15 March 2010
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'I know how important recovery is to you in the UK. Our definition of recovery is a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship – with or without medication.'

CARE OR CONTROL?

Part 2: is 12-step treatment appropriate for abused women?

IMPERSONAL SERVICES

The interests of clients come last in our target-driven culture

THE AMERICAN WAY

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One day conference

Sharps: Best practice in needle exchange and harm reduction

30th June 2010, London

Needle exchanges started in the 1980s as a controversial health improvement initiative, but thirty years on, they are widely acknowledged as being very successful in reducing harm and ill-health amongst drug injectors. A 2004 report from the World Health Organisation found that needle exchanges had significantly reduced HIV infection and there was no evidence that they encouraged drug usage.

Needle exchange services are provided by a range of different organisations in a number of different ways, so best practice and new initiatives need to be widely shared. Working partnerships should be established and maintained between organisations to allow this communication to happen. Some fantastic work is being done up and down the country and this conference will allow this best practice to be publicised, with the practitioners responsible available for questions and comments.

The conference will also look to the future. New challenges for needle exchange programmes will always appear, whether they are caused by new drugs, changes in injecting habits, or different clients. All these possibilities need to be considered and assessed and the conference will discuss solutions and future initiatives, such as the advantages and disadvantages of assisted injecting rooms.

Who should attend?

- Those working in or with needle exchange units
- Drug advice workers
- Those working in harm reduction initiatives
- GPs

As the conference will deal with an important and relevant issue in today's society, it would be of interest to anyone working in or with an interest in front-line public health initiatives.

For more information and a booking form please contact Jennifer Tatman on
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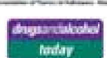


European Association for the Treatment of Addiction

SMMGP

Editorial – Claire Brown

American dream

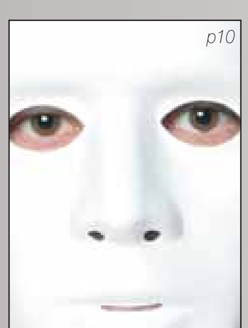
Let's stand back and share the view

President Obama's drug strategy team has a monumental task on its hands if it is going to change the culture of addiction treatment in the United States. Visiting London this week his deputy drug czar, Thomas McLellan, explored some unpalatable truths. Incarceration has been shown to be as ineffective a 'solution' for addiction as it is here. Prevention and screening are non-existent or missing the mark. Options for recovery have been hampered by prejudice against essential types of treatment and medication. GPs are ignorant about addiction or not interested enough to make referrals to specialist services.

It all sounds very familiar, yet if Professor McLellan has his way there will be change afoot and a determined campaign to broker a marriage between addiction services and mainstream healthcare. At the heart of this is the vital recognition that treatment cannot be effective without follow-up support, and the initiatives will also reach right through the prison service to make sure prisoners get the vital preparation for community life right up to their release. During our conversation, he drew on evidence that showed the massive difference that treatment and support made to prisoners in preventing them from returning to jail within a year.

Of course we know all of this in this country – don't we? So why don't we see prison drug treatment and community integration as essential – in economic terms as much as for humane reasons? Why aren't *all* our GPs well-versed in addiction, rather than just the good souls who take a special interest? Why aren't we prioritising resources for young people's prevention and treatment when we know that this is the greatest 'at risk' period in life? It's a brave step to declare that all parts of the healthcare field, including addiction, need to work together with a shared aim – then to do something about it. It's a dialogue we could learn from if we share the common goal of recovery.

This issue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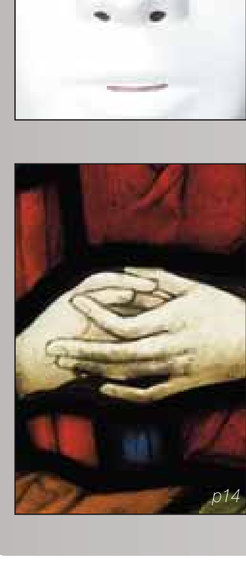
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News in Brief

Get on the ball

Football clubs could help tackle drug problems in their local communities, according to research by Sheffield Hallam University. Researchers looked at two Scottish government-funded schemes – Celtic Against Drugs and Rangers Positive Choices – and found that football coaching for young people could be successfully combined with drug and alcohol education. 'All clubs, including those higher up in the league pyramid, have a role to play,' said Professor John Flint. 'It's about clubs developing partnerships with expert drugs education organisations and schools and exploring funding opportunities.' *A process evaluation of Celtic Against Drugs and Rangers Positive Choices available at www.scotland.gov.uk/Publications/2010/01/07144628/0*

Welsh and Scots act on hep C

Scotland and Wales have launched new awareness campaigns to alert at-risk groups to the dangers of hepatitis C infection. The Scottish campaign is part of a three-year hepatitis C action plan, with a target of getting 2,000 new people into treatment each year. Wales has allocated £1.37m for its action plan – up to 14,000 people are thought to be infected in Wales, the majority unaware of the fact. 'The challenge is to reduce ongoing transmission and reduce the prevalence of hepatitis, which is compounded by issues of social exclusion and marginalisation,' said health minister Edwina Hart.

Peer pressure 'in the mind'

More than one in five people say they've drunk more than they intended because of peer pressure, according to a YouGov poll. However the Department of Health-commissioned survey also found that just 1 per cent of people would 'think less' of someone for refusing a drink or drinking less than them. 'This survey should encourage us all that it's ok to be honest with our friends about when we've had enough,' said public health minister Gillian Merron. 'There is sometimes a certain amount of cajoling that goes on between friends on a night out to have an extra tipple but people need to realise this is usually all in good jest, as this research backs up.'

'No evidence' that enforcement affects cocaine availability

There is no evidence that law enforcement efforts are affecting the availability of, or demand for, cocaine in the UK, according to a report by the Home Affairs Committee.

The wholesale price of cocaine at the UK border had doubled since 1999 but this had had little effect on availability at street level, where prices and purity levels had both fallen over the same period, says *The cocaine trade*.

The number of young adults reporting cocaine use within the past year has quintupled since 1995, against a trend of overall falling drug use rates, while the number of people in treatment for cocaine powder addiction increased by 17 per cent between 2006-07 and 2007-08. Only 12-14 per cent of the drug entering the UK every year is seized, states the report. Any successful policy against the drug would need to address 'both supply-side enforcement and demand reduction' it says. It also calls for the appointment of an independent drugs advisor to ensure government policy is implemented in an integrated manner, as well as increased funding for residential rehabilitation.

'We heard pitiful stories of drugs mules caught up in a cycle of exploitation where they were forced to make the same journey over and over, in some cases having to swallow 20 pellets of cocaine or carry packages the size of pint glasses in body cavities,' said committee chair Keith Vaz MP. 'We were equally horrified to learn that for every few lines of cocaine snorted in a London club, four square metres of rainforest is destroyed in Columbia.'

Release said the report had 'initiated a moral panic reminiscent of that which greeted the rise of the country's first cocaine culture during the First World War and the early 1920s' adding that the issues of drug mules and the rain forests raised by Keith Vaz 'can be laid squarely at the door, not of cocaine, but of the misguided (and in the long run quite disastrous) ways in which 20th century governments tried to deal with the problem of drugs'.

Chief executive of DrugScope, Martin Barnes, meanwhile, said that 'the committee is right to say that there needs to be a balance in tackling both supply and demand – experience shows that enforcement, particularly once the drug has reached the UK, is limited in impact and sustainability. DrugScope remains to be persuaded of the case for appointing an independent drugs adviser as recommended, but endorse the need for better cross departmental coordination and integration in implementing the drug strategy.' Treatment interventions should be tailored to the needs of the service user, he added, as 'evidence shows that the vast majority will benefit from high quality treatment in the community.'

A separate report from the NTA found that one in ten drug users entering treatment in England are now seeking help for addiction to powder cocaine, an increase of 4 per cent over four years. More than a third are aged between 18 and 24, says *Powder cocaine: how the treatment system is responding to a growing treatment problem*, which monitored the progress of more than 3,000 people. However it found that 61 per cent were abstinent within six months of entering treatment.

The Advisory Council on the Misuse of Drugs (ACMD) is also planning a review of the drug. ACMD chair Professor Sir Les Iversen has written to home secretary Alan Johnson stating 'I do not expect our report will advise you on the classification of cocaine since the ACMD believe that cocaine is, and should remain, a class A drug.' The review would instead concentrate on harms and how they could be reduced, says the letter. The review will begin once the ACMD has completed its review of mephedrone and associated cathinones. His predecessor at the ACMD, Professor David Nutt, recently wrote a column for *The Guardian* suggesting that mephedrone be placed in a 'holding class D' for licensed sale in limited quantities until its harms are better understood.

The cocaine trade available at www.parliament.uk
Powder cocaine: how the treatment system is responding to a growing treatment problem available at www.nta.org

Anthrax outbreak continues: three new cases

The anthrax outbreak among injecting drug users is showing few signs of abating, with a second confirmed case in London and two further confirmed cases in Scotland.

The Health Protection Agency (HPA) confirmed an injecting heroin user had tested positive for anthrax and was being treated in a London hospital earlier this month, the third case seen south of the border.

Two further cases have also been confirmed in the Dumfries and Galloway NHS region of Scotland, bringing the total number of Scottish cases to 26, ten of them fatal. There has also been a confirmed case in Germany.

'While public health investigations are ongoing, it must be assumed that all heroin in London carries the risk of anthrax contamination,' said Dr Rachel Heathcock of the HPA. 'Heroin users are advised to cease taking heroin by any route, if at all possible, and to seek help from their local drug treatment services.' Drug organisations had previously called on the Scottish health authorities to implement an 'emergency public health plan' in response to the outbreak and branded advice to stop using drugs and seek treatment 'reckless' (*DDN*, 1 February, page 4).

'Good progress' in treatment but performance measurement lacking

A new report by the National Audit Office (NAO) has found 'good progress in a number of areas' in tackling problem drug use. However, without an evaluative framework for the drug strategy as a whole, the NAO was 'not able to conclude positively on value for money', it states.

Tackling problem drug use found progress in increasing the number of problem drug users in effective treatment and increasing the number leaving treatment free from dependency. The number of adults in effective treatment has increased from 134,000 to 195,000 between 2004-05 and 2008-09 as a result of a £100m boost in funding, with the number completing treatment 'free from dependency' increasing from 6,000 to 15,000 over the same period, says the report. However the NAO wants to see a 'framework for evaluation' to draw on existing individual evaluations of the drug strategy to 'help assess whether funding is being optimally directed at different strategic objectives'.

Action to reintegrate drug users has been less successful, the NAO states, with 'around 80 per cent of problem drug users claiming benefits at a cost of over £40m a year'. Just 8 per cent of people kept a job for 13 weeks or more as part of £13m-a-year government initiatives to get drug users into work between 2006 and 2009, it says, 'costing £11,600 for each drug user who kept a job'.

Overall performance measurement needed to be put in place, said NAO head Amyas Morse. 'Reduction in harm caused by problem drug use presents a complex and chronic challenge. This is being addressed by a series of strategies and very substantial resources: £1.2bn a year. It is achieving improved results but we need to learn from experience as we go forward and measure effectiveness and value for money in order to make appropriate adjustments to programmes.'

The NTA has said it will review all the report's findings and implement those 'applicable to drug treatment'. 'We have always known that society benefits from effective drug treatment because it cuts crime, improves public health and fosters stable family relationships,' said NTA chief executive Paul Hayes. 'We can now demonstrate how the treatment system has risen to the challenge of delivering greater productivity for taxpayers as well.'

Transform, however, said on its blog that the lack of an evaluative framework was a 'pitiful point to have reached'. 'To add insult to injury, this report only covers specific initiatives to "tackle problem drug use". It hasn't even looked at policing costs,' it says.

Report available at www.nao.org.uk/publications/0910/problem_drug_use.aspx

UN warns of drug 'health disaster'

United Nations Office on Drugs and Crime (UNODC) executive director Antonio Maria Costa has used the 53rd session of the Commission on Narcotic Drugs (CND) in Vienna to argue the case for drug control, saying that failure to control the supply of drugs would 'unleash a health disaster in the developing world'.

Inequality within and between states marginalised poor people who lacked access to treatment, he said, adding that health was 'the first principle of drug control'. There were emerging and worsening problems with cocaine use in West Africa, heroin in East Africa and synthetic drugs in South East Asia and the Middle East, he said.

'The developing world lacks the treatment facilities and law enforcement to control drugs,' he told the conference. 'This seems to have been forgotten by people in rich countries calling for loosening of drug controls. Why condemn the Third World, already ravaged by so many tragedies, to the neo-colonialism of drug dependence? While rich addicts go to posh clinics, poor addicts are being pushed into the gutters or to jail.'

Transform, however, accused Mr Costa of 'slandering a whole section of the NGO community' by 'calling groups who support a debate on wider drug law reforms/regulation "pro drugs"', and said that NGOs had been marginalised at the commission. 'To be meaningful, NGO engagement has to be about more than just letting us through the main door – it has to be about providing genuine opportunities for us to express our views and engage in meaningful dialogue with decision makers at the UN,' said the charity's blog.

Antonio Maria Costa: 'Why condemn the Third World, already ravaged by so many tragedies, to the neo-colonialism of drug dependence? While rich addicts go to posh clinics, poor addicts are being pushed into the gutters or to jail.'

News in Brief

Breaking the cycle

Only 4 per cent of the world's HIV positive injecting drug users receive antiretroviral therapy and just 8 per cent receive opioid substitution therapy, according to new research published in *The Lancet*. 'To break the trajectory of the HIV epidemic in Eastern Europe we must stop new infections among injecting drug users and their partners,' said executive director of UNAIDS Michel Sibidé at a press conference for the forthcoming AIDS 2010 event in Vienna. 'People using drugs have a right to access the best possible options for prevention, care and treatment.'

Guernsey 'may ban' mephedrone

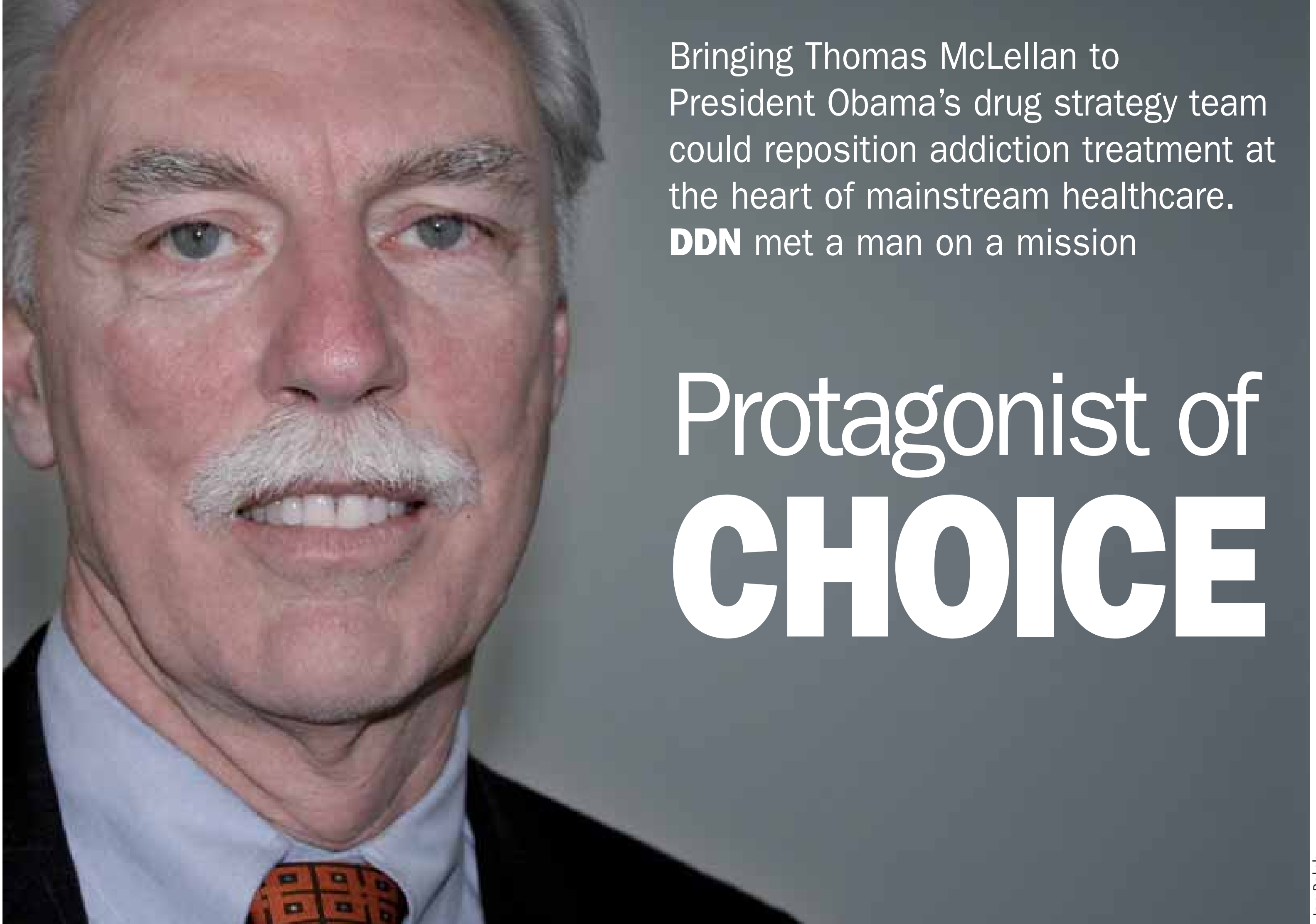
Guernsey officials have said they are considering banning the 'legal high' mephedrone, known as miaow. At the moment the drug – the focus of much media attention – can be bought online (*DDN*, 18 January, page 6). However, Guernsey is considering 'proactive' measures before any decision is taken regarding the drug's status in mainland UK. The island might feel it 'can't wait and that we go it alone,' drug and alcohol coordinator Andrea Nightingale told the BBC.

Single issue

The first dedicated NHS service for women with substance problems has been officially opened by National Addiction Centre director Professor John Strang. As well as inpatient treatment in single sex wards, the Chapman-Barker Unit at the Greater Manchester West Mental Health NHS Foundation Trust offers a range of care options. 'Units such as these are crucial to ensure those with the most complex needs, including patients with dual diagnosis, will receive improved care and treatment,' said Prof Strang.

Making links

An Islington-based St Mungo's scheme in partnership with the Revolving Doors Agency has been praised by the Cabinet Office as an example of a successful early integration service. Neighbourhood Link works with people with complex needs at risk of homelessness and getting into trouble with the law. 'It's vital that holistic services like this are sustainably commissioned and replicated if we are to support vulnerable people more effectively,' said St Mungo's chief executive Charles Fraser.



Bringing Thomas McLellan to President Obama's drug strategy team could reposition addiction treatment at the heart of mainstream healthcare. **DDN** met a man on a mission

Protagonist of CHOICE

Ian Ralph

President Obama's 'deputy drug czar' knows a thing or two about addiction. Before being sworn in as deputy director of the US Office of National Drug Control Policy last August, Professor A Thomas McLellan was director of the Treatment Research Institute – an organisation that he founded 18 years ago to bring greater understanding to addiction treatment and recovery. Alongside 35 years of experience as a treatment specialist, he suffered tragedies within his own immediate family that further convinced him that the US had to completely overhaul its attitude toward drug and alcohol addiction.

Over in London to deliver a lecture at the Institute of Psychiatry last week, he was engagingly clear about the way ahead for his national drug control strategy. 'He's now bringing his skills to bear in the political arena, through a respectful dialogue between scientist and policymaker,' commented Professor John Strang, introducing the guest to his audience of addiction specialists, academics and policy professionals.

Listening to McLellan's talk it becomes clear that his arguments for change are just as valid to the UK. He sweeps through an array of diagrams outlining the way forward for US drug policy. At the heart of his aspirations are better screening for drug and alcohol problems, a major initiative to integrate addiction treatment with mainstream health services, and smarter offender management that will put a wedge in the revolving door back to prison.

All of this is about making treatment more accessible; replacing the stigma of seeking treatment with treatment choices appropriate to any chronic relapsing disease.

'In the US we've been thinking about addiction as just a lot of drug use,' he told his audience. 'And as a result we've been purchasing stupidly. We can't decide if addiction is a crime or a disease so we've compromised and given them treatments that aren't any good.'

Now it was time to 'close the all-too-large gap between those who qualify for treatment and those who aren't getting it.'

He saw mainstream primary healthcare as being at the centre of this, and an essential target in bringing about culture change. 'Most physicians are not trained in how to treat substance misuse,' he said. 'They don't see it as a disease and don't see why they should look for it.'

While he was committed to making a 'sales pitch to doctors', he acknowledged that it was going to be difficult. Out of the 12,000 small treatment programmes in the US, almost half didn't have a doctor or a nurse and only a quarter had a psychologist. The major professional group was counsellors, which had a 50 per cent turnover rate, so it was no mystery that long-term care was suffering.

The task ahead involved integrating addiction services right into mainstream healthcare, he explained, from early screening through to an active role in their patients' recovery.

Early screening went hand in hand with cultivating 'prevention prepared' communities, with particular focus on adolescence – addiction's 'at risk' period.

'If we don't develop a disorder by the age of 21, we have a very low chance of developing one,' he said. 'If this risk period was identified for diabetes I think they'd pull out all the stops to address it… we need to change the way we deliver addiction prevention services. We need to think sunblock, not Band Aid.

'And if you can't prevent or intervene, let's treat… I know how important recovery is to you in the UK. Our definition of recovery is a voluntary maintained

lifestyle characterised by sobriety, personal health and citizenship – with or without medication,' said McLellan.

After his lecture, McLellan explained this definition further to *DDN*:

'I recognise that 12-step is the most popular way of achieving recovery, but it's not the only way,' he said. He demonstrated the complexities of the argument by describing a scenario:

Dr: *'I want you to be sober. I want you to be of good health. I want you to be a good citizen. But you can't take any medications.'*
Patient: *'What? What about insulin?'*
Dr: *'Oh I didn't mean insulin!'*
Patient: *'What about anti-depressants?'*
Dr: *'Oh, I don't know.'*
Patient: *'What about methadone?*
Dr: *'Oh no, definitely no.'*

This kind of polarised view, particularly around methadone, makes McLellan deliberately judgemental about 'a field where it's absolutely clear that we're not servicing, providing care for, anything close to the number of people that need it.'

Methadone is a medication that has had more evaluation in the US than just about any other, he says, adding 'there is no reason on earth why a person can't be on methadone, working, being a good parent and having a normal way of life.

'That this has been a battle, that you are either on methadone or you are on the path of truth, beauty and light, is artificial and unfortunate. One of the things that we're going to do with this new integration, we hope, is that a new batch of doctors won't have these prejudices, because that's what they are.'

As far as McLellan is concerned, methadone is just another option in the 'patient choice' toolkit, and should be offered alongside other medication, social services, employment counselling and psychiatric services to make up the package of rehabilitative care.

He refuses to let stigma surrounding methadone be a barrier to recovery. 'I'm now officially wagging my finger and saying not just to Britain, but to the whole damn field: get past this, this is an artificial contrivance,' he says. 'People ought to have the opportunity to get the medications and other services they need towards the goal of becoming the well- functioning people they want to be.'

If McLellan's vision comes to fruition, addiction care will be integrated with the work of physicians. General healthcare will benefit from the expertise of specialists, and the pyramid – with general health care at the top, then mental health below it, addiction services underneath, and methadone and buprenorphine right at the bottom – will be flattened. At the moment less than 3 per cent of all referrals to addiction speciality care come from any part of medical care, a situation that McLellan is determined to change by emphasising the practical benefits for all involved.

'We've got to make marriages,' he says. 'And we think the way to do that is business. It's a good business case for a doctor to pay attention to something he's been ignoring, and we think it's good business for addiction treatment programmes to start cultivating medical referrals and working with doctors to support them as they begin a very difficult job.'

This integration will, in theory, deny stigma its opportunity, by treating addiction alongside any other condition.

'You may know that the relapse rates for diabetes, hypertension and asthma are almost identical to the relapse rates for any addictive disorder – they're 50 per cent per year,' he says. 'And no one puts their hands on their hips when a diabetic comes back and says "I ate half a bucket of fried chicken and I forgot to take my insulin, and now I'm back here." They just treat them.'

And they treat them for life, which is why McLellan talks of a 'true continuum of care' and not '30 days of treatment'.

'I am talking about the amount of care that you need when you need it to restabilise your life,' he says, 'and take personal responsibility, hopefully with your family and your community, for the management of your illness – as you would for diabetes or schizophrenia.'

This society-wide vision of treatment includes the criminal justice system, and McLellan has persuasive arguments for politicians who think of incarceration as the only response to drug-related crime.

'In the US we've been thinking about addiction as just a lot of drug use... And as a result we've been purchasing stupidly. We can't decide if addiction is a crime or a disease so we've compromised and given them treatments that aren't any good.'

'It's a sort of "pay me now or pay me later" deal,' he says. 'And I believe the data are on our side here. The studies that have been done suggest very clearly that in a prison situation, when you release somebody with a drug problem, they are back and you're going to do it all over again. It's a bad business deal.'

Introducing treatment and support to drug-using prisoners in the US has produced dramatic results. Monitoring people who left San Diego jail after finishing a term for drug-related crimes without treatment and support showed that 74 per cent of them were back inside within a year. So, according to McLellan, 'they changed things and started reintegration work the day somebody gets to jail. They work with the families and the individual, doing assessment, developing training plans, monitoring situations, and they modified the sentence too so that recovery oriented services were part of parole.' The result? The percentage returning to jail within a year went down to 14 per cent.

'Seventy-four per cent to 14 per cent is a big deal,' commented McLellan. 'Now multiply that by $36,000 for a prison sentence, $12,000 for a re-arrest. These are massive amounts of money. That's the kind of thing that gets politicians' attention – as long as you replicate it.'

It's this joined up way of thinking that characterises McLellan's approach to his job with Obama's team. Just as he wants agencies, health professionals, families and community to all play their part, he has a clear role for different treatment modalities – as components that could work with other components to make up a support plan for life.

Once again this requires a step back to appreciate the long view – particularly for those with entrenched views who believe, for instance, that a stint in rehab will see addiction off for good.

'I think residential care is important and necessary, but not sufficient,' he explains. 'It is like having a very good junior high school education. But sending somebody out after good residential care with no follow-up and no continued aftercare plan gets you the same results as sending somebody out from jail.'

His comments remind him that there is still a long way to go to re-educate commissioners on this way of thinking.

'A lot of states in the US will say "We purchase a continuum of care. We purchase detox from him, we purchase residential care from him, and we get outpatient care from him. We've got the whole thing." Well here's the problem – there are no clear relationships among the group. And that doesn't help me as a purchaser, that doesn't help me to help my constituents.

'What I really want is to be able to say "I won't buy from anybody until you show me a package that's going to meet their needs, because I know that if they're in care longer and more actively involved they're going to do better."'

And once again this charming and mild-mannered man reveals a glimpse of the steely certainty that has earned him this prestigious job: 'It's time for true continuum of care,' McLellan says emphatically. 'And it's time for purchasers to purchase the whole damn thing, not just little segments.'

Professor McLellan's London lecture was hosted by the National Addiction Centre and organised by the Conference Consortium, DrugScope and Drug and Alcohol Findings.

Get SMART

SMART Recovery is a US abstinence-based programme that's gaining a foothold in the UK thanks to a pilot project with Alcohol Concern. **David Gilliver** spoke to its founding president, Dr Joe Gerstein

SMART Recovery is an abstinence programme established in the US in the 1990s, using tools and techniques based on cognitive-behavioural principles. Alcohol Concern has helped set up SMART Recovery projects in six pilot areas across England with Department of Health funding, and earlier this month mounted a conference to provide guidance for organisations that want to expand peer-support options in their area. Keynote speaker was SMART Recovery founding president, Dr Joe Gerstein.

'SMART stands for Self Management and Recovery Training,' he says. 'The history goes back about 20 years. The fundamental basis is still the same – CBT – but since that time it's expanded into a four-point programme that covers pretty much the whole panoply of what research has shown to be effective in getting over addiction.'

Those four key points are building and maintaining motivation to abstain; coping with urges; managing thoughts, feelings and behaviours, and lifestyle balance. 'It's about managing life's problems, since most relapses tend to be instigated in some way by problems and personal disappointments,' he says. 'A lifestyle that's about keeping you busy and occupied and getting your enjoyment on a long-term, enduring basis from sources other than booze and drugs.

'Right now we're at the start-up phase,' he says of SMART Recovery UK, but worldwide there have been around 70,000 SMART Recovery meetings since 1994, all provided free of charge. 'The entire structure is supported by fewer than the equivalent of three full-time people,' he says. 'That's for more than 500 weekly meetings.'

SMART Recovery is based around the concept of REBT (Rational Emotive Behaviour Therapy), which uses common sense, self help procedures designed to enhance motivation and allow people to manage their problems without recourse to substances. The programme teaches self reliance as the cornerstone of overcoming addictive behaviour. 'A lot of these things are recognised by AA in the 'Big Book' – in principle,' he says. 'We have nothing against AA – it's a wonderful programme for those that it's good for. But it's not 100 per cent universally applicable.'

Key differences between SMART and AA are that there's no obligation to accept powerlessness in the face of addiction and no element of religion or spirituality. 'Probably half the people who come to SMART Recovery are religious, according to our surveys,' he says. 'But that's irrelevant. We're proponents of choice – there are obviously many roads to recovery, and we're emphatic about actually empowering people.'

Self-empowerment is the programme's touchstone, and he points to studies on the effectiveness of treatment that try to determine the pre-requisites for successful recovery. 'What are the factors that seem to have predictive value for who will successfully and permanently recover? Number one is the belief that it's possible.'

Is that tied in with not viewing addiction as a disease, another tenet of the programme? 'It is, but actually we don't care how you want to view it – if you think it's a disease, you'd better stop drinking; if you think it's not a disease, you'd better stop drinking. Ultimately it's up to the choice of what you want to do and how much you want to do it. As we know, people get better without going to any kind of help whatsoever – millions of people stop drinking and drugging without any contact with organisations or professionals or anything else. It's called natural recovery and you don't hear much about it because you don't see these people – they don't walk down the street wearing a button that says 'I recovered from alcoholism'. If you go to clinics or meetings or doctors' offices you don't meet them. But you can find them in surveys.'

Large scale surveys in the US, including the *National epidemiologic survey on alcohol* and related conditions, which surveyed 43,000 people over a number of years, found that significant numbers of people were able to stop drinking on their own, he stresses. 'Between 25 and 50 per cent, depending on which you look at, so this is common, and we tell people that at meetings. It's good for them to know that people do it on their own. And of course there are millions of ex-smokers who've done it on their own, tens of millions.'

SMART Recovery is funded by donations and the only people to draw any kind of salary are central office web staff. 'The website has 15,000 active registered users, so it's a huge enterprise,' he says. 'Out in the community, nobody's paid,' When someone graduates from the programme, however, they have the opportunity to stay on and help others.

'Most just graduate, but maybe 10 or 20 per cent want to stay on,' he says. 'We've got people in Massachusetts who've been doing it for 15 years and are extremely skilled. On the other hand we've designed the programme so a complete tyro can facilitate a meeting if necessary. Obviously it's structured a little differently to one being run by someone who's been doing it for 15 years, but the important thing is the communication among individuals – it's an interactive programme.'

This communication, however, is very much centred on the present and the future. The organisation states 'We're certainly not into drunkalogues (war stories), sponsors, and meetings-for-life.' 'We want to know the general nature of a person's problem but we limit that to one or two minutes,' Gerstein says. 'The crucial thing is what you're going to do about it, how you're going to handle it – the programme is directed towards helping people get a different perspective on reality and then changing the way they think about it. That usually ends up changing the way they behave.'

With something that must have seemed so at odds with the prevailing wisdom at the time, what kind of reception did it get in the early days? 'There was absolutely no interest whatsoever evinced by the local treatment professionals,' he says. 'I was amazed by how little interest they had in anything except the straight 12-step programme, despite all the scientific data behind the CBT approach.'

He had no substance specialism to begin with but, despite initially not wanting to get deeply involved in the project, he's gone on to facilitate more than 2,000 of the 14,000 meetings held in Massachusetts, 700 of them in prisons. 'I'm a physician but my professional interests are internal medicine and pain management,' he says. 'I didn't know a thing about addiction. I thought I did, but what I learned in medical school was all wrong – after bludgeoning people for 12 years to go to AA no matter what their addiction problem was.'

As well as starting up meetings he was 'running around keeping (others) going' if no one else was available, all the while still practicing as a physician – presumably an exhausting combination? 'It was, but it's worth it. People come up to me and tell me I saved their life – that's a pretty powerful tonic to keep going.'

Almost all of the other facilitators, however, come from a background of alcohol and drug problems, followed by SMART Recovery training. 'I started meetings and then other professionals said "I'd like to see a meeting in my area" so most were originally started up by professionals. But when someone's had about six months of solid sobriety we allow them to take over, so it usually takes six to eight months and then the professional disappears. I've stayed in it just to keep the organisation alive – it's difficult to find people to go into prisons, for example.'

He introduced the project to a local prison in 1992, since which time it's been adopted by prisons around the world. 'Most of the prisons in Australia use it, prisons in Sweden, Scotland, Vietnam – the so-called 're-education centres'. The federal prison system in the US uses a CBT programme that's similar, but it started when we introduced SMART Recovery to one prison and it was very successful.'

'What are the factors that seem to have predictive value for who will successfully and permanently recover? Number one is the belief that it's possible.'

There's been a good deal of debate in this country around defining recovery. How does he see it? 'I'd put recovery into three categories,' he says. 'The first would be a person with a drug or alcohol dependency who becomes completely abstinent from that substance and goes on to lead a normal life, however you want to define that. Then there's a category of people who become and remain abstinent but they're unhappy. The catastrophes they've undergone are sufficient to inhibit them from starting up again but they believe that they ought to be able to drink like everybody else. Then there's a third category and it's hard to establish how many there are, but it's a significant number.'

It's this last category that's a controversial area, particularly in North America. 'Two researchers – a couple called the Sobells, very illustrious – had to leave Canada because they produced research that said people had alcohol dependency but then went back to social drinking. Of course this was anathema and basically they were driven out of the country – they ended up at Florida International University. But I think the research is valid. Obviously it depends how you define alcoholism, but all the people were within the medical criteria that we use in the US. Other studies turn up somewhere between 2 and 5 per cent of people who seem to be able to go back to a social level of drinking, so there are people out there like that – they're unusual, but they're there – and we tell people that. We don't tell them what to do, but I liken it to playing Russian Roulette with a revolver with 50 chambers and 49 have a bullet in them.

'But we're open about it,' he says. 'We say "we're a science-based programme and we're going to tell you the facts". We get accused of being in the moderation business, but we're not – we're an abstinence programme. We do tolerate people who aren't ready to declare absolutely that they're going to become abstinent, because many of them eventually do – the whole point is to engage them, draw them into the group. If in the first meeting we say 'you dumb bastard, you'd better stop drinking or you're going to get in deep trouble' we'd never see them again. The whole point is to engage people with motivational interviewing, open-ended questions and show them the discrepancies between what they want and what they're getting. Most people figure it out on their own.'

www.smartrecovery.org

'Within my piece I acknowledged that stigma directed at individuals can cause harm and pain to those involved and that within therapeutic relation-ships there should be no place for stigma. I pointed out, however, that in social marketing campaigns, stigma has been used in the past to reduce the incidence of socially harmful behaviours such as drink driving.'

Hardening attitudes

My opinion piece on stigma has clearly offended Dr Chris Ford and her co-signatories in raising one of the taboos in our field; namely that some aspects of the stigma associated with illegal drug use may be functionally valuable for society (*DDN*, 15 February, page 14). Ford and her co-signatories would clearly have preferred *DDN* to not have published my piece at all – stating in their letter that if it had referred to homosexuality and homosexuals its publication would not have been allowed under UK law. I don't really know what point the authors are making here, since my article was not about homosexuality or homosexuals and its publication does not breach UK laws.

Within my piece I acknowledged that stigma directed at individuals can cause harm and pain to those involved and that within therapeutic relation-ships there should be no place for stigma. I pointed out, however, that in social marketing campaigns, stigma has been used in the past to reduce the incidence of socially harmful behaviours such as drink driving and that as a result stigma may indeed be an important social barrier to wider drug use.

My guess is that Ford and colleagues are irritated for two reasons. First because the authors of the letter view drug use issues almost entirely through the prism of individual experience. Most of the letter-writers are doctors who are pre-eminently focused on the experience of their individual patients, with Chris Ford's *Post-its from practice* published within *DDN* being a good example of that focus. Drug prevention, by contrast, is a domain of social message aimed at changing the behaviour of wider social groupings and it is in this connection that I offered the view that stigma may be an important tool to reduce the likelihood of wider drug use. Surprisingly the authors of the letter have asked for the evidence that stigma may indeed be an effective tool in public health. They need look no further than the stigma that is directed at smokers, drunk drivers etc for that evidence.

I believe there is another reason why my piece has pricked their irritation, which may have to do with the letter-writers' liberal view of drug use itself. I doubt that Ford and her co-signatories much concern themselves with the issues of drug prevention. Indeed it may even be the case that some of those signing the letter favour drug decriminalisation or legalisation and would view drug use much in the same way as Van Ree, whom I quoted in my original article.

UK society however, as evidenced by the recent social attitudes survey, is hardening, not softening, its attitudes towards illegal drug use and in that context, whether Chris Ford and her co-signatories like it or not, some element of stigma may continue to be appropriately directed at the use of illegal drugs.

Neil McKeganey, professor of drug misuse research, University of Glasgow

Tentative steps

With reference to the article by Professor McKeganey about the notion of 'good stigma': few people would disagree with the notion that we should guard against undertaking activities which could promote the wider use of drugs in society. However, I would take issue with the idea that it is 'stigma' which leads to far fewer people experimenting with heroin and crack than cannabis. Most surveys reveal that it is fear of the health consequences that inhibit use, not any sense of 'stigma'. Can there be any young people who don't know that taking heroin is more dangerous than cannabis? But in any event those working in the treatment sector must give first consideration to the clients and the significant barriers to recovery they face as a result of discrimination.

Professor McKeganey points to the 'success' of attempts to destigmatise mental health problems. Those campaigning against mental health stigma, such as Time To Change, acknowledge some success, but they are also very clear that there is an awfully long way to go – maybe a generation or more – especially when a new film called *The Crazies* carries the strapline 'insanity is infectious'. How much harder is it going to be in relation to those with drug problems? If we are serious about recovery, we can be no less serious about taking what amounts to the first tentative steps in challenging stigma and discrimination.

Harry Shapiro, director of communications and information, DrugScope

The big one

I read with interest Professor Neil McKeganey's thought-provoking article *Bad stigma… good stigma?* as well as the subsequent avalanche of outraged comment (*DDN*, 1 March, page 17) in your letters section. I would like to add a couple of considerations to this debate.

Firstly, in any discussion with drug users about the initiation of their problem drug use, who has not heard addicts themselves talk about heroin as the 'big one', of starting to use it as getting 'really serious' and of smackheads being 'different sorts of users' who had 'crossed the (imaginary) line' from so-called recreational use? Perhaps we should be asking addicts themselves whether class A drug use is perceived as a stigmatised behaviour?

Secondly, why should there not be important public health benefits in retaining the view of heroin use as harmful and therefore stigmatised? The theory of planned behaviour (Ajzen, 1991) specifies the nature of relationships between beliefs and attitudes and the likelihood that adopting a particular behaviour will produce a certain outcome.

While most behaviour models are conceptualised within individual cognitive space, the theory of planned behaviour considers social influences such as social norms and normative belief, based on culture-related variables. Given that an individual's health-related behaviour decision, including class A drug use

or drink-driving, might very well be located in and dependent on social networks and organisation (eg peer group, family, school and workplace), social influences may be very important and often influential. Subjective norms from society or culture, such as negative attitudes and stigma attached to heroin use, may thus be seen to be dissuasive and highly relevant to prevention.

Stigma attached to anyone who has become involved in drug use must be robustly challenged, but surely that need not mean that society should sanction the use of heroin?

Dr Jennifer Payne, Cumbria

Ajzen, I. (1991). The theory of planned behaviour. Org. Behav. Hum. Decis. Process. 50, 179-211.

Ford focus

Dr Ford et al are being disingenuous in the letter *Infamy, infamy* (*DDN*, 1 March, page 17). Prof McKeganey's point is, surely, a simple one; that society's disapproval of addiction discourages addiction and therefore is not all bad. What on earth is wrong with that? As for the analogy with homosexuals in Uganda – oh my word, I laughed quite a lot, in an open-mouthed, dumbstruck way, rather than a jolly 'isn't that amusing' way.

I consider myself a harm reductionist through and through, but some people in this movement need to get out of the politically correct 1980s and join the rest of us in the 21st century.

The efforts of many to normalise illegal drug use is misguided and dangerous. Harm reduction must always be about protecting people – and if certain sections of the movement don't understand that the addict doesn't always come top of that list, then those people don't understand the society we live in, and are a danger to the survival of the harm reduction movement as a whole.

Having said all that, and despite the co-signatories, I honestly think this letter is more about Dr Ford's wider issues with the Prof's views rather than any coherent or legitimate response to the content of this particular article and, in that respect, far from not printing the article perhaps *DDN* should not have printed the letter.

Edward Yates, by email

Selfish cappuccino

In her support of Neil McKeganey's assertion that stigmatisation can be useful in reducing drug problems, Molly Cochrane shows again the dangers of applying unevidenced speculation to drug policy (*DDN*, 1 March, p17).

She says she doesn't accept that liberalising drug laws would not lead to an increase in use. Has she looked at the evidence from those states and countries that have decriminalised drug use, where drug use has not risen any faster than elsewhere (Babor et al. 2010)?

She argues that gangsters would simply move to other crimes if their drug profits were taken away from them. This is a version of the disproved argument that crime prevention always leads to displacement (Clarke 2005). Give people fewer opportunities to offend and they tend to offend less, rather than just shifting their crimes to other victims.

She states that the violence and exploitation associated with the drugs trade means that taking heroin or cocaine is an 'utterly selfish act'. The production of oil, sugar and coffee has long been associated with violence, exploitation and environmental degradation. Does this mean that people who pick up a sweetened cappuccino at the petrol station are also 'utterly selfish'?

The stigmatisation of drug users rests on moralistic and ideological preconceptions of the types of people who use certain substances. It is not, as Professor McKeganey suggested (in his similarly evidence-free article) a rational response to the harms of drug use.

Our research suggests that stigmatisation, far from reducing drug harms, pushes people away from effective treatment (Stevens et al 2008). This echoes McKeganey's own finding that the process of recovery is assisted by overcoming and not increasing stigmatisation (McIntosh & McKeganey 2000).

We should try to change social norms that support the inequality, discrimination and criminalisation which damage so many people's lives.

Dr Alex Stevens, Dr Polly Radcliffe, School of Social Policy, Sociology and Social Research, University of Kent

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Right to reply

I am writing regarding Andy Stonard's article *Fight the power* (*DDN*, 1 February, page 8).

Although I really never discuss politics or have much interest in the subject, I felt compelled to write to my local MP after reading Mr Stonard's article. The letter contained the main points to be put forward to MPs as discussed by Mr Stonard – such as spending commitments on alcohol and drugs, an analysis of the drug and alcohol situation in the UK, funding and support for drug and alcohol agencies, particularly in my local area of Lincolnshire, and details of his strategy and commitment to tackling this over the next five years. I said I was looking for straight answers as my vote depended on it.

At present there are at least 2.75m people in, or in need of, treatment in the UK. I made it clear that I was one of those statistics and that if it was not for these agencies I would not have reached 2010 at all.

Although I do not belong to any organisation in the treatment area at the present time, I am working hard to gain access. I strongly support treatment agencies as I have personally used them myself, and work and stability also is very important. I have been self-medicating since August 09, and in that time I have also returned to learning – in English, maths, drug awareness level 2 and counselling (to be confirmed), finding the support from Addaction very helpful.

I found the reply from Mark Simmonds MP to be exactly as I asked for, although I am waiting for some more specific detail. He gave me statistics from seven sources to show a snapshot of drug and alcohol abuse in the UK and assured me that a Conservative government would work closely with police, health services and charities to reverse the trend of increasing substance abuse. He said he would make sure colleagues were aware of the points I raised, would forward my correspondence to the Home Secretary and ask him to provide figures for total government spending in these areas, and specifically for Lincolnshire.

Paul Strutton, Boston, Lincs.

Chemical soup

With reference to the article on drinks labelling (*DDN*, 1 March, page 4), alcohol has been consumed by humans for thousands of years. There is no saying what health risks arose, however the human race has survived. It is only in recent years that the long-term and degenerative disease, and an increase in violence, have manifested themselves in huge proportion – so can we blame the alcohol content alone?

The human constitution has never before had to deal with so many toxic and accumulative substances, which amounts to a chemical soup. The food and cosmetic/body product industry is bound by law to label all their ingredients (read the label – do you know what half the ingredients are?), but not so the drinks industry.

There is ever-increasing evidence that chemical additives, whatever they are, can and do have a regressive or degenerative effect on health.

Should this not be studied and closely analysed, along with their relationship to alcohol, instead of blanket blame being laid upon alcohol alone, or do the chemical industries have such a financial hold over sensible policies?

People are gullible enough to accept that whatever they are sold, or told, is healthy and the correct way to live. Is it not time that the food, drinks and cosmetic industries are cleaned up and people's tastes re-educated to accept the much more natural way of things?

Christine Hudson, homoeopath, naturopath, volunteer family support

We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3.

The interests of clients are not being served by a faceless, target-driven system, says **Martin Blakebrough**

Impersonal services

AS MARTIN LUTHER KING SAID, 'Hate multiplies hate… and toughness multiplies toughness in a descending spiral of destruction. The chain reaction of evil must be broken'. As someone involved in drugs policy (with nine years on the ACMD) I feel that we have often failed those needing our support. We have created a policy whereby society hates drug users, acts violently towards them by denying them their liberty and, in its toughness, fails to see they are vulnerable and loving human beings. We reap the rewards of their alienation through crime in our communities.

To move away from this chain reaction of evil we must embrace those with drug problems, particularly those accessing services, so that the healing process can begin. There is a growing realisation that service users need to be central to treatment and the NTA says it wants 'to build an equal partnership with treatment service users and drug users, because we recognise that those in treatment and those who have identified a need for treatment have the right to become involved in activities that affect their health and wellbeing'.

The problem the NTA has, however, is in its creation of a target driven tick box culture, which means that service users are seen as data rather than people. In order to demonstrate fairness it has instituted a contract culture that thrives on data outputs but not on real service user empowerment. Under its leadership large drug service businesses have been created that themselves have become obsessed with what the customer wants – that customer is not the service user, however, but the NTA and local commissioners.

Innovative and person-centred projects have fallen by the wayside. Middlegate, a unique residential service in Lincolnshire for young people, has now been allowed to close. The need for intensive residential services is obvious but our vulnerable young people are often forgotten in favour of the utilitarian approach of more – rather than intensive support – services.

Kaleidoscope used to provide a crèche for the children of our clients in Kingston. The director of the World Health Organization (WHO) came to visit and said that the children had the same problems as the street children in Delhi. So why did this service close? Simply because the crèche worker to child ratio was considered too high and it was not a priority in anyone's commissioning plans.

As I visit drug services what still shocks me is how many large treatment providers refuse children access to their buildings. In one such building, a client coming to get methadone was told that the child would not be admitted. So the mother quickly goes to get her methadone, while the child is left to wait on the street of a major city.

Hidden harm is a great document and passionately advocated by the NTA but real care is still missing. The interest of service users is not best served by the present expensive system. Target-driven programmes with key performance indicators often fail because they trespass into micro management, or targets lead drug services to distance their services from the most vulnerable. Retention targets, for example, mean that a homeless chaotic client will mess your figures up so you would be best to find reasons not to treat them.

We can all talk about our passion for service user involvement but what does it really mean? In London, is it right that a service user has to go to a service that a commissioner chooses for them? We have passionate debates about harm reduction versus recovery services but why not let the service user choose – why not create an approved providers list and then let the service user select the best service to meet their needs?

If we enable service users to be the customer and to be at the heart of treatment, it means they are empowered to know their rights. In south west London can it be right that Kaleidoscope is told not to talk to service users about Release? Every service has to have a complaints policy, but is it not right that service users be given the power to challenge commissioners when they do not act in the service users' interests?

Paul Hayes once said if he were a drug user he would rather be in England than Wales. If I were a drugs worker or a drug user I would live in Wales – everyone knows everyone and cares about the welfare of people, not just about data. In Wales creativity is not stifled and services are small enough to want to make the difference to people's lives. Service user and services are naturally closer. And finally, if we had devolved powers we would have a more rational drugs policy – one that includes alcohol as a harmful drug.

Martin Blakebrough is director of Kaleidoscope

Post-its from Practice

Positive thinking

Fear still exists about HIV treatment among some injecting drug users, says **Dr Chris Ford**

Yesterday evening I knew it was bad news by the way all the wonderful receptionists sympathetically handed me an urgent fax. It confirmed that Alex, who had just been discussed at the hospital cancer meeting, had widespread metastases, with the primary as yet unconfirmed.

Alex has been our patient for the last 15 years. He contracted HIV around that time from either sharing needles or having unprotected sex with his HIV positive partner. She had come here from Dublin in the early 1990s when the HIV rate was escalating, to seek treatment for both her HIV infection and her drug problem. Alex agreed to be tested and proved positive for both HIV and hepatitis C.

From the outset he was completely against having active treatment or hospital involvement. He, like several other patients, had seen so many friends die with or without AZT and so he decided that the 'ostrich approach' was best. As his CD4 count was over 800 at that time, we agreed to monitor him and treat his drug problem.

Soon after his diagnosis, Highly Active Antiretroviral Therapy (HAART) was introduced. This made a dramatic difference to many of our patients. I remember a dramatic decrease in the number of funerals I was attending – from many to just one the following year. We again talked to Alex about reconsidering his decision to reject treatment but he refused, even after his wife died from an overwhelming opportunistic infection.

Over the next ten years, as Alex's CD4 count fell from 800 to 120, we had this conversation again and again but he would not budge. His reply became 'but I'm well and those tablets kill you.' Arguments about his compromised immune system did not make him change his mind either. Alex remained well until about 18 months ago when he presented acutely with the worse seborrhoeic dermatitis that I had seen for over 15 years and a bad bacterial chest infection. Still he declined hospital and we treated him in the community. Then, just less than a year ago, he developed candida in the oesophagus and was not able to eat, so agreed to go to hospital. While there, he was stabilised on HAART and transferred to respite care to allow him get familiar with the regime. The HIV doctors and pharmacist were very helpful and agreed to support me in prescribing his HIV medication. He agreed to take this along with his methadone in the pharmacy.

However, only one week after his discharge, Alex came to tell me that he no longer wanted to take his HIV medication. I had fallen for Alex the first time I met him with his cheeky smile and his broad, almost incomprehensible Dublin accent. I almost wanted to punish him to try and keep him on the HAART by refusing to give him methadone if he didn't continue with his HIV medications, but realised that that would have been unethical. He was fully aware of the implications of his decision, knew he was cared for and could reconsider taking treatment at any time.

Since then his health has been deteriorating, particularly over the last month. In this time his drug use has gone up but it took me until ten days ago to persuade him to be admitted, which only happened because his abdominal pain had become so bad that it could not be helped by prescribed analgesia and illicit opioids. We now know that metastases are the cause of his pain.

Evidence suggests that HIV transmission among injecting drug users has increased again since 2002 with prevalence in London of about one in 20. The UK figure is one in 73 with about one third of those IDUs being unaware of their HIV infection despite most of them being in contact with services and being tested. So it is clear that HIV has not gone away. We therefore need to continue to screen all people who use drugs for HIV and hepatitis, and to provide sufficient injecting equipment.

However, not even a diagnosis made Alex accept treatment. In the surgery we have a large number of HIV positive patients. Across all groups, most (70 per cent) use both hospital and general Practice appropriately. On the whole there is reasonable two-way communication between specialists and us. One group (14 per cent), consisting mainly of homosexual men, only really use the specialist services. There is also a third group (16 per cent) consisting mainly of injecting drug users, who, like Alex, only use general practice. These latter two groups have both (thankfully) decreased from 28 per cent and 25 per cent respectively ten years ago.

Perhaps this will mean that in the future fewer people will fear treatments and prejudice against people who both inject and who are HIV positive. I hope Alex gets another chance to reconsider, but I fear he may not.

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical lead for SMMGP

To become a member of SMMGP, receive bi-monthly clinical and policy updates, and be consulted on important topics in the field, visit www.smmgp.org.uk

Events

18 March – London
'What is clinical supervision?'
DDN workshop run by Fiona Hackland. This one-day event explores best practice in clinical supervision and how to achieve safe, efficient and effective services for clients. *www.drinkanddrugsnews.com*

19 March – London
'What is management supervision?'
DDN workshop run by Tim Morrison. This one-day course will help managers look at different elements of their role and identify how best they can ensure they offer appropriate timely and effective supervision so staff can develop their skills through reflective practice. *www.drinkanddrugsnews.com*

19 March – Southampton
The National Needle Exchange Forum (NNEF)
This all-day meeting will showcase examples of good practice from across the UK, with a special focus on the practical, 'bolt-on' services that can easily be delivered alongside needle and syringe exchange to improve appeal, client contact numbers and service quality. *www.nnef.org.uk*

23 March – London
Adfam conference
The one-day conference of Adfam, the support charity for families affected by substance misuse, has the theme 'Be careful what you wish for: Families, drugs and alcohol: involvement or support?' and looks at families' involvement in treatment, the costs involved in caring for a drug user and workforce development to support families. *www.pavpub.com*

26 March – London
'No place for hate'
The Macpherson Inquiry into the racist murder of the black teenager Stephen Lawrence laid the groundwork for the legal recognition of racist hate crime. This one-day conference explores the challenges and opportunities for taking effective action to tackle hate crime by bringing together the latest evidence, policy and practice developments across different sectors and countries. *www.pavpub.com*

20 April – Nottingham
Nacro's youth crime conference
Nacro's 20th annual youth crime event will look at effective targeting of interventions to those who need them most and tailoring them to meet individual needs, as outlined in the government's youth justice strategy, part of the Youth Crime Action Plan. *www.nacro.org.uk*

CARE OR CONTROL? A WAY FORWARD

In a follow-up to their article looking at whether 12-step meetings are appropriate for women who have experienced abuse, **Grace** and **Sarah Galvani** explore the implications for fellowship members and sponsors who support women living with these issues, as well as some broader implications for alcohol and drug professionals

In *Care or control? Part 1* (*DDN, 16 November 2009, page* 6), we raised concerns about the extent to which some key elements of AA may not be helpful to women who have experienced domestic violence and abuse. This is a difficult and emotive subject to think about, discuss and reflect on, both personally and professionally. The emotions this subject raised were apparent in responses to the article and we want to thank the many people who emailed or commented on the article offering their thoughts and experiences. These ranged from criticism and denial of the issue, to moving emails of gratitude and support from people who were also courageous enough to disclose their own experiences of abuse and who had similar experiences to Grace within AA.

In light of these responses, we are focusing part 2 on messages of good practice that stem from research, specialist domestic abuse practice, personal experiences, and other people's work. We hope they will be of interest to professionals, sponsors and the membership of AA. Most importantly, we hope that they offer a way to better support people who experience, or have previously experienced, domestic violence and abuse. We also hope that it may be a small step towards helping women who have experienced, or are experiencing, abuse make the most of AA.

Alternative 12 steps

For decades, individuals and organisations have offered alternative steps or statements for women working towards sobriety. In 1975 Jean Kirkpatrick from Pennsylvania, USA, started Women for Sobriety as a self-help organisation for women out of recognition that their needs in recovery were different to men's. In the *Who we are* leaflet she states: 'Although the physiological recovery from alcoholism is the same for both sexes, the psychological (emotional) needs of women are very different in recovery from those of the male alcoholic.' She developed the New Life programme around 13 self-affirming statements including 'I have a life-threatening problem that once had me' and 'I am a competent woman and have much to give life'. Her reasoning is that others 'use fear, reproachments, and dependencies' rather than learning new, more positive and forward-looking approaches. Gail Unterberger, a Christian pastoral scholar, followed suit in 1989 publishing a feminist version of the 12 steps alongside an explanation of why the original steps, developed by men for men, were not appropriate for women.

And yet, for many women like Grace, AA has been a lifeline that she is now able to reflect on, find fault with, find strength in, and from which she can take what she needs. She also gives something back when she can through sponsoring others and, through her reflections and questions, hopes to continue to make it a positive experience for herself and those she supports.

Messages for sponsors

Women who are, or have been, victims of domestic abuse have experienced feelings of hopelessness, shame and guilt as well as a lack of control over their own life. With help from Grace's personal experiences, we have highlighted some areas of the AA programme that may once again leave such women feeling not in control. The following are some suggestions to integrate into the step work to enable a safe and empowering process.

1. *Explore gently*
   Develop some gentle explorative questions to assess the member's experiences of intimate relationships. The high prevalence of domestic abuse among women with substance problems suggests we assume domestic abuse has been experienced until it becomes clear otherwise. Many sponsors begin the step work by asking the new member to write their 'life story'. Listen out for issues of control, self-blaming, and isolation.
2. *Choose words carefully*
   Consider using different words to explain the process of handing power over to God or a higher power. When exploring 'self-will' make sure you acknowledge that not all their decisions or choices are bad ones. Emphasise that they have the power to make choices that keep them safe. Work with them in an empowering way to build self-confidence and self-belief and to develop a greater understanding of their coping strategies.
3. *Highlight strengths and skills*
   Steps 4 and 5 are pivotal in the process of AA recovery. However, the list of 'defects' can mirror the verbal abuse and blaming that a victim may have

experienced in their abusive relationship. Listing the member's strengths and skills, which were visible even through times of adversity, will be an empowering way to support them through the step work.

4. *Be extra aware of feelings of failure*
   The AA fellowship encourages commitment and involvement, with the group chanting 'keep coming back, it works if you work it' at each meeting. It is a powerful message. Be aware that for members who have experienced abuse their self-worth is often already low and not attending a meeting can reinforce their sense of shame and failure. Be ready to support people who are ambivalent about meetings, choose to dip in and out and who may seek additional support elsewhere.
5. *Don't always make amends*
   Making amends is the link to surrender and serenity in AA's promises. Step 9 refers to making amends to people wherever possible to do so. Sponsors need to be aware that making amends to an abusive partner is not appropriate. It can collude with the sponsee potentially taking responsibility for her abuser's behaviour. Make sure you have spent time exploring the possibility of your sponsee being a victim of abuse, and discuss whether it is advisable to make amends to her partner or ex-partner.

Messages for members

1. *Be aware*
   Be aware that a large number of women may have experienced domestic abuse. Stay away from offering guidance about intimate relationships, even when sought, if you do not know the unique circumstances of the other member's situation. For example, you may suggest a woman makes amends to an ex-partner without understanding the partner was abusive.
2. *Acknowledge the power of language*
   Common words used to describe alcoholics' defects include 'selfish, self-seeking, self-centered, self-pitying and disobedient'. These are words often directed to women from their abusers. Consider exploring other ways to discuss characteristics that may be unhelpful to recovery which are not so critical and negative.
3. *Challenge self-blame*
   Listen for the self-blame when physical violence is mentioned - waking up with a broken wrist because 'we are drunks' is unacceptable behaviour on the part of the abuser; it is not the woman's fault her partner is violent and abusive, even if she does have a drink problem. Gently challenge women taking the blame for the violence of a partner.
4. *Be proactive*
   Discuss having posters and information about domestic abuse at meetings. The domestic abuse helpline number and other information could be placed in the ladies' toilets or visible in meeting rooms as a sign that domestic abuse is not an acceptable behaviour.
5. *Alcohol does not cause violence*
   Don't buy in to simplistic notions of cause and effect. Alcohol alone does not make people violent, physically or sexually. Sometimes the absence of alcohol can mean the physical violence decreases although this is not the same as stopping. Research tells us the verbal and psychological abuse and controlling behaviour can continue, meaning the woman may still not be safe.
6. *Listen with empathy*
   Consider what it feels like for a victim of abuse to hear a male AA member comment 'I was abusive and violent when I drank, but I was sick'. How might this feel to a woman whose partner is abusive when drinking? Research tells us men who are violent and abusive behave that way with and without alcohol.

Messages for professionals

1. *Understand what domestic abuse is*
   More than this, understand how it can make women feel; the shame, stigma, hopelessness, self-loathing, self-doubt, fear and withdrawal to name a few. Then think about the impact this may have on someone's vulnerability and drinking behaviour.

'Although the physiological recovery from alcoholism is the same for both sexes, the psychological (emotional) needs of women are very different in recovery from those of the male alcoholic.'

2. *Asking about domestic abuse*
   Make questions about domestic abuse a routine part of your 'assessment and review' processes. Follow them up with specific questions about harmful behaviours and feeling fearful. Examples of questions are available through the Stella Project toolkit (www.gldvpstellaproject.org.uk). Ask sensitively and empathically beginning with discussion about 'problems at home' or 'conflict'. While conflict and domestic abuse are very different, it is a sensitive way to open the discussion and can be built on from there.
3. *Responding to domestic abuse*
   Make sure you are ready for what you hear – emotionally and practically. Some disclosures are heartbreaking for even the most experienced of professionals. Be aware of your non-verbal and verbal response. Believe what is being said, reassure her she is not to blame, check on her current feelings of safety and that of her children. Offer practical options too, for example, a free telephone call to a specialist service, a leaflet or 'business' card for the local DV service.
4. *Safety planning*
   Many victims will want to stay with the abuser out of love, fear, finances, the children, family pressures, shame of separation and so on. Where someone is living with abuse, discuss safety planning – it's the domestic abuse equivalent of harm minimisation. For example, 'Can you keep a bag of clothes/important personal documents at a family member's or friend's house?'
5. *Familiarity with AA*
   Be familiar with the way AA meetings run. While this will vary, being able to give some information on what happens and what doesn't happen will be helpful. As with any new appointment, it may be a bit nerve wracking and the more information you can provide the better. Advise her to sit with other women and not to feel pressured to do or say anything.
6. *Couples/family work*
   Do not undertake couples or family work where there is domestic abuse or any recent conflict that you think could be domestic abuse. This could put her at greater risk for reprisals post session and also risks you colluding with the perpetrator in your role as a mutually supportive 'therapist'. The victim/s of abuse will be unlikely to speak freely in the abuser's presence.

A final word

In both parts of *Care or control* we have focused on domestic abuse, which is predominantly experienced by women and children from men. However many of the messages are transferable to men and women who have experienced abuse, particularly those who experienced abuse as children. The abuse of power by a loved one, be they partner or parent, can lead to long-lasting emotional and psychological damage. Any organisation that seeks to support people with alcohol and drug problems must consider the links with intimate violence and abuse and be able to honestly and openly reflect on their practice to better support those they serve.

Grace is an AA group member and Dr Sarah Galvani is principal research fellow at the University of Bedfordshire

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OPERATIONS MANAGER

High Wycombe, Bucks

DrugFAM was established as a charity in 2007 for the express purpose of supporting family, carers and friends affected by a loved one's substance misuse.

A full Job Description and application form is available on request. If you are interested in finding out more please call **Ann Canham**, Chair of the Trustees, on 01494 433367/07767 298811, or email drugfam@hotmail.co.uk **Closing Date: Friday 9th April**

New Year, New Opportunities?

Bristol Drugs Project is an experienced, energetic and resourceful service delivering effective harm reduction and treatment services to over 3,000 individuals each year.

Shared Care Worker (full-time, 35 hrs) – ref: GU1

Bristol's successful Shared Care scheme provides treatment to over 1,500 drug users. Based in GP surgeries in the heart of communities you will assess opiate users, provide advice to GPs, monitor prescriptions and develop and implement a care plan. If you are assertive, diplomatic, have good knowledge of illicitly used and prescribed drugs, with excellent organisational skills and are able to work well within pressurised primary care settings, this is for you. Some early evening work will be required. A full UK driving licence and access to a car is essential for this role.

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Closing date: Friday 29th January **Interview date:** Friday 5th February

Funded by Safer Bristol - Bristol Community Safety & Drugs Partnership

You need experience of working with drug or alcohol users. For an informal discussion contact Jayne Peters, Treatment Services Manager on 0117 987 6019.

To receive an application pack please fax, e-mail or write, quoting the job reference, to Angelo Curtis, BDP, 11 Brunswick Square, Bristol BS2 8PE; fax: (0117) 987 1900; e-mail: recruitment@bdp.org.uk.

We are committed to anti-discriminatory practice in employment and service provision and especially welcome applications from Black and minority ethnic groups for all posts, as they are under-represented within our organisation. We also welcome applicants with past personal experience of problematic drug and alcohol use.

No CVs agencies or publications.

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Substance Misuse Volunteering and Training Organisation

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- Delivering substance misuse training
- Volunteer placements
- Information and support services to Black & Minority Ethnic communities

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NVQ ASSESSOR – SUBSTANCE MISUSE

(FT, 37 hours per week)
SCP 21-22 (£ 19,126-£19,621 per annum)

An experienced substance misuse worker is required to act as an NVQ assessor. The post will involve assessing NVQs in Health and Social Care; Qualifications in Working with Substance Misuse and Qualifications for Service Users . In addition it would be desirable for the post-holder to be able to assess Management NVQs.

The ability to travel is required. This is a fixed term contract of two years with the hope that this will be extended. Please note that full training will be given to the successful candidate to achieve their Assessor Award. All posts offer + 6% pension contribution after successful completion of probationary period.

To apply please contact us at recruitment@newlinkwales.org.uk and a pack will be sent to you, or tel. 02920 529002.

For further information on NewLink Wales please visit our website: www.newlinkwales.org.uk

Closing date : 4pm Wednesday 24th March 2010.
Interview date: Wednesday 31st March 2010.
Only shortlisted candidates will be notified. Previous applicants need not apply.

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To apply, please visit www.addictionrecovery.org.uk or call 0117 934 0844 quoting ref: 0301-3D.

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For further information and application pack contact Janet Swaine on 01274 693900 or e-mail janet.swaine@bradford.nhs.uk

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INVITATION TO TENDER

STRUCTURED DAY CARE SUBSTANCE MISUSE SERVICE FOR BUCKINGHAMSHIRE

The Buckinghamshire Drug and Alcohol Action Team (DAAT) invite tenders for the provision of a Structured Day Care Substance Misuse Service in Buckinghamshire.

The contract will deliver structured day care interventions in group and one to one settings. This service will support court orders for Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ATR).

The contract period 1st September 2010 to 31st August 2013 (3 years) with an option to extend for a further two years subject to annual review and ongoing funding.

Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) may apply to this contract.

To receive a tender pack, please send a request in writing, quoting **Ref No. 1896.LP** to,
Finance & Procurement, Rm 21 OCO, Walton Street, Aylesbury, Bucks, HP20 1UA or email: procurement@buckscc.gov.uk.

Requests must be received by 5th April 2010.

For further enquiries please contact James Sainsbury, Bucks DAAT Safer Bucks Commissioning Manager.
Tel: 01296 382780 Email: jsainsbury@buckscc.gov.uk

The closing date for receipt of tenders is 12 midday on 18th May 2010.

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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.

CRI in Sefton are seeking a qualified counselling supervisor with extensive experience of working with substance misusers and addiction to coordinate a new Intensive Psychosocial Counselling service as part of its Integrated Recovery Service.

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(Ref NM370)

£28,037 to £29,681 per annum – 37.5 hours per week
Fixed term until 31st March 2011 with possibility of extension

This is an exciting opportunity to be part of the implementation and development of this new service and to be part of the Drug System Change Pilot which was awarded to Sefton DAT. The service will primarily offer short term interventions (12 weeks) and be based on an integrative model of practice but with a focus on MET, CBT and family systems therapy.

The post holder will be responsible for the recruitment, training and supervision of volunteer counsellors and ensuring that the service employs evidence based interventions, meets specified quality standards and achieves performance targets. The post holder will be committed to the principles of recovery and supporting individuals to lead meaningful and purposeful lives.

In return the successful applicant will become part of a national organisation committed to both its service users and staff and with an excellent record in delivering quality outcome focussed services. CRI provides a comprehensive package of support and training to all its staff as part of its performance management framework.

For an informal discussion please call: Damian Grainer (Services Manager) on 07843 357399.

Closing date: 29th March 2010
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For an informal discussion or application pack please contact Lynn Barker on 0161 484 0000 or email lynn.barker@acorntreatment.org.

Closing date: 24th March 2010. Interviews: w/c 5th April 2010.

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

www.acorntreatment.org

Safer communities, healthier lives Registered Charity No: 1079327
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NHS
National Treatment Agency for Substance Misuse

Regional Workforce Development Officer: Ref 13/10

Salary: Band 4, £27,914 - £35,727 per annum.
This post is funded for one year with the possibility to extend it for a second year.

Delivery of effective drug treatment and of strategies for reducing the harm caused by drug misuse requires skilled staff. In the West Midlands region, the Drug Action Teams collaborate closely on a number of issues including workforce development. This post is a result of this collaboration.

The post holder works to a programme that is set by the Regional Workforce Board, chaired by a representative of the LSC and including local Partnership leads and drug commissioners, the Home Office and the NTA. A number of initiatives have already been implemented through this programme including a Progression Award in Community Justice; a Continuing Development Award; an Advanced Apprenticeship Scheme; a training needs analysis for young people treatment services; a web site to improve the image of work with drug issues as a career pathway.

The Workforce Development post will maintain this work and develop a proactive strategy to increase the effectiveness of the workforce through recruitment, training and staff development.

The post is funded by Drug Action Teams across the region, and will have a remit covering the whole Government Region. For administrative purposes the post will be located within Midlands Consortium and employment will be on the usual terms and conditions of that organisation. The National Treatment Agency and Government Office for the West Midlands support the delivery of the national drug strategy and the Workforce Development Officer will work closely with staff in these agencies, with Drug Action Teams and drug treatment providers, with relevant SHA staff and with training and Skills organisations to support workforce development across the region.

The post holder's office base will be the Consortium's Office at Fort Dunlop but travel throughout the whole region will be required. The post holder will also be supported by close working with the NTA regional team.

Applicants for this post should have experience and understanding of training, workforce development and the learning infrastructure including the LSC, Sector Skills Councils, Further Education etc. Secondments will be considered.

Closing date: 31st March 2010, interviews 28th or 29th April 2010

To access an application pack please visit our website www.westmidlands-probation.gov.uk or write to Human Resources Department, 1 Victoria Square, Birmingham, B1 1BD, for an application form (unless otherwise stated) quoting your name, address and the appropriate vacancy number.

National Probation Service-West Midlands is committed to safeguarding children, young people and vulnerable adults

Team Leader

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Insight – Young People & Families Service – London W10

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As Team Leader, you will have the ability to effectively train, support and challenge a team of workers to improve practice and service delivery. You will carry a caseload of clients, and be a lead practitioner within the team, engaging and supporting young drug users, using a range of 1:1 and group interventions.

You will need to demonstrate supervisory skills, and substantial expertise of working with this client group. An understanding of the needs of younger drug users is essential, as is the commitment to maximise healthy opportunities and informed choices for your clients. The ability to build and maintain effective working relationships with partner agencies is also vital for this role.

REF: BCDP/16/DDN.

To request an application pack, please email info@peterlockyer.co.uk or telephone our response handling line on 01206 570706 quoting the reference number. Alternatively, you can download an application pack from our website www.blenheimcdp.org.uk

Closing date: 7 April 2010.

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