intervene

JANUARY/FEBRUARY ISSUE 153

A FRESH AND BALANCED PERSPECTIVE ON THE HARM MINIMISATION/TOTAL ABSTINENCE DEBATE

REHABS WORKING TOEGETHER IN COOPERATION TO ENSURE BEST OUTCOME FOR THOSE IN THEIR CARE

ADDICTION INTERACTION AND STRATEGIES FOR WORKING WITH THE COMPLEXITY OF THE MULTI-ADDICTED CLIENT

THE TATTOOIST'S NEEDLE – ANALYSIS OF A GROWING ADDICTION TO SKIN ILLUSTRATION

THE CAUSES OF EATING DISORDERS – MYTHS AND FACTS SEPARATED

THE ROOTS OF MEDITATION AND ITS POTENTIAL FOR USE WITHIN THE 12 STEP PROGRAMME

THERAPY AS A CAREER CHOICE FOR YOUNG BLACK MEN – UKCP'S 'BLACK MEN ON THE COUCH'

NEWS, COMPREHENSIVE TREATMENT DIRECTORY, TRENDS, COMMENT, DIARY, BOOK REVIEWS, SELF HELP

Dear readers,

First of all we'd like to wish you a happy and prosperous 2015 and hope very much that your year has got off to a positive start!

2015 is going to be exciting, not least because of the impending general election but also because of the continuing initiatives and commitment to providing genuine treatment options to those who suffer from problems with addiction. We've already covered in depth how professional therapeutic services are encouraging closer associations with 12 Step fellowships to help people sustain a strengthening recovery and it's great to be able to run an interview with Brian Dudley, Chairman of Choices, a growing group of rehabs who are committed to working cooperatively in order to ensure that their clients have the best and most appropriate treatment available to them (see page 24).

This issue of Intervene sees us cover a wide range of subjects including a detailed feature about addiction to the tattooist's needle, eating disorders, the origins and applications of meditation and a balanced and fresh assessment on the harm minimisation/abstinence debate.

This publication of the magazine is also significant for another reason. We are now publishing the magazine independently (the previous directors have stepped down) and will soon be announcing some very exciting plans to broaden our online activities under the Addiction Today brand, exploiting digital technologies to their fullest to bring you the most cutting edge 'one stop shop' available in the sector.

We're also very proud, as ever, to continue to be UKESAD's media partner - Europe's biggest addictive disorder event. As the weeks tick by to May 4th, 5th and 6th we'll carry all the detail you'll need to sponsor, reserve exhibition space, come as a delegate (check out www.ukesad.com or contact us on either of the emails below for more detail).

We'd love to hear from you, your views about ongoing political debate, commissioning, new treatment initiatives or whatever you feel feeds into our mission to spread the word of abstinence based recovery.

One final quick thing, we're tidying up our databases and to be absolutely certain of receiving your copy of Intervene, please send us your address (postal and email) to subscriptions@addictiontoday.org

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INTERVENE'S MISSION IS TO:

- provide advice, support and guidance to anyone suffering from addiction/dependencies and to those involved in their care
- educate, teach and train professionals working with people with drug and alcohol problems in the methods and practices for prevention of and recovery from addiction/dependency
- conduct and disseminate research into the care and treatment of people with addiction or dependency problems.

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JAN/FEB 2015

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Contributors... *january/february*

Inside information on the people who shared their knowledge, wisdom and talents to make this issue of Intervene possible

DAVID BROWN

David Brown is a professional interventionist, mentor, coach, public speaker and educator. He was educated in Cumbria, England and has travelled the world extensively. Given half an opportunity to talk anywhere, anytime about addictions and you will find David in the middle of that conversation. He is a Licensed Addictions Counsellor and a Board Registered Interventionist. He is also a CSAT (c) as he believes that increasing his knowledge will make him more effective in the field. Together with his wife they head Avenues to Recovery, Inc. a U.S. based practice that provides substance abuse treatment, intervention and recovery mentoring services. His personal recovery dates from August 1, 1982.

TARA DAY

Tara previously had a law career, spanning across two decades, working for one of the world's most influential media, defamation, libel and human rights lawyers. Through this professional legal work and as a result of an increasingly human-rights orientated and socially aware case-load, she came to realise that there were unmet needs in the community which gave rise to personal assessment of how best to contribute to society. After careful consideration, she embarked on a certificate in Counselling and Counselling Skills at Birkbeck University of London and was subsequently invited to join the MSc in Addiction Psychology and Counselling at London South Bank University. It was here that she researched and completed her dissertation on The Psychology of Tattoo Acquisition in terms of a 21st Century Addictive Behaviour. Tara is a qualified Addictions and Trauma Therapist. (Photograph by Laura Lewis).

JOHN GRAHAM

John is an established Yoga practitioner and a BACP-registered therapeutic counsellor specialising in abstinence-based addiction treatment – principally Twelve Step facilitation – within the private, corporate and statutory sectors, including the criminal justice system. John is himself in his twenty-first year of abstinence-based recovery and recognises Step Eleven to be the nexus within which all the preceding Steps are subsumed and Step Twelve is predicated on.

JIM SMITH

Jim smith, a qualified social worker, has worked in the caring professions for over 25 years. Jim is now perhaps best known as a sober musician presenting workshops on recovery; he is also Musician in Residence for the Westminster Drug Project. Jim has been a columnist for Addiction Today and Intervene for over 3 years.

GEMMA WOOD

Gemma is very passionate about her work as a fully qualified Person–Centred Counsellor that has over 17 years' experience, both personally and professionally, within the field of Mental Health, Addictions and Eating Disorders. Gemma also has vast experience working with all age groups, including children and adolescents. Since qualifying, Gemma has furthered her training to specialise in Eating Disorders, Trauma and Anxiety disorders. Currently she is training in EMDR (Eye Movement Desensitization and Reprocessing) and offers a multi skilled approach, combining a number of therapeutic models (CBT, EFT, Sedona Method, RPT and Healing) to facilitate a tailored treatment plan for each individual's needs. Gemma is a registered member of the British Association for Counselling and Psychotherapy (MBACP) and abides by their ethical framework and guidelines. More information can be seen at www.bacp.co.uk

CHULA GOONEWARDENE

Chula Goonewardene MBACP has worked with over 500 clients in community-based treatment and moved into Treatment Management and Training in 2010. Alongside his private practice, he currently manages a team of twelve to deliver a group-based Recovery Programme in North Westminster and still finds time to play the drums in two bands.

What we provide treatment for:

The Landre Capital Group provide services for both Private and Statutory services; provision of Primary Treatment models, Secondary and Step-down care span over the group. Our focus on supporting long term abstinence based recovery drives our 'Recovery Community', with re-integration programmes across both sectors.

Addictive problems suffered

Our Treatment Model

The model consists of:

Group therapy & 1 to 1

Equine and music therapy

12

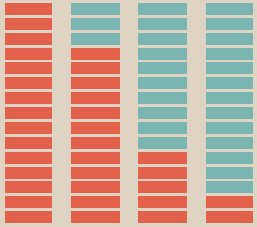
Workshops, relaxation/meditation, core 12-step therapy

Trauma and shame reduction, Aftercare, Replapse Prevention, Alumni and Recovery Community

Admissions Worldwide

Treatment Outcomes

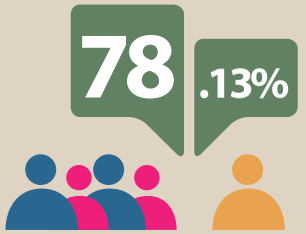
Anxiety improved by 87%



Panic reduced by 89%

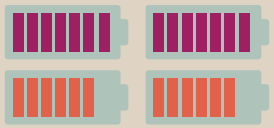
Depression improved by 85%

71.03% had their goals met



said we communicated effectively with your family

Felt they were treated in a safe and respectful way



92% said satisfied

How would you rate the therapists?

Overall: Very good 83.5%

95% Thought our treatment was GOOD/ VERY GOOD

successfully completed treatment

How would you rate the programme?

94% Thought the programme was GOOD / VERY GOOD

Contact us:

t: 020 7486 9646
e: info@one40.org
w: one40.org.uk
admissions: 0800 011 2705
One40 Ltd, 140 Harley Street, London, W1G 7LB

497 Exit survey results May '13 to start Jan '14 @ TTP & One40 Clinics.
244 Follow up surveys 148 = 61% responded, 96 = 39% did not.

DANISH DEVELOPMENT IN COCAINE TREATMENT

A recent Danish study has provided a glimmer of hope for those living with cocaine addiction. Researchers have developed a new drug that would be used in addition to recovery therapy, and although it would not be able to make the cravings disappear completely, it would make the recovery process much easier.

The researchers, from the University of Copenhagen, recently gained more knowledge of the biological mechanism behind cocaine's euphoric effect: They uncovered the interaction which controls access of dopamine, the hormone which signals pleasure in our brains.

"If we have a better understanding of the dopamine transporter function we will become more proficient in developing an antidote against addiction," said Associate Professor Claus Juul Loland, from the Department of Neuroscience and Pharmacology, in a press release.

Cocaine acts as an inhibitor of the dopamine transporter. "We found two amino acids in the proteins that dynamically breaks and forms an interaction," Loland said. "If the interaction were to be broken that would mean that cocaine would no longer be able to produce its pleasurable effect, or as Loland puts it, "cocaine will not then work anymore."

In an email to Medical Daily, Loland explained that theoretically this drug would work similar to how methadone works for heroin addicts.

"The drug would have to be taken regularly. It occupies the cocaine binding site, without the stimulating action of cocaine. But it would also be degraded and have to be replenished," Loland said.

This would not only work on cocaine but also other similar drugs, most notably amphetamine (speed or Adderal) and methylphenidate (Ritalin). The drug, although impressive, would not be the one step "cure" to cocaine addiction.

"The drug is not a wonder drug," Loland said. "It would aid in the treatment of cocaine addiction, but the patient would have to be willing to go into rehab and other actions have to be taken in addition to this."

While one piece of the puzzle has been solved, there is still more research needed before a true antidote for cocaine can be created. Loland says researchers typically say 10 years when they cannot give a time frame, as it "depends on 50 percent research and 50 percent political willingness to put efforts..." forward.

CHILDREN OF ALCOHOLICS DON'T ALWAYS REALISE THAT THEIR OWN ISSUES START WITH ANOTHER'S ADDICTION

Many children of alcoholics seek help from a therapist, but they may not realise that their problems started with someone else's addiction.

The realisation that "my parent is an alcoholic" can be a breakthrough moment for someone in therapy.

Lee Taylor, the family programme coordinator at Castle Craig, says that many families that are affected by addiction try to keep it secret: "They fear that someone will find out. They have learned to lie about it. There's a lot of anger within the family."

Often the family members don't know what's wrong. They might suffer from a loved-one's alcoholism for many years, and develop distinct psychological problems, but without realising the causes.

Kwan Yin-Bruhl, a psychologist from France, says: "children of alcoholics who seek therapy don't often make the link between their issues and their parents' addiction." She recently treated a patient in Lyon who had attempted suicide and didn't make any connection between her problems and her alcoholic father. According to Kwan, "it was only when she started talking about how she felt about her father that she could consciously say: My father is an alcoholic." This is a crucial step in the treatment of the patient.

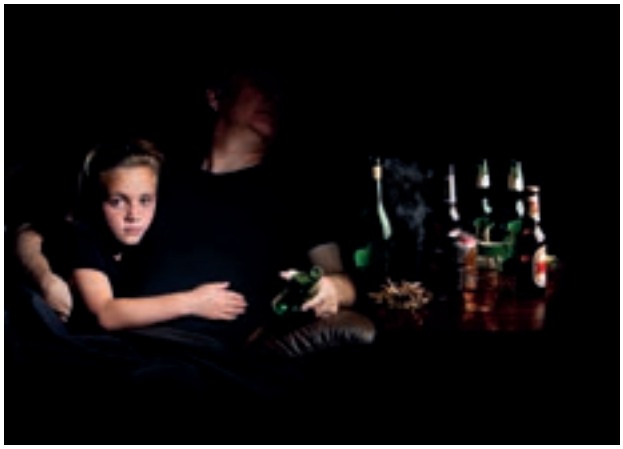
The recovery process can only start when the patient accepts that they're not responsible for their parent's behavior. Having identified the source of the problem the treatment can begin -- by addressing the negative feelings about, in this case, the alcoholic father.

Kwan helps patients identify their negative beliefs and change them. She also helps them understand their strengths and weaknesses.

"I help patients address their shame and guilt", she explains, "then we start treating their anxiety problems, their negative feelings as well as the drinking issue of their parents."

During this difficult process, in which the patients have to address a lot of feelings, Kwan says: "the main problem is that the patients are so scared. They are afraid to talk to their parents about their alcoholism."

Once the patients accept that alcohol is not their problem, they can begin to live their life without guilt.



TRAINING

Following the success of their first Trauma & Re-Parenting Model Training Course in London, Europe's leading trauma experts Chris John (MSc, BACP Accred), Barbara Pawson (MSc, BACP reg) & Sarah Bridge (LCSW) present another opportunity for counsellors & therapists who work with trauma and co-dependence issues to benefit from this pioneering training.

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PEOPLE WHO CARRY A PARTICULAR GENE VARIANT MAY BE MORE LIKELY TO DEVELOP AN "ADDICTION" TO TANNING

A preliminary US study suggests the idea that ultraviolet light can be addictive -- whether from the sun or a tanning bed -- is fairly new. But recent research has been offering biological evidence that some people do develop a dependence on UV radiation, just like some become dependent on drugs.

"It's probably a very small percentage of people who tan that become dependent," said study author Brenda Cartmel, a researcher at the Yale School of Public Health.

But understanding why some people become dependent is important, Cartmel said, so that refined therapies can be developed.

"Ultimately, what we want to do is prevent skin cancer," she said. "We are seeing people getting skin cancer at younger and younger ages, and some of that is definitely attributable to indoor tanning."

In the United States, the rate of melanoma has tripled since 1975 -- to about 23 cases per 100,000 people in 2011, according to government statistics. Melanoma is the least common, but most serious, form of skin cancer.

From a starting point of over 300,000 gene variations, the researchers found that just one gene clearly stood out. The two groups differed in variants of a gene called PTCHD2.

Some other gene variants known to be linked to addictive behavior were not clearly connected to tanning dependence. But Cartmel said that might be because the study group was too small to detect statistically strong differences.

Dr. David Fisher, chair of dermatology service at Massachusetts General Hospital in Boston, agreed that larger studies are needed.

In a recent study, Fisher found that exposing mice to a daily dose of UV light boosted the animals' blood levels of beta-endorphins -- "feel-good" hormones that act on the same brain pathways as opiate drugs, like heroin and morphine.

That suggests UV exposure is rewarding to the brain. One theory, according to Fisher, is that because sunlight triggers the skin to synthesize vitamin D, the human brain evolved to find UV exposure rewarding.

But how do people know when they cross the line into "dependence?" Cartmel acknowledged that the concept of tanning dependence is still debated, and there is no official definition.

People in the study were considered tanning-dependent if they were "positive" on three different questionnaires. Essentially, they had to show signs that mark addictive behavior in general -- like craving, loss of control and withdrawal symptoms when they could not tan.

The current findings, along with other research on the biology of tanning dependence, do help solidify it as a "real" condition, according to Cartmel. But right now, she noted, there is no specific therapy for it.

The study was published recently in the journal, Experimental Dermatology.

SOME DOUBT EFFICACY OF SATIVEX

A leading developer of cannabis-based pharmaceuticals experienced wild lows and highs on the stock market as investors suffered severe anxiety attacks after latest trial updates.

GW Pharmaceuticals has been developing experimental cannabinoid pain-relief medicines for cancer sufferers as part of a programme that has seen the Wiltshire-based company valued on the stock market in recent months at as much as £1 billion.

However, an update this month on late-stage clinical trials into the efficacy of its Sativex medication suggests that the drugs do not necessarily work. The trial, said GW, “did not meet the primary endpoint of demonstrating a statistically significant difference from placebo”.

Sefton Park

For addiction treatment that works

We work hard to make sure that each client receives treatment that is personalised to their specific needs. Each recovery journey will be unique, however, all recovery journeys start with gaining abstinence. We equip clients with the knowledge, the life skills and the confidence needed to live a life free from dependence on drugs or alcohol.

A safe and supportive setting: Where our clients are encouraged to explore and understand the underlying causes of addictive behaviour and it's impact on others.

Therapeutic Community: Working within the group, and supported by our counsellors, each individual will find the support they need to begin their personal recovery journey by becoming abstinent, which leads to recovery.

Living the change: Existing members of the therapeutic community demonstrate how their treatment programme is working for them, and new members gain confidence and the improved motivation to fully and actively participate in their personal treatment programme.

Building a platform for recovery: We help all our clients to re-gain control of their lives and to achieve abstinence. We assist each client to build the platform of abstinence needed to live free of their addiction and gain the tools and resources to maintain their recovery.

Discovery Days Programme: Enjoyable activities such as orienteering, canoeing, caving, climbing, bush craft, falconry, fieldwork and archery. Members of the community participate in a range of activities with the support of their peers.

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Our Therapeutic Programme

Our treatment helps people who want to gain control over their lives and who have decided that being abstinent and free of dependency is the way forward.

The treatment is not 12-step nor is it based on any religious faith. Treatment is available to all who want to take responsibility for their own actions and begin their recovery journey.

The team of experienced and knowledgeable counsellors provide the therapy. Their relationship with the client is individual, empathetic and supportive. Using an Integrative approach they are able to draw on a range of interventions to meet the specific needs of each client.

Healthcare professionals, complementary therapists and our team of support workers and volunteers work with the counsellors to provide our clients a rich and comprehensive treatment experience.

Our commitments to our clients

We will always do everything we can to help our clients achieve their goals.

We provide each client with a safe place and the support they need to explore and understand the causes of their addictive behaviour.

The dedicated focal counsellor works with each client on a one-to-one basis to create the care plan with the client in line with the goals the client has for the future.

We provide the opportunity for our clients to improve their fitness, become healthier and gain the knowledge, the life skills and the confidence needed to live a life free from dependence on drugs or alcohol.

We will help each client to find accommodation at the end of treatment and support the client in developing their plans for a future life free of dependency.

The client experience

Our clients will experience high quality care and the space and support they need to work through their issues.

We work to support our clients in achieving their goals.

We know our treatment works and we are optimistic for every client we work with.

Our clients are treated with courtesy, empathy, honesty and respect.

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"The hope and encouragement you have shown me will never be forgotten"

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HAVING MEDICAL VALUE DOESN'T MAKE A MEDICINE

The primary intoxicating chemical in marijuana – delta-9 tetrahydrocannabinol, or THC writes Professor Mark Kleiman – is also the active ingredient in Marinol, approved by the Food and Drug Administration as an appetite stimulant and anti-emetic and anti-nausea medication. At the same time, the government's drug-abuse-prevention messages stress that THC is the most dangerous element in cannabis. Contemporary pot, we are told, is a much riskier drug than the material sold thirty years ago; it has more THC, and less cannabidiol (CBD), which partially counteracts the anxiety-provoking action of THC.

But we are also told that there's inadequate scientific evidence to show that natural cannabis has medical value.

Somehow the official spokesmen manage to ignore obvious contradiction here. If high-THC cannabis is more dangerous than low-THC cannabis, then how can it be that pure THC is a medicine while natural cannabis, with less THC and at least some CBD, is "Cheech and Chong therapy"? The real answer seems to be that pure THC, taken orally, is so unpleasant that very few people will use it voluntarily except as medically directed.

Surely if THC has medical value, and the other chemicals in natural cannabis add a safety factor, then natural cannabis must also have medical value. That point is so obvious that it can be missed only by someone whose paycheck depends on not understanding it.

But "having medical value" isn't the same thing as "being a medicine." A medicine is a material of known chemical composition and dosage that has been shown in clinical trials to be safe and effective in the management of some condition in some patient population. By that standard, natural cannabis can't be a medicine, simply because natural cannabis varies so widely in its chemical content: not only from one strain to another, but from one plant to another and even from one bud to another from the same plant.

If I have an infection and go to my internist, she does not say to me, "You have an infection. I have heard reports that antibiotics can treat infections. I recommend that you take some antibiotics." No, she writes me a prescription for (say) 100 mg. of amoxicillin, three times a day, with meals, for seven days. "Blow some weed" is not a prescription. That's the reason that "rescheduling" cannabis to recognise its medical value is a non-starter legally; rescheduling needs to follow clinical research, and would apply only to specific products, not to the plant generically.

PRESCRIPTION DRUG MISUSE GROWTH

The first signs of a US-style epidemic in the abuse of prescription drugs in Britain have emerged with an upsurge in the misuse of two anticonvulsant drugs being reported around the country.

The 2014 annual DrugScope survey shows drug workers reporting a significant upsurge in the use of the prescription drugs, pregabalin and gabapentin, especially amongst heroin addicts and within prisons.

The survey says that the two drugs, which are used to treat epilepsy, neural pain and anxiety, when combined with depressants can cause drowsiness, sedation, respiratory failure and even death. It adds that official statistics show that the two drugs were mentioned on 41 death certificates in 2013.

"We have seen a big rise in the illicit use of pregabalin and gabapentin," said one drug worker in York quoted by the survey. "The effects are horrendous and life threatening. People become so heavily intoxicated because they are mixing several drugs at a time.

"The drugs can reduce the heart rate and if taken with methadone can be extremely dangerous, so we now have to consider whether people are using these drugs when we prescribe methadone," he added.

The report says that growing concern has led to GPs and other prescribers being asked to take more care to ensure they do not appear on the illicit market. Public Health England and NHS England warned last month about the rise in prescribing of the two drugs.

They pointed out that there were 8.2m prescriptions issued for them in 2013, representing a 46% rise for gabapentin over two years, and a 53% rise for pregabalin over the same period.

One recent study showed there are now more than 1,800 inmates in prisons in England and Wales being prescribed gabapentin or pregabalin which represents nearly 3% of the prison population and is twice the rate of prescribing in the wider community.

Bargains with Chaos

Counsellor and Interventionist *David Brown* looks at the complexity of multiple addictive behaviour in his work with Addiction Interaction Disorder.

I have been carrying out interventions for around ten years and have completed in the region of one hundred and eighty. I have always been successful in bringing the message to the still suffering alcohol or addict and his family. The loved one usually goes to treatment. In fact, I thought I was good at what I did until the term 'addiction interaction disorder' began to crop up in my daily life. The term was originally coined by Patrick Carnes the renowned, sex addiction guru and has been further refined by Rob Weiss in all of the ground-breaking work that he has been doing in the area of sex addiction. Now when approaching an intervention I ask many more questions because I understand that there are always multiple layers to addiction and there are even more fused into the process or hidden under the surface.

In my interventions what I consciously strive for is to achieve a better understanding of addiction interaction, which, beyond question, puts me in a better position to serve the needs of my clients. This leads to better episodes of treatment for these clients and significantly improved outcomes for them and for their families. I now see what clinicians have long noted which is that sex addiction has been woven into an intricate web of addictions, compulsions, and avoidance strategies. If we consider this in the context of treatment then the client's experience is enhanced as we are addressing the whole person and all of the nuances of their personal addiction.

We know that multiple addictions combine to overwhelm a person by their complexity and power. The phenomenon is so strong that no specific focus is powerful enough to escape from it. As a consequence if the addict has pulled the interaction card they switch from one problematic substance or behavior to another. If they can't use one substance or activity to escape and dissociate from life, they'll take another addictive route. For instance, Marie is an active alcoholic who occasionally feels bad about her drinking and sobers up. But any time she stops drinking, she binge eats, numbing out with food instead of her usual alcohol. Later, when she goes back to drinking, her food consumption returns to normal.

With co-occurring addiction, addicts utilise multiple addictions simultaneously. For instance, Jason drinks alcoholically, uses cocaine, and gambles at the local casino. Most nights he tells himself he's only going to have a beer or two at home, but before he knows it, he's coked up and sitting at the blackjack table, with the nearest cocktail server on high alert. Nearly always, if he's doing one of his addictive behaviors, he's doing all three. The mono-drug user and addict is a vanishing species in American culture. The reality for our patients is that they have made a number of 'bargains with chaos'. If each addiction brings unmanageability to the patient's life, it would be clinically negligent to think that the resulting chaos from each does not compound the problems of the others. The whole may in fact be more than the sum of its parts.

In my own journey I used to attend a meeting in Chicago where a happy and sober friend would announce at the beginning of the meeting that he was addicted to anything he did twice. He would say this in jest! I get it, I understand.

Patrick Carnes produced data that connected sex addiction with other addictions. He followed a sample of 932 sex addicts (Carnes, 1991). Within that sample, 42% reported chemical dependency, 38% reported an eating disorder, 28% reported compulsive working, and 26% reported compulsive spending. As part of their recovery, they also identified multiple addictions in their mothers (22%), fathers (40%), and siblings (56%). Over time, numerous studies have documented the co-morbidity of sex addiction and other addictions.

Let me give you a snapshot of what one of my recent clients looks like and how he demonstrates the way in which addiction interaction disorder presents itself in practice.

The client is wealthy, lives in Florida, married with two children and a practicing Anglican. Education, money and making things 'look good' to the outside world were the primary values promoted in his family. The client has an advanced degree in business and is the CEO of a family owned company. His father is patriarchal and a bully. Father is also a functioning alcoholic whose mother died of alcoholism. The client is the youngest of three children raised by their biological parents in an upper class home. His older brother is alcoholic and his older sister has a long term eating disorder as does her oldest daughter. He described the atmosphere at home as rigid, and emotionally distant. His Mother instilled in him a fear of disappointing significant people in his life creating his guilt, shame and loyalty uncertainty. Expressions of love and support were lacking and there was a general sense of insecurity with poor bonding. He denied any history of physical or sexual abuse, although he did state that he was mentally and emotionally abused. He was 'the lost child' and separated from the family for ten years while in college and living in California during that period. As you can see Alcoholism and Addiction is apparent all over the family map.

He was assessed using theSAST, SDI Core 14, with co-occuring disorders:
Opioid Dependence: 304.01
Cocaine Dependence: 304.21
Nicotine Dependence:
Alcohol Dependence 305.1
Alcohol - At time of admission he reported having maintained sobriety for nearly twenty years, although he continued drinking alcohol on a "social basis" and periodic binges with cocaine. He did have periodic relapses during that time frame as he would go on "fishing trips" or "binge use" trips with no holds barred. He identified as an addict with a multiple drug history that included alcohol, marijuana, cocaine and opiates. He also has a history of experimental use with ecstasy, LSD, during his late teens to his late 20s. He also used Ativan that met diagnostic criteria for dependence.
He scored highest in the following types; Drug Interaction, Anonymous Sex, Seductive Role Sex, Fantasy, Paying for Sex (power), Paying for Sex (commercial)
Associated problems:
• Aversion to personal powerlessness
• Family of origin dysfunction
• Psychoanalytic view of chemical addiction
• Entrenched denial system
• Poor understanding of progression related cravings and loss of control
• Intimacy Deprivation
• Spiritual disconnection
• Emotional isolation
• Problems with occupation and peer group

When this person got to treatment the first priority was getting his substance abuse under control. Only then was it prudent to begin stripping away the layer of all the other elements of the addiction. If we concentrate on curtailing substance use only, the individual will inevitably find it very hard to keep to the rules of behavioral sobriety. After all, as mentioned above, addictive substances are disinhibiting, and the best of intentions often fall by the wayside after a few drinks, a bump of meth, a couple of hits on a joint, etc. In this case our client had a ritualized use of IV heroin which was combined with a street prostitute becoming his friend and shooting him up as he disliked needles.

Cross- and co-occurring addictions are especially common among men and women who act out sexually. In one early survey of male sex addicts, 87 percent reported regularly abusing either an addictive substance or another addictive behavior. Male sex addicts often pair sexual activity with stimulant drugs like cocaine and methamphetamine (plus erection-enhancing prescription medications like Viagra, Cialis, and Levitra). There is no similar research for female sex addicts – in fact, there is a dearth of research on female sexual addiction in general – but we can assure you that women sex addicts do frequently present in treatment settings with cross- and/or co-occurring issues. Often they pair their sexual acting out with an eating disorder, but they may also pair it with alcohol or drugs, including meth and cocaine.

Stimulant drugs are popular with sex addicts of both genders because these substances create feelings of euphoria, intensity, and power, along with the drive to obsessively carry out whatever activity the user wishes to engage in – including sex. In fact, users say stimulant drugs allow them to be sexual for hours or even days on end. Nevertheless, not all cross- and co-addicted sex addicts like stimulants. Many prefer alcohol, marijuana, benzodiazepines, and/or other substances (or even the rush of another addictive behavior, such as gambling). Sadly, the intoxication and disinhibition evoked by addictive substances leaves sex addicts highly vulnerable to STDs, sexual violence, unwanted pregnancy, and other sex-related issues.

Ultimately cross and co-occurring addictions are all driven by the same thing. In short, addicts of all types are seeking emotional control – the ability to reliably escape and dissociate from emotional discomfort and the pain of underlying psychological conditions (depression, anxiety, unresolved early-life trauma, deep shame, etc.) So whatever the addiction – drugs, alcohol, gambling, sex, eating, spending, or anything else – the motivation is the same. The addict wants to control and/or avoid the feelings and emotions evoked by real life. In other words, substance abusers and behavioral addicts alike engage in their addictions not to feel good, but to achieve a sensation of disconnection and numbness.

The threefold result is always the same. There is an obsessive craving for the addictive substance or activity together with an inability to stop the behavior despite adverse consequences and a negative impact on health, self-esteem, family, relationships, finances and career.

When I see this I need to counsel my client that it is time to not only address the more apparent issue, but also to screen for all other potential addictions. The simple truth is that if all of an addicted client's addictive behaviors are not addressed, their chances of having a long and successful recovery are limited. In other words, if I am treating an alcoholic who's stopped drinking, that's great. But if he's hitting the casino every night and achieving the same sense of escape and dissociation, then he's not making progress, and the other issues he's dealing with – impulsivity, relationship issues, trouble at work – are unlikely to go away.

This article could not have been written without the assistance and input of Robert Weiss LCSW, CSAT-S who is Senior Vice President of Clinical Development with Elements Behavioral Health. He has developed clinical programs for The Ranch outside Nashville, Promises Treatment Centers in Malibu, and The Sexual Recovery Institute in Los Angeles.

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The Psychology of Tattoo Acquisition

Tara Day is a trauma therapist and has pursued a specific interest in tattoos within the context of her work. She considers the perspective that tattoo acquisition can be adaptive behaviour or a process addiction and considers what conclusions can be arrived at by studying it in detail.

For centuries, sub-cultures ranging from ancient warriors to those on the fringes of society have organised themselves around symbols etched into their skin. Tattoos are ritualistic, permanent and defining. They are seen as an unspoken symbolic language that are said to echo the experiences of the individual by way of coded messages hidden within layers of imagery.

As society becomes increasingly tattoo-acceptant, tattoo acquisition is fast becoming a growing phenomenon amongst individuals of all socio-demographic backgrounds. Consequently, the number of individuals who express themselves through the symbolism within tattoos to the detriment of self could also be on the increase. Therefore, greater understanding of their prevalence and the concept of tattoo acquisition as an adaptive behaviour or process addiction may prove useful and have implications in terms of treatment and prevention strategies.

Western culture assumes that adult behaviour is rooted in childhood. In the clinically based model of Developmental Immaturity, Mellody (2003) postulates the nature of a child at birth is of a precious ego state, in that children are born: precious just as they are; can expect protection; are human and make mistakes, as such are seen as being perfectly imperfect; dependent upon others for their needs and wants, and need containment. Children obtain their sense of identity by internalising or introjecting the caregivers' perceptions of and beliefs about the child. In order for children to arrive in adulthood as mature functional adults, each characteristic needs to be developed by a major caregiver.

Any behaviour exacted upon a child that is less-than-nurturing,[1] is defined by Mellody as trauma, which may cause developmental immaturity, equally shaping a child's relationship with self, others and their environment. Individuals may grow physically and chronologically, yet remain childlike, and it is these wounds that drive their vertical rather than horizontal adult behaviours. Relationally traumatised individuals experience difficulties with: esteeming themselves from the idea of inherent self-worth; protecting and nurturing themselves, being real, understanding their own needs and wants, and living life with an attitude of moderation in all things. If an individual does not have a respectful, affirming relationship with self, relationships with others automatically become dysfunctional and maladaptive. Such individuals are prone to develop addictions, mood disorders and physical illness.

According to the model, addiction problems usually manifest themselves as a means to attempt to medicate unwanted reality, create intensity or to alleviate pain. It recognises that any substance or process, perceived as relieving distress can become an addiction. Thus addiction is seen as a symptom of developmental immaturity as a consequence of childhood trauma (Mellody, 2003).

Potential relationships between individual developmental pathways, trauma and tattooing have been revealed in a study I conducted as part of a research project carried out London South Bank University. The research involved thematic analysis of interviews with heavily tattooed individuals who identified as aesthetic, committed but concealed or committed collectors[2] . The aim was to garner an understanding of how tattoo acquisition might mirror the addictive process in terms of presenting a compulsive and obsessive pattern of behaviour, engaged in to the detriment of self. Interviews were conducted with twelve amateur and modern professionally[3] tattooed adults, aged between 20 and 47, and varying in culture, gender, profession, sexual orientation, and socio-demographic background.

FAMILY OF ORIGIN

The interviews revealed a number of patterns in how Family of Origin - early relationships and experiences with primary caregivers, whether positive or negative - contributed to or inhibited the participants'

psychological development, and in how adverse life events influenced their developmental pathways. Though almost all the participants interviewed experienced a conventional parental setting during their early, formative years, half experienced parental divorce during childhood and were subsequently raised for significant periods by single-parent caregivers. Of those who experienced conventional parenting, more than half described what each viewed as a less-than-nurturing parental template, with only one of whose parent's remained married. Fewer participants reported a nurturing or neutral template; loss of a parent through death, divorce or estrangement was a common theme.

Of course, starting on a less-than-nurturing pathway does not guarantee arrival at a particular destination – addictive behaviour – but it does make it more probable. However, it would appear that the further down a less-than-nurturing pathway a participant travelled, the greater the probability became. Adverse life events emerged as a variable influencing the developmental pathway followed.

ADVERSE LIFE EVENTS

All participants described experiencing some sort of adverse life event, including emotional, physical and/or sexual neglect/abuse during their life, often - though not always - by a primary caregiver. Some described experiencing emotional and physical neglect/ abuse as a consequence of their primary caregivers; whilst others experienced sexual abuse not directly as a consequence of their primary caregivers. Household Dysfunction was also commonly described, such as witnessing a household family member treated violently, household substance abuse by a primary caregiver or mental/physical illness in the household. Half of the participants had also experienced institutions. The model suggests that childhood abandonment, neglect, abuse and exposure to other traumatic stressors are risk factors for addictive behaviour (Mellody, 2003).

FUNCTION OF TATTOOS

Most participants sought and obtained their first tattoo during adolescence (13-21), supporting the widely held view that initial tattoo acquisition, in the modern, mainly Western and typically collectivist societies from which these individuals are drawn, usually function at some level as an adolescent rite of passage, as individuals struggle for identity and control over their changing bodies. Half described their initial tattoo acquisition explicitly as a rite of passage; although some did not articulate the link explicitly, in their descriptions of themselves in adolescence, it appeared to be implicit. Given half the participants described their initial tattoo

acquisition as an adolescent rite of passage; we might expect that cessation would occur upon execution. However what began to emerge was a suggestion that although stimulated by environmental features, tattoo acquisition served other functions, namely as; an anchor, mask and symbol of change, irrespective of a transitional milestone.

Some participants discussed conceptualising the tattoo as an anchor, marking special memories of stability, in stark contrast to the nomadic upbringings their primary caregivers provided. Some developed the concept of tattoo as a mask, either charting the progression from drawing on paper, to dolls and eventually their own skin as a natural one; to emulating the personas of aggressive, muscular tattooed men within the community as a means to protect against and/or incite violence. Others acquired commemorative tattoos after sudden and unexpected familial deaths. Unable to synthesise the trauma owing to its sadness and enormity tattoos were used as a means to externalise grief and mark changes visually and symbolically.

Although each participant travelled their own wounded path to tattoo acquisition, the common denominator was the exclusion/preclusion of an in-group as consequence of less-than-nurturing parenting, adverse life events and the embracement of the sub-culture of tattoos to dissociate from mainstream society and form allegiances with an out-group – adaptive behaviour. Their tattoos served different functions and five, albeit overlapping strategies were identified as follows: tattoos as a means to control, change feelings,

mask, self-harm/coping strategy and alexithymia (the inability to identify and describe feelings in the self). It also appeared that as a participant's tattoo process progressed in intensity and frequency, the functions tattooing served for them also increased

Negative control issues are seen as a maladaptive-behaviour often in response to dysfunctional parenting (Mellody, 2003). Some participants voiced the function of their tattoos was specifically to control their physical appearance and spoke of the pleasure they experienced by determining another's reality. Others described using tattoos as a means to alleviate their own reality, by way of euphoria or displacement. Further along this continuum were participants who described self-harming as a means of to alleviate internalised shame or symptoms of mental health. They charted their progression from self-harming to tattoo acquisition in terms of a perceived positive emotional regulation strategy.

Of the participants who described the function of their tattoos as alexithymia, all had experienced significant adverse life events during their lifespan which they unable to process or articulate verbally. In the absence of language in which to vocalise and process their trauma, all participants acquired tattoos as a means of creating a new narrative by marking the absence and filling the voice, which can aid healing (Caruth 1996). Of the participants who described the function of tattoos as a mask, all experienced severe abandonment, neglect or abuse. Participants described their tattoos as a symbolic mask developed in response to the systematic abuse they received and the crippling shame experienced as a result.

Although each participant operated from a different motivational position the principal was fundamentally the same: presentation of a false self in which to protect the wounded self. It is here we begin to see how tattoos might mirror an addictive process by initially appearing to be an adaptive behaviour that transgresses into a pathological relationship that has life damaging consequences.

Given that the majority of participants acquired their initial tattoo in adolescence, at time of interview, with an age range of 20 to 47 including five in their 40's, five in their 30's and two in their 20's, – all participants were heavily tattooed and confirmed they would they would acquire further tattoos. More than half cited no intention of cessation until such a time they either ran out of skin or covered up previous tattoos, indicative of both escalation and intensity. Perhaps the most overt evidence of tattooing to detriment to self was the impact a participant's tattoos had on society in terms of how they were perceived, received and in deterioration/loss of relationships.

CONCLUSION

This research was conducted on the premise that tattooing could potentially be seen as an addictive behaviour and that trauma lay at the heart of its foundation. Although, the who, whys and wherefores remained a mystery until a narrative of abuse unfolded from 12 unknown individuals from all socio-demographic backgrounds. The commonality amongst the participants was one of developmental immaturity as a consequence of being relationally traumatised by a primary caregiver, often compounded by significant adverse life events. Tattoos can be seen as a symbolic version of the storied self through which individuals can communicate their identities and experiences, including that of trauma. Little wonder, given that a participant's development was generally arrested during their formative years that their narrative become one of visual imagery, albeit etched onto a living canvas. By figuring out the origin of an individual's symbolic narrative, a physiological road map can be created and the blanks filled in.

For some discourse becomes symbolic, although perhaps not in the sense one would initially assume. For some it is the act of tattooing that is of importance, in terms of metaphorically and symbolically seizing control over a situation for which they initially had none. In essence self-mutilation by proxy but in a seemingly life affirming way. Whilst the functions of tattoos serve many purposes each derived from a separate motivation/wound, the common theme is that they serve as a banner of abuse and neglect, in terms of 'judge me for what I have done to myself, (mask), not for what has been to me (abuse).' This could have important implications for clinicians in terms of employing alternative means of communication through visual imagery which could aid the therapeutic alliance and create a new life-affirming narrative, devoid of permanent ink.

Admitting to needing help sometimes makes people feel vulnerable in front of others, however talking about issues in therapy is the first step towards managing them. But despite attempts within the profession to change the way it's viewed, therapy is still rarely sought by young black men, let alone considered as a career.

With this in mind, in 2011 the Diversity Equality and Social Responsibility Committee of UK Council for Psychotherapy (UKCP) launched Black Men on the Couch. The aim was is to change the status quo surrounding counselling and psychotherapy, and open it up to those who would have never considered either undergoing it themselves or that it might be a career option.

UKCP is the leading professional body for the education, training, accreditation and regulation of psychotherapists and psychotherapeutic counsellors. Our register of over 7,800 individual therapists is accredited by the government's Professional Standards Authority. As part of our commitment to protecting the public, we work to improve access to psychotherapy, to support and disseminate research, to improve standards and to respond effectively to complaints against therapists on our register

In the On the Couch events, we invite special guests to take part in a live therapy session with a professional psychotherapist on stage, to discuss their challenges, successes and views on the value of talking therapy. Guests for Black Men on the Couch have so far included Benjamin Zephaniah, poet, novelist and playwright; David Lammy MP for Tottenham; Ashley Walters, actor and rapper; and Stuart Lawrence, brother of Stephen Lawrence.

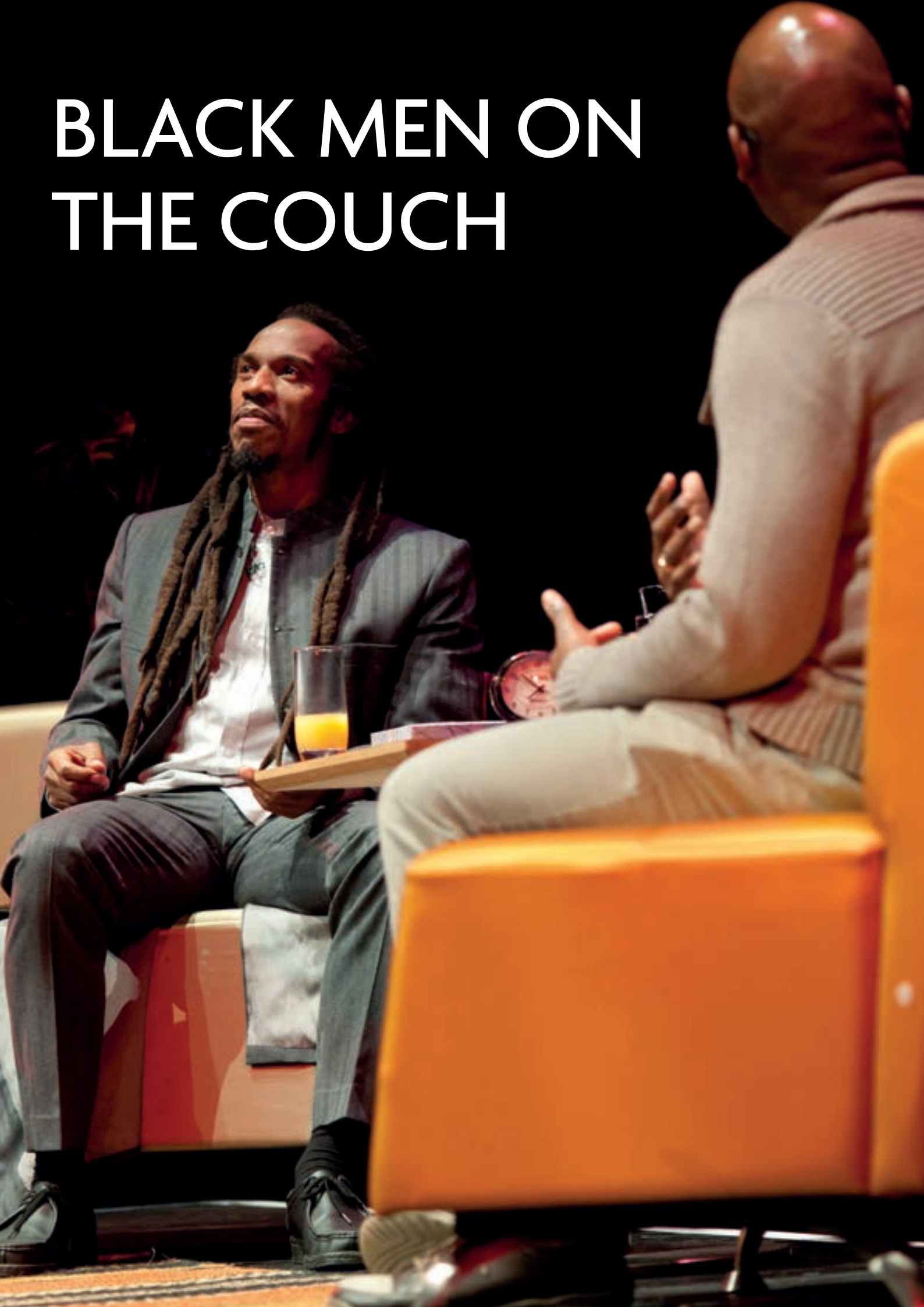
By inviting high profile figures, we hoped to show that even those we look up to sometimes need to turn to others to help them to achieve their goals in life. Rotimi Akinsete, who came up with the idea of Black Men on the Couch says, 'You don't have to be a therapist to know that there is a perceived lack of positive role models in the community. We hear every day of many black men and boys who grew up in dysfunctional families and/or have a lack of positive reinforcement from older black males.'

Having run a number of sell-out Black Men on the Couch events, we are now in an exciting phase of the series. Our aim is to expand the On the Couch initiative to enable us to engage with a wider range of audiences. We plan to focus on other minority groups such as those facing discrimination because of their heritage, gender, sexuality or physical abilities. We also aim to cover specific issues such as addiction, bullying and domestic violence. And we want to collaborate with a number of organisations whose service users and members would benefit from On the Couch events.

David Pink, UKCP Chief Executive, says, 'I am delighted that another of these events is taking place. It seems to me that those most in need of psychotherapy are often the least likely to get it. On the Couch enables us to reach out to groups of people who may not know anything about therapy and who may be in the most need. It also enables us to raise awareness and tackle the stigma attached to mental health issues. It is so important that we do everything we can to make psychotherapy accessible and relevant to as many people as possible.'

For UKESAD our On the Couch event will be a workshop with one of our highly esteemed psychotherapists and a celebrity guest. Addiction can affect people in ways that can manifest as depression and this may be the first way that they find help. Recognising the ways that addiction can manifest in mental health and also understanding that addiction affects all of our relationships and their mental health too is very important in the journey from addiction to recovery.

BLACK MEN ON THE COUCH



CHOICES
VOICES FOR CHOICES

Brian Dudley, of Broadway Lodge, is now Chairman of Choices Group, an initiative aimed at bringing together UK rehabs and treatment centres in order to offer clients the best possible treatment options based on specific need rather than geographical location. In a conversation with Intervene's Mark Jones, Brian outlined the reason for Choices' formation, its growth and the thinking behind bringing together independent residential rehab services to work together in partnership.

MJ: Where did the idea for Choices come from and what was its original objective?

BD: I guess the seeds for Choices were sown four years ago in a conversation I had with Richard Johnson of ANA. We both agreed that the most difficult part of our jobs came when people in our care were asked to leave treatment. Particularly with residential rehab because we knew that the likelihood of them getting funding again was remote and we were, and are, very aware of what many of them would be returning to. By making bad choices, that they'd sometimes find difficult to avoid, many of the people we had in our care would be denying themselves the opportunity to continue with treatment. By working together, when capacity allowed, we wanted to find a way to ensure that the treatment opportunity continued to exist for them and to create a safety net for people finding themselves in this position. That's the place from which we started.

For the next two to three years we worked together and also made commissioners aware of what we were doing – they've been very open to our thinking on the basis that it impacts positively on outcomes. That's not to say that there aren't obstacles, for example when our treatment centres might not have been on their providers list. However we managed to get over this and during the course of the following couple of years we were able to successfully transfer half a dozen people. Having achieved this we got together and agreed that the only way we could really make an impact would be by working with more organisations.

MJ: How have things developed since the initial idea?

BD: Things are still in their infancy but in the last six months have grown really significantly. Richard and I obviously both meet other people in the sector at conferences and exhibitions and get to know our opposite numbers pretty well. Two or three more people joined with us and we then sent out invitations to twenty residential rehabs we felt would be excited by our idea. The proposition was simple: Let's sit round a table and democratically talk through how we can make the Choices initiative work best for the sector. Consequently we've now grown from a group of three or four to twenty, including many of the field's most significant players.

What we'd like to do now is grow even more. We'd love all rehabs to be involved in this. The experience of sitting down around a table with people who, to a

large extent, are 'the competition' has been genuinely exciting. It's been incredibly useful to actually share knowledge, expertise and best practice. We all recognise the difficulties within the sector, we know how tough things are going to be moving forward and Choices realises that the best chance we have to keep rehab alive here in the UK is to work together.

MJ: You mentioned that some commissioners are aware of Choices – how have they responded to it?

BD: The feedback from commissioners has been very positive. Recently quite a few of us attended a local event at South End. It was extremely encouraging, the commissioner there absolutely gets us, loves the idea, and he's already built into the framework for both detox and rehab a component offering a treatment loop before discharge. We're meeting with Public Health England early this year and we're yet to hear any negative voices from commissioners. The Skills Consortium are also interested in our development and we know that our job now is to spread the Choices message as widely as possible.

That said, we're not a political organization, we're not about bashing government, we're all about the client and developing what we, as a group, can offer. We're now talking about developing an aftercare structure so that when clients go out of area they've got that safety net, we're sharing ideas, we're also looking to share savings and potentially, yes, moving forward there's the possibility that we might bid as a consortium for contracts.

MJ: Now Choices has grown in size and membership what are the key benefits it can offer the sector and the individual client?

BD: Clients do make mistakes, we know the field that we work in, we all know that funding is incredibly tight, we know that only between two and four percent of people get the chance of rehab and it's a real shame that if they make a mistake they lose that chance. That's what we're committed to addressing. Post treatment if a client goes out of area we clearly recognise that there are community service providers; we're not competing with them and I think they will also be interested in talking to us in order to understand what we're trying to do and I hope they'd work with us in doing what's best for the client. However, we feel that there is a need that currently isn't being met. For example why should Broadway Lodge only treat its own clients? It seems logical that rehabs should get together and anyone coming back into their area should have access to that level of aftercare as well. And the key is the aftercare is free.

What we have in Choices now is a broad spectrum of offerings including mother and baby units, male only, female only, high/low complexity, Twelve Step, non-Twelve Step, therapeutic communities and more; as a group we offer pretty much every approach. If you have a client coming to Broadway Lodge, which is Twelve Step, and they don't want Twelve Step we'll be able to say to a commissioner that realistically it's unlikely that they'll complete treatment, let's move them into the service that's right for them – everyone in the process benefits.

MJ: What are the long term goals for Choices?

BD: I think that there's a fundamental problem with the current budgeting system in that not all areas have residential rehab. If you have an alliance that's quality marked, CQC registered and NDTMS compliant I think, long term, that it would be beneficial to have Choices commissioned nationally. The reality is that out of 150 areas around 50 to 60 have never sent anyone to rehab, very few clients are sent to residential rehab out of area, and we believe that the government's stated intention to protect rehab is not helped by a local commissioning strategy. Our view is that rehab needs to be funded by the government centrally. In fact, in a nutshell, what Choices wants to achieve is to save the government money, to produce improved outcomes and to offer what we consider to be an appropriate choice for individuals. Let's ensure that clients can access the rehab that is going to offer them the treatment that they specifically need.

Following a successful career in manufacturing industry and the housing sector, Brian Dudley has worked in the field for eight years having been brought in by Broadway Lodge to bring a new dimension to the business management of the charity. He moved from a financial management position to Chief Executive within a year of his arrival.

Choices are at UKESAD 2015 on May 4th, 5th and 6th (see www.ukesad.com)
Please contact BrianDudley@broadwaylodge.org.uk for further details.

From Harm Reduction to Total Abstinence

Chula Goonewardene takes a balanced view on 'warring factions'

The last nine years have been a juggling act for me, in which I have been trying to balance the seeming polarities of the voluntary-sector treatment approach of harm reduction, where I have been working for nine years, with the 12-Step fellowship philosophy of total abstinence, where I have found recovery. When I came into the treatment field in a professional capacity, I was surprised to find these two approaches were warring factions and unfortunately, from my observations, some of this remains today and continues to obstruct our ability to effectively support clients into long-term recovery.

I have witnessed the same arguments and the same debates, over and over again, but in my opinion, it is never quite as clear-cut or one-sided as some people seem to feel. Why, I often ask myself, are we still unable to work in harmony? I have heard of voluntary-sector managers removing meetings-lists from service receptions, and overtly discouraging practitioners from including fellowship attendance in care plans. I have also heard of professionals (who are in 12-Step recovery) proclaiming that immediate total abstinence is the only way to an acceptable recovery, and casting judgement on individuals who can't achieve this goal, only to compound the shame and sense of hopelessness that can accompany a struggle to maintain abstinence.

Some might say that the split I see is because of the rampant, codependent enabling of harm reductionists, others would blame the evangelical and rigid close-mindedness of 12-steppers, and both aspects undoubtedly play their part when the fanatics take hold, but isn't it time we moved passed these perceived differences and narrowed the divide to focus on recovery for all? Surely we are working to the same goal; to support people into better lives (in their own eyes) than they are currently living.

Personally, I have found and maintain my recovery through 12-Step meetings, principles and practice, but what allowed me to reach this discovery was undoubtedly harm reduction. Being on a methadone script for four years, one could say that my addiction was prolonged, creating a longer journey to my rock-bottom, as I continued to use heroin throughout this time, but one could also say that without it, there would have been nothing to temper a venture into;

"Some might say that the split I see is because of the rampant, codependent enabling of harm reductionists, others would blame the evangelical and rigid close-mindedness of 12-steppers."

IV use, homelessness, crime and prison, all things I managed to avoid. Both points of view I believe to be true, and I'm aware that this appears to be a contradiction, however, this is my case-in-point; if we work together, one can lead to the other for those who are able to sustain long-term abstinent recovery, resulting in positive outcomes for all concerned.

When I first started working in the voluntary sector, two years into my total abstinence, I firmly believed it was the only way, that all the chaotic, addicted clients that I worked with, needed to get clean and stay clean, by going to meetings and working a 12-Step programme, I saw no exception to this rule. I then had the privilege of working with some of the most severely traumatised people I have ever met in my life, and saw, as we encouraged them to decrease their substance misuse, a life-time of terror come rising to the surface. It shocked me.

Obviously I had seen and heard a great deal on my journey so far, but these people were the extreme of the extreme, the most deeply entrenched in their addictive defence-mechanisms, protecting their fractured souls from the red-hot pain of their pasts. I questioned whether it was right, safe, or healthy to uncover what they had worked so hard to hide, and if they did open the box, could they survive it? I wonder if our recently deceased celebrities were ever given that consideration, or were the expectations of our society all they could hear. We know that repeated relapse can create sinking esteem, if people are not adequately supported through the process, and if there is nobody there, in our darkest hour, the decisional line between using a substance or complete self-annihilation can evaporate.

Don't get me wrong, I believe that all those who are addicted have the potential to find long-term recovery, but shouldn't the most defining element of that recovery be an improvement of their emotional well-being…from their perspective? Who are we to prescribe this for another, we can only truly evaluate our own happiness, and support others to find theirs, giving them all the education available, so that each individual is able to make informed choices for their future. By adopting this approach we can embrace both sides of the argument, acknowledging that

"The argument that 12-Step is not for everyone, or the notion that harm reduction prolongs active addiction, may contain grains of truth for certain parties, but neither are really the issue when we adopt a wider perspective"

harm reduction is where we need to start, in order to prepare the desperate and motivated for the long, arduous journey ahead, and hold the contemplative ambivalent, safely simmering, until the discrepancies resolve. For this to have value, however, I believe we must ultimately be focused towards total abstinence, and pathways from treatment into fellowship should be seamlessly supported and strongly encouraged, with therapy of some kind running parallel, to work through any emerging trauma. The under-lying issues of the addicted individual can be few, or they can be many, how do we know? The answer is...we don't! We can only guide people to take the next step on their journey and this is true at every stage in the cycle of change that we find ourselves in, as a professional meeting a client who is asking (or sometimes being coerced to ask) for our help.

What I have learnt from my own experience is that even though I have been abstinent for 11 years, one day at a time, my work in personal therapy continues to teach me more and more as the years go by. Not only that, it also reveals to me that there is plenty left to be uncovered and it appears that my internal recovery is going to be a life-long journey, with no end in sight, no clear targets to aim for, and certainly no quick-fixes. This can be a tough truth to digest, especially for those who commission statutory services and demand that clients find long-term recovery via twelve weeks of key-working, a few groups and an IT qualification. Learning how to accept the discomfort of being in such a process can be half the battle when it comes to daily maintenance, and this is where the 12-Step fellowships being a world-wide, free of charge, and consistently available means of support, can make all the difference to client outcomes. The difference between being a temporary tick in a box, or a truly life-changing success.

The argument that 12-Step is not for everyone, or the notion that harm reduction prolongs active addiction, may contain grains of truth for certain parties, but neither are really the issue when we adopt a wider perspective. The reality we need to address is the plight of the still suffering, the shortcomings of our treatment systems, that fail to meet their needs, and the wealth of experience and understanding that we have at our disposal, on both sides of the fence, which together can bring some remedy to an already difficult situation, by working to the best of our ability and aspiring to the highest of ideals.

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Eating Disorders

Gemma Wood takes us through an understanding of the roots of eating disorders.

An eating disorder is an expression of internal suffering. It is a psychological illness that manifests itself physically. An eating disorder is not a choice, nor a passion. Eating disorders are illnesses that stem from psychological and/or emotional distress and result in an obsessive relationship with food.

An eating disorder is often referred to as an additional party by the sufferer.
It is quite often the case that someone who is suffering from anorexia or bulimia can develop an auditory voice that is controlling their behavior, mood and life. Significant numbers of people that suffer from either of these disorders may describe the voice as a "he" or "she," sometimes even naming it. The voice is the eating disorder that becomes the sufferer's way to survive, it's simultaneously a friend and an enemy.
It's very common for young people to strive to "be something that others want them to be or what may be perceived as 'what others want them to be,'… losing the core identity of who they really are and who they really want to become. Seeking approval from adults and peers can dictate a young person's perception of themselves.

All people yearn for protection, love, understanding and safe boundaries even though this may often appear the last thing they desire! Often this yearning can be hugely contradicted by the person's external behavior. This can potentially make being an effective parent even harder as parents may feel isolated, as well as confused, believing they understand the needs of their child whilst the child's behaviour suggests otherwise.
No parent is taught to be a parent, they also learn from their own positive or negative experiences. It's very common that the parents may feel responsible and at times useless and hopeless. The disease can be something that has manifested itself through genetics, family dynamics, environmental upbringing, relationships and many other areas.
A loved one may be suffering from an Eating Disorder meaning the sufferer needs to gain help at this point. The loved ones need a good deal of family support; knowledge of the subject can help them to understand the disease. Eating Disorders are often referred to as a family illness, as they can be an expression of the family dynamics losing control or its footing. It is very important that people try not to blame, as this can influence the sufferer attempting to voice their need for help. Having an eating disorder can be a very secretive illness and it can be hard to detect. An eating disorder, as with any addiction, is the symptom and not the cause. As with many other mental health illnesses or addictions, detecting early symptoms can be very difficult. It is important to be aware of a person's personality make-up, interests, friendships / relationships, internal and external life influences and finally the relationship they may have with food.
Early stage intervention for eating disorder at any age can allow a much faster route to recovery.

> *"Eating Disorders are not just a young female illness. Many males and older people are developing Eating Disorders."*

As mentioned previously, seeking professional support can prove difficult due to specific criteria having to be met, however it would be highly recommended that if a loved one has concerns to see a GP, nurse or therapist as a first port of call.

Most people, at some stage in their life, will have had a different or a less than healthy relationship with food; however this does not mean that everyone has an eating disorder. The very fine line between disordered eating and EATING DISORDER, comes with many components for professionals and families to identify.

The percentage of eating disorders in children and young people is constantly rising. It would appear that over the last 10 years the increase in eating disorders has risen significantly. There does seem to be more awareness, help and support around the subject, however finding professional support can still appear very difficult.

(From the National Association of Anorexia Nervosa and Associated Disorders. 03, 2013.)

Anorexia is the third most common chronic illness in adolescent females.. There are many reasons why people may develop an eating disorder. Factors could include (but are not limited to): personality traits/ development, genetic factors, early puberty, family attitudes and systems, negative family influences, high levels of external/internal expectations, cultural pressures, sport/dance, social problems, abuse/traumatic events, major illnesses, hormonal abnormalities, difficulty coping with change, self-esteem, spiritual or religious influences, confidence and worth, self-acceptance, media and other psychiatric illnesses combined.

Adults, children and young people seem to be more exposed to life influence, possibly leaving them more vulnerable to change. People of all ages (not just children and young people) could be more susceptible to life's difficulties and rely on an eating disorder to cope. This could be influenced by their physical, emotional and personality make-up. External/ internal life experiences seem to have a great influence on a person who may develop an Eating Disorder, as does someone's personality structure. Combine these, and this may leave someone more predisposed to these illnesses.

Eating Disorders are not just a young female illness. Many males and older people are developing Eating Disorders. The statistics state that females are more likely to suffer from eating disorders, however there has been a rapid rise in males seeking support for symptoms which would fall into the eating disorder category. Young and adult males are just as susceptible to suffering with eating disorders due to life experiences and expectations. Eating disorders amongst males can be harder to recognize than those in females due to public perception. Eating disorders are often misdiagnosed as being a "female" phenomenon.

It is believed, with supported evidence, that the increase in sufferers has become more evident over the last 10 years. It's clear that with more research and supported treatments, statistical reporting of eating disorders has risen. External influences in society today appear to be having an impression on many people's emotional and physical well-being. This could be increasing the knowledge and awareness of people suffering with eating disorders. (Nervosa and Associated Disorders. 03, 2013.)

If you or someone you know is suffering from an eating disorder it's important to reach out for help. Eating disorder programs can help adults and teens treat the mental and emotional issues that caused them to develop an eating disorder and treat the physical issues their disorder has created.

What can also make an eating disorder so hard for professionals to treat is the causes can have such a traumatic experience on the sufferer. Dual diagnosis can also be very common with any type of Eating Disorders. Self-harm, obsessional compulsive disorders, trauma, suicidal intention, depression, ADHD, possibly a borderline personality disorder and many other mental health illnesses. The addiction itself needs to be highly understood to not further the pain for the sufferer. Everyone needs to eat, so it can be so painful to see that the main medication is "THE FOOD".

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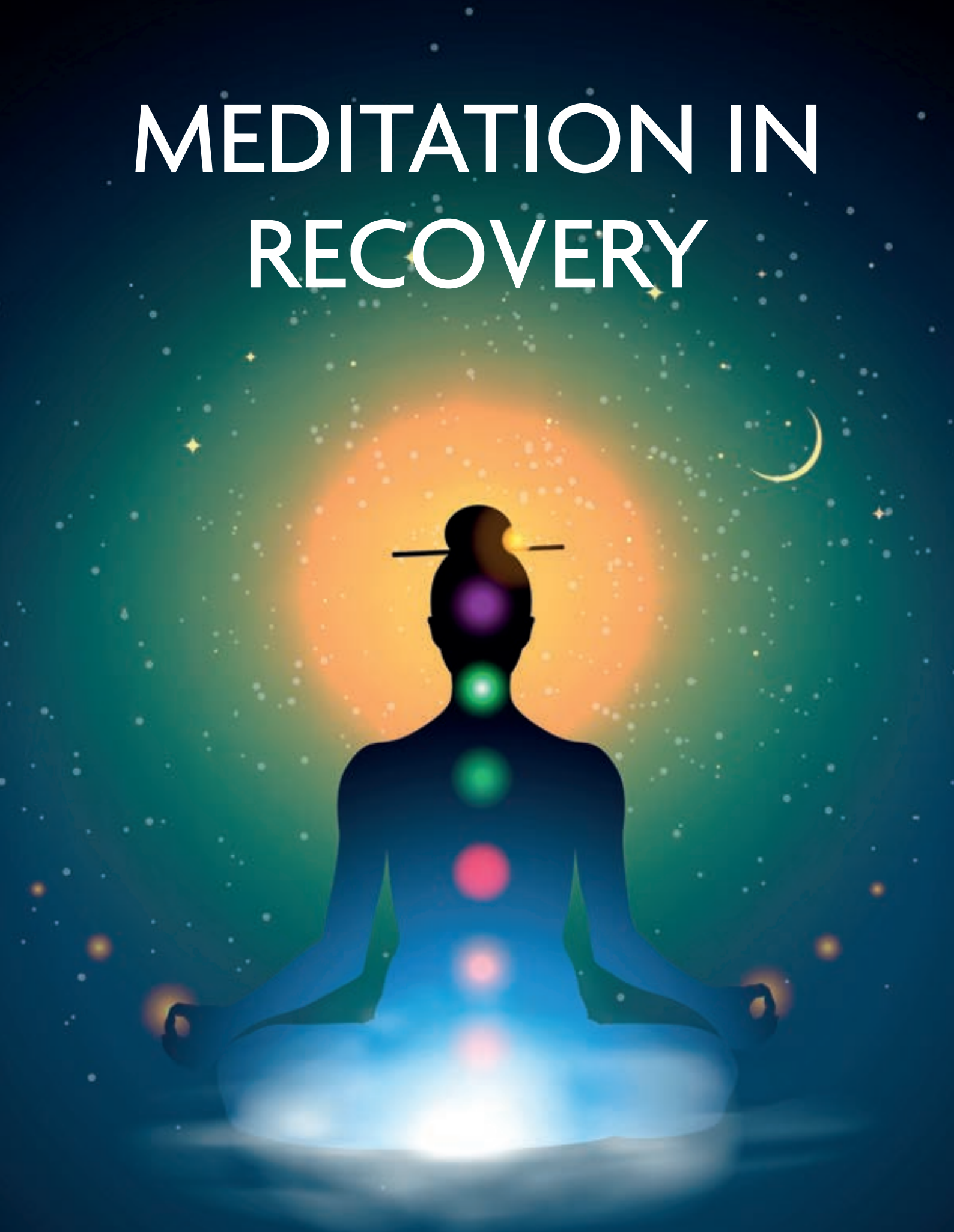
MEDITATION IN RECOVERY



Therapeutic Counsellor, John Graham, looks at the origins of meditation describing its techniques and its relevance to the Twelve Steps

The classical tradition of meditation has its source reference framework in the pre-Buddhist, Vedic Upanishads – the 'Breath of God' – the essence of which is collectively summarised in the Bhagavad Gita – 'The Song of God' – where, in Chapter Six, the basic instructions for meditation includes the idea of 'continuous conscious awareness' in the here-and-now-present-moment while engaging with life-on-life's-terms. Conscious awareness of this sort is nowadays referred to as 'mindfulness' the concept of which has been adapted as an ancillary discipline within Cognitive Behavioural Therapy (CBT) which postulates a challenge to automatic negative thoughts with a basic formula of paying attention while applying a strategy to replace 'ants' (automatic negative thoughts) with a purposeful shift of focus, utilising the breath. This instigates a process of expanded attention provoking those who are applying the process to respond realistically and adaptively rather than to react impulsively, which is of course a common character trait of those in the grip of active addiction.

This process too, finds its source in the classical tradition of Raja Yoga, the text-book for which is the Yoga Sutra. One is instructed to be aware of the spontaneous arising of distracting thoughts during the actual process of meditation and to either let them flow with an attitude of detached observation or to pro-actively cut them off before they can develop.

It is therefore perhaps cogent to think in terms of 'awareness' as the essence of meditation, rather than the mundane term 'mindfulness' with all its modern commercially - flavoured connotations.

'Awareness' is also more onomatopoeically descriptive of the 'Conscious Contact' component of Step Eleven.

"Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of
His will for us and the power to carry that out."

To assist practitioners while working with individuals seeking to establish themselves in abstinence-based recovery from active addiction within the Twelve Step frame-work in a residential setting, an introductory process of facilitation that sets a therapeutic ambience is described below.

These instructions concur precisely with the classical Raja Yoga tradition outlined in the Yoga Sutra and the Bhagavad Gita. Both of these sources refer to 'practice' as the actual means for making gravitational progress towards 'conscious contact' which has self-acceptance implicit in this otherwise somewhat amorphous goal that is beyond verbal description and can only be experienced by actually practising meditation. However, the wording of the Serenity Prayer utilised by all Recovery Fellowships succinctly captures the 'essence' of the goal:

God, grant me the serenity to accept the things I cannot change,
The courage to change the things I can,
And the wisdom to know the difference.

With this in mind, the practitioner can facilitate a meditation sequence in the following way:

"Being aware of what we are doing, first of all, let us place our feet symmetrically on the floor while pressing our buttocks firmly into the base of the chair, simultaneously straightening our spine and tucking the chin towards the cavity of the throat, noticing the slight sense of tautness this reflex creates, which enhances awareness while allowing our gaze to pass beyond the tip of the nose to a self-chosen point on the floor one can focus towards without strain.

Now let us become conscious of our breathing, beginning with a robust out-breath – allowing the in-breath to take care of itself – followed by a further out-breath and so on while we begin to become consciously aware of the space we occupy, sitting together as the atmosphere becomes quiet… although there are some detectable external sounds which we can utilise as a boundary within which we may observe the silence of meditation for a single minute which I will time…"

Further to this deliberately short adaptable means of introducing clients in a treatment setting to the basics of actual meditation practice, a set of guidelines for dedicated individuals – which includes walking meditation as an extension – is set out below. By way of the practice of meditation within this general framework , we can deepen our self-awareness while also effectively dealing with intrusive cravings and other difficulties associated with recovery from active addiction .

As initially outlined in the brief sequence given above, meditation practice begins with an out-breath, allowing the in-breath to establish the rhythm.

In observing this breathing process over time, we gain insight, from which we develop our own direction and understanding while being in receipt of the therapeutic benefits of meditation that progressively establish themselves in our daily lives.

We begin to experience inner poise, and, almost imperceptibly, there steals over us a sense of well-being which melts rigidity and scepticism.

Selfishness, hang-ups, prejudices, egotism, aggression, abusiveness, self-neglect, and other defects begin to disappear, and are replaced by empathy, concern for others, self-care and a selfless attitude towards all. A feeling-tone of peace and contentment begins to replace the toxicity of anxiety and low mood that many addicts in recovery can be plagued with.

This transformation clearly does not happen as we rise from our first sitting.

The ups and downs of "life on life's terms" continue to present themselves as we establish a discipline of regular sitting. Steady progress creates a receptivity that allows the benefits of practice to accrue incrementally which includes by default an increased impetus of the spiritual endeavour suggested by Step Eleven.

When practising in our own space we wear clean baggy clothing, sitting on a cushion in a personally comfortable, perhaps cross-legged, posture that can be held for a period of time without being too awkward, keeping the hands open in the lap to form an oval shape. Alternatively, we can rest the wrists on the knees with the thumb and index finger touching. These positions help establish the meditative mind-set.

Meditation uses the breath functionally, to keep the mind from wandering, by employing the pragmatic technique of counting: one, on the first exhalation, two, on the second, three on the next… and so on up to ten at which point we return to one.

While counting, we breathe naturally; letting the breath follow its own course, simply remaining aware, noticing the fineness or coarseness, the shallowness or depth, the warmth or coolness of the air stream as it crosses the nasal membrane, maintaining the effort on the out-breath.

We attempt to become completely absorbed in this process.

However: when the mind inevitably wanders, we simply return it gently to the point of focus, developing a continuum which allows the cultivation of concentration conducive to unbroken steadiness over time. It is this process of 'repeat attention' while monitoring focus that constitutes the 'mindfulness' component of the original practice of formal meditation while also not letting thoughts or recollections distract us. When we notice these, we simply maintain detachment; confident that the distractions will disperse naturally provided we don't pay them any attention.

We cultivate an enhanced sense of 'conscious awareness' by way of this process.

Over time, we become able to sit for perhaps twenty minutes before seamlessly interspersing the sitting with a brief contemplative walking period while maintaining continuity of focussed breath awareness. The walking serves to refresh blood circulation prior to once more assuming the sitting posture.

Two sitting periods of twenty minutes, followed by walking would normally suffice as a single session on a daily basis. We build up to this.

Between our formal sittings, we develop the ability to maintain an attitude of focussed 'mindful' awareness while going about our daily work and recreational activities. As a consequence a natural continuum of conscious awareness can be cultivated in the here-and-now-present-moment as we gain experience through the consistency of daily sitting.

Meditation, being an energy-generating dynamic activity, can progressively help dissolve any residue of past and/or present trauma, unresolved grief, and other lingering obstacles that threaten relapse while supporting progress in abstinence-based recovery.

Indeed: the potential for 'conscious contact' is now realisable which in turn potentiates one's innate capacity to convey to others by personal example the achievement of redemptive emancipation from active addiction. One has the opportunity to become a living embodiment of the message implicit in the wording of Step Twelve:

"Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs."

JOHN GEORGE GRAHAM
THERAPEUTIC COUNSELLOR/ADDICTION TREATMENT SPECIALIST,
CURRENTLY WORKING IN A SESSIONAL CAPACITY WITH CRI
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PAUL SUNDERLAND Addictions Psychotherapist, Consultant and Trainer with over 30 years' experience, in the treatment of addictive disorders. Presentation: Money Matters in Recovery – explores compulsive debting, spending and under-earning, explaining these processes as addictive disorders that lead to clinically significant impairment or distress. This talk offers understanding of why some people struggle with money and identifies suggestions for a life of recovery and prosperity. Hosted by Action on Addiction.

DR. ANTOINETTE SARASIN: Specialist in Orthomolecular Medicine. Presentation: Biochemical Restoration - a clinical insight into the analysis of specific individual biochemistry to gain a precise understanding of the physiological causes and effects of an individual's addiction; the biochemical imbalances that make a person more prone to the addictive cycle, research and outcomes will offer further insight into this restorative treatment model Hosted by The Kusnacht Practice AG.

DEAR ALBERT Promotional Screening - 3 years in the making DEAR ALBERT is Film maker NICK HAMER's debut feature documentary; Dear Albert follows recovery consultant Jon Roberts as he works with addicts from the earliest stages of their rehabilitation. The film also explores Jon's own journey with addiction. Billed as the UK answer to the Anonymous People, the film will be of particular interest to treatment services, universities, prisons and rehabs and commissioners. It world premiered at the Calgary International Film Festival, shown on tour at the 'To the Reel' Recovery Film Festival in New York, the Cape Town Recovery Film Festival and the prestigious 'Off Cinema' International Documentary Film Festival in Poland, the film will soon be available to view throughout the UK.

JUDY CRANE'S presentation and seminars on PTSD and Sexual Trauma Resolution are known internationally. Judy specialises in training, experiential methods, and holistic concepts. Her profound 5 Module Certification Training, teaches Clinicians and Treatment Professionals how to heal their clients' trauma. Presentation: Broken Lives, Broken Brains, Broken Hearts - Delegates will gain an understanding of 5 long term effects of PTSD and Trauma; identifying 3 ways neuroscience plays a role in both PTSD and the healing process and 3 tools for Trauma Resolution enabling Trauma "Survivors", to become "Thrivers".

LOU LEBENTZ UK radio and media obesity expert, A government spokesperson for the well-known "Frank" teenagers drug advice brand and the Department of Health. Sugar, the baddie on the block - the facts on obesity, diabetes and its addictive impact. Sugar is Big News -This presentation provides the latest scientific updates on sugar, its effects on the brain, our biology, our hormones and our gut. There will be open debates around what treatment forms the best basis for abstinence from sugar bingeing.

BRIAN DUDLEY under Brian's direction Broadway Lodge has increased to a 97 bed registered facility, offering a complete treatment package from Detoxification, to mixed and single sexed units in Primary and Secondary care to Recovery in the Community. Presentation: The future - requirements in the Marketplace for the treatment of addictive disorders. This presentation will identify the restriction faced in the residential treatment of addiction and will look at the disappearing funding options during the coming years.

BARBARA PAWSON & CHRIS JOHN are trauma therapists and co-founders of the UK leading training organisation TW Training offering CPD training on Trauma Resolution, Inner Child and PIT Therapeutic Model. Presentation: I love you BUT... The Challenges with treating Love Addiction & Love Avoidance. Recognising characteristics and symptoms. Linking them to adverse childhood experience and early relational trauma. The toxic dance: when a Love Addict meets a Love Avoidant. Implication and resistance around a chronicle condition enhanced by and within our society. A clear understanding and ways to raise awareness and lead clients through effective therapy and solutions.

CHOICES: a consortium group of independent residential rehabs working together to increase client choice and improve outcomes. Presentation: Busting Myths & Increasing Choices – Their 'Treatment Loop' has already retained in treatment many clients who may otherwise have left. In this dynamic and thought provoking workshop, we invite you to join us as we unpick three myths about rehab. This workshop is suited to practitioners at all levels, including frontline staff, commissioners, policy makers...anyone with an interest in recovery!

MILES ADCOX BS, MS CEO/OWNER OF ONSITE Internationally known Therapeutic and Personal Growth Workshop and Retreat centre, on various topics including Emotional Leadership, Inspiration, Communication, Organizational health, Creative Flow and Family Systems. The Art of Connection -Inside Out- Leading, Loving, and Living from the heart: a must for Students, Professionals and Specialists. Radical Change requires radical relationship. Learn to take the lead when dancing with your own, and others, resistance and build an alliance worth changing for.

LUCY DEAN, BA (HONS). MBPSS. RESEARCH MANAGER, REHABILITATION FOR ADDICTED PRISONERS TRUST (RAPT) Developmental pathways to substance misuse and offending for young people and effective early interventions and treatment. This workshop will discuss research on risk factors for substance abuse and mental health issues among young people, including the role of early attachments, trauma and early identification of mental health symptoms. It will explore early preventative interventions with families and in schools and effective treatment for substance misusing or dependent young offenders. Further RAPt breakout sessions can be found online.

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JAMISON MONROE & MICHAEL HEBB; Presentation: Lets Have Dinner and Talk About Dinner. its time critical to have a conversation about drugs and addiction. There is a critical need to reframe the conversation (policy, treatment models, attitude) about drugs and addiction. DOD have created an online, interactive platform that inspires millions and provides the tools to have an authentic and compassionate conversation about drugs and addiction over dinner; www.drugsoverdinner.com Hosted by Newport Academy. In just 18 months, deathoverdinner.org founder Michael Hebb has inspired spiritual leader Ram Dass and 70,000 other people to organise their own dinners in order to connect with loved ones while discussing to subject of death. Hebb recognized the need for a second topic, a second taboo that could be powerfully faced at the table, and partnered with Newport Academy founder, Jamison Monroe, and Yoga teacher, Angel Grant, to build DrugsOverDinner.org.

DR IRVIN YALOM This event will give the delegates at UKESAD a unique opportunity to engage with him personally as he takes questions from the audience. Yalom will be speaking via live video link from California. 'Ask Yalom' sold out in 2013. It's great to welcome him back' – Richard Smith, BACP Events Team. A Psychiatrist, prolific author and speaker on psychotherapy and existentialism. His first book The Theory and Practice of Group Psychotherapy is the definitive text on the topic, and one of the largest influences in addiction treatment models, having sold thousands of copies worldwide, published basis on the importance of counsellors in the field psychotherapy and openly explores the power of the relationship between therapist and patient. Hosted by Action on Addiction Monday 4th May 6pm

MIKE TRACE has a wide range of experience in the field of drug treatment and policy, from direct work with problematic drug users, to senior positions in national government and international agencies. Mike is the Chief Executive of RAPT. He splits his time between this role and his role as Chair of the IDPC Board of Directors, where he contributes to the IDPC strategy, representation, fundraising and organisational development. Key Note Presentation Wednesday 6th May "Commissioning without Ring fences - why invest in treatment."

OUT OF HOURS – SURGERY Tuesday 5th May 5.30pm onwards. Headed by Consultant Psychiatrist DR Mark Collins MA MBBS MRCP MRCPsych who specialisms include; Addictions, Bi-polar disorder, Psychopharmacology and Trauma. This event is the first of its kind, Psychiatrists will offer their learnings, research and outcomes across the addictive disorders spectrum. Each individual presentation will be an insight in what makes them tick; in their demanding roles and what excites them as Medical Science, Alternative Health and the industry as a whole catapults forward. Full Line up will be featured at, ukesad.com

DR JUDITH LANDAU, MD, DPM, LMFT, CAI, CIP, CFLE, is a Neuropsychiatrist, specializing in resilience and overcoming adversity across cultures. Presentation: The relevance and role of families in an effective Continuum of Care - The ARISE® Model offers an Evidence-Based, Best Practice family-focused Invitational Intervention® at individual and family levels and mobilizes the support system as an effective agent of survival. Workshop participants will practice basic components of the method becoming comfortable the ARISE Continuum through didactic and experiential techniques along with real case study vignettes.

DAVID BADCOCK is head of research and development & BBVs for Addaction and a member of The London Joint Working Group for Substance Misuse and Hepatitis C. Presentation: Can we actually eliminate hepatitis C from the UK within a generation? A report published by Public Health England (PHE), Hepatitis C in the UK 2013, has found that despite hepatitis C being curable, only 3% of people receive treatment each year. By looking at ways in which drug treatment services could develop existing best practice models, more people would be tested for Hepatitis C, and more would be referred into treatment.

PAULA HALL UKCP, COSRT, ATSAC Paula is a UK based Psychotherapist who has been specialising in sex and pornography addiction for over 10 years and delivers training to addiction professionals in the UK and Europe. Presentation: What's Wrong with Porn? – The Rising prevalence of sex and pornography addiction. Paula will explore the growing problem of internet porn addiction and provide up to date information from the UK's largest survey of sex and porn addicts. The latest neuroscience from the UK, US and Europe will also be shared to help explain the overwhelming power of porn and explain why so many users find it so hard to quit.

ADELA CAMPBELL & ANNA NAPIER: work together as Psychodrama and Mentalization Based Therapists. Presentation: Psychodrama & Mentalization - enhancing recovery. In this experiential workshop we will explore how the method of psychodrama psychotherapy can aid the recovery process from addiction and trauma by maintaining a specific focus on increasing the capacity for mentalizing. Participants will be given the opportunity to explore through discussion and practical demonstration key components of Mentalization and psychodrama theory.

'ON THE COUCH' have invited musician Jimmy Somerville to take part in a live therapy demonstration session on stage, with a UKCP professional psychotherapist, to share his experiences, emotional challenges, and successes. Exploring what leads to addictive behaviour, what maintains it, and how it can be overcome. These demonstration sessions reduce the stigma that many people feel about seeking help for mental health issues.

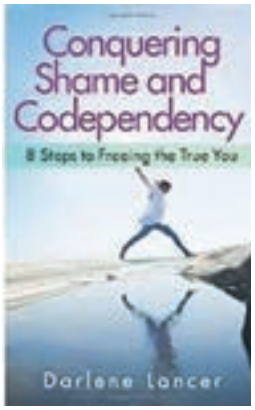
SIMON BLOOM MSC MA ADV DIP MBACP (ACCRED.) Simon has trained and worked as a psychologist, psychotherapist and body therapist over the last 20 years. During this time he has implemented a new form of therapy inspired by Ken Wilber's Integral psychology. Presentation: Integral recovery – its neurobiology and clinical application. A live exploration of the neurobiological processes that play a key role in the addictive cycle and in the road to recovery, demonstrating how an integral assessment lays a vital foundation in our treatment planning.

Where to find... *guides*

This month our reviewed publications look at dealing with shame and codependency, an examination and evaluation of the 12 Steps and ways in which ambitions can be fulfilled when addictive behaviour is addressed.

CONQUERING SHAME AND CODEPENDENCY, 8 STEPS TO FREEING THE TRUE YOU

Darlene Lancer
Published at £11.95
Hazelden Hazelden.org
ISBN 978-1-61649-533-6



To be honest when I read the title of this book, I recoiled in shock, I won't relate I proclaimed! I'm the least codependent person I know! And shame? Well that's akin to a dirty word!

By the time I'd read the first chapter, I have to say (quietly) that the delusion was slowly subsiding. Of course I've experienced every type of shame Lancer talks about, and there's the guilt! I am prone to confusing shame with guilt, which is very damaging to an individual who struggles with these feelings.

What Lancer does, which is extremely helpful, is that she breaks both the feelings and behaviours into tables and addresses, and identifies each type of shame, and explains them in very simple terms.

She follows up the chapters with exercises, these are either immediate questions or tasks to carry out over a period of time.

What was surprising to me is the amount of situations where we experience the feelings of guilt and shame, and how we bury them in order to fit in. Inevitably this leads to feelings of low self esteem, self worth and insecurity, fuelling our codependent behaviours which can be as bright as a beacon, or subtle, manipulative and insidious.

I found Lancer to be very gentle in her writing, almost like a hug. I trust what she's saying. She encourages proactivity in a loving way, and doesn't force the reader to confront their issues without the reassurance that it is a journey, they are on the right path and recovery from past wreckage is possible.

I will return to this book again and again for affirmation and for tools as situations arise, which I suppose is the purpose of a manual?

SUZANNE MOLONEY
Suzanne Moloney is a freelance social worker.
She has worked in family services and specialised in complex needs. Also in recovery.

RECOVERY - TWELVE SIMPLE STEPS TO LIFE BEYOND ADDICTION

Dr Lynden Finlay
Published by 'Accent Press Ltd'
www.accentpress.co.uk
324 Pages
Price PAPERBACK £9.99
ISBN 9781783752973

In 'Recovery' Dr Finlay draws on over twenty years of experience in addiction as both an addict and a therapist. She addresses two issues that frequently arise when addicts searching for recovery think of AA (or any other re-type of 'Anonymous'): the language used and the perception that AA is a religious organisation.

The question 'does the original manual of AA need to be rewritten?' arouses strong opinions on both sides. Anecdotally I've found that just a hint of religion can cause addicted heels to dig in. I've also heard other addicts say they find the language confusing (and felt that myself), since it is written in 1939 American English. On the other hand, the Big Book and other writings have helped thousands, over many years.

I feel that as long as an addict finds a way into recovery, how that's done is not important. This book, however, does show one route.

The first chapter gives a definition of addiction, stressing the disease model used by the original AA manual and also refers to addiction as an obsessive-compulsive condition.

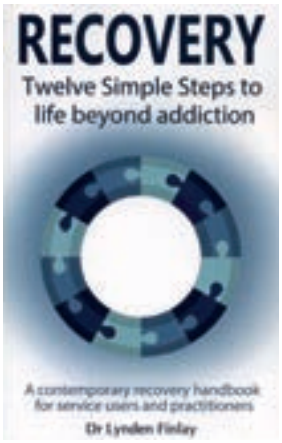
The author's rewording of the 12 Steps, which is the main purpose of this book, is thoughtful and clear and I feel comfortable with her reasoning. e.g. - part of Step 3 - '…guided by the principles of the 12 Step program' instead of 'turn our lives over to the care of God as we understood him'.

Her belief that addiction is a 'family disease' underlies the chapter '12 Steps for Family Members'. The author goes on to describe her own experiences with Al-Anon and then introduces the 12 Steps for family members.

She describes how AA is structured and explains what a person can expect from a meeting.

In the final chapter 'Spiritual Recovery', Dr Finlay talks of her experiences of meeting recovering addicts at reunions and how they've developed spiritually. She introduces a range of spiritual 'shares' from recovering

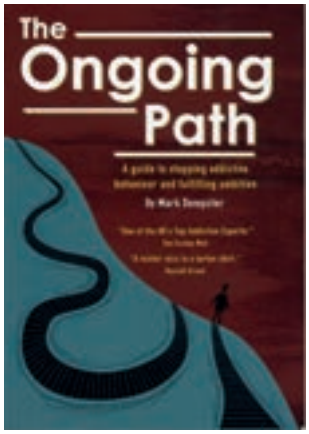
addicts and expands on the benefits of a spiritual life.



'Recovery' is well written, and filled with useful information for a wide range of people affected by addiction. The Steps were designed to be experienced not read about. As a manual for service providers, and relatives and friends, this is a very useful read, but for the active addict or someone in early recovery a workbook format would be less daunting.

Born in 1976 **Rhiannon Jehu** has a long experience of the effects of trauma, mental ill health and addiction upon herself and society. She has been in recovery since 14/1/14 and follows the 12 Step program.

THE ONGOING PATH – A GUIDE TO STOPPING ADDICTIVE BEHAVIOR AND FULFILLING AMBITION
Publisher: www.addictionrecoveryclinic.com
ISBN 978-0-9574305-1-8
206 pages
£12.99



This eagerly anticipated second book by the very highly regarded authority on active addiction and recovery from it, Mark Dempster, is laced with priceless life experience that allows the reader – whether professional or secular – to identify with the colourful and caring human being Mark is; the title naturally suggestive of the readership this reservoir of recovery resources is designed for.

Mark has also reflected the breadth and depth of his professional knowledge and experience, infusing the factual material with personal highlights and case studies to illustrate treatment rationale while an addendum of recommended books for further research and self-therapy contribute to each chapter. There is also assignment-related material linked to the book that can be accessed from Mark's website.

Of particular value is the up-to-the-minute inclusion of neuroscience developments related to both chemical and process addiction, while highlighting gambling, eating disorders and the phenomenal growth of internet and sex addiction for what they are: seductive behavioural indulgences of the modern era requiring urgent intervention.

Pragmatically well-presented, reflecting an overall holistic approach; Mark's book is perhaps unique for its focus on the achievement of personal ambition and the restoration of self-esteem by way of a creative 'vision statement' reinforced by assertively challenging negative thinking and recognising the value of moderate diet and exercise as 'tools' for 'ongoing' recovery from active addiction while pursuing one's ambition.

Mark's passion for recovery and genuine willingness to help others – particularly those still struggling – is evident on every page of this concise explication of addictive disorders that offers self-intervention strategies while also providing contact details for professional and peer-support assistance.

JOHN GEORGE GRAHAM
Therapeutic Counsellor
johngraham123@btinternet.com

WIN A DAY OF LEARNING AND NETWORKING AT UKESAD ON MONDAY 4TH MAY 2015

One *intervene* reader could attend the 11th UK/European Symposium on Addictive Disorders on the Monday of 4th of May 2015 completely free of charge. Mingle with 500-600 colleagues and future colleagues in the field and improve your work with the help of worldclass experts.

THE COMPETITION WINNER will be chosen at random from all *intervene* subscribers on the database at 10th December 2014 — all you need do is make sure your subscription is up to date for a chance to win.

MOST RECENT WINNER: Congratulations to Nicky Lappin from the Tudor Trust subscriber since 1998. She receives a free delegate pass for Monday at UKESAD 4th May 2015.

BOOKS – If you would like us to review a book, CD or DVD, send it to Melissa Gordon at the address on page 4. If you would like the opportunity to review a book and see your name in print, email book editor Melissa at: subscriptions@addictiontoday.org.

Where to find... *treatment*

England	Telephone	Email, website	Contact	Alcohol	Drugs	Eating disorders	Gambling	Dual diagnosis	Detoxification	Sex Addicti	Not-f
ACORN TREATMENT & HOUSING aka ADAS 130 Mile End Lane, Stockport. SK2 6BY	T 0161 484 0000	ed.smith@acorntreatment.org www.acorntreatment.org	Ed Smith Business Development & Promotions	●	●						●	
ADDICTION CARE 1 Wey Court, Mary Road, Guildford, Surrey, GU1 4QU	T 01483 533300	Info@addictioncare.co.uk www.addictioncareuk	Peter J Davies NCAC	●	●	●	●	●				
ADDICTION RECOVERY CENTRE 20 Landport Terrace, Portsmouth, Hampshire, PO1 2RG	T 0800 6199 349	info@arcproject.org.uk www.arcproject.org.uk	Jamie Martin Manager	●	●				●			
ADDICTIONS UK home-based addictions treatment Based throughtout the United Kingdom and the Republic of Ireland	T 0845 4567 030	info@addictionsuk.com www.addictionsuk.com	Simon Stephens Director of Case Work	●	●			●	●		●	
ANA TREATMENT CENTRES Fleming House, Waterworks Road, Farlington, Portsmouth, PO6 1NJ	T 023 9237 3433	info@anatreatmentcentres.com www.anatreatmentcentres.com	Richard Johnson Director	●	●			●	●			
ARK HOUSE TREATMENT CENTRE 15 Valley Road, Scarborough, YO11 2LY	T 01723 371869	ark.house@virgin.net www.arkhouse2005.com	Ges Schofield Registered Manager	●	●	●	●			●		
BAYBERRY CLINIC 6 Church Lane, Wedelbury, Oxfordshire. OX25 2PN	T 01869 321717	info@bayberryclinic.org.uk www.bayberryclinic.org.uk	Maureen Clancy Manager	●	●	●	●			●		
BOSENCE AND BOSWYNS TREATMENT SERVICES 69 Bosence Road, Townshend, Hayle, Cornwall, TR27 6AN	T 01736 850006	jeremy@bosencefarm.com www.bosencefarm.com	Jeremy Booker Manager	●	●			●	●		●	
BROADREACH 465 Tavistock Road, Plymouth, Devon, PL6 7HE	T 01752 790000	enquiry@broadreach-house.org.uk www.broadreach-house.org.uk	Lesley Pickles Lesley@broadreach-house.org.uk	●	●	●		●	●		●	
CASSIOBURY COURT Richmond Drive, Watford, Hets, WD17 3BG	T 01923 804139	info@cassioburycourt.com www.cassioburycourt.com	Darren Rolfe	●	●		●	●	●			
CAPIO NIGHTINGALE HOSPITAL 11-19 Lisson Grove, Marylebone, London, NW1 6SH	T 020 7535 7700	info@nightingalehospital.co.uk www.nightingalehospital.co.uk	Omotola Oladimeji - Admission Manager 020 7535 7732 omotola.oladimeji@capio.co.uk	●	●	●	●	●	●	●		
CHARTER HARLEY STREET LTD 15 Harley Street, London, W1G 9QQ	T 020 7323 4970	info@charterharleystreet..com www.charterharleystreet.com	Mandy Saligari – Director 07956 370928	●	●	●	●					
CHY COLOM Agar Road, Turo, Cornwall. TR1 1JU	T 01872 262414	chycolom@addaction.org.uk www.addaction/chy.org.uk	Ross Dunstan Manager	●	●			●			●	
CLOSEREACH Longcause, Plymouth, Devon, PL7 1JB	T 01752 566244	enquiry@broadreach-house.org.uk www.broadreach-house.org.uk	Gerard Dooley Treatment Team Manager	●	●	●	●	●			●	
CLOUDS HOUSE East Knoyle, Salisbury, Wiltshire, SP3 6BE	T 01747 830733	cloudshouse@actiononaddiction.org.uk www.actiononaddiction.org.uk	Sarah Small Head of Service	●	●			●	●		●	
CNWL NATIONAL PROBLEM GAMBLING CLINIC 4th floor, Soho Centre for Health & Care, 1 Frith Street, Soho, London W1D 3HZ	T 020 7534 6699	gambling.cnwl@nhs.net www.cnwl.nhs.uk	Dr Henrietta Bowden - Jones Consultant Psychiatrist / Lead Clinican				●					
FOCUS12 82 Risbygate Street, Bury St Edmunds, Suffolk, IP33 3AQ	T 01284 701702	info@focus12.co.uk www.focus12.co.uk	Andy Yacoub	●	●	●		●	●		●	
GLADSTONES CLINIC 59 Queens Square, Bristol, BS1 4LF	T 0117 9292102	admin@gladstonesclinic.com www.gladstonesclinic.com	Mike Evans Clinical Manager	●	●	●	●		●			
GLOUCESTER HOUSE TREATMENT CENTRE 6 High Street, Highworth, Swidon, Wiltshire, SN6 7AG	T 01793 762365	Ros.rolfe@salvationarmy.org.uk www.gloucesterhouse.org.uk	Ros Rolfe, Referals/Marketing-Manager	●	●			●			●	
HEBRON HOUSE 12 Stanley Avenue, Thorpe Hamlet, Norwich, NR7 0BE	T 01603 439905	info@hebrontrust.org.uk www.hebrontrust.org.uk	Rebecca Watts	●	●			●			●	
HOPE HOUSE 52 Rectory Grove, London SW4 0EB	T 020 7622 7833	hopehouse@actiononaddiction.org.uk www.actiononaddiction.org.uk	Susanne Hakimi Head of Service	●	●	●		●			●	
KAIROS COMMUNITY TRUST 59 Bethwin Road, London, SE5 0XT	T 020 7701 8130	kairos.bethwin@kairoscommunity.org.co.uk www.kairoscommunity.org.uk	Lee Slater Manager	●	●						●	
KENWARD BARN Kenward Road, Yalding, ME18 6AH	T 01622816086	admissions@kenwardtrust.org.uk www.kenwardtrust.org.uk	Nick Hillman Admissions Manager	●	●	●		●			●	

ion or-profit	No.1st-stage beds	No. 2nd-stage beds	Aftercare offered	Daycare available	1:1 counselling	Males accepted	Females accepted	Age range	Funding options	Conditions of acceptance	More information & extra treatments
	56 in	total	●	●	●	●	●	All	All	Case by case basis	The centre is open to clients requiring residential or non-residential therapies for individuals and their families affected by addiction. Since opening, we have treated hundreds of drug & alcohol users and assisted them in achieving abstinence. Our family programme compliments primary treatment and helps relatives cope with the damage that has been caused by addiction.
			●	●	●	●	●	17+	Private Funding	Subject to initial assessment	Day Care Treatment: an exceptional day care programme tailor made to suit your needs. An alternative to residential treatment allowing you to enter treatment during the day and return in the evenings to your home environment. Ongoing support groups and 1-1' s available following treatment. All addictions treated.
	30		●	●	●	●	●	18+	All	None	Quasi-residential abstinence based 12 week treatment. All counsellors in abstinence based recovery. Highly structured, intensive, professional treatment leading to comprehensive post-treatment strategy and support (inc. post-treatment supported housing). Positive regard ethos. Residential AND day-care. Smoking cessation also offered.
			●	●	●	●	●	18+	Please contact us for options	Must be in settled address with telephone or mobile	Addictions UK, a Social Enterprise, are the leading providers of Home-Based Addictions Treatment in the UK offering a range of addiction treatment including medical, home detox, talking therapies – including 12-steps, relapse-prevention and other customised services including consulting and training. Our services are primarily telephone based with separate24/7 help and coaching lines for clients and their friends and family members. Doctor led Community Detox.
	30	11	●	●	●	●	●	18+	All	Pending individual assessment	Comprehensive Treatment addressing Dependency and underlying issues through Psychotherapeutic models. Incorporating 12 step components. Abstinence Based with Assessment, Primary and Secondary Modules. From Detox through to full Aftercare and Family Support. Extra treatments include co-dependency.
	15	5	●	●	●	●	●	18-65		Detoxed	Treatment based on 12 step philosophy. Fully trained and qualified counselling staff. Manned 24 hours a day.
	8	8	●		●	●	●	18-65	NHS, Private, insurance		We specialise in the treatment of Healthcare Professionals with Addictions (including co-occurring Mental Health). 12 Step and modified Therapeutic Community. 12wks program with 5years free Aftercare from an experienced therapy team. Detox can be arranged.
	15	15	●		●	●	●	Adult	All sources		Providing two discrete residential services in a tranquil, rural setting, which can be stand alone or offer seamless transfer medically-managed detox and stabilisation in individual, en-suite rooms, and primary and secondary rehabilitation based on the 12 Step programme. 24 hour cover. Treatments include group and key work together with a full range of therapeutic activities and Equine Assisted Psychotherapy.
	31		●	●	●	●	●	18+	NHS, Private, Insurance,DSS		Broadreach House offers Detoxification/first stage (2-6 weeks) and a specialist secondary programme (12-24 weeks) for clients with Dual Diagnosis and/or Serious Health issues.Programmes incorporate elements of CBT, MI, in a drink/drug free environment. Resettlement service. Owned and managed by Broadreach House.
	13		●	●	●	●	●	18+	Private, NHS, Medical Health-care	Pre Admission Assessment	CQC Registered. We are a fully residential treatment centre based in Watford. We are a 13 bed rehab offering detox,rehabilitation & aftercare. We have an integrative program offering 12-step, neuro- biology, CBT, psychotherapy, yoga, stress management, nutrition, acupuncture, art, mindfulness meditation & massage. Vibro Acoustic Bed and Music Therapy.
	65 in	total	●		●	●	●	12+	Self pay, Private Medical insurance		Situated in central London our success derives from using an integrative and individually tailored programme, combining abstinence with CBT, MET & Minnesota Model approaches, plus complimentary therapies. Other therapies include Internet and smoking. Tailor-made outpatient/inpatient/daycare treatment programmes. Free aftercare & family support groups.
			●	●	●	●	●	18+	Private	Free assessment	Private and competitively priced treatment centre based in central London specialising in trauma, addiction and mental health. We offer a dynamic and challenging 2, 4 or 6 week intensive outpatient programme. Other services include an Evening Programme, Family Programme, Adolescent Programme, Aftercare, weekend workshops plus counselling and psychotherapy, co-dependency, self harming & work addiction
		13	●		●	●	●	18+	NHS, Private Other	5 days clean/sober	Chy Colom is a second stage residential rehabilitation centre in Truro, Cornwall. Encompassing an individually-tailored programme of support for people with drugand/or alcohol issues, it offers high quality addiction treatment by dedicated, committed and enthusiastic team. Residents are supported in all aspects of their treatment. Family support offered. Expert support is available 24 hours a day.
		17	●		●	●		18+	Private, DSS	Substance-free on admission	Second stage residential treatment for men. Individual programmes. 3-6 months. Work on underlying issues and re-integration. Resettlement service. Owned and managed by Broadreach House.
	38		●		●	●	●	18+	NHS, Private, Insurance, Other		Clouds House provides first-stage abstinence-based residential treatment, and detoxification if required. The 6-week programme based on a 12-Step philosophy includes group therapy, 11 counselling and workshops. Cognitive Analytical Therapy, Family Residential Programme and Family Therapy offered. Clouds House is part of Action on Addiction.
						●	●	16+			NHS Clinic offers assessment and treatment of problem gamblers living in England & Wales (aged 16+). Self referral or referral by other agencies. Services include psychiatric assessment/medical management, motivational enhancement interventions, CBT targeted at gambling disorder, family interventions, debt management.
	16		●	●	●	●	●	18+	All	Must be on detox on day one	CQC registered. A structured day programme offering a realistic balance between residential and community treatment. Typical treatment length is ten weeks followed by aftercare for one year. Family therapy available.
	13	5	●	●		●	●	16+	Private, Health Insurance	Subject to Assessment	Gladstones Clinic offers a unique holistic approach to treatment aimed at healing the body, mind, soul and heart. Our highly structured, supportive and challenging programmes are tailored to each individual in order to overcome the addiction problem. 15 3rd stage beds available.
	12	3	●	●	●	●		18 +	All	Subject to Assessment	12 week min primary and secondary programmes. Group each weekday morning, including 12 Step prgramme, topic and occupational workshops and weekly counselling sessions in the afternoon meeting per week. Clients to also attend 2 fellowship meetings per week. Underlying Christian ethos. Extra treatments include, Smoking Cessation and Occupational Therapy.
			●		●		●	18+	All	Detoxed on admission	Client-focused abstinence-based treatment for women, based on The 12 Steps, in a small, supportive community. Incorporate CBT, Life skills, relapse prevention and focus on relationships, co-dependency and cross-addiction. Underlying Christian ethos.
		23	●	●	●		●	18+	Private, Local authority	Two weeks clean and sober	Hope House is a second stage residential treatment centre for women. The programme provides counselling, group therapy and life skills and is 12 Step abstinence-based. Food disorders if with drugs and alcohol. Hope House is part of Action on Addiction.
	16					●	●	18-65	NHS, private, insurance		12 step abstinence based 3 month programme. Kairos offers residents an opportunity to address their substance misuse problems in a safe environment. Trust, responsibility and accountability are key aspects of our integrated programme. All staff are highly qualified with years of experience working in the addictions field. Kairos umbrellas a 2nd stage day programme & 17 supported move-on houses.
	8					●		18+	Social services or self		Intensive residential group working programme for up to 8 men, set in 15 acres of woodland. 12 step philosophy. Key worker system, weekly objective setting and support provided for daily living skills. Help with moving on.

Where to find... *treatment*

England	Telephone	Email, website	Contact	Alcohol	Drugs	Eating disorders	Gambling	Dual diagnosis	Detoxification	Sex Addicti	Not-f
KENWARD HOUSE Kenward Road, Yalding, ME18 6AH	T 01622816086	admissions@kenwardtrust.org.uk www.kenwardtrust.org.uk	Nick Hillman Admissions Manager	●	●	●		●			●		
KENWARD (THE MALTHOUSE) Church Street, Ukfield, TN22 1BS	T 01622816086	admissions@kenwardtrust.org.uk www.kenwardtrust.org.uk	Nick Hillman Admissions Manager	●	●	●		●			●		
KENWARD (NAOMI) Highgate Hall, Rye Road, TN18 4EY	T 01622816086	admissions@kenwardtrust.org.uk www.kenwardtrust.org.uk	Nick Hillman Admissions Manager	●	●	●		●			●		
LEY COMMUNITY Sandy Lane, Yarnton, Oxon, OX5 1PB	T 01865 373108	sara.lewis@leycommunity.co.uk www.ley.co.uk	Sara Lewis Admissions Unit	●	●		●	●	●		●		
LIFE WORKS The Grange, High Street, Old Woking. Surrey. GU22 8LB	T 01483 745066	enquiries@lifeworkscommunity.com www.lifeworkscommunity.com	Chris Cordell Operations Director	●	●		●	●	●				
LINWOOD PARK Wensley Road, New Lodge, Barnsley, S71 1TJ	T 0800 066 4173	info@thelinwoodgroup.co.uk www.thelinwoodgroup.co.uk	Jill Antley R.M.N R.M.A Centre Manager 08709746526	●	●			●	●				
LONGREACH 7 Hartley Road, Plymouth, Devon, PL3 5LW	T 01752 566246	enquiry@broadreach-house.org.uk www.broadreach-house.org.uk	Emily Wilkins emily@broadreach-house.org.uk	●	●	●	●	●			●		
MERIDIAN COUNSELLING CLINIC LIMITED Brick Barn Hall, Colchester Road, Bluebridge, Halstead, Essex, CO9 2EU	T 01787 473332	office@themeridianclinic.com www.themeridianclinic.com	Bob Frost Programme Director	●	●	●	●		●	●			
MOUNT CARMEL 12 Aldrington Road, Streatham, London, SW16 1TH	T 020 8769 7674	info@mountcarmel.org.uk www.mountcarmel.org.uk	Ruth Allonby Chief Executive	●	●	●		●					
NELSON TRUST, THE Port Lane, Brimscombe, Stroud, Gloucestershire, GL5 2QJ	T 01453 885633	office@nelsontrust.com www.nelsontrust.com	John Trolan Chief Executive	●	●	●		●					
ONE 40 WORTHING 18 Winchester Road, Worthing, Sussex, BN11 4DJ	T 01903 650645	info@one40.org www.one40.org.uk	Chris Simon Admissions	●	●	●			●	●			
OPEN MINDS Chester House, 11 Grosvenor Road, Wrexham, LL11 1BS	T 01978 312120	info@openminds-ac.com www.openminds-ac.com	Jan de Vera Davey Director	●	●		●		●				
PASSMORES HOUSE (WDP) STABILISTION SERVICES Third Avenue, Harlow, Essex, CM18 6YL	T 01279 634200	enquiries@stabilisationservices.org www.stabilisationservices.org	Tom Shyu Service Manager	●	●	●	●	●	●				
PATHWAYS HOUSE 73 Rochester Avenue, Canterbury, Kent, CT1 3YE	T 01227 784953	enquiries@pathwayshouse.co.uk www.pathwayshouse.co.uk	Kenny Milne	●	●	●	●	●	●	●			
PCP-THE PERRY CLAYMAN PROJECT 17-21 Hastings Street, Luton, Bedfordshire, LU1 5BE	T 01582 730 113	info@pcpluton.com www.rehabtoday.org	James Peacock Registered Manager	●	●	●	●	●	●	●			
PRINSTED Prinsted, Oldfield Road, Horley, Surrey, RH6 7EP	T 01293 825400	info@prinsted.org www.prinsted.org	Carole Barnes Operations Manager	●	●	●	●	●		●			
PROVIDENCE PROJECTS, THE Providence House, 17 Carysfort Road, Bournemouth, Dorset, BH1 4EJ	Freephone 0800 955 0945 T 01202 393030	info@providenceproject.org www.providenceproject.org	Paul Spanjar CEO	●	●	●	●	●	●				
RAVENSCOURT 15 Ellasdale Road, Bognor Regis, West Sussex, PO21 2SG	T 01243 862157	info@ravenscourt.org.uk www.ravenscourt.org.uk	Counselling Team	●	●			●	●				
SANCTUM 268-279 High Street, Uxbridge, Middlesex. UB81LQ	T 0330 555 0002	info@thesanctum.uk.com www.thesanctum.uk.com	Peter Paul	●	●			●	●				
SEFTON PARK 10 Royal Crescent, Weston-super-Mare, Somerset, BS23 2AX	T 01934 626371	enquiries@sefton-park.com www.sefton-park.com	Jamie Bird and Clinical Team	●	●	●	●	●	●				
SHARP - BOURENMOUTH & POOLE (SELF-HELP ADDICTION RECOVERY PROGRAMME) The Clouds Building, 1a Station Approach, Boscombe, Bournemouth BH1 4NB	T 01202 399 723	SHARPBmth@actiononaddiction.org.uk www.actiononaddiction.org.uk	Su Ross-Anderson Head of Service	●	●								
SHARP - LIVERPOOL (SELF-HELP ADDICTION RECOVERY PROGRAMME) 1 Rodney Street, Liverpool, L1 9EF	T 0151 703 0679	SHARPLvpl@actiononaddiction.org.uk www.actiononaddiction.org.uk	Karen Hemmings Project Manager 0151 703 0679	●	●			●					
TTP RECOVERY COMMUNITIES NORTH Holly House, 73 Sankey Street, Warrington WA1 1SL SOUTH Telford Place, 1 Telford Way, Luton, LU1 1HT	T 0845 241 3401	admissions@ttprecoverycommunities.co.uk www.ttprehab.org	Admissions 0845 241 3401	●	●			●	●				
SOMEWHERE HOUSE LTD 68 Berrow Road, Burnham-on-sea, Somerset, TA8 2EZ	T 01278 795236	info@somewherehouse.com www.somewherehouse.com	Angie Clarke Manager	●	●	●	●	●		●			
WESTERN COUNSELLING SERVICE Whitecrosse, 18 Whitecross Road, Weston-super-Mare, North Somerset, BS23 1EW	T 01934 627550	admissions@westerncounselling.com www.westerncounselling.com	Admissions Office	●	●	●	●	●	●				

ion or-profit	No.1st-stage beds	No. 2nd-stage beds	Aftercare offered	Daycare available	1:1 counselling	Males accepted	Females accepted	Age range	Funding options	Conditions of acceptance	More information & extra treatments
	31				●	●		18+	Social services or self		Cognitive/behavioural residential recovery programme for men set in 15 acres of woodland. Dedicated Recovery Integration Worker and individual recovery plan. Weekly objective setting, group work, optional one-to-one counselling, life skills, family therapy. Focus on moving on and reintegration.
		8			●	●		18+	Housing benefit or self		Structured residential project for men who have completed a suitable treatment programme and need further work. Key working, counselling, groups, life skills, training in numeracy, literacy and computer skills. Focus on reintegration. Town location, good access to AA/NA meetings.
	9						●	18+	Social services or self		Female intensive residential group working programme, set in village with amenities close by and community links. Addresses addiction using a wide range of approaches, including the 12 Steps, CBT, TA, motivational interviewing and creative therapies. Key worker system and support for moving on. Move on options at Kenward Trust supported housing. projects in Kent.
	46	12	●	●	●	●	●	18-65	Social services, Private, Insuance, NHS	Individual Assessment	The Ley Community was established in 1971 as one of the first dedicated drug and alcohol residential rehabilitation centres in the UK for men and women.Our recovery model is based on a unique therapeutic community philosophy which we have delivered with significant results for the past 42 years. Extra treatments: Auricular Acupunture, Reiki, Smoking Cessation, Yoga, Reflexology, Stress & Relaxation.
	20		●	●	●	●	●	16+	Self funding or private medical insurance	Subject to assessment	Life Works is a private specialist behavioural health facility leading the way in advanced, evidence-based abstinence treatment for addictions, eating and mood disorders. Offering flexible and individually tailored treatment programmes, including detoxification, starting from just 7 days we can accommodate any individual over the age of 16 subject to suitability.
	19	13	●	●	●	●	●	18-75	All	Individual Assessment	12 step abstinence based treatment facility, providing detoxification, rehabilitation and secondary care, 24hr medical cover & psychiatrist on call, Admissions within 24hrs, we provide CBT Group Therapy and 121 counselling also Family and Aftercare workshops.
	22	22	●		●		●	16+	NHS, private, insurance, DSS	Substance-free on admission	First and second stage residential treatment for women incorporating in-depth work on abuse, bereavement, relationships, eating disorders, self-harm. Parenting skills programme. EMDR, SALT. Resettlement service. Owned and managed by Broadreach House.
	5 in total		●	●	●	●	●	18+	All	Treatment contract to be signed	Private, confidential, bespoke treatment facility for day clients. Abstinence-based, incorporating 12-step recovery philosophy plus education, counselling DVDs, lectures and aftercare. Arrangement with local detoxification facility.
	18 in total		●	●	●	●	●	18+	All	Sober on admission	A 12-step abstinence-based residential and day-care programme consisting of group therapy and individual counselling. Holistic approach. Family support. Aftercare. Alcohol as main drug of choice.
	25	16	●	●		●	●	18+	NHS,local authority, private insurance	Post detox	Abstinence-based, residential & non-residential therapeutic environment; six month programme with individual counselling, groupwork, family therapy & workshops. Separate women's house & programme with overnight visiting facilities for children; Resettlement, aftercare; Education, Training & Employment centre with a programme including woodwork, arts, crafts & IT skills.
			●		●			16			One 40 Worthing is a private specialist behavioural health facility leading the way in advanced, evidence-based abstinence treatment for addictions, eating disorders, depression, anxiety and mood disorders. Offering tailored treatment programmes. Admissions within 24 hours.
	14	16	●	●	●	●	●	18+	All	Individual assessment	Abstinence based, structured programme comprising pre-treatment, detoxification, primary, secondary and back to work phases. Residential and day programme. Aftercare and family support. 12-step, Reality Therapy, REBT, Life Skills, access to Training and Further Education. Minnesota Model. Hazelden trained staff.
	9	8	●		●	●	●	18+	All	Case by case basis	Residential detoxification and rehabilitation services for up to 16 residents. Eclectic model. ITEP psycho-social programmes. All rooms ensuite. 24/7 nursing cover and medical on-call. In-house cook for all dietary needs. Complementary therapy available. Aftercare on Fridays for those who have completed.
	5		●		●	●	●	18-70			Small, highly professional abstinence-based drug and alcohol treatment facility, offering residential treatment and detox.
	135 in total		●	●	●	●	●	18-65	Private or statutory funded		Abstinence based Residential Treatment Programmes, 12 weeks primary, 12 weeks secondary and third stage supported housing. Detox facilitated, a choice of 4 different locations Luton, Chelmsford, London and Leicester. Admissions within 24 hours.
		15	●		●	●	●	18-65	Local authority, private	2 weeks clean and sober	Abstinence based , 12-step model, 3-6 months. Second Stage residential treatment. Group therapy, individual counselling, Codependency, living and social skills training, workshops, relapse prevention, aftercare and family workshop and support. Registered with the CQC.
	60 in total		●	●	●	●	●	18+	Private, Local authority, Coprorate	None	The Providence Project offers the complete solution from addiction. Our abstinence based, ecletic model of treatment is tailored to suit the individual. Detox, primary treatment, secondary treatment, aftercare, re-integration and housing are all provided with surperb outcomes and at affordable prices. Programmes from 4 weeks - 6 months.
	17	7	●		●	●	●	18+	NHS, private, Corporate		12 week, 12-step abstinence-based rehabilitation programme. Group therapy. Individual counselling. Family programme. Women's groups. Individually tailored treatment programme.
	20	15	●		●	●	●	18-65	Private NHS, Insurance. DSS	Varies	Our unique strength is how we follow on from detox to through-care; how we enable people to address the issues that have taken them into addiction and give them the skills to cope, long term.
	28 in total		●		●	●	●	18-75	All Sources	Individual assessment Clean/sober on arrival	Sefton Park is a therapeutic community providing an integrative programme for clients who are seeking an alternative to the 12 Step Model. All our interventions are individualised/Person Centred and encourage respect for the autonomy of client choice and responsibility for their actions.
			●	●	●	●	●	18+			SHARP Bournemouth and Poole offers an abstinence based day treatment programme which includes group therapy and one-to-one support. Working Recovery a community based training project that offers wood work skills and creative skills programmes is also based here. These programmes are part of Action on Addiction.
	22 places		●	●		●	●	18+		24 hours drug & alcohol free	A comprehensive 12-Step abstinence-based day treatment programme, including family programme and aftercare. SHARP Liverpool is part of Action on Addiction.
	60	24	●	●	●	●	●	18+	NHS, private	Assessment	Residential drug or alcohol treatment. Therapeutic community. 15 beds m/f. Single rooms. Structured programme, group therapy and excellent relapse prevention. Dual diagnosis service, clients accepted on anti-psychotics. Specialist support group for survivors of sexual abuse. Family Groups, Creative Activities, Benefits Advice.
	14 in total		●		●	●	●	18-+	All	Detoxed on admission	We will treatment match according to the client's needs. We work with individual care plans and offer a supportive and respectful environment for individuals to change and grow. We encourage family support and have been rated 3 Star excellent by CQC. Other Treatments include: Family Therapy, Equine Therapy, Alternative Therapy, Good Aftercare.
	32	18	●		●	●	●	17-64	All Sources	Individual assessment, motivation	12 Step structured therapeutic rehabilitation programme, individual and group therapy. Male and female. Primary care 12 weeks, secondary care 12 weeks. All male house and mixed house available. 24hour support. Counselling training. Family Programme, Holistic Therapies, Smoking Cessation.

Where to find... *treatment*

	England	Telephone	Email, website	Contact	Alcohol	Drugs	Eating disorders	Gambling	Dual diagnosis	Detoxification	Sex Addicti	Not-f
Scotland	**YELDALL MANOR** Yeldall Manor, Blakes Lane, Hare Hatch, Reading, RG10 9XR	T 0118 940 4413 (adm) T 0118 940 4411 (gen)	admissions@yeldall.org.uk www.yeldall.org.uk	Fiona Trim Admissions Coordinator	●	●			●	●		●	
	ALEXANDER CLINIC King Street, Oldmeldrum, Aberdeenshire, AB51 0EQ	T 01651 872100	enquiries@alexanderclinic.co.uk www.alexanderclinic.co.uk	Mark Hepburn Manager	●	●		●	●	●			
	CASTLE CRAIG HOSPITAL Blyth Bridge, West Linton, Peeblesshire, EH46 7DH	T 01721 722763	enquiries@castlecraig.co.uk www.castlecraig.co.uk	Admissions Secretary 01721 725368	●	●	●	●	●	●			
	PRIORY HOSPITAL GLASGOW, THE 38 Mansionhouse Road, Glasgow, G41 3DW	T 0141 636 6116	glasgow@priorygroup.com	Joe Ramsay ATP Team Leader	●	●	●	●	●	●	●		
Wales	**BRYNAWEL REHAB** Llanharry Road, Pontyclun, Mid Glamorgan, South Wales, CF72 9NR	T 01443 226864	info@brynawelhouse.org www.brynawel.org	Jacqui Wood Registered Manager	●	●			●	●		●	
Ireland	**CARLISLE HOUSE** 2 - 4 Henry Place, Cifton Street, Belfast, BT15 2BB	T 028 90328308	carlislehouse@pcibsw.org www.carlislehouse.org	James Small Programme Coordinator	●	●	●		●			●	
	AISEIRI TREATMENT CENTRES Townspark, Cahir, Co. Tipperary, Ireland, and Roxborough, Wexford, Ireland	Cahir 00353 527441116 W'ford 0035353914 1818	infocahir@aiseiri.ie infowexford@aiseiri.ie www.aiseiri.ie	Contact Admissions	●	●		●				●	
	HOPE HOUSE Foxford, Co Mayo, Ireland	T 00353 949256888	hopehouse@eircom.net www.hopehouse.ie	Dolores Duggan	●	●		●					
Channel Islands	**SILKWORTH CHARITY GROUP** Silkworth Lodge, 6 Vauxhall Street, St Helier, Jersey, JE2 4TJ	T 01534 729060	info@silkworthlodge.co.uk www.silkworthlodge.co.uk	Alan Kiley Treatment Manager	●	●						●	
Europe	**ACTEnow** 12 avenue Paul Doumer, Paris, 75116 France.	T +33(0)1 475568 80	contact@acte-now.com www.acte-now.com	David DELAPALME Managing Partner	●	●	●	●	●				
	CAMINO RECOVERY PO Box 16, Linda Vista Baja, San Pedro De Alcantara, 29670, Malaga, Spain	T 00 34 952 78 4228	meena@caminorecovery.com www.caminorecovery.com	Admissions 0207 558-8420	●	●	●	●	●	●	●		
	ONE40 MARBELLA Cortijo Blanco, San Pedro, De Alcantara, 29670, Malaga, Spain	T +34 952 780 181	info@cortijocare.com www.cortijocare.com	Sandra Fernandez	●	●	●	●	●	●			
	SAN NICOLA CENTRE Via Anita Garibaldi 64, Senigallia, Ancona, 60019. Italy	T +39 0731 9142	info@centrosannicola.com www.sannicolacentre.co.uk	Elizabeth Augimeri +39 0731 9142	●	●		●	●	●	●		
South & East Africa	**OASIS COUNSELLING CENTRE** Suite 27, private bag X1006, Plettenberg bay, 6600, South Africa	T +27 44 533 1752	info@oasiscentre.co.za www.oasiscentre.co.za	Anstice Wright Director	●	●	●	●	●		●		
	RIVERVIEW MANOR SPECIALIST CLINIC PO Box 506, Underberg 3257, South Africa	T +27 33 7011911	admin@riverviewmanor.co.za www.riverviewmanor.co.za	Judy Wingrove General Manager	●	●	●	●	●	●			
	STEPPING STONES CLINIC Main Road, Kommetjie, Cape Town, 7975, South Africa	T +27 (0)21 783 4230	info@steppingstones.co.za www.steppingstones.co.za	Donald Gove Hospital Manager	●	●	●	●	●	●	●		
United States of America	**BEHAVIORAL HEALTH OF THE PALM BEACHES** 3153 Canada Court, Lake Worth, Florida, USA 33461	T 001 561 721 9836	astevens@bhpalmbeach.com www.bhpalmbeach.com	Alan Stevens - Director PA Office 001 215 784 1120	●	●	●	●	●	●			
	CASA PALMERA TREATMENT CENTER 14750 El Camino Real, Del Mar, California, 92014, USA	T 001 (858) 481-4411	casapalmera.delmar@gmail.com www.casapalmera.com	Barbara Woods	●	●	●		●	●			
	COTTONWOOD TUCSON 4110 W. Sweetwater Drive, Tucson, Arizona. 85745 USA	T 001 529 743 0411	info@cottonwoodtucson.ltd.uk www.cottonwoodtucson.com	Virginia Graham (UK)020 7229 0211 Linda Barela(USA)001 520 743 0411	●	●	●	●	●	●			
	MORNINGSIDE RECOVERY 3421 Via Oporto, Suite 200, 92663, USA	T 001 949 877 1001	Contact@MorningsideRecovery.com www.MorningsideRecoverycom	Brandon Hilger brandon@morningsiderecovery.com	●	●	●	●	●		●		
	SEASIDE OF THE PALM BEACHES Palm Beach, Florida, 33408. USA	T 001-561-732-7433	info@SeaSidePalmBeach.com www.seasidepalmbeach.com	C.Blayre Farkas	●	●		●	●	●			
	SIERRA TUCSON 39580 S. Lago del Oro Parkway, Tucson, Arizona 85739, USA	T 0800 891 166	outreach@sierratucson.com www.sierratucson.com	Max Cohen 07973 167 245	●	●	●	●	●	●	●		
West Indies	**CROSSROADS CENTRE, ANTIGUA** PO Box 3592, St Johns, Antigua, West Indies	T 1 (268) 562-0035	info@crossroadsantigua.org www.crossroadsantigua.org	Kim Martin - Admissions and Marketing Manager Toll free UK 0800 7839631	●	●				●		●	
Asia	**DARA THAILAND** 113 Moo 1, T. Koh Chang Tai, A. Koh Chang, Trat 23170, Thailand	T +66 8 7140 7788	info@alcoholrehab.com www.alcoholrehab.com	Martin Peter martin@alcoholrehab.com	●	●							

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...on ...or-profit	No.1st-stage beds	No. 2nd-stage beds	Aftercare offered	Daycare available	1:1 counselling	Males accepted	Females accepted	Age range	Funding options	Conditions of acceptance	More information & extra treatments
	24	8	●		●	●		18-65	All	Drug/alcohol-free on arrival unless detox agreed in advance	Residential programme incorporating work, groups and one-to-one counselling. Men over the age of 18 of any faith or none are welcome to our Christian centre. Intended outputs are for clients to live independently in the community without the need to use drugs/alcohol . We seek to ensure clients have safe and secure accomodation and employment, voluntary work or study in place before leaving.
	13	10	●	●	●	●	●	All	NHS, Private		Abstinence based 12 step programme offering residential detox and rehab with aftercare, secondary care, 121 counselling and structured family treatment programme.
	55	67	●		●	●	●		NHS, insuance. private, other	GP referral	24 hour urgent admissions. Free assessments. Minnesota model thus - Steps 1- 5 as in-patient. Counsellor training. Residential family programme. Full time Psychiatrist. All procedures including treatment an outcomes. ISO 9002 audited. Therapists ICRC accredited. 50 acres of private grounds.
								16+	NHS, insurance, self		Free initial assessment. 12 months free aftercare.
	16	5	●	●	●	●	●	18+	Local authority Private	Assessment, either in person or SKYPE	Provides treatment and support both at its semi-rural residential facility and in the community for people and families experiencing alcohol and or drug dependency issues. Cognitive behaviour therapy is core to the programme, which includes psycho-social interventions, is client centred and offers a holistic approach. Family counselling.
	13		●		●	●	●	18+	Health & social care trusts	Motivation to change	Carlisle house offers a 6 week residential treatment programme. We are a registered charity located near the centre of Belfast. Referrals accepted from the Belfast and northern health and social care trusts. Group, Individual and Family Therapy. Complimentary ans ECO Therapy. A move on supported housing project is available.
	24 in	total	2yrs		●	●	●	20+	Private, insurance, VHI, Quinn, Aviva grant aid	Clean and sober on entry	Abstinence based 12 step model. Interventions, assessments, relapse prevention, 5 day residential programme for families of alcoholics/addicts. Renewal week for people in recovery.
	12		●		●	●	●	20+	Private, Health Insurers, HSE, NHS	Assessment	Internationally Accredited Residential Addiction Treatment Centre for alcohol, drug and gambling addictions. 30 Day abstinence based Programme, Counselling staff accredited by Addiction Counsellors of Ireland. Located on the West Coast of Ireland, 30 minutes from Ireland West Airport(Knock).
	12	9	●		●	●	●	18-75	Private Pay, Some Insurance	Drug and alcohol free on admission / Detoxed if necessary /Assessment	Silkworth Lodge residential rehabilitation programme is abstinence based and uses the 12 step programme of recovery and is tailor made to each individual.The treatement requires the client to commit to undertake the programme and challenge their behaviour with alcohol and drugs. After completion of Primary reatment clients have the option to enter secondary treatment through one of our half way houses.
			●	●	●	●	●	16+			Private practice specialising in treatment of addictions & related problems, with offices in Paris & London; uses principles of Integrative Psychotherapy and 12-step approach. Family Work. EMDR. The three partners are bilingual (French & English) and can travel anywhere in the world as needed.
	8	8	●	●	●	●	●	18+	Private, some insurance	Indiviually assessed	Abstinence based, residential care (8 bed) specialises in treatment for trauma, addiction and family work to include alcohol and chemical dependency, co-dependency, mood disorders, eating disorders, trauma,, sexual compulsivity. Family Programme, Trauma, EMDR, Equine therapy. Based on 12-Step philosophy with CBT approach.
	5	16	●	●	●	●	●	18-80	Self, Private, Insurance		Cortijo Care is an exclusive and luxury Psychological Wellbeing Clinic offering a unique, medical, holistic and therapeutic approach to Alcohol and Substance Abuse, Eating Disorders and General Psychiatry. Offering 24 hr medical and Psychiatric support, detoxification where required and high risk mental health care.
	30		●		●	●	●	18-99	Self funded	Assessment	San Nicola is the first addiction treatment facility in Italy that adopts a holistic approach to the treatment of addictions including new psychoactive substances of abuse. Our intervention is tailored to individual patient's needs and include the 12 steps facilitation model, CBT, mindfulness based relapse prevention. EMDR. English and Itailan Speaking.
	11 in	total	●		●	●	●	17+	Insurance , private		12 Step 12 week programme. Intensive therapy to treat drug, alcohol and sex addiction, eating disorders including dual diagnosis. and Co-dependency. Professional international team working bio-psycho-spiritual approach. Includes horse riding, yoga, nature experience, deep sea adventure and family programme. Detoxification can be arranged.
	32	32			●	●	●	16-65	All		Professionally staffed, Individual and group therapy, including in-house 12-step abstinence programme, life skills groups and psycho-educational groups. Holistic approach in tranquil and therapeutic environment. Confidentiality assured.
	30	15	●		●	●	●	18+	Insurance, private	Age 18+	Residential 12 Step-based addictions treatment in a beautiful location. Client - specific combinations of effective therapeutic approaches are used to holistically address individual needs. Family Programme. Co-dependency.London aftercare group for UK clients
	26	100			●	●	●	18+			BHOPB, Inc., offers a traditional 12-step approach with innovative assessment and treatment techniques for its alcohol, substance abuse and mental health treatment program located in Palm Beach County, Florida. The program's mission is to treat each patient with dignity and respect while treating their disease.
						●	●		credit cards, check, cash, insurance		A private rehabilitation center where healing begins. We provide help and healing to individuals and families needing treatment for drug and alcohol dependency, eating disorders, and PTSD.
	45		●		●	●	●	18+			Cottonwood attends to physical emotional and spiritual aspects of life. This holistic philosophy is coupled with the neurobiology of human development and the neuroscience of addiction to design cutting edge programs for each patient. There is also a female adolescent unit for females aged 13 -17
			●	●	●	●	●	18+	Insurance, Private, Financing		Morningside Recovery offers a unique, supervised, open treatment model. All clinical staff are highly qualified and our 'real-world' approach allows clients to attend classes at college, work part-time, cycle to the beach, and have family visits. This facilitates a smooth transition into self-sufficient, sustainable recovery. Extra Treatment: Video Games.
			●	●	●	●	●	18-65	Private pay, insurance		Seaside Palm beach is a luxury addiction treatment centre. The philosophy of SeaSide Palm Beach dictates that no two guests come to us with the same accumulation of challenges. Each individual's path to wellness rehabilitation can only be experienced by addressing their unique needs as individuals, taking into account their mind, body & spirit·
	139				●	●	●	18+	Insurance, Private, Finance	Individual assessment	Sierra Tucson, an international leader in treating co-ocurring disorders, offers comprehensive neuropsychiatric treatment programmes for Addictions, Eating Disorders, Mood Disorders, Pain Management, and Trauma/PTSD. Anabolic Steriod Abuse. Compulsive Spending. OCD. A member of CRC Health Group, Sierra Tucson is dually Accredited by the Joint Commission.
	32	19				●	●	18+	Private	Individual assessment	Intensive residential 12-step programme in serene private environment. Traditional and holistic treatment components including meditation, massage therapy, exercise, spiritual counselling, experiential groups, yoga. Family programme included. Complete medical detoxification provided. Full Re/Post Admission Support.
	Total	30	●			●	●				Helping clients from over 50 countries, DARA is Asia's first and leading international destination for drug and alcohol rehabilitation. Located on the tropical island of Koh Chang, Thailand, DARA successfully combines an intensive rehabilitation center with a luxury resort.

All these projects are also listed, with hyperlinks, at http://directories.addictiontoday.org

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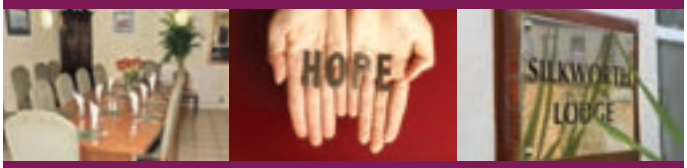

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CODA
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www.codependents.org

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SEX ADDICTS ANONYMOUS
London callback answer phone:
07000-725463
www.sauk.org

SEXAHOLICS ANONYMOUS
for those who want to stop their self-destructive sexual thinking and behaviour
020-8946 2436

SEX & LOVE ADDICTS ANONYMOUS
(The Augustine Fellowship)
07951-815087
www.slaa.uk.org

SHOPPING OVERSHOPPING*
www.overshopping.com

SPEAR*
Supporting people who self-harm
www.projectspear.com

SURVIVORS OF INCEST ANONYMOUS
www.siawso.org

TALKING ABOUT CANNABIS*
Supports families of cannabis users
www.talkingaboutcannabis.org

UK SELF-HELP*
website containing hundreds of listings
www.ukselfhelp.info

VIOLENCE INITIATIVE*
offering violent people a chance to change – meetings, one-to-one sessions, conflict resolution training
020-8365 8220
www.tviccv.org

WORKAHOLICS ANONYMOUS
Celia 01993-878220
or George 020-7498 5927
www.workaholics-anonymous.org

* Resources other than 12-step
Many of these resources are free or by donation – readers should check.

Gloucester House

Salvation Army's Centre of Excellence for Addictions

CQC registered treatment centre with over 50 years experience helping clients rebuild their lives.

- Specialising in addiction and dual diagnosis
- Single occupancy rooms
- 24 hours support
- Primary, secondary, resettlement and aftercare offered
- 1-2-1 counselling and group therapy
- Education leading to qualifications, including PC instruction
- Occupational therapy, including art, pottery and gardening
- Fellowship Meetings and external leisure activities including a local gymnasium and swimming pool
- Mindfulness and relaxation
- Excellent outcomes
- Family/couples sessions offered if required.

Based in the small market town of Highworth, Gloucester House is a small peaceful inclusive centre that offers an integrated 12-Step programme specially designed to meet individual need.

For further information please contact our referrals manager Ros Rolfe on 01793 762365, or email from our website

www.gloucesterhouse.org.uk.

Libby Reid is the founder of A.N.A Treatment Services. For sixteen years A.N.A has helped thousands of people change and begin a new life in recovery.

Intervene's *Jim Smith* talks to Libby about her journey and the growth of her Services.

JS. Libby, you've mentioned to me before that your recovery brought you into this work, and there was quite a change of direction I believe.
LR. Yes, I came from the business world, then trained as a psychotherapist, worked at a project in Eastleigh and Alpha House. I worked generically for two years, then did some voluntary work at Clouds House and the Priory. This experience made me realise I could make a difference.

JS. So you started A.N.A in 1998 in Southsea?
LR. Yes, it was a day programme, quasi-residential; it was difficult for clients to stay sober/clean, there was an average of five callouts a week.

JS. How many houses did you have?
LR. We started with one and as the client population grew so did the accommodation. We started a detox and the project took on a life of its own. Clients started meetings, AA was established in Southsea but not NA, new NA meetings were opened and now in the area there's at least one meeting every day of the week. In 2005 we rented the property in Farlington where Primary Treatment still is and despite our apprehension and anxiety it's the best thing we ever did. The staff were so supportive and made the move with us.

JS. I would imagine your treatment outcomes improved.
LR. They certainly did, the safety of a residential unit enabled people to focus on the programme, and to build on a stronger foundation.

JS. Has the 12 Step model always been at the centre of your treatment?
LR. Always, as well as Gestalt, mindfulness, psycho-dynamic and CBT. We tailor treatment to individual need.

JS. Can you tell me about Secondary Care?
LR. At Lyle house they put into practice what they learnt in Primary, and to start the process of integration into the community.

JS. Is there a requirement for Secondary clients to attend meetings?
LR. We do encourage this, as the 12 Step way of life underpins all we do here, addicts need to understand themselves and their addiction, they go to four meetings a week.

JS. How many clients live in a house?
LR. No more than four, we've found from experience that any more can become unmanageable. Small units work better. We have links with Highbury college (Cosham), our clients can study IT, photography, and other life skills. Soon we will be accredited for an access course. Clients can stay up to a year in third stage to further develop their skills and to gain a foundation towards independent living.

JS. Are there reunions at ANA?
LR. We have special days that people can come to; the year before last we held a remembrance day. We also have fun days, last year we had a 'bake off', the winner of the TV show came down to judge. Can I also mention that ANA has recently been awarded £600,000 to purchase three houses by Public Health England. They will provide follow on accommodation for clients, two houses will accommodate four each, and five in the other house.

JS. Well, the future looks good Libby, it's been a pleasure talking with you, and I hope you continue at A.N.A to make that difference in people's lives.

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PO6 1NJ

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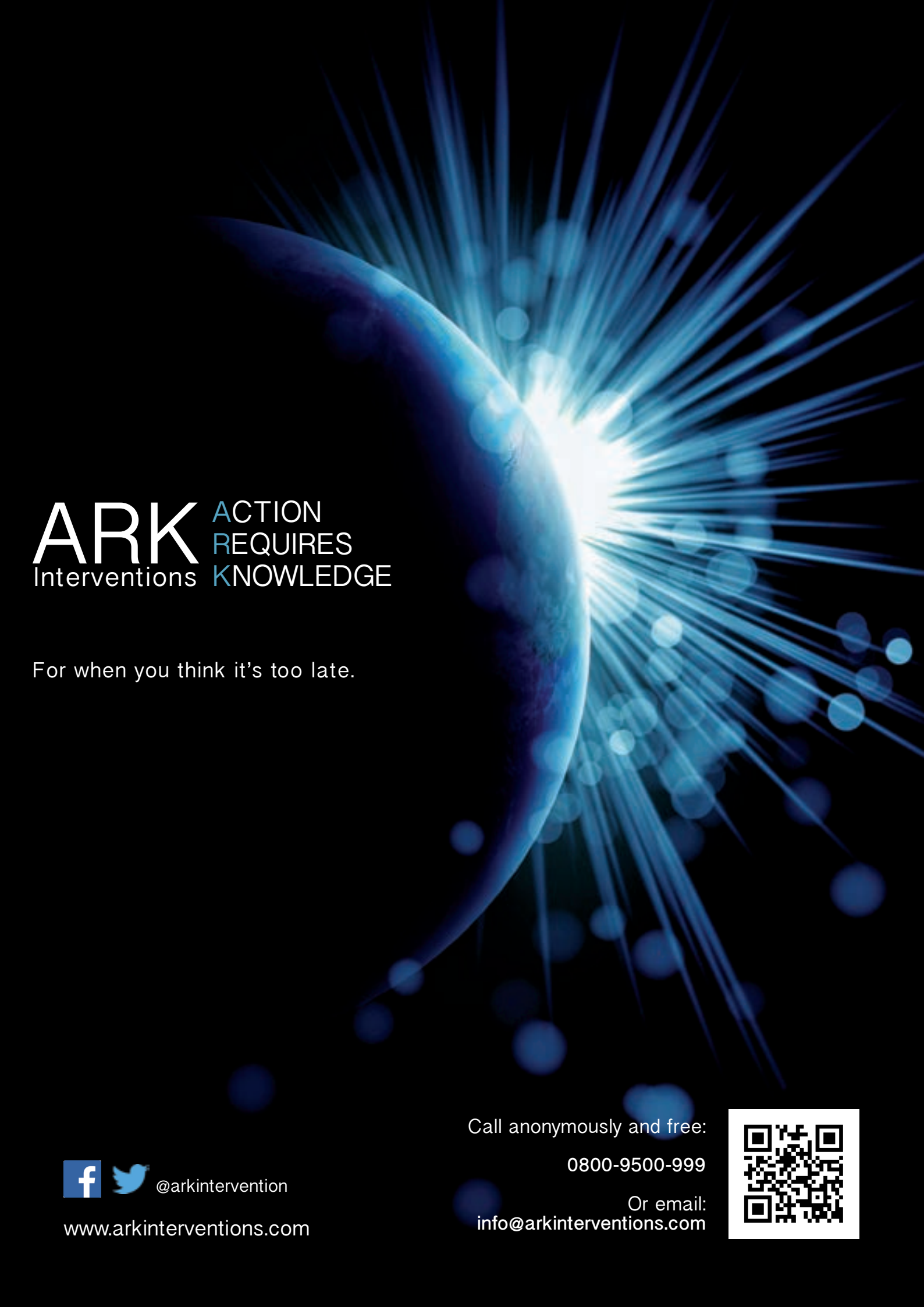

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