Issues in Recovery

Innovative Practice in Alcohol Treatment and Recovery

Adfam
Families, drugs and alcohol

Introduction

This briefing draws out the key themes and findings of a Recovery Partnership roundtable discussion held in Sheffield under the Chatham House Rule, in January 2016. The roundtable was the last in a series of six which highlighted innovative practice in regions across England, and looked at the systems, services and people interested in recovery at all levels; from commissioning systems and service providers, to those with lived experience. The specific focus of the event was innovative practice in alcohol treatment and recovery in Yorkshire and the Humber. It was attended by a manager from Public Health England, drug and alcohol service managers, frontline workers, commissioners, volunteers and service users from the region.

This paper will outline the key themes of the discussion, as well as provide some policy context and background. Its scope is limited to treatment and recovery, and does not consider wider issues such as prevention. We acknowledge that it provides a mere snapshot of the current landscape of alcohol treatment and recovery, and not an in-depth examination of all the issues currently facing the sector. However, a number of clear messages emerged from the discussion, including around referrals into treatment, engaging with the client group, complex needs, commissioning and investment in alcohol services, local priorities and new and emerging client and funding trends.

By Adfam on behalf of the Recovery Partnership

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Context

In 2014/15, there were 89,107 adults in treatment for problematic drinking alone, with a further 61,533 treated for alcohol and other substances[1]. Around nine million adults in England drink at levels which pose a risk to their health, with around 2.2 million drinking at higher risk of harm[2]. Over 1.5 million are thought to have some degree of alcohol dependence and, of these, around 250,000 are believed to be moderately or severely dependent – and would benefit from structured alcohol treatment[3]. Alcohol-related harm is estimated to cost society £21 billion a year, with the NHS incurring £3.5 billion a year in costs. Links between alcohol use and many diseases and conditions have been identified (including heart disease, liver disease, cancer and stroke), and alcohol is responsible for a significant number of hospital admissions (approximately one million)[4].

The coalition government's *Alcohol Strategy 2012* set out proposals to tackle the 'binge drinking' culture, alcohol-fuelled violence, and to cut the number of people drinking at hazardous levels. It included commitments to consult on a minimum unit price for alcohol and a ban on multi-buy alcohol promotions, introduced stronger powers for local areas to control licensed premises and described pilot sobriety schemes to challenge alcohol-related offending[5].

Since April 2013, local authorities have received a ring-fenced public health grant, which includes funding for alcohol services. Local authorities are encouraged to design services to meet local needs, working in partnership where appropriate, to prevent alcohol-related harm. This, according to the government, is intended to maximise the scope for early intervention and better meet the needs of specific cohorts[6]. The Alcohol Strategy promotes the sharing of non-confidential information on alcohol-related injuries by hospitals with agencies such as the police, identification and brief advice (IBA) interventions and the appointment of alcohol liaison nurses in hospital emergency departments. It also discusses the concept of 'shared responsibility' with the alcohol industry, and the delivery of evidence-based, effective education and prevention programmes for young people. The government stated that there were 'real and under-exploited opportunities' for health services to identify those at risk and provide appropriate advice and support, whether via regular contact with NHS staff or in particular settings such as Accident and Emergency Departments, through well-evidenced interventions.

"Recovery goes beyond medical or mental health issues to include dealing with the wider factors that reinforce dependence, such as childcare, housing needs, employability and involvement in crime." HM Government, Alcohol Strategy 2012

The complexity of recovery and the issues surrounding dual diagnosis was recognised, as was the need for the criminal justice system to offer opportunities to support people to overcome dependence, and not simply punish offenders. The role of prisons as a rehabilitative opportunity was also discussed.

In the same year as the Alcohol Strategy, the coalition government launched its Troubled Families Programme (TFP), which aimed to 'turn around' the lives of 120,000 of England's most troubled families. These were families, according to the government, with multiple needs, facing numerous disadvantages and causing high costs to the taxpayer. In 'Listening to Troubled Families,' a report by the Department for Communities and Local Government (DCLG), problems with drugs and alcohol were found to frequently be involved in these families' lives[7]. Earlier research into Family Intervention Programmes (FIPs) – a precursor to the TFP under the Labour government – found that, at the point of referral, 39% of families faced poor mental health issues, 33% substance use and 28% faced alcohol problems[8]. FIPs were found to successfully reduce alcohol misuse by 47%. The opportunities presented by such programmes for engaging people drinking at harmful levels are clear. The TFP provided an opportunity to break down local barriers to support for those affected by alcohol use, and to make use of government funding in drug and alcohol support in the wake of potential disinvestment elsewhere. According to DCLG, as of May 2015, over 116,000 of the 117,910 families identified had been 'turned around,' through improvements in the anti-social behaviour, crime and education outcomes or achieving continuous employment[9]. Whether or not this means that those with alcohol problems have accessed appropriate services and received treatment is, however, not known.

The discussion was held at a time when an increase in awareness around alcohol use in the general population was making headlines: Alcohol Concern's *Dry January* and Cancer Research's *Dryathlon* campaigns encouraging people to stop drinking for the month and revaluate their relationship with alcohol

were underway, and the new Alcohol Guidelines came into effect on the 8 January 2016[10]. The guidelines had been last reviewed in 1995, and have changed to reflect new evidence about alcohol and health harms, particularly cancer. The headline change was the reduction of the alcohol limit for men to match the existing women's limit of 14 units per week. Guidance recommended several drink free days per week, limiting the amount of alcohol consumed on any one occasion and drinking slowly, alternating with food and water. Stronger evidence of the links with cancer, particularly breast cancer, was presented, and the new guidelines aimed to keep the risk of mortality from cancers and other diseases low. The guidelines are still under consultation, and have yet to be finalised.

The Recovery Partnership commissioned Alcohol Concern to carry out research to review the state of alcohol treatment in England in 2015[11]. Three national surveys were conducted, alongside 46 interviews and 14 workshops with a mixture of commissioners, service providers, service users and non-specialist staff. It identified four key findings:

1. The alcohol field is enthusiastic about being involved in a debate about its future

2. A gap exists in meeting the needs of people with 'dual diagnosis'

3. Managing change resistant drinkers with chaotic patterns of behaviour can be very challenging

4. The residential rehabilitation sector is facing challenges itself.

Respondents suggested the need for a review and guidance on how to balance the competition driven by the tendering process with service user needs, and also highlighted the issues around partnership working with other local agencies as a result of tendering. Some respondents felt that the local competition borne of the tendering process was having a detrimental effect on care pathways, with some providers reluctant to share information with competitors. Access to residential services was considered to be the biggest gap among key treatment modalities, with variable access and difficulties in securing funding. There was a feeling that the situation around dual diagnosis was deteriorating as a result of both the cuts to mental health services and the fact that they are commissioned by Clinical Commissioning Groups (CCGs), whereas alcohol services are

commissioned through public health. The needs of carers and families, according to respondents, would benefit from further support, and the challenges of engaging GPs and other primary care practitioners were noted. The report concluded that the findings point to a need for greater national guidance, in order to better meet the needs of service users in a time of health and social care upheaval and budgetary constraints.

Key points of discussion

1. Engaging with the client group

One of the biggest challenges for alcohol services is engaging the largely hidden population which may be drinking at harmful levels and identifying those in need of support or treatment. Roundtable participants recognised that intervening in problem alcohol use 'upstream' can prevent more serious issues developing at a later date. Preventative initiatives targeting young people and raising awareness of alcohol-related harms can be an effective way of reducing long-term harms, and participants discussed proactive outreach in the community and night-time economy and making use of social media to spread the messages. Social media provides an effective platform to disseminate information and engage younger people, whilst a presence in the night-time economy setting allows for targeted identification and brief advice (IBA), as well as signposting to appropriate agencies. Sharing knowledge and training staff in the night-time economy to identify and reduce alcohol-related harm is also key but this, participants recognised, is not without its challenges. Securing buy-in from pubs and clubs, as well as local transport and taxi drivers, can be difficult: licensed premises may be wary of agencies sharing information with the police, and overcoming those suspicions can take time. New approaches to engaging people in non-traditional environments was thought by participants to present myriad opportunities in the field of preventative work, early intervention and IBAs.

Training for non-specialist staff who come into contact with those who are drinking at problematic levels was also discussed more widely, including primary care practitioners. Participants acknowledged that universal health services including GPs are also facing a great deal of pressure; therefore, engaging them in screening and referral efforts is a challenge. A number of

Case Study: SPECTRUM Alcohol Liaison Service (ALS)

The ALS was commissioned in 2013 to help tackle the rising number of alcohol-related admissions into Pinderfields General Hospital (PGH), Wakefield. It is the first service of its kind in Wakefield to provide specialist alcohol care in a hospital setting; offering a crucial link between hospital and community services. The on-site presence of the ALS provides opportunities for dependent patients and those at risk of alcohol-related harm to access specialist support quickly. The ALS offers advice to staff who care for patients experiencing alcohol withdrawal, and delivers alcohol awareness training to nursing and medical staff, enabling them to identify patients at increased risk of alcohol-related health issues. Staff are trained to screen for alcohol use using a validated screen tool (Audit-c) and to deliver brief advice where appropriate.

Continued detoxification at home can be provided to patients who want to stop drinking and would otherwise be medically well enough for discharge from hospital. Comprehensive aftercare is provided, together with daily clinics at the hospital; offering prescribing, relapse prevention, extended and brief interventions and advice about health and alcohol-related issues. The ALS team has established strong relationships with community recovery services, GP practices and mental health services to ensure that all patients have a support network in place when they leave hospital. The overall aim is to reduce alcohol related admissions to PGH by raising awareness of the health risks associated with alcohol.

David's story

David was admitted to PGH experiencing abdominal pain and feeling generally unwell. He reported drinking two to three litres of strong cider a day, and experiencing alcohol withdrawal symptoms if he didn't drink. David was prescribed Chlordiazepoxide and referred to the ALS. A member of the team went to speak to him on the ward: he said he was fed up of his lifestyle, but didn't know how to change. David described being close to his Mum, but having lost contact with his teenage son due to his drinking. He wasn't eating properly and only ventured out of his flat to make essential purchases. Most of his money, he said, was spent on alcohol. David had never before been involved with alcohol services and didn't know help was available.

When David was deemed medically fit to be discharged from PGH, the ALS agreed to support a continued detox at home, if David stayed with his Mum until the detox was complete. The ALS provided telephone support throughout the detox, conducted a home visit and an appointment at the ALS prescribing clinic to discuss David's support and treatment options was made the following week. Whilst he decided to try and remain sober without any further medication, he

knew that he could change his mind if he began to struggle, and was given details for a local Smart Recovery group. Over the following four months, David attended initially weekly, then fortnightly, and, eventually, monthly relapse prevention appointments in the ALS outpatient clinic. The sessions provided an opportunity for David to discuss any difficulties he was experiencing, to prepare him to manage social events without alcohol and develop alternative strategies to manage difficult situations.

When discharged from the ALS, David said he would continue attending the Smart Recovery group, having built a strong support network there, and stated that without the ongoing support he had received after detox, he was doubtful he would have successfully remained sober. David is now enjoying life, and likes waking up sober in the mornings. His next goal is to rebuild his relationship with his son.

participants suggested that a proactive and persistent approach is required. Participants suggested that the return on investment argument could be useful in encouraging buy-in, and stressed the importance of word of mouth in engaging multiple partners across an area. A participant from a service working closely with primary care said,

"It's about word of mouth, building a reputation. It's not easy at first... we've found it's about being visible. We're there every day and you keep plugging away at it."

Participants were enthusiastic about the opportunities provided by the use of alcohol screening tools — particularly for self-referrals — and working with a range of partners such as GPs, pharmacists, social services, the police and other health professionals, to encourage referrals into treatment. Participants saw this as a preferable alternative to the single point of contact model for referrals, which would make the process as quick and easy as possible – an advantage when services across the board are stretched to capacity.

The benefits of working in partnership with employers was also discussed. One participant was enthusiastic about the possibility of including questions related to alcohol use in any health checks that employers require of their employees, in order to identify those in need of support. Participants discussed the *Making Every Contact Count* initiative, which is aimed at everyone who comes into contact with the public and has the opportunity to have conversations about health. Its objective is to encourage conversations based on behaviour change methodologies, empowering healthier lifestyle choices and exploring the wider

social determinants of health, and was thus thought to be a good fit for asking the wider public about their alcohol use.

What is clear from the discussion on how best to engage and provide appropriate support to individuals with alcohol problems is the need for partnership working and a collaborative local approach; requiring adequate investment, time and buy-in from a range of agencies. Primary care was considered particularly crucial in identifying problems and referring into treatment, or providing brief interventions and advice for those below the thresholds for structured treatment. IBA additionally provides an opportunity to disseminate information on related matters such as physical, sexual and mental health, drug use and housing, and this was recognised by participants, who considered IBA an effective and powerful tool for engaging the wider population.

2. New and emerging trends

One participant who works with young people in the night-time economy described how they are going to pubs and clubs later and later, forcing the service to adapt its outreach approach. Several participants attributed this to the phenomenon of 'pre-loading,' where younger people opt to drink at home in significant amounts before going to a pub or club. The fact that younger people have already consumed large quantities of alcohol by the time they reach the venue was said to be a barrier to meaningful discussions during outreach activities. One participant shared experiences in their local area, where clubs are reporting lower drinks sales, yet still experiencing the effects of alcohol-related anti-social behaviour, on account of rising 'pre-loading'. Universities adopting more responsible attitudes in the promotion of pub crawls and similar events was also suggested as a possible explanation for this pre-loading culture, as well as the cost of alcohol in pubs and clubs.

Whilst the focus of the discussion was on alcohol, participants felt that to exclude poly-drug use would be to overlook a large cohort of clients in need of and accessing alcohol treatment and support. The rise of novel psychoactive substance (NPS) use amongst alcohol users was noted, alongside a decline in the number of clients accessing treatment for heroin and crack cocaine use. Chemsex – a term to describe 'intentional sex under the influence of

psychoactive drugs, mostly among men who have sex with men' – was also reported to have increased in the region[12]. One participant said,

"We're seeing changes in the cohorts we're dealing with, and it's really interesting when you start looking at the information and planning around that. For commissioning services, this is really quite important, because the pot is getting ever smaller."

Participants from a service working with older people described how an increasing evidence base on alcohol's effects on older people and alcohol-related admissions in that age group has created a clear argument for targeted initiatives for older people. The number of people aged over 50 accessing services rose 44% from 16,627 in 2009/10 to 24,017 in 2014/15[13]. However, participants noted continuing challenges in engaging people who may not know they are drinking at harmful levels. The ageing population in the country was thought to pose a serious problem for healthcare services if their needs went unmet. Participants discussed the more severe effects of stigma in older generations, which can stem from feelings of shame, guilt and blame. This could contribute to older people's reluctance to seek advice or support. The possibility that older people may be at a heightened risk of harm, dealing with significant life transitions such as bereavement, isolation or retirement, was also discussed by participants, together with the need for greater awareness raising amongst this cohort.

"I was speaking to a lady who was drinking a bottle of wine a day, and I told her she was drinking ten units. She said, 'There's not ten glasses in that bottle!' To her, a unit was a glass, so there needs to be education around that."

One practitioner from a residential service provider reported that their clients were drinking less than they used to:

"A few years ago, it was very common they'd be drinking six to nine litres of strong cider a day. It's less common we're getting those referrals now… we're getting more people who are getting 5% ciders, but it's not the kind of 50-60 units a day, more the 20-30 units a day."

Whether this was as a result of changes in the work of community services or a change in clients' drinking habits due to increases in the price of strong ciders was not known.

3. Commissioning and investment in alcohol services

Participants at the roundtable were asked to discuss whether they felt alcohol services were, with the cuts to public health budgets in mind, a sufficient priority in their local areas, and whether they had suggestions for commissioners to improve the quality of local services. Participants unanimously recognised the challenges commissioners are facing in light of restricted budgets, and expressed a sense of disheartenment at the lack of central government funding.

"When the coalition government were coming forward I was really hopeful we were going to see an investment in alcohol, but I think we're seeing a year-on-year disinvestment and cut budgets."

Many participants agreed with the view that alcohol services have long been the 'poorer relative' of drug treatment, and that this was unfortunately still the case. Participants thought that the demand for alcohol services had increased, but the challenges presented by cuts to public health budgets meant that making the case for investment was a difficult task for providers. Reflecting on the low proportion of the eligible population in contact with services, one participant stated:

"It's difficult to make the case, sometimes, for more money and investment in alcohol treatment if people are not coming forward for treatment. There is a need for alcohol services, but there's not necessarily the demand."

When compared with the number of people accessing drug treatment, the proportion accessing alcohol services appears low. The Crime Survey for England and Wales 2014/15 shows that around 2.8 million people had taken an illicit drug in the last year, with around one million having taken a Class A drug within the last year, the majority of whom will not be dependent users in need of support or treatment[14]. In 2014/15, there were 152,964 people accessing treatment for opioid use, 25,025 for non-opiate use and 28,128 for non-opiate and alcohol use. In comparison, 89,107 accessed treatment where alcohol was the main substance[15]. Participants discussed the idea that when faced with cuts, prioritisation could be given to the service most demonstrating demand, and alcohol services, compared to drug services, may struggle in this respect. One participant working in a strategic role said:

"We're in a very difficult position: having to push early intervention, push screening, with no money to pay anyone to do it. We have to rely on good will, and people wanting to push the health agenda; recognising it pays off in less medication, visits to the GP and A&E in the long term, but it's hard to make the case people should do something for free when it's not a palpable outcome initially – you're asking people to invest to save… where you see results in five or ten years' time."

Roundtable participants were in agreement that whilst 'decisions are being made on the basis of people knocking down doors and needing services,' the case for alcohol services must continue to be made on the basis of its long-term benefits and savings for public health and allied areas such as criminal justice.

5. A national conversation about alcohol

Another key point arising from the discussion was the challenges of managing clients with complex needs and dual diagnosis and providing appropriate and effective support, whilst bearing in mind the similar pressures on mental health services. Participants described mental health services being under-resourced and strained. One participant also mentioned how requirements by mental health services that a patient be abstinent from alcohol before being eligible for support can be a barrier to ensuring clients get the support they need. However, some innovative local practices were highlighted, including designated dual diagnosis nurses and leads, partnership working, and care pathways facilitating inter-agency communication between mental health and substance misuse services.

One participant discussed how, in their experience, complex needs clients tend to be high-intensity users, who can be difficult to engage. Participants suggested that national guidance on the issue is desperately needed to support the workforce in overcoming the challenges presented by the cohort of clients suffering from complex needs.

Throughout the discussion, participants frequently referred to the misconceptions and lack of understanding around alcohol and its harms amongst the general population. Participants were of the opinion that many people do not understand – or are unaware of – the guidance around units and safe drinking levels. Social perceptions of alcohol as friendly, sociable and its

Case Study: Alcohol Local Addiction Screening & Referral (LAS&R) Tool in Sheffield

A significant number of individuals in the country drinking at increased levels go unnoticed by services until a serious life or physical health emergency occurs. Late identification leads to poorer treatment outcomes and physical health complications. To tackle this problem locally, Sheffield Health and Social Care (SHSC) substance misuse services looked at how it could better support the early identification of those drinking at increased risk levels, and support a simple and effective referral pathway into treatment. Whilst local and national policies promoted the use of screening tools, it was found that frontline staff were more likely to use 'intrinsic knowledge and awareness,' rather than validated screening tools requiring scoring and interpretation.

An in-house tool was developed, which provides a number of recognised, validated and recommended screening tools, as well as a range of other features such as unit, calorie, prevalence and cost calculators, a personalised brief advice/information leaflet, an electronic referral wheel (a lookup tool to help refer individuals to appropriate services) and an administrative content management system (CMS).

The online screening tool was first launched in July 2012, and was initially used by community pharmacies as part of an alcohol awareness campaign. It has since been rolled out to various organisations and disciplines, including general practice/primary care, multi-agency support teams, children's social care, mental health services, community pharmacies, specialist general hospital/community services, domestic abuse services and local alcohol recovery/voluntary sector alcohol service providers.

The tool offers a fully configurable screening, intervention and referral interface, to bridge the gaps between multiple universal and provider services. Simple, secure referrals into local services can be made 24/7. Its quick, easy and engaging format is attractive to service users, with no use of complex scoring and unit calculations. The tool allows for the delivery of brief interventions, based on service user specific information, and reinforces the correct local pathways through promoting appropriate tools and pathway entry points, which can be configured based on the (professional) user's role or occupation. One of the biggest challenges was securing strategic support, as well as convincing staff (some of whom seemed to prefer to benchmark against their own use of alcohol as a means of screening) to make use of validated tools.

Since its introduction in 2012, the tool has been used 3,195 times by universal services. Of those screened, 73% met the threshold for referral; 26% of whom accepted the support

offered. Those who did not accept were provided with personalised brief advice. Thirty-one GP practices in Sheffield currently use the tool, although anecdotal evidence suggests it is being largely used as a validation tool, with GPs screening those they already consider to have a problem with alcohol. In comparison, social care is making use of the screening tool with all clients with whom they come into contact. The largest number of referrals are made via GPs (56%), followed by social care/Multi-Agency Support Team workers (30%).

The tool's development continues, with SHSC increasing the range of pathways and screening tools available. Work is also being carried out to be able to extend the use of the tool outside of Sheffield, following significant interest from other areas.

normalisation from a young age were thought to explain the lack of recognition of the potential harms of alcohol amongst the general populace. To tackle these misconceptions and raise awareness of the facts, it was suggested that a debate about alcohol would be helpful to change cultural values.

"There's 'Making Every Contact Count,' there's loads of programmes we can utilise more beneficially. Anyone can hold a debate or workshop for very little cost, and there are lots of free, community venues. It's an interesting idea to get that cultural debate going, and debating workshops.... Going out into groups that already exist, like WI or many other local groups, and making yourself available to go and discuss the issues. Asking: what do you think about the new CMO guidelines? Things like that can work. To give feedback on these guidelines – we should see what others think about it."

In addition, outreach initiatives which engage individuals in alternative settings, such as the night-time economy and festivals, were considered useful in helping generate a debate around alcohol, as well as providing brief advice and information. Such outreach programmes are in a prime position to engage those not yet drinking at harmful levels, getting them to think about their alcohol use and the social perceptions around drinking and providing advice and information.

Conclusion

Case Study: The Blue Light Project

The Blue Light Project, an Alcohol Concern initiative, aims to tackle the perception that if a problem drinker doesn't want to change, nothing can be done to help until they discover the motivation to address the problem. The project shows that positive strategies and alternative approaches can be used effectively to support some of the most risky, vulnerable and costly individuals in society. These clients, who are difficult to engage, may be a concern in other parts of the health, social care and criminal justice system.

The project has worked with local authorities across the country to help them better engage and support change resistant drinkers, and has produced a robust guidance document for practitioners. The document states that requiring someone to be free of alcohol before entering mental health services is not a clinically validated response, and recommends that staff should seek help from mental health services, being persistent if they do not feel they are receiving a response which adequately meets the clients' needs. This will be easier if managers and their teams take time to build relationships with colleagues in mental health services.

Read more online here.

The roundtable raised a number of key points that provide an insight into the challenges and opportunities for alcohol services across the country. Positive examples of innovative and proactive work in the region to tackle some of these challenges, engage communities and provide appropriate support and treatment were highlighted. IBAs seem to be an effective and increasingly utilised method of engaging 'hidden populations,' providing support to people who may be at risk of developing an alcohol problem and referring into treatment where necessary. Audit tools such as that in Sheffield were met with great enthusiasm by participants, who were keen to highlight the opportunities they offer to more effectively identify people needing support in universal healthcare settings, and allowing for quick and easy referrals via the correct pathways into services.

Financial pressures were of great concern to participants, some of whom feared disinvestment in their own services, but there was positivity in the acknowledgement that the wide-ranging benefits of alcohol services to health, social care, criminal justice and community wellbeing would sufficiently demonstrate the value of alcohol services – and the importance in health and

social terms of investment. Given the low levels of referrals into treatment, more work needs to be done to target populations who may not see their drinking as a problem, do not realise the potential harms to their health, are afraid of seeking treatment or are resistant to changing their drinking behaviours. Close joint working with universal health services is a way of identifying and intervening early, and maximising the potential for having conversations with people about their alcohol use. For this to be successful, however, staff from a wide range of agencies and disciplines will require training to recognise the signs of alcohol-related harm and have the knowledge to refer individuals towards appropriate treatment and support.

In order to maintain investment, alcohol services may have to take a more proactive approach in engaging the community, thereby increasing referrals and demonstrating the demand for services. This is by no means an easy task given the pressure on public health services. Nonetheless, the work highlighted at the roundtable is evidence that a range of projects and initiatives are engaging previously hidden cohorts and providing support and treatment to help people manage and overcome problems with their alcohol use.

April 2016

Appendix

The roundtable discussion to inform this briefing took place on 27 January 2016 at Sheffield Hallam University, with a regional focus on Yorkshire and the Humber. Other roundtable meetings in this series focus on learning from London, North West England, North East England. South East England and the West Midlands, and briefings and more information are available on the Recovery Partnership website. We would like to thank the participants of the roundtable for their valuable contribution to this briefing.

Attendees:

Carl Cundall, SASS

Mandy Creswell, Sprectrum

Andrew Falconer, Sheffield Health and Social Care

Jonathan Philpott, St Anne's Alcohol Services

Charlie Plucker, B-Chilled

Philip Taylor, Project 6

Liz Butcher, Public Health England

Helen Phillips, Sheffield DACT

Victoria Marley, Lifeline

Lizzie Bowden, Drink Wise Age Well

Emma Wells, Drink Wise Age Well

Stan Foster, GASPED

Wendy Edmondson, LOCALA

Sam Higgins, Phoenix Futures

Lesley Billington, Sprectrum

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About Adfam and the Recovery Partnership

Adfam is the national charity working to improve life for families affected by drugs and alcohol. Adfam provide information and training to practitioners and local authorities and our work also concentrates on piloting and disseminating good practice, representing the views of family members to decision makers and influencing local and national policy. Adfam is a registered charity (number 1067428).

More information on Adfam's work may be found at www.adfam.org.uk

DrugScope, the Recovery Group UK (RGUK) and the Substance Misuse Skills Consortium formed the Recovery Partnership in May 2011 to provide a new collective voice and channel for communication to ministers and officials on the achievement of the ambitions set out in the 2010 Drug Strategy. Following the closure of DrugScope, Adfam joined RGUK as a lead delivery organisation of the Recovery Partnership's programme of work. The Recovery Partnership is able to draw on the expertise of a broad range of organisations, interest groups as well as service user groups and voices.

Further information is available at: www.recovery-partnership.org

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