'Our present predicament... has brought home to me the inescapable truth – that the Scottish government and the methadone so-called harm reduction lobby have conspired together to betray the best interests of the majority of clients.'

Freedom of choice?

My wife and I, with the help latterly of one full-time staff member, have run a three-bed supported housing/rehab unit here in Shetland since 2003, but have learned recently that we are to be denied funding from our local authority housing department, which previously came through them via 'Supporting People'.

Our local ADAT could only come up with one sixth of what we asked them for and were unwilling to negotiate, while happy to remain in 'conversation' with us. Without even enough cash available to employ a worker we have no alternative but to close this service at the end of May 2009.

We are the only local residential service that makes recovery and rehabilitation a priority, and from now anyone wishing to access abstinence based services will have to go to Aberdeen and start seeing if they can get a look in at the £50,000 set aside for detox and residential rehab.

I have read with interest the many letters and column inches devoted to the abstinence vs harm reduction debate carried in *DDN*, and until now I have always felt that there is room for both approaches. However, our present predicament and that of other rehabs closing down for lack of funds/clients has brought home to me the inescapable truth – that the Scottish Government and the methadone so-called harm reduction lobby have conspired together to betray the best interests of the majority of clients and have succeeded in pulling the wool over the eyes of an all too gullible and largely indifferent public.

In the name of treatment, clients are being maintained in a state of addiction to suit the economic convenience of both government and the pharmaceutical industry.

Andy Holt, Shetland

Respectful advocacy

It was with a mixture of great interest, confusion, sadness and concern that I read Bri Edwards' letter about advocacy (*DDN*, 23 March, page 6), and I feel compelled to write and clarify some of the issues raised.

Peer-led advocacy services need to grow, operate, evolve and exist as an essential component of an agreed, accepted and complementary drug treatment system. Yes, they need to challenge, but they need to do so constructively, and with the involvement of all interested parties. They require the dedication of appropriately trained advocates, the understanding of local service providers and the support of local strategic partnerships.

They require robust service level agreements, transparent recruitment and volunteer processes, and accepted, enforceable operational policies and procedures, alongside systems of regular, effective data collection, audit trails, line management and supervision. They need to be developed, commissioned, managed, monitored and reviewed like any other service. They need to be objective, accountable and evidence-based – but most of all, they need to be professional.

Peer-led advocacy services are not borne of users doing a couple of days training and then expecting services to 'let us loose on their clients' and in fact, this seemingly adversarial approach directly contradicts accepted best practice. Indeed, the Alliance is clear in its message that 'one advocacy course doth not an advocate make', but instead requires ongoing training, research, experience, personal and professional development and reflection.

Independent peer-led advocacy services have to work alongside current drug treatment provision as a critical friend, not outside or against it, and although I understand his frustrations, I'm worried by the overall tone of Bri's letter.

What's particularly worrying for me is that many people will recognise the Alliance's founder Bill Nelles as the man who delivered this 'part one and part two... recognised training', and although I hold Bill and Bri in the highest personal and professional esteem, these were not the Alliance's own RCGP (Royal College of General Practitioners) approved training courses and we need to publicly, respectfully distance ourselves from the approaches to advocacy that Bri seems to have taken from his experience and which are reflected in his letter.

Daren Garratt,
executive director, The Alliance

Failure and compromise

Sharyn Smiles' relapse and recovery (*DDN*, 23 February, page 11) is symptomatic of an industry failing to get to grips with operating in a free market economy, where the effects of business gaming and poor strategic planning cascade down to the end users. Sharyn has a natural brilliance and resilience – many others do not.

The 'rock, scissors, paper' games of commissioning are not addressing the impact on users or carers – Sharyn's story is only half-told. Ask her for the other half – poor supervision, guidance and support; half measures and short cuts.

Ask about the prisoner's dilemma and the trade-offs users and carers have to make to get help.

Alec Fraher, *www.alecfraher.org/purchasing_findings.html*

Nothing simple

I would like to comment on the article 'Choosing life' (*DDN*, 9 February, page 12).

In my case I found smoking alleviated alcohol cravings. I therefore found detox and rehab to be effective and tolerable while being able to smoke outside.

Every life saved by detox and rehab is one more. In hindsight I do not think I would have been able to cope without smoking. I think I would have found the extra strain intolerable, and have given up.

Hugh Anderson, Haslemere

Prison review

As reported in DDN, 7 April 2008 (page 4), Lord Kamlesh Patel of Bradford was announced to chair a prison drug treatment strategy review group. The review group is tasked with looking at the recommendations of a report by Pricewaterhouse Coopers review of prison-based drug treatment funding.

To ensure that the review is transparent, with significant stakeholder feedback, the prison drug treatment

strategy review group website *www.pdtsrg.co.uk* was launched on 2 March 2009. The website has documents from the first meeting of the review group, and will continue to be updated, including news from Lord Patel.

Please take the time to visit the site and leave some feedback or discussion points. There is a forum on the site that Lord Patel would like people to use as an opportunity to voice their views and to invigorate discussion on the topic.

Rachael Hunter,
public health and substance misuse team, offender health, DH

Support before therapy

I'm a client in a rehab/mother and baby unit – I did six weeks at my first unit and I've now been at another for seven weeks.

The first unit was 12 step and I had finally found something that was working for me – I had a good counsellor and I enjoyed the programme and started to open up. I had to move to the second place in order to get custody of my son. The counsellor I have here is OK, but my issue is that they expect you to open up in your once a week key work and then you have the rest of the week to sit with it – with no proper support.

There are only a few proper counsellors here at different times – the rest are support workers that I wouldn't go and talk to, being someone that finds it really hard to talk. I'm sure most addicts are the same.

I was encouraged to speak about something in a group that I'd never told anyone before, a really traumatising event that I went through two and a half years ago – and I wish I hadn't. I was just left with shocked, blank looks around me, then I was given no support after – no one even mentioned it.

I was reading your article about triggering hyper-arousal (*DDN*, 12 January, page 14). Hopefully now this is being recognised they might start to consider the support you have before they start pumping you. I'm actually dreading reading my life story.

Lisa, by email

Nutrition 1: bad science

I see that in your latest edition you feature an article by Patrick Holford on how to regain your brain through nutrition (*DDN*, 23 March, page 18).

I don't know if you're aware of the work of Ben Goldacre, notable *Guardian* columnist and writer of the Bad Science column – www.badscience.net/category/patrick-holford.

I think you'll find that in the real world of evidence-based science that there are plenty of question marks as to the credibility of Patrick Holford. Readers might also like to check out www.holfordwatch.info or www.holfordmyths.org if they'd like further proof.

At a time when staff in the drugs field are being quite rightly directed to delivering evidence-based interventions, it's rather disappointing that our trade paper perpetuates this kind of hokum. Are there properly published studies of this brain nutrition stuff? Clinical trials that other proper scientists can have a look at and ask questions about? I would rather doubt it.

Steve Eastwood,
divisional manager, Halton Drug and Alcohol Action Team

Nutrition 2: snake-oil salesmen

I have to strongly object to the pseudo-science that you have chosen to feature in your pages recently. The article by someone considered to be such a snake-oil salesman and charlatan as Patrick Holford had no place in your magazine and could prove misleading to readers.

The second link after my google search highlights the issues people have with Holford's 'science' leading to http://holfordwatch.info/

Obviously I am not disputing that a good diet is important but it seems to me more rigorous scrutiny should take place before allowing people to write articles promoting their wares.

N Scott, substance use and mental health worker, Staffordshire

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity. Visit our forum at www.drinkanddrugsnews.com

Policy notes

MANY SEE, FEW OBSERVE

One of the problems of having such a reliance on a specialist drugs field as the main engine room of national strategy is that sometimes we miss some really important issues, says Sara McGrail

I was recently speaking at an event where I was describing one of the impacts of the recession on drug use. People who currently feel they are managing their drug use might find that use becoming less controllable if some other areas of their life become more pressured.

For example, the person who knows they have to moderate their weekend drug use because on Monday they have to be in work might find the weekends 'spilling over' into the week if they lose their job. The challenge I asked the people I was talking with to consider is how we could get help and support to these people. The answer came back: 'Well it depends when they turn up at treatment services.'

This seems fairly logical when you think about it. Job one is drug treatment, so people need to come for drug treatment before we can help – right?

Wrong! Our business is to reduce the community, individual and social harms related to drug use and help people achieve better health and a better quality of life. It's an aim that should cut right across all our work wherever we are in the drugs field. That certainly does mean we need to continue to resource and support treatment services. Ensuring free, equitable access to high quality drug treatment is a critical part of any effective approach to drugs. But does our work begin and end there? I remember sitting in on a meeting with Mike Ashton a year or so ago, when he posed the question: Why do we have to wait until someone hits a crisis point before we intervene?

We need to begin to develop ways of supporting people to deal with their drug use before it becomes problematic, to enable people to be aware of and develop tactics to reduce the potential harms of their own use. We also need to explore further what social and economic factors can help prevent use of drugs and alcohol escalating to problematic levels. Work to ensure we invest in measures to protect vulnerable people and communities from the worst impacts of recession may be of equal value to good treatment services in the medium and long term. Within specialist treatment as well, support around issues to do with housing and employment is recognised as important – but support around money, benefits, and debt can make a real difference too.

Recently I was fortunate to meet with a group of service users at the Birmingham conference, *Voices for Choices*. For them there was no denying the links between their economic situation and their drug use. One told the story of how, on being discharged from rehab, he got a grant to help him set up his new life. Unfortunately he had no bank account and no passport, so he couldn't cash the cheque anywhere but at one of those high street 'pay day loan' shops that seem to be springing up everywhere. This meant he lost just over 10 per cent of his community care grant. Another woman spoke about how one of the things that had made a huge difference to her was being in her local credit union – it meant that although her income went down when she went into treatment (as it does apparently for a lot of people), she was able to manage her money better and even save a little bit.

On 23 April in the City of London, the London Drug Policy Forum (LDPF) with Adfam and KCA are running a conference as part of the Both Sides of the Coin project, to look at the impact of money and debt on people affected by drug use – users, family, carers and communities – and how we can work to improve the situation. If you're interested in coming along you can find out more on the KCA website www.kca.org.uk/ and also on my blog at www.saramcgrail.co.uk

Sara McGrail is a drug policy specialist.