17 January 2011
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DDN
Drink and Drugs News

HOME AND AWAY
Local versus out-of-area treatment – is there room for both?

TRADING MODELS
The NTA consults on a replacement for *Models of care*

'Are you actually in the present, or are you living through memories of the past?'

FROM THE ASHES

NEW LIFE THROUGH EMPOWERMENT – SIMPLE STEPS AND COMMON SENSE

Your fortnightly magazine | jobs | news | views | research

BAC Safety

HOW DRUG-FREE IS YOUR SERVICE?

HOW SAFE ARE YOUR STAFF FROM NEEDLE STICK OR OTHER INJURIES?

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- ✔ Eliminating needle stick injuries
- ✔ Maintaining a drug-free, safe environment

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"I was admitting a client to detox and thought to myself, slow down, Phil, remember your BAC Safety training. Thank goodness I did, because the 3rd pocket had a needle in it covered in blood." *Phil Bowman, Support Worker, West Midlands*

www.bacsafety.co.uk **email: enquiries@bacsafety.com** **telephone: 07581 345872 or 07815 497366**

BAC Safety

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Editorial - Claire Brown

Fresh inspiration

On the upside of change

Welcome to our first issue of the new year. We have policy updates for you – the NTA explains proposals to replace *Models of care* on page 10; new resources – Alcohol Concern introduces new outcome measures for alcohol services on page 11; and a fresh look at local treatment services versus out-of-area provision on page 14. John Ryan gives insight into his experiences working with harm reduction in Australia (page 12), while Brendan Georgeson gives a motivational account of organising Bristol's first dual diagnosis recovery conference. And we're pleased to welcome Release's first legal column, as Niamh Eastwood explains the complicated landscape of welfare reforms. Niamh will be among the speakers at our DDN/Alliance service user involvement conference in Birmingham on 10 February – our fourth annual event, can you believe? The DDN team will be there, and we hope to see you. The debates this year will be more crucial than ever.

In the tradition of the new year, our cover story offers a motivational outlook that's based on common sense and practical self audit, which we hope will be useful to pass on to clients as well as spurring you on in the current climate. The article might not be everyone's cup of tea – you only have to see the letters on page 8 to realise that one person's motivator is another's irritant – but we hope the simple steps to empowerment offer inspiration for re-engaging clients in all kinds of situations.

And talking of change, after much deliberation, we have decided to change your fortnightly magazine to a monthly frequency – so we'll be out on the first Monday of every month, starting on 7 February. We read your survey responses, looked at the transition of much of our print advertising to online, and decided to adapt our format. We'll be enhancing the magazine and website, bringing you everything you need to keep you up to date and informed. The most important thing to us is that DDN remains free of charge to our much-valued readers.

This issue

FEATURES

REGULARS

News in Brief

Drug deaths

The NTA has published an updated guide to setting up a local review process into drug-related deaths. The guide, which includes case studies and useful advice, sets out the chain of decisions that partnerships will need to consider in establishing a review process or improving an existing one. *Available at www.nta.nhs.uk*

Mexico counts the cost

Around 35,000 people have been killed in drug-related violence in Mexico in the last four years, the Mexican government has revealed, including more than 15,000 in the last year alone. President Felipe Calderón declared an offensive against the country's drug cartels soon after taking office in December 2006.

Medicinal crackdown

Hundreds of traditional herbal medicines will be banned from sale in the UK from 1 May, following an EU directive requiring the products to be licensed or prescribed by a registered herbal practitioner. 'Even though some products have been sold for a long time they can still cause health problems or interact adversely with other drugs,' said head of life sciences at law firm Eversheds, Janet Knowles. Producers will need to demonstrate that their products have been used safely for 15 years within the EU, or 30 years outside.

Family training

Alcohol Concern has announced a new Family Training Academy to equip practitioners with the skills to work with children and families affected by parental alcohol misuse. The academy is being launched in partnership with Wendy Robinson Consultancy, with free three-day courses in how to deliver the training taking place next month. 'The aim of the academy is to increase the effectiveness of alcohol-related work with children and families and our ambition is that the new pool of trainers will start to deliver training courses throughout England and Wales in the Spring 2011 for professionals working in services for children, parents, families or substance users,' said chief executive Don Shenker.

Cautious welcome for strategy

The 2010 drug strategy has met with a lukewarm response from the field, with DrugScope warning that the challenge would be delivery in the current economic climate and Release condemning its 'one size fits all approach'.

The strategy sets out a 'fundamentally different' approach to tackling drug use and supporting recovery, the government states, with 'more responsibility on individuals to seek help and overcome dependency'. The two 'overarching aims' of *Reducing demand, restricting supply, building recovery* – the short consultation period for which was the subject of controversy in the field (*DDN,* 25 October, page 5) – are reducing use and increasing the numbers in recovery. The government's ambition is to 'offer every support for people to choose recovery', stated home secretary Theresa May, rather than focus on reducing harm.

Substitute prescribing will continue to have a role, however, with the strategy stating that 'there are many thousands of people in receipt of such prescriptions in our communities today who have jobs, positive family lives and are no longer taking illegal drugs or committing crime'. But the government aims to ensure that all those on a substitute prescription 'engage in recovery activities', while examining the role of diamorphine prescribing 'for the small number who may benefit'.

There will also be a substantial shift of power to local areas, with the commissioning and oversight of drug and alcohol treatment a core part of the work of directors of public health. The government will introduce six payment by results pilots this year to provide evidence of affordability and value for money, and a reduction in bureaucracy will be 'fundamental', with all areas encouraged to set up a single assessment and referral system. The government will also ensure that the benefits system supports engagement with services, it says, by offering dependent claimants a choice between 'rigorous enforcement of the normal conditions and sanctions' for those not engaged, or 'appropriately tailored conditionality' for those that are (*see legal column, page 9*).

Echoing the public health white paper (*DDN*, 6 December 2010, page 4), the strategy states that 'prison may not always be the best place for individuals to overcome their dependence and offending behaviour', with the government aiming to ensure that offenders are encouraged to seek treatment at every opportunity in their contact with the criminal justice system. It will also pilot 'wing-based, abstinence focused, drug recovery services' in prisons and encourage more offenders to become recovery champions, with more detail in the Ministry of Justice green paper, *Breaking the cycle: effective punishment, rehabilitation and sentencing of offenders*.

The government has announced that it is committing £125m over the next financial year to support the strategy. The money is made up of £65m from the Home Office and £60m from the Department of Health, and will 'favour frontline workers – with over three quarters of the funding provided for key operational staff'.

DrugScope welcomed the 'content, tone and approach' of the strategy, but said that while the aspiration for recovery was to be applauded delivery would be far from straightforward in the current climate. 'The next couple of years will be a period of transition and managing the process will be crucial in delivering the change the government has outlined,' said chief executive Martin Barnes. 'It is imperative that local authorities and communities are fully engaged in supporting the strategy, and that the strong case for partnership, investment and support for problem drug users and their families is demonstrated.'

Turning Point welcomed the acknowledgement that services 'should understand the needs of the individual' but stressed that providers would need 'the right incentives to work with everyone who comes through their door, including long-term drug users who may require more support' if payment by results is to be effective.

Addaction called the strategy 'rightly ambitious' but Release said the implication was 'if you do not, or cannot, choose recovery you will not meet the criteria' for support. 'It is of course important that those who feel able to come off drugs completely and maintain an abstinent lifestyle receive quality support, and much more funding is required for this to be achieved,' states the charity. 'However, the 'one-size fits all' approach to drug use that informs this government strategy is likely to result in more people being exposed to greater risks and not receiving the support that they actually need.'

For a longer version of this story see www.drinkanddrugsnews.com. Drug strategy at www.homeoffice.gov.uk. Ministry of Justice green paper at www.justice.gov.uk

'Less than half' understand units

Only two out of five adults understand how alcohol units equate to actual drinks, according to a survey commissioned by Drinkaware.

More than 85 per cent of the 4,000 adults questioned by Ipsos MORI had heard of alcohol units but just 42 per cent could equate the term to specific alcoholic drinks.

When asked to choose from a list of drinks, 46 per cent of men and 30 per cent of women could correctly identify which roughly equated to one unit of alcohol, while just 32 per cent of men and 29 per cent of women knew the recommended daily unit guidelines for their gender. Drinkaware has now posted 2.3m unit and calorie counters to households across the UK, along with advice about sensible drinking.

'It's great to see most people have heard of the term 'alcohol units', but we want to help them understand the unit equivalents of their favourite drinks and relate those to the recommended daily guidelines,' said chief executive Chris Sorek. 'Changing the UK's drinking culture won't happen overnight but providing consumers with useful tools such as the unit calculator can help them understand what a unit is and how many are in the nation's most popular drinks. It's important we challenge the norm of people unwittingly drinking to excess, whether that's at home after a long day at work or out at a bar or restaurant.'

Drug strategy doomed without action to tackle stigma

The government's drug strategy (*see story facing page*) 'will fail' unless stigma towards recovering drug users is tackled 'head on', according to a report from the UK Drug Policy Commission (UKDPC).

Getting serious about stigma calls for training and workforce development to improve knowledge of drug-related issues among health professionals, action to address institutionalised stigma and better use of government communications and the media to highlight the dangers of stigmatisation. The report also wants to see an increase in community participation projects to allow more people to come into contact with recovering drug users.

A third of the 3,000 people surveyed for the report felt it would be 'foolish' to begin a serious relationship with someone who had suffered from drug dependence, even if they seemed fully recovered, while 43 per cent would not want to live next door to someone who had been dependent on drugs. On a more positive note, more than two thirds agreed there was a responsibility to provide the best possible care for drug users and 59 per cent saw dependence as an illness like any other chronic health condition.

UKDPC also carried out focus group and web survey research, and commissioned a study of media reporting (*DDN*, 22 November, page 6) which found that celebrities, professionals and young people were far less likely to be labelled 'addicts' or 'junkies' than offenders or parents. Researchers found no strong differences between the broadsheet and tabloid press in terms of the way drug use was explained, but while drug users were 'more likely to be condemned than empathised with' in all newspapers, they were most likely to be condemned by the tabloids.

'If the government's drug strategy is to succeed, it must first address this very real barrier of stigma,' said UKDPC commissioner Professor Colin Blakemore, who oversaw the research. 'Our research shows that the public agree that recovering drugs users need help and support to help rebuild their lives. But they are also seen as blameworthy and to be feared. These public attitudes spill over into public services, so we see time and again former drug users stigmatised and discriminated against when they try to access services. This is not simply a case of disapproving of bad behaviour; it goes well beyond that. Stigma is about a long-term label, often leading to prejudice, discrimination and discouragement.'

DrugScope said the report highlighted 'one of the most significant barriers' to improving treatment outcomes and supporting recovery. 'If people in recovery are to get back to work, find appropriate accommodation and rebuild their lives, more needs to be done to address the underlying factors contributing to stigma, including educating the public on the causes of drug and alcohol dependency,' said chief executive Martin Barnes.

For a longer version of this story see www.drinkanddrugsnews.com

Available at www.ukdpc.org.uk

RAUCUS CAUCUS: a performance from the 25-strong Raucus Caucus Recovery Chorus formed part of last month's 'Christmas taste of recovery' event at Mersey Care NHS Trust's Hope House centre, which brought together a wide range of the city's recovery organisations. 'The choir is about people in recovery having a voice through music and about giving the members of the choir a chance to showcase their talents,' said SHARP admissions worker Mandy McBlain. 'Most of the people in the choir would never have dreamed of singing in public when they were in active addiction.'

Poppy cultivation 'up 22 per cent'

Opium poppy cultivation in South East Asia jumped by 22 per cent between 2009 and 2010, according to the United Nations Office on Drugs and Crime's (UNODC) *South East Asia opium survey*, with the potential value of opium production rising by 82 per cent to $219m.

While poppy cultivation in the region remains far below the peak figures of the mid-1990s, says the report, the trend since 2006 has been 'relentlessly upward'. The global economic crisis will have tempted many poor communities to enter the opium market, says UNODC, with rising prices making cultivation increasingly attractive. 'Poverty and instability are two of the drivers which push farmers to grow – or sometimes return to growing – illicit crops,' said UNODC executive director Yuri Fedotov.

Opium production in Afghanistan – which produces around 90 per cent of the world's opium – halved in 2010 as a result of plant disease in the main poppy-growing provinces (*DDN*, 11 October 2010, page 4), sharply pushing up prices. Last year UNODC also reported that increasingly large amounts of synthetic 'amphetamine-type stimulants' were being produced in South East Asia (*DDN*, 6 December 2010, page 5).

Available at www.unodc.org

News in Brief

Drug prices up

Illegal drug prices in the UK have risen sharply over the last year, according to a survey by the Independent Drug Monitoring Unit (IDMU). There has been a sharp increase in prices for all varieties of cannabis, while wholesale cocaine prices have increased by around 50 per cent at import level. Although street cocaine prices have remained relatively stable, 'single-figure' purity is now common in street-level seizures of the drug, says the survey. The criminalisation of mephedrone, meanwhile, has led to a 50 per cent increase in average prices compared to those offered online a year ago. Crack prices have remained relatively stable and the survey found no evidence of increased heroin prices 'despite reports of a drought in some areas'. *www.idmu.co.uk*

Panel posts

Alcohol industry body the Portman Group is looking for new members for its independent complaints panel, the first time that vacancies have been publicly advertised. 'The panel performs a vitally important role in ensuring the strict standards for alcohol marketing in the UK are upheld,' said panel chair Sir Richard Tilt. 'I am seeking applications from people with expertise, objectivity and sound judgement.' Details at *www.portmangroup.org.uk*

I'm not what I yam

The UK Border Agency has revealed some of the more unusual drug smuggling attempts of last year, including around 10 kilos of cocaine hidden in yams that had been cut open and glued back together and more than a kilo concealed in packets of nuts. A kilo of cannabis was also found inside a wooden-framed painting of Manchester City footballer Emmanuel Adebayor. 'These smuggling attempts show the lengths that organised criminals will go to in a bid to get drugs into the UK,' said head of border force Brodie Clark. 'Criminals are prepared to invest large sums of money to come up with even better concealment methods because they know the potential profits.'

NEW YEAR, NEW HABITS

From working with all kinds of people to help them change their outlook on life, Cathy Dixon has developed an empowerment programme based on simple steps and common sense. **DDN** reports

Cathy Dixon has coached people from all walks of life. She teaches empowerment through different forms, from hypnotherapy to Chi Kung, in each context seeking to put her clients back in the driving seat, whether they are business entrepreneurs or homeless.

A few years ago a young man was referred to her privately because he had become 'disengaged from life'. He wasn't drinking or taking any substances – in fact he wasn't doing anything at all. He said to Dixon 'I can't do any more therapy', having tried every sort, and it set her thinking about what on earth she could try to re-engage him with life.

At first she admits to being at a bit of a loss. Then an idea popped into her head – a step-by-step programme that they would develop together from scratch. The first stages would be simple and clear and would be based on his agreement to do three things – keep a check that he was eating properly, take some exercise, and do a regular meditation.

Meeting every week, the man showed Dixon that he had kept a log of what he had done. What it achieved, she says, was to get him re-engaged. Six months on, he's now working, but it started with the gradual build-up of processes, from 'let's do something' to 'find a job'.

'He told me that coming to see me with the list really helped,' says Dixon. 'We talked about what had gone on and he stopped sitting in his bedroom all day saying "nothing's happening in my life". Talking about it put structure there and created boundaries. It re-engaged him and made him say "hello, I'm here".'

This encouraging experience made Dixon actively seek feedback from her clients, particularly people in aftercare – 'those who have come to a decision that they want to stay in sobriety or in a controlled space'. She wanted to know what was working for them and what they did to keep themselves well, so she could compile a self-help programme.

The key element, she realised, was a sense of self-responsibility – the willingness to say 'I made this choice, I am making this choice'. This, she says,

'brings a sense of confidence, energy and optimism that you're making decisions and choices that are right for you.'

Her other realisation was that much of her material would be based on common sense: 'It's about keeping yourself well – and the only person that can keep you well when you're an adult is yourself.'

Developing a sense of wellbeing would be the foundation of the programme, the core from which other skills would be developed – 'because if you don't have wellbeing in place, it's difficult to become empowered.' You can think of this in very simple terms, she adds – 'this energises me in a positive way, or this drains me and takes my energy away.'

She describes an exercise she often uses with new clients: 'I ask them to draw a circle and write everything they like about themselves – even if it's only a few things. Then they draw another circle round it, with everything they do to keep going; then another circle around that, with everything that drains them. The picture suddenly becomes very clear – how the outer circle takes it all away. It's a very simple exercise to get to the heart of the matter.'

It's an exercise that contributes to developing self-awareness – a key element in self change, she explains.

'To listen to ourselves and our inner dialogue, to really tune into what's going on around us, starts to expand our universe,' says Dixon. 'Are you actually in the present, or are you living through memories of the past? That's not an empowering place. Or are you living mainly in the future? That's quite an anxious place because you don't know what's going to happen.

'What I mean by self-awareness is being aware of what's happening today. I get my clients to engage with today, rather than dwelling on what happened yesterday, or last year, or 20 years ago.'

Later on this can lead to clients being ready for a detailed self-audit, when they ask 'what's strong about me? What do I need to watch out for? What are my real needs in life? What do I really value?' But she stresses that the beginning stages are all about cultivating self-honesty, which can be a tough exercise in itself.

The encouraging feedback from Dixon's drug and alcohol client group is that she has found them to be high in self-knowledge: 'They are so honest with themselves, they don't kid themselves at all – and that's such a big step towards successful recovery,' she says.

The next stage, she suggests, is to build a vision – 'I need to have a life that includes these things.' It's the absence of vision that creates depression, she says. 'If there's no vision and nothing going on in the future, you feel like a prisoner of your past, so you don't engage in your present.'

Letting go of a relationship with chemicals or alcohol can be a similar process to mourning the loss of any other relationship, says Dixon. It all involves adjusting to a different situation, realising that 'I used to have something to do, and now I don't do that anymore. It can be about addressing boredom sometimes.'

So it's vital to develop new habits, she says – 'and you don't create habits just by thinking about them. You have to do them.' Her empowerment programme involves discipline, including filling in a diary that charts progress on the action plan.

'But it's a loving discipline,' she emphasises. 'It's giving back self-esteem and saying "I'm doing something good for myself". Even if you haven't felt cared for in your life, it's still important to think "I care about myself".

'This is very much about basic self-care and nutrition,' she adds. You're making sure that you're eating enough protein and drinking enough water. You're being mindful of how much exercise you're taking and putting in spaces to be with yourself through meditation.

'Some people will have this already in their lives, to varying degrees, and some people won't. But most people will benefit by having an MOT at this first stage.'

Acknowledging that 'some people are very intimidated by exercise', she is keen to emphasise that the exercises she recommends are about stretching and walking – 'things that don't pump up the adrenals and make you feel anxious'.

'Even ten minutes exercise a day is good,' she says. 'I think that one of the reasons people fail is where they try to do too much too soon.'

And that rule applies to the entire programme, she adds. 'There are eight processes in the programme, but someone might only decide to do three. It's better to do that than to stop altogether and think "I'm not doing that again". The idea of this is that it's very flexible and the real thing about it is the engagement. Even if you just do the meditation every day, there's a habit changed.'

The other element that she suggests can really help is 'buddying' – doing the programme with a friend, or in partnership with a keyworker who can give guidance and support, or just be there to ask 'how did it go this week?'

'Doing the programme by yourself is possible, but it's the hardest route,' says Dixon. 'That's for very highly motivated people – of which there aren't many.'

While she has found the programme particularly successful with drug and alcohol clients, she is careful not to demonise addiction. She regards substances such as drugs, cigarettes and alcohol as 'comforting tools' – and says it's a case of choosing different comforting tools that are more supportive.

'Some substances give you a sense of power – but it's an empty power. They can comfort you momentarily, but in the long term they take away your self-esteem.'

She calls her initiative a 'self-love programme', because the idea is 'you love yourself enough to get dressed up, go out, look after yourself, exercise, eat nicely…'

And this brings Dixon back to making the point that her empowerment programme is for people in all walks of life. Her recent clients have included an Olympic athlete and an entrepreneur with several companies – 'and I use the same material, because it's life skills,' she says. 'It is learning the life skills that's important, not the context.'

'The concept will apply equally to a highly competitive Olympic athlete and someone stepping out of recovery – it's very challenging. It takes a lot of courage, a lot of determination and self-belief.'

'I really respect my clients for having done that,' she adds. 'They are literally creating a new life, so they need all the help they can get.'

Cathy Dixon's new toolkit, *Empower your life*, part one (an introduction to the programme), is available at www.cjwellings.com

EMPOWER YOUR LIFE: THE BASICS

Skill one: self-care
Learn to nurture your physical health. Follow a daily programme to develop a balanced diet, regular exercise, a stable sleep pattern and control anxiety.

Skill two: self-awareness
Develop awareness of your strengths and talents – and be mindful of your vulnerabilities.

Skill three: clarity
Develop a personal vision that's based on your strengths, values and needs.

Skill four: goal setting
Develop simple, yet effective, goal-setting skills.

Skill five: self-belief
Build your self-esteem and self-worth through exercises.

Skill six: self-management
Learn to manage stress and maximise resources through time management.

Skill seven: communication
Communicate effectively with yourself and others.

LETTERS

'It's time to speak up and be counted and say it like it is. If we do not invest in treatment or aftercare we will go back in time – and we won't be achieving in tough times, we will be failing again.'

DON'T PATRONISE US

I feel compelled to write in about the appalling, patronising article, 'Achieving in tough times' (*DDN*, 6 December, page 14). It was extremely insensitive to the job losses in the public sector and the voluntary sector in the coming months.

Firstly, what is the relevant experience of Peter Mason with regards to the field of substance misuse? Secondly, over the last few months I have had to see my long-standing experienced colleagues face job losses never seen before in our sector. Many of these people cannot be replaced with their vast knowledge and skills. This was the most demeaning article I have ever read, by someone who obviously knows nothing about working in either the public sector or the substance misuse sector.

Having worked for 20 years in both voluntary and public sectors I have seen, in the main, absolute professionalism and creativity. As most of your readers know, the field of substance misuse and problematic drinking has never been funded adequately. For many years we have had to be creative in getting essential services like treatment funded on a shoestring. It's time to speak up and be counted and say it like it is. If we do not invest in treatment or aftercare we will go back in time – and we won't be achieving in tough times, we will be failing again. It is not always our responsibility to tighten our belts and make do. We are fed up with doing that! There is nothing wrong with speaking up, saying 'this is not fair' and explaining how it will affect our clients.

The piece was full of ridiculous 'new speak' like 'sparkplugs' – er, that would be volunteers, which our sector has always used to great effect. Harness community groups and volunteers? Novel idea, Peter, but we have always had to do that! In my local authority we had a pot of money for innovative and community-led initiatives. With that now cut, there is no one to take up the baton for small and creative ideas run by local people. Oh, and while we are at it – 'increase productivity…' Where have you been, Peter? We have been doing that year on year. We will have to continue to do this if our pooled treatment budget is cut and more meaningless targets are brought in, just called different things under this new government – ideas like welfare reform, where the poor get poorer.

Far from being wasteful with our time and energy, we are not bemoaning our conditions. It's more than that – we just don't want to go back in time to pre-1998 when there was no drug strategy and addicts died on the streets. Now is not the time to be condescending to those who have worked tirelessly and expertly in the field and telling them they must do better!

Kate Langan (In a personal capacity), by email

GLASS HOUSES

Around ten years ago I was new in treatment and took a card from my local service provider's desk asking for drug users to express their views. I'll always remember the saying going round at the time – that allowing current and ex service users to get involved in the running of drug services was 'letting the lunatics take over the asylum'. It seems quite funny regarding the government we have now, because in my personal opinion it seems like the lunatics are taking over the asylum, and the country, and don't seem to know what they're doing.

Not just within drug services, which have seen a drop in the number of heroin users being treated, but a group more suitable to Gamblers Anonymous and officially known as 'bankers and politicians' – who keep preaching to us that we're all in this together but who constantly take high salaries and bonuses and own multiple homes. It is the people at the bottom end of the scale, on benefits or poor wages, being made redundant and homeless, that are paying the most and engaging in services that not so long ago they either ran or helped to run.

Not only has this led to a massive lack of self-esteem among frontline staff, but also among management, who are finally realising that the cuts they expected weren't as bad as first feared but who have lost confidence in the services they run, and so now encourage their staff to push people into detox units and residential rehab centres, as there continue to be no services available to those who would be dead if it weren't for substitute prescribing. If there were more interim services to help them move forward into a sustainable lifestyle of their choice then they could go on to legally earn a decent wage.

David Cameron has spoken at great length about his idea of the Big Society and how we're all in it together. This would be fine if we cracked down on tax havens where the rich are allowed to hide away their money while enjoying life in Britain, and the fat cats gave up their bonuses for gambling with taxpayers' money.

Take the recent student uprising – what would happen if everyone affected by drug or alcohol use rose up to protest about cuts? It would come to light, as it always does, about the ministers who drink a bottle of wine of an evening and all the other people in high positions of power coming out as having had substance misuse problems. Indeed, Tony Blair's recent revelations about his drinking to unwind from the pressures of being prime minister show that he was drinking more than his own government's guidelines. I ask us all to take a close look at ourselves and our actions, and see what category we would fall into, and not judge those we consider less skilled than ourselves to deal with issues like budgeting, emotions and childcare, all of which are demanding of any human being.

Lee Collingham, Nottingham

ACCESSIBLE SCIENCE

BBC Three is screening three documentaries across January entitled *How drugs work*, covering cannabis, ecstasy and cocaine. The highlights are the stunning visuals, via the use of CGI technology, which show the journey of each drug's key active chemicals racing though the body and brain, from administration to ingestion, and impact on vital organs and subsequent sensations, feelings and mood – all overlaid with explanations from the usual experts.

The first episode on cannabis concentrates on skunk. The science is interspersed with timeline cameos of young users, providing reasonable balance by dealing with occasional, controlled and dependent use. Consumers ranging from middle-class space cake eaters wandering through the woods to chilled-out young professionals and a heavy skunk user planning to quit to save a romantic relationship keep up the interest.

The ecstasy slot follows the same format but starting with a history lesson. The current dubious contents of ecstasy are well illustrated. We follow two users through their weekend noting they are using crystal MDMA in the hopes of taking the real thing – which, given their MDMAmazing, empathy-filled adventures, they probably were. There is a lot of accessible science here as CGI journeys cover all the stages of MDMA ingestion, with serotonin, dopamine, oxytocin and noradrenaline production and transmission, all illustrated and linked back to the user's physical and emotional state.

The synopsis for the final slot on cocaine promises a detailed explanation of the effects of cocaine on body and mind, explaining the production of the highs and lows. It focuses on the role of cocaine on nights out,again via cameos of users, posing the usual questions about the benefits and risks of cocaine use in terms of physical and mental health.

The series' main shortcomings revolve around the absence of implanting poly substance use as a complicating factor. It feels like the programme

makers got their neuroscience in the can and then followed young drug users who explained their more complicated psychoactive menu. So we see E-bombs swallowed with cider and stimulant nights ending with a big spliff. None of this poly substance use is found in the CGI modelling.

There are multiple screenings of each episode across January, which can be viewed/downloaded with iPlayer. The programmes are likely to be repeated and hopefully will become available on DVD. If so, there are several short edits which will be of value to drugs educationalists, workforce trainers and under 18s/transitional-young adult services. The CGI drug journeys through the body should genuinely engage users in treatment supplementing those tired handouts. Some of the case studies can also be used for staff training and motivational work.

Professor Howard Parker, Merseyside.
www.howardparker.co.uk

STICKY CASH-MAGNET

Is it just me, or do I discern positioning-for-the-future rumblings from the direction of the National Treatment Agency? Out with the old spin and buzzwords and in with the new. Yes, I bet you never thought that recovery could mean so much and so little at one and the same time. I had hoped that this sticky cash-magnet would be quietly dumped along with the rest of the quangos, but sadly the government is failing as badly as the previous administration to grasp the seriousness of the addiction problem and get radical.

Why is it that no politician has the courage to act on in government what they espouse in opposition? Namely that the war on drugs is an unwinnable conflict, so let's try a new approach. Addiction is not a crime, it's a medical, psychological and spiritual problem and punishing those who suffer from it is stupid. I hope and pray that one day we will look back on this punitive approach and regard it pretty much how we view Victorian lunatic asylums now. Happy New Year!

Andy Holt, North House, Papa Stour, Shetland

SOMALI HELP WANTED

I am a mature student at London South Bank University and have just finalised my second year of Addiction Psychology and Counselling. I am now working on a dissertation on the Somali community's experiences of substance misuse treatment.

If you are interested in participating in this project (or know of anyone that may be interested) I would be most grateful if you (or they) could telephone me on 07858 415 706 or 020 8241 0642 or contact me on markashby@yahoo.co.uk in the first instance. This will take the form of an hour-long structured interview, which will be recorded so I can later transcribe it. All information would be totally confidential and no participant would be recognisable.

This will be a supervised student research project, which has to be passed in the first instance by the university's ethics committee. The aim of the dissertation is to establish what would make treatment for Somalis with substance misuse problems more useful/beneficial to the Somali community.

I look forward to your response.

Mark Ashby, London

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

WELFARE **WARNINGS**

In the first of a regular legal column, Niamh Eastwood warns that the government's plans to reduce welfare support for problematic drug users can't help but increase inequality

WELFARE REFORM has been on the political agenda for the last three years. The previous Labour government introduced the Welfare Reform Act in 2009, which brought in a number of provisions specific to claimants who were suspected of being problematic drug users. The original bill had contained a clause which would have required benefit claimants to enter treatment – for up to two years – if they were determined to be problematic drug users who were unable to work because of their drug use, with failure to attend resulting in benefits being withdrawn.

The notion of mandating people to treatment with the threat of sanctions was criticised by those working in the drugs field and many in Parliament, particularly peers. Although this clause was dropped from the final bill, the Welfare Reform Act 2009 contained a number of coercive/sanction-led interventions, including drug testing and required assessments. However the regulations pertaining to these provisions were reviewed by the Social Security Advisory Committee (SSAC) in May 2010 and, as a result, the proposals were shelved.

The committee identified that drug users were already disproportionately affected by the sanctioning regime within the benefits system because of the chaotic nature of their lives, and the proposed regulations under the Welfare Reform Act 2009 would have resulted in even greater levels of sanctioning. Release had successfully lobbied, along with others in the field, against the introduction of the powers contained within the Act – indeed SSAC referred to Release's submissions in their own final report.

A new government is now in power and welfare reform is even higher up the agenda. The coalition's drugs strategy, launched last month (*see news story, page 4*), outlined their vision in respect of welfare provisions relating to people who use drugs problematically and who are in receipt of benefits. The strategy speaks of ensuring that 'the benefit system supports engagement with recovery services' and offers 'claimants who are dependent on drugs or alcohol a choice between rigorous enforcement of the normal conditions and sanctions where they are not engaged in structured recovery activity, or appropriately tailored conditionality for those that are'.

Reading between the lines, this would appear to be proposing the introduction of a 'treatment allowance', probably the only aspect of the Welfare Reform Act 2009 which was welcomed by the field – once it was clear the benefit would not actually referred to as 'treatment allowance'. Rather, engagement in treatment would meet the conditionality for employment support – this is a positive approach to supporting people in treatment and does not have the punitive impact of the previous legislation. However, some caution must be exercised when considering the use of language in the strategy. To propose 'rigorous enforcement' suggests that there will be a greater level of compliance required by those who use drugs and are not in treatment than other claimants. Legally, this would not be possible.

Finally, the welfare reform agenda of this coalition government is in the very early stages. The proposed introduction of 'universal credits' will mean significant changes to the benefit system, and without full details of how this system will operate it's difficult to assess what will be the impact on the clients we represent. What we do know is that reductions in welfare support for problematic drug users will inevitably lead to an increase in inequality. Evidence has clearly shown that those countries that have lower rates of state support for the unemployed and those unable to work through illness have higher rates of injecting drug use. Recognition should be given to the importance social support plays in reducing harms related to drug use.

Niamh Eastwood is head of legal services, and deputy director, at Release. She will be debating the government's welfare reform agenda with David Burrowes MP at the DDN/Alliance conference* Seize the day *in Birmingham next month. To book a place visit www.drinkanddrugsnews.com

Trading in for a new Model

The NTA is about to launch its consultation on a framework to replace *Models of care*. Director of delivery **Rosanna O'Connor** gives DDN an exclusive taste of what it might look like

ORIGINALLY PUBLISHED IN 2002, *Models of care* outlined the four-tiered model that still shapes service delivery. Now the NTA is about to launch a consultation on what should replace it in the wake of the 2010 drug strategy (see news story, page 4).

'The strategy sets out a real vision for a recovery-focused treatment system, and this document – which will be titled *Building recovery in communities* – will replace *Models of care* and be seen as the sector's action plan to make the drug strategy happen,' says NTA director of delivery Rosanna O'Connor. 'It also gives everyone in the sector a chance to share their knowledge, skills and experience.'

The framework, which will cover alcohol alongside drugs, is expected to focus on a whole-person approach rather than just dependency, while the consultation process itself will take a slightly different tack. 'We're departing from our normal approach – we're not publishing a document as such,' she says. 'It's going to be an interactive format with some big overarching questions – but rather than flesh that out and expect people to agree with us we're giving people much more opportunity to shape it. It will be in stark contrast to the drug strategy consultation process, where people felt it was a bit of a *fait accompli* (*DDN*, 25 October 2010, page 6). We'll have a 13-week consultation and there'll be plenty of opportunity.'

Models of care was launched in 2002 and updated four years later, with a new focus on harm reduction. How different does she anticipate the new framework will be? 'Our thinking – and the thinking and approach of the field – has changed quite dramatically since the last time *Models of care* was updated. I guess probably the most critical issue is that the recovery agenda has emerged, so what we wanted to do was make sure treatment systems were re-orientated and transformed to promote recovery. One of the ways we're envisaging it will be different is in that it will move away from the tiers approach that was pretty critical in the early days of the NTA when we were trying to get a grip on an underdeveloped treatment sector. That rightly set out expectations for local systems, but we want to move beyond that.'

Presumably with more of a focus on wider services like housing, employment and family support? 'Certainly, at a local level, and we also want to bring together the approach towards prison and community treatment – something that was absent from the previous documents – [because] we want people's experience to be as seamless as possible. We also particularly want to promote a culture of ambition in all services and within the workforce, and offer every opportunity for people to think about their own recovery and get the appropriate support to help them on that journey.'

A move away from a tier-focused approach would help put these journeys at the heart of commissioning and delivery, she believes. 'I think where commissioning and service design has been pretty crude in the past is that there's been almost an expectation that people will "go through the tiers" – for example, people doing a certain amount of time in tier 3 and seeing tier 4 as the next bit. We want to get rid of that notion and ensure that, whatever point a person is at, staff and services are attuned to any opportunity to take them one step further towards their recovery. We think a tiered approach isn't the way to best facilitate that any more – very, very helpful in the early days, but less so now. Most people's aspirations when they come into treatment is to get better, and we need to be able to articulate what that means to them and provide the building blocks to help them get to that place.'

One of the main themes of the drug strategy is the shift of power to local areas and *Building recovery in communities* will aim to help local commissioners and providers refocus their systems and services. 'One of the things that was absent from the last framework was the role of mutual aid and peer groups, and we're now working far more closely with mutual aid groups with an expectation that each system makes sure that pathways into mutual aid are readily available.' It's also essential that the visibility of recovery is apparent in services and systems, she stresses. 'That has never been clearly articulated previously – we've come to the conclusion that the visibility of recovery is pretty critical in terms of aspiration and ambition.'

What would she say to the people who maintain that no one really takes much notice of consultation responses? 'Well, one thing is that we're not going to present anybody with a written document – they can see we haven't got a version on the shelf that we're just going to bring out the day after the consultation finishes. We need to hear the views of those who work in the field and people who use the services. If we'd got together groups of influential players from different bits of the system and come up with a document that we'd thrashed out internally and then shared that with the field, people would be right to be sceptical about to what extent we were going to listen to them. But this will provide a definite opportunity for us to develop something in response to the consultation process. We're impatient to get this out there.'

The consultation launches this month at www.nta.nhs.uk

Star quality

Don Shenker describes holistic new outcome measures for alcohol services

DEVELOPING RELIABLE OUTCOME MEASURES FOR ALCOHOL SERVICES has always been an important issue. However, given the emphasis on outcomes in the NHS white paper, this issue is about to move to the top of commissioners' 'to do' lists.

Alcohol Concern has been working with NHS East Midlands, Derbyshire Drug and Alcohol Service, Addaction Lincolnshire and Lincolnshire Alcohol Service to develop a set of outcome measures. At the core of this tool is the Alcohol Outcomes Star, which is a joint development between Triangle Consulting and Alcohol Concern.

The East Midlands pilot reviewed a number of possible outcome measures, including patient satisfaction and impact on hospital admissions. However, the study came to the conclusion that the most effective tool was the Alcohol Star combined with an alcohol consumption measure based on a weekly drink diary. Positive changes in consumption levels were highly correlated with positive changes in client and worker perceptions of changes in the domains covered by the star.

The Outcomes Star builds on the earlier Outcomes Spider and monitors scores across ten domains – alcohol, emotional health, physical health, family, managing money, use of time, offending, social networks, drug misuse and accommodation. Clients, in combination with key workers, measure changes in their ability to deal with different aspects of their life. The measure uses a ten-point score which runs across five stages including 'stuck', 'accepting change' and 'self-reliance'. This approach not only helps measure change but also supports key working, and by looking at scores at various points in the care pathway, change can be measured and even mapped across tiers.

In the pilot, 15 workers completed the Alcohol Star with a total of 170 new clients. Fourteen of the 15 workers in the pilot study reported that the process of using the Alcohol Star with clients was positive and that the majority of their clients had found it helpful. Overall, the reasons given by participants for the positive feedback were that clients appreciated the visual aspect and simplicity of the tool, which supported engagement, and both clients and workers appreciated seeing the progress at review. Clients could also recognise themselves within the scale descriptions, helping them place themselves within the overall journey of change and identify where to go next.

The star also helped clients and workers identify areas to work on, and was a good basis for developing a support plan as well as a useful focus for opening discussion. Person-centred counsellors were able to incorporate it into their counselling practice and commissioners were reported to be positive about the tool.

Workers' comments, meanwhile, included:

- *'It's a good and useful tool and means that clients themselves identify the areas they need to work on'*
- *'I loved having the statements because I could read them out and my clients would straightaway say "yes, that's me!"'*
- *'It's a really good visual way of getting people to reflect on what they have told you*'

In terms of client feedback, all but one said they enjoyed completing the star with their worker (the other was unsure), none found the process too long and most found the scale descriptions helped them understand what they needed to do next. All found the visualisation of their progress from one reading to the next encouraging.

The research suggested the use of an alcohol consumption measure, requiring the regular completion of a simple drinking dairy. The East Midlands data shows significant correlation between individual clients reducing their alcohol consumption and an increase in their star score. All of the clients with a substantial or moderate decrease in their alcohol consumption showed an increase in their overall score on the Alcohol Star, while 86 per cent of the clients who showed an increase on their Alcohol Star score had decreased their alcohol consumption and a further 7 per cent had stayed abstinent.

The research also highlighted two optional measures – crime and dependency. The crime measure records changes in contact with the criminal justice system as a result of alcohol misuse and has been adapted from the NTA's TOPs measure, substituting alcohol-related crimes for drug-related crime. The Leeds Dependency Questionnaire (LDQ) is a quantifiable and validated measure of dependent drinking and can also be used to complement the alcohol consumption measure, providing harder evidence of the results tracked by the star.

The East Midlands research provides a good framework for moving forward on outcome measurement in alcohol services, and Alcohol Concern is looking forward to working with commissioners in other areas to develop local outcome frameworks.

Don Shenker is chief executive of Alcohol Concern

Full tool available to download at www.outcomesstar.org.uk

More information at www.alcoholconcern.org.uk/publications

John Ryan is CEO of Anex – an independent harm reduction association in Australia. On his recent visit to London, DDN **asked him about his work and whether he faced similar challenges to those in the UK.**

USING THE EVIDENCE

Anex was set up in the 1990s by a group of needle and syringe exchange workers. Through volunteer work they established networking, support and advocacy services that reduced the harms associated with drug and alcohol use, and when they got some money to employ their first full-time worker ten years ago, John Ryan came into post – a law graduate with a strong personal commitment to social justice.

'Harm reduction, to my mind, is about a realistic pragmatic approach – a public health evidence-based approach,' he says. 'And we're very precious about maintaining that as a core value of the organisation.'

While drug issues are as 'highly politicised and highly emotional' in Australia as anywhere else, the evidence-based approach has been the thrust of their organisation. Anex's patrons include leading scientist (and former 'Australian of the year') Sir Gustav Nossal, a former high court judge, and medical doctor and former vice chancellor of Melbourne University Professor David Penington, who was on the prime minister's first Aids task force in the early 1980s.

From its initial focus on needle and syringe programmes, Anex has now broadened its remit to trying to improve access to quality services, including pharmacotherapy services for substitution treatments.

'We still don't have an evidence-based approach to drug problems in Australia or internationally. But we're interested in trying to move drug and alcohol services to a more harm reduction based approach,' says Ryan. 'There are still outposts of opposition unfortunately. But we're hopeful that as people become more willing to look at the evidence, that will whittle away.'

There has, however, been tangible progress in the Australian media.

'What breaks my heart is going into prisons and seeing what kind of people get locked up... The way we treat drug issues, mental health issues and prisoners is very much still in the dark ages.'

'We have "shock jocks" in Australia – radio announcers that are tabloid in their style and usually quite right wing in their politics, but they love argument and on-air "biffo",' explains Ryan. 'I've had the pleasure of being on some of their shows arguing about needle and syringe programmes and they all roll over, because they prevent infection, illness and death.

'But the real reason it becomes a no-brainer for them is because it's so cost effective. The savings in terms of healthcare dollars are so big, they can't help but begrudgingly agree it's a good idea.'

He acknowledges that the media aren't always as kind and generous to harm reduction initiatives – 'in fact they're often quite adversorial about them. There's been a very negative campaign against the injecting facility in Sydney by some media, even though the evidence is quite strong.'

But on the positive side, he adds, 'the needle and syringe programme is really part of the furniture in Australia now, and it's always been supported by both sides of politics, so it lacks the fuel to have a real pitched battle'.

This progress doesn't extend to the criminal justice system, however – 'a new frontier' for Anex.

'Because Australia is a federation of states, when those states have elections it's typically a law and order auction and it's a race to the bottom for who is the toughest, who has the harshest penalties, who'll do three strikes and you're out,' explains Ryan.

The prison union typically comes out against harm reduction, he says, 'which the media likes, because it offers a fight between opposing positions'.

But more often than not, they are preoccupied with creating scandals over prisoners with televisions, internet access or educational opportunities.

'Sometimes they even report that it's appalling

that they have access to healthcare at all,' says Ryan. 'But what breaks my heart is going into prisons and seeing what kind of people get locked up. They're basically people who have had few opportunities to make a go of it in life and we end up locking them up and usually making them worse when they're released. The way we treat drug issues, mental health issues and prisoners is very much still in the dark ages.'

Equally challenging for Anex is to convince prison staff that needle and syringe programmes would protect prison officers and their families as much as the prisoners themselves.

'Prison staff say that the reason they don't want needle and syringe programmes is around prison safety,' says Ryan. 'But in actual fact we've done serious research in this area and prison staff are majorly at risk. Our argument is that they'd be much better off with a controlled system. Their risk of needle stick injuries is very high and it's quite arguable that with a prison needle and syringe programme it would be significantly reduced.'

Coming over to the UK has given Ryan the chance to think about harm reduction from another perspective. While his country is geographically much bigger than ours, in population terms it is so much smaller (just over a third of the UK's), so he says that in some ways it is easier to engage with politicians at all levels on harm reduction issues.

The service user groups are government funded – a national one, with state and territory affiliates so every jurisdiction has one – set up at the time of 'HIV panic'. 'But their area of interest has traditionally been much more around bloodborne viruses than drug treatment services *per se*, so they're not intimately connected with drug treatment services,' says Ryan.

Australia lacks the grass roots connection that seems to be happening in the UK, he says. 'It's a difficult issue because so few people with drug and alcohol problems are willing to be publicly identified. Some of the most articulate advocates are so afraid to self-disclose because of the stigma around the issues, that you end up with a much less powerful engine of lobbying than in the HIV area, for example, where there was such successful lobbying by gay men's groups who were out and proud.'

But the big challenge in Australia mirrors our own – 'a much broader discussion around health policy reform'.

'Our Labour government wants to overhaul the way that hospitals, community and primary care services interact, and so there's been less attention to drug and alcohol issues because they're trying to overhaul the whole system,' says Ryan. 'That's our big challenge moving forward, to make sure we don't lose what we've achieved so far – and hopefully we can achieve more under the new system.'

There's an element of irony, he adds, in that 'what we're really paying attention to is your healthcare system – that you're now going to dismantle!' He ruefully observes that we are living in interesting times.

DUAL IN THE CROWN

Brendan Georgeson **reports on a very personal project – Bristol's first dual diagnosis recovery conference**

RECOVERY IS THE GOVERNMENT'S NEW BUZZWORD and is starting to appear ever more regularly, alongside 'Big Society' and 'more for less'. For many in the voluntary sector working with drug, alcohol and mental health issues, these ideas are nothing new. So it was with the fear of being seen as a government stooge that I decided to suggest the idea of a free dual diagnosis recovery conference to my local dual diagnosis strategy group in Bristol.

The idea received a good response and my fears were unfounded. Our local commissioners were glad to provide funding of £550 and we booked a local community centre to seat 100 people, with a light lunch, which left me with £10 for photocopying! Relying on the networks I'd made over the years, I contacted as many people as possible about giving a brief presentation on the service they provide for people experiencing dual diagnosis.

My vision was to get everyone networking and talking about what we can do, instead of fantasising about a big government handout to pay for loads of staff to sort all our problems out. It had to include everyone – statutory, non-statutory, service users and ex-service users, and the key to it being a recovery conference was that service user and ex-service user voices be given equal weight to psychiatrists and social workers.

I had a belief in the passion for recovery in Bristol and I wasn't disappointed. The 100 places were booked within a couple of weeks, and I was struggling to fit in all the speakers. Eventually I ended up with ten speakers in the morning, with a strict timetable of 15 minutes each. Together they represented a cross section of the help available in Bristol for those experiencing dual diagnosis – a joint mental health commissioning manager from the NHS, a community services manager, senior drugs practitioners, dual diagnosis consultant nurses, service users and many more.

I opened the conference with some home-made definitions – recovery is a personal experience of improved wellbeing, and dual diagnosis means a combination of mental health and substance misuse issues for which you don't necessarily have to have received a formal diagnosis. Then I did something I'd thought long and hard about before the conference – I disclosed that I was in recovery myself from dual diagnosis.

This wasn't an easy decision, and I didn't know how it would be received. Would people think I was trying to steal ownership of the issues? Would people think I was showboating, or the reverse – would it be the end of my career, with people having their beliefs about me having issues confirmed? I decided to do it, as now, because if we are ever to defeat the stigma of dual diagnosis, get the services we need, and get acceptance from our communities then ex service users like myself need to stand up and be counted. If current service users can have the courage to do so, then so could I.

In the afternoon, well-attended workshops covered how to provide clear guidance on referral routes and entry criteria, how to improve service user participation, diversity issues, improving access and – the most requested workshop – 'how can the statutory and non-statutory sector work more collaboratively?'

By late afternoon I felt a bit like a German officer counting the prisoners at Colditz – I was certain there had been more in the morning than now stared back at me in the afternoon, but it had been a tough programme to get through and maybe the 'light' lunch had finished a few off. The feedback was great, and the goal of a free entry dual diagnosis recovery conference in Bristol, for Bristol and by the people of Bristol had been achieved.

I'd like to thank again all the people that volunteered to make it possible and we hope that the conference can be an inspiration to others to put on their own. Remember, there doesn't need to be a lot of money – just a lot of willingness.

'By late afternoon I felt a bit like a German officer counting the prisoners at Colditz - I was certain there had been more in the morning than now stared back at me in the afternoon.'

Brendan Georgeson is treatment coordinator at Walsingham House, Bristol

HOME AND AWAY

The new culture of localism must not blind us to the benefits of out-of-area treatment, stresses Nick Barton

In the treatment system's reorientation to recovery, the building of recovering communities and, especially, in the context of 'localism' there is – quite rightly – an ambition to quicken the establishment and replication of locally-based services that facilitate recovery. It's a new take on the old adage 'there's no place like home'.

The very sound principle at work is that of helping the person recover amid the realities of the world in which he or she lives. If that's possible, then all well and good – I have listened to some persuasive conference presentations on the subject and am directly involved in the development of such models. I've written before about our Self-Help Addiction Recovery Programme (SHARP) (*DDN*, 27 September 2010, page 6) and there is much interest in this approach, I'm pleased to say.

But, as ever, a word of caution is required. Our field can so easily get carried away with its newfound enthusiasms and the dogmas that spring from them. We convince ourselves that either this or that is 'right', and consequently tend to lean in one direction or the other to the point of losing our balance. Let's not throw out the baby with the bathwater. In other words, let us not lose sight of the value of out-of-area treatment for some – and I emphasise some – clients. We need to think more imaginatively about geography and not put compliance with the dogma of localism before a person's properly assessed needs.

Some people seem to think localism means that everything should be provided locally. We need to recognise, however, that referral to a local service will actually do some clients a disservice and, in any case, may not be their choice – and presumably choice still counts for something. Staying on home turf may actually be counter productive, particularly when a person is at their most vulnerable. Localism should mean procuring access to whatever services can respond effectively to the presenting needs of local people – wherever they may be located. Open the geography as we open our minds.

I have heard it argued that the days of the 'house on the hill' are gone when it comes to treatment – no longer on the hill but over it, apparently, by which it is suggested that the classical model of the residential treatment centre is now passé. But if this option is of real benefit to many – and clearly it is – why should we be in any hurry to discard it or risk doing so by default? Perhaps there's an inverted snobbery at work, a lazy association of such facilities with 'upmarket' clientele who can choose where they go for treatment. Or is it all to do with price? Price as opposed to value, that is. For example, if first-stage centres – to use the term coined by EATA – are more cost effective than NHS hospital-based inpatient units, which they may well be, then shouldn't we hold our excitable horses?

So let's look into the question of value, both in terms of the service user and those delegated by the taxpayer to purchase treatment on their behalf. I must, of course, declare an interest. Action on Addiction runs Clouds House, a first-stage unit of 38 beds and most definitely situated on a hill, as well as Hope House, located in the relative flatlands of Clapham, and I have no doubt that such centres still have an important place as national resources. But I want to argue that position not just because of a proprietary pride in the wonderful help that has been provided in these facilities for nearly three decades, but by setting out more dispassionate, considered perspectives.

First stages first. What is on offer at somewhere like Clouds House that facilitates a person's journey into recovery?

24-hour total care

People arrive in varying degrees of physical and psychological distress, and the first-stage centre offers concentrated physical and psychological health monitoring and management by treatment and care teams operating as one, fully-resourced, round-the-clock response.

CQC registered

This provides some degree of reassurance to purchasers, clients and their families that the essentials required to deliver a decent and safe standard of care are in place. Or it did when CQC was CSCI – the previous rigour has been weakened, and it would be wise for commissioners to take into account a facility's rating under the old regime.

TOWN AND COUNTRY: Action on Addiction runs 'house on the hill' Clouds House in Wiltshire (right) as well as Hope House in London (pictured left).

Continuous assessment and reassessment

Conditions and needs change – sometimes quite rapidly in the first stages of physical and psychological withdrawal and adjustment, and you can greatly improve your understanding of those changes with 24-hour care.

A socially-mixed community

There is a benefit to be had from sharing the treatment experience with people from all parts of the country, all backgrounds and all walks of life. This equates to recovery in the real world and thus prepares clients for one of the principal aftercare resources available to them – the 'anonymous' fellowships. This social mix also improves our understanding of addiction as a cross-cultural phenomenon.

A concentrated community of recovery

A contained environment helps people steep themselves in recovery principles, culture, values and practices. In a safe setting they can begin to incorporate the essentials of a fundamental lifestyle change to take with them beyond treatment.

Intensity

Because the introduction to recovery is all encompassing it makes for a powerfully memorable experience – one that stays with the person and has a therapeutic afterlife on which they can continue to draw.

Care of those with complex needs

Experience has shown us that expertly managing and reassessing a person's mental health and related medication in the context of the therapeutic environment is most valuable. It often allows for more clarity regarding the relationship between mental health issues and addiction and, if managed well, will have a significant impact on the part they can play in managing their own recovery journey.

Detox integrated into psychosocial treatment

Detox on its own is known to be ineffective, but may be worse than that. The first-stage service supports and enables physical withdrawal within the context of recovery (*DDN*, 16 November 2009, page 12) – the psychological shift to recovery has already begun with the decision to undergo withdrawal, so why waste time? Let's put and end to 'detox and'…and replace it with recovery-oriented treatment with detox included as required. We are treating addiction, of which intoxication is only a part, and detox is certainly not the key to recovery, which lies almost entirely in the psychosocial domain.

Safety

The boundary between recovery and a substance-dependent lifestyle is more easily managed through being away from the powerful cues for relapse likely to be found in the home environment for a significant period, and where vulnerabilities can be closely monitored.

The care pathway

There is an opportunity to take stock of resources and fully plan and prepare for reintegration in all its dimensions, including via second stage provision if required.

Value

This is about the amount and quality provided for the money, and what it achieves. For the comprehensive care it provides, and the significant progress clients can make over a relatively short period of time, the value of properly run first-stage provision is of great value. Relatively quickly, clients establish foundations on which their longer-term recovery can be built with the right support.

Outcomes

What we are here for? Remember *NTORS: the national treatment outcome research study*? As many people will recall, it found that 'the clients who were treated in the residential programmes presented with some of the most severe problems and complex needs, and these clients made some of the greatest treatment gains' (NTORS third bulletin,1998).

Readers may not be aware, however, that the report combined so-called rehabs and NHS in-patient units into one category, thereby disguising the performance of the latter. It subsequently emerged that the rehabs had outstripped the in-patient units by some distance according to the outcomes being investigated, and because the NTORS reports did not disaggregate the results an entrenched model of poor practice has been allowed to continue, clients have been denied a far better option and the rehab sector has suffered from a damaging decline in funded referrals. This is despite NTORS indicating that 'a balanced and integrated national treatment response requires that such services continue to be available and that they be supported in ways to maximise their effectiveness'.

And so to second stage services. Once a person has achieved an initial treatment and recovery gain they need help to sustain it and build upon it. Not for one minute can a first-stage episode be a 'magic bullet'. For those wishing to avoid a home environment of great vulnerability, admission to an out-of-area second stage programme helps the process of eventual resettlement. It is also consistent with the first-stage experience while lowering the intensity of inputs and moving self-directed recovery along.

Sustaining recovery can be enabled in a variety of ways. For some people without adequate recovery capital, a second-stage unit offers the best option, for reasons similar to those itemised in the discussion of first-stage services. For some women, an all-female environment such as at Hope House may be required, something that might only become apparent, even to them, during treatment in a mixed-gender centre. In a somewhat less intense but nonetheless contained and structured setting, a client can continue to practise recovery behaviours while taking more responsibility to engage constructively with the external world. It is a bridge. Like any good bridge it helps the traveller over a divide, providing a firm footing and giving them the confidence to cross.

So is it to be treatment in the home community, or treatment away? Both have a part to play, and if we want to ensure the best possible array of options for the great diversity of clients, and maximise benefit, we had better ensure they are both still in a position to do so.

Nick Barton is chief executive of Action on Addiction

CPD: Skills Development Training

Psychotherapy Skills Toolbox

Therapeutic Applications of Translational Research

...there is a wealth of psychological research that never touches the therapy field but which has important implications for it, says *Paul Grantham*

Paul Grantham leads seminars **"How to Be More Effective: Therapy Applications of Translational Research"** around the UK:

London
02 March 2011

Birmingham
10 March 2011

Bristol
11 March 2011

Newcastle upon Tyne
17 March 2011

Portsmouth
23 March 2011

Glasgow
28 March 2011

London
29 March 2011

Belfast
30 March 2011

Manchester
31 March 2011

Harrogate
01 April 2011

Q: Hi Paul. You are about to run a new course at SDS that looks completely different to everything you've done before. It is called "How to Be More Effective: Therapy Applications of Translational Research" and even the title sounds intriguing. Can you tell us about the course please?

PG: Sure. It has always struck me that there is a wealth of psychological research that never touches the therapy field but which has important implications for it. Research in social psychology, the psychology of memory and environmental psychology are just three fields which immediately come to mind where we have well-established consistent bodies of knowledge which are typically ignored by those working in the therapy field but which have major implications for outcomes and effectiveness. The term "Translational Research" means the application of basic research in psychology to the therapy field. This idea is huge in the US with the NIH establishing 60 research institutions by 2012 to specifically look at this. The great thing abut this research is that it has applicability in enhancing practitioners' effectiveness whatever therapeutic modality they work in.

Q: I noticed that this course is a module of "The Certificate in Essential Therapy Skills" – what is the certificate and what other modules does it include?

PG: The Certificate consists of four modules that cover group interventions, problem solving techniques within therapy and time management skills to increase effectiveness without reducing quality of service to clients.

Q: Who is this course suitable for? On one hand - do you have to have a lot of practice experience to attend? On the other hand – is it still suitable for those who already have a lot of experience? Do you think they will learn something new there?

PG: I think the issue of translational research is so new in the UK that the vast majority of practitioners are unlikely to have come across it before, so in that respect all therapists, whatever their experience are likely to gain new insights from the training day.

Equally, the ideas we will be exploring are in many instances so simple to incorporate into practice that even inexperienced practitioners will benefit from them. There are really only two key caveats to bear in mind regarding whether to come. The first is the desire to produce better outcomes for your clients within your existing resources and secondly a willingness to be open to new ideas that may challenge existing assumptions. All the ideas can be incorporated into existing modalities of work - exploratory, CBT, client centred etc, however, they do require counsellors to be willing to "think outside of the box" regarding how they currently apply such therapies.

Q: Are you accommodating in your pricing the current financial pressures?

PG: Things are hard financially for most therapists these days. There are either problems related to obtaining funding or, in case of the self funding practitioners, – feeling the pressure on their own income. SDS recognises this and has adopted a number of measures to try and help. There are all sorts of discounts available from early bird bookings, bookings online through to booking of multiple events. Equally, those who have registered on the SDS website get first chance opportunities to hear about special offers on training events that are regularly introduced. For this particular course there will be three major price–bands related to the time and the mean of booking, which, combined with the VAT difference in 2010 and 2011 means that delegates can save up to £50 if they book early.

Q: Please share with us some lessons that you've learnt yourself from translational research? How has it changed your practice or, indeed, your everyday life?

PG:... (for further answers – see below)

Read the full interview at:
www.skillsdevelopment.co.uk

10 Second Quiz:

Telling your client that you were both born in the same town is most likely to...
A. Make the client feel anxious about confidentiality
B. Make the client more likely to comply with your requests
C. Encourage the client to talk about where they live (rather than their problem)
D. Make the client more dependent on you leading to greater problems with discharging them

What one object added to your working environment has statistically the most positive effect on client change?
A. A pot plant
B. A mirror
C. A stimulating "abstract poster"
D. A comfortable armchair

Statistically, what is the most important reason why clients don't seek treatment for their problems?
A. Lack of knowledge of resources
B. The stigma of their problem
C. Low confidence in the effectiveness of the therapy offered
D. None of the above

Come along and find the answers to these and many other questions.

SEIZE THE DAY

Thursday 10 February 2011

Holiday Inn, City Centre, Birmingham

DDN Drink and Drugs News

The Alliance
Taking treatment forward

***DDN* and The Alliance are pleased to present the 4th annual service user conference, *Seize The Day*. This is YOUR chance to speak up and speak out about issues around service user involvement.**

Service users, drug and alcohol workers and treatment service providers are invited to the must-attend event of the year. The latest and hottest topics will be discussed – with plenty of time to ask questions and share your views.

With a new government and an increasingly difficult economy, what can service users do to ensure their voice continues to be heard? Budget cuts mean that services are looking to make 'efficiency savings' – and it is up to service users to make sure that your views are not lost in the fight for survival. We will look at innovative ways to keep your service user group going, as well as how service users, drug and alcohol workers and treatment services can work together to make sure that support does not suffer.

Full conference details, programme and online booking:

www.drinkanddrugsnews.com

If you would like to exhibit in the service user or service provider exhibitions, please telephone 020 7463 2081 or email conferences@cjwellings.com

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Training and presentation
Drugs and alcohol
Children and young people

Book onto our open course programme (see listings opposite or contact us for full programme details), or bring us in to deliver training tailored to your organisational or area needs.

For an informal discussion contact Steve or Jo on 0117 941 5859 or info@trainingexchange.org.uk

Visit our website
www.trainingexchange.org.uk

Open access programme 2011

All courses closely mapped to DANOS
Bristol venues *(contact us for dates in Plymouth)*

One day courses (£125 + VAT)

Addiction, dependency & recovery	*25 Jan*
Alcohol - Brief interventions	*8 Feb*
Resilience skills	*10 Mar*
Hepatitis C	*29 Mar*
Steroids & other body building drugs	*5 Apr*
Group supervision	*18 May*
Difficult & aggressive behaviour	*26 May*
ITEP and Node link mapping	*14 Jun*

Two day courses (£225 + VAT)

Motivational interviewing	*3 & 4 Feb*
Groupwork skills	*10 & 11 Feb*
Brief solution focused therapy	*17 & 18 Feb*
Community reinforcement approach	*15 & 16 Mar*
Adolescent development & substance misuse	*6 & 7 Apr*
Supervision skills	*4 & 5 May*
Controlled drinking programme	*10 & 11 May*
Relapse prevention	*28 & 29 Jun*
Management & leadership (*£275)	*5 & 6 Jul*
Dual diagnosis	*7 & 8 Jul*
Training for trainers	*12 & 13 Jul*
Working with concerned others (*£295)	*18, 19 & 20 Oct*
Project management	*10 & 11 Nov*

Online booking available

SEIZE THE DAY

Thursday 10 February 2011

Holiday Inn, City Centre, Birmingham

DDN Drink and Drugs News

The Alliance
Taking treatment forward

SUPPORTED BY National Treatment Agency for Substance Misuse NHS

***DDN* and The Alliance are pleased to present the 4th annual service user conference, *Seize The Day*. This is YOUR chance to speak up and speak out about issues around service user involvement.**

CONFERENCE PROGRAMME

9 am – 10 am Coffee and registration

10 am – 11.15 am Survival of the fittest!
Get inspired by these groups who are achieving maximum impact with minimal funding!

ASUD User Group France, ***Fabrice Olivet*** – ASUD's ongoing campaign for drug consumption rooms in Paris, and how direct action has achieved results.

The Recovery Federation, ***Annemarie Ward and Alistair Sinclair*** – How the rapid growth of The UK Recovery Federation has been achieved by empowering individuals.

The London User Forum, ***Tim Sampey*** – How the rebirth of the London User Forum has been achieved by user groups and treatment providers working together.

11.15 am – 11.45 am Coffee break

11.45 am – 1 pm Welfare reform
What will it mean for service users? With benefits such as disability allowance and housing benefit under review, and the possibility of sanctions on benefits as a means to coerce individuals into treatment, service users need to be aware of the proposed changes and know their rights. ***Niamh Eastwood***, Release, will highlight concerns around the proposed changes, while ***David Burrows MP*** will put the case for the reforms in this session chaired by ***Alex Boyt***, Camden user involvement officer.

1 pm – 2 pm Lunch

Service user group exhibition
With over 35 different groups attending, this is a fantastic opportunity to network with people from all over the country, share ideas and gain inspiration! This is your chance to showcase the work you're doing in your local area. To make sure your group is there email *conferences@cjwellings.com*

2 pm – 3.30 pm Question time
Join a panel discussion with a range of speakers to debate topical issues. Suggestions for topics so far include: Payment by results – will this threaten fair treatment for all? Time-limited scripts – could there ever be a place for enforced reduction? Drugs and alcohol – what will their place be in the proposed new public health service?

This is your debate at your conference – let us know the topics you want to discuss and the questions you want to put to the panel of policy makers, treatment providers, doctors and service user activists. *Email conferences@cjwellings.com* with questions and suggestions.

3.30 – 3.45 DDN Film awards
A chance to view the service user made films shortlisted for the DDN film award.

The DDN training zone:
If you would like your courses or resources in this new dedicated area, please telephone 020 7463 2081 or email conferences@cjwellings.com

Delegate rates: Service User Places £90 + vat Professionals £145 + vat.

This unique one-day event gives service users and providers the chance to network and share ideas on how service user involvement can continue to improve treatment in the current economic climate.

Full conference details, programme and online booking:

www.drinkanddrugsnews.com

MEDICAL EVENTS INTERNATIONAL AND HEALTH
MEDINEO
FOR MEDICAL EVENTS
CONFERENCES

Substance Misuse Conference
CHILDREN AFFECTED BY PARENTAL SUBSTANCE MISUSE
8 March 2011
Radisson Blu Hotel, Edinburgh, Scotland

Speakers include:

Adam Ingram MSP
Minister for Children and Early Years

Joy Barlow MBE
STRADA: Centre for Drugs Misuse Research, University of Glasgow

Professor Sarah Cunningham-Burley
Professor of Medical and Family Sociology, Public Health Sciences section, Division of Community Health Sciences, The University of Edinburgh

Rowdy Yates MBE
Senior Research Fellow, Applied Social Science, University of Stirling

Anne Whittaker
Nurse Facilitator Spittal street, NHS Lothian

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The CPD Certification Service

This conference includes seminars and workshops.
For more information please visit our homepage or contact us.

Visit our website for details and booking. Sponsorship opportunities available.
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Book Before 25/02/2011 to receive a 10% discount on the booking fee

CONFERENCE
Wednesday, 30th March 2011
Optimising Treatment Effectiveness

Location:
IET Savoy
Savoy Place
London
WC2R 0BL

See enclosed flyer for further details

The following are some of the questions the conference aims to answer:

- Are there **imaginative and novel ways to commission and provide services** that can offset some of the current challenges and threats?
- What does **recovery capital** mean in practice and how can we best develop and draw upon it?
- What can be done to promote pathways to **employment, treatment, education, and other forms of meaningful activity** that contribute to people's **reintegration, well-being and quality life** during a period when public sector employment is falling?
- What are the existing and emerging **recovery networks** and how we can best exploit these?

This conference will critically examine ways that new thinking can best be applied across all services including:
Service user representatives, Drug & Alcohol Action Team Commissioners and Strategic Leads, Drug & Alcohol service providers, probation teams, Prison Staff & Social Workers.

Further Information:
www.kca.org.uk/pages/kca_conferences

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Amber offers a safe residential environment for unemployed men and women aged 17– 30 who want the opportunity to make a new start.

Amber has a 15 year track record of getting people from socially excluded groups back into independent living, offering those who have lost their way the chance to put the past behind them and move forward.

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- The opportunity to learn skills and overcome barriers to progression, helping rebuild self-esteem and confidence
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- Opportunities to return to further education and to enter employment, with on going support
- Accommodation whilst working towards self sufficiency

If you would like further details of what Amber has to offer or would like to visit one of the Amber centres, please contact Olly Giddings, Recruitment Manager on: 01769 582022 or email olly.giddings@amberweb.org

"Amber could be just the answer you are seeking. The benefits to the individual and society far outweigh the costs"

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Initial day viability assessment is free of charge. To book an assessment or for any further information please contact us on 029 2041 5400 or visit our new website www.ashcrofthouse.org.uk

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Please contact the Centre Manager: Kate Lyons for further information or to arrange a referral or assessment.

The Huntercombe Centre,
Sunderland, Leechmere Road, Sunderland,SR2 9DJ
Tel: 0191 523 5516
Email:huntercombe.centre.sunderland@fshc.co.uk

DDN Drink and Drugs News

fdap

DDN/FDAP WORKSHOPS

We are pleased to offer the following workshops:

16 February 2011
Help! I'm a registered manager!
This course will help anyone new to the role of registered manager as well as anyone who wishes to further understand the new registration and inspection arrangements introduced by the Care Quality Commission (CQC). The course complements the following day's 'Quality Matters' workshop. David Finney was the national policy lead for substance misuse services with CSCI and is now an independent consultant specialising in the relationship between the CQC and registered substance misuse services.
Places are only £135 + VAT. If you book on this course and the following day's (quality matters), places are £245 + VAT for both days. Costs include refreshments, lunch and course materials.

17 February 2011
Swimming in clear blue waters: quality matters
This workshop will introduce participants to the concepts and processes underlying quality monitoring. The focus will be on services registered by the Care Quality Commission (CQC) who will be introducing a 'provider compliance assessment' system, and will help anyone responsible for quality monitoring in an organisation or commissioners and contractors seeking to understand the CQC process. Uniquely the workshop will be presented by a service provider and an independent consultant. *Places are only £135 + VAT. If booked in conjunction with David Finney's other course on the previous day (Help! I'm a registered manager!), places are £245 + VAT for both days. Costs include refreshments, lunch and course materials.*

17 and 18 March 2011 (two day course)
Safer injecting and needle exchange
Kevin Flemen runs KFx, a drugs information and training business and has been delivering safer injecting and needle exchange training since the mid-nineties. He has worked with agencies across the UK and this two-day safer injecting course is held in high regard by participants. Needle exchange and advice around safer injecting remains an essential skill set for drugs workers – not only can effective needle exchange reduce harm in the short term, but well delivered interventions can provide an essential route into treatment and long term change. This two day course looks at key issues in safer injecting and needle exchange including theory, paraphernalia, process, technique, sites and anatomy and complications. This course is essential for all workers who have contact with injectors, especially those working in Needle Exchange settings. It is mapped to DANOS and includes handouts and resources.
Place: £220 + vat including lunch and refreshments

23 March 2011
Healthy Eating for a better life
Specialist nutritional advice for people with substance misuse issues. Includes updated DDN Nutrition Toolkit.
Place: £115 + vat including lunch and refreshments

15% discount to FDAP members.

All courses run from 10.00 am – 4pm in central London, and include lunch and refreshments.

For more details about these workshops email lexy@cjwellings.com or call 020 7384 1477. Or visit www.drinkanddrugsnews.com

DDN training is run as a partnership between DDN magazine and independent training providers. DDN offers trainers promotion, advertising and marketing resources, a central London venue, and admin support. If you are a trainer working in the drug and alcohol field and would like to discuss partnering with DDN on a training course, please contact us.

EMPOWERMENT TRAINING DAY

WEDNESDAY 2 MARCH 2011

This one-day training course will show you how to teach the Empower Your Life programme to your clients, using the new toolkit

The Empower Your Life toolkit is a practical, dynamic and inspiring coaching programme that develops healthier lifestyle habits to increase wellbeing, self-reliance and self-esteem. If you are a key worker, therapist, facilitator or coach interested in using this material with groups or individuals, this training day is for you!

YOU WILL LEARN HOW TO:

- ✔ *Assess whether clients are at the right stage in their recovery to benefit from the toolkit.*
- ✔ *Introduce and present the toolkit.*
- ✔ *Engage clients and get commitment from day one.*
- ✔ *Present and explain the different processes.*
- ✔ *Negotiate how much of the programme clients wish to commit to.*
- ✔ *Monitor progress and keep clients on track.*
- ✔ *Recognise and deal with resistance when it appears.*
- ✔ *Assess results at the end of the month.*
- ✔ *Set up a system to encourage clients to keep momentum going beyond the programme.*
- ✔ *Work with individuals or groups.*

For an introductory price of £175 (including VAT) you will get a full day's training (including lunch and all refreshments), a copy of the toolkit (normally £29.95) and a copy of the facilitator coaching manual.
The course runs from 10am-4pm in central London.
To book, email lexy@cjwellings.com or call 020 7384 1477.

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RECRUITING NOW!

Trust The Process are again seeking to recruit dynamic, forward-thinking staff for our exciting new projects in the North West (Cheshire and Bradford) and our existing centres in Bedfordshire.

For these posts you will have: experience in the substance misuse, social care or related fields, providing direct client services; an understanding of the effects of substance misuse on individuals and different sections of the community and the consequent needs of those individuals and communities; The ability to work on your own initiative as well as part of a team and demonstrate willingness and ability to work a shift pattern.

Salaries: very competitive

Please contact david.durand@ttpcc.org for an Application Form and Job Description or call on 01582 816056 for more details

TTP is an equal opportunities employer. Those with personal experience of addiction or dependency on drugs/alcohol and who are at least two years drug free/sober are also encouraged to apply for the above positions.

Doctor

We are seeking to recruit a Doctor with experience in the drug and alcohol misuse/detox fields for our centres based in the North West. This is a full time, permanent post.

Detox Clinic Nurses

RMN or SRN trained nurses to work with us in exciting new ventures in London and Bradford. Our programme offers clinical detox opportunities to individuals with alcohol and drug dependency and addiction. You will need have a current registration with the NMC.

Recovery Coaches and Support Workers

We need Recovery Coaches for our high quality therapeutic support programmes to substance misusing clients in Bedfordshire and the North West and to deliver a structured therapeutic support programme through group-work sessions and one to one interventions and offer support to the multi-disciplinary counselling teams.

Counsellors

Counsellors will require a BACP or equivalent accredited Diploma. A knowledge and/or personal experience of the twelve step model is essential for our Bedfordshire vacancies.

ttp counselling

alcohol and drug rehab

www.ttpcc.org