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DDN
Drink and Drugs News

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Summer 2011

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  Neil Hunt (University of Kent, UK Harm Reduction Alliance)
- *'Recovery in the community: The challenges & opportunities'*
  Brian Morgan (SU Coordinator W.Sussex DAAT, EXACT, Whole Person Recovery Project)
- *'Building a recovery movement'*
  Carol McDaid (Faces and Voices of Recovery)
- *'Building a Recovery-Oriented Integrated System (ROIS)'*
  John Strang (National Addiction Centre, King's College, London)

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www.drinkanddrugsnews.com

The third UK Recovery Walk will take place in Cardiff on Saturday 10 September, 2011. Thousands are expected to parade around Cardiff City Centre to celebrate the fact that people can and do recover from substance use disorders and mental health problems.

For more details visit:

www.ukrf.org.uk

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What price life?

Why naloxone should be everyone's business

THE NALOXONE DEBATE seems to be taking a long time to come to a conclusion but the NTA's report on its recent pilots provide evidence to underline what many have been calling for for more than two years – a roll-out of the easy-to-administer and cost-effective overdose antidote (page 14). There is no more simple and effective intervention to prevent fatal overdose, so bringing naloxone into mainstream drug treatment, as Danny Morris suggests, should surely follow. Certainly the policy direction in Wales is highly encouraging (page 18).

The threat of homelessness takes our cover slot (page 8), because the figures are continuing to rise with no turnaround in sight. Brighton and Hove Street Services team say they are seeing a new cohort of people who have exhausted all other options. There's good work going on down on the south coast, but are we destined to keep remodelling support services when more holes appear in the welfare net?

You may or may not agree with Alex Boyt's personal views on 12-step philosophy, but we know it's an issue that many readers want to talk about, so here's the invitation (page 12). And while we're in the debating corner, Prof Neil McKeganey gives insight to his controversial views (page 16). Our letters page awaits.

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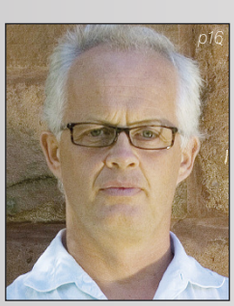

FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: JOBS, COURSES, CONFERENCES AND TENDERS

CENTRE-PAGES: THE DDN SUMMER 2011 TRAINING AND DEVELOPMENT DIRECTORY

News in Brief

THEY'RE THE LIMIT

The House of Commons' Science and Technology Committee has announced an enquiry into the evidence base for the government's alcohol guidelines – currently 2-3 units a day for women and 3-4 for men. The committee will also look at how the government communicates its safe drinking messages and how the guidelines compare to those in other countries, many of which have higher limits. Alcohol Concern, however, has stressed that 'up-to-date medical research should take precedence over any existing practice when considering UK guidelines'. *Written evidence of no more than 3,000 words can be submitted to scitechcom@parliament.uk before 14 September, marked 'alcohol guidelines'.*

DEADLY TRADE

An industrial unit in Boston, Lincolnshire, that blew up killing five people was being used for illegal alcohol manufacture, local police have confirmed. Counterfeit alcohol – which can cause blindness and death in some cases – is a growing problem in the UK, according to trading standards officers. *See news focus, page 6.*

REWARDING WORK

The Young Addaction project in Halton, Cheshire, has won a 2011 Diana Award for its anti-bullying work. 'A lot of the guys we spoke to said that bullying was a problem, and they told us how drugs and drink were a way of coping with the feelings bullying caused,' said the project's Colin Hughes. The charity ran a series of two-hour sessions where young people were able to use drama to explore the issue, with the group eventually writing a short play and performing it for friends and family.

KHAT OUT OF THE BAG

The number of khat users in Europe is growing, although the 'scale and nature of the problem' remains poorly understood, according to a report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Migration from the Horn of Africa, where khat leaves have been chewed for centuries, has been associated with the spread of its use, says *Khat use in Europe: implications for European policy. Available at www.emcdda.europa.eu*

Phenazepam to be banned

Imports of the benzodiazepine phenazepam have been banned, the Home Office has announced.

The UK Border Agency will now seize and destroy shipments of the drug, which is sold on the street under various names including 'Bonsai' and on the internet as a legal high. The government will also take steps to control the substance as a class C drug when Parliament returns.

The government was advised by the Advisory Council on the Misuse of Drugs (ACMD) that phenazepam is sufficiently harmful to justify an import ban, the Home Office states. The drug is not prescribed in the UK for treatment and does not have a UK marketing authorisation. 'It has been identified as being a potent member of the benzodiazepine family causing harms such as amnesia and drowsiness that may potentially proceed to a coma with respiratory depression,' says the Home Office. The government is also introducing 12-month temporary bans for new psychoactive substances as part of the Police Reform and Social Responsibility Bill (*DDN*, 13 September 2010, page 4) while the ACMD assess the harms they pose.

Phenazepam, which is mainly produced in Russia, is often sold as counterfeit Valium (diazepam) online, says the ACMD, or in powder or dropper form, sometimes in combination with dimethocaine. Its potency is around five times that of diazepam, the council adds, making overdose a significant risk, especially as peak effects are not reached for around 2-3 hours and the substance has a 60-hour half life. Last month researchers at the University of Dundee wrote to the *BMJ* warning of an increasing trend of misuse, having identified nine cases this year in which postmortem blood samples contained phenazepam.

'Banning the importation of this harmful substance and taking steps to control it sends a clear message to unscrupulous traffickers and dealers trying to start a market here for their dangerous drugs,' said crime prevention minister Baroness Browning. 'The ACMD's advice on phenazepam reinforces what we already know — that substances touted as "legal highs" contain dangerous and illegal substances. Users need to understand they could be breaking the law and risk seriously damaging their mental and physical health.'

The Association of Chief Police Officers in Scotland (ACPOS) has also issued a warning about the stimulant PMMA (ParaMethoxyMethylAmphetamine), that has been found in some legal highs as well as tablets sold as ecstasy. PMMA has been identified in pink tablets with a Rolex crown logo and white tablets with a four-leaf clover logo, and has also been recovered in powder form.

'PMMA is a stimulant drug similar to ecstasy, but it is not as potent,' said Scottish Crime and Drug Enforcement Agency (SCDEA) national drugs coordinator, detective inspector Tommy Crombie. 'Users may believe they have taken a weak ecstasy tablet, when they have actually taken a tablet containing this highly toxic substance. They may then be tempted to take more tablets to achieve the desired effect, increasing the risk of a potentially fatal overdose.'

See September's issue for our feature on the growing problem of benzodiazepine use

Classification change fails to affect use of ketamine and mephedrone

Classifying ketamine as a class C substance in 2006 has not had an effect on levels of use, according to a report from the Independent Scientific Committee on Drugs (ISCD).

Researchers carried out a review of existing data on the drug dating back 11 years 'in response to a clear lack of public and professional understanding'.

The average price of ketamine fell from £30 to £20 per gram between 2005 and 2008, and has since become cheaper still, says the report. There were an estimated 113,000 users in 2008/09, up from 85,000 in 2006/07, while 68 per cent of clubbers claimed to have taken the drug in a 2009 survey, nearly three times more than at the start of the decade. The report shows that the drug 'can be addictive' and presents 'clear physical and psychological harms', including ulcerative cystitis severe enough to require surgical removal of the bladder.

'It is vital that ketamine users and professionals have access to accurate information on ketamine use to reduce its potential harms,' said co-author, Professor Val Curran. 'With only one facility offering treatment specifically for ketamine addiction in the whole of London, there is an urgent need for an increase in addiction services nationwide for ketamine users, linking these with urological clinics and reviewing the effectiveness of classification as a means of reducing drug harms.'

DrugScope said a public health response to the use of the drug, rather than the 'blunt instrument' of reclassification to a higher class, was crucial. 'Concern has been building for some time about the physical risks associated with ketamine dependency, but this report provides compelling evidence of both the physical and psychological harms associated with the drug, which are particularly acute for those who become heavy or dependent users,' said chief executive Martin Barnes. 'It is imperative that there is a robust public health response, including both the dissemination of good quality information to drug users and adequate resourcing for treatment services. Young people need to know the risks – for example, that heavy and prolonged use of this drug could leave them using a catheter for the rest of their life.'

Meanwhile, the latest British Crime Survey reveals that last-year use of mephedrone is now at similar levels to ecstasy use among 16 to 59-year-olds. For those aged between 16 and 24, however, mephedrone use is at a similar level to powder cocaine, the second most used drug among young people after cannabis. Mephedrone was banned by the government last year (*DDN*, 26 April 2010, page 4).

Ketamine report at www.drugscience.org.uk
British Crime Survey at www.homeoffice.gov.uk

Treatment must guard against 'drift into long-term maintenance'

Drug treatment should increase its focus on supporting people to recover from dependency and guard against 'incorrect provision or unnecessary drift into long-term maintenance or substitute prescriptions', according to a report by Professor John Strang of the National Addiction Centre for the NTA. Prescribing must not be allowed to be delivered in isolation from other treatment components, it says.

Drug workers should review all their clients to make sure they are 'working to achieve abstinence from their problem drugs' and give them the opportunity to come off medication when ready, says the interim report, *Recovery-orientated drug treatment*. Treatment should also incorporate wider social interventions alongside medication, it says, and clinicians should call on the 'full range of psychosocial and pharmacological approaches' to reduce the risk of relapse. A full report and guidance by the expert group chaired by Prof Strang will be published next year.

'The drive in recent years to reduce waiting lists and retain people in treatment has generally been successful with the result that much larger numbers of patients with addiction problems now enter treatment,' said Prof Strang. 'This has undoubtedly been accompanied by significant benefits for many patients and the communities in which they live. However, the desire of clinicians to secure these benefits has led, in some instances, to over-reliance on medication and patients being allowed to drift into long-term maintenance.' Insufficient attention may have been paid to reviewing the benefits and considering alternative methods to maximise chances of recovery, he added.

DrugScope called the report a 'welcome reminder of the challenges that face the sector' but stated that, in light of the forthcoming payment by results (PbR) pilots, 'recovery goes well beyond the treatment gates; an individual's failure to access housing, training and employment, for example, will inevitably undermine both treatment outcomes and the wider ambitions of the recovery agenda'. *Available at www.nta.nhs.uk*

Naloxone pilots save 18 lives

Eighteen drug users survived overdose as a result of carers administering naloxone during the NTA's overdose training programme pilots, the agency has announced.

Two more were saved by basic life support techniques, says the agency's report, *The NTA overdose and naloxone training programme for families and carers*. Most of the incidents were 'opportunistic' interventions, where the carer used naloxone – which blocks the effects of heroin overdose – on somebody other than the person named on the prescription.

The NTA launched its overdose and naloxone training programme for family and carers of drug users in response to the inconsistent distribution of the drug, (*DDN*, 13 July 2009, page 4), with pilots running at 16 sites from July 2009 until February 2010.

The 2007 UK Clinical Guidelines support the use of naloxone as a means of preventing fatal overdose and, although the drug is only available on prescription, with the right training anyone can use it in an emergency. 'The first people to find overdosing drug users are often family members, partners and other carers (who may be drug users themselves),' says the report. However, a wider impact could be possible, it says, 'if the training focuses on all service users at risk of opioid overdose'.

Report available at www.nta.nhs.uk

See feature page 14

Cuts bite hard on young people's services

Government cuts are having a 'devastating' impact on young people's drug and alcohol services, according to DrugScope and other charities.

Both treatment for those young people already using drugs and alcohol and preventative work in schools are being affected, along with support for professionals, they warn. Some local authorities have imposed funding cuts of up to 50 per cent on young people's services, according to Addaction. In a survey of 79 local education authorities (LEAs), almost 30 per cent said their secondary schools had had no specialist drug education support since April, rising to 34 per cent for primary schools. While the government's drug strategy emphasises the importance of prevention and education, the reality is one of 'cuts and local disinvestment' warns DrugScope.

'While it is difficult to get a full national picture of the extent of the cuts, there is no question that local provision in many areas is suffering,' said chief executive Martin Barnes. 'The importance of early intervention is recognised by government, yet the work of local services already delivering high quality interventions and support for young people is currently being dismantled.'

'We are probably in the worst situation for drug education for decades,' said Mentor UK chief executive Paul Tuohy. 'We won't see the real impact for at least another 18 months, when the effect of a complete lack of infrastructure for drug education will become apparent. It could have devastating implications.'

Meanwhile, statistics from the NHS Information Centre show a six per cent fall in pupils who had tried alcohol since 2009, from 51 to 45 per cent. Eighteen per cent admitted to taking drugs, down from 20 per cent a decade ago.

Brinksmanship: SMMGP has welcomed Steve Brinksman as its new clinical lead. A Birmingham GP for 20 years, he was one of two lead GPs in substance misuse employed by Birmingham DAT to develop their highly successful primary care based drug treatment model, which will be showcased at this year's SMMGP conference in Birmingham on 13 October.

News in Brief

HAVE I GOT AN AWARD FOR YOU

Swanswell's Reducing drug-related reoffending programme (*DDN*, July, page 14) has been given the runner up prize for best practice in the Howard League for Penal Reform 2011 community programme awards, presented by Ian Hislop. The 12-session programme saw the amount of money offenders spent on illegal drugs fall by more than 70 per cent. 'We're delighted to have been recognised for this innovative project that has the potential to change thousands of lives for the better,' said chief executive Debbie Bannigan. 'Swanswell's programme tackles the underlying cause of someone's offending and identifies ways of avoiding potentially risky situations, reducing the possibility of them getting involved in crime again.'

EATA EXEC

Former head of drug and alcohol policy at the Department for Work and Pensions (DWP), Colin Wilkie-Jones, has been appointed the new chief executive of eATA, the organisation has announced. 'Colin's experience of working at senior level in central government will be a real asset to our members,' said chair of eATA's board of trustees, Steve Cooke.

HEATED DEBATE

Neil McKeganey and Stanton Peele will debate 'The Future Of Harm Reduction And Drug Prevention In The UK' on September 21 and 22 in Glasgow and Edinburgh. *More information at http://addictiondebates.com/index.php/forthcoming-debates/*

See our Neil McKeganey profile on page 16

ALCOHOL EVIDENCE

A new alcohol test service has been launched by Concateno TriTech, testing specialists for child protection and family law. 'Sobriety to excess' is made up of a series of tests carried out over a period of weeks, providing substantial evidence that a person is not using alcohol. 'Undergoing alcohol recovery, people often feel "no-one believes me"', said clinical director of the Charles Jones Institute, Michael Jones. 'Any tool that provides evidential support that someone is doing what they say they are doing is a significant help in their recovery.'

CRIMINAL GANGS PROFIT FROM DANGEROUS ILLEGAL ALCOHOL

A fatal explosion in Lincolnshire has drawn attention to the murky world of the UK's illegal alcohol market. ***DDN*** investigates

Last month five men were killed and another seriously injured in an explosion at an industrial estate in Boston, Lincolnshire, with police later confirming that the unit housed a filtration plant for the production of 'illicit alcohol being distributed and sold as vodka' (see news story, page 4).

Earlier this year, a Bolton gang was jailed for supplying illicit alcohol to local retailers from a network of warehouses – allowing the ringleader to amass a foreign property portfolio – while last October, fire crews attending a blaze in Manchester also found an illegal alcohol factory. HM Revenue and Customs (HMRC) officers seized 25,000 litres of counterfeit alcohol, along with bottling and labelling equipment for 'hijacking a well-known brand name'.

Counterfeit alcohol is a problem that customs and trading standards officers have been dealing with for years. HMRC and the UK Border Agency seized nearly 7m litres of alcohol in 2008/09 – an increase of more than 30 per cent on the previous year – and two years ago the two agencies published their renewed *Tackling alcohol fraud* strategy, which stressed the involvement of 'highly organised criminal gangs'.

So is illegal alcohol now a lucrative revenue stream for organised crime? 'It is often linked to wider criminality,' lead officer for health for the Trading Standards Institute, Dennis Ager, tells *DDN*. 'The Lincolnshire incident seemed to be quite an organised operation, with an industrial unit, and that's indicative of what goes on. What we find with any counterfeit product is that it's rarely sold in isolation. There'll be a link between counterfeit alcohol and counterfeit – or illegally-smuggled – tobacco, and what we find is they're supplied in areas of deprivation, as affluent people can afford to buy the genuine stuff and tend to be better informed. The profits involved are high – that's the incentive.'

Indeed, as counterfeit alcohol costs almost nothing to produce, manufacturers can undercut legitimate retailers by huge percentages and still make a profit. But cheaply produced counterfeit alcohol can mean serious health risks. The main ingredient is usually methylated spirits, mixed with, as Ager says, 'all sorts of chemicals'.

Is it sold exclusively on the black market, or does some find its way into shops? 'It's a combination of the two,' he says. 'Colleagues have recovered counterfeit products from legitimate retailers. You get circumstances where the imitations are so good that retailers can buy it in good faith – they don't necessarily realise what they're doing. But then at the other end of the scale you get people selling it out of a box at a car boot sale, which should ring alarm bells.' While some fake bottles have poor quality, misspelled labels, it's not always possible to tell if a product is counterfeit by looking at it, he stresses. 'Sometimes you'll get spurious brand names people have never heard of, but the price is the giveaway.'

Police and firefighters attend the scene of an explosion at the Broadfield Lane industrial estate in Boston, Lincolnshire. Police later confirmed that the unit was used for the production of illicit alcohol.
Pic: Chris Radburn/PA Wire

Do legitimate retailers ever buy the products to sell on, knowing that they're fake – and potentially dangerous? 'The majority wouldn't,' he says. 'The vast majority of retailers want to comply with the law, but there will be a small minority who'll deliberately flout the law, and there'll be others who buy it in good faith. The overtly illegal sales tend to be the car boot sale or bag-in-the-pub scenario, which could be attractive to someone with an alcohol dependency as it's seen as a bargain.'

Penalties for selling it vary significantly, with retailers risking loss of licence if they're caught. 'And supplying counterfeit products – for example, imitating a known brand like Smirnoff – is a very serious offence and could in the worst case scenario result in imprisonment,' he adds.

But the risks are nothing compared to the risks people take by drinking it. 'We've had examples where local authorities have recovered counterfeit spirits that – in extreme cases – have resulted in blindness,' he says. 'It can be very dangerous. The key thing is that it's not manufactured in a regulated environment with quality controls. You can get it where it's potentially lethal, and you can get it where there's probably less alcohol than what's available in the supermarket, but we don't want people risking their health. The other danger that's linked to the price is that the people involved don't care who they sell it to – including kids – and that's a worry.'

While much of the illegal alcohol sold in Britain is produced here, it can also be manufactured abroad and smuggled in. 'Over the past few years, with the explosion of budget airlines with routes to Eastern Europe, there's been a huge link with imported tobacco, and vodka is a popular drink with Eastern Europeans, so there's links there,' says Ager. The five men killed in Lincolnshire were all Lithuanian nationals, and usually the manufacturers will be supplying it to people in their own communities. 'Reaching out to those groups with the health messages and information about the risks is not necessarily easy.'

It's difficult to estimate the true size of the market – which makes tackling demand difficult – so enforcement officers tend to target their efforts on known 'hot spots', he says. 'The important thing is to try to raise awareness of the health risks. Where we identify illegal products being sold we publicise that, and that raises awareness as well.'

Some estimates put the loss of tax revenue from illegal alcohol at almost £1bn, and it's thought that the illegal spirits trade could represent close to an astonishing ten per cent of the market. Is that accurate? 'We don't have that data yet,' he says. 'But we do have it for tobacco. And it's consistent with that.' **DDN**

Ignorance isn't bliss...

- Five out of every six people with chronic hepatitis C are unaware of their infection

  Hepatitis C Action Plan for England

- All injecting drug users and their partners should be offered testing for hepatitis

  Drug Misuse and Dependence: UK Guidelines on Clinical Management 2007

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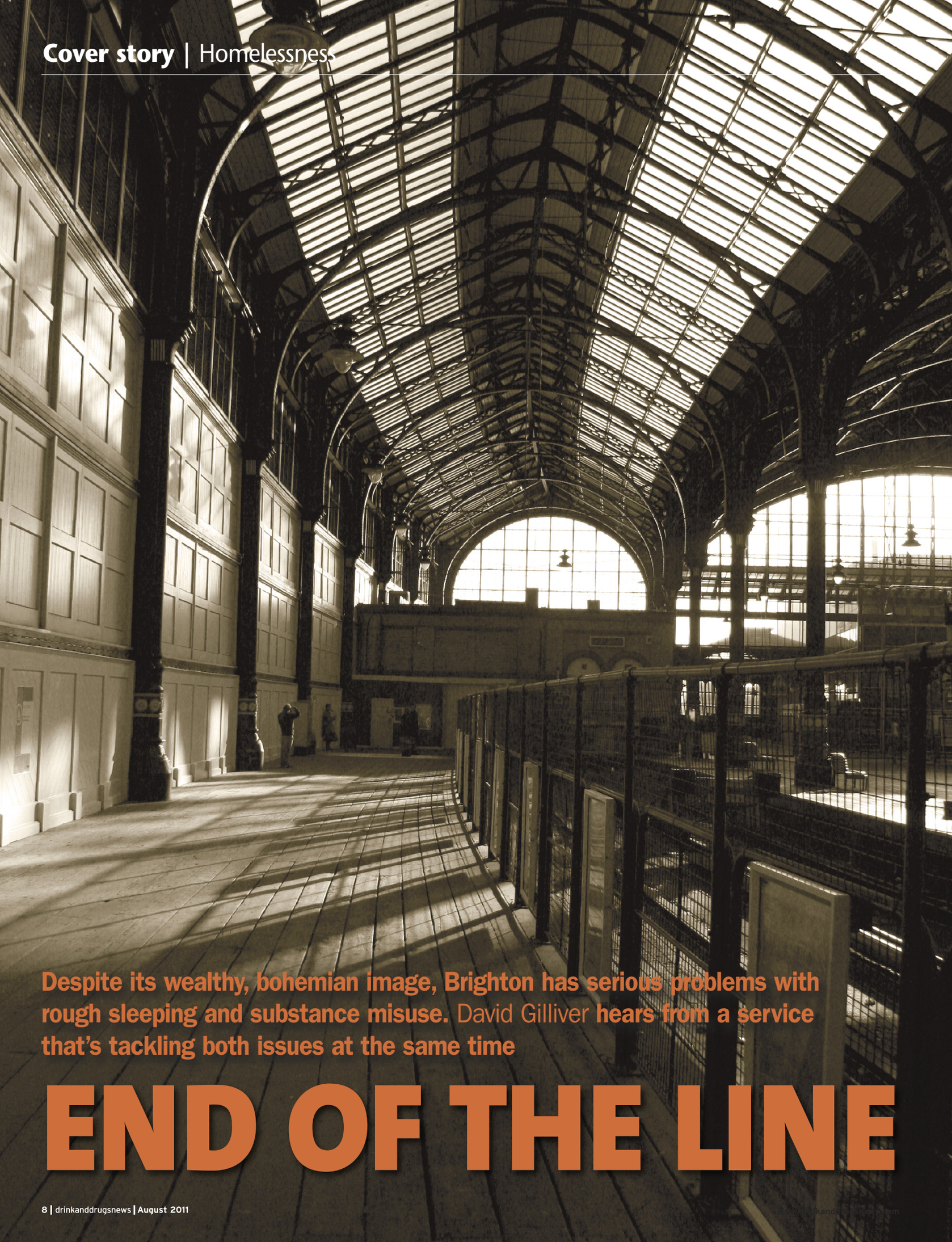


Despite its wealthy, bohemian image, Brighton has serious problems with rough sleeping and substance misuse. David Gilliver **hears from a service that's tackling both issues at the same time**

END OF THE LINE

With the economic outlook remaining defiantly gloomy, homelessness charities have been issuing stark warnings about the rising numbers of people at risk of becoming homelessness and sleeping rough, as traditional safety nets disappear. Indeed, a letter from communities secretary Eric Pickles to David Cameron leaked to *The Observer* last month warned that as many as 40,000 families could be made homeless as a result of the government's planned welfare reforms.

National homelessness charity St. Mungo's says that around two thirds of its clients have issues with substance use, and the Brighton and Hove Street Services Team has been tackling both issues together for the past decade. Service manager Sarah Mitchell says that her workers are now beginning to see the stark evidence of the emerging crisis on the streets.

'Nationally you're seeing the figures increasing, and what we're seeing is people who are new to rough sleeping, be it through losing employment or accommodation, or relationship breakdown,' she says. 'While – hopefully – families won't be rough sleeping because there will be a duty to the children, we're already seeing people without care of their children rough sleeping. We're seeing more couples rough sleeping in Brighton, for example, than we have historically, and the demographics of the clients are changing – these are people who've exhausted all their other options.'

The service is delivered by CRI and commissioned by Brighton and Hove Council, and the team – a mix of full time and part time staff – includes a social worker, four project workers, a relocation worker, a recovery champion coordinator and two anti-social behaviour staff. The team carries out assertive community outreach work, responding to individual needs and addressing alcohol and drug use alongside physical and mental health.

While most people's image of Brighton and Hove is as a wealthy, bohemian sort of place, the reality is that homelessness is a serious problem, with a combination of high property prices and low average incomes – 'London prices, Brighton wages', as locals say – meaning that the demand for affordable accommodation far outstrips supply. 'Brighton is a really diverse city and that's what attracts people,' says Mitchell. 'A lot of people travel to the south looking for work, and they're attracted by the fact that Brighton is quite cosmopolitan, plus it's the end of the line – the train doesn't go any further. We ask service users why they come and it's variously that they're looking for work, people have spoken well of the place, they like the cosmopolitan feel and they feel accepted, so we're always having an influx of people. Also, there are good support services in the city and they're very integrated – there's a lot of partnership working, which we just tend to take for granted, while in other areas that isn't the case.'

The Street Services Team operates a recovery model, which can mean different things, to say the least. How do they define it? 'We believe that people can do it, given the right tools, and that their journey starts from point of contact,' she says. 'We look at what people can do rather than what they can't do. For us, it's having that value base, which I don't think services necessarily have – somehow they don't always really believe that their clients can do it. For our team it's around looking at people's strengths and tapping in to those qualities to help them on their journey. I just think that services have to shift their mindset.'

This fits perfectly into the service's assertive outreach method, she stresses. 'We'll be talking to our clients along the lines of "you can do this, you can make changes, these are your skills", rather than just thinking "all we need to do is sort out your accommodation". We've been doing all that for quite a long time, it's just that recently it's been given a bit of a different label.'

Two years ago the service was also given money from the migrant impacts fund to work with nationals from the A2 (Bulgaria and Romania) and A8 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia) countries who are rough sleeping in the city, and the team now has two extra part-time workers able to speak those languages. 'It was about bridging the gap,' says Mitchell. 'They were a group of people who weren't really receiving any interventions, because no one could communicate with them.'

The fund came to an end last year – 'scrapped by the government without any publicity', *The Guardian* reported at the time – but the team has since been given extra money by the homelessness grant to continue delivery. Meanwhile, another successful development has been the addition of an alcohol nurse seconded to work with hostels in partnership with Brighton Housing Trust and the Sussex Partnership Trust hospital, after the team secured funding from the South East Alcohol Innovation Programme to run a 16-week pilot (*DDN*, June, page 18).'

'The nurse was put in post to work with a group who historically either didn't engage in treatment or did engage but had poor outcomes, and were causing the most strain on ambulance call-outs.' One client alone had 20 ambulance call-outs before working with the nurse, she points out, while two others had 36 call-outs between them in the space of a month. That figure has now fallen to one call-out, and CRI estimated the savings to A&E and ambulance services at more than £100,000 after just three months. Funding is now in place to run the scheme for a further nine months.

'The aim was to get to get people into treatment and, amazingly, quite a few people actually stopped drinking in the hostels, but in a safe, measured way – a self-detox rather than having to wait for the community alcohol team to assess them. We wouldn't suggest that people self-detox, but a lot of people chose to do it and we supported that process.'

The nurse works closely with the St Thomas Fund, CRI's residential rehab in Brighton. 'She has very good links with our services, preparing people for residential when the time comes that they want to engage, so the partnership and the integration of that post are really important. Through the last ten years, substance misuse services and housing services weren't really linked up – we've done a lot to realign treatment services with the accommodation services that we refer into, and we've had great success. Ninety-five per cent of our clients, historically, weren't in drug treatment and now 95 per cent are in treatment.'

'Nationally you're seeing the figures increasing, and what we're seeing is people who are new to rough sleeping, be it through losing employment or accommodation, or relationship breakdown.'

Again, this fits seamlessly with the assertive outreach model, she says. 'The beauty of this post is that it's very focused. In order to get people into accommodation, we go out and find them and take the service to them. The alcohol nurse does that within the accommodation, so people don't have to make appointments. People engage very, very well and the nurse doesn't pitch it as "you need to detox" – it's about improving their health, because a lot have significant health issues that they've ignored. All of the clients that she's currently working with have now engaged with their GP, instead of waiting until things get to crisis point.'

Feedback from clients has been excellent, she says, and there has been a noticeable change of mindset on the street. 'What we've identified now from working with street drinkers is that if you ask them whether they know of anyone who went into detox, they all know of people who were successful. It's been quite hard to access alcohol treatment because it's been underfunded and there have been long waiting lists, so changing how we work with the hostels – preparing people a lot better – means there's now a better outcome for people who historically didn't engage. Or people who didn't think they can do it.' **DDN**

LETTERS

'My simple analogy is this: celebrating recovery can be symbolised by everyone inside Glastonbury festival enjoying themselves.'

CALL SECURITY

One can become increasingly confused, swayed or simply disinterested with current opinions and polarised arguments between the efficacy of harm reduction and recovery.

My simple analogy is this: celebrating recovery can be symbolised by everyone inside Glastonbury Festival enjoying themselves – some completely drug free and some with voluntarily sustained controlled use of drugs.

However, to get into Glastonbury the individuals had to go through security, which symbolises harm reduction. It would have been hard to get into the concert, albeit not impossible, without going through security. Also, you have security or harm reduction inside Glastonbury for those who choose to use or lapse.

My obvious point being you can't have recovery without harm reduction! Does this help the continuing debate?
Mark, Sunderland

CHALLENGING THE DRUG STRATEGY

A damsel in distress? No, quite the opposite. Kathy Gyngell's CPS report on the miserable failures and exorbitant costs of the last half century's drugs strategies is a lesson in investigation, courage and professionalism (*DDN*, July, page 6).

The nature, paucity and devious arguments of those who have criticised her work reveals that organisations like DrugScope (which claims to be 'a centre of expertise on drugs' but has no record of ever having brought addicts to lasting abstinence) demonstrate none of their much vaunted 'independence' as they rush to protect failed and still failing psycho-pharmaceutical treatment systems.

'A few breaths of fresh air' is the best description for the coalition's new drug strategy, for the work of Professor Neil McKeganey, for Kathy Gyngell's reports and for her robust rebuttal of ridiculous and transparent criticism from those who have helped prolong our disastrous NHS/NTA based addiction handling sector.

That sector is replete with commissions, networks, consortia, trusts and forums, all intent on keeping addiction recovery within the commercial realm of the psycho-pharm industries.

But as such treatment has been energetically failing for 60 years, there is no reason to believe there will emerge from current NTA-led PbR pilots a psycho-medico-pharmaceutical system of bringing addicts to a lasting drug-free condition in less than six months and at reasonable cost to the taxpayer.

In every community there is a regular clearing away of old structures to permit the construction of something better. Whether the new public health service will prove to be better than the NTA remains to be seen, but the works of Gyngell, McKeganey and others are clearing the ground for the delivery of effective lasting abstinence via a new structure which can make PbR work.

All the limping criticisms about exact costs and savings of existing treatments voiced by DrugScope and its fellow travellers miss the point. The financial figures are far less important than the fact that status quo treatments do not work to deliver the results required by the government at a success rate high enough to allow PbR to keep providers solvent.
Kenneth Eckersley, CEO, Addiction Recovery Training Services (ARTS)

LITTERED WITH PSEUDO-SCIENCE

It is tempting to ignore Kathy Gyngell's comments, as she ignores those who attempt to correct her repeated miscalculations and misrepresentations of the evidence. But it is clear from Andy Winter's article in the same issue (page 24) that some people are mistakenly using her as a reliable source of evidence.

Mr Winter wrote 'Kathy Gyngell said prescribing methadone to addicts delays their recovery'. The only evidence that Ms Gyngell uses to support this claim in her *Breaking the habit* report is a reference to an article in the *BMJ* by Jo Kimber and colleagues. She claims it is its 'main finding'. This study did find that people who were on methadone for longer were also likely to take longer to stop injecting. But it did not conclude that methadone prolongs drug use (both long methadone use and long injecting careers could, for example, be caused by the underlying severity of dependence). Ms Gyngell does not mention the authors' own statement of their main finding, which was that opiate substitution treatment reduces the risk of death.

I'm afraid that Ms Gyngell's reports are littered with this kind of pseudo-scientific sleight of hand; making claims that are not substantiated by the evidence they refer to. They suck us back into the pointless argument about abstinence versus harm reduction, when we should be increasing support for recovery as well as doing more to reduce harm, for example by setting up safe injection sites, expanding the availability of heroin maintenance and progressively decriminalising drug users.
Alex Stevens, professor in criminal justice, University of Kent

ABSTINENCE IS FUNDAMENTAL

Having just read Andy Winter's 'Soapbox' article (*DDN*, July, page 24), not only do I applaud him for what he says, but I also recognise the synergy of services he offers. Harm minimisation is recognised as a valuable service, while identifying abstinence as the goal that has an outcome such as the examples of the two individuals he cites in his article, both of whom seem to be doing so well. I am sure they recognise abstinence to be the fundamental factor that allows them to achieve a brand new opportunity in recovery and continues to allow them progress in their respective careers.

I am so heartened that someone of Andy's stature and role can articulate, in the manner he has, the importance of abstinence in today's treatment and recovery climate, since there is an ominous 'zeitgeist' that does not auger well for others to achieve what these two individuals have so wonderfully achieved and continue to achieve.

There is a real concern regarding the rolling out of methadone maintenance in prisons too, and those given DRR court orders as an alternative to a prison sentence being maintained on such a prescription while engaging with the DRR. This neutralises the effectiveness of structured treatment and limits the scope of the intervention to harm minimisation only, allowing the criminal behaviour to remain preserved, and even active, while

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.

serving a sentence or on a DRR court order.

There is effective treatment that can be accessed, either in prison or in the community. But to dismantle the pattern of behaviour that results in a prison sentence or a DDR requires the establishment of abstinence in order to dismantle a pattern of recidivism, which is otherwise sustained and remains rampantly active by way of ingestion of substances, including alcohol. It is an actual fact that it is abstinence that allows the dismantling of a pattern of recidivism; indeed it is well known within criminology that prison-based treatment must be abstinence-based otherwise it simply will not produce the outcome it is designed for.

An individual will fall back on, and revive, the pattern of behaviour that has been preserved by the methadone or subutex or benzodiazepine prescriptions – or a synergistic cocktail of all of these substances – that individuals can now access while serving prison sentences. It is a sort of secular blasphemy, given that a prison sentence or a court order is meant to be at least an opportunity for rehabilitation and new way of life by way of contemplation of the mistakes that got the person into the situation they find themselves in.

Every single sentence-serving prisoner and person I have worked with in the community on drug treatment programmes of one sort or another have all expressed – without exception – that they want to be free from active addiction, not maintained on prescribed legal chemicals more toxic chemically and virulently corrupting behaviourally than the substance(s) they are trying to become free from. They recognise this to be the initial task confronting them in order to deal with their offending behaviour and/or – as Andy will have real hands-on experience of – homelessness and impecuniosity due to not being in gainful employment.

Working towards and achieving the goal of abstinence at least allows a sense of real purpose in such individuals, whereas government-sponsored maintenance prescriptions breed a sense of futility and hopelessness, and allow a pattern of recidivism to run rampant, or homelessness and vagrancy to be accepted as one's lot in life.

John Graham,
therapeutic counsellor

IT'S RESULTS THAT COUNT

Andy Winter's 'Soapbox' makes no mention of PbR, but sensibly concentrates on providing much needed emphasis for the abstinence result upon which the success of the whole drugs strategy depends.

With the discredited NTA conducting the PbR pilots, it's not surprising that far too much attention is being focused on the payment system rather than on achieving the government-specified abstinence result, without which payment will never be forthcoming.

Or are we perhaps already being nudged by those who cannot cure addiction towards a modified result, rather than fairer payment? Moving the goalposts further apart means that more of the inferior results the NTA have championed for a decade can continue to claim payment, and it would appear that that is their first ploy – *ie* bending the coalition's strategy to fit the NTA's status quo, instead of sensibly changing to those recovery providers and programmes that can already deliver fulfilment of that strategy.

Of course the main results should be measured in terms of the former addict's 12 months of continuous and formally proven abstinence. But there should also be acknowledged the recovery programme's day-by-day benefit to the society during which it keeps addicts away from drink and drug criminality – and payment for this should be made by reimbursing their bed and board monthly, thus helping the provider's solvency.

Over the years many addicts have been financed to recovery by banker personal loans. Written proof that an addict is enrolled in a government PbR scheme should make the taking on of such borrowing and the granting of such loans much more certain, making PbR a strong incentive for the addict and his family.

Elisabeth Reichert, school head

CAPTION CORRECTION

In our July issue (page 20) we wrongly captioned a picture of the SMMGP team, which included Dr Steve Willott and not Dr Steve Brinksman as stated. Our sincere apologies to both gentlemen.

Claire Brown, editor

MY CANNABIS DIARY

In the fifth part of his story, Nigel Chambers fights to see his children

At this time of my life I really had hit rock bottom and felt I could not get any lower. I could not control myself, the mood swings were horrendous and my attitude was not very good at all. I had lost so much that I couldn't see my life continuing any further and this was no fault of anybody else – it was all down to me and what I had done. My addiction had made me a compulsive liar and manipulator, always playing the sympathy card (it could only happen to me) and wallowing in selfishness.

The only thing that saved me was the thought of my children growing up with no dad – they were only babies at the time and they definitely wouldn't remember me. So they saved my life, and if in the future they ask questions I will explain to them what had happened so they don't fall into the same trap.

It had been difficult when we had three children in 31 months. Because of my background with my own father, I didn't want my children to have the same life that I had had. But little did I know then that I was abusing my children in a different way. I gave my children the love and affection that I did not have and was a very hands-on dad if anything needed doing for them, changing nappies, bathing them, reading them bedtime stories – all the things that I never received from my own father. But though I never used in front of my children, I couldn't wait until bedtime came so I could then go and use my drug.

The separation from my children has been the hardest part of recovery. I have two daughters and a son, who were aged six, five and four at the time. My ex-wife prevented me from seeing them because of my addictions and I fought in court for a year and a half to see them. I've been through many courses including behavioural abuse, safeguarding children, hidden harms, as well as hair-strand tests – the list goes on and on and I have done all the court has asked me to do and a lot more.

I was granted access in July 2009, but because it had been so long since I had seen them, it had to be supervised at first. Getting my ex-wife engaged with this was a very big problem, and obviously I had no control over her and had to leave it to the judgement of the courts. I found I had to change the way I was thinking to control my resentment – if I was in the same position, what would I have done trying to protect my children?

After all the court appearances my ex-wife had to agree to contact eventually, but it went right to the very limits that she could push for. I've now got a court order in place and feel I have a lifetime to make up for. I've just completed the three supervised contacts and they have gone very well – it was a joyful experience.

We're back at court in a couple of days so the courts can see the reports about the sessions and how they have gone, and I'm now hoping for unsupervised contact. I'm looking forward to the day that I can pick my kids up and enjoy every moment that I have with them. **DDN**

Next month: Nigel seeks long-term stability

higher POWERED

Finding comfort and support at NA or AA doesn't necessarily mean you have to feel comfortable with all of its guiding principles, says Alex Boyt

As I start to write this, one of the 12 traditions read out at every Narcotics Anonymous (NA) meeting begins to gnaw at the back of my brain: 'We must retain personal anonymity at the level of press, radio and films.' A gagging order has been issued – I must not put my name to my experience.

At a recent sitting of the All Party Parliamentary Group on Drug Misuse, the chief executives of the Betty Ford Clinic and other bastions of the American 12-step recovery movement spoke to the assembled experts in the field. There were repeated references to the role of divine intervention and the disease of addiction, views expressed not as opinion or belief but as fact – those addicts who failed to see this needed to have their denial broken. The representatives of UK 12-step rehabs nodded in agreement, relief and solidarity while some harm reductionists caught each others' eyes with worried looks, shook their heads and muttered a few words under their breath.

My father used to say 'there's only so much hypocrisy I allow myself', and as I sat in the meeting, incredulous and mentally pigeonholing the 12-step champions' presentations as part of a pseudo-Christian evangelical lunatic fringe, my truth is that I use NA as an integral part of my ongoing personal recovery. There is a lot to recommend it, but much of the literature and the peer pressure to conform leave me with a nasty taste in my mouth. I have tried to reconcile my instinctive reflex hostility to much of the 12-step ethos with the fact that I continue to engage with it, and gain a certain sense of comfort, support and stability from the experience.

Twelve-step recovery has undergone a remarkable expansion around the world, and part of the secret of its success is the cult-like glue that holds it together – the message given to the often desperate and vulnerable is that, in order to prevent the inevitable jail, institutions and death, you must surrender your will, you must keep coming back and you must recruit new members ('carry the message'). The idea that you can leave a 12-step fellowship and lead a healthy life is seen as 'the disease talking'. There is a constant undercurrent that suggests that if you leave, you will die.

At meetings, the reading-card mantras declare 'we realised we were sick people' and 'we were entirely ready to have God remove all our defects of character'. We did *what*? The cards rattle on, telling us we need to be open minded. Open to what? To the possibility that 12-step language is wholly out of date? To talking in meetings about healthy ways to disengage and move beyond the need to keep attending? To the idea that a glass of shandy need not mean relapse?

For many, the language of the 12-step literature is sacred, and there are texts with biblical-style numbered lines, but for me much of the literature – particularly the strange, obsolete language of the steps themselves – would do well to be replaced with something less prehistoric and more user friendly. God, pray, God, pray, God, pray – repeat the steps, and the literature then reminds us it's not religious. If it didn't sound so obviously religious they wouldn't have to keep telling us it isn't. In an attempt to make the whole God notion more accessible to your average atheist, there are alternative notions offered for a 'higher power', but try praying to the NA group itself and you soon realise there is not much of a compromise on offer.

I personally do not believe that anything happens for a reason, nor is there something watching over me. I came close to death a few times, but I was lucky and pretty tough – many special people didn't make it. When I have the strength I declare in meetings that I do not believe in God and I do not believe in a benevolent universal force of any kind (a higher power), and I invariably get someone sharing back how they took a long time to find God to bring the meeting back on track. Then someone else shares that falling to their knees is what helps to keep them clean, people nod and I am forgiven – they know I will get there eventually.

For those who are able to embrace or negotiate the strange, outmoded language, subtexts and rituals, 12-step recovery works as well as, if not better than, anything. It is remarkable what happens in the 12-step movement – there is something undeniable in the therapeutic value of one addict helping another, the free aftercare/group therapy around the world, the empathy and the peer support.

'For those who are able to embrace or negotiate the strange, outmoded language, subtexts and rituals, 12-step recovery works as well as, if not better than, anything.'

The programme teaches the habit of self-reflection and helps develop tools for worrying less, finding hope for the future, offloading some of the negative feelings about the past, and communicating in a cathartic way.

The disease model may be a mechanism to help learn that overcoming long-term addiction is an extended process – that changing well learnt, deeply ingrained counterproductive behaviour can be a prolonged journey. There are aspects of the disease model that can reduce stigma and encourage interventions weighted more towards care than enforcement. However the notion that your disease is growing in the background as you move forward in recovery, that you are never cured, that the only medicine for your disease is 12-step recovery is fear based and restricts peoples' vision and potential to move beyond a view of endless treatment.

Total abstinence is a two-edged sword, and thankfully the party line is softening a little in some areas. Yet many in 12-step recovery who are on anti-depressants or need sleeping pills or pain management are reluctant to declare it for fear of being judged or accused of diluting the message. There is no denying that total abstinence, particularly when initially attempting a recovery from problem substance use, can form a central platform of stability for those who have had negative experiences of trying to use socially, but some examples of the total abstinence ethos backfiring are painful to witness.

I have heard many who, after years of total abstinence from chaotic class A drug use, have come into a meeting crushed by their failure in having had a glass of wine. Their clean time and associated status is wiped, and the post mortem starts as to why such a disaster happened –usually because they took their will back, didn't work their programme properly, stopped praying or disengaged from the fellowship.

You can have ten cans of Red Bull, 60 fags and three cakes a day, but half a spoonful of shandy means relapse – it can sound bizarre, but these rules of abstinence work for many. For me, being honest is a central strand of my ability to function in a 12-step environment, and a large part of the reason I don't have the odd glass of wine is that I refuse to be demoted. I negotiate the God obstacle by using the notion of time – all things are possible in time, time is a great healer and, as I have moved forward in my recovery, I have learnt that 90 per cent of what I worry about on any given day I will have forgotten about 48 hours later. Time will take care of it, but time is not God – I will not pray to it and I will not pretend I have a higher power so that I am welcomed more wholeheartedly into the bosom of the fellowship.

In my not very humble opinion, the focus should move away from God and onto not being alone and giving and receiving support. In the 21st century the level of evangelical reference to miracles and divine intervention leaves the potential of much mutual aid out of the reach of many, and the notion of abstinence is extreme and can be punishing. In spite of the new drug strategy, many drug workers still struggle to point clients in the direction of a programme that requires you to humbly ask God to remove your shortcomings.

My view is probably not representative. Most with my level of misgivings about the 12-step ethos fail to engage, but by way of counterbalance there are reportedly Narcotics Anonymous gatherings with tens of thousands in football stadiums in Iran, and I daresay God being central to the programme is the root of its appeal. There are many in NA who embrace the whole 12-step programme of recovery with gusto, enthusiasm and passion, and some of them are deeply upset and worried that the concept of recovery has been hijacked and diluted by the mainstream treatment agenda. I, however, welcome a wider vision.

Voltaire said, 'The human brain is a complex organ with the wonderful power of enabling man to find reasons for continuing to believe whatever it is that he wants to believe'. I happen to believe that if I get run over by a bus tomorrow, or fall in love, none of it will mean anything. Strangely enough, in jail I was prepared to invoke Apollo to give me strength and Aphrodite to bring me love, but give me an evangelical American in parliament and I tremble in my boots. **DDN**

Alex Boyt is client participation coordinator at Camden Drug Action Team and represents the National User Network (NUN) on the All Party Group on Drug Misuse

Lives in the BALANCE

In 2009, pilot programmes across England saw carers trained in how to respond to overdose, and how to administer the overdose antidote naloxone. *DDN* had an advance look at the NTA's report

Even in a sector riven with controversy, naloxone has stimulated a significant amount of debate. It's a drug that can save lives by reversing the effects of heroin overdose, yet only a small proportion of those at risk have access to it.

The NTA has just published its report into a series of pilot projects which saw nearly 500 carers at 16 sites trained to respond to an overdose using basic support techniques, with all but one also training them to administer naloxone (*see news story, page 5*). The pilots appear to have helped save 18 lives, despite 'limited evidence that carers are the most appropriate people to receive the training', says the report, as people who inject drugs are more likely to be in the company of peers than family at the point of overdose.

When the pilots were announced two years ago, organisations such as DrugScope called for an extension to make sure that naloxone and training was also provided to drug users and their peers (*DDN*, 13 July 2009, page 4) and the report states that pilot leads and carers felt it made sense to train those likely to be present when users were taking drugs. Several sites trained pairs of mutual carers – partners, close friends or housemates – and provided them with a naloxone supply.

This was the approach adopted by the Herefordshire pilot, facilitated by Danny Morris, development manager at DASH (Drug and Alcohol Services), part of the 2gether NHS Foundation Trust. 'We looked at carers in the truest sense – they were living with people who were using, and might have been using themselves, but they still had a caring role,' he says. 'The feedback was fantastic – people fully engaged.' Many said that they hadn't had a full understanding of overdose risk before the training, he points out, and they also valued the opportunity to talk about difficult issues. 'Overdose is not often spoken about – even if you've witnessed it, or lost someone, it's still a taboo because it's drug related.'

Four people have been saved by naloxone since the initial round of distribution, he says, but what was also striking was the sense of empowerment that people felt. 'We've had people saying "I've never felt so valuable before" or "I didn't realise I could be of use". Virtually every person we trained wanted to learn more and asked how they could be a part of training other people.'

This is all part of a major 'secondary benefit' of the training, he points out. 'Having a potentially life-saving drug available is obviously incredibly valuable, but beyond that nearly everyone we trained has engaged more effectively in treatment, and some of those with very long-term drug-related issues have either managed their use or become drug free. So there are a lot of additional benefits in terms of supporting people's recovery process.'

Some sites found it more difficult to recruit people than they expected, the report says – although they remained committed to the training – and the Herefordshire pilot did experience some difficulties recruiting parents. 'We trained some, but most parents were saying that they weren't usually around when their sons and daughters were using, and it was also something they found difficult to deal with. It was much easier for the partner of a heroin user – irrespective of whether they were using or not – to become engaged, whereas with parents there were other challenges. Being reminded of the risk was unsettling.'

Another site that targeted people who had just left inpatient detoxification – and therefore had a higher risk of overdose – found it difficult to recruit, as many thought detox was 'the point beyond which the user would not take drugs again', rendering the training unnecessary.

The report concludes that while training carers is beneficial, providing training and naloxone 'to as many people as possible may need to be considered to achieve a wider impact on overall fatal and non-fatal overdose rates'. National clinical guidance already supports the use of naloxone as a way of preventing fatal overdoses, and an NTA spokesperson states that 'there are no obstacles to local areas wanting to provide naloxone, having made a local assessment of its cost effectiveness. Many local areas do already provide naloxone to service users or carers or both.'

Morris, meanwhile, is firmly of the opinion that naloxone training and distribution needs to be embedded in mainstream drug treatment. 'We've had a massive demand to roll it out subsequent to the pilot and we're looking at how we might be able to do that,' he says. 'The actual practicalities are very straightforward – you can train people very quickly. We took longer because people wanted to engage with some of the more emotional issues around overdose, but you don't necessarily need to invest that level of time.

'It's a first-line response – if you call an ambulance, that's what they'll use,' he states. 'It's an incredibly powerful drug. There was some level of wariness of its effectiveness until the first two reports came in within about a month of us rolling out the pilot programme, and the staff here were blown away – people coming in talking about how they saved somebody's life is a very powerful thing. You do hear concerns about the cost implications, but at ten pounds per unit it's not a lot to save a life.'

The NTA overdose and naloxone training programme for families and carers is available at www.nta.nhs.uk

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

The fame of Amy Winehouse did not rest solely upon the quality of her voice. Her public appeal also lay in the very lifestyle that has now killed her... And drug-taking has been tacitly encouraged by the Great And Not-So-Good, those well-heeled but grossly irresponsible committee clones who have decided that illegal drugs are not as damaging to society as the laws that keep them illegal – and who have accordingly helped present drug-takers as romantic rebels against the system. People like me have warned for years about the consequences of all this sloppy thinking. But such warnings have been brushed aside by a society that has decided to inhabit a never-never land where evidence, morality and common sense are denied.
Melanie Phillips, *Daily Mail*, 25 July

I find it hilarious that the state hands out methadone to junkies with no worries, but is obsessed with policing the behaviour of those who have the backbone to handle pleasure without pathologising it and whining 'Ooh, poor little me, I'm an addict, GIVE ME FREE DRUGS!'
Julie Burchill, *The Independent*, 15 July

Pete Doherty has just been released from prison – six weeks into a six-month sentence for possessing crack cocaine. Never mind his 14 previous court appearances and 25 drug charges, the 32-year-old rock star is once more a free man... What message does this send out? That it is OK to boil your eyeballs and fry your brains with industrial amounts of drugs, to become an addict, to ruin the lives of those around you, not to mention having a connection to the death of several friends and acquaintances through drug use? Just keep calm-ish and carry on and you'll get away with it, just like Mr Doherty.
Jan Moir, *Daily Mail*, 8 July

Suddenly not even mild intoxication is accepted as normal in most jobs – even a glass of wine at lunch seems decadent, and indicative of a defective work ethic. As for appearing tipsy at the office or smelling of booze in the afternoon, most of us frown on such conduct... This new emphasis on clean living and healthy minds makes life safer, and more serious, and perhaps less entertaining some of the time.
Andrew M Brown, *The Telegraph*, 4 July

You can't cut a family's benefits then pay a Sure Start centre 'by results' to run parenting classes about how stress and debt are bad for your family dynamic. Well you can, but it's an insult and a waste of money.
Zoe Williams, *The Guardian*, 13 July

They are the guilty secret we don't like to talk about. The acceptable drug we can't give up. We denigrate people who binge on coke and booze, but what's so different about a group of prescription drugs doctors are dishing out to women in massive quantities, when all they might need is a regular chat and someone to listen and be supportive?
Janet Street Porter, *Daily Mail*, 11 July

Addiction is ceaselessly diagnosed and self-diagnosed, used as a publicity strategy or a bargaining chip, even monetised as entertainment.
Sam Leith, *London Evening Standard*, 12 July

LEGAL LINE

'WILL I LOSE MY DRIVING LICENCE FOR TAKING METHADONE?'

Release solicitor Kirstie Douse answers your legal questions in her regular column

Reader's question:
I am on a methadone prescription and my new doctor says I have to tell DVLA about it but I'm really worried about what will happen if I do. I need to drive as I have to take my partner to hospital appointments and we live in a remote area. Will I lose my licence?

Kirstie says:
Your doctor is correct that you should disclose your use of methadone to DVLA. While your GP does not have a duty to reveal this information, they may decide to do so if they feel that there is a risk to yourself or others if you continue to drive while using methadone.

If a driver is thought to persistently use, or be dependent on, opiates they will be requested to undergo a medical enquiry; if drug misuse is confirmed, the licence will be revoked until the driver can demonstrate that they have not used drugs for at least one year. This may be an issue if you started taking methadone less than a year ago as this would indicate that you had misused drugs in the last 12 months and so would not satisfy the drug-free period.

However, if you are on an oral methadone programme it may be possible for you to continue driving. You would be required to undergo a medical assessment – if the outcome of this is favourable you could keep your licence. The requirements are quite strict – it is essential that you fully comply with the supervised methadone programme in order to retain your licence. If there is any evidence of illicit drug use (including cannabis) in addition to the prescribed methadone, your licence will be revoked. Drivers who are licensed in this way also normally need to have an annual medical review.

'If you are on an oral methadone programme it may be possible for you to continue driving'

To make the disclosure and assessment process as easy as possible it is advisable to get supporting letters from your prescriber and anyone else involved in your treatment. This should confirm your engagement with the programme and refer to how successful this has been. You will not avoid the independent medical assessment but it will definitely assist, particularly as the treatment provider has personal knowledge of you and your circumstances.

Unfortunately personal circumstances such as needing to drive your partner to appointments will not be taken into consideration when deciding whether you keep your licence. The decision is based purely on medical grounds.

If your licence is revoked you can appeal the decision at the magistrates' court. These cases do not attract legal aid so you would have to represent yourself or pay privately for a solicitor to help you.

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

For more information about this issue, contact the Release legal helpline on 0845 4500 215.

MORAL MAZE

Has the drugs debate become so dominated by pragmatism that any moral dimension has been sacrificed? Prof Neil McKeganey talks to David Gilliver **about morality, stigma and the choice facing harm reduction**

The University of Glasgow has announced that its Centre for Drug Misuse Research, headed by long-time *DDN* contributor Professor Neil McKeganey, is to close after 17 years, a tough decision the university had to make in the current economic climate (*DDN*, July, page 4). Prof McKeganey, however, has no intention of withdrawing from the field of drugs research.

'I'll continue to write and publish because I can't imagine a time when I'm not doing that, and I'm looking at various options through which I and close colleagues will continue to make contributions to the debate, but from a different organisational base,' he says. 'In a way, I also didn't want to keep working in the same capacity – to be the sole person running any research centre for that length of time is too long to be in one environment.'

The latest of his books to be published, *Controversies in Drugs Policy and Practice*, is an analysis of the key issues in the drugs debate, from enforcement and legalisation to harm reduction and the often-fraught relationship between the science and politics of drugs research. It also comes to the stark conclusion that the drug problem has the potential to pose a threat on the same scale as global terrorism or climate change.

Is the view that our society will somehow always be able to cope with the drug problem an overly optimistic one? 'Yes, I think in a way that has held us back and to an extent continues to do so,' he says. 'I'm surprised how little attention is given to the relatively recent nature of our current problems, and how rapidly they've escalated. That, I think, would lead one to be much less sanguine about the possibility of society coping with a drug problem much greater than it is at present. We place a great deal of faith in numbers, so I think we have a rather simple-minded notion that if the numbers go up, the problems go up, when actually it may well be that – as the nature of our current problem and its various facets become more evident – we may not cope with the numbers as they currently are.'

Could that mean we might one day see the sort of drug-related violence that other countries experience? 'I don't think we should assume at all that we'll be immune from those problems,' he states. 'I don't think that we should assume, for example, that our political systems will be immune from the capacity of the drugs trade to corrupt those systems – I think there's a certain naïvety that we think it's other countries whose political and economic systems run that risk, and our own system of parliamentary democracy will be relatively immune. I think one of the lessons we will learn about the situation with News International is the way in which access to personal data may well be a mechanism through which the political process is subject to undue external influence. We may actually come to see our own systems as rather less strong and robust than we originally thought they were.'

Another of the book's themes is the absence of a moral dimension in the drugs debate, with discussions instead framed in wholly pragmatic terms. 'I think the experts and commentators often regard the moral dimension as a rather backward step – as a dimension that should somehow not be there – and as if the enlightened mindset is one that emphasises pragmatism. But I think the moral ambiguity that that can lead you into can be quite troubling.'

It's now rare that a week goes by without a broadsheet op-ed piece advocating some level of legalisation – does he see this as the default position for liberal intellectuals? 'I think the liberal intelligentsia seem to have driven themselves into

'Individuals in communities where people are confronting the reality of drug addiction and drug-related criminality on a day-to-day basis are not the ones articulating growing liberalisation.'

one single position, which is some form of increasing liberalisation of our drug laws, and I think that is of great concern,' he says. 'I've also noticed that those who propose that position most vociferously are often in their own lives at greatest distance from the drug problem itself, while often individuals in communities where people are confronting the reality of drug addiction and drug-related criminality on a day-to-day basis are not the ones articulating growing liberalisation. I think that can be quite telling.'

One of the roots of the problem, he believes, is the tendency towards 'massive over-simplification' of the messages around drugs, such as with the thorny issue of stigma that so ignited *DDN*'s letters pages last year. 'I think there's almost a rallying cry that we should seek to reduce the stigma associated with drug use, yet stigma is a powerful way in which society reflects those behaviours it wants to encourage and those it wants to discourage,' he says, pointing to research he carried out with colleague Jim McIntosh.

'We found that stigma was a really important catalyst for an individual's eventual recovery from dependent drug use – it was, in a sense, the desire to repair a stigmatised self-identity that had arisen out of long-term drug use which actually generated much of the individual's resources to come out of drug dependency. So I think the rallying cry that we should tackle stigma is a gross over-simplification, but also indicative of how this field latches onto statements and seeks to give them a great authority without really focusing on the particulars of the ways these issues may affect individuals' lives.'

Was he surprised by the response to his original *DDN* article on the subject (15 February 2010, page 14)? 'I did feel that there were some individuals who – rather mischievously – deliberately misrepresented what I was saying. I think the public health arena is one where the use of stigma has been quite powerful – smoking in enclosed places, for example. I think we're well used in society to the use of stigma as a tool to change the behaviour of large groups of people, and I think those people who chose to misrepresent what I had written were doing so solely from the focus on specific individuals. I think we have to be more sophisticated than that.'

This tendency towards over-simplification also extends to the way the Portuguese experience of decriminalisation has been represented, he believes, with it having become 'a rallying cry' for liberalisation. 'That's in advance of a serious independent assessment,' he says. 'I think the more we come to understand what's going on in Portugal, the more cautious we need to be before citing it as the clearest evidence of the benefits of a liberal drug policy. It's also kind of surprising that often those who argue that drug policy has little impact on behaviour tend to spend a disproportionate amount of their time discussing changes in drug policy.

'I've seen other comments along the lines that "as long as we provide more access to drug treatment, it doesn't actually matter if levels of drug use go up",' he continues. 'I think most people would recognise that once people become dependent on drug use, treatment services really have a massive job to enable individuals to come back from addiction, so I think that the almost effortless discounting of the possibility of a significant increase in the scale of our drug problem, so long as we continue to provide high quality treatment, is shockingly naïve.'

David Best told *DDN* (April, page 20) that he sometimes found the field's polarisation and personal attacks difficult to deal with. Does he ever feel the same way? 'I've been subjected to some pretty extreme adverse comments, but I'm quite thick-skinned and, in a way, I feel it goes with the territory,' he says. 'It's inevitable, but as an academic in a university your space to comment on matters of sensitive public discourse is protected – much more than most other individuals – and I don't think that academics should ever take that lightly, or give that up for fear of experiencing critical comment in return. But, at the same time, it does get a bit wearing and I do on occasions share David's sense of exasperation.'

His work in the drugs field began when an approach by Glasgow University – which had received a charitable donation to carry out research in a socially relevant area – coincided with a Glasgow GP describing how he was seeing more and more young people in the Gorbals area starting to use drugs. 'This was in the mid '80s, so I came to Glasgow specifically to do a small piece of work and then HIV hit everything like a tsunami. Since that time there's been no point when I've not been doing research around drugs.'

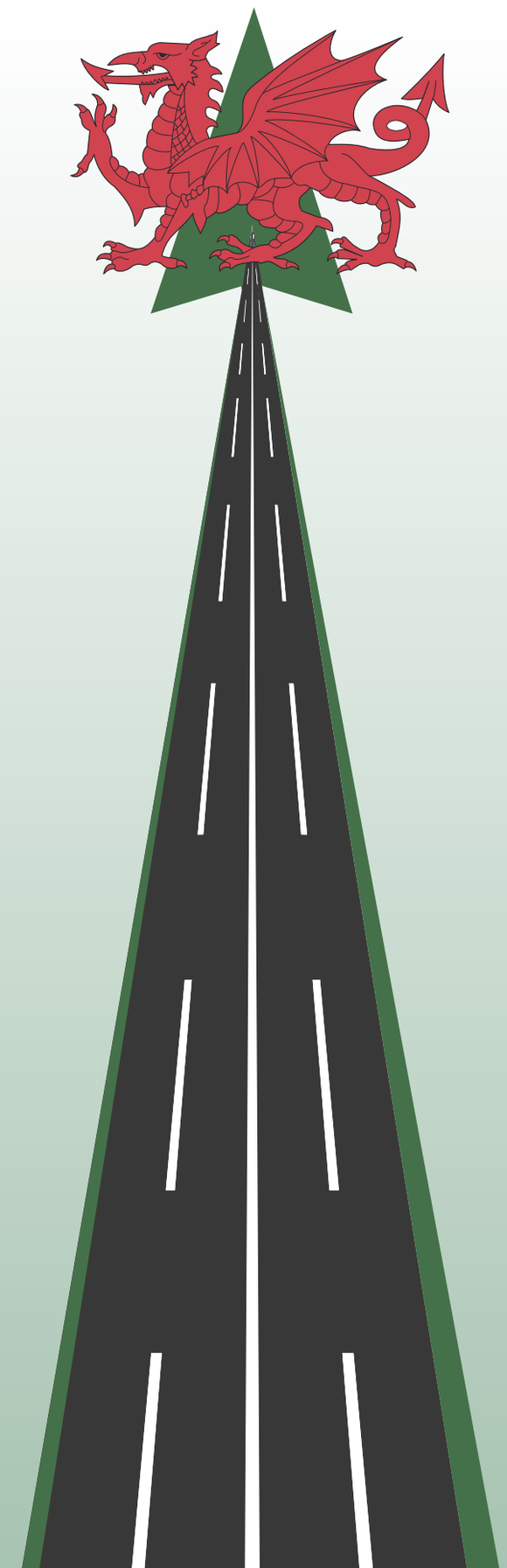
On the subject of HIV, each chapter of *Controversies in Drugs Policy and Practice* is rounded off by a series of discussion questions, one of which is 'to what extent is harm reduction a Trojan horse for drug legalisation?' Harm reduction has been a 'fascinating period in drug policy evolution,' he says, but it now has to face up to some difficult questions.

'It's gone from being this radical new kid on the block to this somewhat over-funded, somewhat self-satisfied and rather bloated entity that has marginalised almost entirely the notion that it might actually be valuable to help people overcome their drug dependency. Harm reduction is a broad church, but certainly when you look at some of the key players fleshing out the harm reduction approach you don't really need to get too far below the surface before you see the political issues they're actually taking up – of arguing for a change in the legal position of drugs – and I do think that creates a real tension now for harm reduction.

'It does have to choose. Is it really about public health protection and enabling individuals to develop their life to maximum potential, or is it a political position for legalisation? I don't think it can easily maintain both of those wings.' **DDN**

Controversies in Drugs Policy and Practice is published by Palgrave Macmillan

WELSH ROADS TO RECOVERY



The recent Welsh service user conference brought participants from all over Wales – those in services, those running services, and those funding services – to share their visions for recovery. *DDN* reports

The whole of the Welsh government is committed to the service user agenda and its focus on recovery, Karin Phillips, head of the government's community safety division told the gathering at Cardiff's impressive City Hall.

The day kicked off with some formal presentations to set the scene with information, before delegates broke into groups to explore topics relating to recovery and their own experiences.

Phillips explained that area planning boards had taken partnership working to a new level and there was an ambition to have a service user representative on each board.

'The inclusion of service users around the table means we have a joined-up collaborative approach throughout Wales,' she said. 'We've made a conscious effort to get involved and this conference, organised totally by service users [All Wales Service Users Movement (AWSUM)], is another example of how far we've come.'

The Welsh Government was committed on a practical level, she emphasised. Since 2009 they had issued more than 700 naloxone kits, which had had 65 reported uses. 'That's potentially 65 lives saved, so it will be rolled out and made available to all service users across Wales,' she said.

Across the country the All Wales peer mentoring scheme was also proving to be an important cog in helping people back into employment.

'We ask commissioners to talk to service users, find out what's needed and act upon it,' she said. 'Working together for the common good makes sense.'

Next up, June Price from Jobcentre Plus gave a whistle-stop tour of welfare reform which, she said, had been overhauled 'to make the tax system fairer and simpler' and 'make sure help goes to people with the greatest need'.

Incapacity benefit would become based on a more accurate reassessment of a person's ability to work. 'It will ensure people who can work are given correct support to do so, but it doesn't aim to reduce support to people who need it,' she said. 'Severely ill people won't be required to work and they won't have their benefits time limited.'

Acknowledging that housing benefit reforms would cause difficulties for some, Price said Jobcentre Plus was committed to 'helping to smooth the transition'. The recent disability living allowance reforms included personal assessments that would result in a Personal Independence Payment for those judged to have long-term impairment. A new single system of support called Universal Credit would replace a number of working-age benefits and was 'designed to make sure work will always pay'. Practical support was being offered to jobseekers at a local level to get people into sustainable jobs, she said, and this work programme would offer flexible personalised support for substance dependent claimants.

Workshops during the afternoon looked at all aspects of sustaining recovery, including the nuts and bolts of aftercare. 'Let's think about what aftercare could and should be,' said Sarah Davies of Recovery Cymru, a fast growing support community. She brought comments from members of her community support groups to share with the workshop.

'They say that it's easy to stop, but that staying stopped is the hard thing,' she reported. 'Others say that our whole culture is focused on drinking, and that drinking and using is all they know. Many people say they just don't know what to do with their time now it's no longer devoted to their addiction.'

Davies asked the workshop participants what they wanted in aftercare. 'If you take something out of life you want to be replacing it with something good – otherwise there's a massive void,' she suggested.

Everyone agreed that filling this hole needed 'an awful lot of support' in the early stages. Peer support was seen as extremely valuable – 'you need people who know what you're going through'.

'Anything going wrong at the beginning of recovery can seem huge', said one participant. It was vital to make sure people weren't left in isolation but were helped to find routine and meaning in their life. Social networks and associating with role models were suggested as ways to make a real difference in preventing and managing relapse.

Boredom and lack of self-esteem were other enemies. Participants agreed that aftercare had to incorporate constant motivation – ways to inspire people and give them something meaningful to move on to after addiction. Discussion also moved to the clinical side of aftercare – from making sure doctors gave the right prescriptions to control symptoms such as sleeplessness, to encouraging chemists to foster a non-discriminatory environment for clients' regular visits.

'It should be about recognising there are different stages in recovery and that it doesn't happen overnight,' said one participant. Others agreed that

'This conference, organised totally by service users, is another example of how far we've come.'
Karin Phillips

'Incapacity benefit... will ensure people who can work are given correct support to do so.'
June Price

'Let's think about what aftercare could and should be.'
Sarah Davies

'I'm a great believer in people standing on their own two feet, but when you're... just coming off drugs, you need help.' Joan Brown

while the traditional routes through aftercare, such as 12-step groups, were as valid as ever, the recovery movement was about making sure everyone had choice.

Joan Brown, service manager at Drugaid, told the workshop how the peer mentoring scheme was working. Drugaid was the lead agency of a consortium with TEDS and Kaleidoscope, delivering peer mentoring across Merthyr, Rhondda Cynon Taf, Caerphilly, Blaenau Gwent and Torfaen.

'The goal is to get people into employment, into good quality careers,' she said. 'I'm a great believer in people standing on their own two feet, but when you're at the point of just coming off drugs, you need help.' Peer mentors would go with them whenever they needed support in the early stages.

She explained to the group how the process usually worked. 'You come along and have an assessment, so we get to know you and what your needs are. We then do an action plan. A peer mentor is appointed to work with you on it, so you can work out what you want. We can find a course for you, or volunteering – whatever you want to do.'

Initially clients might be given a home visit, with the aim of getting them out into the community and back to work via courses and volunteering. 'There's no rush but sometimes people need a gentle push and some tough love,' she said.

This was where the recovery community concept fitted so well, at the stage of changing a person's life and moving them through treatment, added Sarah Davies. 'It's about bridging that gap between treatment and independent community living, sharing experience and understanding. That's what Recovery Cymru is about – we're all going on a journey, but by sharing ideas it makes it easier.'

PRICELESS OPPORTUNITY

Peer Mentoring Wales describe how their new Recruit Plus service is getting people with a history of substance misuse problems back to work

Looking for work can be difficult, particularly if you have been out of work for a long time and have a history of substance misuse. We have just launched a new initiative called Recruit Plus, a specialist employment service, which has been created specifically to help peer mentoring participants find sustainable employment opportunities in Wales.

We provide practical support to help participants find and succeed in meaningful work – working with candidates so they can work. First they'll be offered a formal registration interview with our recruitment specialist to get to know their skills, goals and ambitions and to match those skills to the needs of local employers.

The next stages of support are individually tailored to meet participants' needs. They'll be offered personal development, including assistance in building confidence, developing skills and achieving their goals. They'll be given help with job searching, preparing CVs, completing job applications and interview techniques, and be introduced to work trials and voluntary work opportunities.

Peer mentors are an integral part of the support network for participants registered with Recruit Plus and will continue to provide practical and emotional support, including accompanying them to their first interviews and days at work. Most importantly, continued support, ongoing development, advice and mentoring will be provided by Recruit Plus and peer mentors for as long as it's needed.

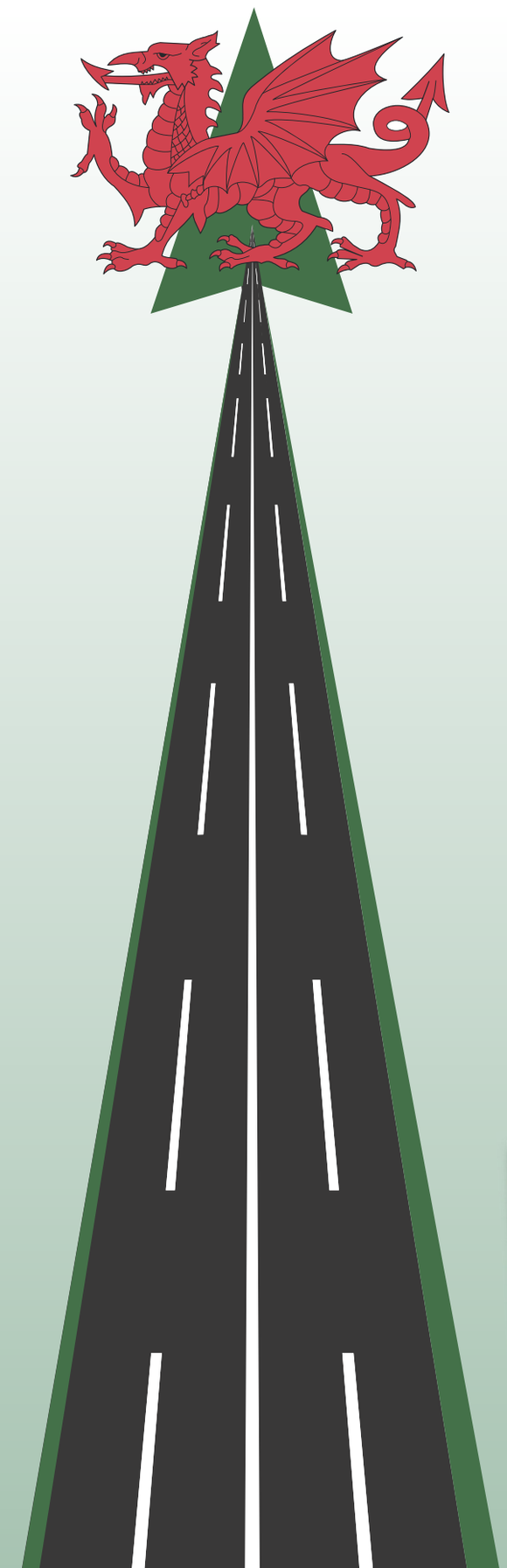
Our aim is that participants develop to a stage where they and their employers are confident they don't need us anymore. We also give out a strong message to employers – that life-changing opportunities are priceless. People who have been involved with drugs or alcohol bring with them the same variety of skills, qualities and commitment as anyone else. We tell them that having overcome so many hurdles, these candidates can be determined and tenacious in sustaining the changes they have made and this could be an asset to any business. There's no fee for them to use our service.

Through a dedicated recruitment specialist, employers have access to a significant pool of talent to get the best people for their jobs. Candidates have been professionally interviewed and screened and work trials can be arranged. It's also a way for companies to enhance their corporate social responsibility.

We aim to counter misconceptions and break down barriers between employers and people with a history of substance misuse. Recruit Plus offers support every step of the way and we're confident those barriers can be broken.

To find out more, contact Peer Mentoring/Recruit Plus. Tel: 01685 721991 or 07879 434911.

WHAT DOES RECOVERY MEAN TO YOU..?



Personal experience played a large part in the Welsh service user conference, with delegates encouraged to contribute their own stories. The afternoon speakers offered their versions in the spirit of sharing recovery

PERSONAL EVIDENCE

'Recovery is ours – it's yours,' said Wulf Livingstone of the Recovery Academy based in North Wales.

It had become the emperor's new clothes, he said. Services were rebranding as 'recovery' the same things that they were offering five years ago.

'Recovery for me is about getting a life after the treatment services have closed at 5pm,' he said. 'It's beyond taking drink and drugs – it's about being yourself and being human.'

The Recovery Academy was about developing both academic and anecdotal evidence to say recovery worked, he explained. It held big gatherings twice a year and tried to produce material that showed how recovery worked and was self-funding, 'so we can say whatever we want to say'. Meetings had revealed that people did not want recovery to be hijacked by professionals, but that it should be about new ideas and interests and start with personal choice for change.

'We're trying to bring people together to share and celebrate recovery,' said Livingstone. 'We want to celebrate policy and practice and see change. Some people are just peddling the same revolving door and the biggest pedlars are doctors.'

'Recovery is a complex subject and in North Wales we've created a space to explore what it is,' he said. 'We long for the day when commissioners don't feel the need to measure everything by targets and outcomes.'

COMMUNITY FOCUS

When Martin Riley started as a substance misuse development worker 15 years ago the quality of services was poor, 'with accommodation I wouldn't have kept my dog in'.

Now services fully engaged with service users offering all kinds of group work, therapy and interest groups like cooking courses and music groups.

He gave the example of 12 Café, run successfully by service users over the last two years. 'It's about more than the money. Through the café service users engage with the local community while learning the skills to help them move on.'

Local bands such as the Shed Heads – formed in an allotment shed by people in recovery – had performed in the café, and visiting speakers had included Phil Valentine, executive director of the Connecticut Community for Addiction, who had commented 'It doesn't need people to be abstinent. It needs people who say "I'm on the journey of recovery and I'm taking part."'

Rowan Williams from Drugaid gave a provider's perspective: 'We rely on peer support groups to give us feedback. We need to expand our communications networks using different channels like email and Facebook.'

'If you're in a group you need to make sure that group is part of the local community and that you interact with the community,' added Chris Campbell, chair of SMUG user group. 'But we have all come a long way – everyone should feel very proud of themselves.'

PUTTING A VOICE TO RECOVERY

'One more drink would have been fatal.' Stuart inspired delegates with a story of success.

I started drinking 31 years ago and stopped six months ago. I was in hospital in Whitchurch, away from my friends and family. I'd been sober for two weeks and knew my next drink would be fatal.

I wanted my two children to see me as the father I am and not the drinks I'd drunk. I came to the point where if the drink didn't kill me my friends would've. I nearly lost my life over the price of a drink.

'My mum said as soon as I learned to walk I stood up with my pram attached to my back and ran off. '
Justin (left)

I needed and wanted to change my life. I didn't want to feel depressed anymore and I wanted to regain trust from my two sons.

Being sober for six months is a success story in itself – I can walk with my head held high. It'd be easy to find the next drink and wash it all away, but I now wake every day with a clear head.

ONE HECK OF A JOURNEY

From burning beds to love and stability – Justin's story

Before I was drug dealing I was a criminal. My mum said as soon as I learned to walk I stood up with my pram attached to my back and ran off. My behaviour was berserk and extreme. Once I set my brother's bed on fire while he was in it.

I went to festivals where drugs were available, and progressed to other things – I never knew how to have boundaries. I was extreme in everything.

At 22 I was a hell of a mess – heroin, methadone, Valium. I went to prison and then to a rehab in Birmingham, where I stayed for two and a half years. They sent me to work at a centre in New York. It was quite an experience and taught me good habits.

I proposed to my girlfriend then ran off and joined the Foreign Legion! I left after a few months and married her. I have a five-month-old son now and I love him. I tell my wife – 'tell him you love him when he does something wrong.'

I've been involved in service user involvement for two and a half years and it's been one heck of a journey.

'Our group has become a thriving recovery forum. It was started by Mike, one of our participants, and it's unleashed some remarkable talent. We have people who've never painted before and it's helped them to look beyond the problems they've had. They're creating talents so they can move on.'

Joan Brown of Drugaid

'WE'RE SURVIVORS. WE'VE COME THROUGH IT.'

Wynford Ellis Owen is now president of the Welsh Council on Alcohol and Other Drugs and a leading light in the recovery movement. He told delegates how he learned to seek help the hard way

I was dependent on alcohol and drugs. Then on 20 July 1992 I saw myself as I was and it brought me to my knees. I ended up on the streets of Aberystwyth, running away. I tried to kill myself but failed. I was an abject failure. That's when a miracle happened and I saw myself as I was.

An immense willingness to get well entered me. I know how people slip and slide all over the place, but I was prepared to do anything to recover. It's what kicks me out of bed in the morning. It gets me picking up the phone – things to help other people.

Even though I was slowly committing suicide with drink and drugs I was still terrified of dying. But then the fear of death left me. I started to think of it as a union with God. I feel nothing but joy for people who've died. I realised I couldn't blame myself – the alcohol dictated.

I went back to my bedsit and took my drugs. I woke up the next day and couldn't move. I've never been so frightened. I was suffering from the DTs and that's when I asked for help.

I went into a treatment centre. They gave out a questionnaire – and one to Meira, my wife, and my daughters Bethan and Rwth – and that's when I realised the effect I'd had on my family.

We have to recognise our need of help. Don't knock suffering – it's the most creative force of nature. The biggest risk for people like you or me is to become vulnerable – to be human and accept and recognise. It's about making mistakes and falling flat on your face, knowing it's OK to be human. The paradox is around being human on one hand and toughening up on the other.

We're survivors. We've come through it, and that's so important. And storytelling is so important – putting a face and voice to recovery. It's about standing up and saying 'I matter', 'I count'.

We're all unique, we all have something to contribute to life's rich pageant. Recovery is a wonderful concept – look at the positive, what's working in your life. Men and women put their lives back together and their world falls into place.

To me, recovery means playing my part. Recovery's your chance to play your part, and it's never, ever too late. Too often recovery is a dirty little secret – it's not. Let's put a face and a voice to recovery and celebrate it.

MAKING RECOVERY A REALITY

Alistair Sinclair invites you to explore the business of being human

'We will play our part in the beginnings of a new British recovery movement.'

Not long now until the UK Recovery Federation's second national conference in Cardiff on 9 September.

We've called it a 'summit' for a number of reasons. A couple of months ago Keith Humphries, the keynote speaker at the UKRF conference, wrote a piece for *Druglink*, in which he identified two things that started to turn the tide in the US in bringing abstinence and harm reduction-focused people together to form a consensus around recovery.

The first was a Washington 'summit' where some people from previously polarised camps came together to find a common cause and build on their similarities rather than their differences. The other was the formation of Face & Voices of Recovery (FAVOR). This grassroots community-led organisation was created in 2001 to honour recovery in all its diversity and support the development of a US recovery movement founded on political advocacy and community-led organising. It has been profoundly successful in the US, principally because of its open and inclusive membership and the dedication of its community members, board and staff. Carol McDaid, outgoing chair of FAVOR's board will also be speaking at the UKRF conference.

We have called our conference a 'summit' partly because of the debt the UKRF owes to pioneers of recovery in the US, but principally because it is a statement of intent. The UKRF intends to bring a diverse range of people together – abstinence-focused people, harm reduction-focused people, service users, people in recovery, treatment practitioners, professionals, commissioners, policymakers, family members, community members. These are some of the labels we apply to ourselves or others apply to us.

We are inviting people to attend the UKRF conference as equal human beings; more similar than different, with the same basic needs. Human beings with strengths, abilities, experience and passion who want to make new connections with others so they can learn, grow, and explore the business of being human.

There's lots of rhetoric about 'recovery', talk about 'recovery-oriented integrated systems' and 'full providers of recovery'. The UKRF intends to create spaces where we can explore some of the reality and share the 'lived experience' we all have of recovery. The UKRF is not in the business of providing answers, but it will give a platform to people who have been working within communities to develop recovery networks, to people who have been supporting recovery in treatment services and primary care, to community members who have been living their recovery every day and supporting others within the community.

We will focus on our strengths and abilities and how we can use our 'assets' to generate real recovery-oriented values and standards within services and within the communities in which they sit. We will play our part in the beginnings of a new British recovery movement. We would like you to join us.

We make the path by walking it.

Alistair Sinclair is a UKRF director

Post-its from Practice

The right time?

Be patient with support, says **Dr Chris Ford**

Steve entered my room with an enormous grin on his face, wishing me a belated happy birthday. As he took a seat, he said 'I don't really have a reason to be here' and I responded that it was always wonderful to see him, especially looking so well. For a fleeting moment I remembered what he had looked like on other occasions – agitated and paranoid after a crack binge or suffering from severe withdrawals after going cold turkey following heroin. But he was always motivated to come back to see me.

He then said he had come to tell me he had done '90 meetings in 90 days'. We hugged and cheered as I shared his delight and he went on to say how different things were now.

Steve had been registered with the practice since birth and had developed a severe crack and heroin habit 12 years ago. He looked dreadful, with obvious loss of weight, multiple skin lesions and he couldn't sit still. Initially, he had appeared terrified but after a while, relaxed and enquired 'So you aren't going to throw me out?' when I admitted that I didn't know much about crack but was happy to learn from him. He said 'I'm not ready to stop yet, I just want to go back to using when I want to rather than 'cause I have to'.

He settled well on low dose buprenorphine and was beginning to feel better. We then each went on a journey of learning how crack could be used more safely and efficiently. There were many tears and also much laughter during this time. I think I did both when Steve joked that he was going to the papers to tell them that his GP had shown him how to smoke crack better!

Over the next few years, Steve stopped and started using many times, and went into rehab twice, on both occasions remaining drug free for almost a year. Each time he slipped he was so hard on himself, feeling he had failed me and his parents. But each time he came back and we discussed all he had learnt.

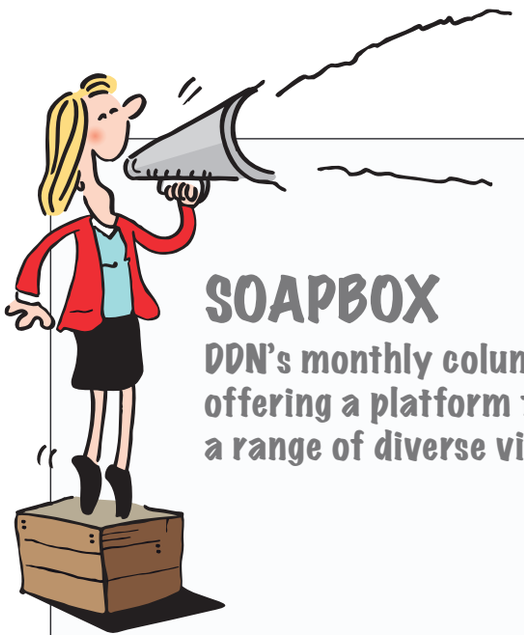
After another relapse early last year, he said he had to do it for good this time. He was fed up with using and his parents had given him an ultimatum of throwing him out. He convinced the care and assessment team to fund him again for an intensive structured day programme. He seemed to do well and graduated, but something was missing. I suggested he came and saw me and Mel, our counsellor, at least once a week, as well as keeping up meetings, but he dropped this after a couple of weeks.

Just four weeks later he came back and said he had relapsed on heroin, diazepam and crack but that he only needed a short buprenorphine detox. I enquired what would be different and he said 'Because I am doing it for me'. I just knew he would do it this time.

It took Steve two weeks and the odd meeting to complete his detox. He then set himself the target of '90 meetings in 90 days'. He told no one because he knew he had to start being honest with himself first, recognising and fully accepting the basic ideas of the fellowship, which he hadn't done before. He felt he needed to 'detox' himself not only from the drugs but more importantly, from his unhealthy emotional patterns.

In a parallel to the fellowship invitation to 'keep coming back', Steve did just that – because in general practice you never get discharged! It's been a long, winding path for Steve on his self-defined journey. It's been a privilege for me to support him throughout and offer him a range of different responses and encouragement over time. We have to support people until they feel they are ready to change.

Dr Chris Ford is a GP at Lonsdale Medical Centre, clinical director for IDHDP and a member of the board of SMMGP www.smmgp.org.uk



SOAPBOX

DDN's monthly column offering a platform for a range of diverse views.

LET'S GET ENGAGED

Cuts or no cuts, staff engagement is vital for good services, says **Martin Blakebrough**

In a time of cuts and uncertainty, and an environment of austerity, it seems strange to be discussing staff engagement. The prevailing mood seems to be one of doing more for less and cutting employee benefits like training and support.

If you go to many local authority or government offices for a meeting there's no coffee or tea and no plants – the message is 'we're cutting any extras'. Yet the creation of a positive place to work is vital if we are to succeed as organisations. As CEO of Best Companies, Jonathan Austin, said, 'The way employers treat employees has a direct effect on how employees treat customers. Customers, or service users, vote with their feet depending on the quality of the interaction they experience with any given organisation.'

Our service users are our customers. While they sometimes may not have a choice as to where they go for services, unless you properly engage with them and provide meaningful support the ability to encourage recovery – or my preferred word, change – is seriously compromised.

In Wales they have a unique training event for people providing public services – a week-long summer school. The idea is to train leading professionals from a diverse range of organisations – from the police to local housing associations to consultant doctors – with the aim of breaking down barriers between professions and agencies. In essence, to facilitate joined-up services. As a drugs worker, I know that treatment is only a fraction of the work needed to turn around the lives of the service users I see, and the school has already worked its magic with the contacts I have set up, which will make a real difference to my agency and the work we do.

The programme showed how the Welsh Government understands that to work in these difficult times, one still needs to ensure the workforce is challenged, but also supported, to make changes. If we in the drug and alcohol field are going to provide the best possible support services it's vital that we understand that investment in the people working for us is even more critical than in the past. We may need to do more with less, but we also need to change the way we work so we can be even more efficient and focused.

In the drug and alcohol sphere, the clear evidence is that we do not do enough to create long-lasting changes in people and in too many cases people are still a long distance from recovery. Of course there are interventions that are evidenced-based, but we need to be more innovative and creative if we are to really address the problems of those suffering with addictions.

I believe the greatest asset for our services is our workforce, and ensuring they are engaged in turn gives them the confidence to make a difference in a person's life. So how do we know if staff are not engaged? There are indicators – turnover used to be one of these, but with people worried about job security in the current climate I don't think this remains a reliable indicator.

Sickness is one measure, but the reality is that you can feel an engaged workforce. There is a buzz, there is concentration, there is reflection, there is sharing and there is a confidence in what the worker is doing. The sad thing is that you cannot impose this on your workforce – it is a culture that needs to be created, bottom up and top down.

So how do we change a culture? David Zwinger from Canada, a speaker at the summer school, talks about the value of the 'small thing', and the power of such a concept is that it is liberating for all of us. So often we wait for the lead from the CEO, but we all have it in our power to make the small changes – be it a positive comment to a colleague or making that small change in the way we work.

An engaged workforce is one that is cohesive and clear in its objective, both for the organisation and the individual. At work, we recently held an induction for new staff and at the feedback one of the comments was about being 'impressed by the homemade biscuits'. It was not so much the taste but the effort and sense of homeliness created by such an act – it was the small gesture that probably gave the strongest message.

The issue of engagement is vital if we are to better engage clients, staff and be successful as businesses. Justin King, CEO of Sainsbury's, told us that, 'In our business, with almost 150,000 people, engagement is a key concern. In businesses of our scale, you don't even get started without engagement.'

Engagement is not managers having a new idea and imposing a solution on staff. It cannot be bound in policies, but it is about a culture owned by all. Engagement can be encouraged by management, but for it to take root staff need to embrace a change in culture – the value of the small thing. **DDN**

http://employeeengagement.ning.com

Martin Blakebrough is chief executive of Kaleidoscope

Staffordshire County Council

EXPRESSION OF INTEREST IN THE PROVISION OF A YOUNG PEOPLE'S SUBSTANCE MISUSE SERVICE FOR THE COUNTY OF STAFFORDSHIRE

CONTRACT TITLE: Young People's Substance Misuse Services

CONTRACT REFERENCE NUMBER: SMCT YP001

DESCRIPTION OF THE CONTRACT: Staffordshire County Council, Substance Misuse Commissioning Team is seeking expressions of interest from a range of suitably qualified and experienced providers, either wholly or as part of a partnership arrangement to deliver the following services:

To provide a young people's substance misuse service for the County of Staffordshire. The service provider will be required to deliver a Young Persons Substance Misuse At Risk Project and a Specialist Structured Treatment Service.

The procurement will have TUPE implications.

The tender will follow an open single stage process. To express an interest and request an Invitation to Tender pack please email commissioning.team@staffordshire.gov.uk with your name, organisation and contact details, stating the contract reference number/title. Once you have registered your interest in the tender you will receive the documents by e-mail.

CONTRACT START DATE: 1 April 2012

INITIAL CONTRACT PERIOD: 2 Years

OPTIONAL EXTENSION PERIOD(S): 2 Years

FINISH DATE (inc. extensions): 31 March 2014 but with option to extend to 31 March 2016

TOTAL CONTRACT VALUE (inc. extensions): Between £1.6 and £1.8 million

CLOSING DATE: 12 noon Friday 16 September 2011

CONTACT NAME: Alison Perry, Commissioning Officer, 01785 358613

St Martins Healthcare Services
Community Drug Services

SMHS St Martins Healthcare Services
Providing NHS services

Medical Prescribers, Nurse / Pharmacy Prescribers and Prescribing Facilitators

Full, part time and locum positions available in Leeds and Hull

St Martins Healthcare Services is a dynamic and growing organisation, providing drug treatment prescribing, shared-care co-ordination and medical intervention services in urban primary care settings.

We have recently won a new contract to deliver community drugs services in Hull, in addition to our existing successful service in Leeds. Due to this growth, we have opportunities on a full-time or part-time basis in both Hull and Leeds for Medical, Nurse and Pharmacy Prescribers with experience of working with substance misuse clients. We can also consider Prescribing Facilitators with clinical skills who are experienced in preparing prescriptions and negotiating with clients in relation to prescriptions. A Prescribing Facilitator role may suit someone with a nursing / pharmacist background but who is not yet a prescriber.

We are looking for client-centred, autonomous team-players, who will be responsible for specialist prescribing and delivering brief interventions, working closely with our partner agencies who deliver psychosocial and wraparound services.

We foster a culture of enthusiasm, high quality standards and the belief that we can make a positive difference – to both clients and staff alike. We are looking for experienced and enthusiastic Clinicians with the ability to work under their own direction to join our successful team.

Application pack from Rebekah Drury, Human Resources Manager
rebekahdrury@nhs.net 0113 2444102
Closing date for applications 5pm 8th August 2011
Interview date: 15th August 2011

Daat cumbria

CUMBRIA DAAT PARTNERSHIP

INVITES EXPRESSIONS OF INTEREST FOR ADULT DRUG AND ALCOHOL SERVICES

Our vision is to create a holistic end to end drug and alcohol service, which has recovery and social inclusion at its centre. The new service will be ambitious and innovative, integrating community and criminal justice services including those in HMP Haverigg.

Potential providers will demonstrate creativity and commitment to working with partners, including local community groups.

We intend to award the contract by 1st April 2012 with implementation planned for 1st July 2012.

Please note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) apply.

Please send Expressions of Interest to Janice Ruddie, email: janice.ruddie@cumbriapct.nhs.uk by 12 noon on 2nd September 2011.

Further information will be made available to all applicants, together with the Pre-Qualification Questionnaire.

Under no circumstances will late applications be considered.

University of Brighton

Lecturer/Senior Lecturer in Substance Misuse

0.2 full-time equivalent

from £31,798 to £37,990 pro rata at Lecturer Level
from £39,107 to £45,336 pro rata at Senior Lecturer Level

The School of Applied Social Science (SASS) is a dynamic centre for multidisciplinary social science scholarship. Our diverse portfolio of courses includes a Foundation Degree in Substance Misuse Intervention Strategies. You will become a core member of this course team and also make some contribution to learning and teaching in the SASS undergraduate and postgraduate programmes where you will provide specialist input on substance misuse related topics. You will have experience of working within a service provider in the substance misuse and/or alcohol sector and possess a postgraduate qualification/PhD or an equivalent qualification and an understanding of DANOS. Secondments are welcome. The post is fixed-term for two years.

Informal enquires can be made to Daren Britt, Course Leader, on 01273 643548, or by email to D.Britt@Brighton.ac.uk.

Ref: HA3088 - Closing date 16 August 2011

For more information call 01273 642849 (24 hours) or visit www.brighton.ac.uk/personnel

Working for equality of opportunity

LINKUP CAFE

PART-TIME CAFÉ MANAGER

RECOVERY LINKUP CAFÉS – £12,778 (23 hours) including some evening and weekend working

Would you like the opportunity to be part of a new, unique and growing charity in the addiction/recovery field?
We are looking for a part-time café manager to run three abstinence-based cafés in East and South London. If you have drive, ambition and a genuine commitment to developing services for men and women in recovery from addiction, as well as experience of training, developing and managing volunteers, we would like to hear from you. *We particularly welcome applications from people in recovery.*

For an application pack please call 0208 558 2121 X 28 or email admin@recoveryresourcesfoundation.org or visit our website for more details and application pack
www.recoveryresourcesfoundation.org

CLOSING DATE FOR APPLICATIONS – 12 AUGUST 2011

We are also recruiting volunteers to work in the cafés (cooking and/or serving) and a volunteer for an administrative role. If you would like to know more, please contact us on the email above stating that you are interested in volunteering.

oxfordshire
drug & alcohol action team

Tender for Oxfordshire Recovery Services

Oxfordshire DAAT is designing a community based recovery system and will be going to the market for a range of Recovery Service providers to deliver this ground breaking approach. Oxfordshire's Drug and Alcohol System model is outlined on our web-site at **www.oxfordshiredaat.org**

The introduction of community Recovery Services, to run alongside the separate Harm Minimisation Service and the current Residential Detoxification and Rehabilitation Services framework, is a key element in ensuring that the needs of all drug and alcohol users are met. This service will be the focal point of the Payment by Results (PbR) pilot and will put recovery at the core of our treatment system. A core function of these services will be to provide interventions to people who are ready to recover from addiction and would like to work towards leading a life free from dependence.

The service will receive referrals from the Local Area Single Assessment and Referral Service (LASARS) who will be independent of Recovery Service providers and be the single point of access for drug and alcohol services across Oxfordshire. The scope and scale of this service is detailed in a Memorandum of Information (MoI) which can be accessed by all interested organisations via the Procurement web-site referred to below.

The services will work with individuals across Oxfordshire aiding them to develop their 'recovery capital' to ensure that they are able to maximise all opportunities to become free from dependence. This will include the provision of a range of interventions, including detoxification prescribing, but not limited to the elements described in the MoI.

Oxfordshire DAAT is seeking to procure approximately two to four Recovery Service providers for the provision of these services across a large rural area. It is currently envisaged that providers will operate under a framework model aligned with the Developing Public Health and Health contracting policy.

TIMINGS
The PCT would like to be in a position to appoint Recovery Service providers by December 2011, for commencement of the new services from April 2012.

THE PROCUREMENT PROCESS
For further information about the procurement process, interested parties are invited to access the electronic portal www.pro-cure.bravosolution.co.uk where all Pre-Qualification Questionnaire (PQQ) documentation and a Memorandum of Information (MOI) can be accessed.

The Procurement will be conducted via this e-tendering web site and if you want to express an interest in this opportunity please:

- *Register your organisation on the www.pro-cure.bravosolution.co.uk web-site;*
- *Access the Pre-qualification Questionnaire (pqq_28846) for Recovery Services for Oxfordshire DAAT.*

Please note that the latest date for receipt of expressions of interest and the completion of PQQs is 17:00 on Friday 26 August 2011. All PQQs to be completed and returned via the web-site.

PQQs received/posted to the web-site after 17:00 on the Friday 26 August 2011 will not be allowed or evaluated.

Should you require any assistance in accessing or registering on the e-tendering web site please contact the Bravo eTendering Helpdesk – Phone 0800 368 4850.

Lewisham NHS
Primary Care Trust

Lewisham

LEWISHAM DRUG & ALCOHOL ACTION TEAM (DAAT)

THE 'REC'

AN ADULT REINTEGRATION & AFTERCARE SERVICE

Are you able to champion and drive forward high quality Drugs and Alcohol Services, providing skills in the field of Health and Community Services? Do you have a track record in Performance Improvement and sustaining high quality service delivery?

The DAAT on behalf of the London Borough of Lewisham and Lewisham Primary Care Trust invites expressions of interest from suitably qualified organisations that can demonstrate the knowledge, innovation and ability to deliver substance misuse services to meet the needs of a diverse population. Prospective providers are invited to tender for a multi-purpose service under each of these headings and consortium tenders will also be considered. Services will be expected to provide a range of treatment interventions that include:

- **Education, Training & Employment Access & Support**
- **Psycho-Social intervention & Support**
- **Day programme**

The expected term of services will be from 27th September 2011 initially for one year, with an option to extend for a further two years subject to review. The contracts will be based in part on a performance payment in relation to achieving a set of Outcome Indicators.

To request a tender pack, either in writing or by e-mail, contact:
Mike Hurst, Procurement Team, London Borough of Lewisham,
3rd Floor, Lewisham Town Hall, Catford London SE6 4RU
Telephone: 020 8314 6556
Email: mike.hurst@lewisham.gov.uk

Expressions of interest should be made by 23rd August 2011, and completed tenders must be returned for receipt by no later than 12 noon, Tuesday 30th August 2011.

EXPRESSIONS OF INTEREST

Adult reintegration and aftercare service

South Gloucestershire Council

DRUG & ALCOHOL SERVICES

South Gloucestershire Council is seeking expressions of interest for the provision of a brand new integrated, recovery-focused treatment system.

Our treatment services are recognised for providing a high standard of care. We wish to continually improve service delivery through innovation and change, so that our service users have the best possible outcomes.

An exciting and visionary opportunity has arisen to deliver a treatment service to maximise recovery potential and to support sustained abstinence through a range of council services.

In line with the Government's 2010 Drug Strategy, the Ministry of Justice's 'Breaking the Cycle' and Health Partners legislation, the new system will be designed to provide seamless care throughout recovery and beyond.

It will bring together community and custodial services to improve flow through the criminal justice system. A range of clinical and psychosocial interventions will also be provided based on a bio-pyscho-social model which recognises the importance of education, training, employment and housing to full recovery.

The following lots will be available to tender for at Invitation To Tender (ITT) stage:

- *Drug & alcohol inpatient detoxification and stabilisation services: £100,000-£130,000*
- *Specialist clinical intervention services including rapid access, community detoxification and BBV services: £250,000-£275,000*
- *Integrated criminal justice service incorporating drug interventions programme both community and custodial: £850,000-£900,000*
- *Community through-care and social reintegration services including housing support, education, training & employment: £275,000-£300,000*
- *Early engagement services to include outreach for hard to reach groups, needle exchange and non OCU gateway needs: contract scope is £125,000-£140,000*
- *Family & carers inclusion services: £55,000-£60,000*
- *Specialist dependant alcohol service: £90,000-£100,000*
- *Bio-psycho-social recovery service, including previous shared care, psychosocial interventions, triage and assessment & treatment centre management: £475,000-£500,000*

Expressions of interest are sought from suitably qualified organisations who can demonstrate the knowledge, innovation and flexibility to realise this vision and deliver quality services.

Interested organisations should note that Transfer of Undertakings Protection of Employment (TUPE) will apply.

The proposed contract is due to start **1st April 2012** and will be for a term of three years (with a possible extension of one year based upon the discretion of the contracting authority and satisfactory performance). Information on these proposed services can be accessed via service provider registration on the **'Supplying the South West'** contracts portal at **www.supplyingthesouthwest.org.uk**, all suppliers will need to register to apply for these opportunities.

Providers expressing interest will be asked to complete a pre-qualification questionnaire for evaluation. Providers who are successful at this stage will be invited to an open day which will include a question and answer session with the commissioners.

Date: Wednesday 21st September 2011
Time: 13.30 – 17.00
Venue: Successful providers will be advised

For further information on this tender opportunity please contact: Matt Wills, Joint Commissioning Manager, South Gloucestershire Council, Council Offices, Castle St, PO Box 2078, BS35 9BJ or matthew.wills@southglos.gov.uk