident that they can do something proactive.'

The service has gone further, however, and extended its focus to the city's highest risk populations. Residents in Brighton's homeless hostels have been trained in the use of naloxone and staff trained to recognise the signs of an overdose and administer naloxone injections, while in East Sussex, training and naloxone is also provided to 120 prisoners a year as they leave HMP Lewes. 'Every single one of our hostel residents in Brighton and Hove has been trained and issued with naloxone mini-jets, and drug-related deaths in the city are down significantly,' says Pattinson. 'They peaked in 2009 at about 52, in 2010 they were down to 30, and figures for last year will be in the high teens, maybe 20.'

While all of CRI's CQC-registered sites now carry a stock of naloxone – ordered by a CRI GP – what the organisation is calling for is the ability of all services that routinely come into contact with drug users to be able to hold it as stock.

'At the moment, anyone can administer it but it has to be prescribed to the individual,' explains Pattinson. 'So you're reliant on the individual having naloxone and then a third party being able to recognise an overdose, recognise the fact that they might have naloxone on them, search them, find the naloxone and administer it. We thought a much more sensible way of doing it would be to hold a stock of naloxone in every service that comes into routine contact with people who are at risk of overdose.'

CRI's naloxone provision began 'piecemeal, project by project,' he says. 'But we then set off on a wave of excitement about having an organisation-wide approach to how we would provide naloxone, across not just substance misuse services but also into hostels and outreach teams and so on. It had to be put on hold when I saw the most recent lot of guidance that explicitly says that it's still a controlled drug and you still can't use it in hostels. We knew we could provide it routinely in any CQC-registered locations, any regulated activities, and hold it as stock – which is how it works with paramedics – but what we were looking to do was extend that and order it for sites that weren't necessarily CQC-registered.'

How much of a frustration has he found this? 'It is frustrating because it just doesn't seem to make sense,' he says. 'It's about the law needing to catch up with practice – we know it's safe, we know it's virtually side effect-free, and we know it's an effective way of preventing drug-related deaths. So it seems crazy not to.'

In fact, the Scottish Lord Advocate's ruling allowing treatment and homeless hostel staff to hold naloxone ready for emergency use without prescription, and protecting medical professionals supplying naloxone in cases of liability, was described as 'commendable' by ACMD.

*****

Naloxone does have its critics, however. What about the argument that it could encourage riskier behaviour? 'I'm not sure that people do say that,' says Pattinson. 'I think that we fear that's what people would say, but I've never actually heard anyone say it. There isn't any evidence that that's the case – people take drugs because they want to get stoned, they don't take them because they want to see how far they can push themselves towards an overdose. Almost every overdose will be accidental, unless it's a suicide attempt.'

Indeed ACMD's letter to Anne Milton states that while 'critics have suggested that naloxone provision in the community could encourage people to use drugs more dangerously if they know naloxone is available', the council was 'not aware of any significant body of evidence that naloxone provision encourages increased heroin use', and Pattinson wants to see every service that routinely comes into contact with people at risk of overdose having its own stocks as soon as possible.

'We're ready to go,' he says. 'We have the training protocols written out, we the have patient group directives written out. We know it's relatively cheap, it's effective, and there's no evidence that I know of that people will take more risks because they think they can be resuscitated. If we can extend it beyond the clinical or substance misuse settings to outreach workers, they're the ones who'll come across people in squats or on the streets who've overdosed – it's often people in the homeless hostels, which is why we've done the work in Brighton.'

This would also go a long way to addressing the situations that can result from 'panic among the client group', he argues. 'They know they should call an ambulance but they panic about whether that means the police are going to get involved, and all the myths that are still around, so often people are just abandoned.

'We strongly recommend a review of this because it's such a cheap and effective way of saving lives – you could expand the coverage at almost no cost,' he says. 'If we can have workers on hand we know it can be done, because we've worked out how it can be done. It's only the law that's preventing us from doing it.'

***Consideration of naloxone* available at www.homeoffice.gov.uk**

Nigel Brunsdon can be found at http://injectingadvice.com

scription?

Post-its from Practice

Sliding Doors

Our new Post-its columnist, Dr Steve Brinksman, explains how he was destined to get involved

‘That brief conversation with Chris all those years ago opened up the fascinating world of managing substance misuse in general practice to me.’

Many of you will have read Dr Chris Ford’s ‘Post-its from Practice’ column over the years and it is a privilege to be asked to take over from her.

When thinking about what to write about for this first column I started reflecting on how the little decisions we make can have ramifications for a long time – the *Sliding Doors* phenomenon. Mine involved choosing a place to sit. Over a decade ago I and a couple of other Birmingham based GPs heard about an organisation called SMMGP that was organising some training about working with crack users. As there wasn’t much training about this, and it was a growing problem, we signed up and came down for a day in the big smoke.

Coming in to a fairly crowded room at the last minute as per usual, I recognised a GP from London who always asked challenging questions at the RCGP substance misuse conferences, and next to her was an empty chair so I sat in it. That was the first time I had talked to Chris Ford and throughout the course of that morning I was impressed by her knowledge, passion and compassion.

Over lunch Chris started talking to one of the other GPs about shared care and it was obvious that she wanted them to deliver a talk at the RCGP college. ‘Rather you than me,’ I thought. Unfortunately it transpired that this person would be on holiday that day. At this point Chris turned to me and said, ‘Well you will have to do it then,’ which is when I discovered another thing about her – she is impossible to say ‘no’ to!

Since then I am proud to say that not only has she been an ongoing inspiration to me, she has been my mentor, colleague and very dear friend. Somehow I don’t think she will sit quietly in retirement but will continue to prick the pompous, goad the gainsayers and love, cherish and support those who can’t always stand up for themselves. Please see the YouTube link below for details! I wish her all the best and with a little trepidation I will attempt to fill the space she has vacated.

As for me, that brief conversation with Chris all those years ago opened up the fascinating world of managing substance misuse in general practice to me, which has greatly enriched my experience as a jobbing GP. But more about that in future Post-its.

See Chris on YouTube representing IDHDP at the July AIDS 2012 conference in Washington: bit.ly/MIESHa

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

LETTERS

STIGMA STRUGGLE

‘Everyone’s affected by stigma, but it can hit you harder when you’re from a minority group, or a group that society doesn’t necessarily agree with,’ says Lee Collingham who runs Nottingham’s Shared Care User Forum in an excellent article (*DDN*, June, page 8).

I wholeheartedly agree with that statement but from a slightly different standpoint. If people with an addiction are a minority group then people who are helping those people to walk that road to recovery, and are doing it without the help of other services or outside funding, must be even more in a minority group. I set up a charity a number of years ago with the sole aim of helping people to avoid relapse once they had been through detox and/or rehab. It was done after speaking and consulting with those who had suffered relapse. The charity took the form of a supported housing project with ongoing support groups and one-to-one sessions.

It was definitely not easy to set up such an enterprise, but we thought that we would be an attractive addition to the services around us. However we did not see what was coming. After speaking to the primary care trust for our area they decided that they did not want to help us or even recognise us, which has continued to this day. The local drugs services have been told not to speak to us and not to make any referrals to us, which I find somewhat strange as I thought that we would all be working for the good of the person desperately seeking recovery.

We have been running now for 15 months and have provided around 1,300 days of recovery for people in our supported houses. We have helped them with their addiction and with debt and family problems. We have been there when they have needed us and shared their joy and pain. So why have we been ostracised by the addiction services around us?

We don’t do this for material gain, as we are all volunteers and receive no remuneration. I have been without wages now for two years and am struggling, yet I am still here day after day for the sake of others. I also know that if we want to take this project further then we need funding to expand. I know that what we do works for many people. When PbR comes in, the ongoing recovery work that we provide will be at a premium.

I feel the stigma of a workplace where other professionals will not even look at what we are doing for people’s recovery and even feel like walking away from it at times. It’s a good job that we get support from others who see the value of what we are doing, otherwise it would be just too easy to kick it all into touch and deny people the chance to find recovery via what we offer.

Name and address withheld

RECOVERY MAD

Is there any chance you guys could go one issue without having recovery mentioned on every page, as some people are sick to death of hearing and reading about it? It drives me mad when I hear ‘recovery is different for everyone, recovery is this, recovery is that’. Please just one issue without recovery. Why can't we go back to when recovery meant having a lie down?

Instead of recovery, maybe do something on anthrax killing drug users across Europe and why the warning that was sent out about it advised against using local media outlets to get the word out. Maybe I am just being paranoid from using copious amounts of drugs, but I reckon that if anthrax was in any other drug or killing any other section of society it would be shouted from the rooftops. It’s only killing drug users, so it isn't really big news.

Martin McCusker, Lambeth

We welcome your letters...

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

LEGAL LINE

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

HOW CAN I MAKE SURE I'M GETTING THE RIGHT BENEFITS?

READER'S QUESTION:

I've been awarded Employment and Support Allowance and placed in the work-related activity group. My friend is in the support group – I'm not really sure what the difference is but I know he gets more money, even though my drug problem is worse than his. I'm really frustrated as I took lots of medical evidence to the ATOS assessment, but the examiner wasn't interested. Can I do anything?

KIRSTIE SAYS:

Unfortunately your situation is not unique – many people have similar experiences of the Work Capability Assessment (WCA). You were right to present supporting evidence at the earliest stage. You can still provide this to the DWP and ask them to review the decision. Normally this must be within a month of the written decision, but sometimes discretion can be exercised outside of this.

You mention that you have a drug problem but do not say what other physical and/or mental health conditions you suffer from. Employment and Support Allowance (ESA) will not be awarded solely for a drug or alcohol problem. A claimant has to score points in one or more areas, which may also be related to substance misuse. As you have been awarded ESA you must have scored points for certain physical and/or mental health descriptors.

The work-related activity group means that although it has been decided you cannot work due to illness, you are able to do things which are connected to working and aimed towards moving you back into work, including attending work-focused interviews with an adviser. However, depending on your individual circumstances it is possible for attendance at interviews to be deferred or even waived. The support group means that your condition is so serious you cannot even undertake work-related activity. Claimants in this group get £5.90 more per week than those in the work-related activity group and do not have to attend work-focused interviews.

Allocation to the support group is quite rare as the descriptors are very narrow. Although you may feel that your condition is severe, and you have medical support for this, if your circumstances don't fit into one of the specific categories you will be placed in the work-related activity group. Alternatively, if there is a substantial risk to yourself or others posed by work-related activity you could also be placed in this group. If you think you meet the criteria for the support group you can request a review of the decision and should provide as much evidence as possible. If this is unsuccessful you can appeal to an independent tribunal. It can be difficult to get legal representation for a review/appeal, but your local CAB or law centre may be able to assist in some way.

Email your legal questions to claire@cjwellings.com
We will pass them to Kirstie to answer in a future issue of DDN.
For more information on benefits and drug use call the Release helpline on 0845 4500 215.

OBITUARY

BRI EDWARDS

It's sad to sit here in Canada and record the death of my great friend Bri Edwards. He faced his final days with great courage, and passed away on 2 July at home with his family all around him. Two weeks before his death he had completed his final examination for his batchelor's degree from the Open University. Examiners came to his home in Seascale, Cumbria and he dictated his exam answers.

Bri and I first met in the late 1970s when we were both residents at the ROMA (Rehabilitation of Metropolitan Addicts) in West London. ROMA was in a few large houses along Talgarth Road, past the North End Road and West Ken tube where the A4 broadens and swells out of London. It was more of a housing project than a residential community, although that was to change when a young organisation called Turning Point took on its challenge in 1980.

Bri was a tall gangling Scotsman in his mid 20s. He stood out because of his extraordinary height and his animated delight in chatter and argument. We had things in common from the start – we were 'working' residents out of the house during the day. Bri worked for the RANK organisation on Wardour Street, maintaining the building and its fittings from a dimly lit basement cavern that was his own little place. He was intense, funny, and passionate about the things he loved – music, horticulture, and the care of trees. He was also compassionate and interested so I found it easy to share my own feelings and sadness.

We both had 'scripts'. Mine was a plain oral variety from UCH. Bri had 'private' doctors and needed a more exotic prescription. He was hard working all his life, but private scripts needed an income and Bri was incredibly organised about managing this part of his life.

As I learned of his early life, I started to understood why he needed such a release. It was sad and short on love and security, and his sister Linda had looked after him when they were abandoned as young children. Such events had shaped the person I knew in the 1970s but not the man he became later in his life.

I didn't know this until the end of 2007 when my telephone rang here on Vancouver Island and a Scots voice came out of the phone asking if I was the Bill Nelles that had once been at ROMA.

It was Bri, of course, and as we talked, he told me he was married with children and had a strong and loving wife, Lyn. They lived in Seascale where Lyn and Bri had founded a youth outreach program called Shackles Off. He advised a local castle on their trees and gardens, which had been his livelihood until an accident which left a hand crushed.

As we talked further, I realised that we had followed much the same path to strengthen ourselves and maximise good health. Like me, Bri hadn't used street drugs or injected for years. He knew of my advocacy work and was involved in the local Cumbrian Service Users Group. He had found a strong Christian faith and he had a wonderful family – so important to him after his own experiences.

I followed Bri's work over the next five years as he and Lyn pursued their projects. In 2008 I spent a week in the UK doing some advocacy training for his group, so I was able to spend some quality time with Bri, and see how our lives had changed.

We had both found life partners who loved us. And we had also found recognition and involvement in issues like advocacy that also helped us to feel good about who we were. We had each found what we needed to fill our sadnesses and it was called love. I'll miss you, my friend.

Bill Nelles

Real-life repairs

East Coast Recovery are creating a thriving hub of community enterprise in the seaside town of Lowestoft. **DDN** paid a visit

'Trudge the road to happy destiny' and 'keep coming back' say the slogans in stained glass on the windows of the Meeting Place café just off the high street in Lowestoft, where Leah and Vicky bring sandwiches to satisfy the lunchtime customers. At a table outside, East Coast Recovery manager Daniel Farnham discusses activities with a colleague. Inside, against a colourful frieze – backdrop for the regular monthly 'Live Lounge' sessions – referrals coordinator Paul Wheeler explains how a thriving model is being replicated in different parts of the business.

Originally based in Watford, the rehabilitation centre – formerly known as Clean and Sober Living – moved to the area five years ago as part of managing director Lester Morse's vision of combining recovery with a therapeutic environment.

'There was a lot of grief when we first moved the centre, a lot of "keep the junkies out",' says Wheeler. 'We had to work closely with partners to establish it.' From a primary unit with 23 beds and a secondary unit with eight beds, the café, together with a framing shop business and a working garage, have transformed the centre into a thriving recovery enterprise.

'If you create something attractive that works, people get drawn into it,' says Wheeler, explaining the aim to link people to the goal of long-term employment via recovery pathways. 'You're not going to go from hero to zero in 12 weeks, so you need the eco-system for them to find their own way.' Through giving them new practical skills as a foundation for employment, they move on beyond treatment – 'it happens organically', he says.

The Meeting Place café is not all about profit – although those lessons are included for its workers. The purpose of the venture is to teach life skills alongside business and create aspiration.

'Our society is full of short-term strategies – the political system is full of them,' says Wheeler. 'The worst thing you can do is give people hope and then remove it from them.'

By encouraging rehab clients to become involved in one of the businesses, they are reintroduced to life beyond addiction while still in a supportive environment. Managers are aware that the client may fail and are always ready with help and support. All they ask is total commitment to recovery – by which they mean abstinence – and they will work with them to try and achieve it.

'It takes four years for the brain to recover, but one in six people will relapse during the next 15 years. We don't make that one relapse the end,' says Wheeler.

As Daniel Farnham takes us to the framing shop, he talks of the team's commitment to the recovery community, motivated by their personal experiences of addiction. The social enterprise is supported by 'friends of recovery', such as Lisa, who sings at the café's Live Lounge sessions as well as managing the framing shop, and contributes to the local network of support. Clients can spend

'Our society is full of short-term strategies – the political system is full of them... The worst thing you can do is give people hope and then remove it.'

time at the shop when they are on the fifth of the 12 steps, and learn about all parts of the business while interacting with customers.

Near the harbour, the garage is thriving – both as a business and a recovery hub – thanks to a partnership created with the owner and Suffolk DAT. Men and women from East Coast Recovery are supported in doing their apprenticeships, learning everything about mechanics, from stripping down a car and trading parts to sales and accounts. There's also a strong community element – a recent recovery event at the garage attracted 60 people, helping to secure the local support network.

As we arrive at the garage, salesman Graham has just concluded a new transaction and watched a satisfied customer drive off. He explains that he is about to move into 'third stage living' with East Coast Recovery – moving out of the rehab to live completely independently, but within the 'recovery eco-system'.

'A life beyond your wildest dreams needn't mean a holiday in Hawaii,' he says, as he talks about his excitement at his forthcoming trip back to Scotland for a family wedding, his first time back in six months. Working within the community has given him enough support to regain his confidence and independence, and a sense of normality that he thought had deserted him.

'The garage is a fantastic opportunity,' adds Farnham. 'It's like starting society again – creating society within society, and that will open up other avenues and opportunities. But there are more people than opportunities at the moment, which is why we're trying to grow these pathways through more investment and partnerships.' Helping people to move beyond treatment into sustainable employment in the community will help ease this bottleneck and open doors for other clients, he says.

East Coast Recovery is already working in partnership with local organisations, such as WDP and Open Road, to make sure clients have the strongest support possible, and using different organisations' expertise on criminal justice and psychosocial issues. The idea is to keep linking in with like-minded partners to give people the four or five years they need in the recovery community.

Longer term, the hope is that the partnership working on recovery will become more unified, says Wheeler. 'There are lots of pockets of people around the country doing this stuff, but they're not linked in yet so there's not much overall clarity. Our hope is for us to be part of an organic recovery eco-system – that'd be beautiful!' **DDN**

FAMILY MATTERS

A NEED TO CONNECT

Family members are too often isolated behind a barrier of confidentiality, says **Joss Smith**

The Big Lottery Fund has recently announced a significant investment in coordinated services for people struggling with severe exclusions, namely homelessness, reoffending, mental ill health and substance use. There are an estimated 60,000 adults facing these multiple and complex needs at any one time in England. These adults, whose drug or alcohol use and mental health problem are often exacerbated by their lack of somewhere to sleep or being repeat offenders, also often get moved between services and lost in the bureaucracy. This focus has got me thinking again of how families cope with these often very significant and severe problems and how the failure of services to respond can tear relationships and families apart.

As Adfam has highlighted in the past, families living with someone with multiple needs can experience confusion, isolation and distress. We know those affected by multiple needs experience intractable problems: increased risk of suicide, aggression/violence, crime, homelessness, a greater risk of HIV infection and poor social outcomes. We also know that there is a lack of coordinated provision for those affected by dual diagnosis and their families, as this group tends to fall between gaps in services. The devastating impact on families affected is, in part, due to the fact that neither support services for carers of those with drug/alcohol problems nor services for carers of people with mental health problems respond fully to the complexity of their experiences.

Families often report feeling frustrated at the rigid boundaries some services apply to their provision and are often left confused about where indeed they can get help. Many family members are supportive and often have vital insights into their loved ones' behaviour, which may provide professionals with a clearer picture. However family members report that they simply don't feel listened to by some professionals and that the barrier of confidentiality prevents them from being heard.

As one family member wrote, 'The frustration can be massive – going around in circles, being pushed from here to there, waiting for weeks between appointments, unanswered letters, unreturned calls, and all the time being told "we cannot talk to you – it's confidential". Imagine hearing the words "my hands are tied" when you are desperate for help because you can clearly see someone at risk.'

In our communications with family members and the services that support them, it is very clear that there is an urgent need to support families facing this issue. It is clear that family members and those working with them find it difficult to negotiate the number of – often uncoordinated – services involved. There is also a clear need for better information for family members to enable them to navigate and advocate within the complex service systems. Often family members are very isolated and frequently stigmatised due to the multiple exclusions their loved one faces, and suffer extreme frustration and distress trying to help curb the chaos and damage caused by multiple needs.

As another family member said, 'We have the services – it's the connecting, sharing training and a willingness to work together that I know would make a huge difference. It was a journey we will never forget.'

Joss Smith is director of policy and regional development at Adfam, www.adfam.org.uk

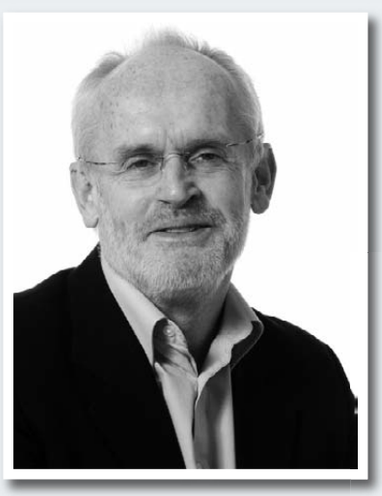
Families First, the Adfam/DDN families conference is on 15 November in Birmingham. Details at www.drinkanddrugsnews.com

MEDICATIONS IN RECOVERY

An expert group convened by the NTA has made recommendations on reorientating drug dependence treatment to fit the recovery agenda. The group's chair *Professor John Strang* explains

FOR YEARS the treatment field has vigorously debated the balance between reducing harm and helping recovery. I believe we are approaching the point where we can achieve a genuine consensus that will be of benefit to practitioners and also to patients. July's publication of the final report on recovery-orientated drug treatment (see news, page 5) was the culmination of nearly two years' work by the expert group convened in 2010 at the invitation of the National Treatment Agency.

The interim report in July 2011 on the group's work had already indicated the balance we were attempting: to incorporate protection of the long-established benefits of opioid substitution treatment (OST) while also supporting the ambitions of the people who use our services and of the government's Drug Strategy 2010 for more heroin users to recover and break free of dependence. The group's final report goes further in describing how to meet these legitimate, deliverable and overdue ambitions.



'The treatment field has vigorously debated the balance between reducing harm and helping recovery. I believe we are approaching the point where we can achieve a genuine consensus...'

Our work has benefited greatly from the wealth of expertise and experience represented on the expert group, and from the contributions of renowned international experts, including US addiction experts Tom McLellan and Bill White, who have written an independent commentary on our work that will be published shortly.

Investment in drug treatment since 2001 has given more people access to long-term, high-quality treatment, which has substantially improved their health. England has lower rates of drug-related deaths and blood-borne virus infections than most of our European and North American neighbours. Our report describes how we can ally safe, evidence-based recovery-orientated practice to the public health and wider social benefits we already accrue from treatment.

Entering and staying in treatment, coming off OST and exiting structured treatment are all important indicators of an individual's recovery progress, but they do not in themselves constitute recovery. Recovery is a broader and more complex journey that incorporates overcoming dependence, reducing risk-taking behaviour and offending, improving health, functioning as a productive member of society and becoming personally fulfilled. These recovery outcomes are often mutually reinforcing.

Overcoming drug dependence is often difficult. According to the research, the international track record and clinical experience, not everyone who comes into treatment will succeed. We know from the same sources that it is not possible or ethical to predict which individuals will eventually overcome their dependence. Some people have a level of personal and other resources (called 'recovery capital') that enables them to stabilise and leave treatment more quickly than others. Many others have long-term problems and complex needs, meaning their recovery may take much longer and they require help to build their recovery capital. But the existence of an accessible, evidence-based, drug treatment system in every part of England gives us an excellent opportunity to improve on the past – creating a treatment system that makes every effort to provide the right package of support to maximise every individual's chances of recovery.

Well-delivered OST provides a platform of stability and safety that protects people and creates the time and space for them to move forward in their personal recovery journeys. OST has an important and legitimate place within recovery-orientated systems of care. The drug strategy is clear that medication-assisted recovery can and does happen. We need to ensure OST is the best platform it can be, but focus equally on the quality, range and purposeful management of the broader care and support it sits within. Clear and ambitious goals, with timescales for action, are key components of effective individualised treatment, especially when working collaboratively with the individual in their planning.

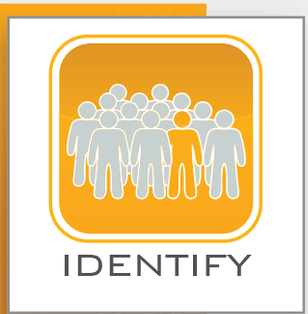
Coming off OST or exiting treatment prematurely can harm individuals, especially if it leads to relapse, which is also harmful to society. Clinicians and services need to understand the risks associated with a more ambitious approach. It requires careful planning and increased support, and inclusion of a 'safety net' in case of relapse.

There is no justification for poor-quality treatment anywhere in the system. It is not acceptable to leave people on OST without actively supporting their recovery and regularly reviewing the benefits of their treatment (as well as checking, responding to, and stimulating their readiness for change). Nor is it acceptable to impose time limits on their treatment that take no account of individual history, needs and circumstances, or the benefits of continued treatment. Treatment must be supportive and aspirational, realistic and protective.

Delivering on these ambitions will depend on the continued professionalism and commitment of drug treatment practitioners, and the development of systems that integrate clinical care with the wide range of services required to deliver long-term recovery. It will also depend crucially on the quality of shared vision and effort from those who are (or have been) dependent on drugs, their families and communities, and on the government's continued determination to tackle this important challenge. Our report describes how more can be achieved: the task is now to achieve it.

Professor John Strang is chair of the Recovery Orientated Drug Treatment Expert Group

3 SIMPLE STEPS TO SECURE AND EFFICIENT METHADONE DISPENSING



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Ian Houghton describes how private prison Forest Bank is demonstrating success with its focus on achievable recovery options and reintegration

BREAKING FRE

Sodexo Justice Services (SJS) operates at 120 sites across the world, including four in the UK – HMP Forest Bank, HMP Peterborough, HMP Bronzefield and HMP Addiewell. An arm of the multinational Sodexo corporation, SJS provides justice services to more than 30,000 offenders worldwide and one of its core aims is to help reduce reoffending, aligned with its mission to change lives for the better – not just the prisoners' but those of their families and communities.

Forest Bank is one of the largest prisons in the UK, with a capacity to hold more than 1,350 male offenders, and the prison demonstrates custodial excellence in many areas including its strategy for directly engaging key local organisations to produce real jobs and employment opportunities for offenders on release.

It recently won a prestigious Guardian Public Service Award, in partnership with The Co-Operative Bank, for a scheme that made it possible for prisoners to open a fully functioning bank account while in prison, to make them better prepared for release and life in the community.

The prison is proud of its many proactive innovations to help reduce re-offending, including its approach to helping prisoners with substance misuse problems. At the heart of its substance misuse strategy is the ambition to provide realistic and achievable recovery options. A comprehensive range of services includes substitute prescribing, psychosocial interventions, complementary therapies, employment, education, housing and healthy lifestyle elements.

Last year the management team began discussions with the NTA about improving current practice and within a few months the Forest Bank recovery steering group – together with colleagues from across the healthcare sector – established the new Eden recovery pathway for substance misuse, which is supported by the local PCT and DAT commissioners.

While previously there were two main stages to addiction treatment – the reception and stabilisation stage followed by the primary treatment stage – a third stage now takes place in the drug-free wing (DFW). This aims to continue vital support to those who have achieved sustained recovery from substance misuse in stages one and two and no longer require medical interventions.

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On arrival at the prison, each prisoner undergoes routine screening for substance misuse. Those identified as having a problem, either via self- declaration or testing, are immediately referred to the Eden recovery pathway where they receive a first-night intervention, which could include substitute prescribing where appropriate. Each individual is then allocated a clinical and non-clinical recovery worker based on need.

Stage one is reception and stabilisation. Over a period of five days, prisoners are further assessed by the clinical recovery team on the induction unit, leading to an initial recovery plan. Once prisoners have been stabilised and settled they are transferred to the motivational wing where they undergo psychosocial assessment and a detailed personal recovery care plan is created.

The motivational wing offers a wide range of interventions, with the aim of encouraging participants to commence their own personal recovery pathway. Prisoners receive both intensive clinical and non-clinical support from staff and a range of specialist healthcare agencies. In addition to the full suite of in-house clinical interventions, the prison provides a range of bespoke non-clinical support including the specially commissioned reduction and motivational programme (RAMP) delivered by partners Acorn Treatment and Housing.

After a few weeks on the wing, most prisoners believe they are ready to move towards personal recovery and take the next step of applying for a transfer to stage two, the Eden recovery unit. The unit panel carefully assesses each application for suitability, as stage two is an intensive intervention and participants have to agree to a proactive reduction in any prescribed medication regime. Prisoners commit to a programme where they are required to reduce their substitute medication each week, and the unit sees many become abstinent in around 12 weeks. The typical average reduction is 5ml per week, and those who become drug-free have to commit to maintaining their abstinence.

A key element at this stage is random drug testing, with a zero tolerance approach towards any breaches. However, no individual is ever dismissed from recovery and those who breach their recovery plan are referred back to earlier elements of the pathway. Stage two also operates a recovery asset-based model, identifying the key bespoke personal elements for each individual that will enable them to succeed, such as social skills and ability, repairing family relationships or developing other life skills.

The unit panel meets weekly to discuss prisoners' progress and any breaches or other issues, and ultimately decides if someone is to be referred back to stage one. Over the last three months, the unit has had more than 110 prisoners engaging in a positive reduction programme of substitute prescribing. Even more impressive is that the unit has delivered 48 prisoners from serious substance misuse to complete and sustained abstinence, and a recent graduation ceremony for those completing the early stages of the Eden recovery pathway saw a number of prisoners receive awards in recognition of their success.

Stage three is the drug-free wing (DFW). This facilitates vital ongoing support for those who have completed stages one and two. Support is provided by previous Eden unit graduates who act as peer mentors, helping to ensure that

prisoners remain focused while on the wing – graduates are provided with training and support to deliver in-house mutual aid interventions to complement the core service.

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A common issue raised by graduates who achieve abstinence is that on release they are often referred to community treatment systems which, by design, seek to deliver prescribed interventions. Forest Bank is committed to working with community partners to ensure that the drug-free success achieved by prisoners continues on release, as continuity of care is vitally important. In fact, the prison has been approached by external organisations on behalf of individuals at other prisons who are seeking to transfer to Forest Bank specifically to get help from the unit.

A particularly exciting project now under development is our employment-focused social enterprise, which will allow prisoners to learn specific skills and experience through an NVQ-accredited training programme. The social enterprise element will secure relevant commercial contracts in the community and offer prisoners the opportunity of real paid employment on release, with potential jobs including facilities management services like grounds maintenance and catering.

Forest Bank prisoner Barry is serving his sixth sentence and is currently based in DFW. 'After being on the Eden recovery pathway, I've learned to lead a life without drugs,' he says. 'I have all negative MDTs [mandatory drug tests] and VDTs [voluntary drug tests]. I'm now acting as peer support on the wing as a mentor. I deliver group work sessions once a week to up to 12 other prisoners. I'm just hoping I can carry it on when I get out. I'm reducing at the moment, and hopefully by the time I get out I'll be completely drug free.'

Recent independent inspections by the Ministry of Justice and the National Offender Management Service (NOMS) commended Forest Bank on the excellent quality of its substance misuse interventions, with one citing the prison as 'a model of excellent service delivery which others should follow'.

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Ultimately, what Forest Bank wants to achieve is the following scenario:

A prisoner arrives with a serious and sustained offending-related substance misuse problem. During his sentence, he begins his personal recovery journey. He achieves complete and sustained abstinence and receives employment-related training. On release he is offered suitable accommodation at a project where he receives ongoing support to maintain his recovery, and the social enterprise offers him paid employment, which allows him to use his new skills and gain valuable work experience, leading to a permanent full time job, no reoffending, and successful reintegration back into society.

Ian Houghton is head of commercial development at HMP Forest Bank

ENTERPRISE CORNER

'A YEAR ON...'

The social media and messaging between young people involved in the riots last year showed that they need never be hard to reach, says **Amar Lodhia**

This time last year, our country was coming to terms with the UK riots. Young adults conformed to commit acts of theft and vandalism, which were brokered through technology and social media, namely BlackBerry Messenger. The riots brought home that in fact 'hard-to-reach' young people aren't hard to reach. So how can innovation and technology reach, inspire and support young people to progress and abstain from reoffending through a means and a language they know very well?

In March I got to thinking how we could possibly begin to answer this. It is a sad fact that young people growing up in these troubled times have lost their access points with over a third of Connexions services now closed. This has a major impact on the work that youth offending teams do with post-16 young offenders. More than this, it came to light in the debate around the multiplier effects and combined costs that all the wraparound services that go into dealing with troubled families amount to over £200,000 per family per year.

Part of the answer for us was in finding a way to empower and enable young people to interact with media technology they know in a positive and enterprising way. We're currently developing Enterprise = Apps² (E=A²) a groundbreaking programme that will allow participating young people to build a smartphone app and launch it on the various app stores. The platform is being developed in partnership with an Aberdeen-based tech entrepreneur, Andrew Sage.

I was personally shocked that when I logged into the Research in Motion website (manufacturers of the BlackBerry) and typed in 'riots' in the search bar, nothing came up. One of the main recommendations to businesses made by the Riots Panel, chaired by Darra Singh in March 2012, was that brands that young people interact with should show more corporate social responsibility and that government should do more to encourage responsible capitalism. So on the back of this I will be personally approaching Research in Motion, manufacturers of the BlackBerry, as well as Google UK, Apple and Facebook, to support E=A².

I'd love to hear your views. Email me personally at ceo@tsbccic.org.uk and follow us on Twitter @TSBCLondon. Tweet your comments using the #tag DDNews.

Amar Lodhia is chief executive of The Small Business Consultancy (TSBC)

Man of HONOUR

David Liddell used his recent OBE to draw attention to the work of professionals, service users and their families. He talks to **David Gilliver** about the challenges facing the sector north of the border

When Scottish Drugs Forum (SDF) director David Liddell was awarded an OBE in the recent Queen's birthday honours (*DDN*, July, page 4) he made sure that the kudos was shared, issuing a statement that the award was a 'testament to the efforts of the incredibly gifted and committed people – professionals, drug users and their families' that the organisation worked alongside.

'It's almost an embarrassment to some extent, but it's obviously really gratifying to have that recognition for myself and the SDF, as we've been together for 26 years now,' he says. 'The nature of the work is to focus on what needs to be done rather than looking for recognition for ourselves, but everyone here was very pleased.'

After training as a biochemist then realising that it wasn't for him, he went into volunteering, and it was at the Dublin Committee for Travelling People that he developed an interest in substance issues. 'It was the early '80s, working with travelling children – that was my first experience of homelessness and things like glue sniffing,' he says. 'We actually set up – controversially, at the time – a very early harm reduction intervention, working with young glue sniffers. From there I went into social work and then to [DrugScope forerunner] the Standing Conference on Drug Abuse (SCODA).'

It was during a SCODA study of Edinburgh's drug problems that the SDF concept came up. 'The idea was to set up a Scottish SCODA. We had a steering group, and in the way these things often go, its first decision was to become autonomous from England.'

At the beginning the SDF staff numbered three, working in a sector that was similarly tiny. 'In 1986 there were only 20 drug services in Scotland – now there's about 240,' he says. 'It was a very small field and most services only had about two staff, so there were no more than 40 or 50 people involved in total. There were no planning structures and just a couple of officials in the Scottish Office who were dealing with drugs issues. Everyone was learning together, in a sense.'

The forum hit the ground running, however, having been established just as the heroin epidemic in Scottish cities was taking off, and he was one of the people urgently calling for the introduction of needle exchange. Was it a tough job to convince people or were the arguments just too strong? 'The powerful arguments for the Conservative government were obviously around public concern over the spread of HIV to the general population. It did need a fair bit of pushing, but ultimately there was no way the government could argue with that. Substitute prescribing was a lot harder. Initially it was only people who were HIV-positive who had access to methadone. We argued very strongly for appropriate distribution.'

The SDF remains a powerful advocacy voice, with its proposal to set up a formal national emergency plan to deal with incidents like the anthrax outbreak recently accepted by the Scottish Government (*DDN*, June, page 5). 'We played a key role [in the outbreak] in terms of disseminating essential information and briefing frontline workers, as we were best placed to deliver that,' he says. 'There have been recent HIV cases among drug users in Glasgow, so obviously the issues are not completely separate

'There's this notion that drug policy can make an impact in itself, but it has to be seen in the context of poverty and deprivation.' David Liddell

in terms of dealing with outbreaks and epidemics – these outbreaks will occur and we need to be ready for them. The challenge is to revisit your plans on a regular basis and make sure you have the people there who can be pulled in to assist – it's about how you get the information out to those who need it.'

One salutary lesson, however, was how problematic it can be attempting to do that via the mainstream media. 'You only need to compare the level of coverage of the recent Legionnaires' disease outbreak with the miniscule coverage of the anthrax outbreak. If they're not interested then we need to rely on the user networks to get the information out.'

The forum's vision is to work towards a society where everyone can fulfil their potential, with the needs of people affected by drug use met 'effectively and with empathy, compassion and respect', and a key aspect has always been service user involvement. 'Since the '90s we've supported the first user involvement groups,' he says. 'That's become much more mainstream now, whereas people used to say, "Why on earth would you do that?" A key part is to provide feedback in a systematic way to the people running the services – using our volunteers to undertake peer research has been a terrific model, so there's a huge potential for consistently delivering that feedback. It's about a more open approach to recognising that services are never perfect and can always improve. In Scotland, with a population of 5m, it's possible to do that – you can have a model that operates across the country.'

Another vital aspect is the benefit for the volunteers in terms of the skills and experience they gain, he points out, with most moving on to education, training and employment. SDF's award-winning addiction worker training project has been running since 2004, providing paid-for placements in services and a qualification in social care at the end. 'About 15 people a year do it, and around 80 per cent move into paid employment. Even in the recession we're managing to keep up that level of movement into paid work, but this is a real issue – you have people with 15-20 years of unemployment, and some have never worked at all, so we really need to be developing these routes into meaningful employment and voluntary opportunities. It's a huge challenge.'

This means that housing, welfare reform and family support underpin a good deal of SDF's work, he stresses. 'Poverty and deprivation are so crucial to the scale of the drug problem we've got, and if we want to reduce the numbers of young people coming into problem drug use then we need to really address the problems of the poorest communities.'

In terms of the recovery agenda, that means being realistic about what can be achieved, he states, while continuing to develop 'real and meaningful' opportunities to help people's recovery. 'There's this notion that drug policy can make an impact in itself, but it has to be seen in the context of poverty and deprivation.'

The SDF has consistently argued that the roots of Scotland's drug problems lie in poverty – are there still people who don't believe, or acknowledge, that? 'You do still get people who say that drugs are drivers of poverty and deprivation, rather than the other way around, just as you get people who say substitute prescribing is the problem rather than a response to a problem. You only need to consider how challenging recovery is to people who are constantly being pushed around and harried over benefits issues and so on.'

He's also repeatedly called for more services to be targeted towards the needs of older drug users, and their problems with isolation and chronic health conditions. Does he feel more is being done to address their needs, or are they still a comparatively neglected population? 'Again, this is one of the challenges for the recovery agenda,' he says. 'From the work we've done it's clear that there's an increasing number of older drug users across the whole of Western Europe – mostly males living on their own, many of them still on substitute medication but with failing physical and mental health.' For some, he says, there 'really is an ambivalence about whether they continue living' or not.

'In terms of services, they're perhaps not always regarded as a priority because they're not seen as causing too many difficulties for wider society, but there is a huge need to engage with them and improve their quality of life. There are some very good international models – particularly in Germany – which involve things like shared accommodation and mutual support, but obviously these need to be very well resourced. The risk in the current climate is that it's a population that will just be forgotten about.' **DDN**

QUALITY TIME

A recent event showed the recovery community in the East Midlands to be buzzing with ideas and activity, as **Vince Williams** reports

Holding the Celebrating Recovery East Midlands Event (CREME) marked a day of firsts for the East Midlands Recovery Forum (EMRF). It was the first showcase for the newly formed forum and the developing Quality of Life (QoL) service, the first regional event of recovery agencies from across the East Midlands, and the launch of a new recovery booklet *Hope on the horizon*.

For QoL, as a new and innovative recovery based treatment service in Leicester city which only started in July 2011, it was a chance to show what can be achieved by members in recovery in such a short space of time. Governed mainly by service user members, its board has had genuine decision-making power to set QoL up the way members think best, which has led to a successful service being developed.

QoL provides a wide variety of recovery activities including structured group work, recovery groups, complementary therapies, information, advice and guidance (alongside NACRO), peer mentoring and various activities such as arts and crafts, music, poetry and drama. QoL also provides support for the family, friends and carers of members through the Drug and Alcohol Family and Friends Support (DAFFS) service. All aspects of QoL are run as a partnership between professionals in conjunction with ex service users, many of whom have become peer mentors and employed members of staff.

Many QoL members volunteered their time and effort to make CREME a great day. Around 350 guests, including professional workers and service users from throughout the region, attended and there were 48 different exhibits from counties across the East Midlands, as well as the UK Recovery Federation.

Agencies promoted the recovery agenda through the range of different services they had on offer, relating to housing, harm reduction, mutual aid, holistic therapies, mindfulness, wellbeing and much more. Every room in the QoL building was packed with people explaining, through briefings and workshops, what they do and sharing best practice on achieving and maintaining recovery.

Also on show was the brand new basement gym, which will be ready soon for members to use, and the new recovery café, which was up and running on the day, with Rachel's cakes proving to be a big hit. As well as live performances in the QoL car park from the music group, visitors were privileged to see an inspiring and powerful premiere performance by the drama group. A recovery play *Just for today* was developed as a joint project between QoL and Off the Fence theatre company, ready for a full production at De Montfort University's PACE theatre.

The CREME event also saw the launch of the new recovery booklet *Hope on*

the horizon, produced by service users in the East Midlands, in partnership with the NTA who facilitated its production. This recovery tool was written by service users for service users giving help and ideas to the reader, as they embark on their recovery journey with the character Ed/Edwina for company. This informal and incisive booklet can help make the difference for those who are daunted by all the aspects of lifestyle changes in recovery.

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Another important aspect of the day was the official launch of the new East Midlands Recovery Forum (EMRF), previously the East Midlands Service User Forum, which is now run independently by ex service users to promote the recovery agenda using recovery champions from the different counties in the East Midlands region. Chaired by an ex service user, the forum is independent, has its own aims and principles, and is always looking for new members and the views of those using services on what needs to be changed in the ever shifting recovery arena.

While all this was going on, the music group was outside in the sunshine jamming along for all the visitors to chill out to, helping make a relaxed informal atmosphere for guests to mingle and network. The day showed how the recovery community in Leicester is buzzing with activity, while welcoming the rest of the region to join in and celebrate all the great work that is being done throughout the East Midlands.

QoL and the CREME organising committee would like to thank its members, board and staff, the exhibitors for their support, and all the visitors to the event, who we hope found the day as worthwhile and inspiring as we certainly did.

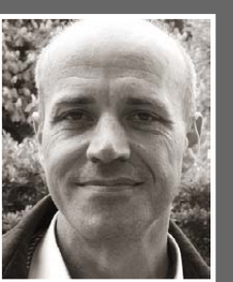
Vince Williams is chair of the East Midlands Recovery Forum (EMFR).

Find more information about Quality of Life by liking their Facebook page or calling 0116 2389977. For more information about the EMRF, contact Vince Williams at emrfnet@gmail.com or follow @emrfnet on Twitter

VOICES OF RECOVERY

CREATIVE FORCE

Organisers of this year's recovery walk wouldn't take no for an answer, says **Alistair Sinclair**



THE FOURTH UK RECOVERY WALK will take place this year in Brighton on 29 September. The first one was in Liverpool in 2009, followed by Glasgow in 2010 and Cardiff in 2011. This year's walk (organised and delivered by people from the local recovery community) has adopted 'creativity' as its theme and will welcome all those who want to celebrate and promote recovery in their communities. It's taken a lot of commitment and work. Here's Pete Davies, this year's event manager:

'The journey towards the fourth UK recovery walk 2012 began for the organising committee in August 2011 when we, all of us individuals in recovery, were invited to a meeting to discuss Brighton hosting the walk. None of us had heard of the concept of bringing recovery out into the open, making it public, making it visible. So it was with curiosity that some of us travelled to Cardiff for the 2011 UK recovery walk where we witnessed the passion and power of the recovery community out on the streets, celebrating individual and collective recovery.

'Inspired we set to work, constituting ourselves as a community interest group, seeking political allies within the council, assigning roles and beginning the process of delivering an event that would reflect the joy, hope and solidarity we had experienced in Cardiff. Meeting in cafés and rooms within services, building on our strengths and assets, we contacted the 'powers that be' – the events department, police, highways etc.

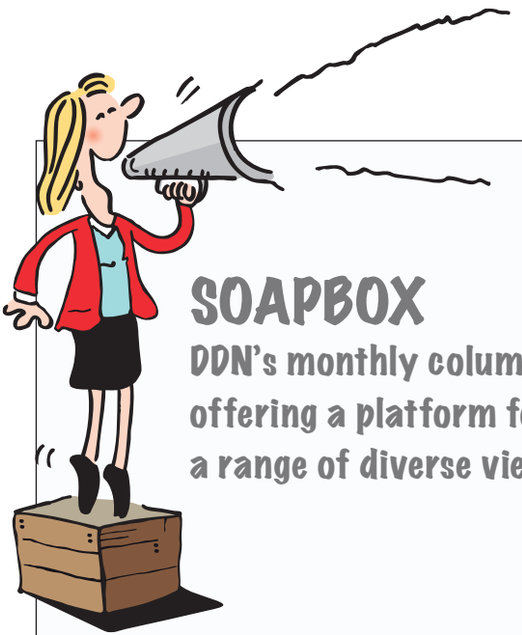
'Initially we encountered a slightly dismissive attitude from some of the cogs within the bureaucratic machine. After jumping through the many hoops presented to us (including being given a two-hour deadline to resubmit a revised document on a Friday afternoon) we were told in February that we couldn't hold the walk this year... bad move on their part! We got stuck in and the politicians who had shown us enthusiastic support back in September were contacted, as well as heads of local services, and within days there was a change of heart. 'No' is a not a word that is commonly understood by people who have survived addiction and alcoholism!

'And here we are, within touching distance of 29 September. As individuals we have grown, as a team we have become stronger. We now demand, and have earned, at least some begrudging respect from 'the powers that be'. We are being recognised as an independent organisation, unaligned with any service, which can deliver coherent and thorough plans, risk assessments, communication strategies and programmes of service user empowerment. We have brought the word 'recovery' to the wider community in Brighton and we believe this will help build on the legacy of this year's recovery walk.

'So, on 29 September thousands will gather next to the sea and walk with hope and pride through a city that has topped tables for drug deaths and alcohol-related admissions to hospitals for years. We will be walking to a festival – a celebration of recovery where friends old and new will share music, food, laughter and joy. It's been quite a journey. We have made the path by walking it.'

www.ukrf.org.uk
www.recoverywalk2012.org.uk

Alistair Sinclair is director of the UK Recovery Federation (UKRF)



SOAPBOX

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

MINIMUM PRICING – AT WHAT COST?

Politicians are getting it wrong on alcohol strategy, says **Mev Brown**

MINIMUM PRICING IS IN THE NEWS AT THE MOMENT, particularly in Scotland where, if things go according to the Scottish Government's plans, it will take effect next year.

Alcohol abuse costs Scotland an estimated £3.6bn annually, so it's hardly surprising that there have been calls for years that 'something must be done'. It would seem that minimum pricing is seen as that 'something' and Westminster seems keen to follow.

It's at times like this when my frustration with the political process becomes tangible. Two points come to mind. Firstly, that nobody has undertaken a risk assessment of minimum pricing. Secondly, that anybody with any real life experience would ever consider this policy. Nobody is more committed to tackling alcohol abuse than I am. Ten years ago I started working with Edinburgh's homeless. For somebody with no previous 'frontline' experience of homelessness, family breakdown, social dysfunction, mental health, alcohol abuse and drug addiction, it was an eye-opening experience. It wasn't too long before I realised that, despite the best efforts of politicians, there were flaws in the system. Indeed, sometimes there was a complete absence of policy.

In 2004 I started writing in the *Evening News*, sharing my experiences with readers. My work also provided the opportunity to talk to colleagues in other agencies and professions, including the police and NHS. This is why the Frontline Policy website was set up. Many frontline professionals are as frustrated with failures in policy as I am, so our independent, social media/web-based think tank provides a platform for frontline professionals, past and present, to tweet, blog and write about policy and to meet, discuss and engage with politicians in the policy debate.

I think part of the difficulty for politicians is that all they see are the glossy reports and the statistics. They don't have a 'street-level perspective'. As frontline professionals, we can put names to the faces. That was why I started to write my *Evening News* articles. It was my way of expressing my frustration at the system.

In general, we believe there are four main reasons for policy failure. Firstly, the proverbial and yet inevitable 'loophole'; secondly, the so-called 'law of unintended consequences'; thirdly, that policy can be based on flawed, incomplete or 'cherry-picked' evidence; and fourthly, 'blinkered vision', where policymakers simply don't see the big picture.

In the first three cases, frontline professionals can make an invaluable contribution to the policy debate because, by definition, we are much closer to the public. We have a much greater understanding of how people and our society works. In the case of 'blinkered vision', this is a challenge. It requires a multidisciplinary approach as well as a full understanding of interdepartmental issues. But by providing a multidisciplinary platform for all professionals, we feel it's a challenge we can meet. Any sensible initiative to tackle alcohol abuse must be supported. Unfortunately, the minimum pricing policy is a prime example of a policy that meets all four criteria for policy failure.

Frontline Policy has organised a conference in Edinburgh to undertake a risk assessment of minimum pricing. The guest speaker will be Dr Richard Simpson, MSP, who has considerable experience of working with alcohol abuse. We will be looking at the behavioural and cultural issues surrounding alcohol abuse as well as looking at the policy from the four policy failure perspectives. Indeed, I will strongly argue that minimum pricing is a gift to organised crime and have research that gives an insight into the impact and benefits crime could experience from this policy.

And there are many perfectly valid alternatives to minimum pricing. For example, given that so much antisocial behaviour is committed when under the influence of alcohol, where better to start than ensuring that convicted offenders pay their fines? Currently, if an offender refuses to pay a fine, there is little the courts can do – their hands are tied. A recent report published by the cross-party public accounts committee showed that almost £2bn of fines remains unpaid. If Home Office ministers wanted to ensure offenders pay their court fines, this could be easily achieved. And HMRC and the Benefits Agency can provide the solutions.

In the case of working offenders, rather than arrest wages, existing HMRC mechanisms must be used to collect fines by adjusting the offender's tax code. So if an offender moves to a new job then collection of the fine will automatically follow them to the new employer.

In the case of offenders on benefits, the courts simply need to get the offender's NI number. If a fine is not paid within 28 days then the court must be compelled to use the Benefit Agency's existing 'third party deduction' mechanism to guarantee collection in full.

In the case of on-the-spot-fines, the issuing police officer would record the offender's NI number, ensuring that unpaid fines will be collected using the above mechanisms. Nationally, over half of on-the-spot-fines never get paid. Ensuring offenders pay their fines would send a powerful message to those offenders who think, perhaps rightly, that they are above the law.

For more details and background information visit our website, www.frontlinepolicy.org.uk and follow us on Twitter @frontlinepolicy

Commissioning Recovery from Drug and Alcohol Addiction Conference

7th September 2012 – Manchester, UK

THE CONFERENCE OUTLINE

The landscape of public sector commissioning is undergoing significant change and the impact on commissioning for the drug and alcohol sector is not yet clear. The Recovery from Drug and Alcohol Addiction Conference, taking place in Manchester on the 7th September 2012, brings together a broad range of commissioners and providers to debate these issues in an open and transparent environment.

The conference will be chaired by **Roger Howard**, Chief Executive of the UK Drug Policy Commission and speakers include **Paul Hayes**, Chief Executive of the NTA, **Steve Broome**, Director of Research at the RSA and **Professor John Ashton**, Director of Public Health for Cumbria PCT.

HOW MUCH DOES IT COST?

The cost to attend the conference is just **£195.00 per person** + VAT. This cost includes all meeting materials, refreshment breaks and lunch.

WHO SHOULD ATTEND?

This conference is aimed at professionals who currently commission drug and alcohol services, or those who will do so in the future. These include Drug and Alcohol Action Teams, Directors of Public Health, future Police and Crime Commissioners, as well as those involved in wider commissioning structures such as mental health and the Troubled Family agenda.

WORKSHOPS

Giving you the opportunity to explore different commissioning models and debate with other commissioners and stakeholders on the current issues and challenges that you face:

- The prime provider and whole system change model
- The eclectic, multi contractual commissioning model
- Choices, options and outcomes
- "Treat us like people" – the service user perspective

EXHIBITION OPPORTUNITIES AT THE CONFERENCE

A limited number of exhibition spaces are available – contact Karen Anthony or Lucie Flint from the conference team on 01462 476310 or email Karen@medivents.co.uk for information.

Full programme and online registration:

www.commissioningforrecovery.org.uk

Conference helpline: 01462 476310 / Karen@medivents.co.uk

RECOVER AT PCP

Pcp are a cqc-registered, established residential treatment centre that offers clients the best possible treatment at affordable prices. We have established centres located in Luton, Chelmsford and Clapham.

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For further information, please contact:
James Peacock, senior stat co-ordination OR
Darren Rolfe – treatment director on

08000 380 480

Email: James@pcpluton.com or darren@pcpluton.com

PCP
a new beginning

INVITATION TO TENDER

CHESHIRE Drug Action Team

HM PRISON SERVICE
Public Sector Prisons

Information relating to the upcoming tender for the provision of

Substance Misuse Services in HMP Styal, Cheshire

On behalf of the Cheshire DAT Partnership, this announcement is to confirm that the procurement of a Substance Misuse Service is being undertaken by the Cheshire, Warrington and Wirral Commissioning Support Service (CWW).

The *Open Procedure* via OJEU, instead of the *Restricted* process will be followed. This means there will be no Pre–Qualification Questionnaire (PQQ) stage in the procurement process.

The Invitation to Tender advert will be placed on the Supply2Health website on Friday 28th September 2012. The tender return date will be in line with *Open Procedure*; Monday 19th November 2012.

It is the wish of the commissioning organisation to ensure this new contract is built upon the current service delivery, whilst offering further innovation to meet the policy demands of the DH, NOMS and the National Recovery Agenda. The commissioner is very keen to ensure that potential bidders are focused upon providing an innovative range of recovery orientated services to address the unique environment of HMP Styal.

The focus on increasing recovery and sustaining recovery with outcomes based commissioning will require realistic targets, with the need to reward a good outcome and to encourage innovation.

It is anticipated that the contract will be for 3 years with a start date of 01 April 2013, with the opportunity to extend for a further two years.

THE SALVATION ARMY

Gloucester House

addictions rehabilitation centre

Gloucester House is a CQC registered treatment centre that has provided residential rehabilitation for people with substance misuse, drug and alcohol issues since 1961.

It is situated in the market town of Highworth near Swindon and offers accommodation for 12 people on-site, with further accommodation for three in our second stage community house.

Gloucester House recognizes and understands the damaging effects caused to individuals, families and communities through substance misuse, and our holistic, integrated 12 Step programme is designed to empower and support every individual to attain a life free from dependency, to look beyond their issues and to explore ways of changing their lives.

Our balanced programme is designed to allow our clients the time they need to reflect and explore new ways of learning and being and all the staff team at Gloucester House work from a caring motivational approach.

Gloucester House offers both primary and secondary stage treatment, with supported aftercare move on where required.

For more information please contact our referrals manager by calling 01793 762365.

www.gloucesterhouse.org.uk

Recovery Pathways

- Altered Attitudes 12 step programme
- CBT
- NLP – creative workshops/ psycho -drama
- Community cafe and work placements
- Sober coaching and personal development
- Interventions
- Family workshops
- Pathways to education and employment
- Developing and supporting recovering communities
- Continuous aftercare

+44 (0)1502 587269

www.eastcoastrecovery.co.uk

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EXPRESSIONS OF INTEREST

southend onsea BOROUGH COUNCIL

Tender for Supported Housing Services for Adults with Substance Misuse issues

Southend on Sea Borough Council, on behalf of the Southend DAAT, is inviting expressions of interest from experienced providers, for the provision of Supported Housing Services for Adults who substance misuse.

The aim of this service is to:

a. meet the needs of substance users in Southend and support them to stop using & stop offending
b. to successfully reintegrate substance users into our communities
c. to provide appropriate accommodation for Adults with substance misuse issues, should they need it, to facilitate successful reintegration

This contract will be split into two separate lots, both of which will be required to provide Tenancies and Housing, alongside Drug & Alcohol related care programmes and treatments.

Lot 1:* *'Pre-Detox and Rehabilitation' related treatment *– which will focus on people still using substances, who are engaged in structured treatment provision (delivered by other providers).*

Lot 2:* *'Post-Detox and Rehabilitation' related recovery *– those who have been through detox and or rehab, either in community or custodial settings and require support for maintaining recovery.*

Southend Borough Council are keen to hear from parties who are qualified to deliver supported housing services to either, or both of these groups, in partnership with other local treatment and recovery services. A Payment by Results element will be incorporated into this contract.

If you are interested in this contract opportunity, please contact Suzanne Clark, to request the Pre-Qualification Questionnaire documents. Address: Corporate Procurement, Civic Centre, Southend-on-Sea, Essex, SS2 6ER • E-mail: procurement@southend.gov.uk • Tel: 01702 534026 • Fax: 01702 215110

Closing date for document requests is 12.00 noon on Wednesday 12th September 2012.

Closing date for Pre-Qualification Questionnaires (PQQ) submissions is 12.00 noon on Wednesday 19th September 2012.

LANCASHIRE DRUG AND ALCOHOL ACTION TEAM — NHS North Lancashire — NHS Central Lancashire

Expressions of interest to tender for the provision of Tier 2 and 3 Adult, Community, Criminal Justice and Prison Substance Misuse Treatment Services in North Lancashire

Substance Misuse Services in North Lancashire are changing. Our vision is for an integrated community and prison drug and alcohol treatment service, clearly focussed on the principles of recovery and the further development of service user led treatment programmes in North Lancashire. North Lancashire is comprised of three districts, Lancaster and Morecambe, Wyre, and Fylde. Two prisons are included: HMP Kirkham (Cat D open) and HMYOI Lancaster Farms.

The successful provider will;

- have a proven track record in delivering recovery orientated services that creates a positive culture for both service users and the workforce,
- recognise the importance of the wider family and community and focus on the social re-integration of service users.

The ability to work in partnership is essential.

The contract will initially be for 3 years from 1st April 2013, with the possibility to extend for a further 2 years subject to performance, recurrent funding and national policy. The likely contract value is in the region of £3.9 million to £4.3 million.

- A memorandum of information will be available from the 6 August 2012 at: https://nhssbs.eu-supply.com
- A bidder information day is scheduled for 16 August 2012, 1-4 pm at Lancaster Town Hall. Further details are available on https://nhssbs.eu-supply.com
- The service specification will be made available to short listed bidders at the invitation to tender stage.

To record an expression of interest and to request a PQQ please go to https://nhssbs.eu-supply.com

Late applications at any stage will not be considered under any circumstances.

KINESIS LOCUM
Specialist Recruitment

- Total Recruitment for the Drug and Alcohol field. (DAAT, Nurses, Commissioning. NHS. Criminal Justice...and more)
- The Trusted Drug and Alcohol Professionals.

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Project Leader & Coordinators to provide HepC support through Volunteering and Mentoring

Experience, Strength & Hope ESH Works

Project Lead £22,500 - Coords £16,750 - p/a pro rata

Part time roles 28hrs and 18hrs per week to establish a hepatitis C peer led support project to increase the testing and treatment uptake in Warwickshire. Contact Sue or Paul 01926 889 356 or email vacancies@eshworks.org - Closing Date Friday 24th August

"Helping people to help people..."

Substance Misuse Personnel

Permanent • Temporary • Consultancy

Supplying experienced, trained staff:

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

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AdAstra Treatment Centre

t: 020 7607 7717 m: 07981 809 609
info@adastratreatmentcentre.com

Independent Healthcare provider (fully CQC Compliant) in central London seeks experienced

GPwSI in Addiction

RCGP II Certificate required, MB in Psychology preferred.
24 hours per week initially, with prospect of more hours in future.
For further details, please contact
Sandrabarrett@adastratreatmentcentre.com or call on ***07981 809 609***

Redcar and Cleveland NHS
Primary Care Trust

Redcar & Cleveland Partnership

SUPPLIER INFORMATION EVENT/ TENDER OPPORTUNITY

Redcar and Cleveland Borough Council (on behalf of Redcar and Cleveland DAAT) intend to recommission the clinical adult drug and alcohol treatment service in the near future via an open tendering procedure.

We are seeking organisations to deliver a full range of clinical treatment and prescribing services to drug/alcohol using adults within the Redcar and Cleveland area.

This presents an exciting opportunity for forward thinking, innovative organisations to consider a future tender for the provision of Clinical treatment services.

If you are interested in submitting a future tender for the above services you are strongly advised to attend the information event taking place at:

The Innovation Centre, Kirkleatham Business Park, Vienna Court, Redcar, Cleveland, TS10 5SH on Wednesday 15th August at 10.00 a.m.

Representatives at the event will provide information on the current Redcar and Cleveland needs assessment, treatment model and contract opportunities.

To confirm/reserve a place please telephone Julie Hunter on: 01642 490440 or email: julie.hunter5@nhs.net

Organisations unable to attend the event can request a copy of the presentation slides from this event by contacting Julie Hunter on the above contact details. Please note information will not be released until 16th August 2012 at the earliest.

MENTAL HEALTH SERVICES BORDERS ADDICTION SERVICES TEAM MANAGER

NHS Borders

Band 7, £30,460 – £40,157 per annum.
37.5 hours per week, permanent. REF MHS160.

THE NHS BORDERS ADDICTION SERVICES HAS A VACANCY FOR A TEAM MANAGER.

The successful candidate will hold responsibility for the day-to-day supervision and operational management of Borders NHS Addiction Services (BAS). The Team Manager will lead the teams on the development of services whilst maintaining a systematic approach to care and treatment for people who may be experiencing difficulties with drug and/or alcohol misuse. The person appointed will be expected to maintain a nominal professional/clinical workload. The post holder will ensure the effective and efficient use of resources whilst maintaining the highest standards of service provision in line with NHS BAS Protocols and Borders NHS policies and Professional Codes of Practice and Conduct.

This post forms part of a large multidisciplinary team, which covers the whole of the Borders area and works in partnership with other statutory and non-statutory services. There are excellent opportunities for the right candidate for further development within this area, supervision, appraisal and CPD are priorities that are well established within the services.

For further information please contact Lynda Mays, Service Manager, telephone: 01896 827138.

Closing date for completed application forms: 5pm on Friday 24th August 2012.

For an application pack please telephone 01896 827728 or email recruitment@borders.scot.nhs.uk quoting the appropriate reference number.

(Note: if you are emailing your completed application forms some web-based email services are blocked by nhs borders firewall e.g. hotmail and yahoo.) If you have not heard from us within 4 weeks of the closing date, then we regret that your application has not been successful on this occasion.

POSITIVE ABOUT DISABLED PEOPLE

EXPRESSIONS OF INTEREST

Swindon Borough Council

Community Drug Treatment and Recovery Services

Swindon Borough Council Drug and Alcohol Action Team (Swindon DAAT) invite expressions of interest from suitably qualified and experienced service providers for the provision of an Adult Community Drug Treatment and Recovery Service throughout the Borough of Swindon, serving a population of approximately 200,000 residents.

The Adult Community Drug Treatment and Recovery Service is a newly designed, recovery focussed service where a successful provider will ensure seamless and accessible pathways for service users by providing:

- **Intake Service**
- **Clinical Service**
- **Recovery Service**

Full details relating to the three service elements are provided in the Invitation to Tender (ITT) document:

The resources, range and depth of skills needed to provide the service are such that it is the expectation of Swindon DAAT that some organisations may wish to collaborate to form a consortium in order to bid, with a lead organisation becoming the main contracting party with the Swindon DAAT. However, this does not preclude a single provider tendering all the resources and services required by the Invitation to Tender.

The contract will be initially for a period of 4 years commencing 1 April 2013 with an option to extend for a further 12 months subject to satisfactory performance This is a competitive tender, and a contract will be awarded to the organisation that is deemed to represent the most economical and advantageous tender.

Organisations wishing to Register Interest and download tender documents which will go live on **20 August 2012,** should apply via the South West Portal using the following URL link:

https://www.supplyingthesouthwest.org.uk/procontract/supplier.nsf/frm_home?openForm

Click on "Search Latest Opportunities" and locate Contract ID ***SWCE-8WQKZG***

If you have any problems with this link, please email the contact Chris Stickler on cstickler@swindon.gov.uk and Jennifer Laibach at JLaibach@swindon.gov.uk

The closing date for the receipt of completed tenders is 12 noon on 24 September 2012