NO.1 IN THE SUBSTANCE MISUSE FIELD

DDN
Drink and Drugs News

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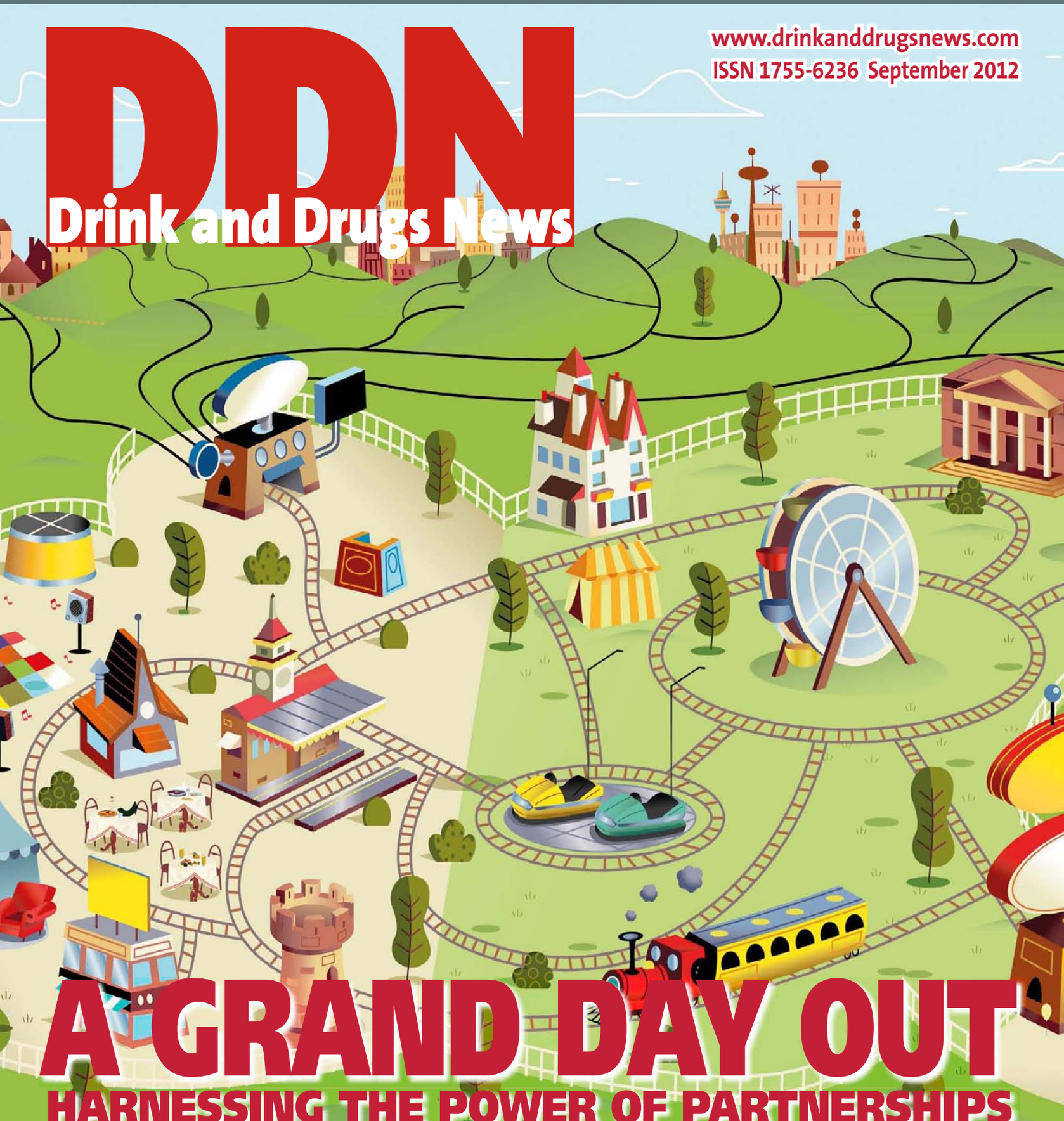


A GRAND DAY OUT
HARNESSING THE POWER OF PARTNERSHIPS

PCP
a new beginning

PERRY CLAYMAN PROJECT – CLAPHAM

PCP opened its doors to Clapham due to the great success stories of clients who have come through our programmes in Luton and Chelmsford. In Clapham we cover the whole spectrum of addiction, including full medical assessments and facilitating detox. We offer a full residential programme based on the abstinent 12 steps of recovery and this is supported by many holistic therapies. Clients will also be entitled to free aftercare for a period of 12 months as long as they complete their respective treatment programmes. We also take into consideration the damage addicts cause their families so we have a family programme to help understand what addiction, tough love and healthy boundaries mean, and also guide family members to the right areas of help in the hope they meet like-minded people and find their own recovery.

DAY CARE AT PCP CLAPHAM

An extremely effective day care programme is offered at our centre in Clapham. It could be that you live within easy commuting distance of our centre or you simply prefer to attend a structured treatment course as a day care client, but whatever the reason here are a few important key facts about our day care programme in Clapham:

- *Tailor-made care plan for the duration of your stay*
- *1-12 week programme*
- *Monday to Friday 09.00 – 17.00 with lunch included*
- *Doctor' s medical assessment and detox available*
- *Group therapy*
- *1-2-1s*
- *Workshops*
- *12-step assignments*
- *Holistic therapies (art, yoga and nutritional guidance)*
- *Meditation*
- *Weekly aftercare for a period of 12 months free of charge.*

ONGOING DAY CARE SUPPORT

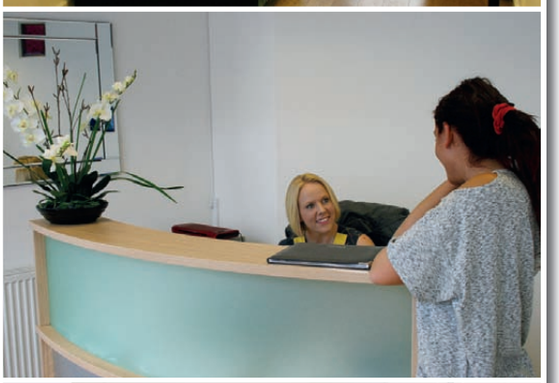
After treatment has been completed we recommend ongoing support whereby you can start to integrate back into society gradually, having been treated at our centre as a residential client. There is strong evidence to support that by attending our clinic after a period of rehabilitation, the ongoing support reinforces integration and reduces the risk of relapse and behavioural slips. It will also enforce your daily structure, which is so important in the early days of recovery and additionally gives you a safe place to process your daily life realities and changes with help and support around you from people who understand what you are going through.

Our reduction programme starts from five days a week and reduces down to one day a week in the fifth week. However, there are other programmes available to suit your individual needs.

Please contact our admissions team and speak to Darren or Jade on 08000 380 480 or 01582 730 113

or see our website for more information:

www.rehabtoday.com



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Joint-thinking

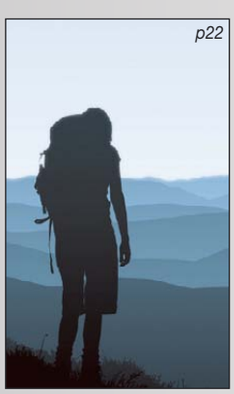
When several heads are better than one

Joint-working may be an overused phrase but it's a woefully underused concept where homelessness is concerned. The government's new report promises to bring together health and housing sectors to improve the outlook for homeless people with a dual diagnosis; our news focus (page 6) looks at its chances of success. If proof were needed of the potential of partnerships, Stephen Birrell shares the story of Glasgow's GRANDweek (page 8), an inspiring example of how joint-working can give highly effective results.

In this month's Soapbox, Oscar D'Agnone reminds us that 'nothing has been more contentious than the divide between the proponents of the abstinence approach and the defenders of substitute prescribing', a fact borne out by DDN letters pages over the past eight years. Worth noting, then, that we have a rare strand of consensus running through this issue. Recovery should only be defined by the individual, says our GP columnist Dr Steve Brinksman (page 17), while Bill Nelles (page 10) makes a highly informed personal case for every service user getting the treatment they want.

In other news, we've moved! Please note DDN's new address (left). You can reach us on the same phone numbers for the time being and our email addresses will be staying the same.

This issue



FEATURES

REGULARS

NEWS IN BRIEF

COURT APPEARANCE

The UK's second Family Drug and Alcohol Court will be established in Gloucestershire this autumn, following a successful project in London (*DDN*, 3 December 2007, page 5). The service – a partnership between Gloucestershire County Council, NHS Gloucestershire and Her Majesty's Courts and Tribunals Service – aims to support children experiencing neglect by shortening the time it takes to resolve care proceedings. Drug and alcohol professionals, social workers, mental health staff and health visitors will provide coordinated support, with families seeing the same judge throughout. The intention is to 'give families struggling with drug and alcohol problems intensive support to turn themselves around,' said cabinet member for vulnerable families Paul McLain. 'The focus will be on the family's needs, concerns and strengths, with everyone working towards the best possible outcome for the children – a stable and safe home.'

ON THE ROAD

The theatrical adaptation of Elizabeth Burton-Phillips' book *Mum Can You Lend Me 20 Quid? What Drugs Did To My Family* (*DDN*, October 2011, page 20) will be on tour in the autumn, with performances at the Citadel Arts Centre, St Helen's (25 -26 October) and Alba Theatre, Wigan (27 October), followed by HMP Reading (29 November) Oxfordshire DAAT annual conference (30 November) and HMP Peterborough (3 December), with more dates to be announced soon. Merseyside Police has also commissioned the play for performances next spring. *More information at www.drugfam.co.uk*

MAKING THE CASE

A new briefing paper on young women and drugs has been produced by Youth RISE and the HIV Young Leaders Fund. *Ain't I a woman? Recognizing and protecting the rights of young women affected by HIV and drug use* describes how young female drug users are particularly vulnerable to HIV and poorly served by mainstream health services and policy makers. *Available at www.youthrise.org*

MATERIALS OF SUBSTANCE

A new training resource for people working with families where there is problematic parental substance use has been produced by the Substance Misuse Skills Consortium. The manual includes group-based training exercises designed to help improve the wellbeing and safety of children. *Leading for outcomes: parental substance misuse available at www.skillsconsortium.org.uk*

Scots record highest ever drug deaths

More drug-related deaths were registered in Scotland in 2011 than in any previous year, according to figures released by National Records for Scotland. There were 584 deaths, says *Drug-related deaths in Scotland* in 2011, an increase of 20 per cent on the previous year.

Six of the past ten years have seen increases, with an overall increase of 76 per cent since 2001. Although 73 per cent of those who died were male, the number of female deaths was the highest ever, with a 117 per cent increase in 2007-11 compared to 1997-01. The percentage increase among men over the same period was 85 per cent.

Thirty-six per cent of all deaths were among 35 to 44-year-olds and 32 per cent among 25 to 34-year-olds, with the largest percentage increases recorded for 35 to 44 and 45 to 54-year-olds. There was, however, a fall in the number of deaths among those aged under 25. More than 30 per cent of deaths were in the Greater Glasgow & Clyde NHS Board area.

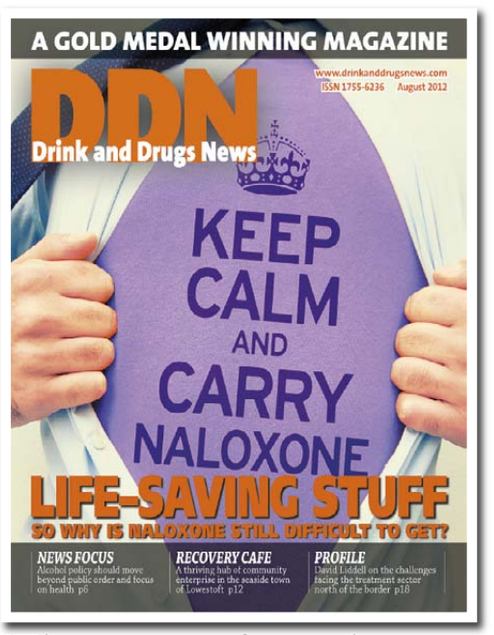
Methadone was 'implicated in, or potentially contributed to' 275 of the deaths (47 per cent) compared to 174 in 2010, which has led to calls in some parts of the Scottish press for a parliamentary inquiry into substitute prescribing. Leader of the Scottish Conservatives, Ruth Davidson, also issued a statement that the 'appalling loss of life illustrates the human disaster that is the methadone programme. It would appear hundreds of families are being blighted by what is little more than legalised drug-taking on an industrial scale.'

However it is unclear how many of the people who died had been prescribed methadone, as the information is not collected by the death registration process or pathologists' questionnaires. Methadone, potentially combined with alcohol, was recorded as a 'strong factor' in 112 of the deaths and the sole cause of death in 14.

The report was a 'stark reminder of individual human tragedy and the scale of wider social need in Scotland' said Biba Brand of the Scottish Drugs Forum (SDF). 'Wide-ranging income, health and social inequalities continue to devastate the lives of many people and the communities they live in – to the extent that services are now seeing their third generation of families seeking help for drugs problems.'

National coordinator of the SDF's government-funded take home naloxone programme (*DDN*, August, page 4), Stephen Malloy, added that the statistics were 'a reminder that the vast majority' of deaths were opiate-related overdoses. 'There remains a huge amount of work to be done to ensure adequate supplies of take home naloxone are available in Scotland's communities,' he said.

Meanwhile, figures from the Office for National Statistics show that drug poisoning deaths – involving both illegal and legal drugs – in England fell by six per cent for men and three per cent for women between 2010 and 2011. The overall number of male drug misuse deaths (involving illegal drugs) fell by 14 per cent to 1,192 in 2011 but female deaths increased by 3 per cent to 413. Deaths involving heroin/morphine decreased by 25 per cent – although these were still the substances most commonly involved in poisoning deaths – with the mortality rate among males falling by 39 per cent in two years.



'There remains a huge amount of work to be done to ensure adequate supplies of take home naloxone are available in Scotland's communities.'
Stephen Malloy

The report cites the ongoing 'heroin drought' since late 2010 as a possible cause, with availability remaining low in some areas and consequent falls in purity. 'Drugs workers were concerned that the heroin drought may result in more drug-related deaths, as users who had developed a reduced tolerance could overdose if they used a high quality batch of heroin,' it says. 'However, ONS data show the opposite trend with deaths involving heroin falling in recent years.'

There were nearly 300 drug poisoning deaths involving benzodiazepines, with mortality rates among men reaching an all-time high of eight deaths per million population in 2011, while deaths involving barbiturates and helium have increased consistently over the last five years, despite the number of prescriptions for barbiturates more than halving over the same period.

Reports at www.gro-scotland.gov.uk and www.ons.gov.uk

Homelessness report slammed

Homelessness charities have criticised the government's new report into preventing homelessness, in the light of ongoing welfare reforms.

While *Making every contact count* sets out a 'cross-governmental approach to ensuring that anyone at risk of homelessness gets help at the earliest possible stage' and details 'clear commitments from government to stop the slide towards homelessness in its tracks', housing charities have warned that cuts to services and benefit reforms risk dramatically worsening homelessness rates.

The report pledges earlier support for people with drug, alcohol and mental health issues, young people and prisoners, as well as improved joint working between the health, criminal justice, local government and voluntary sectors. Housing minister Grant Shapps also announced an extra £3.5m funding for the 'No second night out' initiative which aims to stop anyone spending more than one night on the streets.

'No single voluntary service, government agency, council or government department can prevent homelessness alone – but working together we can make a big impact,' said Mr Shapps. 'Every single contact these vulnerable people have with our public services – from council drop-ins to healthcare visits – should be made to count, turning prevention into the cure for anyone facing the real and frightening prospect of sleeping on the streets.'

The umbrella body for homeless charities, Homeless Link, however, said that while the report's vision that 'homelessness is everyone's business' was to be welcomed, the potential for welfare reform to 'further fuel homeless numbers and funding cuts to the very services that help homeless people' meant that the report lacked detail in how its aims could be achieved in practice.

Crisis called the report a 'missed opportunity' that failed to address the key issues of lack of support for single homeless people, the impact of cuts and the 'desperate shortage' of housing, while the Local Government Association (LGA) said the document 'missed the bigger picture'.

'Councils are working closely with partners to place people into secure, appropriate accommodation and provide the most comprehensive support they can, whether that be equipping them with the skills to find work or ensuring their health and wellbeing,' said chair of the LGA's environment board Mike Jones. 'However, this is only getting tougher as a result of job losses, rent increases and welfare cuts. Councils, who are contending with significant cuts to their budgets, cannot do this alone and the future of this type of support will be dependent on the whole public sector sharing resources and working together.'

Report at www.communities.gov.uk

See news focus, page 6

Heavy cannabis use can cause lasting cognitive problems in young

Persistent cannabis use is associated with 'neuropsychological decline' among those whose use began in adolescence, says a new study.

The findings are 'suggestive of a neurotoxic effect of cannabis on the adolescent brain' and highlight the importance of 'prevention and policy efforts targeting adolescents', concludes *Persistent cannabis users show neuropsychological decline from childhood to midlife*.

Researchers followed more than 1,000 people in Dunedin, New Zealand, from birth until the age of 38, with participants undergoing memory, intelligence, problem-solving and other neuro - psychological testing at age 13, before cannabis use had begun, and again at 38, 'after a pattern of persistent cannabis use had developed'.

The IQ of those who had been regular cannabis users in their youth was found to have dropped by an average of eight points, a finding not replicated in those whose use began after the age of 18. The study also found that stopping use of the drug 'did not fully restore neuropsychological functioning among adolescent-onset cannabis users'.

Study published in the Proceedings of the National Academy of Sciences of the United States of America www.pnas.org

Fatal anthrax case in England confirmed

The Health Protection Agency (HPA) has confirmed that an injecting drug user with an anthrax infection has died in hospital in Blackpool. The case is the eighth to be identified since June, with one in Scotland (*DDN*, August, page 4), three in Germany, two in Denmark and one in France.

The HPA says it remains 'unclear' whether the UK cases are linked to those on mainland Europe but in all instances the source is presumed to be contaminated heroin. The cases are the first among injecting drug users since the Scottish outbreak of 2009-10, which was the largest UK 'common source' anthrax outbreak in humans for half a century (*DDN*, January, page 6). Before that, only one case of a drug user infected with anthrax had ever been reported, in Norway in 2000.

A rapid risk assessment by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and European Centre for Disease Prevention and Control (ECDC) concluded that heroin users in Europe remain at risk of anthrax exposure, and that 'it is possible' that the batch of contaminated heroin has the same source as that of the 2009 Scottish outbreak.

'It's likely that further cases in people who inject drugs (PWID) will be identified as part of the ongoing outbreak in EU countries,' said HPA expert in zoonotic infections, Dr Dilys Morgan. 'The Department of Health has alerted the NHS of the possibility of PWID presenting to emergency departments and walk-in clinics, with symptoms suggestive of anthrax. Anthrax can be cured with antibiotics, if treatment is started early. It is therefore important for medical professionals to know the signs and symptoms to look for, so that there are no delays in providing the necessary treatment.'

Risk assessment at www.ecdc.europa.eu

NEWS IN BRIEF

A FULL ADMISSION

The Alcohol Health Alliance (AHA) has called on the government to make sure hospitals record when alcohol is an 'important contributing factor' to an admission as part of its response to a Department of Health consultation. The AHA is calling for the government to continue with the system of monitoring all alcohol-related conditions in official figures, as it concerned that any change would mask the true extent of alcohol-related health issues. 'Alcohol-related health harms aren't just about the obvious things you would associate with alcohol,' said AHA chair Sir Ian Gilmore. 'In 2010-11, 35 per cent of all alcohol-related hospital admissions were the result of high blood pressure attributable to drinking. These outnumber the admissions for alcoholic liver disease and alcohol-related accidents, violence and injuries combined.'

COMMUNITY RECOVERY

The second National Recovery in the Community Conference on 13-14 September will look at how recovery can become part of a community health strategy. Speakers at the Sheffield event include Carl Cundall of the Alcohol Recovery Community, Paul Hayes and Mark Gilman of the NTA, David Best of Monash University and director of Philadelphia's Office of Addiction Services, Roland Lamb. *Full details at www.sheffieldalcoholsupportservice.org.uk/conference. See October's DDN for a profile of Roland Lamb.*

NINE DAYS, NINTH MONTH

The FASD (Foetal Alcohol Spectrum Disorders) Trust is urging people to abstain from alcohol for the first nine days of this month and donate the money they would have spent to the trust instead, to help raise awareness of the condition. 'Mums-to-be get mixed messages in pregnancy,' said FSAD's Julia Brown. 'The most dangerous time is the first and last three months of pregnancy. The first three is when the foetus is forming physically; the last three is when the brain can suffer significant damage. The message should be that there is no safe time and no safe limit for drinking if you get pregnant.' In some areas of the UK, up to 90 per cent of children released for adoption suffer from FASD, with only an estimated 18-25 per cent of people affected able to live independently as adults. *Email info@fasdtrust.co.uk for more information.*

A MISSED OPPORTUNITY?

A new government report pledges to stop the slide into homelessness, particularly for those with drug and alcohol issues. But are these empty words in the wider context of welfare cuts? ***DDN*** reports

The Department for Communities and Local Government's *Making every contact count – a joint approach to preventing homelessness* has a 'simple aim', it says – to ensure that every contact between local agencies and vulnerable people and their families 'really counts' (see news story, page 5). To this end it intends to bring together government commitments to improve both joint working between the health and housing sectors and outcomes for homeless people with a dual diagnosis.

It also pledges to tackle 'troubled childhoods and adolescence', provide better advice about employment, skills and finances and improve access to housing for prisoners. Early engagement with drug and alcohol treatment agencies and interaction with the criminal justice system are critical points for identifying and helping those at risk of homelessness, the report states, and it praises the London Drug and Alcohol Network for supporting frontline organisations 'to work together strategically, share good practice and improve the quality of service delivery' for homeless people with drug and alcohol issues.

The government intends to work with local drug and alcohol treatment teams to 'develop sector-led guidance to improve understanding of how the two sectors can work together', with initial material promised later in the summer. Meanwhile, Homeless Link – the membership body for organisations working with homeless people in England – is being funded by the Department of Health to work with five local authority areas to support local services and commissioners to understand and identify clients with dual needs, and 'develop and disseminate effective service models'.

While homeless people with both mental health and substance issues might have a formal dual diagnosis, others will be undiagnosed or fall below treatment thresholds. Whatever the definition, however, they are often unable to access the services they need, project lead and Homeless Link policy manager Helen Mathie tells *DDN*. 'While effective approaches do exist, what impact will the changing NHS commissioning landscape and reduced funding have?' she says. 'At this time of change, we need to think creatively to make sure the most vulnerable do not fall through the gaps in services.'

Homeless Link will provide free support to the five areas over an 18-month period, helping to understand the extent of local problems and the needs of those with co-existing mental health and substance issues. It will also review the effectiveness of local practice, identify gaps and 'develop targeted solutions that take into account the new commissioning landscape'.

The aim is to bring 'measurable improvements' to the wellbeing of homeless people with co-existing issues, says Mathie. The project will also feed directly into future policy work, such as the ministerial working group on homelessness and the Department of Health's inequalities team, with solutions helping to shape an evidence base and share learning across the country.

The organisation is calling for extra commitments from the government, however, including the means to hold organisations to account if they don't provide good services, and to make sure that health, social care and other bodies understand the numbers of homeless people they deal with. Does this mean that there still low levels of awareness among these services about homelessness?

'We would say there is a low level of understanding in many areas,' she says. 'For example, housing status or need is not routinely asked about or recorded by many health services, so opportunities may not be taken to put preventative measures in place, such as referring someone for housing advice. There are indications that some homeless people also experience prejudice.'

In fact, a recent Homeless Link report found that more than 70 per cent of homeless people were being discharged from hospital back on to the streets (*DDN*, June, page 4), while others were turned away or experienced poor standards of care because they were homeless or deemed 'too difficult'. 'We also know that significant numbers of homeless people are refused access to a GP or dentist – often because these services demand specific forms of ID or proof of address, when in fact this is not required,' she says.

Ideally there should be routine training for health professionals on how to work with vulnerable or homeless patients, she states. 'There are some great examples of joint training sessions or networking between the sectors and this is something we would like to see far more of. The other thing that would help would be better recording of housing status and awareness of how to respond to a patient if they are homeless.'

While homelessness organisations have welcomed the report's aims, however, many have been highly critical about its publication in the context of ongoing welfare reforms, which, they say, risk both increasing the number of homeless people and the existence of the services designed to help them.

'Early engagement with drug and alcohol treatment agencies and interaction with the criminal justice system are critical points for identifying and helping those at risk of homelessness.'

The government has done much to 'encourage innovation in helping individuals off the streets', Mathie says, but some welfare reform policies 'threaten to make the homelessness problem worse, while many decisions about funding are made at the local level.

'The vision behind the government's prevention report – that homelessness is everyone's business – is welcomed, as is the ambition that we should all expect the best possible help if we find ourselves threatened with homelessness. However, if we are to realise the plan, we'll need strong commitment from government, councils and every professional group which comes into contact with homeless people.' **DDN**

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Anyone – be they left-wing, right-wing, centrist or totally non-political – can see Scotland's policy and attitude to dealing with drug misuse has to change. There needs to be a parliamentary inquiry into drugs in Scotland... and soon. As a country, we are struggling to find the money to reduce class sizes for our children and buy books for our schools. Yet we throw away £36m every year doling out more and more methadone in the face of less and less evidence that it achieves anything but line the pockets of those involved with dispensing it.
Daily Record editorial, 21 August

Rather than compel the criminal drug user to abandon his habit, the authorities force bus drivers, postmen, doctors, nurses and school dinner ladies to buy stupefying drugs for criminal parasites, who would otherwise steal directly to obtain them. The phrase 'legalised theft' can seldom have been more apt.
Peter Hitchens, *Daily Mail*, 25 August

Police chiefs are still peddling their softly, softly sociological claptrap about 'engaging with the community' – which is little more than an excuse for turning a blind eye to drugs dealing, petty crime and intimidation on sink estates.
Richard Littlejohn, *Daily Mail*, 7 August

Amy Winehouse's ex-husband Blake Fielder-Civil was on a life-support machine last night after collapsing following a cocktail of drink and drugs... The junkie – said to have also taken heroin – was rushed to hospital in Dewsbury, West Yorks, with multiple organ failure... Sarah Aspin, mother of the junkie's 15-month-old son, has been at his bedside every day since his collapse.
Sun news story, 9 August

If we really can make every contact with all agencies count, as [*Making every contact count*] aims, then it will be a big step towards effective prevention. But this bold vision will be undermined if policies elsewhere, such as welfare reform, lead to increased homelessness. With homelessness services facing an average funding cut of 15 per cent last year, progress will also be hampered if there is not the local commitment to protect the very services that are critical to preventing homelessness.
Alice Evans, *Guardian*, 20 August

Claiming that drug addiction is a disease does a disservice to those who really do have a disease through no fault of their own, with no say in the matter. Yet drugs clinics are full of addicts claiming that it is not their fault and health workers vigorously agreeing with them. They are coddled in sympathy and benevolence. Rather than pander to this no-fault notion, wouldn't it be better to apply the big poultice of tough love instead?
Jan Moir, *Daily Mail*, 10 August

It is no accident that the permitted recreational drugs are those that have long been prevalent in 'developed' western societies, while the outlawed ones include those that are widely used by indigenous people in poorer countries.
Amanda Feilding, *New Statesman*, 8 August

That is the problem with the [Russell] Brand model. As Sardar once wrote: 'Just because you've been an inmate in a mental hospital, doesn't mean you are an expert in clinical psychology.'
Yasmin Alibhai-Brown, *Independent*, 12 August

LEGAL LINE

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

CAN I GET MY MONEY PROBLEMS BACK UNDER CONTROL?

READER'S QUESTION:

My Employment and Support Allowance (ESA) was stopped after I failed a medical. Then my housing benefit stopped and apparently I've been paid too much as well. I already had rent arrears and have been threatened with eviction before. I didn't open the letters for a long time because I knew they were serious and I was scared and it looks like I've missed all the deadlines to do anything. I have no money and I'm really worried about losing my flat.

KIRSTIE SAYS:

You are right that there are usually deadlines to appeal decisions and make applications, but often discretion can be used outside of this time where there are good reasons for delay. Not opening your post because of worry and anxiety linked to depression can be a good reason – if possible you should get some independent supporting evidence from a medical professional about how these conditions affect you.

You can ask to appeal the ESA decision out of time, and if accepted you will be placed on an appeal rate of the benefit. You can also request that this be backdated to the date the benefit stopped originally.

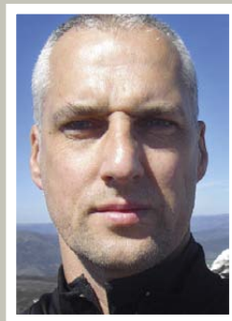
Your Housing Benefit (HB) would have stopped because you were no longer entitled to ESA. However, you don't need to be receiving a benefit to get HB – you can be paid it if you have a low income or even no income. You can make a backdated application for HB based on having no income at that time – you will need to make a statement to this effect and support it with bank statements and letters from people who helped you financially at the time. If this is accepted, it will cover the time you are supposed to have been paid too much HB and also the time where you have not been paid any at all. This means you won't have to pay anything back, and your rent will be paid.

If you deal with these matters quickly it is unlikely that any action will be taken about your flat. Landlords generally try to resolve things before taking legal action. Even if they have taken this step, it can be withdrawn, and possession proceedings can take a long time.

In relation to the old rent arrears, you should consider applying for a Discretionary Housing Payment to cover the full amount. If this is not accepted you should make sure you are repaying the arrears at an affordable rate – for social housing there is a statutory minimum for people on benefits of £3.55 per week.

It may seem like there is a lot to do but your local CAB or law centre should be able to help with making calls and writing letters to the various departments on your behalf.

Email your legal questions to claire@cjwellings.com
We will pass them to Kirstie to answer in a future issue of DDN.
If you need advice on any of these issues contact the Release helpline on 0845 4500 215 or ask@release.org.uk



By using partnerships to create an imaginative week of activities, Glasgow is successfully involving the community in drug and alcohol awareness, as **Stephen Birrell** explains

The second week in September has come to hold a very special interest for alcohol and drug forums, community groups, voluntary organisations and statutory services across Glasgow. Since 2007 it has been highlighted as GRANDweek – Getting Real About Alcohol 'N' Drugs – a citywide initiative that enables communities to develop local responses to alcohol and drug issues.

GRANDweek brings together a broad range of partners to raise awareness of alcohol and drugs issues and services. It builds partnerships and networks between communities, services and organisations and gets communities involved in tackling alcohol and drug issues.

This year's event takes place from 8-15 September and includes an extensive programme of almost 80 locally led activities across Glasgow, with a major event taking place in each community health partnership (CHP) sector. Events are funded through a local grant scheme of up to £1,000 for community groups and projects as well as allocations of £6,000 to each of Glasgow's three CHP sectors to plan and deliver large-scale area events. Around 50 funding applications were received this year and more than £65,000 has been awarded to support GRANDweek events and activities across Glasgow's communities.

Plans for the week come from the communities sub-group of the Glasgow City Alcohol and Drugs Partnership (ADP), established in 2003 to strengthen links between drug and alcohol forums, local communities and services, agencies and organisations. Its members include representatives of all of Glasgow's alcohol and drug forums, service user involvement groups and recovery groups, police and fire and rescue services, plus the broad range of local voluntary organisations and statutory agencies, and it has the remit of agreeing an action plan to protect communities from alcohol and drug-related crime and antisocial behaviour. With significant support and investment from Glasgow ADP and an equal investment by volunteers and in-kind support from services, it has made significant progress in fostering community engagement and involvement.

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Now in its sixth year, the GRANDweek initiative has grown in scope and ambition thanks to the positive contributions from partners across the community, voluntary and statutory sectors. The first one in 2007 had less that ten events taking place the city. Since then it has grown in size and ambition and last year more than 80 events were funded via the GRAND local grant scheme, including arts and drama, information events and project open days. Activities have been varied enough to reach out to all parts of the community, from workshops and training sessions, to treasure hunts, music events and quiz nights, to writing newspaper articles and running competitions. Many ideas are considered, the common theme being that initiatives help to build partnerships and networks that get communities involved in addressing drug and alcohol issues.

One of last year's highlights was the *See You, See Me, Hep C* drama devised and performed by the North West Community Drama Group, supported by Irene Hunter, senior addiction nurse (HCV) and an enthusiastic supporter of the initiative.

'Funding from GRAND last year allowed the Hep C Community Drama Group to become established and make a real difference in the way we reach "at risk" groups about HCV and BBVs,' she said. 'Since GRANDweek 2011 the drama

RAND ideas

'This year's event takes place from 8-15 September and includes an extensive programme of almost 80 locally led activities across Glasgow, with a major event taking place in each community health partnership sector.'

Photos, left to right – Glasgow Council on Alcohol's 'One Woman' drama performance, North West Glasgow Community Drama Group at the GRAND week 2011 launch and serving up GRAND mocktails.

group has performed locally and nationally to a wide range of audiences and has been included in health board planning groups across Scotland. A highlight for the group was being invited to perform for the Scottish Parliament at Holyrood – next stop Hollywood!'

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Events this year will be particularly diverse with recovery becoming an increasing focus in the week's activity. Partners in Glasgow's north west have used GRAND funding to plan for three conversation cafés about recovery, while a city centre recovery hub will open on Saturday evenings. A celebration event, It's GRAND to be a Volunteer will recognise the work of volunteers in the addictions field in north east Glasgow. Drama productions will include *Autumn Falls*, performed by Toonspeak Young People's Theatre and pupils from secondary schools in Glasgow; a film premiere and dance event focusing on how alcohol and drugs have an impact on young people in the south of the city; and a family support drama, *Knock at the Door*, developed by Family Addiction Support Services with input from Strathclyde Police and the procurator fiscal, looking at the issue of drug-related deaths.

'Planning for these events has involved service users, recovery volunteers and supporters of recovery from across the wider community,' says Jackie Smith, team leader at Glasgow's North West Community Addiction Team. 'It's been a genuine team effort which has led to really positive networks and partnerships being supported across the sector.'

This year's week will also be heralded by more than 150 members of Glasgow's GRAND Recovery Runners doing the 10k at the Great Scottish Run. Runners include people in recovery and working in the field, as well as those supporting recovery for individuals and communities, and they can participate at no cost as race entry fees have been jointly funded by the ADP communities sub-group and Glasgow Life, the event organisers. The sub-group has also commissioned jogscotland to deliver a bespoke 'jog leader training course' with 20 people signing up for accredited training to establish and support jogging groups across the community rehab network.

Investment such as this is central to the GRANDweek ethos, with an increasing focus on nurturing and sustaining community involvement and participation. The sub-group is now keen to link its work with the wider aspirations that are being highlighted as part of Glasgow's staging of the Commonwealth Games in 2014. We want individuals and groups to be well recognised for their significant contribution to supporting community responses to alcohol and drug issues and GRANDweek provides a banner for lots of different partners to work together in raising awareness, involving communities and building partnerships.

Interest in the initiative recently went beyond the UK when I was invited to deliver a case study and workshop presentation at the WHO European Healthy Cities Networks annual business and technical conference in Liège. European delegates responded enthusiastically to the idea of GRANDweek and a number of countries wanted to know more about what we were doing – an exciting development in sharing ideas further afield. **DDN**

Stephen Birrell is service manager (alcohol, drugs and communities) with Glasgow Community and Safety Services and is chair of the ADP communities sub-group and the GRANDweek steering group. For more information email stephen.birrell@glasgow.gov.uk or visit www.glasgowgrand.org

VIEW FRON

Galvanising the service user movement in the UK before returning to Canada's inferior drug and alcohol treatment system has given **Bill Nelles** a unique perspective on treatment policy. Time to unite, he tells DDN

Nowadays I live a long way from my friends and colleagues in the UK drug field, but I've not forgotten you. So when news reached me even here on the Pacific rim that politicians back home were trying their hands at rubbishing scientific evidence when determining treatment practices, I sighed and started to take note.

First, a bit about me and my life to date. I've been an AIDS worker, a manager in the NHS, and CEO of The Alliance, which was a very satisfying experience. I'm now the counsellor for a family practice here on Vancouver Island. And all that time I've also been 'in treatment' myself – being a methadone patient, with a couple of breaks, for the last 35 years.

Being born in 1950s Southsea of Canadian parents was my own particular lucky break in the game of life. Nothing like the UK drug and alcohol treatment system existed in Canada in 1976 (and it still doesn't) and I had a UK passport. By leaving Canada when I did, I got to live while all the Canadians I started using with got to die. In 2004, I returned to live in Canada where my own treatment was finally available – at least where I happen to live.

Starting The Alliance in 1998 was a high point in my life. We gave a voice to people using treatment services and a say in the way their treatment was provided. We showed we could be partners in determining treatment policies. We educated people with information about treatment and how to reduce overdoses. And we fought the stigma and opprobrium that is often heaped on the heads of methadone patients.

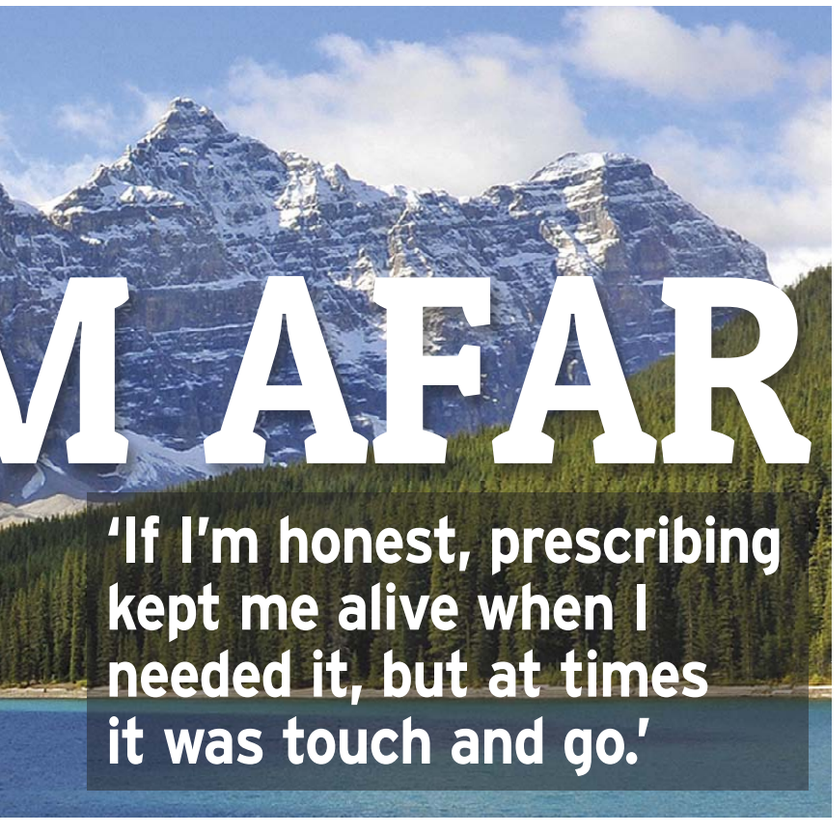
By 2001 our helpline was taking several hundred of calls a year. These calls sometimes turned into cases and from these we also developed advocacy services that had credibility with services users and treatment providers. We followed the principle of an 'honest broker', and followed a step-by-step protocol that helped both advocate and client work through cases together.

Our cases ranged from helping individuals who couldn't get more than a 50mg dose to an entire town of patients who had suddenly found themselves all put on supervised consumption (honest). Besides this advocacy service, we provided training to service users about their treatments and how they worked. This in itself could lead to improved outcomes and happier patients. Lastly we helped set the stage for the many service user organisations that now exist up and down the UK.

The Alliance never sought to make methadone the 'only' treatment for opiate dependency but we wanted to make sure it was there if it was needed. I don't want to go back to the unhappy times that existed when I started in treatment 35 years ago. Patients took what they were offered and there was no effective way to challenge it. Some were badly underdosed and subjected to arbitrary changes. The result was a patchwork of clinical inconsistency and a state of uncivil war between many of the consultants.

When *Putting full recovery first* came out in early 2011, I read it with little enthusiasm. I trusted that the raw imperiousness of the document would be leavened with common sense and indeed this seems to have been the case.

The recently published guidance on *Medications in recovery* is a well-written document produced by a working party representing all the views. Professor John Strang brought together all the major players in the 'recovery' debate including



people from Adfam, Lifeline and (I'm delighted to say) The Alliance. Their report appears to safeguard access to treatments like methadone and buprenorphine while rejecting compulsory detox or time-limited scripts, but there were also some ambiguities that could be the devil in the detail.

If I'm honest, prescribing kept me alive when I needed it, but at times it was touch and go. In late 1980, I overdosed and nearly died trying to chase a buzz with Palfium in the bathroom of a Shaftsbury Avenue hotel. I was lucky enough to come round, but after that I couldn't convince myself any longer that a script was my only option and I entered rehab smartish. The 15 months I spent in an '80s therapeutic community was full of hard work and challenges but it also helped me learn essential lessons of self-control and deferred gratification that users need to learn to stay alive. I never returned to injecting.

Nowadays, I'm less of a die-hard supporter of any one treatment over another, especially when it comes to opiate dependency. I want people to get the treatment that they want. I understand that some people want to work to 'extinguish' their drug dependency and it's great when this happens.

I don't actually have a problem with reminding patients on methadone scripts that an exit is available as long as no one is arbitrarily drop-kicked through it. Compulsion to come off methadone should have no place in our treatment system. This is particularly egregious if the person is doing well and not using street drugs. People must consent to such a change in their care because they are the ones who have to live with the jeopardy of a relapse.

The best defence to arbitrary policy change is a strong and united service user movement. It is everyone's interests to stick together to oppose any attempt to turn the treatment clock back to the bad old days.

Do write to me through *DDN* or at billnelles@telus.net if you have questions or comments.

Look out for Bill's occasional columns in future issues of DDN

BE THE CHANGE...

The sixth national service user involvement conference will take place on 14 February 2013 in Birmingham. To be a part of the consultation process on the programme please email conferences@cjwellings.com

POLICY SCOPE

New rules introduced this month could reinvigorate the public consultation process, says Marcus Roberts

MAKING IT REAL

The government will introduce new guidance on the conduct of public consultations in September. The Cabinet Office minister Oliver Letwin says that 'the aim is to replace potentially unproductive process with real engagement with those affected'.

Most controversially, the government says that the principle that consultations should be held over 12 weeks is too restrictive, and suggests this could vary from two to 12 weeks, depending on the kind of consultation and the nature of the issues.

My sense is that there is frustration with consultation processes on both sides. For government, the volume of responses can be challenging (for example, there were 1,850 responses to the consultation on the *2010 drug strategy*) and may appear disproportionate to the opportunities to exert influence and add value. From the perspective of the drug field, there is scepticism that the government is always giving sufficient attention to what we say, and therefore about opportunities to influence policy.

It is important for both sides to channel these frustrations into a shared commitment to developing consultation processes that work for everyone, rather than to disengage from constructive dialogue.

Public consultations are one of the main routes through which providers and users of drug and alcohol services can influence local and national government. They provide an opportunity to have a say on policies that have an impact on our services and communities. And that benefits government too. Neil Cleeveley, director of policy and communications at the National Association for Voluntary and Community Action, comments that consultation 'isn't done as a favour to the voluntary sector; it's done because talking with service users and organisations delivering services leads to better services and more efficient public spending.'

Currently, the risk is that 'bureaucratic' consultation practice is creating a relationship between government and the drug field that puts me in mind of the old Soviet quip directed at Nikita Khruschev's nomenklatura: 'they pretend to pay us and we pretend to work'.

The Cabinet Office's new consultation principles declare that the aim should be 'real engagement rather than following bureaucratic process'. This commitment could provide a basis for reinvigorating consultation practice. It is also encouraging that the new principles explicitly say that the terms of the Compact between government and community sector organisations – revised and relaunched in 2010 – will continue to be respected, as this includes an expectation that any departures from a 12-week consultation timeframe will be publicly explained and justified.

The risk is that a more 'flexible' framework will legitimise 'quick and dirty' consultations on key policy issues where formal consultation guided by established best practice would be most appropriate. The bottom line is that DrugScope and organisations like us generally do need 12 weeks to consult with members or service users, identify good practice, review the evidence and prepare responses that can really help to make better policy.

Marcus Roberts is director of policy and membership at DrugScope, the national membership organisation for the drugs field, www.drugscope.org.uk.

The new cabinet office consultation principles are at www.dft.gov.uk/mca/consultation_principles.pdf

The arts can play a vital and powerful role in recovery, says Katrina Lahmann

All the world's a stage

That we all have our roles in the theatre of life is not a new concept. The Bard himself tells us that 'one man in his time plays many parts'. If you like, it's fundamental to the concept of recovery – nobody has to live in only one role. We know recovery is possible. Given the opportunity, we're all capable of expanding our repertoire of roles and adjusting the lens through which we view the world. We are multi-dynamic individuals with the ability to connect with under-used aspects of our multi-layered selves.

We all organically step in and out of many roles every day – mother, daughter, sister, aunt, friend, lover, peer, consumer, survivor, and inner-self. In each scenario there are a host of complex boundaries to negotiate but sometimes, as life unfolds, we find ourselves stuck in very restrictive roles.

With this concept at its centre, Barnet, Enfield and Haringey NHS Mental Health Trust's dual diagnosis network embarked on a journey to create a therapeutic theatre project as part of Haringey's 'Recovery Pride' event (*DDN*, May, page 16), a creative partnership generously supported by Haringey's DAAT and recovery champions and open for pan-borough drug and alcohol service referral.

The dual diagnosis network is – despite the public sector spending cuts – an expanding team and recognised as a vital component in the delivery of recovery-consistent, risk-aware substance misuse interventions across Haringey and Enfield. The network operates a 'hub and spoke' model, with specialists embedded at each stage of the client's mental health treatment journey, and in December last year the call went out to 'try something new in 2012'. The remit was for potential cast members to script a self-generated narrative and ultimately produce a performance piece in the context of 'stigma'.

The wider aims of the project were to improve confidence, deepen understanding of recovery and the implications of stigma, develop team-working skills and demonstrate improved health and wellbeing. Arguably a tall order, but the subsequent project evaluation unarguably identified that all required boxes had been positively ticked.

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The initial driving force came from myself – a drama therapist within the dual diagnosis network who sits on Haringey's recovery champions steering group – and Sarah Hart, DAAT joint commissioner and recovery champion. The ensuing energy was soon revved up by each brave new member who ventured out of their comfort zone to sign up to getting the show on the road. Eight potential performers and a photographer stepped up to the proverbial plate and committed to the process.

What evolved between 10 January and 30 March was a genuine privilege to witness, as a narrative emerged in the empty space allocated to us in the former arts therapies department of St Ann's hospital. The project inspired impressive levels of commitment, with a diverse group of women and men aged between 26 and 62 devising a therapeutic theatre performance that explored the perspectives and inner dialogues of 24 hours in recovery.

The final performance was witnessed by an audience of more than 200 family members, friends, industry professionals, local politicians and many, many peers, and before the final curtain viewers were invited to have dialogue with the artists. There was a tangible and genuine sense of community and appreciation for the honesty of the work that had been shared. As a result there are now plans to offer clients a therapeutic theatre intervention as part of Haringey's drug and alcohol treatment pathways, aimed particularly at those transitioning from problematic to stabilised drug and alcohol use or abstinence.

The project has reinforced the value of arts in mental health and the power of the arts and arts therapies as a means of overcoming the stigma experienced

'Nobody has to live in only one role. We know recovery is possible. Given the opportunity, we're all capable of expanding our repertoire of roles and adjusting the lens through which we view the world.'

by many clients on either side of recovery. It's perhaps best summed up by Yaz, one of the performers, who wrote this letter after the project ended:

'I believe that the theatre project has a future for being a tool to build confidence, self-esteem, trust and relationships. My story is with a background of domestic violence, single parenthood, addiction and homelessness, and without the support and help of the theatre project I wouldn't be where I am today. I wouldn't have gained confidence to re-connect with the outside world.

I came to the project whilst on my rehab programme with no intention or focus at all initially – I just wanted something to do. My first day was feelings of fear, dread and excitement but all I wanted to do was run, as this was totally out of my comfort zone. Even though I recognised most people there, I didn't know them but I stuck with it and now here I am studying for a diploma and also volunteering and hoping to continue with the theatre project.

My peers and I had produced initially, with difficulty, a number of sketches related to "stigma" and we then performed in front of over 200 people during the recovery event held on 30 March. We have laughed, cried, been frustrated but all in all we have gained.

The project has definitely bought me out of my shell, where I was totally lost and couldn't find a way to come out.'

Katrina Lahmann is a dual diagnosis specialist

ENTERPRISE CORNER

MAKING CHANCES

Collaborate and innovate with the voluntary sector, don't condemn it says **Amar Lodhia**

At the TSBC, we are celebrating our 'year of innovation'. As part of this, I recently visited those involved in commissioning drug and alcohol treatment services in Edinburgh. I spoke to them about how they can bring innovation and ideas to their system to encourage more joined-up working of voluntary and statutory services that do fantastic work, to better support people to recover from their addictions.

The systems and available resources we have in the UK, compared with those in Karachi, Pakistan for example, where opiates are cheaper than food, are remarkable. A recent BBC *Our World* documentary showed how 6,000 heroin addicts in Karachi have to go 'cold turkey' at the Edhi centre, which survives only on donations. Those who enter treatment there are only given vitamins, food, sedatives and painkillers with no substitute drugs or further support available.

It really makes us realise how much statutory and voluntary sector partnership working can achieve in the developed world. Talking to our own service users who have been through our enterprise and entry to employment programmes shows that recovery journeys are like embarking on the tube across London – whichever route they take, as long as they don't loop round on the Circle Line for the rest of their lives, there are exit points everywhere from which there is a chance to reintegrate back into society.

The point is that there is no one route to exiting treatment. Fortunately for them the collaborative work done by the state and the voluntary sector ensures that, unlike in Karachi, there are maximum exit opportunities and support available at all points along the journey.

It came as a shock to hear Clare Gerada, head of the Royal College of General Practitioners (RCGP), say that many charities are 'not set up to offer services to what is a particularly chaotic, transient group'. I couldn't disagree more. Just look at the examples of what charities like ourselves and CRI do here in UK working extensively with this 'chaotic and transient group'.

I would urge the 'experts' to rethink their criticism of charities who provide drugs and alcohol treatment services and instead look at collaborative working between state and third sector to bring innovation and a focus on providing as many exit points as possible for those in treatment, something the NHS evidently cannot do alone. While I will not discount the role GPs play in supporting patients to recover from addictions, I wouldn't imagine them being able to deliver our reintegration services, which are commissioned and designed to ensure sustainable recovery and break the cycle of what some may argue is a 'state sponsored addiction'.

I would argue strongly that the work the voluntary sector does is the antithesis of 'taking services backward' as Gerada put it. I believe, like a lot of you, that social enterprise and charities are at the forefront of public service provision, especially at a time when resources are shrinking – albeit not to the level of underfunding in Karachi, where it is only the voluntary sector providing treatment services.

Can you help our research into the effect of troubled families on substance misuse? I'd love to hear your views. Email me at ceo@tsbccic.org.uk, follow us on Twitter @TSBCLondon and tweet your comments using the #tag DDNews.

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

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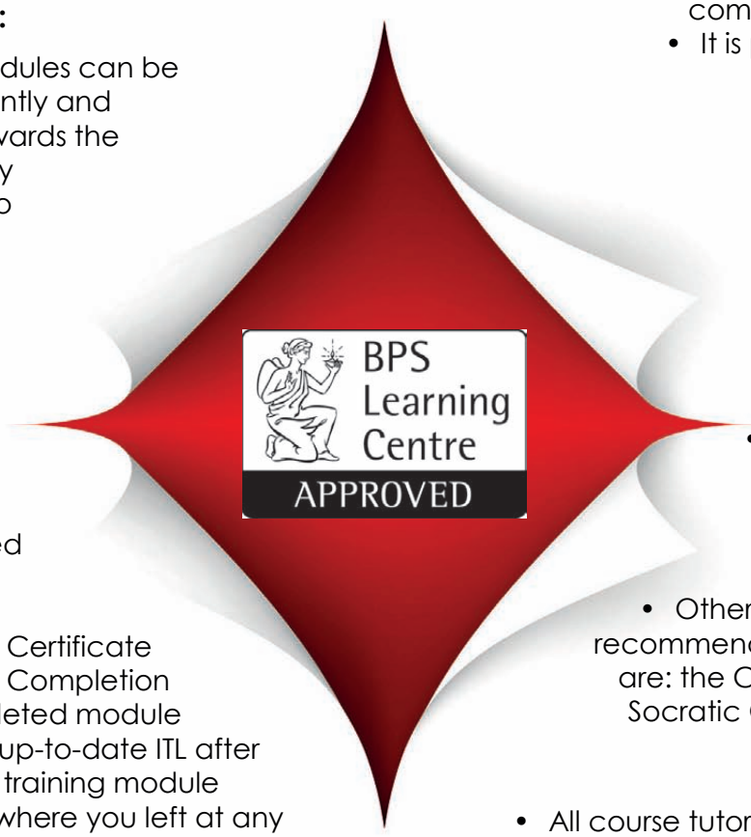

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Worthy yarn

Recovery for people misusing alcohol and drugs is the first priority for treatment services but Swanswell believes there should also be a focus on families, says Stuart Goodwin

UNDERNEATH A BLUE BARNSLEY SKY, a group of keen knitters are setting up camp for the day at a popular town spot. Before long, they're hard at work creating brightly coloured masterpieces – we're not talking woolly jumpers and scarves however, but recovery.

Over the last couple of months, residents in Barnsley have been waking up to a new form of temporary street art that is sweeping the world, called yarnbombing. Handmade banners saying 'recovery for families too' and other colourful knitting have been appearing on buildings throughout the town, all to raise awareness of the support for carers of loved ones affected by substance misuse and show how important it is for families to get their lives back too.

The decorative messages have been created by carers, along with team members and volunteers from Swanswell's carer support service. The service is part of Barnsley's integrated treatment system, offering emotional and practical support on a range of issues, from understanding a friend or relative's treatment to help with carers' allowance applications.

Swanswell's carer support service also provides a range of activities like days out, and art and craft workshops called Knitswell, which is where the yarnbombing idea started out. During July and August, the team decorated some of Barnsley's well-known landmarks, with the permission of the buildings' owners.

The awareness-raising initiative has generated a lot of interest from the public, who've been actively supporting the campaign by donating wool and knitted squares and businesses have also offered their help. It's all been building up to an open day in Barnsley, where the group will be attempting to cover the local carers' cabin entirely in wool.

As Jeni Upperdine, senior practitioner at Swanswell's carer support service says, there's a serious message behind yarnbombing:

'Caring for a loved one affected by substance misuse can be a very isolating experience and many don't know where to turn for help. So we've come up with an eye-catching way of letting people know that we're here and there are organisations like Swanswell that can help.

'Over the past couple of months, our Knitswell project's been highlighting that it's not only the person misusing alcohol or drugs who needs recovery, but their family also needs to recover from the bad effect substance misuse has had on them and their loved ones.'

Stuart Goodwin is PR executive at Swanswell. To find out more about Swanswell and the carer support service in Barnsley, visit www.swanswell.org or to offer your support to Swanswell, visit www.justgiving.com/Swanswell.

Team members and carers from Swanswell's carer support service will be involved in the first Adfam/DDN family conference, Families First, on Thursday 15 November in Birmingham. Details at www.drinkanddrugsnews.com

FAMILY MATTERS

BE THE VOICE

This year's Family Voices competition is now open so please encourage family members to take part, says **Joss Smith**

EVERY YEAR ADFAM RUNS A FAMILY VOICES COMPETITION, asking families to submit their poems or pieces of creative writing about their experiences of a loved one using substances. The entries never fail to impress, move and inspire us and demonstrates the strength and resilience families show in the face of devastating circumstances. Below is last year's winner, which shows both the hope and strength families can offer to a loved one's recovery.

For My Daughter

There is a light within you
It's buried deep inside
Lost and tinged with sadness
From the world that lies outside.

Your life is not in a bottle
Or in a powdered haze
These are just a smokescreen
For the dark relentless days
Of feeling down and useless
The pain of something more?
The painted face of misery
That knocks upon your door.

Look within your heart
And find what you thought lost
Let go of all your anger, your sadness
And your pain...
Let love be there to guide you
I'll be with you all the way.

The road ahead's not easy
Just take it day by day
Together we will beat this
Just give it one more day.

Remember that I love you
You are my precious child
And I'll be here beside you
To walk along the way
And when you're feeling weary
And the road ahead seems tough
I'll put my arms around you
And shower you with love.

Sometimes on life's journey
We choose a path that's wrong
We feel like giving up at times
It's then you must be strong.

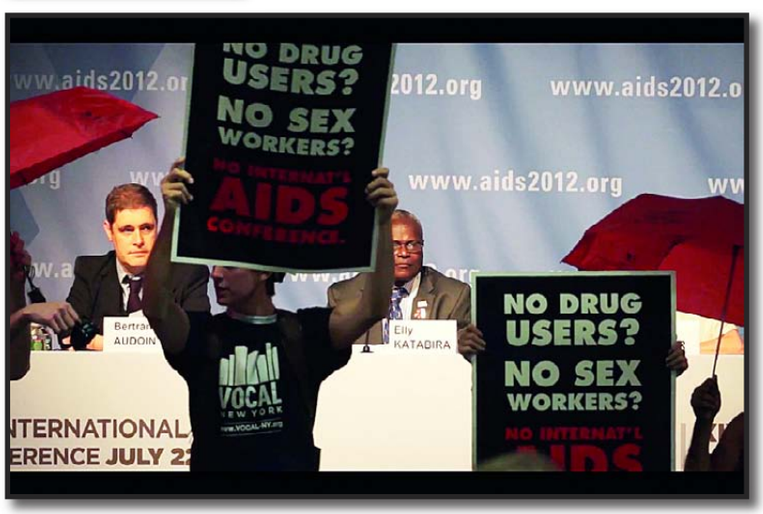
Please ask family members to submit their poems and creative writing to familyvoices@adfam.org.uk. Details can be found at www.adfam.org.uk.

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

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

Frontline challenge

Stigma and prejudice still stand firmly in the way of achieving an AIDS-free generation says **Dr Chris Ford**, who shares her observations on the 19th International AIDS Conference



Activists interrupt the International AIDS Conference with banners and chanting: 'No drug users? No sex workers? No International AIDS Conference!' See http://bit.ly/QrR0R8

It was a difficult decision to go to the International AIDS Conference in Washington after hearing that most people who use drugs and many sex workers – those very much directly affected by HIV and HIV policies – couldn't attend because of US visa restrictions. The US government had lifted the exclusion of people living with HIV, but there remain legal entry restrictions against people who have criminal records for crimes of 'moral turpitude', which includes drug and prostitution offences. This made travel to the US difficult or impossible for many people who use or had used drugs, and sex workers.

After much debate about the politics of compromise and realising there was much important work for International Doctors for Healthy Drug Policies (IDHDP) to conduct with others attending the conference – including holding our first patrons' meeting, members' business meeting and expanding IDHDP's membership more into the HIV world – I decided to go. Having some of those who could not travel to the US represented via excerpts from the pre-conference 'alternative' event in Kiev shown throughout the conference, helped with the decision as well (*http://bit.ly/OqiPHY*).

Direct action occurred throughout the conference, starting with a march through Washington and continuing in the opening plenary session, when activists interrupted with banners and chanted 'No drug users? No sex workers? No International AIDS Conference!' *(http://bit.ly/QrR0R8)* giving a voice to those who were not there. Throughout the conference it was my impression that the cries of exclusion were warranted. Its agenda tended to give short shrift to drug use as an important method of transmission of HIV, with the exception of the Global Village, a lively, but segregated area two floors below the plenary and major session halls.

Arriving for the first time at the venue was almost scary with more than 24,000 delegates and 4,000 others, my biggest previous conference having been 1,500 delegates. But the staff, volunteers and delegates were all instantly friendly and after an easy registration I headed off to the Global Village, sometimes referred to as 'the real heart' of the conference, where many NGO stalls and the drug, harm reduction, human rights, sex worker, and youth networking zones were located. The Global Village, although isolated form the main conference plenary and session rooms, was a platform for communities, activists and practitioners representing diversity and solidarity. Here there was a full programme of presentations about the social and economic links of HIV, as well as HIV and drug use.

Throughout the presentations there were common, recurring themes relating to stigma, prejudice, social exclusion, discrimination, violence and vulnerability. I was moved by the individual stories of outreach workers, doctors and other health professionals and people who are HIV positive, especially those working in Russia. They risk all by providing care to people who use drugs and they have to conduct outreach in terrible conditions. I was also moved by the story of the Kenyan drug worker who walks to different villages talking about harm reduction and testing people for HIV, trying to explain that the second wave of the HIV

epidemic is occurring in people who inject drugs. I realised again how easy we have it in the UK and how vital it is that we hang on firmly to the improvements we have made.

In the main conference, US secretary of state Hillary Clinton headlined the first plenary session, and although most delegates celebrated her passionate call 'for a generation that is free of AIDS' I was disappointed that she didn't address some important issues. While speaking broadly about the need to focus on key populations, she didn't directly address injecting drug use and the links to poverty and prejudice. She said that the administration's strategy included increasing access to condoms and HIV testing, and gave special emphasis to three other interventions – treatment as prevention, voluntary medical male circumcision, and stopping the transmission of HIV from mothers to children – but she did not address the need to overcome poverty and stigma, and the need for good healthcare to be accessible to all equally.

'The 'war on drugs' is in fact a war on people. In my opinion, for the world to reach the goal of an AIDS-free generation, AIDS strategies must include people who use drugs. Most importantly, decision-makers and the rest of the field need to address this group of people with respect.'

Mrs Clinton and the other main speakers did talk about the importance of focusing more resources on women, children and men of colour, pointing out how globally AIDS is now the leading cause of death for women of reproductive age and that black women represent 92 per cent of women living with HIV. She gave a small mention of marginalised groups, saying 'humans might discriminate, but viruses do not'.

The focus of the conference was clearly not on reducing injecting-related HIV, but it should have had a more prominent place in the programme. HIV in people who use drugs is both preventable and treatable by using evidence-based interventions relating to science and knowledge. People who use drugs account for a third of all new HIV infections worldwide outside sub-Sahara Africa; globally one in five people who inject are infected with HIV and in countries where injecting drug use is treated as a criminal offence such as Russia, US and China, the HIV prevalence in people who use drugs has increased to 37 per cent, 16 per cent and 12 per cent respectively. This is in comparison to an almost stable HIV rate in people who use drugs in the UK of less than 2 per cent.

The 'war on drugs' is in fact a war on people. In my opinion, for the world to reach the goal of an AIDS-free generation, AIDS strategies must include people who use drugs. Most importantly, decision-makers and the rest of the field need to address this group of people with respect, and we should all fight against their discrimination and criminalisation.

I suggest changing the slogan, popular at the AIDS conference, from 'Criminalise hate not HIV' to 'Criminalise hate not HIV and people who use drugs'.

Dr Chris Ford is clinical director of IDHDP, www.idhdp.com. IDHDP are on Facebook and on Twitter @idhdp

Post-its from Practice

One driver

Recovery should only be defined by the individual, says **Dr Steve Brinksman**

I WAS PLEASED that the recently published *Medications in recovery* report makes it clear that 'arbitrarily or prematurely curtailing opioid substitution treatment will not help sustain recovery', for while I am keen to see people become abstinent from illicit drugs, I have never been a proponent of time limited treatment. I believe that the individual patient has a much better idea of where they are and what they are trying to achieve and my role is to help them to achieve their goals – although this may occasionally entail a gentle push.

Reflecting on the sensible advice from the expert group reminded me of Robbie, who first turned up at the practice about 15 years ago. He had been sleeping rough, was underweight, unkempt, had chewing gum stuck in his hair and the broadest Scouse accent I had heard since moving down from Liverpool to Birmingham ten years earlier.

Much of his story would be familiar to you. He was estranged from his family in Liverpool and felt too much shame to return while he was still using drugs. He had rapidly progressed from smoking heroin to injecting it and as a result of poor technique his arms were a mass of scars and lumps and he had begun to inject in his groin.

Over the next few months he stabilised on OST, started a relationship (although a fairly stormy one!) and generally he felt he was doing well. He would come and see me every few weeks and after about 18 months he told me he wanted to come off methadone as he 'owed it' to his family and partner. A slow reduction ensued and the last time I saw him for a while he was down to 5mls of methadone a day.

Somewhat naively at that time I assumed he had simply stopped taking methadone and not felt the need to come back and see me. I was quickly disabused of this idea when his name came up on my computer screen and I went into the waiting room to call him.

Things had deteriorated quickly when he realised that his relationship was not the source of support he had hoped it would be and, having ended it, he effectively became homeless. Sofa surfing among 'old friends' had led to a reintroduction to heroin, and guilt-ridden, he was indulging in riskier drug use than before and his neck veins were now the choice for injecting.

We restarted his methadone and with persistence from his drug worker, permanent accommodation was found for him. Stable once more, he went off and did a college course to improve his literacy skills. He started volunteering with a local church's mental health support group. After a couple more years he told me he wanted to come off methadone again, although this time he said he wanted to do it for himself and not out of a sense of duty to anyone else.

Partway through the reduction he was offered a job and moved to a different part of the city and off my list. This time I had to hope he would continue to do well. Many years later there was a Christmas wish from him in my inbox – he had been off all drugs, including medication, for five years. He was working and still volunteering, and had found a role in society he had thought impossible to achieve when we first met.

No one is beyond recovering from problematic drug or alcohol use, but it is their recovery, not ours, and they define it. We are just lucky enough to share the ride.

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

Vital funct

As liver disease rates continue to rise – and the ages of those diagnosed continue to fall – **David Gilliver** talks to British Liver Trust chief executive Andrew Langford about awareness and taking on the drinks industry

Three years ago the Department of Health warned that 'without firm action', liver disease – already one of the top five causes of death – could become Britain's biggest killer 'within ten to 20 years' (*DDN*, 2 November 2009, page 5). Despite a commitment to minimum pricing, many campaigning organisations feel that action remains some way off.

Andrew Langford has been chief executive of the British Liver Trust – the only UK charity dedicated to helping people affected by liver disease – for just over a year, following a distinguished career across the charity sector. Although liver disease prevalence is rising, treatment and research are still under-funded and awareness remains low, and the trust has widened its emphasis from working with people with the disease to include prevention and early detection.

'The remit is changing, and hopefully the financial support around that will follow,' he says. 'But like all charities we're affected by the recession – it's very much a hand-to-mouth existence.'

With its dedicated team of 20, the trust works closely with patients, medical professionals and government to make sure that people get the best possible support and care. It also funds research, operates a helpline and actively campaigns, including to raise awareness of the stark health inequalities between liver disease patients and those with other conditions. People dying from heart disease are likely to live up to 20 years longer than those dying of liver disease, something that government is beginning to take notice of, he says.

'We're certainly being listened to a lot more by the Department of Health. Part of that is knowing who the right people are to talk to, and making sure we choose who we fight our battles with. It's the only disease where the average age of death is decreasing year-on-year.'

That average age is now just 59, he points out. 'One of the reasons is that it's no longer unusual to have a 25-year-old dying of alcohol-related liver disease,' he says, but while alcohol is a very significant factor, there are also issues like obesity and blood-borne viruses.

'It's about making sure that all of those different arms of the Department of Health are aware that all those, in different ways, can be a cause of liver disease. A good example would be hepatitis B – awareness is so low in this country, and we're one of the only financially better-off countries that doesn't have universal vaccination. How come the rest of our affluent EU partners have introduced this – surely we're being negligent if we're not following suit?'

Parliament is starting to listen to this argument, he says. 'What I've been saying is if we had a vaccination for HIV and weren't using it, can you imagine what the uproar would be? We have another blood-borne virus which has an equal effect on people's health and does lead to death, and we're doing nothing about it. The only people who get screened for hep B are pregnant women and I think it's important that we make a stand and say that's not good enough.'

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While NICE is looking at ways to improve the uptake of hepatitis B and C testing (*DDN*, July, page 5), it's alcohol treatment that has long been known as the 'poor relation' compared to drugs. Many hope that combining them under Public Health England will improve matters but Langford is unconvinced.

'I don't think we're spending enough on drug treatment, so alcohol is going to be even worse – the economy will make it very difficult to have good drug and alcohol services,' he says. 'The other thing is that we really do have to educate the health and wellbeing boards, and particularly the directors of public health, to have a far better understanding of why alcohol is equally as important as drugs. I think – as with society as a whole – public health still don't see alcohol as being as big a problem as illicit drug use.'

Alongside other bodies, the trust walked away from the government's alcohol responsibility deal, saying that for too long campaigning organisations had been persuaded to 'play the long game' – waiting for the industry to get its house in order while it continued to cultivate its relationship with the government (*DDN*, March, page 6). Although the government has since committed to minimum pricing, much will depend on what influence the industry has on deciding that price, he stresses.

'Along with others, we're asking for a minimum of 50p per unit, and if I'm really honest, for the British Liver Trust that's incredibly conservative. We think to have a true impact it would need to be far more in the region of 65p, but because of the stranglehold the industry has that really would be pie-in-the-sky at the moment.'

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What about the role of the press in dictating policy – demanding action while attacking anything that they see as nanny statism? 'I still think that the press focus an awful lot on the law and disorder problems of alcohol,' he says. 'It's rare that you see a quality article about the health effects, and quite often there'll be

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'In no way are we about abstinence... for your liver to stand a chance of regeneration you do need two to three days off every week. I think that's a far more realistic message for people.'

Andrew Langford

things like having two glasses of red wine a day helps your heart, and whatever else. What we'd like to see is more balanced articles saying that two glasses a day might help your heart but – depending on what size those glasses are – you may well be damaging your liver. If we're going to put these messages out, let's be sensible and have them balanced.'

To this end, one of the trust's central messages is the importance of having alcohol-free days every week. 'Even though a key message is to try not to drink too much in the first place, for those of us who do choose to drink – and in no way are we about abstinence, I'd be a real hypocrite if that was the case – for your liver to stand a chance of regeneration you do need two to three days off every week. I think that's a far more realistic message for people.'

Despite the industry's undoubted power, given the mounting costs of alcohol-related illness is he confident that the government will eventually have no choice but to get tough – in five or ten years could we see genuinely effective legislation on advertising and marketing?

'I think we'll be on the road to that. If we think how long it took to get good legislation in about tobacco then we need to be realistic about what we can achieve – I think it's more a process of slow chipping away and having political parties that are signed up to making significant change. But I don't think our present government is as signed up as I'd like them to be.'

Ultimately, what should signed up mean in terms of advertising? 'Bluntly, a complete ban,' he says. 'We'd like equity with tobacco – a complete ban on advertising and a complete ban on sponsorship, particularly sporting events, and a real consideration for how alcohol is sold, particularly by the supermarkets.'

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His ambition now is to make the trust a household name, and through that to improve people's knowledge of their livers, he says – 'what the function of the liver is, how easy it is to damage, what you can do to look after it as effectively as possible. And that would be on a UK-wide basis, so we have equity of impact among all four countries, some of which have specific issues about which should focus in a little bit more – the fact alcohol is such an issue in Scotland, for example.'

But ultimately it does all come back to awareness, he says. 'Just that reminder that the liver is a very important organ, and people should think about it in the same way they think about their lungs or heart.' **DDN**

Recovery coaching is quietly transforming the world of recovery, says **Anthony Eldridge-Rogers**

REVOL

A simple revolution has been occurring in a number of places across the world of recovery. The mainstream hasn't caught onto it quite yet – so far it's been the domain of a range of people involved in trying to foster, build and transform recovery. Part of this simple revolution is called recovery coaching, which, while it seems as if it's just arriving, has actually been around since at least 2000. I describe it as 'simple' because the set of concepts on which it is built are just that. I believe that we will look back in a few years and realise that we have indeed had a revolution, and that recovery coaching has played a significant part.

The term 'recovery coach' and the practice of recovery coaching have emerged largely from two pathways, both of which are primarily outside of existing treatment channels. The largest of these is the peer-to-peer support environment and movement that has existed for some time in mutual aid organisations and developing recovery communities, while the second has arisen from the coaching environment. Here, people training as coaches and who are familiar with recovery and its requirements have realised the benefit of coaching approaches to building and maintaining recovery.

The attractiveness of recovery coaching lies in the concepts that underpin it. These allow for an emerging practitioner landscape that embraces peer recovery coaching – free at the point of contact within the recovery community – through to professional recovery coaches offering paid-for services to individuals and organisations.

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Recovery coaching is built on several key concepts and approaches. The first is that recovery comes from the person themselves – something that is generated by the person looking for, or in, recovery. This deep respect for an individual's resourcefulness in finding their own path to recovery lies at the heart of the coaching. The agenda for a recovery coaching session always comes from the person being coached, and the relationship is actively designed between coach and coachee, with priority given to the coachee's needs and requirements.

This coaching is also applicable across all models and approaches to recovery – recovery coaches have no agenda other than to assist and support others to find and develop recovery, so they work with whatever recovery pathway a coachee is on at any given time. It is also systemic; recovery coaches recognise that recovery develops and takes place within a series of relationships within a system or network, such as a community. They work with coachees to develop their understanding of this system, its assets and debits, and the risks it poses to their recovery.

All recovery coaching sessions are grounded in agreed action for the coachee to take, with associated feedback and accountability with the coach. Through this mechanism coachees build their levels of commitment to their own actions and have an opportunity to increase self-understanding and learning through evaluating the consequences of actions taken – or not – on their own lives.

The coaches are an invaluable gateway to resources that may be practical – for example, local meetings – or more general, conceptual, philosophical or educational. The emphasis, however, is on coaching while interacting with these resources.

Recovery coaches are not experts in treatment, nor are they offering it – coaching is an addition to the existing recovery environment. It should be seen as a new combination of tools that perform a particular role and function outside of medical or therapeutic treatments, although often in alliance with them.

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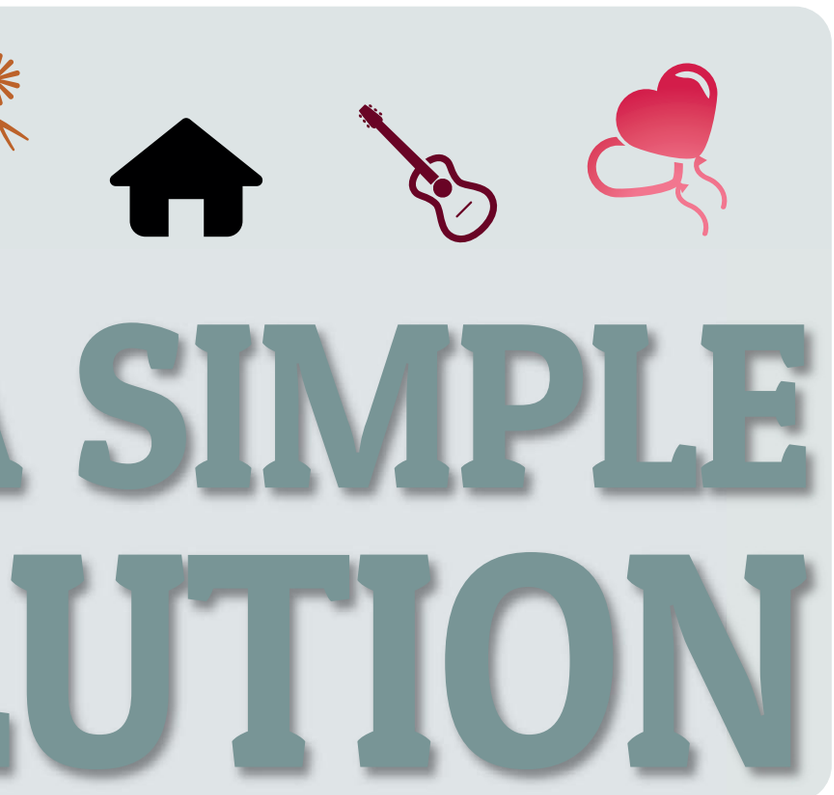
Why is it growing fast? There are several factors, and the first is widening engagement. Recovery coaches sit outside of particular pathways and services and therefore can provide a continuum of relationship when a person disengages from them. They also offer a particular pathway of engagement for people unable, unready and/or unwilling to interact with other pathways to recovery at a given time.

Recovery coaching is 'sticky', with recovery coaching skills, techniques and approaches to relationships rubbing off on the coachee. They will start to use coaching approaches and skills spontaneously in their everyday lives, and these in turn tend to rub off on the people close to them.

Importantly, there are also low barriers to entry. The ability to acquire and use recovery coaching skills requires no particular educational or academic experience – almost anyone can learn and practise them, and they are inexpensive to train. Plus, there are immediate returns. As the skills and approaches that form foundational recovery coaching principles are essentially already aligned to existing human behavioural tendencies, they are easily understood from almost the very beginning of training, so there is a near-immediate return on the investment made in learning them.

Recovery coaching focuses on the strengths, assets and abilities of people. It



is based in a 'wellness' approach, which provides an empowering energy for a person developing recovery.

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And what is the impact? People who have had contact with recovery coaching report a wide range of responses, including increased confidence in and attitude towards recovery. They feel respected as individuals and less like cogs in a system or machine. There are more feelings of control on one hand and healthy interdependence on the other, as well as a deeper sense of self-determination coupled with a positive attitude to community.

We are seeing a paradigm shift in the way we both view and embrace the idea of recovery, and recovery coaching is a profound part of that. The reason for that is twofold. Firstly, it facilitates an extension of the mutual aid concept across multiple pathways and roads to recovery, connecting them together and providing a continuum of relationship that is vital for a person building recovery. In doing this it also complements and leverages the growing appetite for the formation of recovery communities by enhancing natural relational skills while maintaining a non-professional culture within them.

Secondly, it offers a low-entry threshold in terms of skills and personal development that provides immediate returns for both individuals and those they relate to. By embracing these skills and concepts the person receiving recovery coaching is in turn spreading these same skills and concepts within their life and community. This can only increase the sum total of possibility for recovery.

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So, where to next? There are questions that need resolving and exploring. Most important is how the recovery field can fully embrace recovery coaching to preserve the unique and promising role of the peer recovery coach and allow for the development of the professional recovery coach.

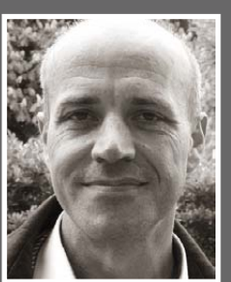
These and other topics will be developed and debated at the first ever International Recovery Coaching Conference (IRCC) in London on 1-2 October, organised by the Foundation for Recovery Coaching CIC. www.ircconference.com

Anthony Eldridge-Rogers is the founder of the Foundation for Recovery Coaching (FRC) www.recoverycoachingfoundation.com and the IRCC conference www.ircconference.com.

VOICES OF RECOVERY

COME TOGETHER

It's time to make recovery more visible, says **Alistair Sinclair**



IT'S NOT LONG NOW TILL THE FOURTH UK RECOVERY WALK, which will take place in Brighton on 29 September. This year's walk – planned, organised and delivered by people from the local recovery community – has adopted 'creativity' as its theme and welcomes all those who want to celebrate and promote recovery in their communities. The walk will be a celebration. It will be fun. It will bring together recovery community members from all over the UK, and for a little while it will make recovery very visible on the streets of Brighton.

So why is visible recovery important? I wrote a piece recently for the NTA website about the importance of hope and optimism within services that seek to become more recovery orientated and within communities that nurture and build recovery. I said that by making recovery visible hope is generated for individuals and communities, and new possibilities for transformation opened up.

Recovery must be encountered if it is to become 'contagious'. In a society where unhealthy dependencies are spiralling out of control as communities fragment and fracture, there is an ever increasing need for visible recovery. The UK Recovery Walk is one articulation of recovery and is, along with more and more visible recovery activity within the UK, beginning to challenge stigma and discrimination through its embracing of diversity, championing of individual and collective strengths and through an emphasis on connections, belonging and community.

However there is a need to make recovery much more visible within all our communities. The New Economics Foundation (NEF) has, having analysed a huge amount of national and international research, identified 'five ways to wellbeing': be active, take notice, learn, connect and give. The UKRF believes that we need to focus on the assets that support the five ways for individuals, groups and communities and challenge our current deficit/needs-based culture. In identifying and supporting the assets within our communities that support the five ways, we will support new and diverse forms of mutual aid and make recovery visible and accessible for all.

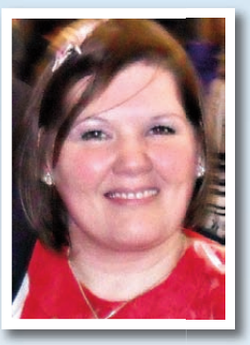
We will ensure that recovery networks are there for all who are recovering. An asset/strength-based philosophy and practice, grounded in social justice and rooted within communities, will make recovery visible. The UKRF plays its part by focusing on the identification and support of recovery community organisers and networkers within its recovery seminars and the development of affinity networks. Others are concentrating on 12-step facilitation, establishing new SMART groups, developing and delivering recovery coach training programmes, forming new community-led social enterprises.

We are all, in our very different ways, seeking to make recovery visible. We are all in the business of supporting new and vibrant forms of mutual aid, all of us exploring the five ways to wellbeing and making the path as we walk it.

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

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

In the first part of her story, **Marie Tolman** explains how an incident in her childhood turned her world upside down and sent her down the path to addiction.



My journey of self-discovery

ON 21 MARCH 1968 I ENTERED THE WORLD, named Marie, I was a person with the same opportunities and chances we are all born with.

Until I was seven years old, I was a happy-go-lucky child. I loved playing with my toys and daydreaming about life and what I was going to do when I was grown up. I was the eldest of three children and we had a busy family social life. Our extended family was a major part of our lives and every day we would go and visit a relative – up to three times some days – or they would come to our house.

We were just a normal family, until tragedy hit. On a family day out to visit relatives in Stoke-on-Trent, my little sister Pauline was brutally killed in a road accident. It seemed like it happened in slow motion and there was a silence that cloaked the screams of horror. I recall a bystander saying it was OK, my sister was OK. I looked at her wondering if I had gone mad, watching her tiny mangled body strewn across the road. Was it a bad dream, with my head playing tricks on me?

Pandora's Box was about to be opened. I was a seven-year-old kid struggling to understand what exactly had gone on and finding it difficult to make sense of it all. The world seemed to go on as normal, but it was far from normal. My resentment for people grew – all around silly things. My mum and dad had said a funeral was no place for child, but I wanted to be there to hold my dad's and mum's hands, but instead I was made to stay with Uncle Jimmy. I made that man's life hell – he had never done anything wrong, but simply because he was the one who had to mind me. I picked up resentments everywhere, putting them in my backpack of insecurities. It was a heavy burden for a child to carry, but somehow I felt the accident was my fault.

When my playmate was killed in a road accident in September that year, I began to feel there must be something wrong with me. I became disconnected at school, and rather than study I would just daydream. My parents never gave any reason for me to feel this way, but somehow, in my distorted mind, I felt I was burden and that it was probably my fault Pauline had been killed. So I began testing them, first of all by storytelling, then by faking accidents. When that didn't receive any attention I drew gravestones all over my bedroom and schoolbooks, on my hands, anywhere and everywhere, saying I wished I was dead. Nobody really took any notice so I thought I would try faking suicide. I lay on the landing with a bottle of pills by my side, pretending to dead, or at the very least unconscious, but mum and dad would just step over me. Obviously they knew I was attention seeking.

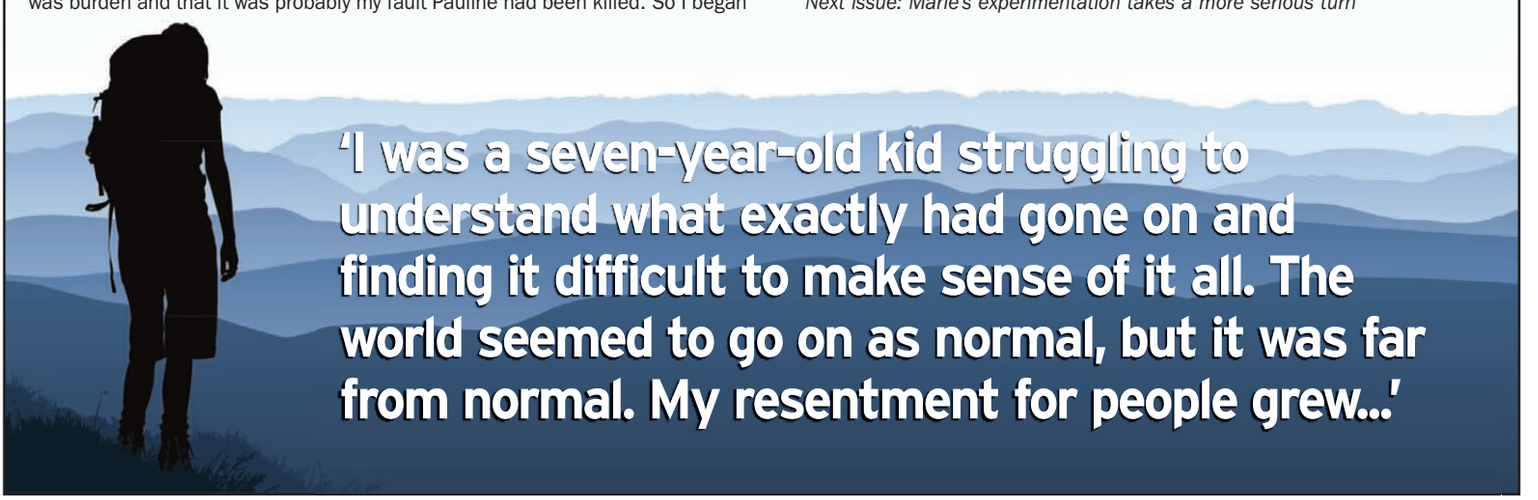
These elaborate attempts to try to feel accepted had no impact, so by 12 years old I was at the experimental stage of drinking and partying – then at 13 I discovered drugs. This was great, I thought. At last I had found a place where I belonged. This quickly moved into using to increase my social status – although in reality I was just a little girl crying out for help. Drug taking, partying, criminality and bunking off school were all part of my daily activities and I found a sense of purpose and belonging.

By now I had lost even more friends. Katrina, my rebellious friend in school, had a massive brain bleed and died, as did Mark, the bad boy whom I so admired. The list went on and included family members, which reaffirmed to me that everyone I got close to died and I felt that I was somehow to blame for this.

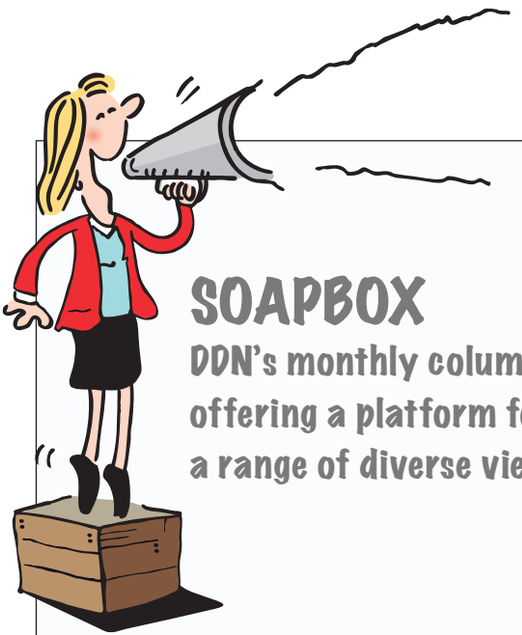
I was just 14 years old when I first tried heroin. It was in a house in New Brighton, with an older lad, Gary. I had acquired a load of barbiturates and he wanted to swap. I wasn't impressed at that stage, preferring stimulants, acid and downers.

It wasn't until I was nearly 16 that heroin re-entered my life. All the lads were doing it and it was all very alluring and exciting. Through shoplifting and excessive drug and alcohol taking I had gained acceptance to the bad boys' club and was given full membership without knowing exactly what I had signed up for, apart from a feeling of belonging and acceptance.

Next issue: Marie's experimentation takes a more serious turn



'I was a seven-year-old kid struggling to understand what exactly had gone on and finding it difficult to make sense of it all. The world seemed to go on as normal, but it was far from normal. My resentment for people grew...'



SOAPBOX

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

ONE STEP BEYOND

It's time to move clear of the abstinence v prescribing debate and agree on a holistic, pragmatic approach, says **Oscar D'Agnone**

HOW BEST TO TREAT PEOPLE WITH DRUG ADDICTION? Nothing has been more contentious and encouraged more passion than the divide between the proponents of the abstinence approach and the defenders of substitute prescribing. As with every controversial debate, each camp has its pros and cons. Those who promote abstinence argue that 'parking people on methadone indefinitely' does not provide a solution as it is substituting one drug with another drug without solving the issue of addiction itself. On the other hand, those who recommend substitute prescribing highlight the extremely high rate of relapses among addicts that undergo full abstinence and the very dangerous consequences of such relapses.

What has seemed to be a never-ending discussion within the sector might actually come to an end with the NTA's most recent report on prescribing substitute medication. The report recognises that both sides have valid points and that the division between the 'abstinence' and 'prescribing' approaches is a false dichotomy. Indeed, drug treatment services do not have to choose to favour one approach over the other but should move towards a holistic approach that uses a wide range of interventions that are considered best for the individual. When treating addictions, you cannot apply the same 'medicine' to every patient. Having come across thousands of individuals through my work at the national health and social care charity, CRI, I have come to realise that there are so many complex social and medical factors involved in each person's addiction, that every situation is intrinsically different.

On 5 September CRI and the University of Manchester will run a conference where leading clinicians specialising in drug misuse treatment will be looking at the ways to ensure the sector moves away from the dogmas of the past and develops a holistic approach, integrating medical, psychological and social interventions, where each case will be treated according to the individual needs.

Such a holistic approach must be based on a real partnership between individuals and the clinicians involved in their care. It is the doctors' responsibility not to apply a blanket rule for all those seeking treatment but to tailor treatment options to their patients' specific needs. It is also vital that individuals provide their informed consent by being made aware of the benefits and risks involved in different treatment options.

For some individuals, seeking abstinence can be the most effective way of overcoming their problem, but for many others this could lead to serious consequences and an approach focusing on harm reduction will be more suitable. Indeed, individuals who are not quite ready to be abstinent would benefit from being prescribed a substitute medication for as long as they need in order to enable them to join structured recovery programmes including psychosocial interventions, involving family members and friends, addressing housing and educational needs and looking into other physical and mental health problems. Methadone should not be an end in itself but a means to eventually become totally free from drug dependence when ready.

Once doctors and patients have agreed on a treatment option, it is important that individuals take ownership of their recovery programme. This should be reviewed and adapted on a regular basis and progress evaluation should not only look at clinical information but should also take into account quality of life factors. Doctors should ensure individuals are involved in decision making on issues such as appropriate medications, doses and regimes. They should also work jointly with patients to ensure they can come off opiate substitute medications at a rate that is safe and they feel comfortable with.

Beyond clinical support, it is vital that people starting drug treatment programmes are able to see exits from it at some point, for instance by developing links with a recovery community or by having the opportunity to become peer mentors or coaches once they have stopped using drugs.

We feel it is important that a holistic approach includes psychological help and support to address other aspects of their lives which are intrinsically linked to their drug use. Whether it involves helping them to get a job or find suitable housing, it is vital that we address all these complex social issues to ensure drug users are able to get their lives back on track.

It is time for us as a community to end this division and come together to endorse a more holistic, pragmatic approach focusing on individual needs, where the service user (not the drug) is at the centre. Only then, will we be able to support drug users effectively and will society reap the benefits of improving public health.

The Recovery and beyond conference – clinical research and practice for building the holistic recovery model and policy of the future is being held by CRI and the University of Manchester at the Midland Hotel in Manchester on 5 September. For more information please visit www.cri.org.uk/clinical.

Dr Oscar D'Agnone is CRI's clinical director

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Bristol's successful Shared Care scheme provides treatment to approx 2000 drug users a year. Based in GP surgeries in the heart of communities you will assess opiate users, provide advice to GPs, monitor prescriptions and deliver recovery plans. If you are assertive and diplomatic, with excellent organisational skills and are able to work well within pressurised primary care settings, this is for you. It is essential that you have an appropriate driving licence and access to transport (car, moped, motorbike) for the above posts.
For an informal discussion contact Maggie Telfer 0117 987 6006.

Closing date for applications: Midday, 14th September 2012
Interview date: 25th September 2012

Please contact Angelo Curtis for an application pack:
BDP, 11 Brunswick Square, Bristol BS2 8PE
Tel: (0117) 987 6004,
E-mail: recruitment@bdp.org.uk

Safer Bristol

We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation. No CV's agencies or publications.

Registered Charity No: 291714 Company Limited by Guarantee: 1902326

ACORN TREATMENT
OUTCOME FOCUSED SERVICES
PART OF THE ALCOHOL & DRUG ABSTINENCE SERVICE

'Our aim is to help all service users, their families, and the wider community to repair the damage, caused by active addiction'

As a fast developing Abstinence Treatment Service, we are now planning to extend our Hull team to work within the J2R partnership and have vacancies for:

RAMP (reduction & motivational programme)
PRISON & COMMUNITY FACILITATORS

Facilitators required to deliver motivational interactive lectures, presentations and workshops to motivate, encourage, and challenge ambivalence. Facilitators will prepare and orientate service users towards abstinence. **Salary £NEG dependant on experience**

FLOATING HOUSING SUPPORT WORKER

Based in Dukinfield, the post will involve case managing clients in the Primary Services and recovery community houses. This will include ensuring clients have working recovery plans and risk assessments, collecting rents, and providing practical support for clients. **Salary £17-19k dependant on experience.**

LIVE IN RECOVERY CONCIERGE/SOCIAL COORDINATOR(S)

We need – live in Recovery Caretaker's who are professional, sociable, enthusiastic and happy to live as part of a recovery community and spend time with Service Users during their stay. The successful candidates must be capable of working using their own initiative and also possess excellent interpersonal and communication skills. You must be completely abstinent for at least 3 years. **Salary £10k, Benefits: Free Rent/Utilities/council tax/food/ongoing professional development.**

CLOSING DATE FRIDAY 21 SEPTEMBER
For Job Descriptions and application forms phone 0161 484 0000
We are an Equal Opportunities Employer – All positions require CRB clearance.
Acorn Treatment & Housing Projects, registered charity No 1063589

Redcar and Cleveland NHS Primary Care Trust

Redcar & Cleveland Borough Council

Redcar & Cleveland Partnership

COMMUNITY DRUG AND ALCOHOL CLINICAL TREATMENT SERVICES TENDER OPPORTUNITY

Redcar and Cleveland Borough Council are seeking suitably qualified and experienced organisations to deliver a full range of clinical treatment and prescribing services to drug and alcohol using adults within the Redcar and Cleveland area.

The contract will be for a period of 3 years commencing 1st April 2013 with an option to extend for a further 2 x 12 months.

Organisations wishing to express an interest must register, download tender documents and submit their tender via the NEPO Portal at www.nepoportal.org. The tender pack will be available via the NEPO Portal from 7th September 2012.

If you have queries regarding registering on the NEPO Portal please contact Michelle Gray by email at michelle_gray@redcar-cleveland.gov.uk

The closing date for the receipt of completed tenders is 12 noon on 22nd October 2012

The DDN nutrition toolkit

"an essential aid for everyone working with substance misuse"

- **Written by nutrition expert Helen Sandwell**
- **Specific nutrition advice for substance users**
- **Practical information**
- **Complete with leaflets and handouts**

Healthy eating is a vital step towards recovery, this toolkit shows you how. £15.95

AVAILABLE TO DOWNLOAD

To order your copy contact Kayleigh Hutchins:
e: kayleigh@cjwellings.com t: 020 7463 2085

SMHS St Martin's Healthcare Services CIC

LEEDS COMMUNITY DRUGS SERVICE

An opportunity to join a Community Interest Company, part of a dynamic and innovative partnership delivering specialist drug intervention programmes in Leeds.

CLINICAL SERVICE MANAGER

Full Time (37.5hrs) or Part Time (28hrs)

Responsible for managing the clinical service, maintaining high standards of clinical and staff care, ensuring clinical and financial targets are met. Agenda for Change Band 6. You will be required to work across more than one site within the city, car owner is an essential requirement.

Application pack from: Emma Haigh, St Martins Healthcare Services CIC,
0113 244 4102, ehaigh@nhs.net
Closing date for applications: 9am Friday 14th September 2012

Families First

The first Adfam/DDN family conference



Thursday, 15 November 2012 – BIRMINGHAM

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

This conference will bring together family members – many of whom are providing support networks around the country – along with policy-makers and professionals. This is a must-attend event for family members affected by substance use and for all agencies and organisations who genuinely want to support them

Early bird delegate rates for bookings before Friday 14 September
Family members £80 + vat
Professionals £135 + vat
(An additional £10 will be added to bookings made after this date)

Full programme and online booking on
www.drinkanddrugsnews.com
e: conferences@cjwellings.com *t: 020 7463 2081*

Adfam
Families, drugs and alcohol

DDN
Drink and Drugs News

Putting families at the centre of recovery

CONFERENCE PROGRAMME

9.30–10.30am **Coffee and registration**

10:30am **Opening session**
Chaired by Adfam chief executive **Viv Evans**, the session will include a national overview from NTA chief executive **Paul Hayes**, and **Christine Tebano**, founder of Parent Support Link, will give her personal perspective of setting up a family support service.

11:30am **Coffee break**

11:50am **Session two**
Alex Copello, consultant clinical psychologist at University of Birmingham, will present research on coping strategies for families and **Niamh Eastwood**, director of Release, provides advice on families, legal rights around bail, arrest, search warrants, and access to treatment.

12:30pm **Lunch**
Including relaxation therapy and the family groups' exhibition area.

1:45pm **Workshops**
Small practical workshops including help with criminal justice, practical coping strategies, boundary setting and the impact of alcohol

2:45pm **Afternoon session**
Dr Steve Brinksman, chair of SMMGP, will provide a GP's perspective on families affected by drug and alcohol issues and **Karen Biggs**, chief executive of Phoenix House, will examine how treatment services provide support for families.

4pm **Finish**