DDN
Drink and Drugs News
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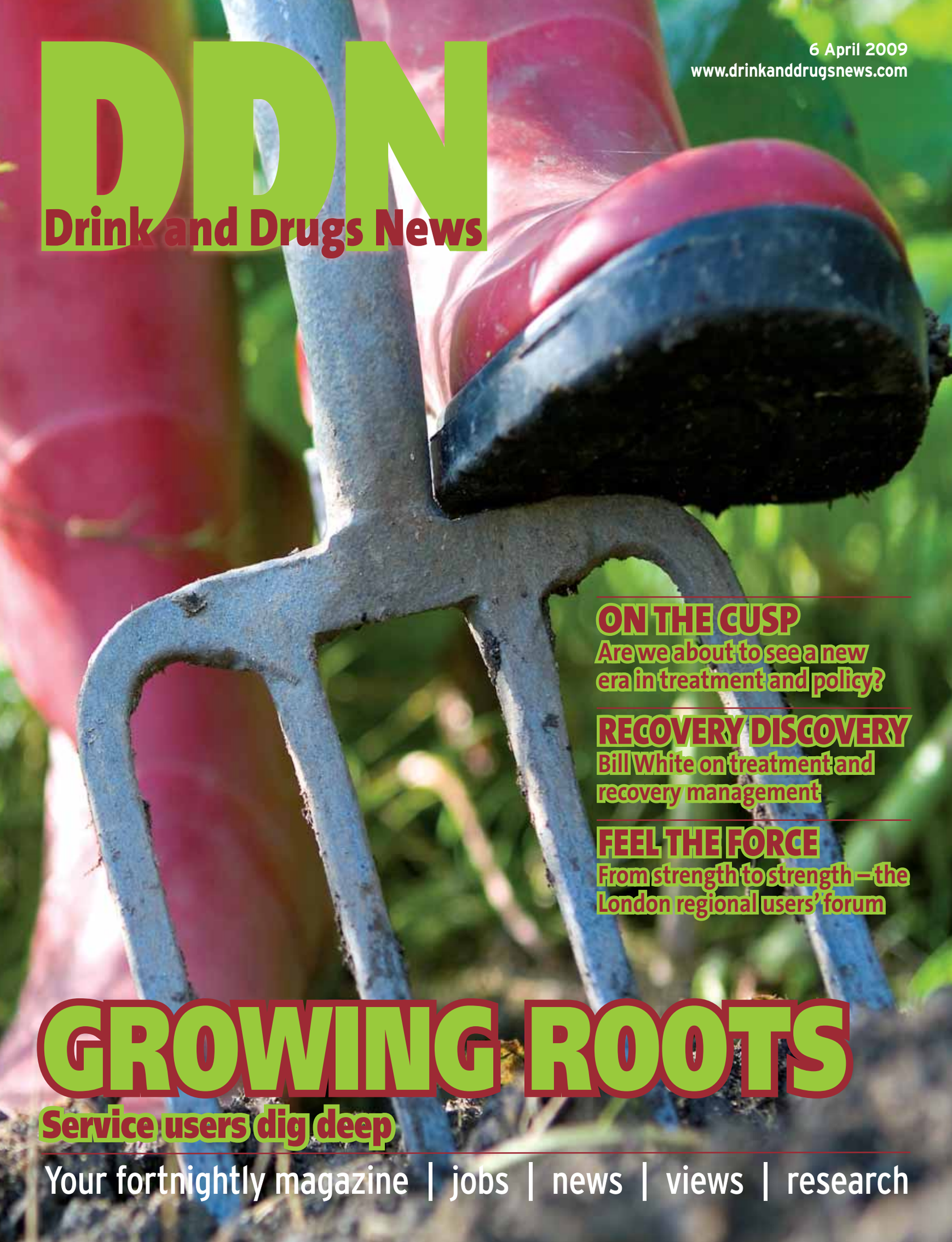

ON THE CUSP
Are we about to see a new era in treatment and policy?

RECOVERY DISCOVERY
Bill White on treatment and recovery management

FEEL THE FORCE
From strength to strength – the London regional users' forum

GROWING ROOTS
Service users dig deep

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DDN
Drink and Drugs News

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Editorial - Claire Brown

Back to our roots

Why sustaining growth is a personal business

With all this talk of recession threatening to get us down, it's time to focus on practical value-for-money ideas that get results. Our cover story explores an initiative that makes economic sense – but most importantly offers inspiration and social interaction alongside therapy. Participants found that getting involved with the project opened doors to something more meaningful for them, and I was struck by the sheer sense of involvement and ownership the initiative inspired – surely signs of progress where recovery is concerned.

American guru Bill White makes the point (at his seminar, reported on page 14) that successful movements are not built on anger and victimhood, but on empowerment and organisation – to which ethos the gardening project adds a good deal of energy.

Having the commitment to become self-sufficient is massively important – the other part of the equation is knowing the practical resources to live life away from substance dependency are within reach. Sara McGrail (page 9) talks of the impact of recession, pointing out that to ignore the link between economic situation and substance misuse is to be deliberately blinkered.

We are always trying to focus on practical support in *DDN*, looking at ways to prevent people from going back to drug or alcohol use by default. Keeping one step ahead of recession is a necessary part of this – can we afford to 'save' now on vital support services for people in danger of losing homes, jobs and means of income, if it means picking up a massive treatment bill much later down the line? Be actively interested now, Sara urges, and I would echo the need for service providers and users to get together with all parties that can make a difference, from government, banking, welfare services, community groups – our field's own G20? – to debate practical ways to avoid disaster on a very personal scale.

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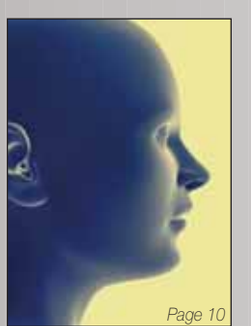

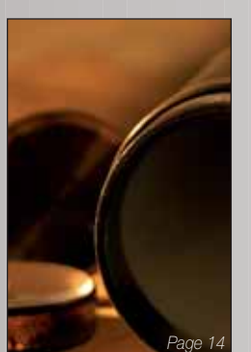

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News in Brief

Get in motion

DrugScope is urging people to lobby their local MP to support a parliamentary Early Day Motion (EDM) recognising the value of drug treatment and calling for continuing investment. EDMs allow MPs to express their support for a particular cause. This one, tabled by Brian Iddon MP, states that 'an effective treatment system must provide a range of evidence-based services, as different approaches will suit different people at different points of their journey out of drug dependency' (*DDN*, 23 March, page 4). A template letter/email is available on DrugScope's website at *www.drugscope.org.uk/newsandevents/currentnewspages/DS_EDM_write_to_MP.htm*

Charity begins in the Cabinet Office

The Cabinet Office has raised the income thresholds for charities above which stricter accounting rules apply – the changes are designed to make sure that more money directly helps the charitable cause and gets 'to where it's really needed', said minister for the third sector Kevin Brennan. The threshold above which annual accounts and trustee annual reports must be submitted to the Charity Commission has been raised from £10,000 to £25,000, and that above which charities prepare accruals accounts raised from £100,000 to £250,000. Delegates at the NTA's recent London regional user forum heard how charitable status could help user groups access more money and become more transparent. *Full report from the London user forum on page 12.*

Drinking down, says BBPA

UK alcohol consumption fell by three per cent last year and was six per cent lower than in 2004 – at 8.9 litres per head against 9.5 litres per head – according to figures compiled by the British Beer and Pub Association (BBPA). 'These figures show that the persistent perception of rising alcohol consumption in the UK is false,' said BBPA director of communications Mark Hastings. The association says consumption has fallen by nearly 5 per cent since the introduction of the 2005 Licensing Act, and is calling on the government to abandon plans for further alcohol tax increases. 'Government policy should be based on the facts, not reflect the myths about alcohol,' he said.

Service reform on the way, promises Scottish Government

Scottish drug and alcohol services will be reformed to make their delivery more responsive to local need, the Scottish Government has announced.

A new framework replacing the model of alcohol and drug teams is to be set out later this month, and there will be a requirement for the NHS to reduce waiting times, said community safety minister Fergus Walsh.

The announcement follows the publication of a report by Audit Scotland which states that spending on drug and alcohol treatment services is not always based on evidence 'of what works or is needed in a particular area'.

Given the wide range of agencies involved, more coordinated effort is needed to make sure services are delivered to consistent national standards, says *Drug and alcohol services in Scotland*, and the government needs to work more closely with local councils, NHS services and others to make sure all public bodies are clear about their collective responsibilities.

Last year public sector agencies in Scotland spent £173m on drug and alcohol prevention, treatment and enforcement, and the complexity of funding arrangements and wide range of agencies makes planning for appropriate services difficult, says the report. The country's substance misuse problems are estimated to cost £5bn annually when criminal justice, hospital admission and economic costs are factored in, with deprived areas by far the worst affected.

A separate report looking at waiting times for treatment, compiled by Information Services Division Scotland, found that, of those clients still waiting for an assessment at the end of last year, 25 per cent had waited more than a year, while a further 29 per cent of those who were waiting for their treatment to begin had also waited more than a year.

Drug and alcohol-related death rates in Scotland have doubled within the last 15 years, with alcohol responsible for three times as many deaths as drugs.

'Drug and alcohol misuse is a significant and worsening problem in Scotland,' said auditor general Robert Black. 'The range of services for people in need of help can depend on where they live, and there is not enough information about the effectiveness of these services. The Scottish Government has published two new strategies in the past 12 months, and there is a lot of activity going on at local level to address drug and alcohol problems. A coordinated effort is needed by all agencies involved to make sure people get the support and treatment they need and also to really find out which services work best in which circumstances.'

The roles and responsibilities of public bodies would be 'clarified and confirmed', promised Fergus Walsh, and the new local partnerships would have a remit to develop local strategies based on 'a robust assessment of needs in their area, a transparent evidence-based process for agreeing how funds for tackling alcohol and drugs misuse should be deployed, and a clear focus on the outcomes which that investment is achieving for their communities'. National coordinators would be recruited, and local partners would have 'clear lines of accessibility' to the government and each other, he said.

Drug and alcohol services in Scotland available at www.audit-scotland.gov.uk/docs/health/2009/nr_090326_drugs_alcohol.pdf

Drug treatment waiting times information framework report October – December 2008 available at www.isdscotland.org/isd/5913.html

Teen drug use down but binge drinking increases

Illicit drug use among 15-16 year olds has fallen slightly across Europe, while 'heavy episodic drinking' in this age group has risen sharply, according to the latest European School Survey Project on Alcohol and Other Drugs (ESPAD). Of the 35 countries looked at in the research, only teenagers in Denmark and the Isle of Man had higher rates of binge drinking than those in the UK.

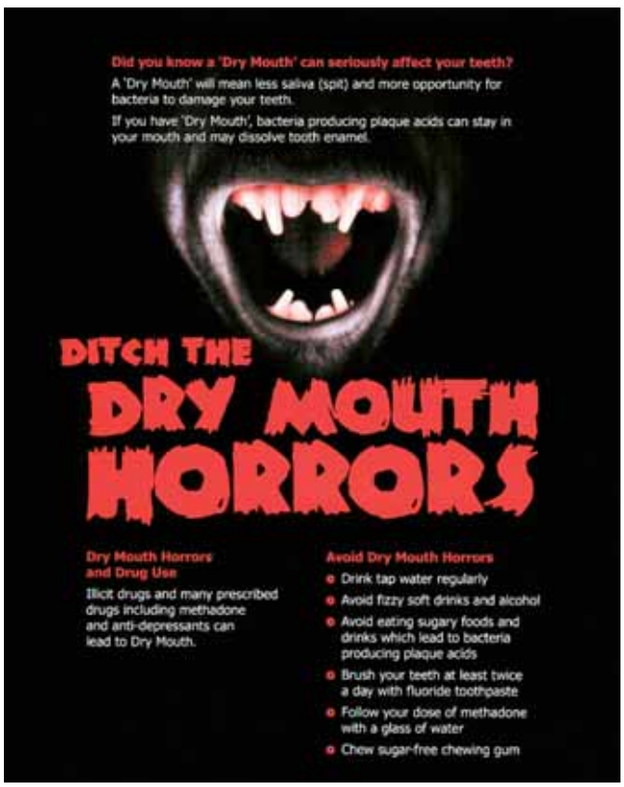
Girls in the UK were more likely to have had a period of heavy episodic drinking in the last 30 days than boys, while the report found narrowing gaps between rates of male and female drinking across countries. Thirty-three per cent of British 15-16 year olds admitted being drunk in the last 30 days, compared to 49 per cent of Danes and 35 per cent of those from the Isle of Man – Austria and Ireland were ranked fourth and fifth.

The chief medical officer for England, Sir Liam Donaldson, recently called for the introduction of a minimum price of 50p per unit of alcohol in an attempt to reduce damaging rates of binge drinking, including among young people, as part of his annual report, but the recommendation appeared to receive a lukewarm response from government (*DDN*, 23 March, page 5).

More than 1,000 students took part in the survey, the fourth carried out by the project, following previous studies in 1995, 1999, 2003 and 2007. Cannabis use in the last month was reported by an average of 7 per cent of students and lifetime use by 19 per cent, while seven per cent had tried one or more other drugs in their lifetime. 'ESPAD data show that, overall, the increase in illicit drug use – mainly cannabis – had come to a halt, if not a decrease, in 2007,' says the report.

'Information collected by the ESPAD project offers us a crucial window onto country differences and changes in adolescent substance use in Europe today,' said director of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Wolfgang Götz. 'The report highlights harmful patterns of alcohol use which call for broad based health education approaches when addressing the prevention of substance misuse among young people.'

2007 ESPAD report: substance use among students in 35 countries available at www.emcdda.europa.eu/html.cfm/index77163EN.html



Mouth to mouth: a new campaign has been launched by Oxfordshire DAAT to raise awareness of the potential dental health risks associated with drug use. It includes leaflets and posters describing the causes of – and how to avoid – 'the dry mouth horrors', as well as campaign packs including toothbrushes, toothpaste, bottles of water and sugar free chewing gum, which are being distributed via pharmacies, police custody suites, open access services and the Oxfordshire User Team.

Government will expand criminal justice interventions

New areas of 'intensive' Drug Intervention Programme (DIP) activity are introduced in Wales, Bedfordshire and Blackpool this month, the government has announced, while restriction on bail (RoB) has been extended across Wales.

More than 172,000 offenders with substance misuse problems have entered treatment through DIP since it was introduced in 2003, says the Home Office, which claims a corresponding fall in acquisitive crime of 28 per cent. The aim of RoB, which has applied in England for three years, is to reduce re-offending on bail – any adult who appears in court in England or Wales can be eligible for the provision, which aims to engage offenders in treatment if they have tested positive for heroin or crack. Failure to access treatment or support can mean a greater risk of bail being refused.

Testing on arrest – rather than charge – along with required assessments by drug workers has also been expanded to Blackpool and Bedfordshire, with the aim of identifying drug misusing offenders earlier in the criminal justice process, so that 'even people who do not go on to be charged can access help and treatment before their offending gets further out of control'. Testing on arrest and required assessment are now operative in more than 100 police command units across the country.

For the latest in our series looking at how people with substance misuse problems are dealt with by the criminal justice system see page 13.

Tougher global legislation yields few results

Ten years of tougher policies have had little effect on world drug problems, according to a new report from the European Commission.

A report on global illicit drug markets 1998-2007 found no evidence that the global drug problem had been reduced in the period, although the situation had become more complex.

Drug retail prices had generally declined – by up to 30 per cent – in Western countries, 'including those that increased the stringency of their enforcement against sellers, such as the UK and USA' it says, and it found 'no evidence that drugs have become more difficult to obtain'. Specific policies against drug production usually served to move the problem elsewhere, it says, such as the shifting of cocaine production from Bolivia and Peru to Columbia. Harm reduction, however, though still controversial in some countries, was finding 'wider acceptance'.

The report looked at the period since the declaration adopted by the 1998 UN General Assembly Special Session (UNGASS) on drugs, which aimed to reduce demand and supply through international cooperation. It was made available to delegates at the recent UN Commission on Narcotic Drugs meeting in Vienna, the aim of which was to review the last ten years of drug policy, and which was criticised for strictly adhering to the prohibitionist approach and issuing a political declaration that failed to mention harm reduction (*DDN*, 23 March, page 5).

'Broadly speaking the situation has improved a little in some of the richer countries, while for others it worsened, and for some of those it worsened sharply and substantially' it says. The number of frequent users of heroin had declined in most western countries, although there had been a 'serious epidemic' of opiate use in parts of Eastern Europe and Central Asia. Although cannabis use had become 'part of adolescent development' in many Western countries, the report estimates that the number of cannabis users worldwide had 'probably declined.'

'Though illicit drug markets generate more than 100bn Euros in sales, the overwhelming majority of those involved in the drug trade make very modest incomes,' says the report. Those who made 'great fortunes' in the smuggling and wholesale sector represented a small share of the total income, while links to terrorism and armed insurrection were 'important but only in a few places,' such as Afghanistan and Colombia.

Report available at ec.europa.eu/justice_home/doc_centre/drugs/studies/doc/report_short_10_03_09_en.pdf

News in Brief

Naomi goes live

The Naomi Project, a Kent-based intensive group programme operated by and for women has been officially opened. The facility, housed in Highgate Hall in Hawkhurst, Kent, was set up by the Kenward Trust in response to an acute shortage of residential rehab places for women (*DDN*, 12 January, page 4). 'Given the acute need for residential rehabilitation projects for women we are not surprised that there has already been significant interest in the Naomi Project from care managers,' said Kenward Trust chief executive Angela Painter. 'Although the recovery programme is designed for a minimum of six months, in acknowledging that everyone is an individual with individual problems and issues that need to be addressed, it is accepted that some women may need a longer recovery time.'

Part of the furniture

Baroness Massey has been re-appointed as chair of the NTA until 2011, following an advertised competitive process. She has been chair since 2002, and is also a trustee of the Teachers' Advisory Council for Alcohol and Drug Education (TACADE) and member of the All Parliamentary Group on Alcohol and Drugs.

Getting Engaged

The Engage project in Staines has completed an upgrade of its facilities, with funding from Surrey DAAT. Improvements include an internet training area to help clients back into work, along with disabled access and a stairlift. Engage, which is run by Surrey Alcohol and Drug Advisory Service (SADAS), does not require clients to have an appointment. 'We are working with some of the most vulnerable people in our region, many of whom have dropped out of conventional treatment programmes,' said SADAS chief executive Mike Blank. 'Our aim was to provide better facilities to help people get their lives back on track. We anticipate an improved environment will allow us to a wider and more diverse group of drug and alcohol users, including those from the disabled community.'

Growing roots

Frances Webster observes how service users at a day programme gardening project began to dig deep and enjoy a two-way nurturing process with the garden

Tuesday 1 July 2008 – the hottest day of the year so far. From a kitchen window on the first floor, Debbie overlooks the back garden as she prepares a lunch that includes freshly picked salad leaves. Danny works in the garden at a steady pace, muttering to himself as he hammers a new bolt to the gate.

Jason and John paint the fence, working together in harmony, chatting quietly. They stop for a cigarette break. Jason often sits on the fish pond wall, reflecting, looking into the pond, looking for life. There are tadpoles and frogs and the promise of some goldfish. John gives up on the painting before Jason. John does what he has to do, but for Jason the garden is more personal and the pond is personal too. There is a connection.

Debbie, Danny, Jason and John are among those who have passed through KCA's day programme in Harmer Street, Gravesend. The gardening project is one of four that KCA provides across Kent in its day programmes, and they form part of an integrated range of services that have gradually been developed over the last 30 years, including community prescribing, psychosocial interventions and needle exchange. People using the services have problems with drugs or alcohol – some attend as part of a drug rehabilitation requirement (DRR) and others have independently decided that their recovery would benefit from a period of structured, therapeutic activity alongside others who are wrestling with similar problems.

Growing interest in horticulture as a means of therapeutic and social interaction has driven development of a range of gardening and allotment projects across the Kent KCA Day Programmes. This includes a variety of small gardens and allotments at Gravesend, Sittingbourne, Canterbury and Dover. Each project, like each service-user, has its own story.

Here is Jason's view:

'I've only got a balcony at home – I haven't got a garden. If you plant something it grows; it's relaxing and therapeutic to be part of creating something, to watch it grow. It starts out as a seed or cutting and then you watch it grow and blossom – it's amazing. I find that I'm able to concentrate when I'm in the garden, out there doing bits and pieces. I feel like it is my garden and I take pride in it. All you need is that key person to water it, watch over it. And it is full of different colours and that cheers me up – bright colours, not grey and dreary.

'I noticed tomatoes growing today. It's the first place that I go when I come in. Before I go and make a cup of tea, I go and check on the garden, to see what's growing.

'The sunflower that appeared in the garden – we don't know where it came from. A bird might have dropped a seed. And the potatoes – you start out by planting one small potato and now they have grown and multiplied. Amazing! If you look after things, if you nurture and care for the plants then they will grow. Like the pond – it was full of weed blocking the pipe. I always go and check in the pond. And this morning I cleared the weed away so that the pump will work. Nurturing and caring.'

'To get out of that spiralling trap [people] must ground themselves in something. In my experience, when it comes to grounding, the earth is as good a place as any to start.'

The garden project at Gravesend took off after Andrea Hammond, Gravesend's day programme coordinator, attended KCA's first national day programme conference. Andrea was particularly struck by the words of speaker Martin Riley, substance misuse lead officer of Neath Port Talbot County Borough Council, who commissioned the Domino Project – operated by West Glamorgan Council on Alcohol and Drug Abuse in 1997. The way that the project developed service users' engagement and motivation, enabling people to acquire new skills and work with others, seemed like something that could also work in Kent.

Back at Gravesend the garden was badly in need of attention and so a garden project was begun. As Jason explains:

'It began as an experiment. Me and Paul dug it all over and then me and John sorted out the pond. Dan cemented the bricks. Now the pumpkins have taken over one side of the garden and the pansies have been an ongoing patch of colours.

'Perhaps one side of the garden could be all grass and the other side have patches for vegetables and flowers. It needs structure. It needs people who are interested in it to plan. But at the moment I think we need to allow what is out there to die off, and then we can be thinking about the next season. The next harvest.

'There are others who will water the garden on days when I'm not in – keep their eye on it. If there is just one person on the day programme who is interested and values the garden, someone who will check on it daily and water it. It's no big deal to just get the hosepipe and give it a water. I would put money on the fact that there will always be someone who will care for it and nurture it. Someone who, like me, has passion and commitment for the garden.'

Danny describes his own belief in the therapeutic benefits of the garden:

'If we put the right effort into the garden it will be a special place which we should all take pride in, because over the years it will grow into its own shape and form with the help from us as a group. What we put in we should get back year after year. I feel lucky to have the garden to sit in at break time where we can have a fag and rest.

'Being in the garden is very relaxing – it takes my mind off drugs and all other problems, if I have any. It keeps you fit as well as making the mind work with the body.

'The colours, the noises of the birds – it is all good for the soul and wellbeing of the mind. Watching everything grow makes you think about how you as a person have grown, and others, and how some things may grow and keep growing, but some might die along the way.

'I start to think about the ways of growth. The plants start off as seeds or cuttings then grow into these nice colourful things and the place has a very calming effect on me. I've always done gardening from a small child, so it takes me back to a time with my grandad and now my mum.

'Everybody is getting involved with the project and the whole group is willing to get involved with the garden. Some people have planted certain things and are keeping an eye on them growing, especially when it comes to the pond and the tadpoles, and in time to come we may have some fish.

'The garden should be a place where we should be able to come out when it's done and where we should all feel it's a special place and feel relaxed and chilled out. I feel we have done something to make it a special place.'

Like the seasons, the cycle of service users within the programme changes and each has a unique relationship with the garden. Perry says 'it frees the mind' as he tirelessly weeds. Lee sees potential and order as he washes down the paving area, table and chairs and plans a garden bench. Many appreciate the social side of sitting around the garden table. In truth, not every service user is as committed and hard working as Jason and Danny. And Jason has difficult days:

'I don't like being told to do things. It makes me feel that I don't want to do something. I like to be left alone to get on with things and work at things at my own pace. But everyone is different. That's just how it is for me.'

One issue that caused outrage was the incident of a tree badly damaged by a storm. The group worked together to save it, but felt angry that their work had been overridden and that they had not been respected, when an independent gardening agency was employed to make the tree safe. As Jason put it:

'I felt angry about the tree being cut back so much. It felt like murder. It felt like it was destroyed and it was not necessary. It had its arms chopped off. But it is sprouting now and it will grow big branches again.'

For service users like Jason and Danny who feel deeply passionate about the garden, there is a sense of ownership and a relationship with it. Jason communicates with the garden and the garden has a capacity to nurture and heal. In his book *Growing out of Trouble*, Monty Don says:

'To get out of that spiralling trap [people] must ground themselves in something. In my experience, when it comes to grounding, the earth is as good a place as any to start.'

The garden is a remarkable metaphor for life through nature's resilience and capacity to be creative and overcome. Gardening projects have the potential to change people's lives physically, psychologically, spiritually and socially. If our service users experience love and care, nurturing and affirmation, perhaps they too would have the capacity to survive a brutal pruning and live to grow again a different way.

Thanks to all of the clients for constructive input to the project and in particular to Danny Pask and Jason Smith for their important contributions to both the project and to this article.

Frances Webster is employed by KCA as a day programme worker at their Gravesend Programme.

'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.

On the cusp of a new understanding

We could be about to witness a fundamental shift in drug policy and treatment, says **Marcus Roberts**

On first entering government in 1997, Tony Blair was quick to declare that drug use would be a policy priority for his government. Within a year, New Labour had appointed a drug tsar – Keith Hellawell – and published a ten-year national drug strategy. By 2001 it had set up the National Treatment Agency (NTA) to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

While drug tsardom is an increasingly distant memory, the NTA is very much still with us – with an annual operating budget of around £11.5m – and we are now a little over a year into a second ten-year plan (as set out in *Drugs: protecting families and communities – the 2008 drug strategy*). Meanwhile, drug policy continues to have a political profile that would have been unthinkable 20 or 30 years ago. With an election approaching, different views about drug treatment have been helping to stake out the political battleground between the two main parties.

The debate catches fire

The political touchpaper was ignited in October 2007 following the publication of the NTA's figures for 2006-07. These figures showed that nearly £600m had been invested in drug treatment in England in that period; that the number of people in drug treatment had risen from 85,000 in 1998-99 to 195,464 in 2006-07; that waiting times were down to an average of one week, and that over three-quarters of people were remaining in treatment for at least 12 weeks.

In short, the NTA was able to report that it had exceeded its performance targets, increased treatment capacity and slashed waiting times. Despite this, then shadow home secretary David Davis responded by writing to the chair of the House of Common's public accounts committee declaring that the NTA report was 'an absolutely shocking revelation', which 'spoke volumes about the government's incompetence and distorted priorities'.

So, what's the story? Well, it's one thing to get nearly 200,000 people into drug treatment (and not to keep them waiting for it), but how many are coming out of it, and what sort of outcomes are being achieved? The fact that 'only' 5,829 people had been discharged from treatment 'drug free' – 3 per cent of the total – raised eyebrows and hackles in the media: soberly, in a notable BBC report by Mark Easton; more shrilly in the tabloids. *The Daily Mail* complained of a '£1.9m bill to help just one drug addict kick the habit', while *The Sun* announced that 'the NHS blows £130m curing 70 junkies'.

This spluttering of the red tops came on the coattails of more substantial critiques of the priorities of the drug treatment system. These included, most notably, the report of the Centre for Social Justice Addictions Working Group (overseen by former Conservative leader Iain Duncan Smith and aimed at informing Tory policy), and a stream of critical papers and comments emanating from the Centre for Drug Misuse Research at the University of Glasgow.

In an article in Druglink in January/February 2008, Mike Ashton labelled this approach 'the new abstentionism'. Its rallying cry was the complaint that the drug treatment system had become excessively dependent on methadone – not only to stabilise people while other interventions kick in, but over long (and

sometimes indefinite) periods. This was (unhelpfully) dismissed by some critics as merely sustaining addiction.

The figures are striking. In 2006-07, 118,107 people were being prescribed substitute drugs, compared to 5,350 people receiving treatment in a residential rehabilitation centre funded by the Pooled Treatment Budget. So, does this mean that the drug treatment system is 'failing'? Should it give grounds for concern? And how is it to be reconciled with the new emphasis on quality of outcomes and social (re)integration?

Moving things forward

On 19 March, DrugScope published *Drug treatment at the crossroads* to address precisely these questions. It sketches out the broad contours of a new prospectus for the development of drug treatment in the next ten years, rejecting a polarised approach as misleading and unhelpful, recognising the real and substantial achievements of the last ten years, but seeking to raise the bar in terms of our expectations of drug treatment.

The *Crossroads* report is not based on new research or statistical analysis, but on a series of discussions and debates with people involved in various ways with frontline drug services that DrugScope hosted in 2008, which we called The Great Debate. It is the voice of the frontline. Naturally there was disagreement at these meetings, but also a surprising degree of consensus between participants – not least the agreement that drug treatment has achieved much and deserves support and investment.

There was little evidence at events in Edinburgh, Manchester or London that the drugs field had any appetite for dividing into factions under the banners of 'abstinence' and 'methadone', and slugging it out to the death. On the contrary, there was agreement that drug treatment services should support a range of approaches – it was about providing the right intervention, to the right person, at the right time and in the right way.

On the one hand, there is a strong evidence base for substitute prescribing. After all, the National Institute for Health and Clinical Excellence (NICE) recommends methadone and buprenorphine for opioid dependency. On the other hand, it was widely accepted that 'parking' people on methadone – for long periods and without other forms of help and support – is (a) common and (b) not good enough. Peter McDermott of The Alliance, who spoke about the vital role that methadone had played in his own recovery, also commented that 'there are quite a few people who work in the drug treatment system who do see methadone as about control... who have very low expectations of, and aspirations for, the people they work with... and who do not have faith in the ability of service users to make positive changes to their lives'.

Much of the debate we had about the value and role of different treatment modalities was less about clinical judgement and evidence base, and more about the service user's entitlement to choice and control. At the Manchester event someone said that 'treatment services can be incredibly egotistical about their role and their importance in someone's recovery... we get bogged down in a debate about harm reduction or abstinence that probably does not mean a huge amount to a lot of service users. We should be focusing on the individual service user's perspective and how they define their pathway to recovery'. Another contributor – who described himself as a 'hard core harm reductionist' – commented that 'when people say they want to stop using, they're told that "you are not ready yet",' adding 'I've worked in the field for 20 years and I don't think it is my decision to say to someone "you are not ready".'

The loudest message was about the need to tackle the social causes, contexts and consequences of drug use. A valid objection to a system that is over-reliant on 'parking' people on methadone is that it does too little to support service users to access the social capital that they need to move on with their lives. A valid objection to simplistic variants of 'new abstentionism' is that it is not realistic to expect people to become 'drug-free' so long as problems from their past are unaddressed (such as experience of trauma and abuse), problems in the present persist (such as homelessness), and they see little prospect of a better future for themselves (for example, of meaningful employment or of reconnecting with their families). One contributor commented at Edinburgh: 'when we use language like abstinence, treatment and recovery, we are using medical language for what is a social care issue'.

'It is striking that much of the Crossroads report is concerned with concepts and ideas that would have been totally absent from the drug treatment debate as recently as ten years ago...'

New horizons

There are a number of indications that we could be on the cusp of a fundamental shift in the policy and practice of drug treatment. Three points in particular stand out.

First, a political debate that pitches 'methadone' against 'abstinence' has nothing at all to say about some of the key challenges that drug treatment faces now and is likely to face in the future. Substitute drugs are largely restricted to the treatment of opiate dependency. The young people who may be gearing up to be the next generation of 'problem drug users' appear to be developing problems linked to cheap alcohol and cocaine, maybe along with cannabis, ecstasy and tranquillisers.

Second, it is striking that much of the *Crossroads* report is concerned with concepts and ideas that would have been totally absent from the drug treatment debate as recently as ten years ago – ideas like service user choice and empowerment, individualised care pathways and respect for equality and diversity. The drug field needs to be engaging with broader agendas and institutions that can help it to embed these values in its practice – such as the new NHS Constitution and the work of the Equality and Human Rights Commission.

Finally, there is a link between methadone prescribing and the crime reduction paradigm. One of the virtues of methadone is that it tends to reduce or eliminate reliance on illicit drug markets, and therefore the incentive to raise money to fund drug purchases through criminal and anti-social activity. It is perhaps no coincidence that the challenge to the prevalence of methadone prescribing within drug treatment has coincided with a greater focus on social (re)integration within drug policy.

This brings us to the final challenge – to argue for investment in drug treatment on the basis of compassion and effectiveness, not simply fear. We were therefore encouraged to find that the public may be much more supportive of drug treatment services than is sometimes assumed. DrugScope commissioned a DrugScope/ICM poll, which found that, of 1,039 respondents, 76 per cent agreed that 'investment in drug treatment is a sensible use of government money, so long as it benefits individuals, families and communities', and 88 per cent agreed that 'drug treatment should be available to anyone with an addiction to drugs who is prepared to address it'. (*DDN*, 23 March, page 4.)

As well as highlighting the importance of drug policy to his new administration, another of Tony Blair's earliest announcements following that historic election victory in 1997 was the establishment of a social exclusion unit, reporting directly to the Prime Minister. Thereafter, drug policy was co-opted by the crime reduction agenda, and parted company with social inclusion policy to a surprising extent. With the right combination, It may be coming home....

Marcus Roberts is director of policy at DrugScope. Drug Treatment at the Crossroads – what's it for, where it's at and how to make it even better, *is available on the DrugScope website at www.drugscope.org.uk If you would like a hard copy or have any comments on this article or the report, e-mail Marcus Roberts at marcusr@drugscope.org.uk*

As our recent *Voices for Choices* conference proved, service user involvement is truly going from strength to strength. **David Gilliver** reports from the NTA's vibrant London regional user forum

A force to be reckoned with

'I didn't think service providers would go for it. What really surprised me was that the response was the complete opposite.' Kensington and Chelsea service user coordinator Tim Sampey was describing his first ventures into user involvement to delegates at the NTA's London regional user forum, *Get involved, influence change*, which saw an impressive turnout late last month.

DAATs genuinely valued feedback from service users, he said, and it was important to remember that service providers also had a responsibility to the NTA. 'Positive feedback from service users is seen as kosher by the NTA, and it's also encouraging for keyworkers,' he stressed. 'A lot of people aren't doing this because they're well paid – because they're not – but because they want to do something positive.'

The NTA's London regional manager Lynn Bransby told the forum that it was important to recognise how far things had come in a short space of time, with the same event six years ago attracting just half a dozen people. Half of London was now doing service user involvement very well, she said, and she was confident that the remaining boroughs would be up to speed by this time next year. 'We want to be confident that service users get to know what's happening in drug treatment at exactly the same time as everyone else,' she said. 'That's what we're aiming for.'

Key things to remember for those new to user involvement, said John Howard of the Reading User Forum (RUF), were the importance of being prepared, patient, persistent, professional and polite. Being properly prepared was essential in order to do the best for yourself and others, he stressed. 'You can't just send people to meetings – you need to train them. You can't drop people in at the deep end – ask for the minutes of past meetings, get to know the guidance, the 'orange book', look at websites.'

Patience was a pre-requisite as things could take a long time to change – 'keep phoning, keep leaving messages,' he urged, while professionalism and politeness could make all the difference. 'It's about building bridges, not barriers. Build up partnerships – it really helps when you're not working in isolation.' Setting up a service user group from scratch could be daunting, he acknowledged, and funding could be an obstacle to mobilising user involvement. It was important to remember, however, that vast amounts of money were not necessary to get things going. And it was also always important to bear in mind, said Tim Sampey, that user involvement was low maintenance for service providers. 'They don't have to do anything except provide a room, tea and coffee, and some biscuits.' Getting the message across that you were out there and looking for people to get involved was a good use of funds in the early stages, said John Howard – money for printing, advertising and magazines. It was also essential to put aside money for things like volunteers' travel, mobile phone use and refreshments. 'Whatever you do you should never be out of pocket for it,' he said. 'You're doing this voluntarily – you shouldn't have to pay for it. Go to your DAAT regularly with receipts.' Attendance at certain meetings should also be paid for, he stressed, along with consultation work. 'It's your time and your experience – other people there are being paid. Quite a lot in some cases.'

Renting some modest office space could be another good use of resources, particularly when doing advocacy work that involved people's confidential files, he said, while anyone worried about payment affecting their benefits could always be paid in kind through things like training courses.

'So you've got your funding and you're set up – what are you going to do?' he said. One key area was community activism, such as challenging the practices of the local media. His organisation was also involved in working with the police in helping the local community understand the issues around drug use, addressing prejudices and helping to allay fears. 'You can really change the priorities and views of communities,' he said.

Peer education and support and mentoring were other crucial areas, he said. 'But a lesson learned is don't work for someone indefinitely – if your time's limited you can only do so much.' It was important to set and maintain boundaries, he said – 'keep a line between supporting someone and giving too much' – as was effective supervision, if only as a way of letting off steam. 'We're not professionals – things will play on your mind and you'll need to be able to get things off your chest.' He also urged delegates not to be afraid to say no. 'Prioritise,' he stressed. 'You will be inundated with requests.'

Volunteering was another key area of user involvement. 'We don't mind if people are bang at it, as long as they don't come to our meetings gouched out, and we don't mind if they have current criminal justice issues,' he said. 'We judge people on merit and what they have to offer.'

Good service user involvement required flexibility, trust, honesty, respect and compassion, he told the forum. 'You do get incompetent workers in drug services, and you get incompetent managers. At times you will feel like giving up, but persevere – things will get better. We can help shape the future of drug treatment and policy. Take care – of yourselves and each other – and take control, of your drug treatment and your life.'

Partners in criminal justice

The first point of contact service users have with the criminal justice system is arrest. George Gallimore of the Police Federation tells **DDN** how things have changed for the better since the 1990s

I was involved in drug enforcement policing as far back as 1981. I managed a drugs unit in Moss Side in 1995, and it was shortly after that we changed the way we did business – when we started to really embrace partnership work.

We're probably the best we've ever been in terms of partnership working and helping with harm reduction opportunities. The police never used to do that – they'd target street dealers, put their door in and take them away. In 1995 average sentences were five years for a dealer at street level – we only focused on the arrested person and didn't really worry about any partner or family left behind. The police didn't worry about consequences, we were just enforcing the law. We've changed very much for the better – a lot of European police forces are miles behind us when it comes to working with other agencies. We're one of the most advanced when it comes to dealing with people properly.

There are very good examples of where you can get to if you sit in the same offices as other agencies. Partnership working is embedded – we have drugs workers in each of our custody suites. If you're arrested it's almost part of the process – we take your fingerprints, your photograph, your DNA and do a drugs test. It used to be just for acquisitive crimes but now it's also on the authority of an inspector if they think you need one, because then we know whether or not drugs are part and parcel of your criminal behaviour. The drugs workers work well with the police culture, but things don't happen overnight – you have to build up relationships and trust the people you work with, because they're trying to do a good job as well.

Users have always been the ones that get caught in the policing net – persistent offenders are often only persistent because they're easy to catch. The police are very well placed at that initial point of contact so we can use our discretion to make sure we don't get to the 'throw away the key' stage. Everyone deserves a chance, whereas once upon a time we might have locked them up and not worried about anything else.

Alcohol is interwoven through British society, but the money's not there in the same way it is for drugs. It can be weeks before you get your follow-up appointment for alcohol, whereas you can go and see the drugs worker tomorrow. We're trying to get those waiting times down as well, but they're all pressures that need staff and resources to deal with. I've always thought alcohol was a bigger problem than drugs for the police service – most violent offences have alcohol in them somewhere. All substances should be looked at together, because they're all linked.

It's about what works, about how many people are not offending because of the intervention. We know that it's not easy to come off drugs, so it's always difficult to measure success. If we had a better measure of success then we could get more support – if it doesn't work, tell us and we'll try something else. If ten people go through the system and one comes out and is no longer a prolific offender and manages to get their life back on track, then that's a success.

Funding is the ultimate issue – if you don't have the funding you can't provide the best service. If we have to restrict our budget we can still have the workers in there, because it's not our funding stream, but if budgets are cut elsewhere then the police couldn't deliver that service, because we're not the experts in this arena. The police are a great point of early interception but if we don't have the other support services around us it won't work – it will be back to us processing you as a criminal and hoping others, such as CARAT teams, pick you up in prison.

> **'The police are a great point of early interception but if we don't have the other support services around us it won't work - it will be back to us processing you as a criminal and hoping others, such as CARAT teams, pick you up in prison.'**

What we have now is a good model that's evolved over ten years but it's labour and cost intensive and what the future holds in the current economic climate I'm not sure. We work well with the drugs agencies and the health service – they were always the last to get involved because they were so unwieldy to engage with locally, but even that's at a good level now. Partnership working is the best I've ever known it, but whether it can continue to improve depends on other factors – it won't be because of lack of commitment from police officers. We're happy to make full use of discretion because we've lost a lot of discretion over the years with chasing targets, and this makes our job much easier. Whatever we can do to support getting people off drugs and getting their lives back together, we'll do.

Understanding what is working and the 'pinch points' in the criminal justice system relating to drugs and alcohol is the aim of the Conference Consortium's forthcoming event, Somebody else's shoes, *on 25 June in London. Visit www.conferenceconsortium.org for details. In the run-up to the conference DDN will be interviewing a selection of people working within the system, to give insight into different roles and how they relate to each other.*

The discovery of recovery

Highly respected American author, researcher and trainer Bill White gave a rare UK presentation last month, explaining the cultural and historical context of drug treatment and looking to a new era of 'recovery management'. **David Gilliver** reports

'Why now?' senior research consultant at Chestnut Health Systems Bill White asked delegates at the *Recovery advocacy, recovery management and recovery-orientated systems of care* seminar. 'Why is the emergence of recovery as an organising paradigm for the addiction treatment field happening now?'

Invited to speak in the UK by Action on Addiction and Wired In, Bill White has 40 years experience in the addiction field – from street worker to clinical director and many points in between – and is the author of 14 books on the subject, all, as Centre for Addiction Treatment Studies director Tim Leighton told delegates, characterised by their extremely high levels of cultural and historical context.

Addiction treatment was shaped by history, he said, with fundamental shifts in the design of treatment in the US. First, prohibition and drug control had effectively meant the collapse of treatment, turning it into 'penal colonies for alcoholics and addicts'. It wasn't until the 1970s – following extensive advocacy throughout the '60s – that government-supported treatment was in place, only for the '80s to see a move to 'zero tolerance' and 'just say no'.

'People were shifted from systems of care to systems of control,' he said. 'Prisons became big business in the US.' However the 1990s witnessed a backlash against the 're-stigmatisation, re-criminalisation and de-medicalisation' of the previous decade – by now the recovery community was extremely diverse, with a huge growth in mutual aid groups, widespread institution building and a plethora of new recovery organisations and programmes, including recovery employment co-ops, recovery churches and the 'wired' recovery of internet-based communities.

The latter development was particularly significant, he said – online activity could allow people who might not feel comfortable attending meetings to access the support of others in recovery. For women in particular this had been a boon, with around 80 per cent of Alcoholics Anonymous online members now women, compared with just 34 per cent of the organisation as a whole.

'There is a new recovery advocacy movement, which in many ways is challenging the treatment system,' he said. Recovery celebration marches across the US last September had seen more than 40,000 people take part – 'and when we have 40,000 people marching, then politicians start to take notice'. All of this was a reaction to the way in which addiction treatment had become disconnected from recovery and moved instead towards a system of 'aggressive, behaviourally managed healthcare.'

'We're recycling a growing number of individuals through treatment,' he told delegates. 'Interventions fail and we then punish them because they've "had their chance".' Treatment institutions had become detached from the grass roots organisations they had grown from, he said, as the 1980s had seen them encouraged to become businesses. 'We needed some of that,' he acknowledged, but what it had ultimately led to was a multi-billion dollar treatment industry of which recovery constituted a tiny part.

This recycling of people through the system came at great cost, he said. 'We know a huge amount about addiction, and a growing amount about treatment, but not much about recovery. I know people who've relapsed after 20 years – what do we know about that from a scientific point of view?'

However a paradigm shift was taking place in America, with calls for a recovery-focused research agenda and a new nuanced language – attempts to define recovery-orientated systems of care that challenged the increasing stigmatisation of language. 'Is there any other medical condition that the word 'abuse' has ever been applied to?' he asked. 'Words really matter.'

Recovery-oriented systems of care were networks of formal and informal services developed to sustain long-term recovery, he told the seminar, to avoid people being released back into communities that then 'devoured' them. 'It's not just about treatment – we need to start talking about treating *communities*, building communities that people can recover in. People know how to get sober – they don't know how to stay sober in the community.' Staff turnover on the frontline of addiction treatment worldwide was now huge, he added, meaning clients were effectively abandoned – stabilising the workforce was central to recovery management.

Hitherto, the two prevailing models of addiction treatment in America had been the acute care model and the chronic care model, he continued. In the first a professional expert drove the process, with services taking place over an ever shorter period of time and clients given the impression on discharge that recovery was now 'self sustainable.'

The chronic care model, meanwhile, originated from a goal of medication-assisted stabilisation. 'When Nixon was facing a huge increase in urban crime he decided to massively infuse methadone into the community,' he said. 'But he stripped away all the psychosocial and support aspects and set up methadone filling stations.' It was clear however that treatment did work, he stressed. 'We know that it works in that we get better outcomes through interventions than no interventions.'

The paradigm shift, however, was not a fine-tuning or tweaking of treatment but a

fundamental revision. Recovery-oriented systems hinged on national or local infrastructures with the strength to fundamentally redefine themselves, recovery-focused service process measures and long-term recovery outcome measures, he said. One key issue was that of getting the people into treatment that needed it, he said, as just 25 per cent of those needing treatment would actually receive it in their lifetime, with a substantial amount of that down to coercion, as drug treatment became 'an appendage to the criminal justice and child protection sectors'.

'The majority of people who enter treatment do it at the late stages of the problem's severity and complexity,' he said. Both the US and the UK, however, were starting to address issues of access and attraction, with some success. Recovery focused, anti-stigma campaigns were becoming more and more visible, along with early screening and brief intervention programmes, and assertive models of community outreach.

Access to treatment was compromised by long waiting lists and specific obstacles for some populations and, across the US, more than half of clients admitted to treatment did not successfully complete it. 'Is there any other condition where you can go into a hospital, become symptomatic of the condition you were admitted for, and get thrown out because of it?' he asked. 'History is a humbler. In the future, what will people say about us?'

There was a widespread view that 'those who really want it will stay', he said, whereas the reality was that those least likely to complete treatment were the ones who needed it the most – the people with the most severe and complex problems and the most disrupted lives. It was not about 'hitting bottom' as a catalyst for seeking treatment for this client group, because 'they live on the bottom', he said – outreach workers who were themselves in recovery and from the same community could play a hugely beneficial role here.

Recovery planning should be based on strengths, he said, emphasising recovery capital, the community and self-assessment. 'The scope of assessment includes individual, family and the recovery environment. Assessment becomes a continual activity – it's not just carried out on intake.'

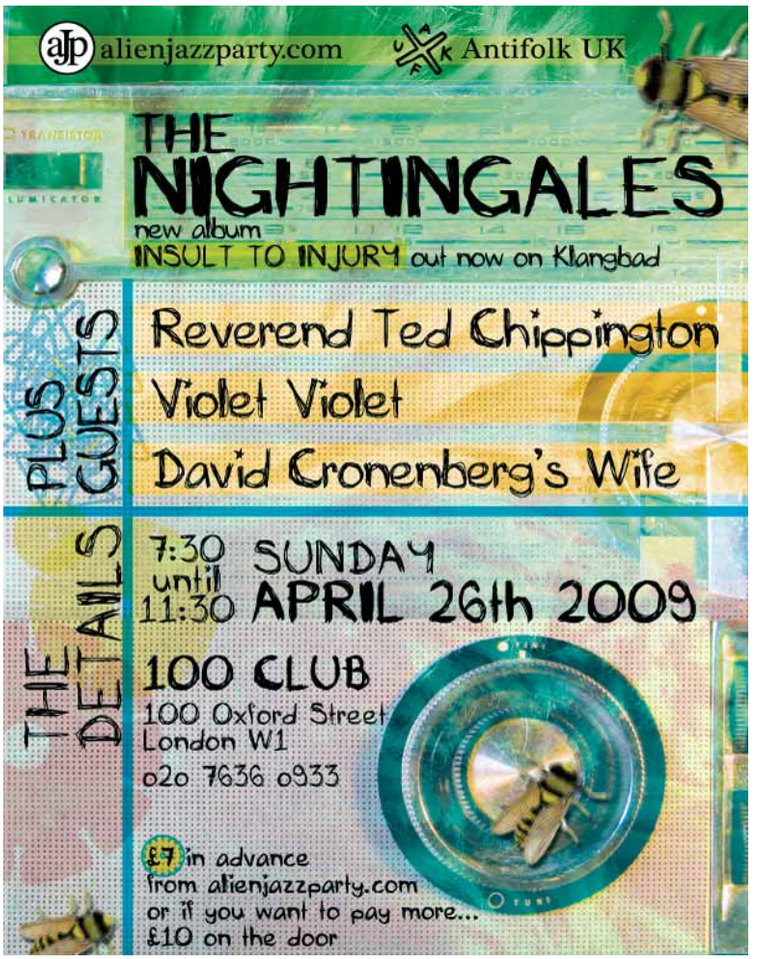
There was a widespread use of approaches that lacked scientific evidence for their effectiveness, he said, alongside a reliance on 'going through the programme.' 'For example, there's a considerable amount of evidence on the administration of methadone, but in methadone clinics there is no clinical time'. In a recovery management strategy, however, the emphasis was on evidence-based practices with a high degree of individualisation and a commitment to constant, rigorous evaluation. 'The emphasis is on mainstream services that are gender specific and culturally competent,' he said. 'So, for example, the question is not "is CBT effective?" but "is it effective for whom, and at what particular time?"'

While acute and chronic care models used a recovery rhetoric but had a declining representation of recovering people within them, the recovery management model had new roles like recovery coaches and used new organisations such as community recovery centres, alongside a renewed emphasis on volunteer programmes, an excellent stewardship of resources in an economic downturn, he stressed. Recovery management was based in the home, neighbourhood and community, underpinned by the philosophy that long-term recovery has to be anchored to the individual's natural environment.

The acute care model was characterised by its frequency of discharge, relapse and readmission, much of it down to the 'fragility of early recovery', he said. People left treatment with a fragile balance between addiction and recovery, so what was needed was aggressive post treatment interventions and evaluation. 'Drug dealers do post-treatment monitoring and intervention after discharge, and drug using peers do the same,' he said. If, as was likely, there was to be a limited pot of money in future, then this was how to get 'more bang for your buck'. 'With alcoholism, the risk of future lifetime relapse drops below 15 per cent only after four to five years,' he pointed out – acute and chronic care, designed to replace the 'revolving door of jails and drunk tanks' had merely become the new revolving door, he said.

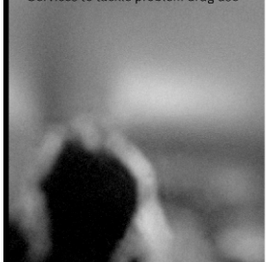
Acute and chronic care models were based on relationships that were hierarchical, commercialised and time limited, whereas recovery management was a partnership model, based on embedding the client and family in recovery. 'Study other movements,' he urged delegates. 'The women's movement, the gay and lesbian movement – how do they grow? How do they get hijacked? How do they get commercialised? I know of no successful movement built on anger and victimhood – that needs to be turned into empowerment and organisation.'

Recovery management was not a refinement of treatment but a fundamental re-design, he told the seminar. Transforming the sector would require ideas to be implanted and policies aligned, but overselling what existing treatment models could deliver risked a backlash from politicians and the public. It would take years to make the transformation to sustained recovery support, he said. 'So we may as well get started.'



Compass

Services to tackle problem drug use



Compass is a rapidly expanding independent sector organisation providing services to help communities cope with the impact of illicit drug use.

Since 1986, in an increasing range of locations in London, Northern and Central England, Compass has been at the forefront of service development in the drugs field. In seeking to provide an effective combination of health and social care interventions we have earned a national reputation for our innovative responses to problems of drug misuse and for the high standards of our work.

Charity Registration No. 518048

www.compass-uk.org

TACKLING DRUGS IN THE COMMUNITY

COMPASS COMMUNITY SERVICES **YORKSHIRE**

Service Manager/Nurse Team Manager

Compass Band F, Pts 1-7, £33,662-£40,989 pa, full-time 37 hrs.

We are looking for an experienced and enthusiastic manager to lead a well established Specialist Prescribing Service and a Primary Care Link Team in York, working with service users who have drug problems.

This post will take the lead on fulfilling all of the operational requirements for delivering the services and implementing the service development plan. The manager will ensure a balance of attention between contract compliance, staff management, clinical governance and budgetary controls alongside adherence to Compass Corporate Procedures.

The role calls for close co-operation and partnership working with other drug treatment agencies and other services in the area, to further develop our services and enhance the treatment for service users accessing the services.

Knowledge of prescribing in substance misuse would be preferred but not essential.

Compass managers are offered a comprehensive personal development package to meet their individual needs. The manager successful in the post will join a team of managers in the area who offer a range of services for drug users and meet regularly for peer support and development.

For an application pack please contact Compass Recruitment on 01904 666370 or alternatively, email recruitment@compass-uk.org stating your name and address details and quoting REF 077.
Closing date: Friday, 17 April 2009.

THIS POSITION IS EXEMPT FROM THE REHABILITATION OF OFFENDERS ACT (1974), AS A RESULT ALL OFFERS OF EMPLOYMENT WILL BE SUBJECT TO A SATISFACTORY CRB DISCLOSURE CHECK.

COMPASS IS COMMITTED TO DIVERSITY AND EQUALITY OF OPPORTUNITY.

WORKING WITH PEOPLE IN YORKSHIRE

Stockton-on-Tees
BOROUGH COUNCIL

INVITATION TO TENDER

Stockton Drug Action Team welcome expressions of interest from suitably experienced organisations for the provision of the following drug treatment and support service within the Borough of Stockton-on-Tees.

Harm Minimisation Service

The contract will initially be for two years, with the option to extend for a further one year. It is likely that TUPE will apply.

Applicants will, in the first instance, be required to complete a pre-qualification questionnaire, the PQQ will detail financial status, resources, experience, policies and management systems.

Please see the Stockton-on-Tees Borough Council website for further details regarding how to apply for the contract. www.stockton.gov.uk/business/howbusi/curcontopp/

TACKLING DRUGS CHANGING LIVES

BRAND NEW, PURPOSE BUILT, 12-BED CENTRE

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For adults wanting stabilisation or detoxification from drugs/alcohol

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EATA European Association for the Treatment of Addiction (UK)
the independent voice of the sector

Vacancy for EATA's Chief Executive

(21 hours a week) Circa 53K pro-rata

An exciting opportunity has opened up for a part-time Chief Executive to provide maternity cover from July. EATA's Board of Trustees will consider applications that propose to fill this post on either a part-time, consultancy, secondment or freelance basis.

The successful candidate will be responsible for the day-to-day management of EATA's resources and activities. He or she will also undertake the delivery and review of the board's strategic and business plans.

Areas of responsibilities will include:

- Overall organisational strategic and operational management
- Financial management
- Income generation (priority for 2009/10)
- Top level outward facing role of EATA
- Strategic level decisions input on national policy/consultation.

For an informal discussion please contact Steve Rossell, Chair of EATA's Board of Trustees on 020 8335 1830. For further details including full job description and benefits, application criteria and how to apply please contact eata@cranstoun.org.uk or call 020 8335 1830.
Closing date for applications 13 May 2009. Interviews 26 & 27 May 2009.

The DDN nutrition toolkit

"an essential aid for everyone working with substance misuse"

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

Healthy eating is a vital step towards recovery, this toolkit shows you how. Available on CD Rom.
Introductory price £19.95 + P&P

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e: charlotte@cjwellings.com t: 020 7463 2085

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re:source NHS

Derbyshire County NHS
Primary Care Trust

Expressions of Interest required for the delivery of Tier 3 Alcohol Services

The NHS re:source procurement hub, acting on behalf of Derbyshire County Primary Care Trust's Drug and Alcohol Action Team (DAAT) are seeking expressions of interest for potential providers of a Tier 3 alcohol service, in accordance with the Models of Care for Alcohol Misusers (MoCAM), across the county of Derbyshire from the 1st January 2010 (excluding the area of Derby City).

The Drug and Alcohol Action Team (DAAT) is a partnership of agencies within Derbyshire that work together to reduce the harm caused by drug and alcohol misuse throughout the county (excluding Derby City).

Expressions of Interest are required for:

A Derbyshire wide (excludes Derby City & Glossop) community based specialist alcohol service which provides expert guidance and advice and delivers Tier 3 evidenced based interventions in a range of community settings for people with alcohol problems, their families and carers. This service will include the provision of community based specialist alcohol misuse assessment, alcohol treatment that is care co-ordinated and care-planned, supervised community detoxification for people with high dependency and preparation for people wishing to access Tier 4 specialist residential rehabilitation.

It will also deliver alcohol treatment requirements (ATR's) for criminal justice clients across Derbyshire (excluding Derby City but including Glossop) and provide an integrated care pathway for clients moving to and from the Tier 2 service with which it will need to operate extremely closely.

To receive instructions on how to express an interest please email Susan.grayson@resource-cph.nhs.uk or telephone 07775 823106.

Please note the closing date for submitting Expressions of Interest and Pre Purchase Questionnaires is the 24th April 2009 at 5.00pm.

Only parties who have submitted an Expression of Interest in accordance with the directions will be provided access to further information about the above contracts and the procurement process.

We are a no smoking and equal opportunities employer.

THOMAS
Those on the Margins of a Society

Specialist detoxification nurse

Ref 001 – RGN/RMN – Blackburn
Starting Salary £24,331 (Pro Rata)
20 hrs per week

You will have experience in the treatment of drug and alcohol detoxification and will work within a residential care home.

Senior project worker

Ref 002 – Salford
Starting Salary £21,244 – 37.5 hrs

You will work as a senior member of a residential support team within a total abstinence community and will need to have several years' work experience of the total abstinence concept. You will need to have a knowledge of the broader drug and alcohol treatment sector and hold a substance misuse practitioner's qualification, level 3.

Project worker

Ref 003 – Blackpool
Starting Salary £19,370 – 37.5 hrs

You will work as a community support project worker within a total abstinence community. You will need to have knowledge of the broader drug and alcohol treatment sector and hold a substance misuse practitioner's qualification, level 3.

For application form contact: Sean Curic, 01254 59240
Witton Bank, Spring Lane, Blackburn BB2 2PW

Closing date for all posts: 5pm, Monday 27 April 2009

mind
Drug and Alcohol Agency CAIS Asiantaeth Cyffuriau ac Alcohol
ARIENNIR GAN Y LOTERI LOTTERY FUNDED

SPECIALIST DUAL DIAGNOSIS LEAD COUNSELLOR

Up to £32,415 pa (37.5 hours per week). Base: Colwyn Bay/Llandudno

We need you to take the lead in developing a dual diagnosis service throughout Conwy, ensuring that adults who have substance misuse issues and mental health problems get the support they need to build more positive futures. It's all about maximising the potential of partnership working and creating care pathways that deliver meaningful outcomes for service users. You'll also take on a caseload of service users yourself, so you won't lose touch with the operational aspects of dual diagnosis practice.

You'll bring solid experience in a mental health/substance misuse setting, together with a good understanding of dual diagnosis. Strong leadership and communication skills are also important, plus a commitment to multi-disciplinary working and a real enthusiasm for taking dual diagnosis to another level.

If you're interested, please phone Rosemary Hunter on 01492 863007.
Applications should be received by 12.00 noon on Monday 11th May 2009

CWNSELYDD ARWEINIOL ARBENIGOL – DIAGNOSIS DEUOL

Hyd at £32,415 y flwyddyn (37.5 awr yr wythnos). Lleoliad: Bae Colwyn/Llandudno

Mae arnom angen arweinydd i ddatblygu gwasanaeth diagnosis deuol ledled Conwy, gan sicrhau bod oedolion sydd â phroblemau gyda chamddefnyddio sylweddau â phroblemau iechyd meddwl yn cael y cymorth y mae ei angen arnynt i adeiladu dyfodol mwy cadarnhaol. Y nod yw manteisio i'r eithaf ar botensial gweithio mewn partneriaeth a chreu llwybrau gofal sy'n sicrhau canlyniadau ystyrlon i'r defnyddwyr gwasanaeth. Byddwch hefyd yn ysgwyddo baich achosion o ddefnyddwyr gwasanaeth eich hun, felly ni fyddwch yn colli cysylltiad â'r agweddau gweithrediadol ar ymarfer diagnosis deuol.

Bydd gennych brofiad cadarn o weithio mewn lleoliad iechyd meddwl/camddefnyddio sylweddau, yn ogystal â dealltwriaeth dda o ddiagnosis deuol. Mae sgiliau arwain a sgiliau cyfathrebu cryf hefyd yn bwysig, yn ogystal ag ymrwymiad i waith amlddisgyblaeth a brwdfrydedd gwirioneddol dros ddatblygu diagnosis deuol i lefel newydd.

Os oes gennych chi ddiddordeb, ffoniwch Rosemary Hunter ar 01492 863007.
Rhaid i'r ceisiadau gyrraedd erbyn 12.00 hanner dydd, dydd Llun 11 Mai 2009.

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INVESTOR IN PEOPLE BUDDSODDWR MEWN POBL

Cyngor Alcohol Information Service Limited Reg. Charity No. 1039386

Service Care Solutions

Criminal Justice Drugs Practitioners

Birmingham

Our client requires criminal justice substance misuse practitioners to work within a DIP setting. The applicant must have held a case load of class A adult users and have experience conducting assessments and designing and developing care plans. Any experience working with substitute prescriptions and working in an outreach capacity would be beneficial.

The applicant will be required to work as a member of a multi disciplinary team within a Drug Intervention Programme, working towards the reduction of re-offending and drug related harm. The candidate will be delivering a range of direct interventions to individuals on the caseload who have a DRR in addition to key working these clients. The applicant will also be involved in referrals and may be providing harm minimisation advice to chaotic substance misuse clients.

The initial posts are temporary offering excellent hourly rates, however there may be opportunities for permanent positions.

If you have any queries please don't hesitate to call Chris Musgrove on 0800 3112020 or email chris.musgrove@servicecare.org.uk

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Addiction Advisor
TRIAGE HEALTHCARE

Triage Healthcare Ltd Nursing Agency requires substance misuse nurses for full and part- time roles around the uk

Roles are varied and available within private and NHS settings. These include face to face assessments, home detoxification visits, and placements within CDAT, PCT, hospital and prison settings.

- More than two years experience of working in a substance misuse environment is essential
- Working hours varied and based around your availability and locality
- Salary: from £20.00 to £50.00 per hour based on placement type

We welcome applications from qualified professionals for positions within the drug and alcohol field.

To apply please email your CV to stacie@triage-healthcare.co.uk

Contact Stacie Lees on 01227 813001 for general enquiries

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CRI Midlands

STOKE-ON-TRENT safer city PARTNERSHIP

CRI works to create safer and healthier communities.
We help people to break free from harmful patterns of behaviour by delivering innovative services which have a measurable impact on both health and community safety issues. Our services are hallmarked by an emphasis on quality, a responsiveness to local priorities, and an outstanding record of achieving targets.

Stoke-on-Trent Adult Community Drug Service
Stoke-on-Trent Young Peoples Substance Misuse Service

CRI are delighted to have been commissioned by the Safer City Partnership to deliver a range of community substance misuse services across Stoke-on-Trent. From May 1st 2009 CRI will be providing adult DIP, low threshold/open access, structured treatment and Shared Care services. We will also operate the Young People's Substance Misuse Service. A large staff team is transferring to CRI from existing providers and in addition we are seeking to recruit to the following posts:

Adult Community Drug Service Manager

£40,501 – £42,290 • Full-time 37.5 hours • *(Ref NM174)*

This is a new post central to driving forward service delivery and development across the Adult Community Drug Service. Reporting to CRI's Area Manager, the post holder will lead and supervise a team of thematic managers, have responsibility for achieving targets and outcomes, budget management, data & reporting, premises, governance and relationship building. Candidates will need to have significant experience of working with substance misuser's and possess a range of demonstrable managerial competencies. A commitment to partnership working and a pro-active approach will be vital.

Adult Substance Misuse Worker

£23,327 – £25,045 • Full-time 37.5 hours • *(Ref NM175)*

Reporting to the Shared Care Team Manager, you will carry a case load and work across Tier 3 clinics and primary care settings. The post holder will have considerable experience of assessing, care planning and reviewing people with substance misuse issues. A thorough understanding of prescribing and psycho-social interventions will be needed as will the ability to work in a team, build relationships with partners and contribute to the development of a recovery model.

2 x Young People's Case Workers

(1 fixed term until 31.03.10)
£23,327 – £25,045 • Full-time 37.5 hours • *(Ref NM176)*

Reporting to the Young People's Substance Misuse Team Manager, you will carry a case load and deliver Tier 2/3 interventions on a geographical patch-based model in a range of community settings. The post holder will have considerable experience of assessing, care planning and reviewing Young People with substance misuse issues. A thorough understanding of engaging and communicating with Young People will be needed as will the ability to work in a team and build relationships with partners.

All candidates will need to possess IT skills and, with appropriate training, be capable of utilising the Halo data management system.

Closing date for all posts is Friday April 17th 2009

Only electronic applications will be accepted via www.cri.org.uk

The successful candidates will be subject to a Criminal Records Bureau check at enhanced level.

In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

Committed to anti-discriminatory practice, CRI aims to be an equal opportunities employer.
Crime Reduction Initiatives is a registered charity in England and Wales (1079327) and in Scotland (SC039861), Company Registration Number: 3861209 (England and Wales).

INVESTOR IN PEOPLE

safer communities, healthier lives

THE ALBERT CENTRE

Alcohol & Drug Advice, Counselling & Training Services

The Albert Centre is a voluntary organisation and registered charity that has been operating throughout the Tees valley district (Middlesbrough, Stockton, Redcar and Hartlepool) for the past 29 years. Our current vacancies are:

COMMUNITY COUNSELLOR (Full Time)
Stockton – £20,878 per annum funded until March 2010.

CARERS COUNSELLOR (Part Time)
Middlesbrough – £20,878 per annum pro rata funded until March 2011. To provide information, advice and counselling in various venues to residents affected by Substance Misuse

ALCOHOL HEALTH EDUCATION / AFTERCARE WORKER (Full Time)
Hartlepool – £21,000 per annum pro annum funded until March 2010. This post will deliver information campaigns and working with local communities to improve knowledge and raise awareness of the potential consequences of alcohol misuse.

Full time positions will be considered for job share. For full job descriptions please visit www.drinkanddrugsnews.com/ListJobs.aspx

Closing Date for all posts is 14th April at 12 noon

For further information about the posts please contact Tanya Scott (Operations Manager) 01642 221484

Criminal Record Bureau checks will be conducted on all successful candidates. The Albert Centre is an Equal Opportunities Employer and welcomes applications regardless of race, colour, nationality, ethnicity, religion or belief, gender, sexual orientation, marital status, disability or age. All applications are considered on the basis of their merits and abilities for the job.

Registered Charity No. 1103901. Registered Company No. 5069305

EASTERN SHIRES PURCHASING ORGANISATION

acting on behalf of

LEICESTERSHIRE DRUG & ALCOHOL ACTION TEAM

INVITATIONS TO TENDER:

Leicestershire Drug & Alcohol Action Team – DAAT – has identified the need to increase the provision of alcohol training to staff both within and outside of healthcare settings in order to provide tier one screening and brief interventions for alcohol misuse, which are aimed at contributing to the reduction of some of the negative impacts of alcohol misuse in Leicester, Leicestershire and Rutland, and will help to deliver Local Area Agreement targets across the sub region.

Funding has been secured for two years, and to maximise the value obtained from the contract, service delivery must ideally commence in June or July 2009. (Any continuation beyond the two-year period will be dependent on continued funding.)

The Eastern Shires Purchasing Organisation ('ESPO') has been engaged by DAAT to manage a procurement process designed to identify and appoint a suitable provider for these training services. For more details and a copy of the tender document, please contact Hollie Ruston at ESPO, Barnsdale Way, Grove Park, Enderby, LE19 1ES. Fax (0116) 294 4399 or email h.ruston@espo.org

Please quote ESPO contract reference number 2974 in your response, and note that the closing date for the receipt of tenders 5pm on Thursday 23 April 2009.