Nº1 IN THE SUBSTANCE MISUSE SECTOR

www.drinkanddrugsnews.com
April 2011

'Our goal is to make recovery visible throughout the treatment system – and to give people the opportunity to engage in ways that have previously been impossible.'

SUPPORT MEASURES

PEER MENTORING IN A GENUINELY RECOVERY-ORIENTATED SYSTEM

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Dr David Best – recovery champion – talks about building success p20

IN DEPTH
Advocacy, support and harm reduction services for Nepalese women p16

NEWS FOCUS
Will the UK drinks industry always get its own way in the alcohol regulation wars? p6

ONE MORE MONTH TO HAVE YOUR SAY ON THE FUTURE OF DRUG TREATMENT

The demands on the drug treatment system have changed a lot since 'Models of Care' was updated in 2006. The focus now is increasingly on supporting recovery and reintegration.

Our aim is to refresh the framework for the drug treatment system so that it promotes recovery and the ambitions of those who work in it and use it. As part of this, we are seeking views from across the treatment field. Remember, this applies to community services, residential providers, and prisons.

The consultation is available now on the NTA's website for you to download and complete. The deadline is 4 May, so don't delay – make sure that your views and ideas are heard.

DOWNLOAD THE 'BUILDING RECOVERY IN COMMUNITIES' CONSULTATION NOW FROM WWW.NTA.NHS.UK/RECOVERY-CONSULTATION.ASPX

www.nta.nhs.uk

NHS
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Editorial – Claire Brown

Spare some change

Recovery pilot offers an all-inclusive approach

Recovery is here there and everywhere, but our cover story describes how Sefton had the chance to look at what it could mean across their entire treatment system. It was not just a case of shoehorning the word recovery in to get funding, but of looking at what service users really needed by consulting them.

Realising that services were not accessible enough to everyone, ex service users were trained up as peer mentors to make sure everyone had a fair chance of getting exactly the right support. This is taking a user-led needs assessment to its logical conclusion, and Sefton were lucky to be selected as one of seven pilot areas. Let's hope the benefits of their experience can now encourage others to take a fully inclusive approach by being adopted much more widely.

Much further afield, Gill Bradbury brings some tough challenges to our attention by talking to Parina Limbu Subba about her women's harm reduction programme in Nepal (page 16). The scale of their challenge is daunting, right down to trying to run a service with daily power cuts lasting up to six hours. The attitude with which they tackle seemingly insurmountable obstacles, not least basic funding, is inspiring in itself.

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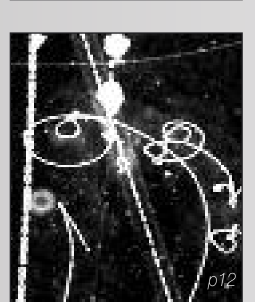

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THROUGHOUT THE MAGAZINE: JOBS, COURSES, CONFERENCES, TENDERS

Sentencing Council consults on new drugs guidelines

The Sentencing Council has launched a public consultation on proposals to introduce new sentencing guidelines on drugs offences for judges and magistrates.

The proposals aim to distinguish between 'leading players' in smuggling and supply and people in subordinate roles, such as drug mules, who are often coerced or tricked into carrying drugs.

The role of the council – an independent public body of the Ministry of Justice – is to issue guidelines that the courts must follow 'unless it is in the interest of justice not to do so'. The draft guidelines cover importation, supply, production, possession and permitting premises to be used for drugs offences, and will mean that sentences are based on the court's assessment of the offender's role and the quantity of drugs involved – until now there has been no statutory guidance covering drugs offences in the Crown Court.

'We want to ensure that those who are responsible for the most serious drug crime receive the longest sentences and that punishments overall are in proportion to the offender's role and the amount of drugs involved,' said the council's chairman, Lord Justice Leveson.

The guidelines split offender roles into 'leading', 'significant' and 'subordinate' categories, and drug quantities into categories ranging from 'very large' to 'very small', with a range of mitigating circumstances including lack of previous convictions, exploitation of vulnerability and only supplying the drug to which the offender is addicted. An example of 'small' for heroin and cocaine is given as between 5 and 49.9g, which could potentially carry a high-level community order rather than a custodial sentence, something that has prompted an outraged response in sections of the press, with *The Sun* stating that 'barmy new sentencing plans mean criminals could carry enough heroin to supply up to 20 junkies – knowing they will not be jailed if caught.' *The Daily Express*, meanwhile, called the guidelines 'one more attempt by the authorities to downgrade offences and so bring about the de facto legalisation of drugs.' A report from the government's 'champion for active safer communities', Baroness Newlove, has also recommended that money made from the sale of drug dealers' assets is given to their local communities in an initiative called 'Bling Back'.

Meanwhile, the Home Office has announced greater freedom for police to drug test people on arrest for 'trigger offences' such as burglary. Chief constables will now only have to inform the Home Office that they are using the power rather than apply for authorisation to use it at specific police stations. 'We must give those who know what works in their neighbourhoods the power to develop plans which meet local needs,' said crime prevention minister James Brokenshire.

Finally, the Department of Transport has announced plans to streamline the enforcement of drink and drug-driving offences, with the government examining the case for a new drug-driving offence which would remove the need for the police to prove impairment on a case-by-case basis where a specific drug has been detected.

'It is just as dangerous to drive impaired by drugs as alcohol so we need to send a clear message that drug drivers are as likely to be caught as drink drivers and that drug driving is as socially unacceptable as drink driving has become,' said transport secretary Phillip Hammond.

Sentencing consultation at www.sentencingcouncil.org.uk/sentencing/consultations-current.htm. Consultation period ends 20 June. Our vision for safe and active communities available at www.homeoffice.gov.uk/publications/crime/baroness-newlove-report. Drink and drug driving law details at www.dft.gov.uk/pgr/roadsafety/drivinglaws/. Drug testing guidelines at www.homeoffice.gov.uk

Alcohol deal is 'the worst possible'

Leading alcohol and health groups have pulled out of the government's 'responsibility deal' with the drinks industry.

The alcohol deal – one of five that make up the overall 'public health responsibility deal' announced in last year's public health white paper (*DDN*, 6 December 2010, page 4) – involves a partnership between government, industry, retail and voluntary sectors (see news focus, page 6). However, Alcohol Concern, The Royal College of Physicians, The British Medical Association (BMA), the British Liver Trust and others have all refused to sign, with Alcohol Concern branding it 'the worst possible deal for everyone who wants to see alcohol harm reduced'.

According to the government, the responsibility deal can deliver 'faster and better' results than regulation. As part of the deal, drinks retailers and manufacturers including Diageo, Majestic Wine and Carlsberg have pledged to provide clear alcohol unit labelling, develop a new 'sponsorship code' on responsible drinking and support awareness campaigns. Clear unit labelling on more than 80 per cent of alcohol will be achieved by 2013, the government states.

'We know that regulation is costly, can take years and is often only determined at an EU-wide level anyway,' said health secretary Andrew Lansley. 'That's why we have to introduce new ways of achieving better results.' However, Alcohol Concern, which was previously involved in the responsibility deal alcohol network (RDAN), branded it 'all carrot and no stick' for industry

News in Brief

PRICE OF PREVENTION

Project Prevention has now paid nearly 30 British women to use long-term contraception, according to an interview with the charity's founder, Barbara Harris, on the BBC's *5 live Breakfast* show. The controversial US-based charity, which offers cash incentives to people with drug and alcohol dependency to use 'long-term or permanent' birth control, established itself in the UK last year (*DDN*, 10 May 2010, page 5). However, its website states that it will not be paying for sterilisation procedures in the UK as 'the BMA just makes that too difficult'. Ms Harris told the show that 26 women had received payments of £60 to have a contraceptive coil or implant fitted.

RELEASE REPRIEVE

The financial crisis facing the Release helpline has been averted, at least temporarily, the charity has announced. The helpline – which has been giving expert confidential advice since 1967 – was facing closure until the Department of Health's financial assistance fund stepped in. However, the helpline still urgently needs support to ensure its long-term survival.

To find out how to donate visit www.release.org.uk

PAIR OF CHARLIES

A new animation by Mike Linnell of the Lifeline Project explains the problems that can be caused by crack cocaine. *The Ballad of the Two Charlies* booklet and DVD draw on the real-life stories of people engaged in crime and crack use, and are designed to be given to people who test positive for cocaine on arrest.

Available at www.exchangesupplies.org/shop disp_A33.php

SPEAK YOUR MIND

Members of the public will be able to voice their opinions at an Advisory Council on the Misuse of Drugs (ACMD) open meeting on 12 April. Attendance at the London event is free but places are issued on a first come, first served based.

To register visit www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/open-meeting-april11/

WDP THE PLACE TO BE

WDP (Westminster Drugs Project) has been named in the 2011 *Sunday Times* list of the 100 best public and charity sector organisations to work for. It has also announced a merger with Vale House Stabilisation Services (VHSS) in order to offer residential rehabilitation services in Hertfordshire and Essex.

Law enforcement fuelling world-wide drug violence, says study

The extreme levels of drug-related violence in countries like Mexico are the direct result of drug prohibition activities, according to a major peer-reviewed study to be released at the International Harm Reduction Association's (IHRA) annual conference in Beirut this week.

The effect of drug law enforcement on drug market violence: a systematic review looks at all of the available English-language literature dating back more than 20 years, with almost 90 per cent of studies concluding that increased levels of law enforcement activity are associated with increased violence. Prohibition drives up the value of banned substances to create lucrative markets exploited by criminals, says the report, with disruption of the markets through enforcement serving only to create power vacuums and more violence.

Mexican president Felipe Calderón launched a major countrywide counter-narcotics campaign upon election in December 2006, since which time more than 29,000 people have been killed. Governments that simply increase enforcement spending may inadvertently be making the situation for people in communities affected by drugs far more dangerous, says the document, which calls instead for governments to look towards a public health approach and to recognise the unintended effects of prohibition.

'We've seen this phenomenon in South America, and as drug traffickers increase their reliance on Middle Eastern trafficking routes, I am concerned that we may see similar increases in violence as governments in the region aim to stop the flow of illegal drugs,' said IHRA executive director Rick Lines. 'Among all the harms related to drug use, it now seems that the very measures most countries use to reduce drug use are actually causing harms to drug users and the community. Law enforcement is the biggest single expenditure on drugs, yet has rarely been evaluated. This work indicates an urgent need to shift resources from counter-productive law enforcement to a health-based public health approach.'

Rick Lines: 'This work indicates an urgent need to shift resources from counter-productive law enforcement to a... public health approach.'

This is the first year that the IHRA conference has been held in the Middle East and North Africa (MENA) region, where there are approximately 1m injecting drug users and high rates of HIV transmission. The conference will see the issue of the *Beirut Declaration on HIV injecting drug use: a global call for action*, which will aim to put pressure on world leaders gathering at the UN General Assembly High Level Meeting on HIV/AIDS in June.

'The international response to the needs of people who use drugs and the support for HIV-related harm reduction lags far behind that needed to halt or reverse the epidemic,' said Rick Lines. 'The Beirut declaration is a united call from NGOs from around the world for the international community to end its neglect of harm reduction as an essential element of the HIV response.'

Available to buy at www.elsevier.com/wps/find/journaldescription.cws_home/600949/description#description. See the May issue of DDN for a full round up of news from IHRA's conference in Beirut

and retailers, with no firm targets or sanctions for failing to deliver.

The organisation wanted the deal to include an agreement by retailers not to carry out price-based marketing, cinema advertising to be limited to 18-certificate films and health and unit messages to be included in adverts, among other measures. However the final version was 'clearly the result of determined drinks industry lobbying, coupled with a coalition government seemingly in thrall to business,' said chief executive Don Shenker. 'If the government are going to mistakenly rely on self-regulation to reduce problem drinking, they must clearly state what they intend to do if it fails. All the evidence so far is that the alcohol industry has no interest in reducing alcohol consumption.'

Writing in the *Guardian*, the BMA's associate director of professional activities, Vivienne Nathanson, said that given her organisation was 'so dissatisfied with the deal, and given the government does not seem to accept our concerns, we believe we had no option but to publicly walk away.' Cancer Research UK, meanwhile, did sign up to the deal but said that it remained 'concerned that the alcohol pledges as they stand do not go far enough'.

The deal has been welcomed by industry bodies, however, with the Portman Group calling the targets 'challenging' and the British Beer and Pub Association (BBPA) saying that 'only by working together can we change the drinking culture in the UK.'

Meanwhile, the Northern Ireland Executive has launched a new consultation aimed at tackling alcohol and drug misuse, which looks at 'taking a population approach to alcohol' including minimum pricing. Alcohol misuse is estimated to cost Northern Ireland around £900m each year.

Consultation available at www.dhsspsni.gov.uk/index/consultations/current_consultations.htm Consultation period ends 31 May

News in Brief

LET A HUNDRED FLOWERS BLOOM

Community and grass-roots initiatives are central to addressing problematic drug use, according to United Nations Office on Drugs and Crime (UNODC) executive director Yuri Fedotov. Mr Fedotov's appointment was seen as a 'backward step' by many (*DDN*, 19 July 2010, page 5), with the perception that he would bring a hardline stance to the role. However, he has stated that he welcomes dialogue with all parties, including those with opinions different to those of UNODC. 'Let us not argue on the key issue – there are people who need treatment,' he said.

'RIGHT TO PROVIDE'

The government has announced its 'right to provide' scheme to enable NHS staff to set up as independent organisations to run their own services, 'where clinically appropriate'. Around £10m has been given to the Social Enterprise Investment Fund to support the scheme, which the government stresses is 'not designed to make it easier for private providers to enter the NHS'. 'I've heard from many NHS staff over the years that they could run their services better if they were given room to breathe and felt their voices were heard,' said health secretary Andrew Lansley.

B VACCINATED

Uptake of the hepatitis B vaccine in prisons in England and Wales has increased by 300 per cent in the last six years, says the Health Protection Agency (HPA). More than 80,000 prisoners had the vaccination in 2009, according to *Health protection in prisons report 2009-2010*, with prevalence of the virus among drug-using prisoners falling by 13 per cent. The figures confirmed the need for the continuation of vaccination and screening campaigns, said HPA prison health lead Dr Brian McCloskey.
Available at www.hpa.org.uk

PSYCHOSIS GUIDELINES

New guidelines on the assessment and management of people with psychosis and coexisting substance misuse have been issued by the National Institute for Health and Clinical Excellence (NICE). The institute has also issued a call for GPs in areas of high HIV prevalence to offer routine HIV testing to new patients and anyone having a blood test, as almost half of people in the UK diagnosed with HIV are diagnosed late.
Available at guidance.nice.org.uk/CG120

Another missed opportunity to get tough on the UK's drink problem?

DDN considers whether the drinks industry will always get its own way with 'all carrot and no stick' regulation

The day before last month's budget, a coalition of health organisations including Alcohol Concern, Balance and Alcohol Focus Scotland issued a joint statement calling on the government to make the budget a 'meaningful' one by introducing a minimum price per unit of alcohol.

Perhaps unsurprisingly, the budget contained no such thing. What it did include, as announced late last year (*DDN*, 6 December 2010, page 5), was an additional duty on high-strength beers to avoid penalising responsible drinkers, described by Alcohol Concern as 'tinkering at the edges'.

The government has also announced its flagship 'responsibility deal' between industry, retail and voluntary sectors, something that major players like the BMA, Royal College of Physicians, Alcohol Concern and the British Liver Trust refused to sign, appalled at the lack of industry sanctions (see news story, page 4). So is the government, as Alcohol Concern maintained when it walked away from the deal, 'in thrall' to the industry?

'Pretty much,' says British Liver Trust chief executive Alison Rogers. 'I don't think they're ballsy enough to do anything significant, and I have to say I'm not sure they care strongly enough about the cohorts of people who are affected either.' The trust stated that the deal represented a 'fundamental conflict of interest' – does she believe that self-regulation ever had a chance of being effective? 'In truth I don't think it did,' she says. 'I don't say that because of inherent cynicism, because we've tried to work on this basis since 1992 and seen no evidence whatsoever that it works. I think on the part of some companies it's actually played quite cynically – it's just words.'

Clearly, alcohol is a tricky issue for any government. Balanced against the health and criminal justice considerations are the enormous amounts of tax revenue it brings in, plus it's an emotive issue, to say the least. Labour often seemed to be legislating with one eye on the popular press, and the coalition government is equally mindful of media reaction, but alcohol is far from a black-and-white issue as far as the media is concerned. On the one hand, papers like to thunder that 'something must be done' about 'binge Britain' – usually accompanied by pictures of scantily-clad young women on a night out – but at the same time they balk at anything that looks like 'nanny statism'. When the proposed minimum-pricing framework was first announced, for example, a sizeable proportion of the media appeared to be reacting to something else entirely, as if a pint of beer was suddenly going to cost £6.

The road towards minimum pricing has been a rocky one. The then-chief medical officer Sir Liam Donaldson called for it two years ago (*DDN*, 23 March 2009, page 5) but it failed to find its way into Labour's mandatory code on alcohol (*DDN*, 1 February 2010, page 5), while Scottish MSPs vetoed the measure in the Alcohol etc (Scotland) Bill (*DDN*, 22 November 2010, page 4). The government's preferred calculation now is for no alcohol to be sold at below 'cost price', defined as duty plus VAT.

'They claim to have started the stepping stones with that,' says Alison Rogers. 'A health economist worked out that it might save three lives a year.' Did the trust have any optimism at the start of the responsibility deal process that this time things might be different? 'We thought "let's hear them out",' she says. 'That after 15 years' experience of voluntary codes not working, this government – being new – might push a little harder. We've been saying "let's take a proper strategic approach and not have it run by the industry" – certainly not on the basis of voluntary pledges.'

However, pulling out was far from an easy decision, she stresses, and some organisations, like Cancer Research UK, did sign while at the same time making it clear that they thought the measures didn't go far enough. 'Clearly the people who remain at the table remain a bit closer to government, which means you feel you can have a bit more influence,' she says. 'We agonised over it, but I don't think any of us thought there was much of a chance of the voluntary codes working, because they never have. And the Drinkaware Trust is an absolute joke for something that's supposed to be an independent charity – no one outside the industry thinks it's effective.'

The Portman Group called the deal's targets 'challenging', however. 'It's a nonsense,' she says. 'They're not challenging at all, and some are just regurgitated pledges that they've already made elsewhere. Much of this stuff is being put together very quickly on the back of an envelope, which is part of our complaint about it all – that the government is not taking an alcohol strategy at all seriously. All they're doing is letting the industry say a few things that they hope will quieten down the health campaigners.'

Alison Rogers on self-regulation of the drinks industry: 'We've tried to work on this basis since 1992 and seen no evidence whatsoever that it works. I think on the part of some companies it's actually played quite cynically – it's just words.'
Pic: www.britishlivertrust.org.uk

The trust would like to have seen action on 'the levers that really make a difference', which means a crackdown on advertising and a minimum price of between 40 and 50p. 'It's quite clear to us that people who are drinking excessively do need the nudge of slightly more expensive alcohol to change their behaviour. That's the only evidence-based behaviour change that we've got on the table and they're resolutely refusing to look at it, and I'm quite convinced that's because of drinks industry lobbying. I think it's a decision that's been taken by the Treasury and not by health or anyone else. There's a long history of not being very joined up about this.

'One of the things that is quite striking is that we are seeing liver disease deaths going up on an exponential curve, and there's no doubt that one of the key drivers is alcohol. That shouldn't be ignored, but it is.' **DDN**

LETTERS

ROAD TO RECOVERY – CLOSED FOR REPAIRS

The purpose of the Scottish Government's drug policy set out in 2008 is clear: 'to set out a new vision where all our drug treatment and rehabilitation services are based on the principle of recovery.'

Fergus Ewing in his ministerial foreword highlights the need to reduce problem drug use and get more people back to work. This is emphasised in the policy document: 'The integration of treatment with activities which allow individuals to move towards employment is especially important.'

The services that have been fulfilling this aspect of the Scottish drug policy are now under threat. Progress2Work operates within treatment services to support people into education, training and employment but is now being considered for inclusion in the more generic DWP Work Programme. This will remove the specialist support that was highlighted as being central to the Scottish Government's drug policy.

Fergus Ewing has stated that he is aware of this situation but restrictions on finance make it very unlikely the Scottish Government could substitute resources for those that are potentially being withdrawn by the DWP.

Where does this leave the Scottish Government's drug policy? The road to recovery will close unless we can convince the Scottish Government to address this gap.

Giles Wheatley, Cowal Council on Alcohol and Drugs, Dunoon

TREAT THE PREJUDICE

Dr Ford's latest column was illuminating (*DDN*, March, page 29). I have experienced many disinterested GPs but it was still shocking to read that today's medical training, which includes drug and alcohol knowledge, does not make the slightest bit of difference to some new doctors.

The problem goes much wider than specific medical school training. It is down to attitudes and prejudice that appear everywhere, everyday in our newspapers and on the television. Doctors like Chris Ford are all too rare and there should be more effort by the medical profession to lead by example and inform the rest of society that drug and alcohol problems are to be treated, not used as an excuse to stigmatise.

Stan, by email

SHARE YOUR EXPERIENCES

I'm an MSc student doing some research into individual differences regarding substance misuse. It's about the trajectories people have with their legal and illegal 'recreational' habits, and what influences those who try, don't try, continue or desist in their drug taking. I am looking to see if any of these patterns of use reflect different aspects of personality, hedonism, or risk-taking.

Most research on these topics to date has examined prisoners, people with mental health problems, or undergraduates. I would like to sample the demographic outside these groups, 'snowballing' by word of mouth. I would be very grateful if *DDN* readers would participate by using the following link: http://tinyurl.com/ElaineF

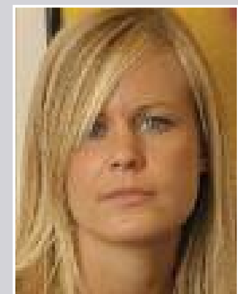
Elaine Fehrman, MSc student, Leicester

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 – please limit submissions to 350 words.

LEGAL LINE

'HELP! THEY'RE STOPPING MY BENEFITS!'



Kirstie Douse, a solicitor working with Release, answers your legal questions in a new regular column

Reader's question:
I've just received a letter saying my benefits are going to be stopped because I failed a medical assessment. I don't know what to do – I really can't work. I'm on methadone, which I collect from the chemist every day. On top of this I suffer from depression and sometimes feel suicidal. This is making everything worse – I can't stop worrying about what's going to happen.

Kirstie says:
You can appeal against the decision that you are able to work. Contact your local Citizen's Advice Bureau or Law Centre to ask for assistance with the appeal. You might get free representation, but if not you can still represent yourself. The process is the same for incapacity benefit or employment and support allowance.

You should have been sent an appeal form (GL24) which you must complete and return as soon as possible (within 28 days of the date on the letter). Once this is received and registered you are entitled to a lower rate of benefit until the appeal is decided and any housing and council tax benefit should be unaffected. The DWP will then review their decision, but they rarely change it so your case will probably be referred to the Tribunal Service for a hearing.

Start collecting supporting evidence about your medical conditions and ability to work. In your case this will be documentation from your drugs worker, methadone prescriber and GP. These should confirm any conditions and treatment, and refer to how these affect your ability to work. If you see psychologists or counsellors, get letters from them too.

The DWP will send you a copy of their submissions, including a copy of the medical report. You can submit a response to this (including supporting documents) as there is likely to be a lot of information that you disagree with. The appeal is not about the way that the doctor or nurse did the assessment – the focus is how you meet the criteria to be considered unable to work.

The appeal can be dealt with on paper or at an oral hearing – it is advisable to have a hearing, as you will be able to answer any questions that the tribunal may have. The hearing is informal and the judge and a doctor who will ask you questions are independent of the DWP. If you win, the decision will be sent to the DWP who will reinstate your benefit at the full amount, backdated to the date it was reduced. This can take some weeks. If you are unsuccessful it may be possible to appeal this decision.

Email your legal questions to claire@cjwellings.com.
We will pass them to Kirstie to answer in a future issue of DDN.

If you have any questions related to a benefit appeal call the Release helpline – 0845 4500 215.

SYSTEM

Roots-up pilot

Peter McDermott describes how Sefton is using peer mentoring to create a genuinely recovery-orientated system

IN APRIL 2009, SEFTON WAS ONE OF SEVEN DRUG ACTION TEAMS AWARDED SYSTEMS CHANGE PILOT STATUS. The Systems Change programme gave areas increased funding, freedom and flexibility and looked to them to deliver a step change in treatment. One of Sefton's great strengths has been its commitment to user involvement, which has permeated the whole of the treatment system for several years. The Alliance had already been working in Sefton, facilitating a local treatment advocacy project, and we'd also helped with a user-led needs assessment in 2008 which had highlighted a number of potential problems.

According to members of the service user forum, it's now extremely rare for somebody to have a problem with heroin or heroin/crack use and not be in treatment. Nevertheless, we went to some lengths to locate people and ask why they didn't use treatment services. Some identified treatment as methadone, which didn't suit them, while others had stigma-related concerns about being seen entering a service. There were also perceptions about lack of access to detoxification and residential rehabilitation facilities, views shared by people both in and out of the treatment system.

People who were relatively young and new to treatment believed they would only remain in treatment for a short period – six months to a year – whereas those who had been in treatment over the longer term tended to believe that they'd still be in treatment in five years time. While this might reflect the relative severity of problems between the two groups, it seemed pretty clear that treatment wasn't doing particularly well in helping to meet people's aspirations for an improved quality of life.

Systems Change pilot status provided the treatment partnership in Sefton with a real opportunity to address these issues. As an area where a large proportion of the population has been in methadone treatment for a long time, the concept of recovery was a challenging one. Many people associated it with abstinence, and there was no shortage of concern that a recovery agenda might mean the withdrawal of opioid substitution therapy. One of the first things we did was hold a number of consultation events – firstly with local service users, but eventually with all stakeholders – to get people to share what recovery meant to them. Eventually we came up with our own consensus statement, which was not a million miles away from the UKDPC's (*DDN*, 28 July 2008, page 5) but had the advantage of local ownership.

One of the key differences with Systems Change was the separation of assessment from treatment, via an independent single point of assessment. Service users had told us that they'd come looking for detox or rehab, but somehow get lost in the system, while providers were rewarded for attracting and retaining people and so had an interest in keeping people in treatment. By separating out

MIC CHANGE

Peter McDermott **and** Mark Fallon **describe Sefton's change pilot from two perspectives**

assessment and treatment delivery we hoped to be better able to match the service user with the treatment that was best for them. A core part of the vision was that mentors would operate from this single point of assessment and that, as people came into the system, they'd not only have an assessment with professionals but also the opportunity to sit down and talk with a peer – someone with relatively recent experience of the treatment system who was doing well and thriving.

There was a consensus, however, that our mentors shouldn't just be abstinent people. We wanted them to reflect successes from all aspects of the treatment system as well as to understand that just because something worked for them, it wasn't going to work for everybody. The mentor's goal was simply to try to have an honest conversation about what someone's treatment objectives might be and to persuade them to think about some of the options they might not otherwise have considered. Whatever option they were thinking of taking up, we would have somebody with recent experience who could talk honestly and openly about the strengths and weaknesses.

We were aware that what we wanted required a relatively high degree of sophistication, and could be a big ask for people who might not have had a job for a long time, if at all, so we needed a mechanism to train and select our mentors. It had been obvious to us was that Sefton was lacking a visible community of recovering people of the sort that can be seen elsewhere, as historically we'd purchased our abstinence-based services from outside the borough – we shipped people off to get clean and they never returned.

One of our goals for the mentors was that they'd provide the basis for that visible recovering community, so it was important that the training course we used to select them was delivered by someone who had been a member of the local drug using community and would be known by many of the candidates. We were extremely fortunate to be able to use a local man who had recently been through Phoenix House and was delivering training elsewhere (see overleaf).

The training was the mechanism that we used to select those suitable for doing the actual work and, over the weeks, it became clear which people were able to perform what we considered a highly professional function. Something else happened during the first training cohort, however. The majority of the intake was drawn from members of the service user forum, with a much smaller number of people who had recently been in rehab or detox. As the course progressed, a growing number of those who had been in long-term opioid substitution therapy decided they wanted to take a stab at detoxification – out of an intake of 12 people, six started some form of abstinence-based treatment as a consequence of doing the mentor training course.

Now we're running the course for the third time, and we've trained 36 mentors in the last nine months. While not everybody will get the opportunity to perform that public-facing role at the single point of assessment, we do try to find people roles that fit with their abilities and their skills.

The primary role of the peer mentors is really one of information giving at the point of assessment. Everybody who enters our new recovery-orientated treatment system receives an assessment from a team that's independent of all of our treatment providers, and before, during, or after the assessment they're able to have a conversation about their treatment options with one of our mentors. The mentors can not only talk authoritatively about their own experiences of the treatment system, they've also had a reasonable grounding in the evidence base, and so can discuss what people's expectations might be depending on the choices they make.

This core role requires mentors who are relatively skilled and confident so we try to have a range of other roles that people who don't have quite as much confidence can perform. These include meeting people who are being discharged from detox or residential rehab to ensure that they don't go adrift between there and their first appointment, accompanying people to their assessment at detox or rehab or just taking them for a first look around. Some of our mentors are regulars at self-help fellowship groups so taking people to their first NA or AA meeting is another useful role, alongside simply being around to make people feel welcome as they arrive.

'As an area where a large proportion of the population has been in methadone treatment for a long time, the concept of recovery was a challenging one. Many people associated it with abstinence.'

As the programme grows, we're finding mentors who are able to take on more specialised roles, and eventually we'll be locating them throughout the treatment system. Some have interests in working with women, or the criminal justice system, while others have a leaning towards harm reduction. All of our mentors have a personal development plan, which identifies their future goals and looks at ways we can support them in achieving those goals, such as through training, shadowing or placement opportunities. Our goal is to make recovery visible throughout the treatment system – and to give people the opportunity to engage in ways that have previously been impossible.

Most recruits for the first mentoring course came from our local service user forum and, as previously stated, the treatment system locally is dominated by people in long-term methadone treatment. Those in methadone maintenance therapy (MMT) who constitute the best examples of people in recovery tend to be the least visible, as a result of the stigma associated with both heroin addiction and MMT. There's very little incentive for somebody in employment to stand up and declare themselves in treatment, and some of those recruited for training weren't able to make the break with patterns of thinking associated with active addiction. While these coping strategies served them well on the street, they were not helpful in a role model context, and excluding some of these people from the programme was extremely difficult as they had been core members of the forum and made enormous contributions in that context.

Working with those who have recently become drug free is also something of a challenge, as there's always a chance of relapse. We try to let people know that they need to be open about this possibility, and the faster they let us know, the faster we can get them back into treatment and into their mentoring role. However, drug dependence and relapse is deeply entwined with people's identity and sense of self, and even though people know heroin addiction is a chronic and relapsing condition, there's invariably a sense of shame. Often, when it does happen, people will either lie about it or drop out of sight completely. Cultivating a culture in which it's OK to own up the fact that you've relapsed and make an informed decision about what happens next is an important part of our future work.

Many people sign up for mentoring because they've had no experience of other

work, and see drugs work as a possible future career. Because of the enormous growth of the field in the last ten years, large numbers of recovering people have been brought into this area of work, but the next few years are likely to see some fairly significant contractions, and we have to be careful that we're not encouraging unrealistic expectations in order to meet our own targets for volunteers.

One final challenge around working with mentors is the occasionally unrealistic expectations of the workforce – it's important to have clarity about what the role of the mentors is, and what the boundaries are. It's important that you don't put either the service user, or the mentor, at risk, and clear expectations and boundaries serve to minimise that.

Although we're absolutely certain that mentors are having a significant impact on our treatment system, demonstrating those outcomes isn't quite as easy as one would like. We're able to count the number of mentoring sessions that are delivered, but that's an output rather than an outcome.

We're also certain that the existence of the mentors has a huge impact on people's perceptions of the treatment system as one that's committed to the therapeutic alliance and working towards mutually-agreed goals. Having said that, this perception is heavily dependent on the existence of an active service user forum, a DAT and local providers that are profoundly committed to user involvement in the decision-making processes, and an advocacy programme that works alongside the mentors to highlight and deal with problems in the system. There has to be a genuine commitment to partnership working, otherwise people will feel as though it's yet another box-ticking exercise. While I believe that mentors can genuinely transform the treatment system at relatively low cost, low cost doesn't mean no cost, and there has to be an adequate infrastructure in place to provide for training, support, ongoing mentor development and expenses.

Sefton's involvement in the Systems Change pilot enabled us to resource this work properly in the first instance, and I think that's been a key aspect of its success. Like many of the changes we've initiated locally, the impact is likely to be most visible over a longer term, because so much of it is about cultural and structural change. Nevertheless, even in an era where resources are dwindling, Sefton is committed to mainstreaming the mentoring programme after the pilot ends this month, and making it a core part of our local treatment system.

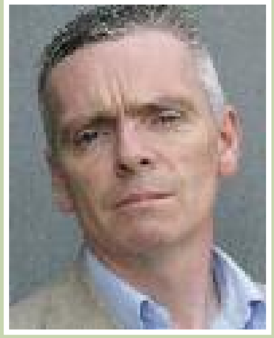
For much of the last ten years, drug treatment has leaned towards a sort of therapeutic pessimism. It's almost as though the field had decided that opioid addiction is a chronic and relapsing condition so it's enough to just put people on a methadone script and forget about them – polydrug users often have complex needs, and given how hard it is to make any significant progress, why bother trying? Mentoring has the capacity to turn around that pessimism by taking successes from the system and rendering them visible for the first time. And not just visible, but right at the heart of our treatment system, using their strengths and experience to build a local community of recovering people.

Quite a lot has been written lately about the importance of local recovery communities. From our experience, these things don't just emerge spontaneously, nor can you commission them. However, you can commission projects that facilitate the growth and development of such a community just as you can make commissioning decisions that are an obstacle to their growth.

Good treatment mentoring projects – those that are well designed, adequately resourced and well managed – are probably one of the biggest single steps that a treatment system can take to facilitate the emergence of a local recovering community, but they are just one component in a recovery-oriented treatment system and can't work miracles without a treatment infrastructure that's supportive of the goals of recovery in its widest sense.

Peter McDermott is policy officer for The Alliance

Learning curve



Mark Fallon, recruited to deliver the training, describes a profoundly rewarding experience

'Week three was when they began to realise just what they'd got themselves into. "Homework? Give us a break mate – I'm not in school anymore."'

I'VE JUST DELIVERED A TRAINING COURSE TO A CLASS OF 11 SERVICE USERS, having been brought in because I'm not a million miles away from using services myself. Since leaving a residential rehab less than two years ago I've started a teacher-training course and have already delivered short courses in other parts of the North West.

The local DAT wanted to recruit and train service users to act as mentors based at their new single point of assessment – an integral part of the Systems Change pilot status – and the group was made up of those who were either abstinent or who had a degree of stability. 'The good news is we have the possibility of attaining two level 2 qualifications – the bad news is that you'll have to do a bit of work first', was how I informed them of our new accredited status with the National Open College Network. It was met with total indifference.

Not a good start, I thought – why aren't they all cheering and slapping each other on the back? Week three was when they began to realise just what they'd got themselves into. 'Homework? Give us a break mate – I'm not in school anymore' was the attitude, with people rolling in 20 minutes late and watching the clock. Some had to have work returned and when two people dropped out within the first three sessions, I had to ask myself if what we were asking of them was just too difficult. I'd already delivered this course twice, but before the accreditation process – when it had 90 per cent retention and was designed to be more 'therapeutic'. Now it was much tighter and more focused.

I have a recurring nightmare where I'm standing, naked, in an empty classroom in front of a flipchart and can't move a muscle, and I began to feel this might become a reality. I felt I was losing them. Was it my teaching style? Their motivation? Was the standard pitched too high? Was my initial assessment rigorous enough?

Well, we were in it now, so time for a little team talk. 'What would you say to someone who said we couldn't do this?' I asked in the best barnstorming voice I could muster. 'What would you say if someone said you couldn't take a group of people like you, people with little education, recovering from years of addiction, and enable them to achieve two nationally-recognised qualifications in such a short time? What would you say?'

'Who said that?' they demanded. 'I'd tell them to fuck off!' shouted one. An extremely reserved young learner said something I didn't hear, which I only noticed because I'd been trying to draw her out. I asked her to repeat it. 'I'd just go away and do it,' she replied.

At that moment, every person in the room got it. The following week I overheard two of the group arranging to meet later in an almost clandestine fashion, but they weren't meeting to partake in anything other than education. This was the beginning of an amazing phenomenon – the study group. As someone who has benefitted from the reawakening that education can bring about, this was almost a spiritual moment.

By the home strait I was almost an irrelevance. One group member had displayed terribly low confidence in his literacy and his ability to complete the work, frequently voicing the opinion that this might be his last session as he was struggling so much. In the final week I saw him patiently helping a colleague to complete an assignment. The personal development involved in that brief encounter would be impossible to measure on a TOPs form.

On the final day a young lad who was stable on his script and tended to work in a methodical, almost painstaking, way finished the last of the 23 assessment criteria. As he sat there exhausted I asked him what qualifications he'd achieved at school. 'Nothing really,' he said. 'I used to enjoy woodwork though.' I informed him that with that last piece of work he'd earned two GCSE-equivalent qualifications. He walked out that day with a little bounce in his step.

These were people undergoing massive change and dealing with issues that the typical student could not imagine – court cases, health issues, fighting for custody of their children, even detoxing while on the course. But by identifying strengths and weaknesses, skills they unconsciously possess, techniques for dealing with challenging situations and possible avenues for future development, they can put in place the first building blocks of a new outlook.

It could be argued that the process is in some ways more important than the product for this group. However, if the two can be aligned – if we can take people on a journey that not only achieves tangible rewards, but intrinsic rewards that cannot be measured – then we can enable them to build strong foundations to improve their lives. For the teacher it's a fine line. But if the right balance between therapeutic and educational aims can be found, you might just be able to make a real impact in a short and precious window of opportunity.

Mark Fallon is a freelance trainer and a member of the Institute for Learning

CHAOS THEORY

With public services in a state of flux under the wave of reforms, a recent London conference looked at how drug services could deliver recovery in a chaotic environment

'There's a lot of change, and a lot of change happening at a time of spending restraint and cuts,' DrugScope chief executive Martin Barnes told delegates at the LDAN/DrugScope conference *Capital concerns – the future for drug and alcohol services*. The drug strategy was just one of the wide ranging and radical reforms either underway or proposed, he said, including GP commissioning, the criminal justice green paper, public health white paper, Welfare Reform Bill 2011 and forthcoming work programme.

The government had 'sent out a clear message' that it wanted to support and build recovery, he said, 'so it's about welcoming that ambition at the same time as being pragmatic about the challenges'.

A reduction in funding of just 2 per cent for the sector was 'significant' in the current climate (*DDN*, 7 March, page 5), MP for Enfield, Southgate, David Burrowes told delegates. However, while the government recognised past progress and investment, the system had been too narrow and prescriptive – 'it's been too target-driven, it's been about processing people'.

'When we talk about recovery, it's important that we get to the reality of it,' he said. 'That has to come about through building those recovery communities that will sustain the funding.' The government was 'passionate about outcomes', he said – health, wellbeing and employment – but when asked whether payment by results (PbR) would 'create the same sort of number crunching you're trying to get away from' he acknowledged that there was 'always that danger with the creation of new processes'. However, local areas would be 'much more incentivised', he promised. 'One of the aims of the PbR pilots is to make sure we don't get into a whole new area of metrics and processes – that would be a failure, and we need to make sure it doesn't happen.'

The challenge was ensuring the system was locally led and locally owned, he told the conference. 'It's a case of "how involved is your local council?" and "how much do your local councillors know and understand about local need?" It also means effective communication and a much greater connection with the public – clear, transparent information going out to local communities that is accessible to local decision-makers.'

However, while localism was 'fully centre stage' in government policy, many local councillors were clearly 'not that fussed about drugs', warned policy adviser for the London Drug and Alcohol Policy Forum, David Mackintosh. 'It's not a priority.' Localism was 'not new', he told delegates. 'Drug action teams were meant to be agents of localism – from a central government point of view, it's nerve-wracking to be giving out hundreds of millions of pounds and not being sure what people are doing with it. What's cause for concern now is that when money is in short supply people tend to adopt very defensive postures and concentrate on core services. If you're in social services, for example, you're probably going to be concentrating on services for the under-fives and keeping yourselves out of court reviews.'

The move from a centralist approach – which 'clearly had its faults' – to a position where much of central government seemed to have 'to some extent abdicated responsibility' and were not providing sufficient guidance had been swift, he said. 'This isn't about nostalgia – if there was a "golden age" then I slept through it.' The problem was not just about localism and money but the whole range of structural change, he stressed. 'There's not a lot of certainty out there about who you're going to be working with and how you're going to do it. It's being called a "period of transition" but that doesn't do justice to the chaos going on – there's no road map. What's needed is consistent and effective leadership, which is not the same as micro-management, and consistent central championing to make the case for drugs as a cross-cutting issue.'

The NHS was in chaos, agreed Annette Dale-Perera of CNWL NHS Foundation Trust's addictions and offender care directorate. 'It's a really difficult time,' she said. 'Go ahead and commission me on outcomes – we all want to be transparent. But let's be realistic. I do well to keep some people alive – they're chronically very sick people – and 35-40 per cent of my service users are over 40 and have never worked. We can improve quality of life and health and wellbeing, but employment is going to be more difficult.'

On the question of PbR, DrugScope's director of policy and membership, Marcus Roberts, told delegates the proposals were not only 'profoundly radical' but part of an overall reform of service delivery that was 'potentially breathtakingly radical'. In other areas where PbR had been introduced, such as NHS acute and mental health care, it had taken 'years and years and years', he said. 'But in our sector the pilots need to be up and running by October. It's going to be an interesting challenge.

'The recovery payment by results is radical because it's about results, not activities, and it's much more ambitious in scope than

'It's being called a "period of transition" but that doesn't do justice to the chaos going on – there's no road map. What's needed is consistent and effective leadership, which is not the same as micro-management, and consistent central championing to make the case for drugs as a cross-cutting issue.'

anything previously attempted,' he continued, adding that it was the providers who would shoulder the risk. 'There is no extra money for this. If it's going to work we need realistic outcomes, we need to be realistic about the small steps on the way, and realistic about relapse.'

There were also the risks of 'cherry picking and parking', he warned. 'And if the outcomes are going to be set by government, where's the space for service user and family input? And how many smaller local and voluntary and community sector services are going to be in a position to manage the risks?'

To deliver radical change, it was important to 'radically change what people get, not just who pays for it', RAPt's director of development, Ryan Campbell, told delegates, which would mean addressing the 'sector's inertia'. 'It's about implementation. Saying isn't doing – we might say we're inspired by vision, but I'd like to be inspired a little more by implementation. We've over-defined the word "recovery" as if it's some kind of biblical text – the definition doesn't matter. People engage with services because they want their lives to be better. We're rebranding ourselves with a recovery focus as if that's not what we were about before.'

The move towards large, integrated services was also a risky one, warned chief executive of Blenheim CDP, Debbie Lindsey. 'We're in danger of losing that focus on individual needs. I'm the CEO of a charity and the issue of "charity" is enormous at the moment. As a sector, we've plugged a lot of gaps in treatment services over the last ten or 15 years, and the danger is that we're seen as the cheap provider.' Small and medium-sized organisations were becoming increasing vulnerable to mergers, she said, which could 'dilute values and ethics'. There needed to be some 'common sense' around change, she told the conference. 'My fear is that common sense is going out of the window.'

One area where this was the case was around getting people back into employment, delegates heard. 'There seems to be an assumption that if we can get people skilled up then the jobs are going to be there,' said the UK Drug Policy Commission's (UKDPC) director of policy and research, Nicola Singleton. 'Obviously, that's not the case.'

'If you're a service user you're going to find a lot more interest in your employment ambitions, and if you're a provider you'll find a lot more emphasis on this issue in terms of outcomes,' said Marcus Roberts. In the UKDPC's stigma research (*DDN*, 22 November 2010, page 6), three quarters of respondents felt that people recovering from drug dependency should have the same rights to a job as everyone else, but there were an 'array of hurdles' said Nicola Singleton, not least stigma. The same research had revealed people having job offers withdrawn, or even being sacked, after disclosure, as well as employees being told to come off methadone even if their performance at work was unaffected.

The drug strategy had been 'borne out of a lot of malevolent thinking', said Debbie Lindsey, and gradually 'moulded into something more palatable'. 'We're basically asking for reintegration from people who are hated by society.' Many employers felt employing former drug users was a risk, said Nicola Singleton, with perceived issues around company reputation as well as concerns about how to manage if someone relapsed. But it was important to recognise these concerns – 'they're running a business, they're not charities' – and provide positive examples, as it was usually lack of knowledge that underpinned the fears. 'We have to recognise that there's a long timeframe, and that's the concern with PbR,' she said, stressing that her organisation was working to ensure that 'interim outcomes' were included in the pilots.

Volunteering was also a key issue, with several service user delegates describing threats to stop their benefits. Although the Department of Work and Pensions' (DWP) official line was that volunteering should not affect benefits (*DDN*, 7 March, page 23), they were effectively 'not in control of many of their Job Centre staff' said Annette Dale-Perera. 'To me it's about survival at the moment, rather than recovery,' said chair of the London User Council, Paul Paterson. 'You've got nothing on your CV, no employment record, no confidence and you're facing all the stigma you get from society.'

'If we're going to raise the bar for service users then we need to make sure we make the cultural changes to allow that,' said Rick Rutkowski of Addaction. 'It's not that we don't have decent and skilled people working in a rich and diverse delivery system, it's that we're still delivering the same services we did back when HIV was seen as the biggest threat. We haven't moved on to asking service users where they want to be in two years' time, five years' time.'

'The key thing, given the massive reform agenda, is that service users' voices are heard,' said Martin Barnes. 'One of the concerns with PbR is that it's getting very technical, and there's a risk that those voices will get lost. Yes, let's improve outcomes, but let's not lose the humanity.' **DDN**

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Questions and Answers

BACK BY POPULAR DEMAND!

Last issue we heard how Carol's personal loss had turned her sense of vocation to despair...

I came into the drug and alcohol field because I lost my brother to heroin. But I'm now finding it very difficult to deal with other people's problems and my feelings of vocation have turned to despair. I don't want to waste my training and experience – what should I do?
Carol, by email

I have seen a lot of people come into the drug and alcohol field led by the need to help others, their motivation based on some experience in their own lives like a death or family member using. But you cannot use this work as part of your own therapeutic process – you must use supervision or an external counselling agency to attend to these feelings.

Workers can quite easily become demotivated and demoralised and can experience compassion fatigue without even realising it – especially when there are such weighty feelings and emotions involved.

My suggestions would be: Evaluate if this is the type of work you wanted in the first place. Seek some good supervision and support for yourself, whether that's internal or external. Then look at how you care for yourself, both in and out of work. Use some strategies to lower your stresses that will help you value yourself and your emotional process.

Above all, attend to the emotional stuff that's coming up for you, because if it's there for you, it could quite easily be picked up and misinterpreted by the people you work with and on behalf of.

If you attend to your feelings, you may find that you are once again able to listen effectively, without taking on other people's stuff, and put all your training to good use.

Peter M, drugs worker

Working in the substance misuse field is one of the hardest yet most rewarding career paths anyone could embark upon. Whatever you do don't give up, take some time off and have some quality 'me' time.

Speak to your supervisor or line manager and tell them how you're feeling. I've been working in the field for the last 12 months after having 24 years of substance misuse issues myself and I wouldn't give my job up for anything in the world.

Sometimes it is hard to distance yourself and not feel affected by other people's problems, but it's something we all have to do. Services need people like you so keep up the good work and don't let all that valuable training and experience go to waste.

Shane Borwell, The Lifeline Project, Redcar

Sometimes it does feel a bit like trying to stay afloat in quicksand. In my experience it is essential to have support both in and out of treatment. It can become very over-bearing when it becomes more a way of life than a vocation.

Lee Collingham, DDN Facebook page

Hold on to the successes in your mind. Get support from those you work with and perhaps try to take a back seat for a while, doing support or activity-based work.

Sian Waters, DDN Facebook page

NEXT ISSUE'S QUESTION...
Can you help out a fellow DDN reader?

We've just been asked to deliver the same service as before but with a massive cut in our funding. Our core cost is staff, but the last thing I want to do is make redundancies. Does anyone have any creative ideas for sharing the burden across the whole of our workforce? *Nicky, by email*

Email your answers for Nicky to claire@cjwellings.com by Tuesday 26 April for publication in our next issue. Send any questions you have about any aspect of your working life or treatment experiences and let our readers help you out.

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

What, for example, do fashion designer John Galliano, actor Charlie Sheen and film director Oliver Stone all have in common? Yes, you guessed it. All are present or former drug addicts – and all have expressed ugly and utterly loopy prejudices and conspiracy theories... The reason the Jews figure so heavily in these rantings is that they have always dominated the paranoid imaginations of conspiracy theorists. Cocaine and other illegal drugs are known to cause paranoia – and these 'luvvies' are or were drug users. Yet no one ever puts these things together. Instead, such drug use is ignored, minimised or indulged.
Melanie Phillips, *Daily Mail*, 15 March

Now I feel like I'm the crazy one, because Charlie Sheen is starting to make sense. Because contrary to what the talking-head television therapists have been saying, addiction doesn't have to end in rehab or death... Maybe people are fascinated with Sheen because he's putting two fingers up to a touchy-feely therapeutic industry that says that in order to kick drugs we have to surrender to a higher power and be humble.
Catherine Townsend, *The Independent*, 17 March

A jobless layabout who receives incapacity benefit for alcoholism was branded 'the embodiment of the welfare dependency culture' when he appeared in court for failing to carry out his community service... The stunned judge vented his anger, calling the defendant a 'sponger' and branding the situation 'extraordinary'.
Daily Mail news story, 9 March

The myth of a safe level of drinking is a powerful claim. It is one that many health professionals appear to believe in and that the alcohol industry uses to defend its strategy of making the drug readily available at low prices. However, the claim is wrong and the supporting evidence flawed.
Professor David Nutt, *The Guardian*, 7 March

Adults who allow children to become addicted to alcohol or nicotine before they know their tables are simply unfit to be in charge of those children, who should be taken away. By the time a child of primary school age has become addicted then teachers should notice, if they are not too busy dispensing sex education to kids whose preferred reading is Postman Pat.
Anne Widdecombe, *Daily Express*, 16 March

Now the evidence that cannabis is a danger to mental health grows clearer each week... Yet in the media and in the government, the falsehood that this is a 'soft' and harmless drug continues. Why? As with cigarettes, because people don't want to admit the truth.
Peter Hitchens, *Daily Mail*, 5 March

While I know it sounds pessimistic, I rather think we irreparably screwed up when we first legalised and promoted alcohol. It is a crippling example of exactly how hypocritical and ill thought-out our stimulants laws are.
Dr Christian Jessen, *London Evening Standard*, 16 March

BECOMING VISIBLE

Dristi Nepal offers much-needed harm reduction advice and services to female drug users. **Gill Bradbury** talks to its programme director and joint-founder, Parina Limbu Subba, about the many challenges ahead

Nepalese women have lower socio-economic status than men within the family and community. On top of this, many female drug users endure sexual, physical and mental abuse in supporting their drug habits, and are trapped in a drug dependent and deprived lifestyle. They are denied access to good nutrition, healthcare and education, making them vulnerable to sexual exploitation, poor health and HIV, and a higher risk of death. The government turns a blind eye to the situation, failing to protect those in most need of support, and leaving them desperate. Suicide remains the biggest cause of death in women aged 15 to 49.

Gill Bradbury: Parina, tell us more about the organisation and what it provides.

Parina Limbu Subba: Dristi Nepal offers advocacy, support and harm reduction services to female drug users (FDUs). We aim to reduce transmission of HIV and viral hepatitis, challenge discrimination, and enable social reintegration. Dependent drug use is largely acknowledged only as a male problem, so women remain hidden and services are not attractive to FDUs. Dristi was founded in 2006 by a small group of female ex-users. We try to offer positive role models, peer mentoring and a feminist approach based on personal empowerment.

The project was initially supported by a friend in the US who helped us with the first six months' rent, then by family and local community members. We've provided a range of services over the years but have been unable to develop comprehensive services because of funding constraints. Our service provision can be inconsistent – currently we're only operating a drop-in centre, needle and syringe programme, outreach and peer education services. Previously we provided opiate substitution treatment (OST), primary health care, structured daycare, life skills training and residential rehabilitation. All too often we have to move because we can no longer afford the premises, and our administrative capacity is reduced every day by 'load-shedding' – daily scheduled power cuts that last at least six hours.

How are Dristi Nepal and other similar NGOs funded in Nepal?

We receive funding from donor agencies, such as United Nations Office on Drugs and Crime (UNODC), UNAIDS and Family Health International. We'd like more opportunities to increase capacity and build on previous successes but grant arrangements don't permit this. Funds are usually only allocated for one year and are sometimes unreliable in terms of regular installments, which doesn't enable strategic planning.

Other funds are raised through canvassing friends and family to collect money from associated networks – for example, we receive donations from Gurkha regiments in Nepal and the UK. We also organise fund-raising events, and recently we started selling second-hand clothes.

What issues do girls and women generally face in Nepal?

Women are second-class citizens in Nepal. We live within a male-dominated, patriarchal society, which continues to influence not just our status and value, but also the extent of treatment and care. Gender bias and inequality exist in each and every sector, and there is little legislation to protect the rights of women in the 14th poorest country in the world. Girls and women aren't afforded equal access to education across different castes and tribes, and are denied basic health and social care.

Many people live in a state of severe poverty and deprivation. Women's lack of educational attainment, with consequent illiteracy, impedes their ability to gain employment and independence. Domestic abuse is commonplace, and girls and women frequently suffer physical and sexual violence.

Girls can be seen as a burden to the family and are increasingly trafficked across

Far left: Parina Subba with women at Dristi Nepal
Left: Gill Bradbury with Parina Subba

'Women are second-class citizens in Nepal. We live within a male-dominated, patriarchal society, which continues to influence not just our status and value, but also the extent of treatment and care.'

the border to India to work in the commercial sex industry. Both the World Bank and UNAIDS have warned that this cross-border sex trade presents a significant public health threat to Nepal, since at least 40 per cent of trafficked women, when repatriated, are HIV positive. Many of these women (and children) are abandoned by their families and shunned by the local community. Those returning from the brothels have virtually no chance of acceptance and may also be drug or alcohol dependent.

It's not known how many women have a drug problem in Nepal, nor how many are HIV positive and/or infected with hepatitis C – there's no research or reliable data. Women remain the most marginalised group in society, particularly FDUs, women living with HIV and women who work in the sex industry – a disregard that threatens public health and creates a significant disease burden.

What are the gaps in service provision relating to the needs of FDUs in Nepal?
FDUs need targeted services and gender-sensitive care, coupled with awareness-raising campaigns. Women must be made to feel less isolated, and empowered to address their drug-using behaviour. There are few residential rehabilitation centres that focus on the needs of women – and those that do can only be afforded by a minority. We need access to crisis and stabilisation centres, alongside free detoxification and rehabilitation programmes that help women achieve abstinence, and which include aftercare services to develop individual life skills and promote employment opportunities.

Provision of OST is wholly inadequate and fragmented. It needs to be hugely scaled up to reach more people, both within cities and in rural areas. It should not be confined to hospitals, which do not have capacity. With longer-term vision and resourcing, properly supervised NGOs could be used to expand treatment reach. Women take less than 5 per cent of the 250 methadone treatment places available in Kathmandu, as they often feel too inhibited to attend services dominated by men.

All services should address the psycho-social experiences of drug users and offer counselling support and motivational interventions. Women have some very basic, additional needs – to be educated, learn new skills and gain employment, so they can earn a livelihood and be independent.

What healthcare is there for people generally?
While most medical services are available in Nepal, there are limited free services, and good healthcare depends on individual ability to pay. Aside from this critical factor, healthcare and hospital services aren't drug user friendly, with FDUs being widely discriminated against.

What treatment provision is there for women living with HIV and/or tuberculosis (TB)?
There are several NGOs, international non-governmental organisations (INGOs), HIV networks and alliances that support people living with HIV. However, they're not always female or family-friendly places. Stigma also persists for HIV positive drug users and FDUs within the women-only care homes, so they find it hard to engage.

Approximately 45 per cent of the total population of Nepal is infected with TB, and there's a significant incidence within drug-using and vulnerable populations. TB treatment is free; we have adopted the directly observed treatment, short-course (DOTS) strategy and other prevention measures are in place.

What screening and treatment is available for hepatitis C (HCV)?
There are limited opportunities for hepatitis C treatment and it's prohibitively expensive. As far as I'm aware, there's no national strategy to address HCV, although a WHO-sponsored, Ministry of Health 'open forum on viral hepatitis' was facilitated in December, which we were involved in.

We do have voluntary counselling and testing (VCT) centres, which screen for BBVs and STIs and provide treatment as necessary. Vaccination for hepatitis A and B is also available, although Dristi is unable to offer vaccinations at the drop-in centre because of lack of resources.

What services are available for women with more complex needs?
Most mental health service users are treated as outpatients and while we do have some inpatient psychiatric units in the country, community mental health services are patchy. The main hospital is in Patan, Kathmandu where there are about 50 beds and more expertise. There are a lot of private clinics too, but these are expensive. Generally, conditions and standards do not compare with those of the UK.

We have organisations fighting for the rights of women and NGOs which support those experiencing domestic abuse, gender-based violence and sexual exploitation. Sadly, many women remain ignorant of them or are physically unable to get there.

Homelessness is evident in many areas and intensified by economic migration. There are some homelessness organisations, mostly concerned with child welfare, but little to meet the specific needs of vulnerable FDUs.

If you could wave a magic wand, what would be happening for FDUs in Nepal now?
There'd be more focus on the needs of FDUs with collaborative partnerships between stakeholders to ensure a comprehensive, integrated approach to treatment and care.

Research must be conducted into female drug-using behaviours, demography and prevalence. A needs analysis and service mapping would mean that effective responses could be planned and implemented.

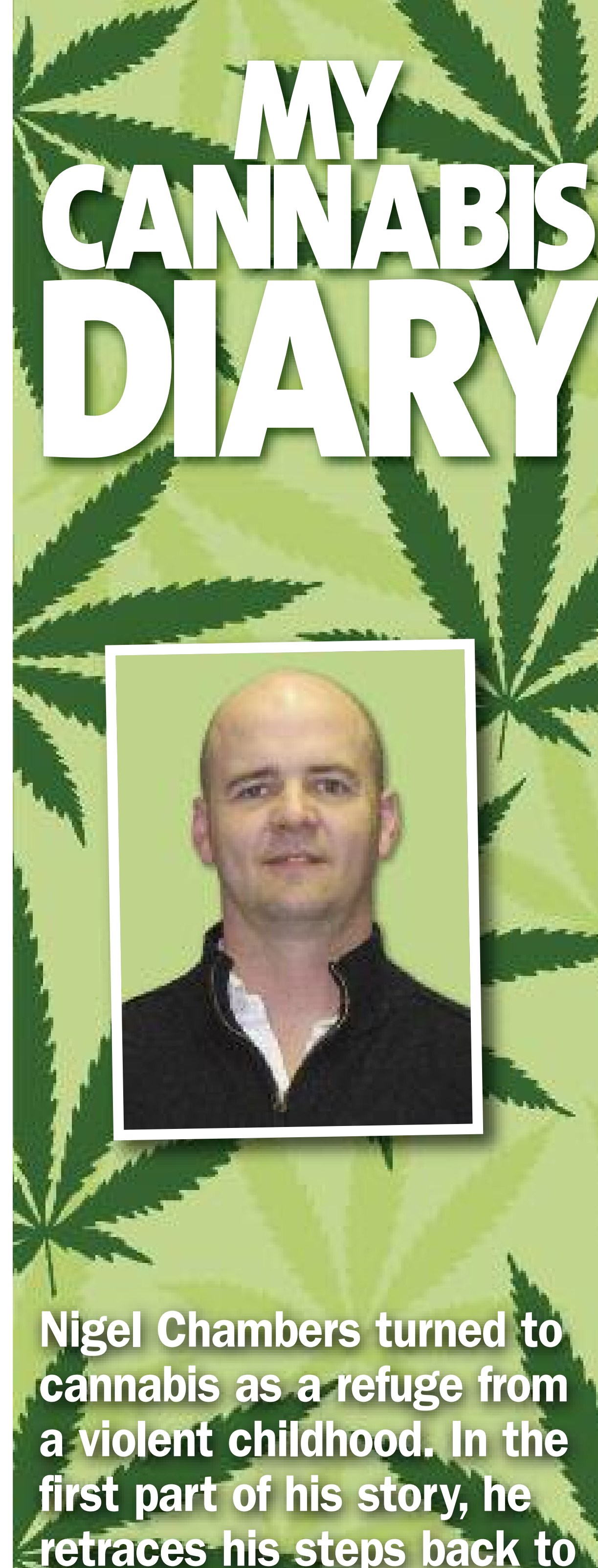
There needs to be longer-term commitment to funding and investment in development from donor agencies. We have to scale up harm reduction and outreach services, OST, residential rehabilitation, crisis and stabilisation centres, HIV/hepatitis respite care homes and VCT facilities countrywide, with access to treatment for sexually transmitted infections, free condoms and reproductive healthcare.

We need a national strategy to address bloodborne virus prevention, transmission and co-infection, with universal access to HIV and viral hepatitis treatment.

Learning resource centres should be developed to increase skills, enable reintegration and give equal opportunities. A training programmme for multi-agency/multi-disciplinary staff would help to change attitudes and improve individual competency, and performance monitoring should be in place for medical staff and drug service employees. **DDN**

Gill Bradbury is an International Advisory Board member and offers technical advice and management support to Dristi Nepal

MY CANNABIS DIARY



Nigel Chambers turned to cannabis as a refuge from a violent childhood. In the first part of his story, he retraces his steps back to his first experiences of a seemingly harmless drug

I HAD A VERY STRICT UPBRINGING FROM MY FATHER. I suffered physical violence and emotional and psychological abuse at his hands. My parents separated when I was 16 as my mother couldn't take any more abuse from him.

My father was a long distance coach driver and one weekend when he went to work my mother plucked up the courage, took my sister, my brother and me, and left him. When he returned, he wondered what was going on and rang my grandparents where we were all staying. He realised that the marriage had ended, so he tried manipulating the situation to get us all back. He threatened to commit suicide, so without my mother knowing I went back to him. After all, he was still my father.

I soon realised that he was manipulating me to get my mother back by acting out suicide bids. He never even tried to commit suicide – it was just an act for me to ring my mum to try and get her back. They sold the house and we moved into my grandmother's house, but I soon realised I needed to be out of the situation as he was still abusing me.

So at the age of 17 I applied to go in the RAF. I passed all the exams, but I failed my medical because I had a dodgy knee. I was so desperate to get out of the situation with my father that when I then found cannabis through friends I began using it daily.

I started off just using a bit of the drug to get through the day and to deal with my father's abuse. I found I could escape from the nightmare and thought I had found the remedy to all my problems. I was still attending college at the time, so I could escape from him during the day, and again at nighttime by using cannabis. It masked all the problems I was suffering and, at the age of 17, I thought cannabis was the best thing since sliced bread. No one could tell me any different.

'I had to make a spliff the night before so I had cannabis as soon as I opened my eyes in the morning, although gradually I was becoming nocturnal.'

I began to be able to handle the things that were happening to me, and as I got more heavily into cannabis as time went on, I didn't realise that I had developed a psychological and physical addiction.

I left college and seemed to spend all my time using, just hanging out with my friends. By then I was using a lot of cannabis – I just thought that it was only a soft drug and I could put it down when ever I wanted to. But it had a hold of me, relentlessly taking all my emotions and locking everything away. I didn't know that by using it I was adding to my problems, which I would have to deal with later on in life.

I couldn't contemplate a day without cannabis in case it let me fall into the same routine of living a life full of hell. Back then it gave me the lifestyle I thought I wanted. Having a comfortably numb mind and body meant that I didn't have to deal with life on life's terms, let alone confront the torment I'd suffered at my father's hands. It was providing me with a happy existence and I wasn't suffering any bad side effects. I got the giggles and munchies – but to everybody who uses cannabis, these are the good and normal effects.

I was leading a life of not bothering about anything connected to me. I didn't care about the way I looked, or the way I treated the people around me. As time went on, my cannabis use got heavier and I became more tolerant of it, so I needed it more and more. It was taking over my life.

I couldn't find the energy to get up in the morning. I had to make a spliff the night before so I had cannabis as soon as I opened my eyes in the morning, although gradually I was becoming nocturnal.

In the early stages of this lifestyle I never thought there was anything wrong with what I was doing. After all, my father was an alcoholic and there wasn't the violence within me to make me think that I was going to walk down the same path. In fact, I wanted to be the entire opposite of what my father had become.

I had so much resentment about the way my father had treated all my family – little did I know that I had already started abusing my family, but in a different way. I realise now I must have put them through so much hurt, as they watched me continuing to be oblivious to the problems I was creating for myself. **DDN**

Follow part two of Nigel's story in next month's issue.

SCHOOL OF LIFE

Fred Breakell describes how a multi-agency group in North Wales is taking an imaginative approach to educating young people about drugs and alcohol

MEIRIONNYDD IS A DISTRICT OF NORTH WALES with a population of around 30,000 and issues of drug and alcohol use among its young people. Communities Against Substance Misuse (CASM) was established to develop educational programmes for children and young people aimed at preventing drink and drug-related problems developing into habitual use in the future. The CASM committee is a multi-agency group that includes the police, youth justice services, Communities First, Tai Clwyd Housing Association, Gwynedd Council, Citizens Advice Bureau, South Gwynedd domestic abuse services and GISDA, a homelessness charity for young people.

The two main projects developed through the committee are Senior Trip Trap, aimed at 13-14 year olds, and Junior Trip Trap, aimed at younger pupils. Senior Trip Trap is delivered at five secondary schools with year 9 pupils, with each school receiving a day of interactive workshops run by agencies including the South Gwynedd domestic abuse services, GISDA, the police, youth justice services, road safety and ambulance services and the school nurse. The nurse explains the long-term effects of alcohol misuse, while the ambulance and road safety team provide a joint workshop showing the dangers of driving under the influence of drink or drugs.

Feedback comments from pupils so far have included 'today taught me a lot I didn't know about drugs – I've made my decision and I will never take drugs'; 'a day full of information – it's important that young people know of these dangers' and 'it helped my point of view and perspective of drug addicts.'

Other initiatives include taking pupils on prison visits and the development of a DVD, and the committee has also obtained funding to invite the Liverpool-based Choose Life project to provide a workshop where ex service users tell the pupils their life stories and describe the long-term effects their decisions have had on their lives and the lives of their families.

Junior Trip Trap came about because the committee was concerned that some pupils were already drinking heavily and smoking by the time they reached year 9, so a project was developed to target year 6 primary school children. All 36 primary schools in Meirionnydd are invited to attend a one-day event at a local theatre, again with different agencies providing workshops highlighting the perils of substance misuse.

The committee obtained funding to commission a professional theatre company to write and produce bilingual scripts that reflect issues in the local community, and put on stage productions showing how drugs and alcohol can affect not only physical and mental health but relationships with family and friends and future prospects. The main emphasis is on peer pressure, and at the end of each scene the pupils are able give advice to the characters and ask them questions, before being invited onto the stage to show how the characters could have reacted in a different way.

'All the plays were very good, but the last one was very hard hitting,' a representative from the local police told us. 'The initial stages of the girl's downfall into drink and drugs almost mirrors problems we're experiencing with a 14-year-old in Blaenau at present. Very good.'

Feedback comments from Junior Trip Trap pupils, meanwhile, included 'it was a fun way of learning'; 'I will never forget what I've learned here today'; 'I didn't think that alcohol would affect that much of your body' and 'it helped me to understand the consequence's of drinking alcohol'.

CASM also identified the need to work with pupils who are not in mainstream education, such as those in the pupil referral unit (PRU). The students – whose ages ranged from 12-16 – were taken on a trip to Altcourse prison where they were able to talk to some of the prisoners and see the impact prison can have, with the aim that they re-evaluate their actions and strive for a more positive future.

The committee is now working to develop relevant resources, such as a joint project with Coleg Harlech WEA to produce a DVD in Welsh to address substance misuse issues specific to the area, with local youths as actors. Evaluation is a key component of improving and implementing future projects, and we've used a variety of methods to gain feedback on our events including the views of pupils, young people, teachers, multi-agency staff and committee members.

In all of our projects we've tried to fully utilise local resources and work with partner agencies and service providers to highlight the dangers of drug and alcohol misuse to pupils of all ages. Has it worked? Only time will tell. **DDN**

Fred Breakell is community development officer at Tai Clwyd housing association

RAISING THE BAR

Dr David Best is an outspoken critic of the culture of 'learned hopelessness' in drug treatment services. He tells David Gilliver **why the sector needs to concentrate on building success**

One of the most vocal and eloquent champions of the recovery agenda, David Best is set to leave the University of the West of Scotland in May to take up a two-year post as associate professor of addiction studies at Melbourne's Monash University. 'It's exciting, and nerve wracking,' he says. 'It's effectively a long sabbatical, but I'll be continuing with a lot of the work I'm doing here.'

That work has been to tirelessly champion recovery, responding to accusations that it is ill-thought-through and lacking evidence via prolific articles and conference appearances, while becoming frustrated at attempts to categorise what is essentially personal. 'It's a complicated subject that doesn't lend itself readily to simple classifications, and obviously that's challenging for people,' he says. 'There are two groups it makes it very difficult for – one is policy makers and the other is academics, because how do we start measuring something that's so personal and so individual? That's compounded by the fact that we're talking about something that shifts – capturing it is difficult.'

It is the 'potential openness' of the recovery agenda that allows the 'nebulous' tags, he believes, often from people with vested interests in maintaining the status quo. 'There are people who are threatened by this agenda, and it means that people like myself have to go for some kind of operationalisation – to start counting some of the things that we think are interesting – but it doesn't mean we're capturing it in some way. And that twin-track approach is difficult, and does leave us open to various kinds of accusations.'

In the light of all that does he get wearied by how divided the sector has become? 'I think we go through phases of this, but yes I do, and I do find the personalised attacks and constant polarisation difficult things to deal with. It doesn't serve us very well, and it doesn't look impressive to the outside world that there's such barbaric discussions. We don't move forward very quickly – we get stuck in a rut of the same problems recurring time after time.'

He came into the field 'largely through opportunity and chance', he says – there was no Damascene moment. 'I've got some family connections with the area, so that was part of the reason, but I was doing my PhD and got the opportunity to do some work with John Davies at Strathclyde University. There was no sense of mission.'

Have his views changed since then? 'Oh absolutely, both in terms of delivery of treatment and philosophy of addiction. In some sense I've almost come full circle. John Davies' view was very strongly *The Myth of Addiction* – his most famous book. His argument was that it was a social construct and it was very convenient to label people in this way. I'd no longer subscribe to that view. Having worked in clinical services on and off for years I'm very much of the view that addiction is a reality for many people, but we massively understate the possibility and the likelihood that people will eventually come out the other end.'

One of the problems, he believes, is that treatment has become largely a self-serving industry, where clients are processed and 'in far too many situations not treated with the personalisation and humanity that enables them to start making decisions about long-term recovery'. Much of this has been the inadvertent consequence of policy, he states. 'I think *Models of care* as a service framework has had a whole series of negative, unanticipated consequences – the huge number of people that services have been required to deal with has led to a processing model based primarily on methadone.'

The most important role drug workers can have is to create a 'therapeutic alliance' that enables belief in the possibility of change, he stresses, putting clients in touch with people and communities that allow them to see what's available for themselves. 'We've created a model where we focus far too much on capabilities of specialist workers and doctors to turn people around, when that's well outside their gift. They should act as a bridge to icons of recovery in communities of recovery.'

Does he get the sense that this is actually happening on a significant scale? 'Absolutely, and it's not even new,' he says. 'When people have had housing or relationship or debt problems there's always been an aspect of drug work that's been about effective linkage into some of these other things, but its centrality has been downplayed. The notion that there are life preconditions before sensible recovery options are possible – a safe place to live, some basic human rights and choices – has been underplayed. That's to some extent what I mean by my views

'We've created a model where we focus far too much on capabilities of specialist workers and doctors to turn people around, when that's well outside their gift. They should act as a bridge to icons of recovery in communities of recovery.'

coming full circle. I'd probably subscribe to the model that addiction is an imbalance disorder – the onset may well have physiological and neurochemical substrata, but the resolution of addiction is primarily about social factors as the driver towards personal change, and the growth of personal recovery capital.'

But isn't all that under very serious threat these days – is he worried about the impact of the economic situation and drastic cuts in services? 'Of course, but there's a real danger that it just adds to a sense of bleak pessimism and gloom for our clients. Obviously at times like this it's much, much harder. I've heard several people say that the recovery agenda is incredibly mistimed because it coincides with an economic downturn, but people have the right to make these decisions and choices irrespective of whether they can walk into a job today or tomorrow.'

An 'unanticipated consequence' of the harm reduction agenda has been 'to convince workers that they really shouldn't set their goals too high', he believes, and coupled with the time pressures imposed by targets has meant 'an appalling reciprocal dynamic of sharing pessimism' with clients. 'You go into services and think "the last thing I'd want to do is try and get better here", because the workers themselves are just disenfranchised. Of course it doesn't happen everywhere, but it happens in too many places to just dismiss it. We do need to focus much, much more on success building.'

He is, however, under no illusions and accepts that will take 'a long, long time' to address. 'But I don't think that's grounds for thinking it's not going to happen at all. One of the big challenges is that some of the people who have perhaps benefitted from nothing much changing, nothing much happening, are going to have to buy into the recovery agenda, and obviously that's asking a lot.'

He believes the field has made progress in some areas, but certainly not in terms of the knowledge base. 'I don't think there's a very good research evidence base, and what there is has been massively shaped by a very narrow agenda. It seems to me that the same people who frequently sit on research commissioning groups and say that recovery is not an appropriate area for research are then the people who'll say "there's not much evidence in this area". Well there's not much British evidence because there's been little or no encouragement from policy makers to develop it. There are encouraging signs that it's getting better, but internationally it's not a problem – I see it as one of the more vibrant and exciting areas. There's a whole range of people doing some great work.'

It's this work that he intends to build on and develop in Melbourne. 'One of the interesting things about working out there is that they're relatively recession-proof, so there's the availability of resources. And Australia is very embedded in the harm reduction model, so it will be very interesting to see how they adopt to perhaps a different philosophy and approach.' **DDN**

Post-its from Practice

No pain relief, no gain

Don't forget pain relief in the recovery debate, says Dr Chris Ford

TWO MONTHS AGO ONE OF MY PARTNERS CAME TO SEE ME TO ASK ABOUT A PATIENT. Johnny had been registered for six years, had used opioids for 12 years and then two years ago had become drug free after successfully completing rehab. He had started using heroin as he hadn't been able to get effective relief for pain in his hip and pelvis, which he had smashed up badly in a motorbike accident. He found heroin really worked, began to use more and soon developed a dependency on it.

Johnny was requesting that my partner prescribed dihydrocodeine, which he had been using for several months, as his pain had returned with vengeance after he became drug free. She was concerned that she would be helping to trigger a relapse. I agreed to assess him the next day.

When Johnny walked in I could see he was a man in great pain. He explained that the pain had restarted days after leaving rehab but by using meetings and psychological support he had been able to avoid use of any analgesia for several months. He had then started buying codeine preparations, had not injected and had slowly begun to feel well enough to use his ongoing counselling and meetings constructively again. He had been using 2 x 30mg dihydrocodeine for four months and had picked up no other drugs.

Chronic pain is too often forgotten in people who use drugs. We know 10-25 per cent of people who use opioids say they start because of pain and the prevalence of chronic pain is between 30 and 50 per cent in treated substance users, compared with 10-15 per cent of the general population.

Under-treatment is common and often based on a whole series of misconceptions, including that opiate substitution treatment (OST) provides adequate analgesia and the pain complaint may simply be a manifestation of drug-seeking behaviour.

The assessment of chronic pain in the context of substance use is complex and time consuming, and needs not only to take account of the pain history but also provide a mental state assessment. The early prescription of adequate effective analgesia reduces the risk of persistent pain. (See *Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care*.)

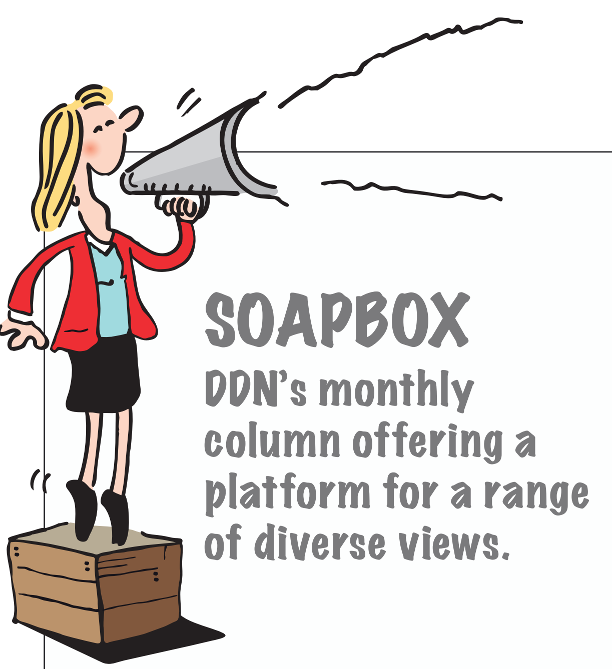
There is no evidence that using opioids to treat pain will trigger relapse. It is more likely that inadequate analgesia and the stress associated with pain will play a role in relapse and continued use.

With this in mind we agreed to prescribe for him weekly because the risks of forcing Johnny to use the black market were far greater. I saw him yesterday in the emergency surgery where he had brought his son with a temperature. He looked cheerful and said he was well. He was on the list for a new hip, his pain management remained the same and his home support meeting had not barred him for using analgesia.

In our move towards a recovery-focused system let us respect that pain needs treatment in its own right.

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



WARNING SIGNS

Are unskilled drug workers starting to jeopardise client recovery and service contracts? **Andy Ashenhurst** is concerned.

I deliver drug and alcohol education to undergraduates at the University of Kent and I've become aware of a growing chorus of concern about the future of substance use education in the higher education sector. Circumstances appear to be coalescing to threaten a key area of training for those working on the frontline with clients with drug and alcohol problems.

For some time now, service providers in the voluntary and statutory sectors have been delivering basic drug and alcohol training in-house to their practitioner staff, particularly new recruits. From the service provider's perspective this is understandable. But is it acceptable?

In a climate of competitive tendering, delivering basic in-house training cuts costs, while at the same time rendering such trainees less attractive to the competition – where the qualifications gained typically have no validation or are at a low level. Trainers are often not qualified to teach and can end up delivering sessions on topics like dual diagnosis or CBT that lack a coherent theoretical context or a bigger biopsychosocial picture. I know of a certificate in community justice being taught at a further education college with four basic drug and alcohol related units in a total of eight – this is not to critique the course *per se*, but many students completing this one-day a week, one year, level 3 course are snapped up by local service providers where they are employed as 'qualified' drug workers.

Uncertainty about upcoming fees for all higher education programmes is threatening drug and alcohol undergraduate courses – my students worry that their employers will no longer be able to send them to us because of cuts, while colleagues in higher education around the UK tell me their drug and alcohol programmes are being closed or threatened with closure. Those of us working directly or indirectly with this client group all agree that education for practitioners should be maintained and improved, not dumbed down, as much of the work of frontline drug workers is similar in character to that of social workers, with elements of psychology and mental health nursing – no easy task. I was a front line practitioner myself for five years.

As the costs of higher education undergraduate programmes are increasingly out of reach of many students and their employers, further-education level courses – short two-to-three-day courses from the private sector and in-house training – will increasingly take up the slack. But problem drug and alcohol users are a complex client group, needing expert skills and professional input. Having poorly trained practitioners with large caseloads risks offering below-par interventions that fail clients.

The 2010 Drug Strategy introduces a recovery agenda and reveals ambitious programmes with radical expectations, but there is no mention of the training or education needs of the practitioners expected to deliver this agenda. The strategy seeks to commission umbrella services from initial client contact through treatment, reintegration and into work – there are major challenges here for skilled professional teams, let alone someone with brief in-house training or a level 3 certificate.

If service providers under financial pressure start to sacrifice training budgets it could trigger a competitive race to the bottom. Drug and alcohol services are unarguably essential for the benefit of users and society at large, so it's equally essential that they are staffed with skilled practitioners – otherwise why bother? This must be a strong case for ring fencing all training elements within budgets.

The voluntary sector in particular does a brilliant job with Cinderella budgets – maybe too well for their own good, as it's now taken for granted by governments that they will work for peanuts (*see conference report, page 12*). Is this the Big Society? The lowly status of many frontline drug workers also compounds tensions in a multidisciplinary workplace, where professional colleagues – nurses, doctors, social workers, counsellors – often see drug workers not as equals but as unskilled (which many are) and not to be trusted with confidential information. This can be humiliating for the staff involved, and more importantly detrimental to the care of clients. These things are not happening everywhere, at least not yet. But it is increasingly worrying that key front line staff are being systematically deskilled and therefore undermined.

Payments by results is coming, the demand for successful outcomes will grow, and drug workers will be under increasing pressure to get clients through recovery to completion. Poorly trained practitioners will be expected to work to a high therapeutic standard and deliver successful outcomes, and the same people could find themselves at the sharp end when outcomes are not met or clients complain about the service. This prompts me to ask whether poorly trained staff will be a key factor when service contracts are lost because of poor performance. **DDN**

Andy Ashenhurst is a lecturer in the psychology of dependence at the University of Kent and an executive member of the Substance Misuse Skills Consortium.

Photo: John Migden, whitelightphotography.co.uk

recovery communities

GREATER CHOICE OFFERS UNIVERSAL BENEFITS

Bringing different treatment choices together under one provider helps keep clients at the heart of the treatment journey and can provide the flexibility to give everyone the best chance to begin drug and alcohol free lives. Tom Kirkwood **talks about the experiences of TTP and Inward House Projects (IHP) following their recent merger.**

Walter Lyon House *in Lancaster, with its purpose-built extension and accessible facilities, has not housed clients for two years but will reopen in May following the amalgamation of TTP and IHP.*

THE BENEFITS TO CLIENTS of offering a diverse range of rehab and detox treatment modalities and settings are huge. We all know that every client is unique, with different needs, experiences and responses. What works for one isn't necessarily going to give the best results for others.

With us, a client may start with medically managed or medically monitored detox but can step up or down between the two as required. We can then provide rehab in a community or residential setting and there are options of 12-step, Therapeutic Community or Integrated Therapeutic treatment modalities.

Offering options 'under one roof' has benefits for clients, referrers, funders and communities:

» *Clients have control of their recovery pathway*
» *Referrers can work with clients to make decisions about the care plan, seamlessly transferring to other settings or modalities as dictated by need*
» *Clients do not need to be discharged back to the referring community and so successful completion rates are higher*
» *Pricing remains the same, so there are no financial shocks for funders*
» *Clients are the major stakeholder in their care plans and are able to deal with lapse and relapse in a safe therapeutic setting.*

Probably the most important advantage we see of a broad treatment spectrum is the ability to respond quickly to need. For example, if a client is struggling in a community setting, we can move them quickly to full residential services and vice versa. Or, if the spiritual nature of 12 step is not working for them, they can try a different treatment modality. All this can be quickly and easily arranged with the minimum of fuss and turbulence, allowing the client to continue to focus on their pathway to recovery.

100 EXTRA BEDS CONFIRMED IN FIRST STAGE OF TTP AND INWARD HOUSE PROJECTS PARTNERSHIP

The recent merger of TTP and Inward House Projects (IHP) has created an extensive organisation with the capability to expand quickly and effectively, bringing more beds and more choice to the sector. More than 160 staff, including 11 GPs, 22 nurses and some 70 qualified psychotherapists and social workers, are supported by 100 volunteers and clinical placements across the country. Over 80 of these volunteers are working towards NVQs or on an apprenticeship with TTP, just part of the organisation's commitment to the future growth of addiction treatment.

In the first phase of TTP and IHP joint working a number of new facilities are being opened, cementing the partnership and making more than 100 extra beds available to the sector.

» *In Lancaster, a 20-bed secondary stage unit with a Recovery Academy model will open at Walter Lyon House in May. The recent merger has saved the centre, which is being brought back into service after two years.*
» *Withnell House, another IHP centre whose future was secured by the partnership with TTP, will expand shortly afterwards, opening a 13 bed detox unit bringing much needed inpatient detox capacity to Lancashire.*
» *TTP's first Integrated Therapeutic Community Rehab will open in early summer at TTP Bradford. It will combine the existing 12 bed Inpatient Detoxification unit with a new Community Rehab of 24 beds on the same site.*
» *The existing day care programme at TTP Coventry will be augmented by a Community Rehab model, increasing the bed capacity from 10 to 24.*
» *IHP will open and manage third stage Recovery Housing for TTP in Sefton and the Wirral where 12 and 20 beds respectively have been funded by DoH capital grants and TTP investment.*

As well as these confirmed openings, further expansion is planned. It is hoped that up to an additional 300 beds will come on stream in the coming 18 months spread across inpatient detox, residential rehab, community rehab and third stage recovery housing.

Hayden Duncan, Executive Manager at IHP, will be responsible for the new accommodation: "So many new centres opening means a lot of challenges for us but we're ready for that and have everything in place to ensure that things go smoothly and successfully," he said.

"It's important that move-on housing and support provide options for those in recovery. Shared housing, private and housing association properties all play a part in creating individual support packages. We aim to offer real choices for clients and referrers alike," he continued.

For more information visit www.ttprecoverycommunities.co.uk or call 0845 2413401

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www.mds.bham.ac.uk

Conference Swansea May 19th 2011

MARRIOT HOTEL, SWANSEA

About the conference:

Naloxone has the potential to save lives and is increasingly being accepted as a valuable intervention in efforts to reduce overdoses and drug related deaths. There is a growing interest in the use of naloxone with heroin and opiate users and a greater recognition of its role within a wider range of treatment and support in reducing harm and supporting recovery. Various schemes of take home naloxone are in place across the UK and the conference will hear from experts from Wales, Scotland and England.

Key note speaker: Dr Sarz Maxwell – Chicago Recovery Alliance, USA

Dr Sarz Maxwell is the medical director of Chicago Recovery Alliance in the United States. Dr Maxwell is a passionate advocate of wider use of naloxone as a tool in the prevention of drug related deaths. She has been involved with the first large scale distribution of naloxone and is widely regarded as one of the pioneers of using naloxone with opiate users.

Speakers:

- *Karin Phillips, Head of Community Safety Division, Welsh Assembly Government*
- *Danny Morris & Neil Hunt, Leading Harm Reduction Consultants*
- *Professor Trevor Bennett & Dr Katy Holloway, University of Glamorgan*
- *Steve Swindon & Marcus Fair*
- *Chris Moore, Governance Integration Manager*
- *Andrew McAuley, Chair Scottish Naloxone Network*
- *Michelle Judge, National Treatment Agency*
- *Prof Sheila M Bird, Senior Statistician, Medical Research Council*

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Delegate fee: £55
To book contact Martin Jones, Swansea Drugs Project, 73/74 Mansel Street, Swansea SA1 5TR.
Email: mjones@swanseadp.org.uk. Telephone: 01792 472002

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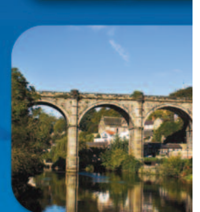
The RCGP 16th National Conference: working with drug and alcohol users in primary care



The public health agenda: making patient centred care the imperative

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RCGP Royal College of General Practitioners

For more information, please call Matt on 020 8541 1399 or email matt@healthcare-events.co.uk
Alternatively visit www.healthcare-events.co.uk

WHERE NOW FOR WOMEN SUBSTANCE MISUSERS?

Brighton Oasis Project
24th May 2011
Audrey Emerton Building, Brighton

New drug strategy • Recovery and reintegration
The Big Society • Munroe Review

WHAT DOES IT ALL MEAN FOR WOMEN AND THEIR CHILDREN?

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- *Women offenders*
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Following the success of our Women & Children First? Conference in 2010; this year we will bring together speakers from a variety of disciplines to address and debate the issues affecting female substance misusers and their children in the new economic and political climate. Themes to be covered in both plenary sessions and workshops include:

- *Communicating with children affected by substance misuse*
- *Domestic Violence and substance misuse*
- *Addressing Women's needs in Primary Care*
- *Gender specific recovery for female drug misuse*
- *Safeguarding Children*
- *Meeting sexual health needs of women substance misusers*
- *Working towards recovery*

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EXPRESSIONS OF INTEREST

The Conwy and Denbighshire Community Safety Partnerships' Substance Misuse Action Team wish to invite expressions of interest from suitably qualified Service Providers for the performance of the following contract:

To provide a Children and Young Peoples Substance Misuse Service within the Counties of Conwy and Denbighshire. The Service Provider will be expected to deliver a range of substance misuse services to children and young people including a Tier 1 Universal Education Programme, a Tier 2 Prevention and Early Intervention Service, a Hidden Harm Service and a Tier 3 Structured Treatment Service, as well as linking in with Tier 4 services.

The Contract will be awarded for 3 years with an option to extend, with an anticipated start date of September 2011.

The tender process will follow the restricted procedure.
The Pre-Qualification Questionnaire (PQQ) will be evaluated on the basis of: Financial Appraisal, Previous Experience, Commercial Aspects, Quality Assurance Methods, Policies and Procedures.

Expressions of Interest by formal request should be sent to: Lynne Vincent, Contracts Officer, Conwy County Borough Council, Town Hall, Lloyd Street, Llandudno, LL30 2UP. Telephone 01492 574127, email lynne.vincent@conwy.gov.uk ***no later than 12 noon on Monday 18th April 2011.***

Following which the PQQ and briefing document will be sent to the Service Providers who have expressed an interest in this Contract.

The closing date for completed PQQ submissions is:
12 noon Friday 27th May 2011.

This advert is also placed on **www.sell2wales.co.uk**

THE LONDON BOROUGH OF BEXLEY IN CONJUNCTION WITH BEXLEY DAAT INVITES EXPRESSIONS OF INTEREST FOR THE PROVISION OF A STRUCTURED COMMUNITY-BASED DRUG AND ALCOHOL SERVICE AND THE DRUGS INTERVENTION PROGRAMME

The London Borough of Bexley on behalf of Bexley DAAT is seeking expressions of interest from suitably qualified organisations for the provision of the following services:

- *A non-specialist structured community service for adult drug and alcohol users*
- *The Drugs Intervention Programme team as defined by the Home Office's Operational Handbook for a non-intensive borough*

Expressions on interest are invited from organisations for either one or both of the above services.

This opportunity will be formally advertised on the London Tenders Portal from **Monday 14th March 2011** and further information will be available via this route. If you wish to apply for this opportunity, please follow the steps below:

- *Register your company free of charge on the London Tenders Portal via www.londontenders.org. You will then receive an email confirming your username and password.*
- *Log into the London Tenders Portal from Monday 14th March 2011 and express your interest in this tender opportunity.*
- *Once you have expressed an interest, you will shortly receive a second email containing a link to access the pre-qualification questionnaire.*

The closing date for registering expressions of interest is 12.00pm on Friday 8th April 2011

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ADULT SUBSTANCE MISUSE TREATMENT SERVICES IN HERTFORDSHIRE including CRIMINAL JUSTICE PROVISION

CONTRACT REF: HCC1104158 – (ACS-CEN- 351)

Following an extensive programme of consultation, Hertfordshire Joint Commissioning Partnership on behalf of Hertfordshire County Council and Hertfordshire NHS are seeking Expressions of Interest from suitably experienced and competent organisations to deliver the whole range of community substance misuse services to adults including those provided for Criminal Justice service users in Hertfordshire.

The provider will be expected to deliver innovative services to produce outcomes aligned to Recovery & Reintegration.

THE NEWLY DESIGNED COUNTYWIDE SERVICES WILL INCLUDE:

- *Intensive Interventions for complex service users*
- *Prescribing provision for other service users*
- *An integrated and connected pathway of provision which will support service users and their family/carers in the process of recovery and reintegration provided through locally based Hubs and Satellites*
- *An integrated provision which will encompass Criminal Justice interventions including DIP, DRR, ATR*
- *Open access provision*
- *Pharmacy and Community syringe distribution*
- *Defined interventions for alcohol users with pathways from access to discharge including community detoxification*
- *Innovative approaches to deliver ambitious outcomes for service users*

The annual contract will be in the region of £7.5m in the first year.

It is anticipated that the contract will be awarded for 7 years and will be dependant on funding, performance and flexibility to meet changing demands, with a planned start on **1st April 2012**.

TUPE will apply.

Either single provider or Consortia/Partnership bids will be welcomed and considered. However, the contract will be awarded to a single legal entity.

THIS IS A 2 STAGE TENDERING PROCESS:

*Stage 1 – Completion and submission of Pre-Qualification Questionnaire (PQQ) – **Noon on Friday 13th May 2011***

*Stage 2 – Completion and submission of the Invitation to tender (ITT) – **Noon on Friday 29th July 2011***

The information and documents for this application will be accessible at www.delta-esourcing.com using the Tender Access Code (TAC) Q632YE25S6