STILL THE BIGGEST – STILL THE BEST!

DDN
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'The number of families affected is certainly not going down. Often the numbers are eye watering and those are just the ones we know about – so much is hidden.'

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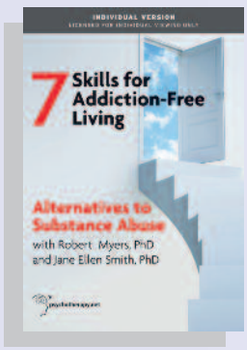

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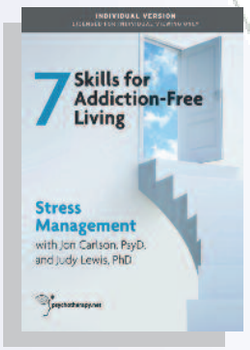

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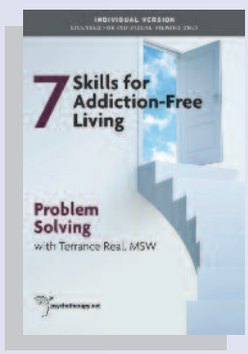

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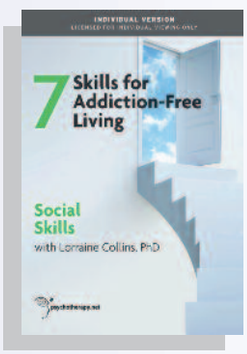

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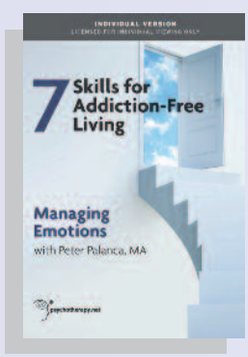

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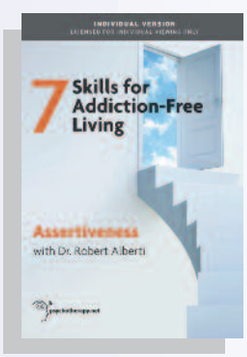

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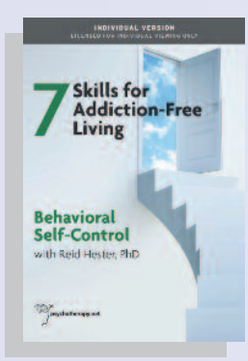

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Family ties

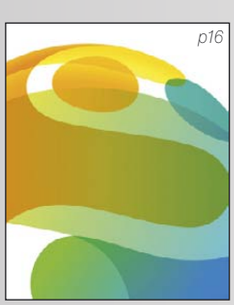
Services can gain much from sticking together

With everyone feeling so cash strapped at the moment, it's good to hear about genuinely effective working partnerships (cover story, page 8). Adfam's conference brought together representatives from all areas of family support – not just those working directly in drug and alcohol treatment, but professionals with expertise in parenting, child poverty, schools and prisons. They looked at issues from family members' perspectives, and shared knowledge and expertise. We may be looking across a very uncertain commissioning landscape but it's good to see a commitment to collaboration that gives essential services the best chance of overriding tough times.

On the subject of family support, Kate Halliday from SMMGP (page 20) and Sarah Brighton from Swanswell (page 21) believe the family doctor is in a unique position to provide drug and alcohol treatment alongside regular healthcare, while on page 12, Hannah Shead gives a working example of incorporating mothers with small children into the treatment model.

Adfam chief executive Vivienne Evans talks about how family services are coming under increasing threat in the current political climate (profile, page 18), but how worried should we be about changes ahead for the entire drug and alcohol field? Read Marcus Roberts' Soapbox and let us know what you think.

This issue



FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: JOBS, COURSES, CONFERENCES AND TENDERS

News in Brief

SCOPE FOR A MERGER

DrugScope and eATA have announced plans to merge, subject to approval from eATA membership. eATA will cease trading as a separate charity, with its membership and support roles incorporated into DrugScope. 'At a time of significant change and uncertainty for the sector as a whole, particularly with the introduction next year of the new public health service, a united membership voice is as vital as ever,' said chair of DrugScope board of trustees Edwin Richards.

WELSH WINDFALL

An additional £1.3m will be allocated to roll out integrated family support services across Wales to help children and families overcome the problems of parental substance misuse, the Welsh government has announced. 'The service supports families by empowering them to take positive steps to improve their lives,' said deputy minister for children and social services Gwenda Thomas.

RECOVERY ROADMAP

A new document, *Putting full recovery first*, has been launched by the Home Office. It outlines the government's 'roadmap for building a new treatment system based on our commitments made in the drug strategy: to restrict the supply of drugs; to reduce the demand for drugs; and to support individuals to be free of dependence'. *The document is available at www.homeoffice.gov.uk*

METHADONE FIRST

India's first methadone treatment centre has been opened in Kapurthala, Punjab state, by UNODC in partnership with the National Drug Dependence Treatment Centre of India. The pilot project will see centres launch in Delhi, Mumbai, Imphal and Bathinda later this year.

LEAP LANDMARK

Dawn Fee has become the 250th client to graduate from LEAP (Lothians and Edinburgh Abstinence Programme) (*DDN*, 14 January 2008, page 6). 'Since the programme began in 2007 I've seen the life-changing impact recovery has on our patients and their families,' said clinical lead for LEAD, NHS Lothian, Dr David McCartney.

Government commits to alcohol minimum pricing

The government's long-awaited alcohol strategy contains a commitment to introduce a minimum price per unit of alcohol, something widely considered unlikely until David Cameron's recent speech about alcohol harm, delivered at a Newcastle hospital (*DDN*, March, page 6).

The government's alcohol strategy also includes provisions to pilot 'sobriety schemes' to tackle drink-related offending and to give stronger powers to local authorities to control the density of licensed premises. There will also be a consultation on banning 'multi-buy' discounting.

The government will consult on what the actual minimum price will be, although the document quotes 40p, which would mean a 70cl bottle of 37.5% vodka could not be sold for less than £10.52 or a 2l bottle of 5.3% cider for less than £4.24. Home secretary Theresa May, however, told the BBC on the day of publication that the price could eventually be higher. The strategy also urges greater use of brief interventions by health professionals and encourages all hospitals to employ alcohol liaison nurses.

Local health bodies will now have the status of 'responsible authorities' under the Licensing Act, giving them the power to intervene in licensing decisions for the first time. They will be allowed to limit the total number of licensed premises in their area and make impact on health a consideration in granting new licences.

The strategy was released slightly earlier than planned, which led to accusations from Labour that the government was attempting to divert attention from unfavourable media coverage of the Budget. Alcohol Concern welcomed the strategy but stated that the government would need to show its commitment by allocating more money to alcohol treatment and counselling if the measures were to have any real effect. The average annual PCT spend on alcohol services was around 0.1 per cent of budget, the charity pointed out, meaning that alcohol remained a 'Cinderella service' compared to drugs or mental health.

'It's great that the government is tackling cheap booze in supermarkets – and a raft of other alcohol issues – but current health spending priorities really need to be rebalanced if these excellent objectives are to be translated into real progress on the ground,' said chief executive Eric Appleby. 'Clearly there is now a very real desire to push alcohol misuse much higher up the health policy agenda – but this desire must be matched by real resources, especially in areas such as treatment and advice services.' The British Liver Trust also welcomed the strategy – as 'the beginning of a process' to tackle alcohol harm – but stated that the minimum price should be 50p.

The government has also announced a new initiative to remove 'one billion units' of alcohol from the market by 2015 by improving the availability of lower-strength products. The 'alcohol unit reduction pledge' is part of the controversial alcohol responsibility deal (*DDN*, April 2011, page 4) and has been signed by more than 30 major retailers and drinks producers. Sainsbury's have pledged to reduce the average alcohol content of own brand wine and beer 'by 2020', while Accolade Wines will 'gradually' remove 25m units from products including Echo Falls Rosé and Echo Falls White Zinfandel. Tesco, meanwhile, will reduce the alcohol content of own label beer and cider and expand its range of lower-alcohol wines and beers.

'While initially the headline appears impressive, in reality this pledge is going to have minimum impact with a very small reduction in consumption,' said British Liver Trust chief executive Andrew Langford, adding that it demonstrated the 'incredible lack of ambition' on the part of the alcohol responsibility deal group.

Meanwhile, the Alcohol (Minimum Pricing) (Scotland) Bill has passed its first stage in the Scottish Parliament with no votes against, although Labour abstained.

Alcohol strategy available at www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy

Alcohol pricing table at www.homeoffice.gov.uk/drugs/alcohol/alcohol-pricing/

'Mexxy' banned under temporary drug order

The 'legal high' methoxetamine – also known as MXE or mexxy – has become the first substance to be banned under a temporary class drug order (TCDO).

TCDOs, which came into effect late last year (*DDN*, December 2011, page 4), give the home secretary power to ban any substance considered potentially harmful for a period of 12 months, pending advice from the Advisory Council on the Misuse of Drugs (ACMD) on a permanent ban.

Methoxetamine has been advertised on the internet since late 2010 as a 'safe' and legal alternative to ketamine, the effects of which it is said to mimic. According to advice from ACMD submitted to the home secretary, the chemical structure of methoxetamine closely resembles that of both ketamine and phencyclidine (PCP).

The ACMD said that while there was very little information on the prevalence of methoxetamine use in the UK, there had been at least nine cases of analytically-confirmed acute methoxetamine toxicity in UK hospitals in the last six months. Although the drug is marketed as a 'bladder-friendly' version of ketamine – long-term use of which is associated with chronic bladder pathology – the chronic harms associated with the substance remained unknown, said ACMD.

People caught supplying, manufacturing or importing the drug will now face up to 14 years in prison. Crime minister Lord Henley said the ban showed that the UK was 'leading the way in cracking down on new psychoactive substances'.

The home secretary has also informed the ACMD that a review of the latest evidence on ketamine itself is 'now warranted', as part of a letter setting out priorities for inclusion in the council's 2012-13 work programme. ACMD last reviewed ketamine in 2004, which led to the drug's classification as class C under Labour.

Successful treatment programmes 'cut offending by half'

The number of crimes committed by known drug-dependent offenders fell by nearly half after successful completion of a drug treatment programme, according to research published by the NTA.

The impact of drug treatment on reconviction – the largest ever empirical study in England on drug treatment and crime rates, according to the agency – compared data from the National Drug Treatment Monitoring System (NDTMS) with conviction records from the police national computer for around 20,000 offenders who began treatment in 2006-07. The study matched conviction rates from the two years before, and after, entering treatment and found convictions fell by 47-48 per cent for those who completed treatment successfully after six months or were retained for up to two years. While previous studies have found similar results, they were based on self-reported crime rather than actual convictions, the NTA points out.

However, just over half dropped out of treatment during the two years after their assessment, with the fall in convictions among those retained in treatment three times greater than among those who dropped out. The biggest reduction in offences was for thefts, which fell by 11,000. Convictions for soliciting, fraud and forgery also fell sharply.

'This research shows not only that the longer someone is retained in drug treatment, the bigger the drop in convictions, but that similar crime reduction benefits are gained from the increasing number of people who are successfully completing treatment and sustaining their recovery in the community,' said NTA chief executive Paul Hayes.

Meanwhile, plans to reform community sentences to ensure they are 'tough and credible' have been announced by justice secretary Ken Clarke. They include 'intensive community punishment' sentences such as unpaid work, greater use of exclusions and monitoring, new powers for bailiffs to seize possessions, and a trial scheme to ban people convicted of alcohol-related crime from drinking, using new monitoring technology such as so-called 'sobriety bracelets'.

'All too often community sentences are seen as an easy option, sometimes just a weekly meeting with a probation officer,' said Ken Clarke. 'This is inadequate.' The government is consulting on the proposals, along with reforms to the probation service, until 22 June.

Turning Point welcomed the government's attempts to reduce reoffending but pointed out that the move comes at a time when funding for 'one of the most successful community sentences, the Drug Intervention Programme, is entering a stage of uncertainty' with several bodies, including police and crime commissioners, due to oversee its commissioning. 'It will be the continuing success of community sentences like the Drug Intervention Programme which provide a litmus test as to the effectiveness of the government's rehabilitation revolution,' said director of substance misuse services, Selina Douglas. DrugScope has produced a new briefing on police and crime commissioners, in association with Safer Future Communities.

The NTA also wants to hear views from the sector on proposals to introduce new codes to NDTMS to record additional discharge data specifically for residential treatment providers, who feel that the current codes do not reflect the care pathways for people who finish treatment at residential rehabs. Have your say at www.nta.nhs.uk before 9 April.

DrugScope briefing at www.drugscope.org.uk

The impact of drug treatment on reconviction available at www.nta.nhs.uk

Ministry of Justice consultation at /consult.justice.gov.uk/digital-communications/effective-community-services-1

Liver disease deaths in England up 25 per cent in less than a decade

More people are dying from liver disease than ever before, according to new figures from the National End of Life Care Intelligence Network.

Deaths from liver disease: implications for end of life care in England shows a 25 per cent increase in deaths from liver disease between 2001 and 2009, from just over 9,200 to more than 11,500.

Around 90 per cent of people who die from liver disease are under 70, with the disease accounting for more than one in ten deaths of people in their 40s. Alcohol-related liver disease accounted for 37 per cent of all liver disease deaths – 30 per cent among women and 41 per cent among men. Just 28 per cent of alcohol-related liver disease deaths occurred in the least deprived areas, compared to 44 per cent in the most deprived.

'The key drivers for increasing numbers of deaths from liver disease are all preventable, such as alcohol, obesity, hepatitis C and hepatitis B,' said national clinical director for liver disease, professor Martin Lombard. 'We must focus our efforts and tackle this problem sooner rather than later.' People were also being diagnosed late in their condition, said British Liver Trust chief executive Andrew Langford, exposing the 'inadequacies in our healthcare system in identifying patients early and the lack of will to invest in prevention strategies'.

A separate report from the Office for National Statistics (ONS) found that people aged 45 and above were three times more likely to drink every day than those under 45 – 13 per cent compared to 4 per cent. Among over-65s, 22 per cent of men drank almost every day compared to 3 per cent of 16-24 year-olds, while 12 per cent of women over 65 drank almost every day compared to 1 per cent of 16-24 year-olds. Younger adults were more likely to have drunk heavily in the previous week, however, with 24 per cent of men aged 16-24, and 25 per cent aged 25-44, having drunk more than eight units in a single day.

Liver disease report at www.endoflifecareforadults.nhs.uk

ONS General lifestyle survey overview report available at www.ons.gov.uk

News in Brief

FAMILY FACTS

A new briefing drawing together the findings from three pieces of research on support for family members has been issued by the UK Drug Policy Commission (UKDPC). *The forgotten carers: support for adult family members affected by a relative's drug problems* calls for better workforce development, more integration of specialist and generic services and improved needs assessment. Available at *www.ukdpc.org.uk*. *See our family features, starting on page 8.*

ON TARGET

Two new projects from Lancashire Drug and Alcohol Action Team (LDAAT), DRIVE (delivering recovery in volunteering environments) and BRiC (building recovery in communities) are designed to help people rebuild their lives through education, volunteering and employment. The launch took the form of a Lancashire-wide football tournament between service users, staff and community groups. 'It was great to see so many people coming together to celebrate recovery from substance misuse across Lancashire,' said the Mayor of Pendle, cllr Nadeem Ahmed (above).

ALARMING STATISTICS

More than one in four women in European and Central Asian prisons are there for drugs offences, according to a report from Harm Reduction International (HRI). The figure can be as high as 70 per cent in some countries, says *Cause for alarm: the incarceration of women for drug offences in Europe and Central Asia, and the need for legislative and sentencing reform*. Over 31,000 women across Europe and Central Asia are imprisoned for drug offences, says the report, 20,000 of whom are in Russia – more than twice as many as all EU countries combined. 'Women are disproportionately facing prison for non-violent drug offences, often as a result of poverty and social marginalisation,' said report author. *www.ihra.net*

HAS THE GOVERNMENT DECIDED TO STAND UP TO THE DRINKS INDUSTRY?

The government's alcohol strategy is finally with us. **DDN** assesses the reactions

'We can't go on like this,' says David Cameron of Britain's binge drinking problem in *The government's alcohol strategy* (see news story, page 4). Fifty years ago, the UK had one of the lowest drinking levels in Europe, the document points out, while last year saw almost 1m alcohol-related violent crimes and 1.2m hospital admissions, a state of affairs it attributes to a 'combination of irresponsibility, ignorance and poor habits – whether by individuals, parents or businesses'. It's a situation that the strategy intends to attack 'from every single angle', he states.

So how has the strategy been received, hoo-hah about whether it was rush-released to divert attention from the Budget aside? Despite the inclusion of a commitment to introduce a minimum price – something that no one thought was even on the agenda until recently – health groups have regarded it as something of a damp squib. While all welcome the intention to address the issues, Alcohol Concern pointed out that the strategy will do little good without the government putting its money where its mouth is and committing real resources to alcohol treatment, while Mentor UK said it 'missed an open goal'.

Press reaction has been mixed, with op-ed columns taking strongly different lines even within the pages of the same newspaper. Much of the press has long wanted to have its cake and eat it when it comes to alcohol harm, running apocalyptic 'binge Britain' stories on an almost daily basis and then crying 'nanny state!' at any attempt to address the issue through action on pricing or advertising. 'Binge drinking is a serious problem,' said David Cameron's introduction, 'and I make no excuses for clamping down on it,' which – speaking of open goals – inevitably invited countless references to his Bullingdon Club days. There does, however, seem to be less willful misunderstanding of the likely impact of minimum pricing than when chief medical officer Sir Liam Donaldson first proposed the idea under Labour (*DDN*, 23 March 2009, page 5)

Reaction from the industry, although inevitably negative, has mostly been reasonably measured, despite some talk of 'legal challenges' (regarded as likely to fail). While the big manufacturers and industry groups will obviously defend their interests to the last, they're also aware that they can't be seen as too eager to put profits before public health and welfare. The Portman Group seized on the 'good progress' being made with the much-derided alcohol responsibility deal, while The Wine and Spirit Trade Association said it opposed minimum pricing on the grounds that there was no evidence to prove it would tackle alcohol misuse.

Opinion is split even within different parts of the industry, however. While the British Beer and Pub Association (BBPA) welcomed the strategy's focus on the retail sector, as recent years had seen 'alcohol policy aimed squarely at pubs when more and more drinking is done at home', the British Retail Consortium said it was 'a myth to suggest that supermarkets are the problem or that a pub is somehow a safer drinking environment'.

Ultimately, of course, we're a long way from any of this becoming legislation, and the industry wields a lot of economic and lobbying power in these straitened times. Perhaps tellingly, David Cameron's introduction addresses itself exclusively to the crime and anti-social behaviour aspects of alcohol misuse, without a single mention of health. According to British Liver Trust chief executive Andrew Langford, this reflects the fact the Home Office led on the strategy. 'The health issues around alcohol are well publicised and on their own probably wouldn't have gained the traction needed for the policy change that we witnessed on Friday,' he tells *DDN*. 'That said, we will be doing everything we can to ensure the health impacts of alcohol are well understood by the strategy team in the government.'

Was he surprised that minimum pricing ended up in there at all? 'Yes, and we were delighted to see the government recognising the clear link between price and consumption,' he says. 'It also highlights the differences in departments at the government – some are more ambitious than others.'

The trust called the strategy 'the beginning of a process'. Ideally, what would it like to see happen now? 'There is still lots to be done and we've always been very clear that minimum unit price shouldn't be hailed as the silver bullet, nor the only solution to the problem. Alcohol cuts across society, and the issues associated with it need a population approach. We will be pushing very hard for action on other aspects of alcohol marketing, such as the way it is promoted, labelled and advertised. We are very keen that alcohol treatment services get the investment they so desperately deserve, too.'

The trust dismissed the latest alcohol responsibility deal initiative – to 'remove one billion units' – as an empty, headline-grabbing gesture, but much of the industry reaction to the strategy has been to emphasise the 'good work' being done here. How long can it be before these sort of conflicts become unsustainable?

'The deal is a poorly constructed strategy from Andrew Lansley and offers the alcohol industry far too much leeway in doing things their way rather than what is good for public health,' he says. 'The inherent conflicts of interest and lack of meaningful pledges have become a joke amongst the alcohol health community and, due to the fact we witnessed decades of inaction driven by 'voluntary' agreements on various issues, such as labelling, it makes it very hard to believe the claims they now make.' **DDN**

'There is still lots to be done and we've always been very clear that minimum unit price shouldn't be hailed as the silver bullet, nor the only solution to the problem. Alcohol cuts across society, and the issues associated with it need a population approach.'
Andrew Langford

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

In England, alcohol consumption has actually been falling for over five years. The problem is that in this country we have a culture of drinking that is anti-social, destructive and yobbish. We always have had, and unfortunately, probably always will. And as David Cameron, a former member of the Bullingdon Club, should know, it is something that has little to do with money. So if the government insists on cutting drinking by raising prices, then it should raise them so that Château Margaux goes up by as much as Strongbow Super.
Daniel Knowles, *The Telegraph*, 23 March

This announcement is utterly wrongheaded. I had hoped that the Prime Minister's nannying tendency had gone when his complaints about Terry's Chocolate Oranges being on sale at the checkout counter at WH Smith had been derided a few years ago. It appears not... Why should the rest of us pay for the damage done by alcohol abusers to themselves and to wider society when they should bear the cost themselves? Is it too much to ask that they ought to stand the cost of a visit to A&E and the damage they cause by their drunkenness? Bad drivers pay more each in car insurance.
Donal Blaney, *Daily Mail*, 23 March

Our alcohol crisis in the UK is a daily catastrophe. Libertarians will whinge about regulation and the unfairness of minimum pricing (as if supermarkets loss-leading on alcohol and charging us more for other goods is fair) but as ever they want all the individual licence without the social responsibility. The crisis speaks for itself – we are failing the vulnerable and allowing an unhealthy, under-productive society to persist. We needed a comprehensive alcohol strategy to transform England and we didn't get one today.
Julia Manning, *Daily Mail*, 23 March

Minimum booze prices is a policy I'm with David Cameron on. I don't recall the Prime Minister endorsing the idea when he earned £84,000 on the side from the Tiger Tiger bar chain. So I welcome the repentant sinner, recalling that Gordon Brown also flirted with the plan when he was PM, before letting it go as flat as a day-old pint. We can all sit around complaining about drink-crazed kids kicking heads in and smashing up towns. Or we can do something about it.
Kevin Maguire, *Mirror*, 7 March

To intervene early in some families is not to criminalise toddlers, as some on the left claim. Indeed, we should stop force feeding already anxious but able types, and be less squeamish about intervening in 'chaotic' families.
Suzanne Moore, *The Guardian*, 21 March

The coalition government has continued to criminalise the vulnerable, sad, addicted and sick who make up most of our homeless population. It has also cut funding for services by more than 25 per cent. Since homeless people are the opposite of the Olympian ideal, God only knows what measures they will experience to keep them out of sight this summer.
Mark Johnson, *The Guardian*, 20 March

LEGAL LINE

CAN I WORK FROM HOME WITH A FELLOW SEX WORKER?

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

Reader's question:
I've been sex working for some time and have become more and more worried about working on the streets. A friend and I want to work together in a house as we will feel safer indoors and know that someone else is there in case we get into trouble. I don't want to break the law – are our plans legal?

Kirstie says:
As I'm sure you know, sex working is not illegal but many activities around it are – for instance, soliciting for sex. For this reason, working on the street can be problematic, particularly with undercover police operations. As you point out, it can also be dangerous for some women so I understand that you may feel safer working from a property.

Again, sex working from indoors, even in your own home, is not illegal if you are working on your own. Problems arise where there is more than one person working from the premises for the purposes of prostitution, even if working on different days. Sometimes people try to get round this by renting individual rooms or flats separately, but if it can be proven that they are effectively working together this may also amount to a brothel. Unfortunately, you and your friend working together indoors would not be legal as you would be guilty of 'keeping or managing a brothel', an offence that carries a maximum of seven years imprisonment.

Another way to increase safety indoors is to employ a maid who can be there for security and to do tasks such as cleaning, preparing food and running errands at the shop. If the maid's activities extend past this to taking money (even tips) from clients, then the maid is at risk of being prosecuted for causing or inciting and controlling prostitution for gain. This is an offence that can again carry up to seven years in prison. If you are the only person working from premises, with or without a maid, this is perfectly legal.

You must also keep in mind housing issues, especially if working from your own home. It is likely that using the property for the purposes of sex working will be considered a breach of your tenancy and you may be subject to possession proceedings. If this happens, you are at risk of losing your home. There is also the possibility of the premises being closed by police if they are suspected of being a brothel, but remember the definition of a brothel is more than one person working out of a premises. The court can make an order for the property to remain closed for up to six months, and possession proceedings are likely to take place in the meantime.

You are sensible to consider the safest options for you in terms of minimise the risk of sex working, but unfortunately the current laws do not go far enough in assisting sex workers with this.

Email your legal questions to claire@cjwellings.com.
We will pass them to Kirstie to answer in a future issue of DDN.

Release publish a helpful guide on this issue and more, sex workers and the law.
To order your free copy call 0845 4500 215.

FAMILY BUSINESS

‘Supporting families and parents is not a luxury item – it’s central to both a healthy society and economy,’ said a speaker at Adfam’s conference. It was a sentiment echoed by speakers from all areas of family support, as **DDN** reports

‘Whoever you talk to you’ll get a different view of what family support means,’ said Adfam’s chief executive Vivienne Evans, opening the charity’s recent conference, *Family support: everybody’s business?* ‘The number of families affected is certainly not going down,’ she said. ‘Often the numbers are eye watering and those are just the ones we know about – so much is hidden.’

Dr Katherine Rake, chief executive of the Family and Parenting Institute, gave perspective on the scale of support needed. In England alone there were 117,000 families that had been identified as having ‘multiple problems’. With the cost of intervention projects at around £14,000 per family, it was clear that spending restraints would have an impact.

But she identified a challenge to service delivery. ‘Specific needs flow from specific vulnerabilities, but our tools tend to be generic,’ she said. People should also be careful with concepts of intergenerational transmission, and ‘the media rhetoric of a generation of neglectful parents’, which were not reflected in the evidence.

‘What we know is that parenting style matters dramatically in influencing how children turn out. But poor parenting runs across social class and all parents struggle at some point,’ she said. ‘Everybody thinks there’s some magic blueprint that’s slightly out of reach of them – parents feel demonised.’

There were two streams of policy emerging, she said – one to boost parents’ capacity through information and practical support; the other aimed at reducing parenting pressures through initiatives such as the government’s new Social Justice Strategy, which stressed the importance of early interventions.

‘We need to recognise that supporting families and parents is not a luxury item,’ said Rake. ‘It’s central to both a healthy society and economy.’

‘The danger is that we buy into the tabloid picture of intergenerational substance misuse,’ said Karen Biggs, chief executive of Phoenix Futures. ‘Tabloids present a story where addiction plagues the most deprived, but I don’t want our children to believe they’re a victim of their heritage. If addiction is a disease then surely it can be passed from generation to generation. ‘But we don’t believe that at Phoenix – we believe you can build a firewall.’

The picture was a complex one, she said. ‘Every one of the 20,000 people Phoenix treated last year had a unique experience of family.’ Furthermore, many women hid their addiction through fear of losing their children.

Alison Garnham, chief executive of the Child Poverty Action Group, said a reverse narrative was developing that wasn’t particularly helpful.

‘The government sees drugs and alcohol as a major cause of poverty, but the lack of jobs with decent income is the major cause of poverty,’ she said. ‘David Cameron is very ill advised to talk about poor families as causes of crime and neighbours from hell.’

Policy-driven evidence was replacing evidence-based policy, she said. ‘At best government policies are enigmatic about what they hope to achieve in terms of child poverty reduction.’ Proper quantification of the problem should replace rhetoric, she stressed, highlighting the lack of research on the relationship between poverty and drug and alcohol use.

‘For children living with alcoholics it can be like living on the edge of a volcano,’ she said. £18bn worth of benefit cuts and the closure of many advice agencies would hit the poorest families hardest, with 100,000 more children set to move into poverty – at a cost of £25bn, according to the Joseph Rowntree Foundation.

‘A lot of people don’t realise how much more there is to come,’ she said. ‘There’s a health divide, an education divide and a wellbeing divide.’

Jamie Bartlett, senior researcher at the thinktank Demos, explained the links between parenting and drinking behaviour at different ages, using a quadrant of parenting styles – ‘laissez faire, tough love, disengaged and authoritarian’, with a ‘tough love’ approach linked to happiness and success in later life.

‘Tough love is really difficult when you have difficult circumstances – you have to think of a much more holistic approach to family problems,’ he said. ‘But you can produce evidence that services shouldn’t be cut.’

Wendy Weal, chief executive of social enterprise Interface Associates, was working with the Troubled Families Unit and ‘desperately trying to influence policy’.

‘We need to identify who the right families are – get them on a spreadsheet and look at who we should be targeting,’ she said. Local authorities were failing to do this but there was money available for a network of family coordinators.

‘We need to bring together local agencies – police, Jobcentre Plus, health organisations and schools to put a robust plan of action in place to deal with families. And we need to track it to make sure the right action is being taken,’ she said.

Debbie Cowley, chief executive of Action for Prisoners’ Families, gave feedback from her work improving the wellbeing of offenders’ families.

‘Families are suffering because of the actions of the state,’ she said. An example of this was tagging, which put family members in the role of warden, at great cost to family life. Another example was where women were imprisoned for shoplifting, because their partner had a drug or alcohol problem, ‘making the effects of drug use on the family far more dangerous. It’s an instant where state action has a greater effect on the family’.

There were many pressures on the families of prisoners, from losing income through loss of employment to being pressurised – and sometimes bullied – by their family member to bring food, clothes, drugs and mobile phones. Searches of the home were traumatic, and moving prisoners to different establishments could create immense difficulties with retaining contact, particularly with children – ‘all things that have a toxic effect on family life’.

Curfewing a person at home could bring its own stresses and be ‘deeply oppressive’ for the family, particularly if it attracted criminals to the house. ‘The state’s making families’ lives more difficult. It tips them into a state of needing help,’ she said.

Sharing information between organisations and agencies would help. ‘You need to know the kinds of issues these families face, so you are not, like the state, putting things in their way,’ she said. ‘Then you will help build stronger families and stronger building blocks for society.’ **DDN**

'Whoever you talk to you'll get a different view of what family support means.'

The panel, from left to right: Alan Hopley, Vicky Maloney, Eric Appleby, Edward Stourton, Carole Sharma, Martin Barnes, Jan Tallis

Let's talk...

A discussion, chaired by broadcaster Edward Stourton, showed panel members determined to fight for the future of family services against a backdrop of cuts

Martin Barnes, chief executive, DrugScope

The welfare reform agenda is already having a devastating effect on some families. Of 17 wellbeing board priorities, just one is related to drugs and alcohol and there's the threat of substantial reduction in funding.

Ian Duncan Smith's report made depressing reading. We have a government that will be neutralising the deficit, so services will get worse before they get better. Families will have to move house and problems are closely tied with losing ties with communities. So I'm very pessimistic about the direction of travel. The Social Fund was flawed from the outset, but a safety net. For all its faults, the fact that major safety net taken away stands out as particularly crass in the social care agenda.

Vicky Maloney, service manager, Early Break

The need to influence local commissioning is huge. I'm often met with 'does that tick an outcome box for me?' We try and link with social care – it's about challenging and educating other services that are in contact with children. We're dependent on high threshold cases coming forward. It's about a whole family approach, including domestic violence and mental health. We need to see families who are not in touch with any services.

Eric Appleby, chief executive, Alcohol Concern

Alcohol's always been the poor relation. One of the possible effects of changes is that the playing field will be leveled up a bit.

We need places for families to go – and for them to know that places are there. Many things prevent them from doing this, such as them thinking that it's normal and that they should cope. No one knows how to talk about drinking – it's either a joke or a real problem. Professionals will ask about all sorts of things but find it very difficult to talk about alcohol. We talk about 'binge drinking young people', because that's not us.

Alan Hopley, director of fundraising, marketing and communications, Addaction

Not only will drugs and alcohol compete with obesity, smoking etc, but ring-fencing will come off. So there won't be a joined-up approach – it'll depend on personalities and local authorities.

Payment by Results (PbR) may mean a very quick turnaround; people in and out of the door. These are the sorts of contracts we're going to have to decide whether or not to go for. We need to make successful services more successful and let other stuff fall by the wayside. We have to work in different ways.

Carole Sharma, chief executive, FDAP

We have a challenge in helping the treatment workforce to work differently from how we've always worked. We need to train all staff involved – we're still failing to get the agenda into doctors', schools etc. We've had a culture of targets – and they can clear the mind and help you focus. But some people think if you don't have to do it, you can ignore it, so they don't have a drug and alcohol service.

Lots of reforms are based on the fact that people are passionate about what they do – but this doesn't make it safe. I feel we're going to have to start again from grass roots.

Jan Tallis, chief executive, School Home Support

We're having to put more effort into showcasing our work. Last year we were working in 250 schools – this year it's 150. We lost five local authority contracts. There's no one else there for early interventions, asking the right questions.

School's a brilliant place to start as it's a non-stigmatising environment, but teachers need to have drug and alcohol awareness. People are being required to double their output for half the input – it's scary. Services won't be there that we used to use for referrals.

ENTERPRISE CORNER

POWER OF THE COLLECTIVE

Challenging times need collaborative solutions, says **Amar Lodhia**

WE ARE IN SOME TORRID ECONOMIC TIMES, but as much as many businesses suffered serious damage, some have come out stronger than ever. Over the last three years we have been working with more than 100 entrepreneurs, 60 senior business leaders, 15 corporate partners across 12 local authorities and two cities to create positive change in local communities. We have been extremely fortunate to have the support of valuable corporate partners, who have given us both financial and in-kind support, including time provided by legal experts, venue space for events and free domain names and websites provided to our participants. This form of giving is expressed in what we may call collective ambition – it describes how businesses, their leaders, the entrepreneurs that own them and the employees that drive them think about their collective purpose. It is about how they collaborate to achieve their ambitions in a way that aligns with not just their core values and brand, but also the associations they make with charity and social enterprise partners.

Our supporters have shown that there are companies that do not just fall into the trap of pursuing a single ambition, such as profits. Instead their owners, employees and leaders are given flexibility to collaborate with stakeholders including the local and wider community, to shape a collective ambition that surpasses individual goals and takes into account the key elements required to achieve and sustain excellence – while making a social impact. Businesses are not just employers, or solely profit driven, but a force for positive change.

Recently while discussing the power of the collective with Nuzhat, head of DAAT strategy for Outer North East London, he said: 'In order to inspire and influence local authority decision makers, third sector organisations need to be thought leaders. They must approach local authorities as partners, however they should take the bull by the horns and lead. Business plays such an important role in the recovery of service users. There is, however, a huge gap in providing the skills necessary to start and develop a business. We really need think about how we can fill this gap. Empowering service users to start skilled and practical businesses and trades is crucial. Collaboration with large well-known organisations and local authorities will be key for these startups in order to breakdown the barriers and gain the trust of local communities.'

Earlier this month, we sent two DAAT clients enrolled on our E=MC2 programme to spend a week with Microsoft UK, one of our supporters. The week, organised as part of an initiative called 'Britain Works' was to support people to learn more about Microsoft and what they do, as well as develop key employability, presentation and communication skills. One of the participants said, 'We did things like learn sign language, which was really good and different. We also learned about the importance of body language and how to use it.'

As Dame Anita Roddick, founder of The Body Shop, said: 'Recognise that a fairer world is better for the soul and the bottom line... I have never believed that business was a separate compartment from civilising in the world. That is why I have always been an activist, an agitator and an entrepreneur.'

We'd love to hear your views on the Power of Giving. Join in the conversation at ddn@tsbccic.org.uk and follow us on Twitter @TSBCLondon using the #tag DDNews

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

LETTERS

'I am often told to come back after surgery, but that doesn't usually mean I can see a doctor – it is just to demonstrate that their time is worth more than mine.'

GPS NEED REALITY CHECK

I read with interest your conference reports on the role of GPs in treatment and recovery. Yes, GPs 'can be an effective catalyst to someone's recovery journey', as Rebecca Daddow says in *Treating the whole person* (*DDN*, March, page 13). But the emphasis here, I think, should be on *can*.

Like others in the sector, I've seen the situation from both sides – more years than I care to remember as a service user and now the best part of a decade as a drug worker. Yes there is a problem with GPs not being contracted to work with drugs and alcohol, as Steve Brinksman says (*DDN*, March, page 12), and with lack of specialist knowledge, and it's to be welcomed that SMMGP are addressing this by calling for drug and alcohol training to be included in doctors' training as a matter of course. But what I have more of an issue with is the attitude of many GPs.

Much of the extensive literature around stigmatising problematic drug and alcohol users talks about the patronising, arrogant and contemptuous attitude of healthcare professionals towards people with substance use issues, but isn't the problem simply that – with many GPs – this attitude can often extend beyond the drug-using population to include all their patients, particularly those who may struggle to articulate their concerns within their allotted seven-minute consultation or lack the confidence of the well-informed, middle class professional?

Until some GPs start seeing all of their patients as real people with real problems and concerns, and not an unfortunate irritant to be dealt with before pocketing the £200k salary, there is, I'm afraid, a very long way to go before they become 'crucial to the recovery process'.

Name and address supplied

OK FOR SOME

I would like to feel hopeful when I read the article *Doctor can you hear me* (*DDN*, March, page 12). But I have spent nearly 12 years being messed about by my GPs' surgery and the receptionists treat me like a nuisance.

I am often told to come back after surgery, but that doesn't usually mean I can see a doctor – it is just to demonstrate that their time is worth more than mine. I have changed doctors twice within the practice but the situation has not improved – they seem to have warned each other that I am a second class patient. I was actually told by one receptionist 'why don't you move house then'. I would if I had the choice.

I come out of that surgery feeling demoralised every time. If it wasn't for needing the medicines I do, they wouldn't see me for dust.

Name and address supplied

THERE IN SPIRIT

I was unable to attend the *Together We Stand* conference last month. This was the first *DDN* service user involvement conference that I have missed, and while I was very

disappointed, I did want to say how much I enjoyed the coverage in the special issue of the magazine and watching the video from the sessions on your website.

It was great to see and read about so many familiar faces from previous years events like the SURF group from Somerset, BADSUF and Iain 'Buff' Cameron. Next year I will make sure I am there again in person.
Simon Knight, by email

DDN replies: We're glad you enjoyed the special issue Simon. We are currently looking at venues for next year's event; we were pleased with the NEC but are looking at all our options. If anyone has any feedback on the venue or the conference itself, please email info@cjwellings.com

As soon as we have a place and a time for the next one we will let you know!

ABSOLUTE TRAVESTY

I was saddened to read John Jotcham's *Soapbox* (*DDN*, March, page 28) on the demise of Walsingham House, with all its caring work. The decision to close the rehab is unbelievable, particularly as we are desperately short of resources and expertise to treat dual diagnosis. How this shocking sequence of events was allowed to take its course is astonishing in the face of the service's successful completions.

We are constantly reminded that the Care Quality Commission (CQC) isn't doing its job very well and a barrage of criticism has forced chief executive Cynthia Bower to resign – too late for Walsingham House. CQC staff have admitted that the commission was in disarray as they were asked to take on too much work and felt out of their depth, without proper leadership or strategy.

Why were the commission's decisions allowed to stand when 15 years of dedication and expertise from Walsingham House were swept away within four months? And do the testimonies of those whose lives they saved count for nothing?

I was worried about the outlook for drug and alcohol services before I read this article. Now I am terrified.
Linda Bradley, by email

GOING DOWN?

I remember the good old days when every £1 spent on treatment saved £9.50. I noticed with dismay in your last issue an NTA advert proudly proclaiming that it now only saves £2.50! How can this be? Why has there been a 75 per cent reduction in the amount saved in less than two years?

Are drug treatment staff only working a quarter as hard as they used to, has treatment been so successful that there is hardly anyone left needing to access it, or was the original figure purely an invented headline with good intentions but no basis in fact?

I would be very interested in the NTA's opinion on what has changed so much in the last two years or to hear them admit that the original figure was simply wrong and had no evidence to back it.
Pat Trowbridge, by email

RESIDENTIAL REHAB DIRECTORY

The May issue of DDN will contain the updated residential rehabilitation directory. The directory provides an at-a-glance guide to the UK's residential facilities and lists their contact details as well as providing a snapshot of the services they provide. Our last update is available on the getting help page of www.drinkanddrugsnews.com

If you run a residential service, please check that you are listed and that your details are correct. If you have any changes to make please email them to directories@cjwellings.com by Friday 20 April.

The directory also includes enhanced entries which, for a small fee, offer the opportunity to fully explain the range of services you provide. To find out more please contact me.
Ian Ralph, DDN
Email ian@cjwellings.com
or call 020 7463 2081

We welcome your letters...

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

Post-its from Practice

Unsung heroes

Local pharmacists are vital partners in drug and alcohol treatment, says Dr Chris Ford

Ahmed, one of my local pharmacists, rang the other day to say, 'Chris, don't forget to alter the scripts for the upcoming Easter bank holidays. We are open on the Saturday, but I hear several pharmacies are closed on the Saturday as well.' I thanked him for the important reminder as it would affect so many prescriptions and we then went on to discuss several of our joint patients: Jack who is doing so well, Jean who is still struggling with her anxiety but 'enjoys going into the pharmacy' daily, and others.

The conversation reminded me again how lucky I am in Kilburn having at least five excellent pharmacies very close. The pharmacist is a key individual in drug treatment being successful, but the counter staff are also essential to make the pharmacy a welcoming place without stigma. The pharmacist sees our patients much more frequently than I do and often, like Jean, on a daily basis. She often remarks that Ahmed is her main support worker. She feels he cares and never judges, even when her time-keeping is not the best! He also doesn't judge when she occasionally asks for a clean needle and syringe, but does advice her on overdose prevention. Ahmed was the reason Jean came to us for treatment in the first place. It had taken her a while, as her previous experiences had been poor, but she has now been with us for nearly a year and the changes have been dramatic. Ahmed commented how rewarding it was to have seen these changes and to have been part of them. 'Jean even smiles when she comes in now!'

Ahmed and his local colleagues are also a crucial part of the team that keeps people in treatment when things are not going so well. Jack, mentioned in our call, was currently doing well, but this hadn't been the case until recently. He was missing pick-ups, presenting after drinking or having used other drugs. For the first few weeks it felt as if we were always on the phone to each other as he had missed one, two or more days. But Ahmed never gave up, never got angry, reminded him about loss of tolerance and overdose risk, and kept sending him back to me until he stabilised.

Pharmacists are also extremely helpful with drug interactions with prescribed and over-the-counter medications and doses. Most of the time, I think I get prescriptions right but I feel reassured that there is another good check before it is dispensed. We always ring the pharmacist before sending a new patient, as it's good to start that relationship. I view them as part of the team, and not just someone who dispenses the medication.

They, as with GPs, need to work within their professional guidelines and occasionally they need to remind us of those. The pharmacy contract, which came into effect in England in 2005, enabled pharmacists to potentially play an even greater role in the treatment of people who use drugs, as historically the community pharmacist has been an underused resource. These changes and improved training has supported more pharmacists to become involved, which can only benefit patients, GPs and other healthcare providers.

I couldn't work without my 'vital partners' the pharmacists and feel incredibly fortunate that I have so many good ones around. I also know this is not unique, as having to transfer two patients recently to other areas it was easier to find a friendly pharmacist than a friendly drug service!

A big thank you to all the community pharmacists as I sing praises to you, so often the unsung heroes and an essential part of the drug and alcohol treatment system. We couldn't do it without you.

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

BABY BONDING

A mother-and-baby rehab can prove a positive experience for clients and staff alike, explains **Hannah Shead**

As anyone who has been resident in a rehab, or worked in one, or reviewed a client in one will know, life in residential treatment is hard. Rewarding? Yes. Life changing? Absolutely. But still hard work. I've heard some clients say that prison was easier – you still got fed and watered but could avoid the therapy.

So a rehab with children… well, that presents an interesting challenge. The clients still need to do their personal work around addiction, but they also need to do intensive work around their parenting, and on top of that they have their children to look after.

I'd like to share a day in the life of a mother and baby residential, so if you have any female clients who are thinking about taking this step you can prepare them for the road ahead. Trevi House is one of four mother and child placements in the UK. Located in Plymouth, it's home to a 13-bed residential with an onsite nursery and baby room. A typical stay is usually around six months, and although this may sound like a long time, residents frequently tell us that the time has flown.

So, what's a typical day? Like most rehabs, it's up bright and early for jobs, and then at 9.15am the women drop the children off at nursery and head to the group. The therapeutic programme aims to address both the addiction and the parenting in equal measure, as the relationship between the two is symbiotic and work on one element impacts upon the understanding of the other.

The parenting programme has a wide remit, with topics ranging from attachment through to hazards in the home, and for many women the sessions around attachment can be the most challenging. 'I suddenly realised that I had never made an attachment with my mum,' said one client. 'It was hard to think about how to bond with my child when I was thinking about the bond that I never had.' The group is co-facilitated by nursery and key workers who try to keep the mums focused on the future, as this is an opportunity for many women to break a cycle of intergenerational abuse and neglect.

Groups take a break for lunch, with mums and children eating together – something as simple as sharing a meal can strengthen attachments and it also offers staff an opportunity to support mums with feeding their children.

After lunch, it's time for 'baby and me', a free-flow play session similar to the drop-in sessions new mums might attend in the community. The intention here is to promote play, the importance of which is valued highly at Trevi. As key worker Clare reminds us, 'just 10 minutes of child-led play a day can make a huge difference for both mother and child bonding'. For nursery staff, the balance is between modelling play for the women and stepping back to allow mum to engage in child-led play.

For some women, however, playing is something that she's never done, and before she can play confidently with her child we try to support her in experiencing the fun of seeing things through a child's eyes. 'When we spread cabbage on the floor, or spaghetti, mums will look horrified at the mess, but we encourage mum to get involved, feel the textures and enjoy the sensations,' says the nursery deputy manager of 'food play'.

'Baby and me' ends with a group sing-along, as staff and residents alike are encouraged to share new or original songs. A room full of giggling babies being swung into the air to *Zoom Zoom Zoom* can be a great encouragement for women to incorporate singing into their own daily routine with their baby.

In the afternoon, it's back to group – or key – work. The programme is tightly packed, as each valuable minute that the children are in nursery needs to be filled. Most of the work around addiction falls within the recovery training component of the programme, which covers addiction awareness and relapse

G BOON

'Life in residential treatment is hard. Rewarding? Yes. Life changing? Absolutely. But still hard work. I've heard some clients say that prison was easier – you still got fed and watered but could avoid the therapy.'

prevention, and Trevi also runs the 'freedom to change' domestic abuse programme, which takes an uncompromising look at past and future relationships and challenges women to strive for healthy relationships.

The children are collected at 4pm after which the women begin the routine of parents up and down the county – organising an evening meal and preparing their children for bed. The evening staff are on hand to help with maintaining the bedtime routine, as establishing and maintaining a routine can provide stability and structure and act as a sharp contrast to the chaos that many women have been used to in the community.

For mums with younger babies, nighttime doesn't necessarily equal rest, and they may be woken up frequently for feeding or soothing. It isn't uncommon to see a few bleary-eyed mums on project in the morning, especially if their baby has woken up bright and early ready to play!

As many of the staff and residents will attest, having children on the project brings a huge benefit. They are a constant reminder of extent to which lives can be turned around, and an inspiration to us all to stay positive. Despite the enormously hard work that goes into the group and key work, seeing the bond develop between mother and child and the simple pleasures they find in one another's company makes it all feel worth it.

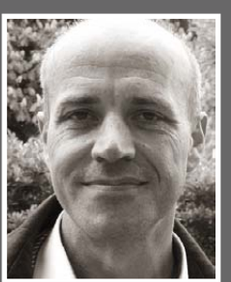
So, it's not your usual rehab experience. But if your client is thinking of residential but is deterred by the thought of being separated from her children, then a mother and child placement might be an option. After all, what we are all striving to offer our clients is treatment options and choices to allow them to pursue what they hope will work for them.

Hannah Shead is service manager at Trevi House, www.treviproject.org. For more information email office@trevihouse.org and follow them on Twitter – @TreviHouse

VOICES OF RECOVERY

PARENTS IN RECOVERY

Coming together as family members can help grow recovery together, says **Alistair Sinclair**



IN DECEMBER LAST YEAR the UK Recovery Federation (UKRF) facilitated a recovery seminar in Salford, attended by recovery activists from all over Greater Manchester. Deb Drinkwater from Salford helped to deliver it. Deb is particularly interested in supporting recovery in families, as she explains:

'We do recover. This is a fact. Recovery can lead families to a place of improved relationships, new perspectives, bigger goals and increased potential. Recovery for individuals and families is not only possible, it's essential for the continued wellbeing of family members.

'Those of us who are part of the growing recovery community in the UK today experience first hand, through events, conferences and our own networks, the powerful visible force of families, adults, children, grandparents and siblings that are all benefitting from the recovery journeys of their loved ones; amazing, powerful and real. There is much to smile about, to be grateful for and to celebrate.

'Yet outside of the recovery community you would never know it. We are aware of the stigma and discrimination people with current addiction issues face. Parents in recovery continue to face this long after their addiction has been addressed. Lack of child-friendly facilities within services that claim to support recovery, failure to fund childcare during school holidays and the blatant disregard for the anxiety and fear that parents face in disclosing their recovery to the wider community are classic examples of how little thought is given to the needs of families.

'However there are ways to overcome the stigma and discrimination faced by parents in recovery – through the development of peer support networks, led by parent mentors, such as the one we recently piloted for the DAAT in Salford. The building of networks, releasing individual and group potential and giving communities the confidence to identify their own strengths and needs in relation to the whole family, requires both strategic commitment from the top and confidence building within communities. The UKRF seminars focus on the confidence building bit.

'People attending a UKRF seminar share knowledge, understanding and enthusiasm for the inspirational work which is going on, often quietly, humbly and at very little cost, within our recovery communities. The asset-based approaches introduced strengthen the understanding of the abundance available to us all once it is identified, acknowledged and nurtured. Co-facilitating the Greater Manchester recovery seminar with Alistair, I had the chance to experience how this approach builds confidence and hope and supports the beginnings of a shared vision; bringing people together around their commitment to recovery and their similarities. We need more spaces like these where communities, families and services come together to learn, share and make new friendships. In doing this we can grow new forms of community-based support and truly support the diverse recovery journeys of families.

'We do recover and, with support and commitment, recovery networks will grow and become more visible, giving the community the confidence to express itself and flourish, and allowing families to share their positive experiences without fear of prejudice. Coming together as community members first, as family members, we can learn and grow together.'

Deb Drinkwater runs DDTC, providing training and consultancy for recovery. Alistair Sinclair is director of the UK Recovery Federation (UKRF).

Jeremy Adderley reports from the inaugural Crew Substance Use Symposium

WOULD YOU HAVE EVER IMAGINED A TIME when more people in the UK reported last-year cannabis use than tobacco? That time is now, according to 2011/12 Global Drug Survey data shared at the inaugural Crew Substance Use Symposium (CREWSUS). The figures are 68 per cent and 65 per cent respectively, compared to 64 per cent and 70 per cent the year before.

An audience of 70 professionals, peer educators and service providers, mostly from Scotland but some from as far south as York and London, arrived in Perth for CREWSUS 2012 to hear this surprising fact in among the very latest news about drug use and what frontline drug services like Crew are doing about it.

One of the highlights of the day was the celebrated Dr Adam Winstock, Global Drug Survey founder, who explored its latest findings. First up, alcohol use in Scotland, where 20 per cent of people scored in the 'high risk' or 'dependent' categories, with the surprise outcome that this level is now the same for both men and women. Looking at the use of novel psychoactive substances, and Adam's phrase of 'mystery white powders', users are now, more than ever, consuming substances when they have no idea what they contain, a result, perhaps, of the marketing of substances under brand names.

Another key – and surprising – finding was that more Scottish respondents had tried cannabis than had ever tried tobacco, with data from the Scottish Crime and Justice survey confirming almost nine in ten (87.2 per cent) of those who had used any illicit drug in the last month had used cannabis in that time. With limited services and treatment options for cannabis users, compounded by increasing referrals for its use, this is truly something to consider. Despite psychostimulants being the drug category of choice for the vast majority of our population, after alcohol, a shocking finding was that very few people would trust a government website for information about them – just 3 per cent – instead preferring to use potentially unregulated internet-based resources such as forums, or more commonly, seeking advice from peers.

So what did CREWSUS reveal about what Crew and sister organisations were doing about it? Opening the event, Crew's national director John Arthur highlighted the perceived 'false dichotomy' between harm reduction and recovery and explored the principles that actually unite them as an approach. Crew promotes a 'stepped care approach' to substance use which meets people 'wherever they are at' in their substance use and, crucially, doesn't wait until people become problematic. It uses these principles in an approach that is person-centred and sets quality of life and wellbeing as important measures. CREWSUS workshops highlighted the key stages of the stepped care approach and invited delegates to look at practical measures that would work within their own organisations.

Innovation was a key message for the day – particularly the potential in using new media for a range of interventions, beginning with information provision through to tackling problematic substance use within an environment increasingly fuelled by unregulated drug marketing. Adam Winstock showcased the brand new web and smartphone based self-assessment tool *Drugsmeter.com*. Crew also announced the successful funding of Crew Online, a service designed to support people looking to stabilise, reduce or stop their substance use based on the findings of their recent pilot and international collaboration OASIS, which clearly demonstrated an online service need in the community.

From discussion with delegates, one of the main needs highlighted was ongoing updates on drug trends in Scotland. Crew training and outreach coordinator Katy MacLeod and George Burton from national training provider STRADA spoke about their development of training around novel psychoactive substances and emerging trends. In exploring key challenges for frontline staff, what was resoundingly echoed by delegates was a gap in services for psychostimulants users, with frontline staff and organisations generally opiate-focused and often lacking in knowledge and confidence to ask about or deal with psychostimulant use.

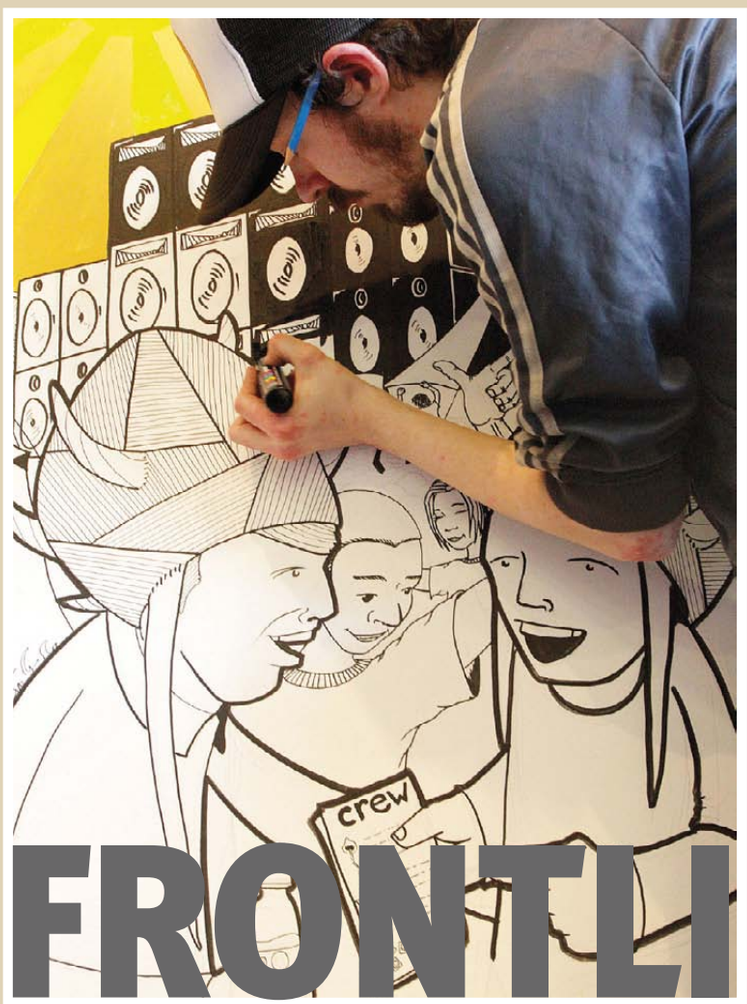
With statistics suggesting Scotland is the cocaine capital of Europe (WHO), the rise in new psychoactive substances, re-emergence of MDMA and an increase in referrals for support around long-term cannabis use, it would be unwise not to respond to these findings. With current budget restrictions and more emphasis than ever on preventative spend, Crew suggests we need to be intervening earlier and not waiting until use becomes problematic. It also suggests the need to recognise that people *can* and *do* use substances relatively safely and therefore we must ensure that we have credible resources available for people to make informed choices.

So a day of highlighting challenges to workers certainly, but moreover a day of exploring ways of tackling these challenges, at every stage of substance use.

In partnership with Incite, Crew will be running open workshops in Aberdeen: Psychostimulation on 24 April and Legally High? on 25 April.

Crew are also running free training for trainers events on 30 April in Edinburgh and 21 May in Glasgow. www.mind-altering.org

Left: Live art at CREWSUS 2012 – demonstrating a range of outreach techniques to reach substance users.



FRONTLINE CREW

DUAL

Kim Johnson describes how her organisation, Helping Groups to Grow, is tackling the problems faced by people with a dual diagnosis

Helping Groups to Grow (HG2G), in partnership with Clinical Psychology Associates, has developed and rolled out an innovative group work programme across mid and west Wales which bridges the gap between substance misuse and mental health provision. Individual users suffering from anxiety and depression and other common mental health problems, but who do not meet the thresholds for community mental health team intervention, can end up falling between the gaps in services and facing significant risks. So funding was obtained from Big Lottery and Welsh Assembly Government – with support from local service providers and commissioners – to deliver an intervention that would increase personal wellbeing and reduce risk and harm.

The 12-week 'Pathways to Recovery' group programme uses a variety of evidence-based psychosocial interventions from both substance misuse and mental health practice, including cognitive behavioural therapy (CBT), motivational interviewing, relapse prevention, mindfulness and acceptance and commitment therapy. This provides service users with a range of coping strategies to enable them to manage difficult situations and help them achieve a healthier, more balanced lifestyle.

The programme is underpinned by the 'lifestyle balance' model, influenced by a CBT framework, which explains how thoughts, feelings, sensations and behaviour can influence us and links these to the person's own situation and circumstances. More than 20 programmes have been run in both community and in-patient settings, and currently two thirds of group members complete the 12-week group. Feedback from service users has been very positive: 'My overall opinion of the programme is that it serves a tremendously useful purpose to those who are willing to embrace its principles,' said one. 'Despite my having started from a rather cynical viewpoint, I soon saw the value in the methods and techniques that were shared with those, who like me, were members of the programme due to misuse of substances.'

We keep in touch with former group members and they are invited to meet with a member of the HG2G team to complete follow-up assessments for up to a year after finishing the programme. While we are still collecting this longer-term data we have completed an interim evaluation of the service to date, which demonstrates statistically significant results – levels of dependence, alcohol consumption, depression and anxiety went down, while levels of social functioning, personal and physical wellbeing and quality of life all improved. We are excited by these findings and we hope that the longitudinal study – which should be published in spring 2013 – will report equally successful results.

To achieve regional coverage we have worked in close partnership with staff from both statutory and voluntary sector substance misuse providers, including Kaleidoscope, Cyswllt Contact, Turning Point, Prism, West Wales Substance Misuse Service and the Dyfed-Powys Drug Intervention Programme. This partnership approach has been a real bonus for us, is welcomed by services and has led to very positive experiences of co-working.

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The Pathways to Recovery programme starts with a brief psychosocial intervention (PSI) assessment over three one-to-one sessions. These are designed to help the person engage, become familiar with a CBT approach and prepare for the group work programme. Group members complete a range of standardised self-assessment measures – such as social functioning, levels of dependency, substance use, anxiety, and depression – with the results presented in a lifestyle profile booklet that gives a 'snapshot' picture of their situation and areas they would like to change.

The programme comprises weekly group sessions, which are highly structured and led by two group facilitators, and each session is supported by an individual key-working session with one of the facilitators. These enable each person to discuss their own circumstances, goals and plans and to work in a trusted relationship with their key worker.

The group programme and key-working sessions explore a range of topics, taking the service user on a journey towards understanding substance misuse and mental health problems and learning to manage them more effectively. First, service users are introduced to the basic underlying lifestyle balance model before moving on to understand the function of their own substance use. The programme helps service users consider potential risk behaviours and helps them to plan for how they might minimise these. Service users learn to understand and manage cravings and urges associated with substance use before being introduced to the possibility of a period of sobriety.

Significant changes to lifestyle are introduced through rebuilding relationships and building new social networks, with self-rewards for successes. There are four related sessions covering mental health – from understanding thoughts, feelings, sensations and behaviours that may be early signs of mental ill health to exploring the underlying beliefs that underpin many mental health problems and strategies to manage or replace these. The programme ends with planning next steps for the future.

An important component is to introduce coping strategies and enable group members to practise and develop skills to help them move towards a healthier lifestyle. Many service users attributed their successful outcomes to the various coping strategies taught on the programme. One example is 'urge surfing', a technique developed by the late Alan Marlatt in his work on harm reduction and substance use which helps people manage the intense physical symptoms associated with urges to use a substance. It is a mindfulness-based technique to

'ride up and over the wave' of the craving, and group participants told us they found this approach helpful when they felt overwhelmed by cravings. 'Urge surfing – a dreadful expression but no matter! – I have found this useful for controlling my alcohol intake and (somewhat to my surprise) in some situations when trying to control my other addiction (nicotine),' reported one.

The coping strategy that – alongside urge surfing – received the most positive feedback from group members is the opportunity to devise their own 'flash cards'.

An effective relapse prevention tool in both substance misuse and mental health practice, a personalised card with a motivational sentence, meaningful photograph or picture of a specific goal helps people stay focused on their values and plans for the future, and can help them return to their goals in the event of a lapse. 'I used coping strategies – [I] got [flash] cards out after a slip, which was alcohol not drugs,' reported one member. 'The best thing was my motivation cards,' commented another.

Although sometimes reticent about joining a group, members tell us that the experience of being with other people who share similar issues is a key part of their recovery journey. The key working sessions were also felt to be essential, as was the focus on mental health, which many saw as a unique aspect of the programme. 'Regarding the key working sessions; I cannot speak highly enough of them,' a service user commented. 'Whilst I admit to having found them very hard work at the outset, these sessions very rapidly clarified my understanding of a particular concept and reinforced the learning of the group session.' Another spoke about 'meeting people which made me think I am not on my own.'

Programme facilitators report that they experience leading the programme as 'a shared journey' with the clients, and although hard work – emotionally and physically – at times, it can bring about change in a way often not seen in other areas of everyday practice. When group members complete the programme, the same assessment measures used in the brief assessment are repeated and they receive an updated lifestyle balance profile comparing their initial scores with the new outcomes in a visual format. This is a powerful motivator – it can be difficult to notice things changing for the better, but a picture, scale or graph presents improvements very clearly. The lifestyle profile of one group member who felt they had never achieved much at school showed them and others that they had 'done well', allowing them to experience positive recognition for the first time in their lives.

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A women-only Pathways to Recovery programme is also now available, following a successful pilot programme in partnership with local women's services in 2011. This is a particularly exciting development, and the first time – as far as we are aware – that a women-only programme addressing both substance misuse and mental health problems using a CBT approach has been offered in the UK. Women told us that they would not have felt safe to talk openly about their problems in a mixed group: '...the confidentiality that the other women show to all group members is amazing... if it was a mixed group... I can honestly say I would not have been as open and honest as I was.'

'Programme facilitators report that they experience leading the programme as "a shared journey" with the clients, and although hard work – emotionally and physically – at times, it can bring about change in a way often not seen in other areas of everyday practice.'

Helping Groups to Grow is named in recognition of the importance of enabling everyone to have the chance to change, develop and move forward. Key to this is enabling self-help and mutual support – service users who have completed the group programme can go on to become mentors to help others to attend future programmes. We are also working in partnership with SMART Recovery UK to train staff and service users as recovery champions and to deliver peer support groups. **DDN**

Kim Johnson is service coordinator of Pathways to Recovery at Helping Groups to Grow

Family favourite

'Family support should be everybody's business'

Viv Evans has been chief executive of Adfam for a decade, overseeing its transformation into a major umbrella organisation with dynamic research, campaigning and policy functions – 'if you don't influence policy then you can't influence practice,' she says. Today's economic and political landscape means the organisation has never been more vital, with family services – and many families – under increasingly intense pressure. Adfam has just published two free guides to help steer organisations through the financial and administrative changes – *Surviving the transition: local structures and networks* is designed to help services navigate changes in commissioning and accountability, while *Surviving the transition: organisational health* details what's necessary to stay 'legal, healthy and robust'.

What's her impression of the mood in the family support sector – how are organisations faring? 'It's not easy for anybody,' she says. 'It's partly the cuts, but having said that there are some small local family groups that have responded by making alliances – perhaps with a treatment agency or with other groups – and we're trying to help them to do that, to be flexible.'

Adfam was originally set up to support family members 'regardless of whether or not they had a user in treatment or whether or not they were actually engaged with, or living with, that family member', she points out. And while that agenda still stands, treatment providers are increasingly adding family support to their own provision. 'There's a fundamental philosophy about family support,' she says. 'At our conference *(see page 8)* what we were trying to do was raise that dilemma, because you can ask a group of people what family support means and they'll all have a different take.'

To some, it will be about parental substance misuse and getting the parents into treatment, while for others it will be 'recovery capital for the family member', she says, with some seeing very much as support in the family's own right. So while more treatment organisations may be providing family support, they're 'ticking off the family members of people who are in treatment', she stresses. 'And there are a hell of a lot more who suffer in silence.'

Family support has ostensibly been a central focus of government drug policies since at least the 2008 strategy – has she seen real evidence of that on the ground? 'There is a lot more awareness of the need to support families,' she says. 'Much more awareness, much more acceptance, but again, the challenge for us is to really make it clear that there are different types of family support. Because people lump it all together you can have difficulties gaining the evidence of what works. And the other thing to say is that family support services are being cut – services are being cut across the board, obviously – while the need for them is growing. That's the great dilemma of the current economic position.'

The 'counter-argument', she acknowledges, is that the government is putting resources into things like the Department for Communities and Local Government's troubled families agenda. 'But I'd go back to my point about family support meaning different things and where we find a home for

Adfam chief executive Vivienne Evans talks to **David Gilliver** about the challenges facing family support in a world of tight budgets and political change

it in policy and practice, because not every troubled family will have a drug and alcohol problem. If you try to pigeonhole it then it doesn't work.'

Family support should be 'everybody's business', she believes. 'Teachers should be aware of it, social workers, people who work in old people's homes – everybody should be thinking about how they can support the family, but being really clear about their underlying principle. Are they supporting the family to support a user, or in their own right, or is it about parental substance misuse and safeguarding? If they've got that right then the right interventions will follow.'

While increasing awareness of family issues since the 2008 strategy – and 2003's landmark *Hidden harm* report before it – meant that the statutory sector and large treatment providers became more interested in family issues, there was a knock-on effect for the rest of the sector, she explains. 'It meant a dilution of the small, local voluntary groups that were set up – like Adfam – by people with personal experience, whether that was people providing one-to-one support or telephone helplines from their kitchen. Now, because of the push towards volunteering and communities taking up these issues – rather than relying on the state to provide it – there's more of a role for us to help local groups respond to that central agenda.'

Commissioning changes and the move to Public Health England mean major challenges, and service provision for families is clearly no different. 'When the money was around that was reflected in the increasing number of services for families and children,' she says. 'Now that's gone the central driver has also gone, so the challenge for us is to support local groups and family services to influence local commissioning arrangements.'

Clearly, as the NTA acknowledges, drugs and alcohol are not going to be a priority for every local authority and every director of public health. 'There are an increasing number of organisations saying, "our campaigning message is that these people are stigmatised and hidden and they need specialist help around drugs and alcohol and family support",' she says. 'It isn't just a matter of putting it all into 'troubled families' or a generic parents' group. There's a need for some specialism, but there's also a political and financial reality about trying to make sure that more and more people across all services recognise that drugs and alcohol can be a key issue and that they need to be trained up to deal with it.'

She's consistently argued that stigma is something that extends to families – does she feel there's more awareness and acknowledgement of that now, or is there still a lot of work to be done? 'I think that's the next thing that Adfam needs to do – to really bang on about that even more. We've been saying it for years, particularly around alcohol, and the effect that can have in a subliminal way on families is often quite acute. So it's about getting people to talk about alcohol in the family. When I first started working in health education, going back nearly 40 years, we used to go to factories in the lunch break and talk to women about breast self-examinations and getting cervical smears and it was really difficult, because people just didn't talk about cancer. Now we can talk about cancer but we don't seem to be able to talk about the impact alcohol is having on families.'

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Viv Evans came to Adfam from DrugScope where she'd headed up a joint education and prevention project with Alcohol Concern, and – apart from a brief period as a teacher – she's always been in the health sector, starting as health education officer for Leicestershire County Council in the early '70s. 'The job was to promote health messages, sticking up leaflets about sexually-transmitted diseases in toilets,' she says. 'And, from a systems point of view, it's very much gone back to that now – it was a population issue, about promoting public health.'

Health education led her to Tacade where she was involved in preventing drug and alcohol misuse among young people, and, increasingly, parental work. She joined the Advisory Council on the Misuse of Drugs in 2000 and was part of the working group that produced *Hidden harm*, which proved highly significant not just for the sector but also for her. 'I was able to bring that into Adfam,' she says. 'There was a lot of direct work then but over the years I've tried to take things in a direction that's much more around prevention and generic issues – whole family issues and looking to see where drugs and alcohol fits into that.'

A defining moment was getting funding from the Esmée Fairbairn Foundation in 2009 which allowed Adfam to set up its campaigning, research and communications functions and become an umbrella organisation able to provide training and policy briefings as well as guide other groups in the family support sector – who can sometimes feel as isolated as those they help. How would she like the charity to look five years from now?

'I'd like us to be financially stable and to have helped more families to get help, in whatever way that is,' she says. 'I'd like to think that whoever you were, if you'd got a problem you'd be able to get that help from somewhere – maybe from a GP, maybe from a specialist service. It may be that you just need some information, or you'd benefit from a much more structured and therapeutic intervention. Whatever your need is, I'd like those family members to get that support.'

She was awarded the OBE in 2008 – how did that feel? 'Surprising,' she laughs. 'And an excuse to get a new frock and have a celebration. I was really pleased for Adfam and the sector that the issues I feel passionate about had been recognised – that was nice.'

The challenge the organisation faces now is to continue to make its case, she stresses. 'I think our role is absolutely vital and necessary, but if you're not a big service provider it can be difficult as that tends to be where a lot of the money is going in the voluntary sector – understandably so.

'I think it's kind of about "keep calm and carry on" now, really. We have to continue to support small local groups while also recognising that if the direction of travel and finance and government policy is towards recovery and the big treatment providers then we've got to be flexible enough to recognise that too.' **DDN**

Ignore primary care based drug and alcohol treatment at your peril, says **Kate Halliday**

Treatment hub

SMMGP is increasingly concerned about reports of the decommissioning of primary care based drug and alcohol treatment. Some seem to be suggesting that treatment in primary care is incompatible with the 2010 Drug Strategy's aim for recovery. Following on from Steve Brinksman's *Soapbox* article (*DDN*, February, page 23) here are four important reasons why localities are putting drug users, their families and their communities at risk if they do not involve primary care based services in their treatment systems.

1. Primary care based drug treatment offers choice

The average day for a primary care clinician involves balancing risks and complexities, which is why providing drug and alcohol treatment can seem like second nature, given the right support. It has long been established that primary care provides effective treatment, and many patients would rather visit their local medical practice than the local drug team. Stigma, distance to travel, and familiarity all play a part.

That is not to say we do not need specialist services; for some patients the level of expertise offered by secondary care is essential. The 2010 Drug Strategy suggests that a 'one size fits all' model will not meet the needs of individuals, and SMMGP agrees. The best system for patients is that of primary and secondary care working together to provide a range of services from a range of settings, as it does across other health problems.

'Primary care based treatment has been characterised by some as a place where people are "parked on methadone" and as being "anti recovery". This is not our experience...'

Primary care based treatment has been characterised by some as a place where people are 'parked on methadone' and as being 'anti recovery'. This is not our experience and over the next few months SMMGP will publish evidence of the phenomenal success primary care based drug and alcohol services have in supporting people to become free of all drugs, including methadone. However, medically assisted recovery and stabilisation – recognised by the 2010 Drug Strategy and the Professor John Strang's interim report on recovery orientated drug treatment as essential parts of the treatment system – remain important options for patients, and primary care can offer this full range of treatment.

We find that when things don't work as they should, it is because the right structures and supports – needed for any multi-agency team – are not in place, rather than some inherent problem with primary care treatment. These can usually be fixed pretty easily.

2. Primary care based drug and alcohol treatment will help localities meet public health outcomes

People with drug and alcohol problems often experience poor health that goes untreated. Drug and alcohol users who receive their treatment in primary care have the advantage of also getting their general health needs met. The 2012 Public Health Outcomes Framework includes the following domains: improving the wider determinants of health; health improvement; health protection; and preventing premature mortality. While all the indicators have yet to be defined, improvement in the health of drug and alcohol users are included in the domains, and localities will be monitored on their progress by Public Health England and given financial incentives where they are achieving these indicators.

3. Primary care is the perfect setting for recovery

In his recent article (*DDN*, February, page 20) David Best suggested that a crucial role of specialist services in providing a recovery oriented service was 'that the specialist service and its link to partner agencies such as housing and primary care enable the person to grow well and safe enough to make recovery choices'. There is no better way of achieving this than by placing services within primary care.

Primary care does not simply offer health interventions; it offers a multi-agency service in people's communities. The primary care team has often known the person using drugs and/or alcohol for years, and also their families. GP surgeries offer a range of services, from mental health to health visitor support – SMMGP is aware of interpreter services, Citizens Advice Bureaux and a mobile dental van being available from GP surgeries!

4. Involvement and commitment from primary care underpins the future stability of drug and alcohol services

The commissioning landscape is changing, and public health and wellbeing boards will be responsible for commissioning drug and alcohol services as of April 2013. Clinical commissioning groups consisting of primary and secondary care doctors will feed in to this process, and will become a powerful local force. As the landscape changes, the need to address the burgeoning health problems related to alcohol increases. The more primary care is involved in delivering drug and alcohol treatment, the greater its understanding and commitment to the future of these services will be.

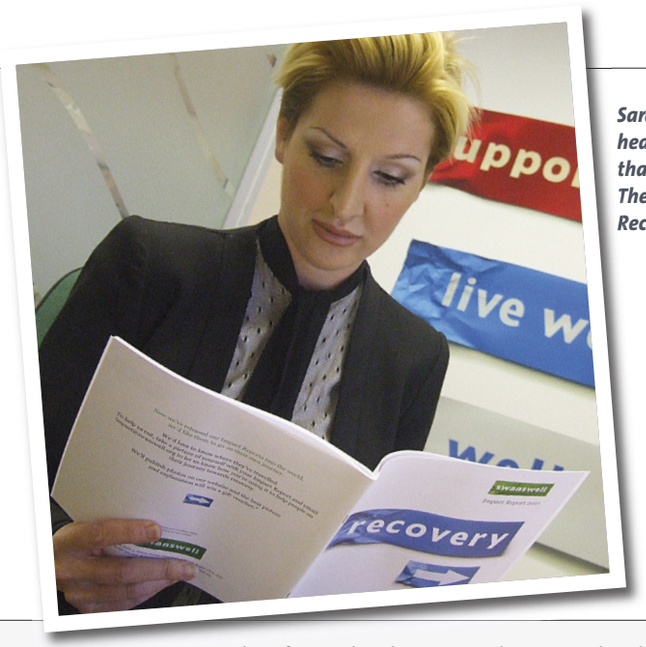
Primary care can also feed important information into the commissioning process; patients often do go to their GPs about drug problems. With the changing patterns of drug use, including growing concerns about legal highs and addiction to medicines, primary care involvement in commissioning will provide an understanding of, together with solutions to, what is happening in local communities.

If commissioners feel that their primary care based drug and alcohol services are not performing as well as they could, SMMGP can offer advice. Our experience is that it is more effective to make changes to improve quality, rather than to go through the upheaval of decommissioning services. Contact us at www.smmgp.org.uk

Kate Halliday is SMMGP policy and development manager

Recovery in PRACTICE

Putting people in charge of their recovery and actively working with their GPs, family and friends is a logical way forward, writes **Sarah Brighton**



Sarah Brighton heads the team that has developed The Swanswell Recovery Model

FOLLOWING THE GOVERNMENT'S 2010 DRUG STRATEGY, treatment in the UK is changing. There's a new emphasis on freedom from dependence, improved mental and physical health and wellbeing, prevention of bloodborne viruses, and improved relationships with family, partners and friends.

With this in mind, national drug and alcohol charity Swanswell has developed a new recovery model. It builds on the 'tidal' model from the mental health field, the core assumptions of which fit well with substance misuse recovery objectives:

- *Change is constantly happening, with even small changes ultimately having a big effect.*
- *Focus should centre upon the development of the client's future and their independence.*
- *The client's experiences are vital and need to be explored safely and holistically.*
- *The relationship between practitioner and client is collaborative, with change occurring for both.*

Swanswell has been delivering successful shared care services in Birmingham for over a decade with substance misuse workers already well established in GP practices, offering sessions that are integrated into existing surgeries. So this was considered an ideal environment to develop and pilot the Swanswell Recovery Model because strong collaborative relationships between clients, team members, GPs and pharmacists are already working well.

Many existing models involve substance misuse practitioners translating the client's story into the third person and framing it against their own recognised domains and indicators. Swanswell's model advocates that the client tells their story in their own words, using their personal experience to identify their recovery objectives.

GPs have a vital role to play in the model, bringing their support networks into the treatment process and enabling collaborative working with significant others in the community. In addition, GPs with Special Interest (GPwSI) act as mentors to other GPs and are often involved in service reviews at each practice.

Over a six-month period, Swanswell ran a pilot with more than 500 existing clients accessing GP surgeries in shared care settings in Birmingham. They were split into two teams – the 'recovery group' (309 clients) and the 'control group' (225 clients).

All practitioners involved with the recovery group were given full training in the delivery of the new recovery model. Shared care GPs participating in the pilot were also fully briefed and engaged and were very enthusiastic about using it. Practitioners in the control group did not have access to the training, model or the Swanswell detoxification and rehabilitation workbook, used alongside the model.

Following the six month pilot, Swanswell found promising evidence that this new approach worked as a way of helping people move away from maintenance prescriptions, become drug free and make positive changes in their lives.

Findings showed a 168 per cent increase in clients accessing inpatient or community detox programmes (compared to a 0 per cent increase in the control group). Twice as many clients on the new programme came off methadone maintenance prescriptions compared to those in the control group, and more than twice as many clients reduced their dose levels of substitute medications.

In addition, clients trying the new model in shared care showed significant positive behaviour changes in terms of their overall health and wellbeing as measured by Treatment Outcome Profile data (an increase of 50 per cent on average, compared with 16.5 per cent for the control group) and experienced a 54 per cent positive change (measured by clients who either detoxed or reduced substitute medication dosage) – double that of the control group.

Swanswell is running a larger scale pilot to gather much more evidence of the model's effectiveness, rolling it out across all of the charity's existing drug services. We would also like to hear from other drugs services who would be interested in taking part in a larger pilot.

Sarah Brighton is Swanswell's business development manager who, along with a team of service users, practitioners and managers, created the Swanswell Recovery Model. For further information, please call Sarah on 01788 559400. An electronic copy of the Swanswell Recovery Model evaluation report will be available shortly at www.swanswell.org

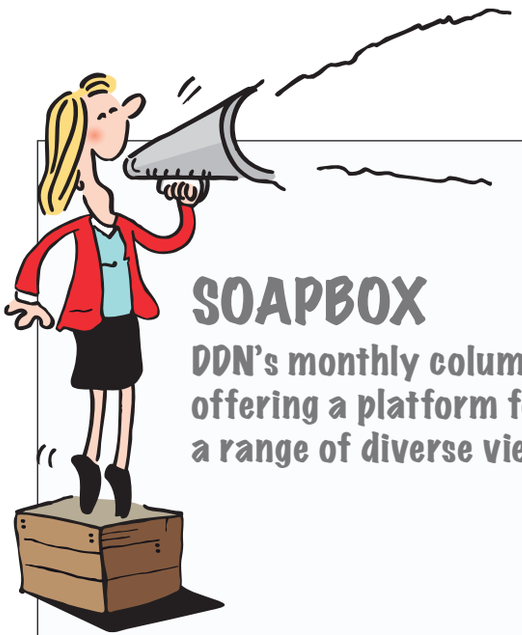
'I've got my old life back again'

Alan's been in treatment with Swanswell since 2004. He'd stopped using illicit substances some time ago but found coming off his methadone prescription a big challenge.

Before trying the new model, Alan had been attempting to reduce his medication gradually, but had many anxieties about it. This meant the reductions had been sporadic and slow, leaving him feeling further demotivated and lacking in confidence in his ability to become medication free.

Using the model, Alan and worker from the recovery group were able to explore different treatment options. He restated his recovery goals and increased his confidence to achieve them.

A few months later, Alan successfully completed a community detox, supported by his worker and GP. To date, Alan remains free from illicit drugs and methadone, exiting drug treatment positively after eight years. He said: 'I didn't realise being on methadone was like living your life through a fog. I've got my old life back again. I have far more energy.'



SOAPBOX

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

ALL THAT IS SOLID MELTS TO AIR

With turbulent change ahead we should resist the urge to start polarising the agenda, says Marcus Roberts

DESCRIBING THE IMPACT OF CAPITALISM in the 1848 Communist Manifesto, Karl Marx and Friederich Engels observed that 'all that is solid melts to air, all that is holy is profaned'. This is a rather apt – if bombastic – prospectus for the change that will hit drug and alcohol services in April 2013.

In 12 months time, the National Treatment Agency will have been absorbed into the new public health service. The 'ringfenced' pooled treatment budget (PtB) may have disappeared into a general public health pot. Local authorities will be managing the next instalment of cuts anticipated for their 2013-14 budgets. Meanwhile primary care trusts will have been replaced by clinical commissioning groups, health and wellbeing boards will be emerging from their shadows, elected police and crime commissioners will be in post, further welfare reforms will be implemented... and the list goes on.

What will the impact of all this change be in practice? Are we on the cusp of a revolution for drug and alcohol services in England? Or is a lot of this likely to prove more like surface turbulence with equilibrium quickly restored and more limited impact on services addressing drug and alcohol problems?

The big fear is that local authorities will disinvest from drug and alcohol services once they have more discretion over their budgets – particularly given a 14 per cent cash terms fall in their overall budgets in the Spending Review period. There is no getting away from the fact that the expansion of drug treatment in England has been centrally driven – it is a product of the NTA, PtB and, indeed, of public service agreements or PSAs. It also happened at a time when public spending was increasing.

Last time the responsibility for treatment lay with local authorities the picture was not rosy. In 1998, New Labour's first drug strategy declared that 'the scope, accessibility and effectiveness of available treatments are inconsistent between localities and generally insufficient', adding 'there is considerable insecurity about funding and disparity of provision'. Where local authorities now have more discretion over budgets the warning signs are there – including cuts to young people's services and a drop in available housing support since the ring fence was removed from Supporting People funding.

By April 2013 the new police and crime commissioners will also be allocating budgets that currently help to fund drug and alcohol services, including the Community Safety Fund and a significant chunk of Drug Intervention Programme money. With the Community Safety Fund falling by 60 per cent from 2010-11 to 2012-13, the director general of the crime and policing group at the Home Office wrote to local authority chief executives in February 2011 to reassure them that ministers intended that 'other funding streams, including DIP grants, will be consolidated with community safety funding for PCCs in 2013/14 and 2014/15 and thus provide them with a significantly larger unringfenced budget overall'. The clear implication is that DIP money could be used to plug the gaps in community safety funding.

So is it all doom and gloom then? Not at all. The government appears to recognise the importance of drug and alcohol services and the vision of recovery-orientated treatment set out in the 2010 Drug Strategy is to be applauded. Localism itself creates real opportunities to work in a more collaborative way that responds to local needs and priorities. The 'ringfence' around the pooled treatment budget has not always been the sort of fence that you chat to the neighbours over, but sometimes more like an electrified fence festooned with 'keep out' signs.

Behind the scenes a lot of thought is being given in government to how the drug and alcohol spend can be protected after April 2013 (expect some combination of national indicators, grant conditions and transparent monitoring and reporting). But even if these protections are effective there is still a real risk of disinvestment from local sources, which accounted for around 55 per cent of the drug treatment spend in 2008-09.

It might be rather facetiously concluded that the prevailing view in government is that localism will work out fine for drug and alcohol services so long as we don't actually do it. A more balanced conclusion is that we should resist the temptation to think in terms of simple polarities – we do not need to choose between 'centralism' and 'localism' any more than we had to choose between 'harm reduction' and 'abstinence'. There is a middle way between 'bureaucratic centralism' and laissez-faire postcode lotteryism, as there is between truculent oppositionism to reform and stoical mustn't grumblism. Strategically, we need to engage constructively with the recovery agenda and the challenges and opportunities of a more localist response without compromising the messages on the dangers of disinvestment, which are real and present.

Marcus Roberts is director of policy and membership at DrugScope

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Please contact Darren Rolfe on 01582 730 113 or email Darren@pcpluton.com

www.rehabtoday.com

INVITATION TO SERVICE PROVIDERS

COMMISSIONING OF NEW DRUG AND ALCOHOL SERVICES FOR HMP BELMARSH AND HMP/YOI ISIS

Royal Greenwich in Partnership with HMP Belmarsh and HMP/YOI Isis are arranging an open day event in the Belmarsh conference centre on Monday 21st May 2012, we would like to extend this invitation to current and potential providers of substance misuse services.

The formal invitation to tender will not be published until July 2012 but the purpose of the open day is to allow interested bidders an opportunity to speak to managers that are currently involved in the delivery of drug and alcohol services and management of the establishments. This will give providers additional time and opportunity to develop and tailor their services specifically to the establishment needs. It may also allow time for partnerships to form between specialist agencies that may wish to bid as expert consortiums.

For more information and to confirm attendance please contact neil.airey@hmps.gsi.gov.uk

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For more information and an application form please refer to our website at www.blenheimcdp.org.uk or telephone our Human Resources Dept on 0207 582 2200.

NHS
Buckinghamshire and Oxfordshire Cluster

TENDER FOR NON-CLINICAL SUBSTANCE MISUSE SERVICES

NHS Buckinghamshire (Buckinghamshire PCT) is requesting tenders for the provision of Non-Clinical Substance Misuse Services at Aylesbury Young Offenders Institution, HMP Grendon and HMP Springhill.

The www.supply2health.nhs.uk advert has now been published, ref CP/1/12/0029. The closing date for PQQ submissions is 16 April 2012.

The *PQQ Instructions/Guidance and Questions* have been published on the **www.pro-cure.bravosolution.co.uk** website; **the PQQ reference No. is pqq_28931**. These documents are accessible to any organisation considering submitting a response.

The contract will run for a period of 2 years commencing 1 October 2012, and may be extended, subject to satisfactory performance, for an additional two years (two, one-year extensions).

Should you require any assistance in accessing or registering on the e-tendering website please contact the Bravo e-Tendering Helpdesk – Phone 0800 011 2470 and/or email help@bravosolution.co.uk.

For any other enquiries please contact Mark Stanbrook on 07879 603466 or by email at mstanbrook@nhs.net

Greig House Addiction Services

STAFF NURSE

Harbour Recovery Centre

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You will be responsible for the clinical management of service users undergoing detoxification from drugs. Your strong communication skills will help you to determine individual care plans and enable service users to be successful in their aim of rehabilitation.

You will be RMN or RGN with at least two years experience in substance misuse, and the management of addictions, with knowledge of current treatments and philosophies of care. Your expertise and a non-judgemental approach are key as is your input into promoting best practice within the team.

This position includes internal rotation to night duty

If you require an application pack please contact Greig House reception on 020 7987 5658. If you would like more information or an informal visit please contact Tarlok Singh, Team Leader, on 020 7987 5658.

Closing Date for applications: 23rd April 2012.

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turning-point.co.uk/workforus

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