MERRY CHRISTMAS AND A HAPPY NEW YEAR TO YOU

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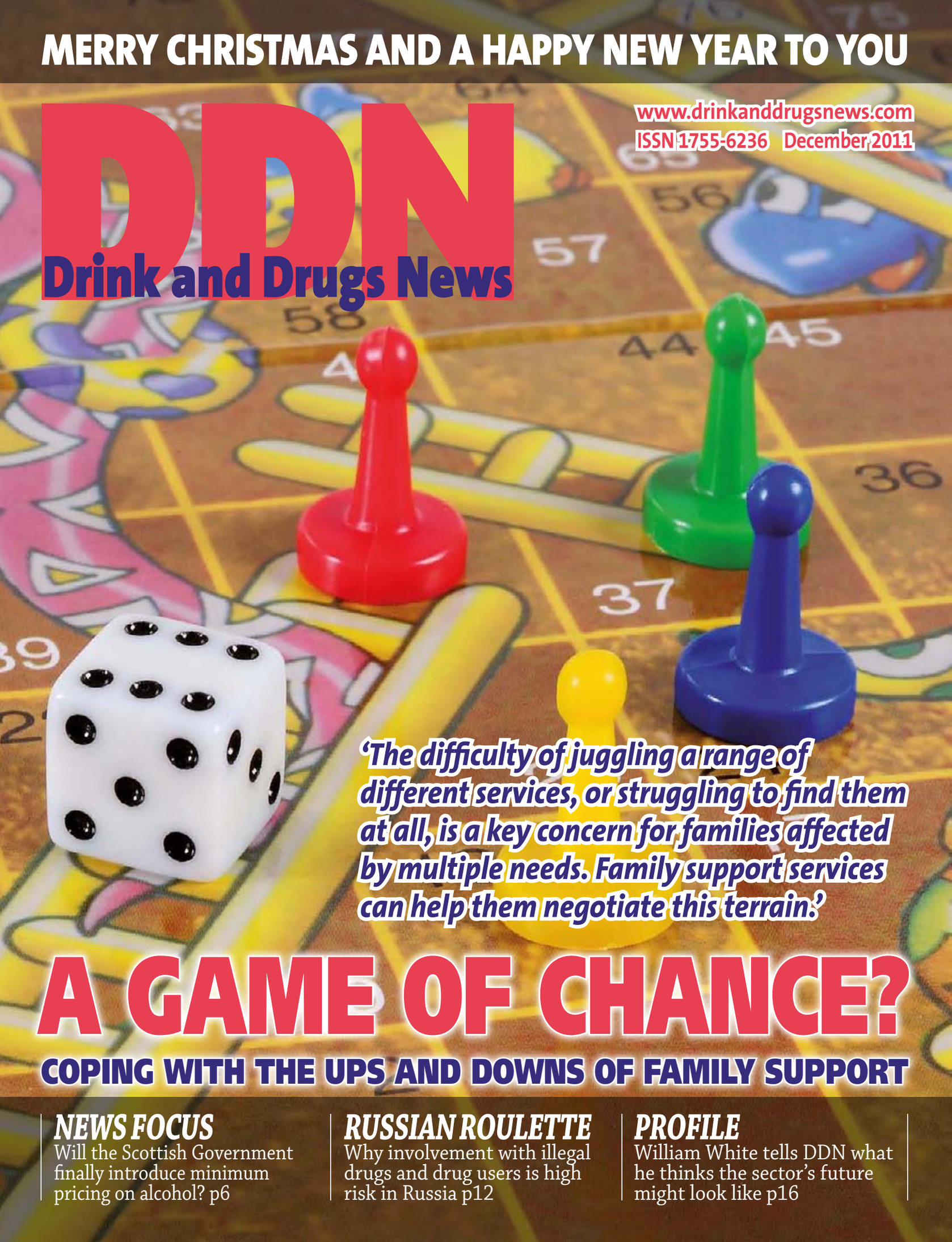

'The difficulty of juggling a range of different services, or struggling to find them at all, is a key concern for families affected by multiple needs. Family support services can help them negotiate this terrain.'

A GAME OF CHANCE?

COPING WITH THE UPS AND DOWNS OF FAMILY SUPPORT

DDN Drink and Drugs News

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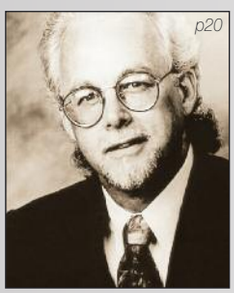
Season's greetings!

Thank you for your loyalty over the past year

DO YOU REMEMBER which month saw the publication of the Health and Social Care Bill? Or when during the year a flood of new drugs made the Misuse of Drugs Act 'increasingly unenforceable'? Or when the Centre for Policy Studies' *Breaking the habit* report kicked off a row about the cost of drug use to the public purse? Looking back at the recurrent themes and thorny problems makes the year seem very short indeed. The drinks industry is among those appearing constantly in our headlines, particularly in relation to debates on minimum pricing and subliminal advertising. See our review on page 18 for a reminder of a rollercoaster year. As we head towards 2012 it's a worrying time for all of us, and we are fully aware of budget constraints right across the field. It's with complete gratitude then, that we thank contributors to our Christmas card appeal (centre pages), who helped towards the production costs of this issue during the traditionally lean period for advertising. You have firmed our resolve to keep DDN as a free magazine that goes to every corner of the drug and alcohol field.

A happy and healthy Christmas to all our readers, contributors and advertisers. Please keep your letters and articles coming and we'll be back with you in print on 16 January. Don't forget to join us on Facebook!

This issue



FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: JOBS, COURSES, CONFERENCES AND TENDERS

News in Brief

DOUBLE STRENGTH

London-based charities Blenheim CDP and CASA have announced they are to merge, allowing the new organisation to offer more services and cover a wider geographical area. 'Joining together CASA's alcohol expertise with Blenheim CDP's drug misuse experience will result in a truly exceptional organisation enabling us to cover a whole spectrum of service provision,' said Blenheim CEO John Jolly. The full merger is expected to be completed by next April.

A FLOP FOR STIFFY

A complaint about vodka liqueur products Stiffy's Jaffa Cake and Stiffy's Kola Kubez has been upheld by the Portman Group's Independent Complaints Panel for 'inappropriately linking an alcohol product with sexual success'. Manufacturers Stiffy's Shots Ltd, trading as VC2, had maintained that 'Stiffy' referred to the nickname of a person involved in the development of the drinks rather than any sexual connotations. 'Following this ruling and our enforcement action, Stiffy's products will be removed from sale in their current form,' said Portman Group chief executive Henry Ashworth.

HEAR, HEAR

Dumbartonshire-based confidential telephone helpline HEAR (Help, Empathy, Advice, Reassurance) is celebrating its third anniversary. Designed by service users and developed by West Dumbartonshire Council in response to a need for out-of-hours support, the service operates five evenings a week, including Christmas Day. 'I've been with the service since it started, and took my first call on Christmas Eve 2008,' said phone operative Scott. 'A young girl was threatening to kill herself, so distressed at being alone because of her drug use. That call ended well, and so far most calls have had very positive outcomes.'

TESTING CALL

The number of people living with HIV in the UK reached an estimated 91,500 last year, according to new figures from the Health Protection Agency (HPA). A quarter are unaware of their infection, says the agency, which is calling for HIV testing to be routinely offered to anyone registering with a GP or admitted to hospital in areas where infection rates are high. The HPA has also released its latest report on infections among injecting drug users, *Shooting up*, which this year focuses on infections caused by bacteria. *Available at www.hpa.org.uk*

Parliament launches major drug policy review

The all-party Home Affairs Committee has launched a 'comprehensive review' of UK drugs policy, it has announced. The inquiry will examine the effectiveness of 2010's drug strategy, the 'independence and quality' of expert advice received by the government, and the criteria used to measure the efficiency of drug policies.

The committee will look at the extent to which the recent strategy is a 'fiscally responsible policy with strategies grounded in science, health, security and human rights', in line with the recommendations of the Global Commission on Drug Policy (*DDN*, June, page 4), it states. Other areas of consideration will include the challenges posed by 'legal highs', the cost effectiveness of different policies to cut drug use and the potential impact of the transfer of functions from the NTA to Public Health England on treatment provision. Oral evidence sessions will be held early next year.

A letter stressing the 'urgent need to break the taboo on rational discussion of drug policy reform' has also been sent to the prime minister, the cabinet and every member of the House of Lords and House of Commons by drug policy think tank the Beckley Foundation, with signatories including Jimmy Carter, Yoko Ono and Sting.

Meanwhile, a temporary control power giving the home secretary the authority to place an instant ban on any substance deemed 'potentially harmful', pending advice from the Advisory Council on the Misuse of Drugs (ACMD), has now come into force. The orders ban the unlawful importation, production and supply of a temporary-class drug in the UK for 12 months.

Chair of the UK Statistics Authority, Sir Michael Scholar, however, wrote to immigration minister Damian Green last month, expressing concern that the government had issued a 'highly selective' press release about drug seizures by the UK Border Agency before the publication of his organisation's statistical bulletin on seizure rates – which reports a decrease in 2010/11 – in order to 'generate positive news coverage' and show the UK Border Agency 'in a good light'. If that were the case, the letter states, it would be 'highly corrosive and damaging to public confidence in official statistics'.

Anyone interested in making a written submission to the inquiry should do so by 10 January – full details at http://bit.ly/vJt5yh

Seizures of drugs in England and Wales a – 2010/11 available at www.statistics.gov.uk

Cocaine use falls in time of austerity

Rates of cocaine use have started to decline across Europe, according to the 2011 annual report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

The countries with the most significant cocaine problems – Spain, Italy, Denmark and the UK – all reported a fall in 'last-year' use among 15 to 34-year-olds, mirroring similar trends in the US and Canada. The UK, however, remains the European country with the highest rate of use among this age group.

With an average price of between 50 and 80 Euros per gram, regular cocaine use may be a 'less attractive option in countries where austerity is now the order of the day', says the EMCDDA, although the drug remains the continent's most widely-used illicit stimulant, with around 17 per cent of those entering treatment reporting it as their main problem substance.

Levels of heroin use have remained largely unchanged, although there are still more than 1.3m regular opioid users in the EU and Norway. Clients in treatment are generally older, however, and the proportion reporting injecting is also declining in most countries, with just 40 per cent of those entering treatment for opioid problems regular injectors. Around 700,000 opioid users received substitution treatment in Europe in 2009, 50,000 more than in 2007, although coverage continues to vary greatly.

Although drug use as a whole appears to be 'relatively stable' across Europe, and cannabis use continues to decline among young people, there are 'new threats' from the rapidly evolving synthetic drugs market, and widespread polydrug use, says the report, adding that European drug policies and responses will need to adapt accordingly.

Thirty-nine new drugs have been reported this year via the European early warning system (EWS), on top of the 41 notified to the EMCDDA and Europol last year (*DDN*, June, page 5). Drug manufacturers are also playing 'cat and mouse' with the authorities in terms of the imported precursor chemicals used to synthesise the drugs, the report states, using increasingly sophisticated techniques to bypass regulations. These include synthesising precursors from 'pre-precursors' or masking them as non-controlled chemicals, which are then reconverted after importation.

'The fast moving and increasingly joined-up world we live in is mirrored by an increasingly fast moving and joined-up drug market which appears quick to adapt to both threats and opportunities', said EMCDDA director Wolfgang Götz. 'This is reflected not only in the sheer number of new substances appearing on the market, but also in their diversity and in how they are produced, distributed and marketed. We need a proactive strategy that allows us to rapidly identify new drugs and emerging trends so that we can anticipate their potential implications. We also need to coordinate our responses across Europe as, without doing so, individual national efforts are likely to prove ineffective. These two factors are crucial if we are to stay ahead in this rapidly developing game of cat and mouse'.

Annual report 2011: the state of the drugs problem in Europe at www.emcdda.europa.eu

Scots drug users getting older

The number of people in Scotland who problematically use opiates and/or benzodiazepines rose to nearly 60,000 in 2010, according to new figures released by Scottish NHS body ISD (Information Services Division). This represents an increase of more than 4,000 since 2006.

The age profile of users also appears to be getting older, with 43 per cent of users aged 35 to 64, compared to 34 per cent in 2006, while the prevalence rate in both the 15 to 24 and 25 to 34-year-old age groups has fallen. The highest prevalence of problem drug use was estimated to be in the Glasgow City Council and Dundee City Council areas.

While the figures showed that 'Scotland's long legacy of problem drug misuse remains unacceptably high' they referred to a period when the Scottish drug strategy, *Road to recovery*, 'had only just been launched', said community safety minister Roseanna Cunningham. 'Recovery from drug addiction is possible and we will continue to drive reform to ensure that recovery is accessible, visible and sustainable,' she said.

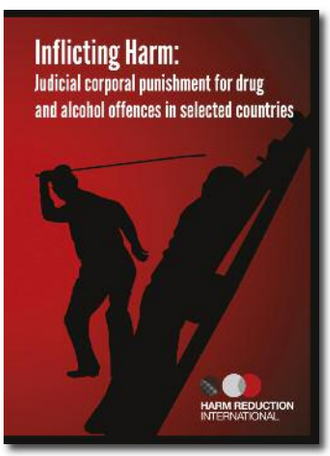
Poverty was 'probably the single biggest' contributory factor to Scotland's drug problem, said director of the Scottish Drugs Forum (SDF), David Liddell, with the combination of unemployment, lack of opportunity and continuing welfare reform 'hugely important factors for determining the future levels of drug dependency' in the country.

'The figures show a very significant level of men aged over 35 with a severe drug problem – research which SDF has previously carried out shows that many are lonely, isolated, experiencing major health problems and have lost hope of ever having a better life in the future,' he said. 'We need to provide education and training opportunities for a larger proportion of this population than at present, and also to look at supported employment programmes to enable more people to recover.'

Estimating the prevalence of problem drug use in Scotland 2009/10 available at www.isdscotland.org

Caning and flogging rife for drug offences

Thousands of people found in possession of even small amounts of drugs and alcohol are routinely caned, flogged and whipped each year, according to a new report from Harm Reduction International (HRI).



More than 40 states enforce judicially sanctioned corporal punishment, says *Inflicting harm: judicial corporal punishment for drug and alcohol offences in selected countries*.

This state-sanctioned violence is in clear violation of international law, says the document, with UN human rights monitors regularly voicing concern. The vast majority of the sentences are carried out in Malaysia, Singapore, Iran and Saudi Arabia, says HRI, with judicial corporal punishment also practised in Libya, Brunei, Yemen, Qatar, United Arab Emirates, Maldives, the northern states of Nigeria and the Aceh province of Indonesia.

The legal basis for judicial corporal punishment varies from country to country and can be provided for in either state or religious laws, says the report, with some countries only using one type of corporal punishment – such as caning in Singapore – while courts in countries like Saudi Arabia and Iran might impose one of a range of methods depending on the offence.

The report calls for far more analysis of the long-term impact of the practices as they leave 'lifelong marks not only on people's physical bodies, but on their psychology', said the report's author and HRI human rights activist, Eka Iakobishvili.

The practices were 'cruel, inhumane and degrading', said HRI's executive director, Rick Lines. 'Effective drug policies are those that respect human rights, international standards and scientific evidence of effectiveness. Corporal punishment for drug and alcohol offences fails all three of these tests. It amounts to little more that a government trying to brutalise its way out of a drug problem.'

Available at www.ihra.net

Sharp rise in hospital admissions for drug-related mental health problems

Hospital admissions for drug-related mental health and behavioural problems have risen by 14 per cent in a year, according to figures from the NHS Information Centre (NHS IC).

There were 6,640 admissions in England in 2010/11 compared to 5,809 in 2009/10.

Although the figures are still lower than the 8,027 recorded a decade ago, admissions where drug-related mental health and behavioural disorders were a primary *or* secondary diagnosis have risen by 15 per cent in the last year, to more than 51,000, almost double the figure from ten years ago. However, NHS IC stresses this may partly be attributable to changes in recording practice.

More than twice as many men are admitted with a primary diagnosis of a drug-related or behavioural disorder as women, with the North West and London strategic health authorities (SHA) recording the highest rates of primary diagnoses. *Statistics on drug misuse: England 2011* draws together previously published statistics with unreported figures from NHS IC's 'hospital episodes statistics'.

Available at www.ic.nhs.uk

News in Brief

KETAMINE CONCERNS

Three quarters of services questioned for DrugScope's *2011 street drug trends survey* reported an increase in people seeking help for ketamine, says the charity. Evidence from drug workers indicates that use of the drug is far wider than the club and party scene, said chief executive Martin Barnes, stressing that services need to be sufficiently resourced to respond. 'People who use or are tempted to use ketamine need to know just how harmful this drug can be, and be able to access timely and professional help if required from their local drug services,' he said. *www.drugscope.org.uk*

CUSTODY COMMUNICATION

The Royal College of Psychiatrists (RCP) has updated its guidance on the assessment and treatment of people with substance problems who are detained in police custody. *Substance misuse detainees in police custody: guidelines for clinical management* has been revised by a working group chaired by Professor Hamid Ghodse, and stresses the importance of shared responsibility and good communication, and that the 'interests of the detainee as a patient' are paramount. 'Addicted individuals should always be cared for and treated without being stigmatised – whatever their personal circumstances,' said Prof Ghodse. *Available at www.rcpsych.ac.uk*

PRE-LOAD PLEA

A campaign to warn young people of the dangers of 'pre-loading' – heavy drinking at home before a night out – has been launched by Lancashire DAAT and the Safer Lancashire Partnership. The campaign, which will run throughout Christmas and includes adverts in bars, on billboards and on Facebook, is in response research by Lancaster University which showed that 58 per cent of 18 to 35-year-olds in the area indulged in the practice. 'When people get extremely drunk early on in the evening, their behaviour can create a real headache for anyone left to pick up the pieces such as the police, medical staff and fire brigade,' said Safer Lancashire Partnership chair, David Smith.

PRISON PRESCRIBING

New guidance on prescribing medication in a prison setting has been published by the Royal College of General Practitioners' (RCGP). The guidance covers issues like use of benzodiazepines in treating anxiety disorders, as well as questions of medication misuse and trading between inmates. *Safer prescribing in prisons: guidance for clinicians available at www.rcgp.org.uk*

IF THE PRICE IS RIGHT?

The Scottish Government is renewing its effort to introduce minimum pricing to tackle the country's costly alcohol problem. Could it be successful this time around, asks ***DDN***

Back in late 2009, the Scottish Government called the publication of its Alcohol Bill – one of the key provisions of which was the introduction of a minimum price per unit of alcohol – a 'once in a lifetime chance' to get to grips with the country's estimated £3.56bn alcohol problem (*DDN*, 30 November 2009, page 4).

It didn't quite work out that way, however. There was predictable hostility from much of the drinks industry, but it was insufficient parliamentary support – despite the ruling Scottish National Party (SNP) offering to include a 'sunset clause' to review its effects after six years (*DDN*, 27 September 2010, page 4) – that led to the proposal being dropped.

Now, the Scottish Government is having a second attempt, with the publication of the Alcohol (Minimum Pricing) Bill (*DDN*, November, page 4) and this time many believe the SNP has enough support to get the bill passed. The party enjoyed a majority win in the May 2011 election and while Conservative, Labour and Liberal Democrat SMPs previously voted against the proposal, the Scottish Lib Dems appear to have changed direction – there was wide support for a motion supporting minimum pricing at their party conference and leader Willie Rennie SMP has pledged to work constructively with ministers to make the legislation 'the most effective it can be'.

Not only that, but the usual suspects supporting the new bill – the BMA, the Royal Colleges, the Church of Scotland – have some unusual company in the shape of the Scottish Licensed Trade Association and drinks companies including Molson Coors, Tennents and Greene King. 'We have consistently argued that the solution must be proportionate to the problem and should not penalise the majority of responsible drinkers,' says Greene King chief executive Rooney Anand. 'That is why we believe a minimum price for alcohol would go to the very heart of the problem.' The Welsh Government and Northern Ireland Executive have also voiced their support.

It's safe to say, however, that the majority of the industry remains steadfastly opposed, with the Scotch Whisky Association issuing a statement saying that the bill is in violation of EU and international trade laws, and 'probably illegal' – a view recently echoed by UK public health minister Anne Milton. The Law Society of Scotland, which is in the process of analysing the proposals, has warned that the final say could ultimately lie with the European Court of Justice, as compatibility with EU duty directives needs to be considered as well as the free movement of goods as set out in EU treaties.

Convener of the society's competition law committee, James McLean, however, points out that the European Court has not had the opportunity to review the proposals in relation to commissioned academic research until now, and there's ample research for them to look at. In addition to previous studies, the University of Sheffield will re-run its minimum pricing modelling – which will help decide the new minimum price – and Edinburgh's Queen Margaret University has been awarded a research grant to investigate what effect a minimum price would have on the consumption levels of Scotland's heaviest drinkers, including whether they would try to source alcohol from outside Scotland – as some in the industry claim – or, more worryingly, turn to 'illicit or substitute alcohols or other intoxicants'.

The Scottish Government is confident that it can overcome any legal obstacles, however. 'We fully believe that the Minimum Pricing Bill is capable of complying with European law', a spokesperson tells *DDN*, adding that the government expects it to have 'completed its journey through Parliament by next summer' but refusing to be drawn on whether the minimum price is likely to be higher, lower or the same as the 45p decided on last time around, stating only that it will 'be decided during the bill process'.

'The Scottish Government needs to find out why the end of the week signals a time to drink ourselves into oblivion.'

The government is also keen to stress that minimum pricing is not the only string to its bow. 'We have invested a record £155m in tackling alcohol misuse since 2008, the bulk of which – £134m – has been invested in local prevention, treatment and support services,' says health secretary Nicola Sturgeon. However, the evidence shows that affordability is one of the drivers of increased consumption, she states. 'In a society where a man's weekly alcohol limit can be bought for about £4 and a teenager can consume enough alcohol to kill themselves for under £5, tackling price is nothing short of essential.'

A key factor, as with so much public health policy north and south of the border, may well be how far the media decides to get behind the idea. Much of the English media seemed to willfully misunderstand and misrepresent the minimum pricing proposals put forward by chief medical officer Liam Donaldson (*DDN*, 23 March 2009, page 5) and rejected by the Labour government, and there was certainly some hostility in parts of the Scottish press last time around.

The government spokesperson offers no comment on whether they think things might be different this time, although opinion columns since the new bill was announced seem fairly even-handed so far. One Scottish *Sun* columnist, however, writes that, while he supports the previous ban on irresponsible promotions, 'blanket penalising with higher prices for all is most certainly NOT the answer and I really hope the SNP may still see sense', adding that the government needs to look instead at the root causes of the country's relationship with alcohol.

'The Scottish Government needs to find out why,' he says, 'the end of the week signals a time to drink ourselves into oblivion.'

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

When policies fail it is incumbent on our leaders to look for new ones. They show no signs of doing so – even as Latin America's body politic is threatened by the tentacles of the narco gangs who pay off politicians, judges, journalists and policemen – or just kill them, so that they can better transport drugs to us.
Observer editorial, 13 November

Former head of MI5 Eliza Manningham-Buller today joins an increasingly long list of 'formers' and 'exes' who have publicly condemned the so-called 'war on drugs' as a 'dead end'... a former President (Switzerland's Ruth Dreifuss), a former chief of the US Federal Reserve (Paul Volker) and a former Chancellor of the Exchequer (Nigel Lawson). They will be among many other retired establishment figures lining up to say that we need to launch a global and national search operation for a workable alternative to prohibition. The question that leaps out, of course, is why didn't any of these people make their argument before they retired from the day job?
Mark Easton, *bbc.co.uk*, 17 November

What's sad, but predictable in the current political environment, is the way the Obama White House has felt obliged to ignore its previously semi-enlightened position on drugs, of seeing abuse much more as a medical than law-enforcement issue. Now, Obama is just another in the long line of presidents prosecuting the cynical and counterproductive 'war on drugs'. Who profits from this insane war? The Mexican cartels, among many others.
Dan Gillmore, *The Guardian,* 8 November

For the umpteenth time, there is no war on drugs in the UK. On the contrary, what there is instead is a refusal to enforce the law against drug use in a coherent, consistent, and effective manner... The campaign to undermine the UN drug laws is being promoted by some very bad people indeed and a large number of useful idiots.
Melanie Phillips, *Daily Mail*, 19 November

Parents and teachers who want to stop children taking illegal drugs get little help from the government. The feeble website 'Talk to Frank' (which we pay for through our taxes) more or less assumes that drug taking is normal, with lots of matey, slang-infested chat.
Peter Hitchens, *Mail on Sunday*, 6 November

They have no fear of police, authority or any consequences, have unprotected sex and get blind drunk underage, that's if they aren't already stoned on drugs.'They' are our children and in a truly harrowing survey the low level of esteem to which they have sunk has been laid bare. Half of adults in this country think children of school age have started to behave like animals and virtually the same number believe the problem is that they are angry, violent and abusive. Additional findings show nearly half of us reckon the situation is even worse and youths are actually becoming feral.
Nick Ferrari, *Sunday Express*, 6 November

LEGAL LINE

CAN WE STOP POLICE FROM TARGETING OUR CLIENTS?

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

Reader's question:
I am the manager at a needle exchange and have recently seen an increase in clients being arrested and prosecuted very close to the service, either on their way into or out of the exchange. It seems the police see our clients as an easy target as they know there is a high probability that they will have drugs on them. Clients are worried about coming to the service because of this – what can we do?

Kirstie says:
What the police are doing is not right, and is in contradiction with guidance issued by the Crown Prosecution Service (CPS) in relation to the arrest and prosecution of people in relation to drugs offences.

CPS guidance recognises that needle exchanges need police cooperation to carry out the important work they do and to reduce the transmission of HIV, hepatitis C and other infections. It specifically states that prosecutions of people who use drugs who are found to be in possession of used needles (on the way to a needle exchange) or sterile needles will not normally be in the public interest. This means that the prevention of spreading serious disease will outweigh the need for a person to be prosecuted.

In relation to the arrest of people for possession of drugs in the vicinity of drugs services, advice is clearly given that the prosecution of people for simple possession of drugs based on information gathered near a needle exchange is also not in the public interest. However, more serious offences are likely to result in arrest and prosecution.

Many services avoid situations like the one you are experiencing by maintaining a good relationship with the local police. I recommend setting up a meeting with the local chief constable, with a view to coming to an arrangement about how clients are treated. This would be an opportunity to put forward your views, and more importantly those of the clients, about how the current situation negatively affects the service's ability to operate effectively. It might be possible to agree an exclusion zone around the needle exchange in which clients cannot be policed.

If the police are not willing to negotiate with you, or a satisfactory agreement cannot be reached, I suggest that a complaint be made to the Inspector at the local police station or to the Independent Police Complaints Commission (www.ipcc.gov.uk). The service could do this on behalf of the clients or those affected could complain individually with your support. Reference should be made to the CPS guidance and how this is not being followed in the specific cases which you are complaining about.

In the meantime please ensure your clients are aware of their rights in relation to stop and search and to have legal advice and representation at the police station.

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 on the issues covered here please contact the Release helpline on 0845 4500 215.

The

While Adfam's concentration has always been on supporting families affected by substance use, more often than not a family member's first reaction on learning that their relative uses drugs is to look for help on the user's behalf. For the families of people with multiple needs – defined by the Making Every Adult Matter coalition as people who experience a combination of problems, are routinely excluded from services and lead chaotic lives – finding this support can be particularly difficult. They can experience the frustration of not knowing if there is anyone at all in the local area who can – or will – help, which can be compounded by the message 'you should try somewhere else' coming from several services at the same time.

The common theory when discussing dual diagnosis (combined substance misuse and mental health problems) and complex needs is that each service concentrates too much on its own traditional sphere. For example mental health workers lack focus – or at least confidence – around substance misuse issues, while drug and alcohol workers see their remit as limited to drug or alcohol use alone.

But if professionals struggle to deal with multiple needs and dual diagnosis, how do families cope? They routinely have to handle both mental health and substance use issues in tandem, and feel they don't have a choice in the matter. Though they may not have accredited training, their experience is undeniable – but they cannot tell their family member to try a different family at the other side of town who might be more suitable to work with their particular needs, and they cannot look to job descriptions, role profiles, managerial support or training history to point them in the right direction.

Where the list of problems being experienced by an individual service user grows, the stigma felt by families is multiplied. It is difficult enough admitting that a family member (especially a child) has a drug or alcohol problem, but when this is twinned with mental health problems and other difficulties such as domestic violence, the situation can be made even worse.

There can be an assumption that people with severe and longstanding multiple needs have little or no chance of being in loving or productive family relationships, and that nobody raised in a properly caring environment could possibly experience such a multitude of problems. This is particularly perceived of the homeless, for whom relationship breakdown is accepted as a primary cause of their difficulties.

But it is extremely important not to make these assumptions, especially when dealing with multiple needs. In these cases, lives are often so complex that family members are the only ones with a true, full picture of the service user's history, and even when family relationships are broken, rebuilding them could be a key ambition of a service user.

Families are aware of problems going otherwise unnoticed in a way that many services are not, and are better placed to identify markers of true progress and sources of hidden concern. As well as often being frustrated by confidentiality barriers – being unable to find out whether their relative has made appointments recently, or has even been seen, for example – families also struggle to give information to services that they think could make a positive contribution to care planning. Just as families can provide a huge amount of recovery capital for people in drug or alcohol treatment, they can also play a key facilitative role for relatives with multiple needs, being fully in tune with their wishes and helping to coordinate their care across a complex mix of local services.

Adfam has always argued that, notwithstanding the recovery capital that families can provide and the importance of involving them in treatment where safe and appropriate, families deserve support for their own, independent needs. We believe that the 'treatment status' of a substance user should not determine the family's need for support; and since people with multiple needs often struggle to access services effectively, there is a real risk that their families will be left out of the picture.

Though Adfam has seen and supported a growth in services for families affected by someone else's drug or alcohol use (with some support also available for the families of offenders), individual support services for the families of people with a variety of complex problems are unknown territory. So while there may be a homeless service, a mental health worker and a drug treatment agency in a local area, there will not be distinct services working with the families of homeless people, the families of people with mental health problems, and the families of substance users. Therefore the families of people with multiple needs will often fall into the remit of 'family drug support', as long as drugs account for one of the multiple problems being experienced – which is extremely common.

e coping game

Services find it difficult to cater for clients with multiple needs and dual diagnosis, so it's little wonder that families struggle. **Oliver French** from Adfam looks at how we can help them with the ups and downs of their vital supporting role

We are not saying that all the separate organisations above should be set up. If anything, an attempt to separate each need into a distinct area of expertise would only mean more people being continuously bounced between services; worsening retreat into the dreaded 'silos'; more arguments about which problem came first or is more pressing than another, and therefore needs to be addressed first; and poorer provision overall. Services should be geared up to support a variety of different needs.

'If professionals struggle to deal with multiple needs and dual diagnosis, how do families cope?'

Existing family support services are in fact well placed to work around multiple needs, as they already have extensive experience of providing a broad range of emotional and practical support. They have a good understanding of the difficulties families can face in these circumstances – for example worrying about their relative's health or safety, involvement with criminal behaviour or even just where they are, and if or when they will come home.

Family support services have a solid base of supporting skills, which is an ideal start. In the same way that services for drug and alcohol users have expanded their professional portfolio to learn more about an area they haven't always felt ownership over, family support services also need to get up to speed on issues of mental health problems, offending behaviour, homelessness, domestic violence and financial difficulties.

No service can be everything to everyone, but family support providers tend to be less prescriptive in terms of who they will or will not work with. The empathetic, peer support background many of them share means that risks like a client being excluded because their hierarchy of needs is not in the correct order (like a mental health problem being secondary to a substance use issue) are minimal.

They also have extremely flexible thresholds and tend to work on 'eye of the beholder' terms: if a family member contacts the service because they think they need support, then there are few or no criteria they must meet in the 'seriousness' of their problem. Many – like Adfam – were originally set up by family members themselves, which continuously ties them to their core mission of supporting families.

Notwithstanding the importance of effective emotional support, these family services also need to have a clear picture of local agencies working with complex needs clients and a thorough command of local working practices. As mentioned previously, the difficulty of juggling a range of different services, or struggling to find them at all, is a key concern for families affected by multiple needs. Family support services can help families negotiate this terrain, and transmit clear messages on the roles and responsibilities of different local services – even if they would design local provision differently, given the chance. They can also play an important advocacy role for families affected by multiple needs, through demonstrating the variety of problems they find themselves working with on a daily basis.

Quite rightly there has been a focus in the multiple needs debate on service users falling through the gaps, but we should also ensure that families are not left out of the discussion – they can fall through these gaps too. Though acknowledgement of families' importance in drug and alcohol policy has improved in recent years, they should also be recognised throughout the range of problems which often accompany substance use – both for the effects that these issues have on them as individuals, and in terms of the invaluable supportive role they can play. **DDN**

Oliver French is policy and communications coordinator at Adfam.

Adfam works to support families affected by drug and alcohol use and anyone who comes into contact with them. For more information visit www.adfam.org.uk.

LETTERS

RECOVERY SMOKESCREEN?

Recovery is transforming the drug and alcohol treatment landscape to the extent that it is possible to use the term as a smokescreen to mask the complexity of the problems still associated with the development of people who embrace the recovery door with so much hope for a better future. A significant paradigm shift is taking place within the world of commissioning – the most profound difference is that we have come to believe that recovery is the white knight that comes to the rescue.

I have no doubt that it is a contributory liberating factor unlocking the potential people have to escape from obsessive-compulsive behaviours and lost opportunities. Yet it is easy to confuse the first stages of recovery with the genuine sustainability factor needed for social mobility. There is no doubt that the peer dynamic concept can help people manoeuvre from the cul-de-sac of despair on to the road of transformational change and, yes, the group dynamic programme can alter and expand the limiting mindset of irrational beliefs and behaviours by embracing the incremental process of a new beginning.

The scientific evidence measuring long-term social mobility success of recovery programmes is still weak, inconsistent and almost nonexistent within credible research journals, especially in the measurement of the sustainability factor with prolific offenders embracing social mobility five years after the drug and alcohol recovery programmes have ended. This is most notable with individuals who have low self-esteem and turbulent backgrounds of institutionalism. The best we can hope for is weak methodology from American culture radically different from our own, with an insufficient critique of research findings. This is not helped by the fact that there is still not a unifying scientific theory of recovery.

As someone who has led a recovery community for over ten years with an empirical evidence base of cultivating a culture of recovery leaders with the five-year sustainability factor of successful social mobility, nurtured from the prison gate and now climbing a professional ladder of success, I feel proud in what we have achieved. However, I also see the many faces of people accessing our drop-in-centre each day who represent the chronically excluded, lost in a world of inner turmoil, devastation and confusion. Recovery is an alien environment for many of these people. Commissioning can be hampered by cognitive limits when dealing with complexity – complex individuals are a heavy burden on criminal justice and healthcare budgets. They remind us that one size does not fit all. Equally some of those who have completed recovery programmes can still be entangled with complexity.

A recovery culture is a complex environment because it can be hard to predict what will happen. We need to differentiate a recovery programme from a recovery culture. A recovery programme is clearly defined – it is time bound with clear goals, rules and expectations. A recovery culture is

Hitting the right high

With the right support, disadvantaged young people could be part of the answer to Britain's debt crisis, concluded a gathering of entrepreneurs and politicians. *DDN* reports

A recent discussion in the House of Lords coincided with the announcement that unemployment levels among 16 to 24-year-olds had overtaken the 1m mark – a record high.

Chaired by Baroness Verma, the meeting was organised by The Small Business Consultancy (*DDN*, November, cover story) with the aim of generating new ideas on tackling unemployment and barriers to social mobility, through business and enterprise.

The panel was made up of Dr Hilary Emery, chief executive of the National Children's Bureau; Rajeeb Dey, co-founder of StartUP Britain and CEO of Enternships.com; Geoff Scammell, senior policy advisor for the Department of Work and Pensions

The enterprise panel, (l-r): Dr Hilary Emery, Rajeeb Dey, Geoff Scammell, Amar Lodhia and chair, Baroness Verma. The parliamentary discussion was held on Social Enterprise Day.

timeless and ambiguous because it is made up of diverse interpretations. Although it is the product of the programme, it operates outside the service that delivers the programme and it moves from a homogenous controlled thinking environment into an ultimately divergent thinking process. A recovery culture is imbued with features that may operate in patterned ways but the multiplicity of interdependence and perception diversity only adds to the complexity.

Recovery is here to stay, and it has the potential to provide an extraordinary economic and social value in the transformation of our communities, yet when everyone is thinking the same we can fall into the trap that no one is thinking at all. Recovery can present itself as the answer to the problem when in fact it is only the gateway to the answer. It can also make and break the individual – the sustainability factor for social mobility is demanding.

Jim McCartney, chief executive, THOMAS (Those on the Margins of a Society)

JOINING FORCES

Southern Addictions Advisory Service, a Surrey charitable status treatment provider, recently acquired a community enterprise business, AES (Alpha Extreme Services) offering extreme cleaning and clinical waste management in the south east.

Six months on, we're optimistic about its future, both as an asset and as a move on/stepping stone for volunteers supporting the project.

As its manager, it's interesting to note how commercial business and charitable treatment provider have fused together, with both supplementing and supporting each other. The charity provides low-cost infrastructure, resource and 20 years of experience/links, while the community enterprise provides a new funding stream/lower costs and an opportunity.

For some, it's 'testing the waters of life' and for others it's a step up toward work. While it's not a simple process to gain all of the necessary licences, business status and insurances, we've had support from our DAT and other similar businesses, and AES is now providing services across the south east to the public, voluntary and private sector. Most potential clients aren't in a position to altruistically choose a social enterprise over cost so the bottom line is essential. Low overheads mean we undercut competitors and we also better understand the requirements of other needle exchange programmes (no onerous contracts). Our profile has raised considerably and we have a wide range of new stakeholders interested in both our service and the charity's works.

SAdAS, while economically careful before, has now cut many running costs. Now that cleaning is in-house, our 100+ staff and volunteers, and many hundreds of visiting clients, feel prompted to pull together just a little more. Visitors value the service more, which in turn seems to improve client attendance and, we hope, translate into outcomes in the future.

So, combine a mix of ideas (good ones), money (speculate and all that!), willingness (dissenters will scupper it), helpful friends (the more the better) and amazing volunteers (they make it a success).

It may provide an income-based sellable asset, improved cohesion, team spirit, client involvement, reduced costs and raised profiles. More importantly, it will improve neighbourhoods and the community and act as a move-on service for your clients where there may be little or none available.

Gary Ochoa, SAdAS

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.

(DWP); and Amar Lodhia, serial entrepreneur and chief executive of TSBC.

'If you're hungry, tired or ill, you don't learn,' said Dr Hilary Emery of the National Children's Bureau, which worked to reduce the impact of inequalities to improve life chances. Beyond these basic needs, 'We need young people to understand what they're great at,' she said.

'Mentors who like young people' could play an important role. 'It's about changing perceptions,' she said. 'We have to build belief of aspiration and make possibility probability.'

She also quoted a young person who had commented on adult society's commonly used tag of 'hard-to-reach young people' as saying: 'We're not hard to reach. You don't make the effort.'

Dr Emery suggested a 'joined-up conversation' between The Prince's Trust and schools to talk about entrepreneurship.

'Schools need to make more effort beyond GCSEs,' she said. 'How do we get schools to think about every young person's progression as well as their academic achievement?'

Geoff Scammell said DWP worked with addiction, ex-offenders and people who had real trouble engaging with the labour market, but didn't have a very good track record of getting people into work.

'We're a great big sausage machine,' he said. 'We tend to focus on the needs of the many rather than the few, so entrepreneurship has taken the background.'

But there had been increasing realisation that disadvantage didn't mean 'without hope', he said, referring to recent research that linked high IQs to likelihood of experimenting with drugs, and pointing to the need to help these young people discover their abilities.

'Entrepreneurship can drive people – people with addiction – turning negative energy into positive,' he said.

Rajeeb Dey of StartUP Britain saw a solution to the debt crisis coming from young people setting up in business.

'It's important to equip young people with an entrepreneurial mindset,' he said. 'Teach them to network, adapt and take risks.' Education needed to be remodelled, incorporating work experience and a different attitude.

Small businesses and SMEs were largely ignored on the university 'milk rounds', which was a wasted opportunity. 'We need enternships [entrepreneurial opportunities] rather than internships, going into SMEs for work experience,' he said. 'We need to make young people realise that they cannot just take a job, but make a job.'

'Honour your mavericks – teachers don't do that,' said Amar Lodhia of TSBC. 'It's about having creative passion. We don't have enough people nurturing the skills of our young people.'

Young people should form a vital part of economic recovery, he said. One in five children came from economically deprived backgrounds and one in three 16 to 17-year-olds was unemployed – but there was a window of opportunity here, he said. 'Entrepreneurs who've come from a deprived background are liabilities turned into assets.'

What they needed were role models, a stable environment, incentives and a sense of aspiration – and businesses needed to invest back into society by hiring young people.

The government's role in all this was in bridging the gap and being proactive in helping young people with their first step into business, he said, acknowledging that there was no 'quick fix' solution.

'If we try harder and work together, we can bridge this gap and increase mobility,' he said.

Members of the audience commented on specific issues related to substance misuse.

Patricia Salt of Hackney Alcohol Service said: 'What's noticeable in some hardened drinkers is that they started about the age of 12 – so before they're the age to be entrepreneurs. They get drunk because they're not coping with life. Also, for some, success is really scary,' she said.

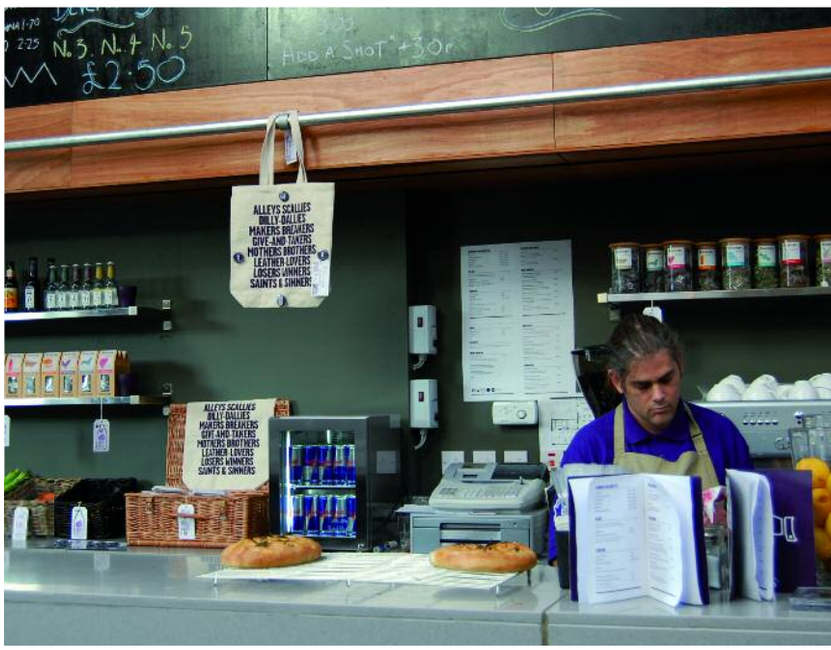
Brent Clark of Spitalfields Crypt Trust pointed out that getting people who had had drug and alcohol problems into employment could be very hard work and that the process often had to be taken in stages. 'Full-time employment can be overwhelming for our group,' he said. Half days were a practical way of giving people a step on the ladder.

The idea of positive role models was reinforced by many. Geoff Dear said his work ethic had been instilled by his father having two jobs to put food on the table. 'What happens when you have parents who have never worked?' he asked.

'Role models are vital,' added Stephen Fear, now the owner of 64 companies. 'When my parents split up, I lived with my father in a council flat. He had to go to work and locked me in, telling me not to look out of the window. Then I lived with my mother in a touring caravan and had two years of schooling in my life. But I loved to read and modelled my whole life on Ivanhoe. Had I not learned to read, I would have had nothing.

'You have to have role models. Young people make role models from drug dealers – I was lucky, I didn't have those. The right role models are the key.' **DDN**

When **Jacquie Johnston-Lynch**'s brother was killed by a drunk driver nearly 20 years ago, she had no idea she would be honouring both him and the man who killed him with a landmark new venture in Liverpool



back from THE BRINK

The Brink is a new Liverpool bar, with a difference – it doesn't serve booze. But it's also so much more – a new recovery social enterprise recently launched by Action on Addiction. With so many people in recovery, and so many people choosing abstinence, we were getting feedback that there was nowhere that integrated the recovery community with the mainstream community – a place that was safe yet state-of-the-art in terms of art, culture, food, drink, entertainment and socialising. So we set about creating a focus group that could add more to the original vision.

The Brink was born, with the name chosen from a list offered up by the focus group. The Brink is a song by the band I Am Kloot about alcoholism, but it also conjures up images of those in active addiction who went over the brink and never came back, as well as those in recovery who went to the brink and came back to live another day.

In Liverpool, The Brink has quickly come to be viewed as a central point for the 'hub and spoke' model of treatment services across the area. Not content to have a range of wonderful drinks and delicious food, the venue also has meeting rooms and an alcohol counselling service.

'It's an amazing venue to work from,' says counsellor for A-Pass (Alcohol, Pre-Abstinence Support Service), Maureen Smith. 'When I became an addictions counsellor, I never once thought I'd be counselling from a bar. What I love about this place is how clients can come in and immediately feel a sense of belonging. There is a lot of positive role modelling happening here, and it's great for new clients to meet other customers and staff who are in recovery. As well as that, it's been great to be able to provide an immediate response to people who have recently lapsed – I can see them and support them to get back on track before a major relapse occurs, all done over a cuppa or a dandelion and burdock!'

During its development, we were adamant that The Brink had to be designed to a high specification. The philosophy was 'why should addicts/alcoholics always get backstreet rooms, mission cafes, church halls or rundown community centres?' They aren't 'less than', so why should they receive 'less than'?

So we set about bringing on board a top architect with a reputation for designing amazing bars and restaurants, along with a marketing company to design the brand. The experience of working with them was funny, because here were two guys who've worked with the top restaurateurs and bar owners with me and a focus group full of recovering addicts and alcoholics. I think they were a bit in shock at how vociferous and confident this group were, and they soon realised they weren't going to get an easy ride.

Once they understood that, however, they used every bit of energy they had to really understand us all – the design architect even came and spent a full day in the SHARP Liverpool treatment centre. From there, the branding guy played on all the personality and character he saw in us all, and he really captured the diverse audience now frequenting The Brink in building the brand.

'I visit The Brink because the venue has a really warm vibe,' says lecturer Sarah Maclennan. 'This comes from the staff who greet everyone with genuine friendliness and make us all feel really welcome – it's like being a 'regular'. The food is delicious and excellent value for money and I like the range of drinks on offer. As a parent of teenage children and as a university lecturer, I worry about the emphasis on alcohol-related social activities – there seems to be a message that unless you're part of the glamorous cocktail/shots lifestyle, you're somehow missing out.

'For me, The Brink provides the glam factor with a full programme of exciting events like live music, poetry and comedy but proves that we don't need to be high on any artificial substance to have fun,' she continues. 'I defy anyone not to feel 'lifted' by the atmosphere of caring, energy and the sheer joy of living in the moment that you get from The Brink. This may sound a bit 'hippy-dippy' but there's something to be said for being around people who have made really positive choices in life, who have struggled and who have won. Maybe that's why the vibe is so good – it's contagious!'

'There's something to be said for being around people who have made really positive choices in life, who have struggled and who have won. Maybe that's why the vibe is so good...'

Left: from left to right, Carl Alderdice, Jacquie Johnston-Lynch, Tom Gill and Damien Kelly at The Brink.
Far left: Phil behind the counter.
Below: Mandi, Alison, Colin and Dave on a focus group site visit.

The Brink is a recovery social enterprise with a focus on regeneration – not just of the area, but also of the person. It's about regenerating the lives of people who were previously lost to addiction – of the 12 staff employed, nine of whom are directly in recovery, many had not worked for a very long time and some had found it extremely difficult to find employment because of a criminal past during active addiction.

The day new front of house staff member Jay started work, seeing him in his uniform and putting his apron on made me weep – it was such a tender moment. He proudly declared to everyone that this was his first 'proper' job, and that earlier in the day he'd signed off the state benefits he'd been claiming for nearly 27 years while in the grip of heroin addiction. Seeing him so joyful and excited just blew everyone away, and people applauded.

The friendliness and warmth of the staff is commented on a lot by customers. Says Clare Campbell, a local artist: 'I, like many others I know, stopped going out into town a long time ago because of the atmosphere in places where so many people were drunk – that edge of aggression and out-of-control crowds. My heart sang when I heard about a grown up, fully-fledged pub where we could all relax and feel safe and enjoy ourselves without that alcohol-induced atmosphere. It lives up to its promise – a warm welcome and a gorgeous place to hang out. It's a treasure – every city should have one!'

Clare's local freelance network group now meets at The Brink, as do other social entrepreneurs, and the next step is to build social enterprise into the fabric of the recovery community, as there's so much talent there and it's amazing what we can tap into. We now have plans for a florist and some other business start-ups for people in recovery. It's so exciting what can be done – I recently heard someone say, 'When I realised the world didn't want me then I wanted the world'. Fed up with being stigmatised, people are frequenting The Brink as valued customers in a venue that crosses the divide and creates exciting opportunities.

Ian, who works in the kitchen, didn't realise he would ever have the opportunity to take up work again in the hospitality industry. 'Surviving my own alcoholism – when my brothers lost their lives to it – means that my life is precious, and having a job I enjoy that gives something back to the recovery community is such a huge gift,' he says.

'This has been a long time coming, but we have all pulled together and made it happen,' says community engagement worker at The Brink, Damien Kelly. 'The recovery community has such passion, and with that comes activism – we are a long way off the recovery communities of the USA where they are out, loud and very proud, but we are definitely moving towards that with social inclusion and de-stigmatisation. I'm very happy to share my own experience of recovery with those who want to hear it, but we still have many people who are fearful of visible recovery. The Brink is clearly changing that.'

Susan, another customer, says, 'I've had 21 years of addiction and alcoholism and now have nearly two years total abstinence. It's great to be able to come here and feel part of something bigger. The great thing about The Brink is that we can party without being off our heads, and we can also just chill like any other customer and no one can tell who is an addict and who isn't in here. It really does break down those barriers of stigma – in here I'm just a valued customer eating my lunch and drinking my hot chocolate. I really love it and the staff are great role models. I even saw someone have their 15th recovery birthday party in here the other night – now that was really something.'

To conclude, I'll say that the man who killed my brother in 1992 needed help. He'd had four previous convictions for the same offence of drink driving, and maybe if he'd had a place like The Brink my brother would not have died.

But we are here now, and many people around the country are coming to see us and asking us to franchise, so I'm sure we will be creating many more opportunities to save and support the lives of others very soon, as any profits from the social enterprise go directly back to Action on Addiction and pay for treatment opportunities for those unable to afford them. We also have a huge debt of gratitude to the Department of Health and Liverpool PCT for getting behind us with this. **DDN**

Jacquie Johnston-Lynch is head of service at SHARP Liverpool, an Action on Addiction service

RUSSIAN ROULETTE

Involvement with illegal drugs and drug users is a high-risk business in Russia, as **Kristina Kashtanova** reports

Drug policy in Russia is a dangerous subject. When I started researching this topic, I was apprehensive about writing about it, because so many people who have tried to help have ended up in prison, beaten in police departments, or accused of drug dealing. There have been many shocking cases, where drug users or people trying to protect their rights have been repressed. Some of those cases became known worldwide, like Irina Teplinskaya (*DDN*, May, page 20) or Denis Matveev, a Russian human rights activist who was accused of drug trafficking on a fabricated case, and sentenced to six years in a high-level security prison.

There are many more cases, which is why there are not too many people ready to fight for the human rights of drug users. They have practically no rights in Russia, and drugs have become an easy tool of repression – not just of those who talk about drug policy, but any activists who provide social critique of the state. Given police and court corruption, and common use of provocation and planting of drugs as a mean to increase arrests, anyone can be planted with drugs and the case would not be even properly investigated.

'Once I was arrested and beaten at the police station, because they accused me of drug dealing,' says Alexander Delphinov, a writer and journalist, who also works as an activist and social worker with drug users during his free time. 'I didn't have any drugs with me, and didn't use any. After several hours of mental pressing and beating they asked me to sign papers, to confess to a crime that I didn't do. I was very scared, and if they continued any longer I would have signed anything, even a confession to something I hadn't done, just for it to stop.'

Drug addicts are met with zero tolerance in Russian society. There are no proper therapies and HIV-positive drug users or those with TB can't get proper treatment, because doctors tell them to stop using drugs first. Every day people die of HIV through drug addiction, and the only detoxification therapy that exists treats the physical problem but does nothing to address the psychological issues of drug use. The state authorities admit that 92 per cent of people who go through the state detox relapse within one year. The government does very little to promote drug rehabilitation centres, and the internationally accepted opioid substitution treatment with methadone or buprenorphine is illegal and opposed by the government.

There is only one non-governmental organisation in Russia that tries to make a difference to drug policy – Andrey Rylkov's Foundation for Health and Social Justice. I spent a day with the activists from ARF, helping drug users on the streets of Moscow. ARF provides users with clean needles, condoms, rapid testing and counselling for HIV and hepatitis C, drug harm reduction advice and referral to medical institutions.

Such social work is very important, because sometimes it's the only one way for drug users to communicate with people outside their criminal environment. ARF can't afford offices – they don't receive any government funding and exist with the help of private donations and small international grants, providing their guerrilla outreach services in a city whose mayorate openly opposes any harm reduction and HIV prevention work with drug users.

Following the group of activists from ARF, I saw their work on the streets from the inside. Since resources are scarce, there are usually only two people in the group, going onto the streets every day. Their limited resources mean that they can only help a few drug users each day, and they are in constant fear of being arrested by the police, who would try to get information about places and drug suppliers from them by any means possible.

'We can't publicly distribute syringes. Even though it's not illegal in Moscow, the city health department opposes it,' says Maxim Malishev, ARF social worker. 'But we can be accused of propaganda for drugs, if we do it publicly. We don't have a drop-in centre, a mobile unit, or any premises, like most programmes in the west do. All this limits our reach to drug users and scope of services we can provide.' Maxim was a heroin addict for 15 years, but ARF helped him to stop using drugs by sending him to drug rehabilitation in the Republic of Tatarstan. Now he helps people like him, sharing his positive experience and help.

We began outside the Moscow railway underground station, looking for any groups of people who could be drug users. When I realised that we could be arrested at any time, even though we were not doing anything illegal, I was worried but fortunately we did not encounter any police.

Maxim spotted several people, who we helped that day – we offered them HIV tests, clean syringes, leaflets, and advice on what to do in the case of an overdose. One of the drug users, aged 34, said, 'I would like to stop using drugs, because I have serious health problems. The quality of drugs has become worse, and the prices have risen dramatically. I was in hospital twice, doing detox therapy, but as soon as I returned to the same environment I couldn't fight my psychological addiction.'

'Several years ago, when I was a drug user, I was caught by police with a small amount of heroin for personal use,' says Maxim. 'When they analysed the substance, it actually only contained 3 per cent heroin – the other 97 per cent was harmful infusions. If we had substitution treatment with methadone, it would not only reduce the amount of HIV transmitted by injections, it would also improve the quality of life for drug users and make them less criminal. When you have to spend all the time trying to find money, often by criminal means, to buy the drug, you can't even think about giving up the addiction.'

That day I saw many drug users of different social classes. I was surprised that all of them took the leaflets and listened to everything activists were telling them. It seemed to me that all of them were willing to quit their addiction, but afterwards Maxim told me that it was mostly because of the high prices and bad quality of the drugs.

The supply of syringes and antibiotics ran out quite fast, but more and more people were coming. Some of them had wounds, some looked really ill. There was a man who was hardly walking, with one of his hands swollen. The activists knew him, but had nothing left to give him. I was really impressed when Alexander Delphinov disappeared suddenly and returned with some extra supplies he bought in the pharmacy – vitamins, ointment and bandages.

'This guy was always so cheerful,' he said. 'Just a couple of weeks ago he was going to quit using drugs and go to the hospital together with his girlfriend, who was also a drug user. He was really worried about her, and we discussed the ways they both could quit. But then she left him, and now he doesn't have the motivation to quit anymore and increased his dose. Such things happen all the time – these people are really ill and need help.'

Irina Teplinskaya was the first drug user in Russia to speak out about her rights in public. She is the face of Russian drug addicts, people without rights, without proper therapy, repressed by the government and hated by society. As soon as she began to talk openly about these problems in public, she began to be repressed. Just a while ago, she was planted with a methadone tablet on her way from Ukraine to Russia.

'They met me at the airport, eight people with a dog,' she says. 'They were really shocked, when after searching me for three hours they couldn't find anything. The tablet appeared out of nowhere – when they knew that they wouldn't be able to find anything on me, they planted it. I am sure it was connected with my activism. It was an attempt to bring down me and discredit my position, to get rid of me, because I began to sue Russia in the European Court.'

When she advocates replacement therapy, she often talks about the Ukraine's drug programme as an example. Ukraine is a former Soviet Republic, which began to apply replacement therapy 15 years ago, and now there are more than 6,000 people receiving treatment.

'I think when Federal Security Service or the Federal Drug Control Service knew that I was receiving therapy in the Ukraine, they assumed it was replacement therapy,' says Irina. 'I think they were absolutely sure that I was bringing replacement therapy drugs back with me. But they were wrong – it was three months in a drugs-free zone, doing a different kind of therapy.'

Irina works for ARF and is a member of the steering committee from Russia in the Eurasian Harm Reduction Network. Even though these two organisations are well known around the world and widely supported, their work goes against Russian drug policy.

'Drug addicts are met with zero tolerance in Russian society. There are no proper therapies and HIV-positive drug users or those with TB can't get proper treatment, because doctors tell them to stop using drugs first.'

'In Russia, "those who are not with us are against us", so it's rather normal that drugs are used as a tool for political repression', she says. 'It's a well-known practice that drugs are planted on objectionable people who go against the political system.'

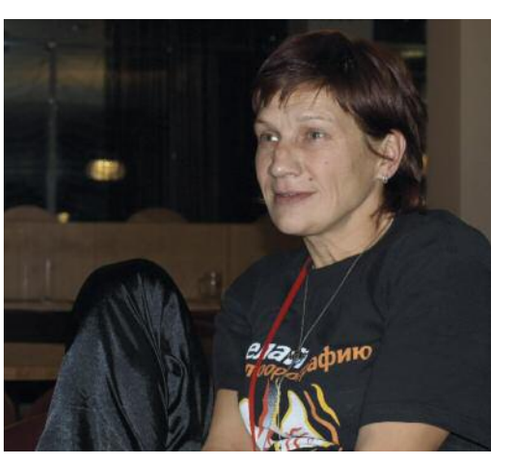
After the drug-planting incident, Irina decided to leave Kaliningrad, the city where she lived, and move to the Republic of Tatarstan, a federal subject of Russia where drug policy is better. There are government supported syringe and needle exchange programmes, and the human rights of drug users are not violated as in Russia. 'The Tatarstan government understands that there is an epidemic of HIV, and it's impossible to stop it with only repressive measures,' she says.

Irina is HIV-positive and had several breaks in her therapy when she was using drugs. 'Drug users who need to think about getting money for their next supply, and then looking for a supplier, can't concentrate on regular medication for HIV,' she says. 'Doctors know that the drug user most likely won't be self-disciplined enough for HIV therapy, so they prescribe such therapy to this group of people quite pessimistically and often find ways to refuse, because they see it as a waste of money for the government.'

There are many problems with drug policy in Russia, and despite the activists' work to try and change the situation, their impact locally does not seem to spread to the country as a whole.

'Society should change its attitude to drug users. It should not only be written on paper that we are all citizens of this country and have our rights, but these rights should be respected in practice,' says Irina. 'People should become more tolerant to drug users. Russia should change its angle in drug policy from repressive to humane, like it is in most other countries around the world.' **DDN**

Kristina Kashtanova is a student journalist



Left: Irina Teplinskaya

Far left: Russian activists


Safer Bristol
Wishing you a harm free Christmas and a recovery focused 2012


Christmas Wishes
BROADWAY LODGE


Festive Greetings
DrugScope


SEASON'S GREETINGS
frontier medical group


Season's Greetings
from Concateno


Merry Christmas
SMMGP
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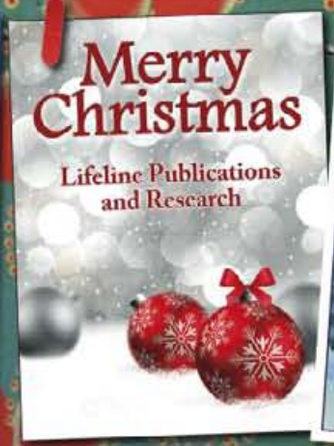
Merry Christmas
Lifeline Publications and Research


Happy Christmas from the UKRF to all the amazing people out there supporting Recovery in communities. 2012 is the year we take it to the next level
UK RECOVERY FEDERATION


Seasons Greetings
Thanks to DDN and all who supported KFx in 2011
KFx


Christmas Tidings from CPI
The Centre for Public Innovation


Merry Christmas
and a
Happy New Year
From the NTA
Building recovery in communities


Christmas Wishes
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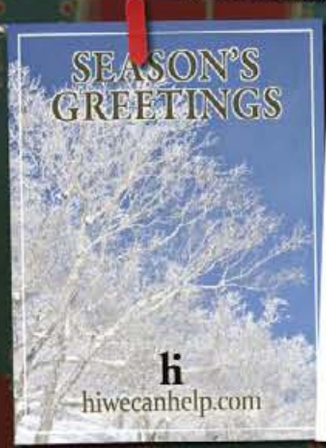
SEASON'S GREETINGS
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MERRY CHRISTMAS AND A HAPPY NEW YEAR TO EVERYONE FROM SHARDALE


Merry Christmas
From the Alliance


Merry Christmas
and a
Happy New Year
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Happy holidays
Camino Recovery
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To all our Clients, Consultants & Candidates. We wish you a
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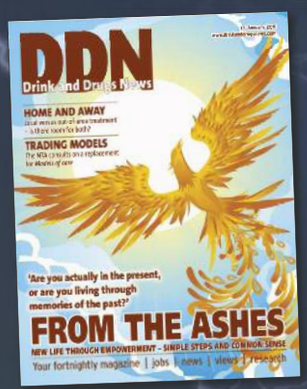
STORMY WE

2011 ACCORDING TO DDN – THE HIGHS, THE LOWS A

With the economic outlook relentlessly bleak and structural upheaval ongoing, 2011 saw a nervy treatment sector simply trying to get on and do its job, while drug use patterns continued to shift and the government wondered how to deal with an ever-changing menu of 'legal highs'



JANUARY

With the field still digesting the new drug strategy – published at the end of 2010 – the new year begins with more official confirmation of major restructuring for the sector with the publication of the government's *Health and Social Care Bill*, one of the most controversial documents in the history of the health service and, according to the King's Fund, 'the biggest shake-up of the NHS since its inception'. Almost a year later, the bitter war of words over much of its content shows little sign of abating.

FEBRUARY

The annual DDN/Alliance service user conference continues to go from strength to strength with its fourth event, *Seize the Day!* in Birmingham, where discussions are inevitably dominated by funding challenges and the looming new treatment landscape. Meanwhile, Release says that funding difficulties are putting its vital legal helpline at risk, and the ongoing 'heroin drought' leads to warnings of a potential spike in overdose rates when supplies become more plentiful. Government reform also continues apace, with the publication of the *Welfare Reform Bill*.

MARCH

The government's much-touted alcohol 'responsibility deal' with industry, retailers and the third sector is branded the 'the worst possible' and 'all carrot and no stick' by Alcohol Concern, who promptly pull out of the partnership along with the BMA, the Royal College of Physicians and other major players. Health secretary Andrew Lansley, however, is adamant that the 'radical partnership approach' can deliver 'more, and sooner' than legislation.

APRIL

Harm Reduction International's (HRI) annual conference heads to the Middle East and North Africa (MENA) for the first time, with delegates in Beirut hearing inspiring – and harrowing – presentations from across the region and beyond. Closer to home, the eight payment by results (PbR) pilot areas are announced by the government and David Best tells *DDN* that 'barbaric discussions' within a divided treatment sector don't look very impressive to the outside world.

MAY

The sheer number of new drugs coming onto the market means the Misuse of Drugs Act is becoming 'increasingly unenforceable', warn the UKDPC and Demos, while new NHS figures reveal alcohol-related hospital admissions in England are now topping a million a year, at an annual cost to the NHS of around £2.7bn.

JUNE

The Global Commission on Drug Policy, which includes former UN secretary general Kofi Annan and a number of ex-presidents, calls for an end to the 'criminalisation, marginalisation and stigmatisation of people who use drugs but who do no harm to others', while the Centre for Policy Studies' *Breaking the habit* report kicks off a row about the cost of drug use to the UK purse, estimating the total 'social and economic burden' of dependency at £3.6bn – 'simply wrong', says DrugScope. The UNODC's *World drug report*, meanwhile, offers yet more evidence of 'soaring' levels of synthetic drug production.

JULY

The death of Amy Winehouse unleashes a tidal wave of conjecture, sermonising, finger-wagging and hand-wringing from the nation's media commentators, despite the fact that the official cause – death by misadventure as a result of accidental alcohol poisoning – would not be known for another three months. The government bans imports of phenazepam, pending its control as a class C drug, while a report from the Independent Scientific Committee on Drugs reveals that classifying ketamine at the same level has had no effect levels of use, and the latest *British Crime Survey* shows that levels of

ATHER

AND KEEPING IT TOGETHER

mephedrone use now equal those of powder cocaine among 16-24 year olds, despite its 2010 ban.

AUGUST

Alcohol Concern launches a broadside against the drinks industry's use of social networking and video sharing sites in its *New media, new problem?* report, which calls for far tougher action in the light of 'inadequate' internet age verification mechanisms. Alex Boyt's article on 12-step launches an ongoing debate on the *DDN* letters pages that's still running three months later.

SEPTEMBER

The Liberal Democrats pass a motion at their autumn conference calling for an independent panel to review British drug laws, which, they say, are costly and ineffective and disproportionately affect the 'poor and marginalised'. The UK Recovery Federation's (UKRF) conference and recovery walk in Cardiff is further evidence of how fast the recovery movement is developing in the UK, while Ivory Wave becomes the latest 'legal high' to face a ban.

OCTOBER

The ACMD recommends that government tackle the 'legal highs' issue head-on by introducing an American-style system of 'analogue legislation' to automatically make all substances bearing a chemical or pharmacological similarity to controlled drugs illegal, although the UKDPC warns that it would save politicians from pressure to 'do something' rather than solving the real problem.

NOVEMBER

The EMCDDA's annual report highlights falling rates of cocaine use across Europe as austerity continues to bite, while synthetic drug manufacturers continue to play 'cat and mouse' with the authorities – the agency says 39 new substances have been reported so far this year, bringing the total to 80 in two years. Meanwhile, the Scottish Government formally launches its second attempt to introduce a minimum unit price with its *Alcohol (Minimum Pricing) Bill*, although lawyers warn of a very long road, leading ultimately to the European Court of Justice.

DECEMBER

US recovery guru William White urges *DDN* readers to seize the moment to create 'a world in which recovery can flourish'. Meanwhile, it's full steam ahead in preparing for next year's service user conference – the event is growing so much that we've now got a new venue, the Birmingham NEC. See you there in February! **DDN**

Post-its from Practice

Ketamine crisis

It's vital to ask about all drugs, says Dr Chris Ford

I first met 21-year-old Seb a few weeks ago. He had walked into my room rather sheepishly, obviously in discomfort, and asked to be signed off from work for a week. He said he thought he had eaten something which had given him severe abdominal cramps and he hadn't slept.

I agreed but asked if he would answer a few questions. I started with smoking and drinking – Seb didn't smoke but admitted to occasionally drinking too much. I moved on to drugs, specifically asking about ketamine because of his abdominal pain. He went pale and blurted out that he thought his pain may be related to ketamine use. I responded, 'you mean k cramps?' He answered yes, and asked me how I knew – he seemed to relax, and then burst into tears of relief.

He told me how his ketamine use had started as an occasional treat but he was now using it three or four times a week. The previous weekend had been an enormous binge, and he now felt suicidal. He had experienced occasional cystitis and cramps, but never as bad as this. He felt lost, had never talked to a professional about it before, and didn't know what to do. He had a good job as a manager in a high street store and until the last six months had had an exemplary record. Now he had taken odd days off and was beginning to get into debt.

We know that increasing numbers of people – especially younger people – are using ketamine recreationally throughout the UK. Many users who run into problems are seeking help from their GPs but may not always disclose their ketamine use – perhaps partly because they don't link their symptoms to the drug, or perhaps because they fear, like Seb, the GP's reaction.

Many people who use ketamine increase their use from 'a little bump' recreationally to a drug of daily and habitual use, with elements of loss of control, compulsion and a move from social to solitary use. Then, on stopping, there is a psychological withdrawal syndrome with severe anxiety and abdominal cramps, and increasing urinary tract pain may occur. Users of 1-15 grams per day can experience even more side effects, including cognitive impairment, lack of energy and increasing isolation and vulnerability.

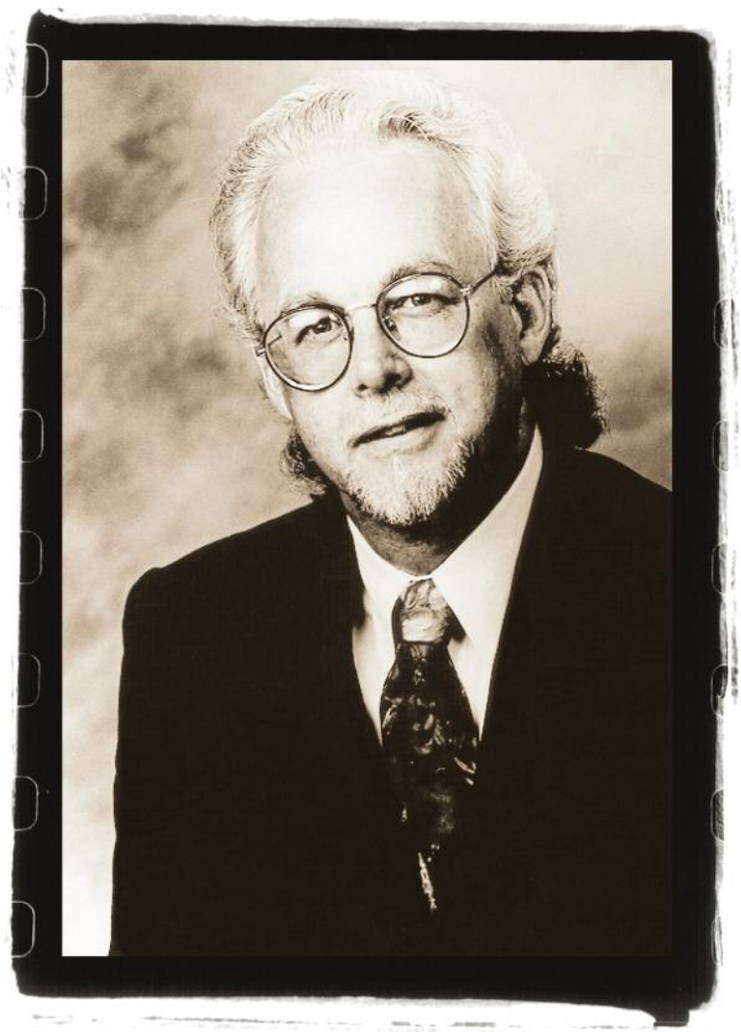
Ketamine-associated ulcerative cystitis is the worst side effect and may require hospitalisation. It is imperative to cut down or stop use once such symptoms have developed. Why ketamine does this is not fully understood, but includes inflammation and ulceration of the bladder and scarring of the ureter, all probably from toxic metabolites.

Seb used his week off to have a long hard look at his use, his life and where he wanted to go in his work. He had joined a support group and started individual therapy, and came back yesterday to say 'thank you for asking and... I've told a few friends'. Another day I feel happy and privileged to be a GP.

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

For more details see 'Association of ketamine, with unexplained bladder and abdominal symptoms' by Rachel Ayres, Fergus Law and Angela Cottrell in Network 27 (October 2009).

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



STAT

In his 40 years in the US addictions field, William White has been an outreach worker, counsellor, clinical director, researcher, trainer, consultant and author. He tells **DDN** what he thinks the sector's future might look like

A pivotal figure in the American recovery movement, and a huge influence on the UK one, William ('Bill') White is a senior research consultant at US-based addiction treatment and research institution Chestnut Health Systems, and has authored or co-authored more than 400 articles and monographs and 16 books, including Slaying the Dragon: The History of Addiction Treatment and Recovery in America and Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement. His collected papers are available for free download at www.williamwhitepapers.com

DDN: *You've been working in the field for more than 40 years. It's a broad question, but what do you think are the most significant changes you've seen in that time?*

Bill White: In my professional lifetime, addiction treatment has grown from a small but committed grassroots movement of a few hundred programmes in the US to more than 13,000 speciality treatment centres that now constitute a multi-billion dollar speciality healthcare industry. There have been dramatic changes in patterns of addiction, the characteristics of those entering treatment, and the profile of the treatment workforce.

Treatment itself has moved from the status of clinical folklore to a much more science-guided endeavour, and screening and brief interventions have been integrated into primary health care, business and industry and educational settings far more than I could have ever predicted.

But even more than these changes, I have seen tens of thousands of people in recovery marching in public celebration events and I've witnessed the diversification of recovery support groups, the birth of new recovery support institutions and an office within the White House calling for greater recovery orientation of US addiction treatment programmes. Many of these are things I could not have imagined witnessing in my lifetime.

Your career began at the end of a very different era, and you've described witnessing the appalling conditions in some state psychiatric institutions – forced withdrawal, shock therapy, straitjackets. What sort of an impact did this have on you – did it shape your future work?

I saw the end of a period of very depraved conditions to which people with severe alcohol and drug problems were subjected – despair-filled drunk tanks in local jails, stench-soaked back wards of aging state psychiatric hospitals, morality clauses of local hospitals whose bylaws denied admission of alcoholics and addicts. I reviewed patient medical records filled with earlier 'treatments' that included involuntary sterilisation, pre-frontal lobotomies, electro- and chemo-convulsive therapies, and drug insults of every description.

Those experiences affected me in two fundamental ways. First, knowing what preceded them, I have never taken for granted the current treatment resources that earlier generations fought to create, no matter how imperfect those treatments may be. Second, I learned a profound lesson about harm in the name of help that I have never forgotten. We judge such harm in history's rearview mirror with great condescension, but it's very hard to see such injuries in our own time – what current practices in addiction treatment will spark future historians to ponder 'what the hell were they thinking?'

TES MAN

Was there a key moment early on that made you realise you wanted to make this field your life's work?

This is the kind of field that takes regular recommitment to sustain one's passion and effectiveness, but I can vividly recall two early incidents that could have either driven me from the field or cemented a lifelong commitment to it. Both involved individuals who I had helped start a recovery process but who later relapsed, were arrested and hung themselves in a jail cell. I was deeply wounded by these deaths and vowed to eliminate the 'drunk tanks' and foul cells in which such deaths so frequently occurred in those days.

I also felt I needed to find ways to give their lives meaning and to answer the haunting question of what I and the field could have done differently that would have made a difference in their lives. Experiencing such dramatic losses while also witnessing so many wonderful stories of recovery transformation – those have been my moments of commitment and recommitment.

You've said that you see people in recovery, recovery advocates and frontline workers as the primary audience for your work, which is a huge influence on the UK recovery movement. What parallels do you see with the way that movement is developing to the way it developed in the states? Have you noticed any significant differences?

Recovery advocacy movements differ across cultural contexts but they do seem to need common ingredients for their germination and ignition – a critical mass of people in long-term recovery, increased contact between people representing different pathways of recovery, a treatment system that has become disconnected from the larger and more enduring processes of personal and family recovery, pervasive addiction-related social stigma and discrimination, and a series of catalytic events that trigger organising efforts.

I think it's too early to talk about major differences between the US and UK recovery movements – those should and will clearly exist, but there will also be many shared elements due to what we are learning from each other through our growing face-to-face and internet connections.

What advice would you give to people involved in nascent recovery groups and organisations in the UK? Are there traps they need to avoid?

Authentic recovery advocacy movements face twin risks – the first is becoming a closed incestuous system that implodes through the processes of isolation, exclusiveness, scapegoating, and ideological schisms, while the second is remaining such an open system that the movement gets hijacked from within – or without – for personal, financial, ideological or institutional gain.

Those threats are not unique to the recovery advocacy arena – they are risks faced by all social movements. Such vulnerabilities must be actively managed by defining and maintaining fidelity to mission, goals, priorities and methods. There are also certain core principles and values that distinguish the recovery advocacy organisations/movements that survive and thrive – the primacy of personal recovery, authenticity of recovery representation, mission fidelity, organisational transparency and stewardship, and adherence to core recovery values such as humility, simplicity, respect, tolerance, service.

Although the situation is starting to change, the UK drugs field has been very polarised and a number of people have told us that they get very disillusioned with all the mud slinging and name calling. Is it similarly sectarian in the US – have things moved on?

We've had our share of such mud slinging on this side of the pond – the harm reduction/abstinence and medication-assisted and drug-free dichotomies have fuelled debates that have become stale, unproductive and too acrimonious. These debates far too often mask concerns not about how to best serve wounded people and wounded communities, but about personal and professional prestige and the financial resources that accrue to those who successfully claim ownership of these problems. That is why these discussions are in such need of authentic voices of affected individuals, families and communities.

We as a professional field, and we as a growing worldwide recovery advocacy movement, have to find ways to rise above such polarised rhetoric and our own personal and institutional interests. This is not an either/or issue – the issue is the right to have choices and the need for different types of services for different people and different types of services for the same person at different stages of his or her addiction and recovery careers.

Every person offered medication as an adjunct in the treatment of addiction should have access to a full range of professional and peer-based recovery support services, and every person offered professional and peer-based recovery support services should have access to a broader menu of medical and psychiatric services,

'Knowing what preceded them, I have never taken for granted the current treatment resources that earlier generations fought to create, no matter how imperfect those treatments may be...'

including medication for those who could benefit from it. We as a treatment field will either find a way to provide integrated, scientifically defensible and patient-centered care or we will become marginalised therapeutic cults.

Do you think the gap between recovery mutual aid societies and professional treatment could one day not exist?

I think there will always be tension between addiction science, clinical treatment and indigenous recovery support institutions. Connectors and interpreters will always be needed to bridge these worlds because they represent different ways of knowing and different value systems. The challenge at a policy level is how to bring representatives from these worlds together to fashion a system of care that blends these perspectives.

It's like a three-legged stool – each leg is needed to assure stability and safety.

After you published your monograph on Recovery-oriented methadone maintenance*, you said that your views on methadone had undergone 'profound changes' over your working life – what were they?*

My earliest experiences in the field were within ex-addict-directed therapeutic communities and 12-step treatment programmes, and my direct exposure to methadone was from the worst methadone clinics and the least stabilised methadone patients. To mention the word methadone to me in those years was like waving a red flag in front of a bull, and my anti-methadone rants continued until I enrolled in an addiction studies programme where one of the leading addiction experts in the world quietly suggested that my passion about methadone maintenance treatment (MMT) was outstripped only by my seeming ignorance of the subject.

Following this humbling milestone, my investigations into the scientific studies of MMT led to a begrudging intellectual acceptance of methadone as an important treatment adjunct for some people. But I didn't really 'get' MMT until I got to know people in MMT with a high quality of recovery. They showed me living proof of its value and legitimacy, and my attention shifted from a focus on methadone as a medication to the lack of recovery-orientation within MMT programmes. That's when I began the collaborations with Lisa Mojer-Torres to promote a model of 'recovery-oriented methadone maintenance'.

Today, I continue to work to transform MMT milieus into strong cultures of recovery, but I don't think these milieus and attitudes toward them will change until a vanguard of people in medication-assisted recovery step forward to put a face and voice on this style of recovery, and challenge the low level of expectations and the low levels of recovery support that have existed within MMT programmes.

One of the greatest challenges people face is stigma. Is that changing in the US – has the success of the recovery movement managed to challenge some of the stereotypes?

The intensity of the social stigma attached to addiction continues into recovery, but the larger picture that is unfolding is a positive one. The dilemma we face is that the addiction problem is very visible but the recovery solution has, until quite recently, been invisible. If all one sees culturally are high profile addiction-related deaths and celebrities crashing and burning and heading to rehab it's little wonder that pessimism prevails about the prospects of long-term recovery. What we have figured out is that attitudes about addiction and recovery change only superficially through the process of professional and public education – what does change attitudes and beliefs is personally knowing individuals and families whose lives have been blessed by addiction recovery.

One of our US recovery advocacy posters says it all: by our silence, we have let others define us. What's changing is that hundreds of thousands of people whose life circumstances allow are standing with others to put a face and voice on recovery. That's how we are making progress on the stigma front, but it will take sustained work for many years to reverse the decades-long demonisation of people whose lives have been wounded by addiction.

Both the US and European economies are in poor shape, and things could get a lot worse before they get better. What kind of impact do you think this might have on people's recovery aspirations, when jobs, decent housing, community and self-esteem are so pivotal?

Ironically, this is the perfect climate within which recovery advocacy movements will rise. The need for recovery will intensify in this climate – funded services will shrink and the need for a larger safety net for people seeking recovery will grow.

What history teaches me is that when existing structures of support prove inadequate or collapse, recovering people and their families and allies will rise to create new systems of recovery support. That's what recovery advocacy movements around the world are beginning to do. Thousands of recovering people marching in the streets of UK cities and new indigenous recovery support organisations will do far more to raise the recovery aspirations of individuals and families suffering from addiction than throwing more money at the treatment industry. What addicted people desperately need is connection to community and this is the climate in which strong communities of recovery will rise – what this movement has to offer is something money cannot buy.

You've said that the field is unique in that it offers the opportunity to see people completely transform their lives – is that what sustains you?

This has been a source of deep joy in my life. Witnessing and sometimes participating in this transformative process we call recovery and to further witness the ripples of such recovery into families and communities are sacred privileges granted to those of us in this field. I think you have to stay in touch with that if you are going to be effective and survive working in this field.

'There are brief windows of opportunity in our personal lives in which powerful events and experiences forever cast our lives into the categories of before and after...'

How do you see the field developing in the future – are you optimistic? You've spoken of a potential 'death by absorption' into bigger, more powerful institutions.

I am concerned about the future of addiction treatment. In the US, we are on the brink of a rush to integrate addiction treatment into mental health care and primary health care. That trend has great possibilities of widening the doorways into addiction recovery, but I worry that there are core ideas, values and technologies that could get lost in the process. I think the big picture for addiction treatment worldwide is to move beyond models of acute care and palliative care toward models of assertive and sustained recovery management, and to wrap these latter models within broader efforts of recovery community development and mobilisation.

Perhaps it's also time we talked about the fact that many neighbourhoods and whole communities have been wounded by addiction and related problems, and that these larger social systems may need a recovery process of their own. In Native American communities there is no distinction between the individual, the family and the tribal community – to wound one is to wound all and to heal one is to heal all. I don't think we will be able to significantly elevate our ability to heal individuals without facilitating these larger intergenerational processes of family and community recovery.

Finally, do you have any closing message for the readers of DDN?

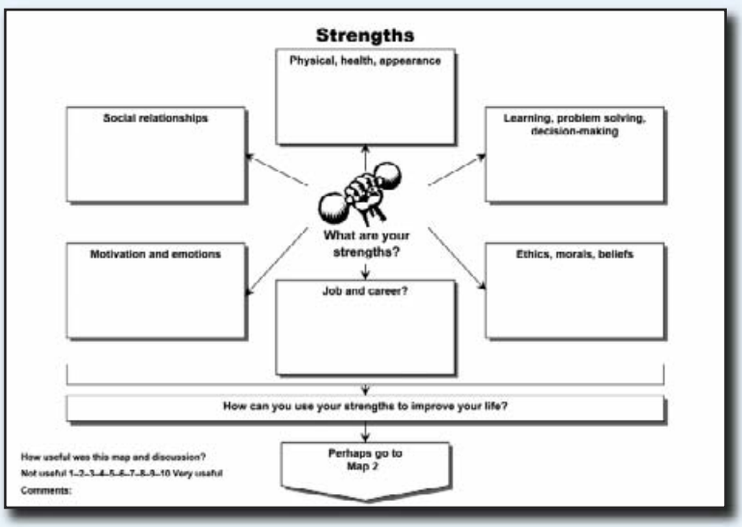
I know such thinking is woefully out of fashion and may be seen as the romantic notions of an old man, but there are *DDN* readers who may have been born for this moment in history – call it calling, call it destiny, call it whatever you want.

There are brief windows of opportunity in our personal lives in which powerful events and experiences forever cast our lives into the categories of before and after. There are similar windows of opportunity within the history of addiction treatment and recovery, and I belief we are entering one of those moments. There is a rising worldwide/UK recovery advocacy movement and to those readers who feel a voice calling them to serve this movement I would say, "Come join us – it's time for recovering people and their allies to create not just recovery-oriented treatment but a world in which recovery can flourish'. And in doing that, we may also bring badly needed larger recovery processes to communities and countries around the globe. **DDN**

Blenheim CDP

COLLABORATION FOR QUALITY TRAINING

On the first two-day course of its kind, Blenheim CDP can now offer practitioners ITEP accreditation in effective psychosocial interventions



The International Treatment Effectiveness Project (ITEP) began as a collaboration between the Institute of Behavioural Research in Texas, the NTA and six service providers in both the North-West of England and London, including Blenheim CDP.

It was found that ITEP gave service users an accessible platform from which they could begin to explore and express their needs. With guidance from skilled workers it was found that service users were able, perhaps for the first time, to witness connections and impacts on resultant behaviour in a visual way. Workers have reported that these interventions sit comfortably within their existing skill set, and stated that with continued practice it became a fluid creative exercise that took the focus away from the worker providing 'the answer'. Due to its visual nature, barriers to communication such as literacy and poor concentration are broken down, allowing service users to move from a more 'passive' stance toward fully engaging in their own treatment/recovery process. As a result, research has shown that service users feel more positive about their treatment (*Collier, Czuchry, Dansereau & Pitre, 2001; Knight, Kalling, Dansereau, Donald, Joe, Simpson 1994*).

Since initial involvement in the ITEP two-year pilot in 2006, Blenheim CDP have continued to embrace ITEP within the core of their organisation. These demonstrably effective psychosocial interventions promote collaborative working between worker and service user in supporting informed choice and capacity to change.

❖ ❖ ❖

The Blenheim CDP ITEP team have travelled the length and breadth of the country delivering quality training to a diverse audience that includes GPs, psychologists, prison officers and drugs workers. The team facilitate an interactive two day training programme that is designed to leave delegates fully grounded in the underpinning theories of mapping, the ability to implement these with their client group, and an understanding of its wider applications and benefits.

In response to requests from delegates and commissioners the ITEP team are now delivering bespoke one-day refresher trainings. These have been developed to focus on implementation in specific areas such as ETE, community services, day programmes etc. This provides a dedicated space for teams to reflect upon and sharpen their mapping skills to develop an action plan for further skill enhancement. The ITEP team consult with individual organisations to ensure successful implementation and embedding of the learning.

The ITEP team at Blenheim CDP have now accredited the two-day course with OCNLR which goes live in 2012. This training programme is the first of its kind in the country and provides delegates with the opportunity to become accredited ITEP practitioners. They are currently developing further ITEP training specific to young people, contingency management and the use of maps in supervision.

❖ ❖ ❖

Tony Margetts – Substance Misuse Commissioning Manager from 'Safe Communities' in East Riding said of the training:
'The East Riding of Yorkshire has used Blenheim CDP to provide training across staff from several agencies working with drug users in both community and prison settings for the last three years. We have always had excellent feedback from this training, both regarding the usefulness of ITEP as an approach and the quality of the training.'

Lucy O'Hare – 'HIT' Training Manager , Liverpool also said:
'We are extremely pleased with how the training has gone. The standout comment was that the trainers were really engaging, and also that the training was very interactive. The process from start to finish went very smoothly, and I wouldn't hesitate for a second in commissioning Blenheim CDP to come back to Liverpool to deliver more courses!'

However, the most powerful endorsement of ITEP and its benefits in the therapeutic setting has to come from the service users themselves regarding their own experiences:
'I love the action plan map. With my worker we make a simple plan that keeps me on track between sessions. I can tick things off, which makes me feel good.' Blenheim CDP Service User

'Because I get to keep a copy of my maps I can remember what we were talking about and I can add to them if I want to!' Blenheim CDP Service User

Kim Maouhoub is the ITEP Co-ordinator for the organisation and can be contacted on k.maouhoub@blenheimcdp.org.uk. For further information about ITEP training and consultancy please email Sharon Burke at s.burke@blenheimcdp.org.uk

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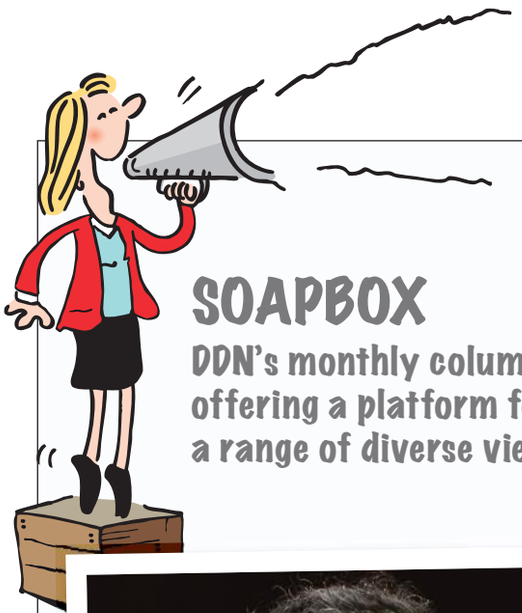

SOAPBOX

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

GETTING NARKY OVER NALOXONE

Are we rolling out an ill-thought-out scheme, asks **Kevin Flemen**

If recent coverage in blogs, tweets and journals is to be believed, it should be full steam ahead for the widespread distribution of the opiate antagonist naloxone. In San Francisco, recent coverage asserted that 'naloxone saves 600th life,' while closer to home in Wales, '20 lives were saved in 18 months in Swansea' thanks, it is claimed, to naloxone.

An expansion of naloxone distribution is very likely and judging by the commentary to date, it is well nigh heretical to raise questions about this. I am keen to see an expansion of any interventions that can be demonstrated to save lives – nonetheless, there are some important practical and ethical concerns that seem to me to have been skated over.

Many years ago, I attended a presentation by Dr Ingrid Van Beek, who set up the drug consumption room (DCR) in Sydney. She explained the low level of frequency with which naloxone was used to manage overdose – most were safely managed until the arrival of paramedics by using oxygen, which provided a safe and less violent method.

A review of overdoses in the supervised injecting facility (SIF) in Vancouver saw oxygen used on just under 300 occasions, with naloxone being used on less than 100. In Sydney, in the 2,000 opiate overdoses managed between 2001 and 2007, naloxone was used on less than one in five occasions.

I share concerns about rolling out use of naloxone, especially in settings such as hostels. Proposed models of distribution have included trained staff holding naloxone, so it can be used in the event of resident overdoses. A key concern in such settings would be that 'naloxone-happy' staff would lead to the perverse outcome of deterring people from using on site, so as to avoid being 'got' with naloxone.

Why though, should staff become overly keen on the use of naloxone? A key reason would be that we have yet to fully consider issues of liability. Given a situation where staff have been trained in use of naloxone, and are facing an overdose situation, they could feel obligated to use it, even where it wasn't needed. Ultimately, while the unnecessary use of naloxone merely distresses an opiate user, the failure to use naloxone by someone trained in its use, where the person overdosing dies, opens up scope for litigation.

All professionals owe the person overdosing a 'duty of care'. Depending on training and role, this could be limited to calling an ambulance. But what are the implications where non-medical staff have been trained and equipped with naloxone – could this be a breach of duty of care? The easiest way for a member of staff to avoid this negligence would always be to err on the side of caution, and administer anyway.

This increase in scope of duty of care presents other challenges. This in part stems from the precedent set by Bolam *v* Friern Hospital (1957) which established the principle that a professional 'is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of (medical) men skilled in that particular art'. So once trained and equipped to administer naloxone, it seems reasonable that the standard to which one would be held accountable would be that of paramedics.

If this is the case, then the implications for people being trained in the use of naloxone are significant. The failure to call an ambulance, failing to wait with a person until an ambulance came, failure to place in the recovery position, or the use of the same needle between two overdose casualties resulting in BBV transmission – each of these omissions or acts would fall below the standard of 'practice accepted as proper' and so could be actionable in the event of death or serious harm. In one evaluation of take-home naloxone in Wales, out of 28 cases of naloxone being deployed, paramedics weren't called on 14 per cent of occasions, despite training.

We need to make more explicit to those being trained in use of naloxone that their involvement in an overdose has potential implications. They could be a life-saver, which is what we of course hope for. But this may not be the case.

A discussion took place a while ago, looking at a monitoring system for pharmacy needle exchange. The revised system had a newly added field for when the pharmacist was re-dispensing naloxone after it had been used. The field asked the question 'successful or unsuccessful?' meaning did the overdose victim live or die? What, I asked, would be the pharmacist's obligations if the person seeking naloxone said 'unsuccessful'? The issue had not been looked at in training, and the consensus was the pharmacists would feel obliged to notify the police, and give details of the person seeking naloxone.

This didn't, of course, mean that the person administering naloxone had done anything 'wrong'. Just that they may well need to speak to police, possibly under caution, would have to go to the inquest, could be found to have done something illegal by the police, and may have been negligent.

I wonder how many people had that explained to them when they were undertaking their naloxone training?

Kevin Flemen runs KFx, a service that provides an information website, training and resources to those with an interest in drugs – www.kfx.org.uk

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Happy Christmas

from Bolton DASCT!!

Bolton Adult Substance Misuse System
FORTHCOMING TENDERING OPPORTUNITY

Bolton Drug and Alcohol Strategy and Commissioning Team (DASCT) will be tendering for a new Substance Misuse Treatment and Support System for Bolton residents.

Our vision is to provide effective and integrated substance misuse interventions and treatment that delivers positive outcomes for individuals in Bolton, whereby exits will be visible to individuals on entry. Families and carers will be fully involved in all aspects of the individuals' treatment journey, whilst also having the opportunity to be supported in their own right.

It is anticipated that the tendering process will commence March 2012 and will be advertised on "The Chest" (The North West Procurement Portal). Following this, the DASCT will provide a bidder briefing session in Bolton; an open event for all those who are interested in tendering.

In order to access the tender documentation and/or bid, a provider must be registered on 'The Chest'. Providers will be able to download the documents from the portal and also submit completed documents. To register an organisation, please click on the following link www.thechest.nwce.gov.uk.

Log onto Bolton's substance misuse website, www.boltondrinkanddrugs.org to keep up to date with the tendering process. Additionally, email the team at DASCT@bolton.gov.uk, with any queries or comments.

Bolton Council

BOLTON DRINK & DRUGS

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Invitation to tender for the

Rochdale Community Alcohol Service

We are inviting a suitably qualified and experienced organisation to tender for the above service.

The successful service will be the main provision for adult alcohol clients in the Rochdale Borough and will be expected to provide structured treatment interventions as well as facilitating access to inpatient treatment and providing alcohol training to a range of frontline services across the Borough. The appointed service will deliver evidence based interventions that successfully engage alcohol misusers in treatment and enable them to recover from their dependency.

The contract is for a period of 2 years anticipated to commence on 1st April 2012 with an option to extend for a further year (subject to continued funding).

Organisations interested in providing this service should submit a tender using RMBC's e-tendering portal "The Chest":- To register go to www.thechest.nwce.gov.uk

Tenders should be completed and submitted no later than 2pm on Tuesday 10th January 2012.

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BOOKING FORM

Please write clearly and in black ink.

Name of service user delegate(s): _____

Name of drug and alcohol professional(s) and job title(s): _____

_____

Booking contact *[person completing form on behalf of delegate(s)]*: _____

We will use this person's email to send information regarding changes to the conference programme and venue.
We will also post out name badges for the delegates prior to the event, to this postal address.

Organisation *(if applicable)*: _____

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Early bird delegate rate: £135 + Vat for professionals or £80 + Vat for service users.
There will be an additional £10 per person charge for all places booked after 31 December 2011.

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TOGETHER WE STAND

The fifth national service user conference

Join us in Birmingham for the unmissable event of the year, where service users, treatment providers and politicians debate what's working and what needs to change!

CONFERENCE PROGRAMME

9 -10 Registration and Coffee

10 – 11.15 Opening session

Hepatitis C: This serious issue directly affects a large proportion of individuals, and is an area where lobbying for improved treatment can make a massive impact on people's lives. A speaker from The Hepatitis C Trust has been invited to give their personal story and highlight the need for early testing and improved treatment access.

Alcohol service user groups: Gary Topley, a service user who has set up a successful award-winning alcohol service user group, will tell delegates about overcoming personal difficulties to establish sustainable alcohol support in his area.

Public Health England Anne Milton, Public Health Minister, has been invited to explain how funding and delivery of treatment fits in the new public health framework, providing an opportunity for delegates to raise concerns – and for us to follow these up in the magazine.

11.15 – 11.45 Coffee and networking

11.45 – 1.00 Concurrent sessions

Naloxone: The session will provide powerful personal testimonials from people whose lives have been saved by naloxone, along with practical advice on lobbying for a UK-wide roll-out.

Older users: Looking at improved specialist treatment and the issues and stigma faced by older users.

Recovery in the community: Inspiration from groups that are establishing practical ongoing recovery communities at a local level.

Pain relief: How to overcome obstacles and stigma faced by both current and former users when trying to access effective clinical pain relief.

1.00 – 2.30 Lunch and networking

An opportunity for delegates to meet the service user groups from around the UK - along with treatment and service providers in the exhibition area, visit the practical demonstration areas and watch service user films shortlisted for the DDN film awards.

2.30 – 4.00pm Afternoon Session

The final afternoon session will bring everyone back together in the main hall for the presentation of the film award, followed by the panel debate. This will give delegates chance to discuss key issues facing service users, including the 'worthy and unworthy ill', stigma, the recognition of methadone maintenance within the recovery movement and the climate of concern around coerced titration.

DDN Drink and Drugs News

The Alliance – Taking treatment forward

NEW VENUE! The NEC, Birmingham

16 February 2012

Speakers and programme timings may be subject to change.

The conference will be filmed for www.drinkanddrugsnews.com and issues raised at the event will be followed up in DDN magazine.

The DDN film awards are open to all films made by service user groups. The shortlist of films will be shown at the event, followed by the award presentation. Email conferences@cjwellings.com to find out more.

Booking form overleaf. Full details of the conference and online booking are available at www.drinkanddrugsnews.com