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DDN
Drink and Drugs News

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'Tough times mean tougher attitudes, and we work with society's scapegoats...'

GATHERING STORMS

NEEDLE EXCHANGE MUST FIGHT TO AVOID FALLING VICTIM TO CHANGING ECONOMIC AND POLITICAL LANDSCAPES

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- *‘Harm Reduction and Recovery: What’s our future?’* **Neil Hunt** (University of Kent, UK Harm Reduction Alliance)
- *‘Recovery in the community: The challenges & opportunities’* **Brian Morgan** (SU Coordinator W.Sussex DAAT, EXACT, Whole Person Recovery Project)

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

For more details visit:

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News in Brief

WINGING IT

The government has announced pilot 'drug recovery wings' in five prisons as part of its criminal justice reforms. The wings – in Bristol, Brixton, High Down, Holme House and Manchester prisons – are aimed at those serving sentences of less than 12 months who need 'intensive support during the early stages of their recovery from addiction', and will also focus on connecting prisoners with community services on release. 'We want to attack the shamefully high rate of reoffending and that means cracking down hard on drug abuse inside prison,' said justice secretary Ken Clarke.

CENTRE CLOSES

Glasgow University's Centre for Drug Misuse Research is to be shut down as part of a package of cuts announced by the university. The centre, which opened in 1994, is headed by *DDN* contributor Dr Neil McKeganey. University vice chancellor Professor Anton Muscatelli said the past few months had been 'extremely challenging' and that 'difficult decisions' had been made.

FOETAL FARCE?

A training programme for midwives to highlight the dangers of drinking alcohol during pregnancy is to be funded by drinks giant Diageo. The programme, to be run by the National Organisation on Foetal Alcohol Syndrome UK, is part of the government's controversial 'responsibility deal' with the drinks industry (*DDN*, April issue, page 4) in which manufacturers promise to support awareness campaigns among other measures. 'It is deeply worrying that alcohol education is being paid for by the drinks industry, as it is then unaccountable and not necessarily based on evidence or public health guidance,' said Alcohol Concern chief executive Don Shenker.

CRIME FIGHTERS

A new national crime agency has been established to tackle drug smuggling, alongside offences like people trafficking, fraud and cyber crime. The National Crime Agency (NCA) will make sure local police are 'linked up to work nationally and overseas', says the Home Office. 'For too long we have lacked a strong, collaborative national response in the fight for criminal justice, with a fragmented approach to policy, prevention and investigation,' said home secretary Theresa May.

Report blasts payment by results as 'doomed to failure'

Payment by results (PbR) is 'well intentioned but doomed to failure', according to a controversial new report from the Centre for Policy Studies (CPS). This is partly because the pilot programmes are 'being run by the very organisations responsible for the current failure of policy', says *Breaking the habit*.

The report brands methadone prescribing 'an expensive failure', and estimates the cost of benefits paid to drug users at £1.7bn a year and the welfare costs of looking after their children at a further £1.2bn. It goes on to estimate the cost of methadone provision at £730m – a figure DrugScope calls 'simply wrong' – bringing the 'total social and economic burden for this population' to more than £3.6bn.

'There are as many addicts today as there were in 2004/05,' the report says. 'Fewer than 4 per cent of addicts emerge from treatment free from dependency. Drug deaths have continued to rise.' The number of referrals to rehab has also fallen to an all-time low, it continues, while a quarter of those on prescriptions having been on them for four years or more.

Subtitled *Why the state should stop dealing drugs and start doing rehab*, the report states that PbR could work if 'the importance of abstinence-based rehabilitation' was recognised. Although 'small, modern rehabilitation units' have been successful in freeing people from addiction, it says none have been allowed to apply to run the PbR trials, and the report urges the government to seek bids from this model of provider. However, the NTA, as 'the organisation responsible' for the previous policy 'clearly favours the current set-up', it states, while the fact that PbR 'will reward operators who can show that addicts have improved health and employment, who have not offended recently and who are not in treatment for drugs' is 'seriously misguided'.

DrugScope, however, has branded the document 'inaccurate and misleading'. The report's calculations of the cost of methadone prescribing include much of the total cost of providing the current drug treatment system as a whole, it states, including detox, residential rehab and treatment for a range of drugs other than heroin, while the report is also guilty of 'seriously understating' the benefits of treatment. The charity has also written to the BBC to complain about its coverage of the report.

'To state that the cost of methadone prescribing is £730m – a total derived by adding up spending on almost the entirety of the drug treatment system – is plainly ridiculous,' said chief executive Martin Barnes. 'Under the NHS constitution, all patients have a right to access evidence-based treatment – which in response to substance misuse, includes substitute prescribing. To assert that receiving an evidence-based, medical intervention like methadone prescribing is "entrenching addiction" increases the stigma surrounding drug treatment and recovery and could make it harder for people experiencing problems to come forward for help. It is a shame that, in trying to bring attention to the issue of access to residential rehabilitation, the CPS has so seriously misrepresented facts about drug treatment. The report and its coverage risk undermining public support for drug treatment and for much needed investment in services which are key to improving outcomes and supporting recovery.'

SMMGP clinical lead Steve Brinksman said that the report seemed 'designed to denigrate the many years of evidence supporting opiate substitution treatment' and used 'financial scare tactics and poor arithmetic' to promote its 'one size fits all' approach.

Meanwhile a YouGov poll has found that more than half of British people think the government's approach to illegal drugs is ineffective. Almost 90 per cent of respondents felt that 'realistically, there will always be people who use drugs, and the aim therefore should be to reduce the amount of harm they cause to users and others'.

Breaking the habit at www.cps.org.uk
*YouGov survey results at today.yougov.co.uk/life/drugs-policies-dont-work**See news focus page 6.*

Up, up and away: winners of the first ever regional recovery awards for people, projects and services in the east of England celebrate their achievements as part of eastern recovery month. The month 'showcased a huge movement in the east of England to increase the visibility of recovery throughout the whole drug and alcohol treatment system,' said NTA regional manager Emma Pawson. 'Our aim is to ensure that anyone needing help with drug or alcohol misuse can access effective treatment quickly and have the support they need.'

Alcohol education should be targeted at parents, urges JRF

National policy efforts to deter young people from dangerous drinking behaviour would be best directed at supporting and educating parents, according to a new report from the Joseph Rowntree Foundation (JRF).

This should include positive messages about how parents can influence their child's drinking behaviour, says *Young people, alcohol and influences*, as well as stressing the impact of their own drinking and what their children 'see and think about this'.

The report is based on a study of almost 6,000 English teenagers aged 13-16 which aimed to develop an understanding of 'what really influences young people's drinking patterns'. It found that young people were more likely to drink – and to drink frequently and to excess – if they received less supervision from a parent or other close adult, if they were exposed to a parent or other family member drinking or getting drunk, and if they had easy access to alcohol. The most common place for getting hold of alcohol was the home, the document stresses.

While friends played an important role, family had a 'strong and direct influence' on children's behaviour, states the report, which found that 70 per cent of Year 9 students (aged 13-14) had had alcohol. 'There are critical points where a carefully timed intervention could generate a positive outcome by reducing the likelihood that a young person will drink frequently and drink to excess,' it says. 'These interventions require coordination at a national, local and frontline level, involving families, schools and support services.'

'Parents have to realise and accept that whether intended or not, their own attitudes towards drinking, their own rate of drinking and any drunkenness are clear signals to children that this is acceptable and standard behaviour,' said Alcohol Concern chief executive Don Shenker. 'Government ministers must also look at some of the causes of why it is so easy for children to obtain alcohol, usually from the home', with the continuing heavy promotion of cheap alcohol by supermarkets meaning people were buying more and storing it at home.

Turning Point called for more specific services to provide interventions for children at the 'earliest possible' stage. 'Our own research has shown that one in 11 children, often living in some of our poorer communities, are more likely to go on to have devastating alcohol and emotional problems because of parental alcohol misuse,' said spokesperson Harry Walker.

A report from the Royal College of Psychiatrists, meanwhile, says that recommended drinking levels for the over-65s should be cut, as older people break down alcohol more slowly and are therefore more sensitive to its effects. *Our invisible addicts* recommends an upper 'safe' limit for older men of 1.5 units per day, routine GP screening of over-65s for substance misuse problems and targeted public health campaigns. A third of older people with alcohol problems developed them in later life as a result of depression or loneliness brought on by bereavement or retirement, and although illegal drug use was uncommon among over-65s, there had been significant increases in the over-40s in recent years and the problem was 'likely to get worse as these people get older'.

JRF report available at www.jrf.org.uk/publications/young-people-alcohol-and-influences
Our hidden addicts available at www.rcpsych.ac.uk

London tops alcohol-related crime table

Despite the media portrayal of regional town and city centres as no-go areas on weekend nights, London has the highest rates of alcohol-related crime in England, according to a report from Alcohol Concern.

There are 12 alcohol-related crimes per 1,000 compared to eight per 1,000 in the rest of the country, states *Reducing the impact of alcohol-related harm in London – how well are we doing?*

Seventy per cent of people in London are under 44 and, while overall rates of alcohol consumption are lower in the capital, Londoners are more likely to binge drink, says the report. London also has the highest rates of alcohol-related violent and sexual offences, as well as the highest rates of people suffering from alcohol problems and mental health issues. Alcohol-related hospital admissions cost the city £264m annually, double the amount spent on smoking-related admissions, while the London Ambulance Service responds to more than 60,000 alcohol-related call outs every year.

The report also found that progress in treatment provision for dependent drinkers was threatened by the economic situation and that less than a fifth of London boroughs had systems to identify alcohol offenders and help them address their drinking. In addition, local plans to tackle alcohol misuse were not regularly reviewed, it says.

'Despite the comparative youth of the capital's population and its burgeoning hospitality industry, Londoners drink less than adults in most other parts of the UK,' said Alcohol Concern chief executive Don Shenker. 'Its challenge lies in a population that is mobile and characterised by high levels of social deprivation, mental illness, drug use and alcohol-related crime.

'Greater investment is needed in identifying and supporting problem drinkers in criminal justice, mental health and health settings such as GP services and hospitals, as their role in reducing alcohol harm is pivotal. In addition, local communities must have confidence in the how local councils and health organisations are tackling these issues and be able to ultimately hold them to account.'

Report available at www.alcoholconcern.org.uk

Drug markets 'stable' but synthetic drug use on the rise

The global heroin, cocaine and cannabis markets declined or remained stable last year, but the production and use of new synthetic drugs grew sharply, according the United Nations Office on Drugs and Crime's (UNODC) *World drug report 2011*.

South East Asia had seen 'soaring' levels of production, consumption and trafficking of amphetamine-type stimulants (ATS), it says. However, the manufacture of the drugs was not 'geographically bound', with laboratories usually located close to markets and precursor chemicals trafficked across regions.

Cannabis remained 'the world's drug of choice', states the report, and although there had been a 'sharp' decline in opium production (*DDN*, 11 October 2010, page 4) and a 'modest' reduction in coca cultivation, the manufacture of cocaine and heroin was still 'significant'. However a decline in the US cocaine market in recent years meant that the European market was now approaching it in estimated value, at US$37bn and US$36bn respectively.

Most drug-related deaths in Europe 'seem to occur' in Ukraine, the Russian Federation, the UK, Spain and Germany, says the document, with the five countries accounting for around 80 per cent of the total, while drug-related deaths as a result of overdose totalled around 7,000 in the EU down from around 8,000 in 2000. The report estimates the global average prevalence of HIV among injecting drug users at 17.9 per cent, equivalent to 2.8m people, and the global prevalence of HCV among injecting drug users at 50.3 per cent, with 13 countries reporting prevalence rates above 70 per cent.

'It is UNODC's responsibility to draw the world's collective attention to the alarming trends that are emerging in South East Asia as well as to point to what can be done on both a national and regional basis to respond to these trends,' said the organisation's regional representative for East Asia and the Pacific, Gary Lewis. 'Urgent countermeasures have to be taken in consultation with governments and civil society, starting from effective preventive measures addressing youth and vulnerable groups.'

'The gains we have witnessed in the traditional drug markets are being offset by a fashion for synthetic "designer drugs" mimicking illegal substances,' said UNODC executive director Yuri Fedotov. Although treatment was 'one of the best ways of shrinking the market', the provisions of the Single Convention on Narcotic Drugs – 50 years old this year – remained 'sound and highly relevant', he said.

Meanwhile, the UN's 2011 Political Declaration on HIV/Aids has been branded a 'missed opportunity' by Harm Reduction International (HRI). The declaration – which aims to intensify efforts to eliminate HIV/Aids and has been adopted by the UN General Assembly – 'will not address the crisis levels of injecting-driven HIV infection', said HRI executive director Rick Lines, particularly in Eastern Europe and Central Asia. It also did little to challenge the refusal of countries like Russia to support harm reduction measures, he stressed. 'When the first Political Declaration was adopted in 2001, there were 100,000 people living with HIV in Russia. Ten years later, that figure is now 1m.'

Available at www.unodc.org

A 'FAILING AND COSTLY DRUG POLICY'?

The Centre for Policy Studies' latest report on the state of drug treatment provoked a predictable reaction in parts of the media, and an angry reply from DrugScope. ***DDN*** talks to its author, Kathy Gyngell

'WE NEED TO SET-UP (*SIC*) SOME COLD TURKEY BOOT CAMPS. Time to teach the smackheads the hard way,' opined one of the people posting comments below *The Telegraph's* coverage of the Centre for Policy Studies' (CPS) latest report on the drug treatment system. 'If you want to take drugs and become an addcit (*sic*) your choice but do it using your own money – why should the taxpayer once again pick up the bill for peoples (*sic*) irresponsible choices,' said another. 'You can debate certain drugs but herion (*sic*)/crack…no way...i,d (sic) boot camp anyone on h…cruel to be kind,' offered a third.

While the first reaction to these comments might be to wonder about *The Telegraph's* reputation as the paper of choice for a well-heeled and literate demographic, they also seem to back up DrugScope's assertion that the report – and the language used in the media coverage of it – could undermine public support in the treatment system.

The gist of *Breaking the habit – why the state should stop dealing drugs and start doing rehab* is that the coalition government inherited a 'failing and costly drug policy' which prioritised methadone prescribing in the hope of cutting crime rates and criminal justice costs, but which ultimately serves to delay people's recovery from addiction (see news story, page 4). In its present form, payment by results (PbR) will simply 'reinforce the status quo', it says, and, although well intentioned, it is 'doomed to failure' and 'seriously misguided'. The solution lies in freeing people from addiction rather than measuring easily manipulated 'proxy outcomes', the report states, adding that the 'one simple measure of success' should be six months of abstinence from alcohol and drugs.

'When the coalition came in, my understanding was that they realised we couldn't carry on going down the road of endlessly maintaining people, and that it was incredibly unaspirational for people,' Kathy Gyngell tells *DDN*. 'Payment by results was absolutely well intentioned, the idea being – and it's always the gap between the concept and the implementation – that good, small charities would have a chance to prove what they could do, and the best ones would emerge as the winners. But the main problem is that everything's being devolved to existing drug action team administrations to manage without any particular specification of how they do it, so at best it looks like it's going to be more of the same, with very limited aspirations in the outcomes.'

'Since the commissioning system never really commissioned for abstinence-based recovery programmes it's structurally kept these outfits marginalised. '
Kathy Gyngell

The report states that PbR could work if there was 'a real transfer of power from large distant organisations to small innovative providers'. Why does she feel these organisations are being sidelined, given that they fit in with the recovery agenda? 'They've never been part of the Department of Health/NTA/DAT treatment economy,' she says. 'They've always been on the sidelines and they'd always had to be on the receiving end of referrals paid by community care funds, and since the commissioning system never really commissioned for abstinence-based recovery programmes it's structurally kept these outfits marginalised. The problem with the new system is that by definition that exclusion continues. When they asked to join in local partnerships to participate in a partnership bid for the pilots, the message came back to several of them that it was a conflict of interests. So they're still in the same marginal position, and not able to demonstrate what they do, and expand what they do.'

She also feels that the results being assessed are effectively 'negative', with crime reduction measured by a 12-month non-appearance on the police national computer and employment measured by 12 month non-appearance on welfare claims data, something that's also 'far too complex' according to the report.

'That's my other real beef with it,' she says. 'I really think it's misguided. Number one, the police

national computer is a joke – it encourages all the type of bureaucracy we've had before. All the money goes into the management of that bureaucracy, and only one out of four or five crimes is detected anyway, so it's meaningless. If these people don't reappear on it, it will satisfy the bureaucrats, but what real meaning will it have? And what an enormous amount of bureaucratic work is it to find out if people are still registered for benefits? Anyway, loads of people who are in work, rightfully, are able to claim a benefit. I just can't see that doing it in this negative way will be able to reward the positive.'

What it ultimately boils down to is lack of trust, she believes. 'If you know you've got good programmes and the quality of staff that I've met in places like TTP, BAC O'Connor, the Providence Project and the Nelson Trust, their judgment should be trusted as to whether that person is clean or not – I really don't think those are the sort of people who are going to manipulate data.'

The results in PbR need to be 'something very concrete that actually demonstrates success', she says – which should be a measure of abstinence. 'If what we're trying to do is really free people from addiction and get them on their feet so they can operate their own lives, it has to be. And the irony is that these small rehabs being excluded are expert in the process of getting people their literacy training, their education, building their confidence, mentoring them, but in safe settings where real relationships build up. You can see why it works – places like Park View and SHARP in Liverpool are almost the hub of the Liverpool recovery community. So I'm hoping they'll reconsider what they're going to take as their measure of success, and trust in honourable programmes that can demonstrably get the majority of their clients completely drug free and on the way to independent living, and to concentrate on the abstinence and sobriety that's key to it.'

The aspect of the report that has most angered DrugScope and others in the field, however, is the statement that the '£3.6bn bill for drug addicts' – to quote the *Mirror's* headline – is partly made up of an annual £730m spend on methadone provision.

This is 'plainly ridiculous', says DrugScope, and the charity quickly issued a statement setting out what the report's figures 'actually relate to' – £380m of Pooled Treatment Budget for the commissioning of all local drugs services, £205m of local funds from councils, PCTs and the criminal justice system, £110m of Ministry of Justice Drugs Intervention Programme (DIP) funding, £25m for treatment of young people – for whom methadone prescribing is 'extremely rare' – and £19m for the NTA's running costs.

'The figures relate to the total cost of providing the current system of drug treatment (excluding treatment in prisons),' says DrugScope, 'which includes, for example, arrest referral, needle exchange programmes, psycho-social interventions, residential rehabilitation, in-patient detox and the provision of treatment for drugs other than heroin (including cannabis, cocaine and dependency related to the use of over-the-counter and prescription medicines).'

Does she accept DrugScope's statement that the figure is 'simply wrong'? 'No, of course it's not,' she says. 'I'm talking about a default methadone-prescribing system, and it's absolutely crystal clear in my report what I'm talking about. If you have a system which has 200,000 people in treatment, and three quarters of them are being prescribed an opiate substitute, I think it is absolutely reasonable to describe that as a methadone system. I think it's extraordinarily head-in-the-sand to pretend that the default system isn't a methadone prescribing system – yes I know we use buprenorphine and other things but it's a default scripted system and I defy you to tell me that in any DAT, at any time, over the country, that isn't the default system.

'The other services actually operate around that,' she continues. 'I have been to enough drug action teams around the country, seen enough breakdowns of expenditure, to know that the other services are essentially support services to that system. Therefore it is absolutely reasonable to say that amount of money is being spent administering and supporting that system. Whatever psychosocial there is – which isn't much – and projects where the drugs workers are doing a sticking-plaster job wouldn't be described as a script service, it would be described and commissioned and paid for as some type of support service. But they're still supporting people on their script.'

What would she say to the claim that the report 'seriously misrepresents' what the system has achieved? 'I would say exactly what [director of Green Apple Consulting] Huseyin Djemil says in his blog on the ConservativeHome site – that it's been good at finding people for treatment. It has, but it hasn't then met their aspirations for what they want to do. The NTA's own figures showed that about 80 per cent want to get better and change their lifestyle.'

Ultimately, methadone was 'an experiment', she says. 'People believed in it – that it would save all this money and you had to reduce the crime. But it was so evident from early on that this wasn't getting people better, and it conflicted with getting people better. If you turn it around, in Sweden they have to fail four times at rehab before they're given methadone. It's the wrong way round.' **DDN**

THE REACTION:

Britain is wasting £3.6BILLION a year giving drugs and aid to heroin and crack addicts... That would pay for 34,000 nurses or 18,000 doctors.
People

'Labour has waged a "phoney war" on the drug problem by squandering billions on ineffective treatment while presiding over Europe's most liberal drug regime...'
Daily Mail

'Taxpayers' footing £3.6bn bill to look after drug junkies.'
Wales Online

'Alert as drug plan flops... £1.7billion goes on benefits and £1.2billion on looking after the addicts' kids.'
News of the World

'Less than four per cent of England's estimated 320,000 drug addicts manage to stay clean after treatment...'
Mirror

'There are only 1,872 beds now available at "affordable" levels of around £500-£600 per week, with none on the NHS, and the sector is "in near-terminal crisis".'
The Independent

'Payment-by-results schemes... being run by the very organisations "responsible for the current failure of policy".'
BBC News

STAYING SHARP

'Tough times mean tougher attitudes, and we work with society's scapegoats,' chief executive of Bristol Drugs Project (BDP), Maggie Telfer, told delegates at the National Needle Exchange Forum's annual conference. This meant that, more than ever, it was essential to 'articulate the health economics', she said. 'The consequences of not providing very simple interventions like needle and syringe exchange are very expensive.'

In order for needle and syringe programmes to survive and thrive, service providers needed to concentrate on 'evidencing' – 'making people understand what we do' – and they also had a responsibility to ensure policymakers understood the 'blindingly obvious, unintended' consequences of past mistakes, she said. 'Are we making enough progress? I think probably not. In this era of recovery, we've got to look at what else we're about – we've always been a gateway into treatment.'

Although an upside of the current policy shift was drug treatment money going to directors of public health – 'they know about epidemiology, they know about the value of these things' – needle exchanges would nonetheless have to compete with other local authority departments for cash, she told the conference. 'It will be a case of "do you want your bins emptied every week, or do you want a needle exchange?" The question is what do we have to do to make policymakers listen this time.' However, more people had been affected by addiction – or knew someone who had – than a decade ago, she said, and there was a sense that public attitudes were changing. 'We can't allow the *Daily Express* and government press releases to dominate the discourse – we have to get our message heard.'

Around 190,000 people in the UK were infected with hepatitis C antibodies, with 90 per cent of new infections among injecting drug users, Dr Natasha Martin of the University of Bristol told the conference. 'The numbers are high, but not as high as some that have been thrown around.' People with access to 'full harm reduction' – substitution therapy and sterile needles and syringes – had an 80 per cent lower risk of infection, she said, and while HCV antiviral treatment was also effective and approved, 'such a low number of injecting drug users are being treated that it's shocking'. This was largely because of clinicians' unfounded fears about them finishing treatment, or becoming re-infected, she said. 'The best way of delivering treatment would be to start with the OST population and work through peer projects and peer support, via treatment advocacy with clinicians.'

Heroin use had 'exploded' in Bristol in the 1990s, but there had been genuine commitment to 'getting people into treatment and keeping them there', said manager of BDP's treatment team, Jayne Peters. 'We're very lucky here in that GPs have embraced the international evidence.' There were 2,200 people in structured treatment at any one time, she said, but there was still a small but vulnerable group that accessed needle exchange and no other treatment, put off by the perceived time it took to get a GP appointment or prescription, and with very high levels of BBVs. However, BDP was starting a randomised control trial with the NHS and the University of Bristol to remove the barriers to structured treatment. 'We're aiming for a script in a day,' she said.

Addaction project worker Nigel Brunsdon told delegates that although needle and syringe programmes were low threshold interventions – 'and at no point should supply of sterile equipment be dependent on filling in paperwork' – he had developed a tool to evidence the work done in needle supply. It asked questions like 'are you in treatment', 'have you overdosed recently' and 'do you use alone', as well as recording things like injecting injuries, mood and health. 'We want to look at the things people are doing to protect themselves,' he said.

There were also questions on housing, employment and training, tying in with the recovery agenda, he told delegates. 'I've always asked those questions, as I'm sure everyone else does, but commissioners tend to think that all we do is throw needles at people. This is a tool that can help programme directors do their job better and hopefully improve outcomes for clients.'

The needle exchange client base was also changing, delegates heard, with staff seeing more and more performance and image enhancing drug (PIEDs) users. 'PIEDs are poly-drug use on a grand scale,' said Martin Chandler of Liverpool John Moore's University. 'And that's taking out of the equation the recreational drugs they may be using at the same time.'

Drugs of choice included anabolic steroids, peptide hormones, diuretics, thermogenics (fat-burning stimulators), thyroid drugs, anti-oestrogens and dietary supplements, he said. Anabolic steroids were usually injected intra-muscularly and peptide hormones subcutaneously, with users combining drugs in 'stacks'. People were 'basically turning themselves into pin cushions', but all the evidence around the use of anabolic steroids and associated drugs tended to look at 'use of one steroid that's been sourced clinically', he pointed out. 'No one's ever given someone such a combination of drugs to see what happened – we just don't know the effects.'

Many PIEDs bought at street level were counterfeit, he said, and usually contained different doses to those stated on the label. 'The quality of these street-sourced drugs is likely to be no better than the quality of street-bought drugs of any kind. Nobody knows what's in the stuff, and I think that may account for a lot of the psychological and emotional problems that come with steroid use.' A key harm reduction message for PIED users was 'the lowest dose possible for the shortest time possible', he stressed. 'This is an enormous subject – every day I find new drugs and more aberrant use, with people just throwing all kinds of things in. The idea that steroid users are somehow not as important as PDUs has got to go out of the window.'

Needle exchange needs to fight its corner to avoid becoming a victim of changing economic and political landscapes, hear delegates at the National Needle Exchange Forum's 2011 conference in Bristol. DDN reports

Another drug that needle exchange workers were hearing more about was ketamine, Rachel Ayres of BDP told delegates. 'We're seeing more and more injecting ketamine users in the service – we saw two this morning. We're seeing problematic, daily use at very high levels, and some injectors are injecting well over the doses used for adult anaesthesia and remaining conscious, which means more work needs to be done around issues of tolerance.'

BDP had started a rolling survey of injecting ketamine use in its needle exchange services, she said. 'It's a sub group of users, but everyone seems to know someone who injects it.' Ketamine dissolved readily in water and was therefore easy to inject, she said, with most injectors doing so intra-muscularly as IV users tended to report that their veins quickly became damaged, through poor technique and the sheer number of injections. 'We've also come across people injecting it with heroin, which has been called a "k-ball" – I don't know if that's become national parlance yet.'

'This is one of those moments when we could all fall off the edge, and the people we work with could fall of the edge as well... We have a real responsibility to make sure that doesn't happen.'

The main risks were the 'obvious ones', she said. 'There's quite a lot of sharing going on, use of the wrong equipment, and people are very unclear about how much they're using – they're certainly not weighing it out.'

The amounts being injected were also worsening the other problems associated with ketamine use, such as ulcerative cystitis, she said. 'We're seeing people needing all kinds of unpleasant interventions, such as catheter insertion and bladder reconstruction. It's really difficult to stop using, and it's a complex issue because people tend to use in very tight-knit social groups, like the squat scene, which can make it difficult for one person to detox.'

It was difficult to get the words 'harm reduction' heard at the moment, Maggie Telfer told delegates. However, harm reduction and recovery were not mutually exclusive, her colleague Paul Sargent told the conference. 'You can't have one without the other. You can't recover someone who's died.'

'The state of UK harm reduction depends greatly on your perspective,' said Danny Morris of the UK Harm Reduction Alliance. 'We readily complain here about lack of services and opportunities, but when you go to other places it's quite humbling. That's not to say we shouldn't fight for the best possible services, but many people still look to the UK as a leader in harm reduction. There's no need to be an apologist – harm reduction works, and we should be telling people that it does.'

It was easy for needle exchange workers to feel under siege, said Kevin Flemen of KFx, with the original rationalisation for the service becoming increasingly forgotten. 'In terms of harm reduction and recovery, one without the other is an incomplete model. At some point, everyone is a pre-contemplative user, but they make the decision to come into a needle exchange and that's a brilliant opportunity for drug workers. Needle exchange is able to act as a gateway, but we need proactive interventions – we need to demonstrate its cost effectiveness beyond BBV prevention.'

'Something of a schism' had developed, he told delegates – 'we need more one-to-one interventions, but we've conditioned our users to expect needles very quickly.' This had come about through an over-reliance on pharmacy needle exchange, along with a lack of space, time and privacy in many exchange settings. It was also a training issue – 'there are staff who don't know how to do needle exchange as well as they could' – and a political issue, with a lack of political will and 'a lot of vested interests', he said.

'We need to slow everything down and look at the quality. We need keen workers with the space and time, and a welcoming demeanour. Every journey has to start with a first step, and for some people going to a needle exchange for the first time could be that step. As many people say, recovery can be contagious. But blood-borne viruses are certainly contagious.

'This is one of those moments when we could all fall off the edge, and the people we work with could fall of the edge as well,' said Maggie Telfer. 'We have a real responsibility to make sure that doesn't happen.' **DDN**

Kevin Flemen discusses the future of needle exchanges on page 12. NSP outcomes tool available to download at injectingadvice.com

LETTERS

'If Paul Flynn were a boy scout he would know that... their activities are founded on being "trusty, loyal, helpful, brotherly, courteous, kind, obedient, smiling, thrifty and clean in body and mind". Were this true for more of our population, Britain's addiction problem might be a lot smaller.'

WHY NOT BOY SCOUTS?

If Paul Flynn (*DDN*, June, page 20) were a 'boy scout' he would know that, in addition to 'being prepared', their activities are founded on being 'trusty, loyal, helpful, brotherly, courteous, kind, obedient, smiling, thrifty and clean in body and mind'. Were this true for more of our population, Britain's addiction problem might be a lot smaller.

Whilst he is right to point out the defects in government policies over the last half century, I find no evidence in his statements that he has in any way 'prepared' a viable alternative to the failing medical treatments which continue to be commissioned by the NHS over the next two and a half years of seeking recovery programmes which will provide a return to lasting abstinence.

The pretence of the NTA is that they are 'piloting' how to make payment by results (PbR) work. However, with the required result already specified by our admirable 'boy Scouts', the first necessity is to have existing commercial providers prove that they actually can deliver lasting abstinence. If they could, we would not be being diverted by the NTA pretence that 'payment' is the problem – when it is lack of abstinent 'results'.

He is however right to recognise that PbR will be twisted and deformed to make it fit the poor results available. Look how the psycho-pharm rehabilitators are already fabricating a plethora of 'recoveries' which have basically nothing to do with the government's goal of lasting abstinence.

I have worked with addiction recovery for nearly 20 years, and the only programmes which consistently provide lasting abstinence are run on non-medical non-treatment lines, and are nearly exclusively delivered by small to medium sized charitable organisations who do not have the capital resources needed to be able to wait 12 months for reimbursement/payment of what they have expended and delivered.

However, keeping addicts off the streets for the months it takes to deliver abstinence is in itself a valuable result for the community and so board and accommodation costs should be paid up-front, and the rest paid in four, eight and 12 month tranches as abstinence proves persistent.

Duncan, Lord McNair

IT'S THE RESULT THAT COUNTS

I am writing in response to letters in your April, May and June issues. It actually doesn't matter whether you are a lecturer, a professional, an expert, an ex-user, a psychologist, a provider or a trainer – the only questions which count are: 'Can you regularly cure alcohol and drug addiction?' and 'How many have you cured this year?'

Five decades experience of teaching addicts how to recover from their dependency has unequivocally revealed that by far the majority (70 to 75 per cent) of people from the list above do not know why or how addiction starts, and have no regularly effective means of helping an addict into a lasting recovery of the natural state of abstinence.

But all providers can make a valuable contribution if they are trained in a viable system of recovery and have gone through a period of on-the-job practice or internship where they actually deliver their clients into abstinence.

In other words, the nature and background of the individual practitioner is of less importance than the nature and proven history of the recovery programme in which he or she is trained.

By definition, an addict is someone who has handed his power of decision-making to a chemical substance, which thereafter controls his decisions and most of his life. To rescue him from this and to restore his responsibility for self and control of his own life, he has to be instructed in what he needs to know, and then gradually take responsibility for getting rid of control by other persons and substances. This is not done by imposing additional control by psychiatrists and other physicians in the form of treatment, but by the client practising reassertion of his own control – based on his own decision-making.

It is not what an addict 'in treatment' has done to him by others that brings him to lasting abstinence – it is what he learns, drills, does and then applies to himself that brings a lasting result.

Elisabeth Reichert, school head

STRUCTURAL FAULTS

The responses to my letter in your May issue are interesting (*DDN*, June, page 22).

Through my own recovery I heard the statement that 'it doesn't work for everyone' and that 'different strokes for different folk' seems to be something that is accepted in the addiction field. Initially I went along with this, more interested in adjusting to life without alcohol.

However I now feel that this is not good enough; flailing around in the dark until 'a cure' can be found that suits the individual, is not good enough. It may seem to be a good thing that there is such a wide range of options but the idea of looking to find an approach which, if not a cure-all, is something that works in general, is ignored or seen as laughable. I appreciate that AA is the most successful approach to weaning alcoholics off the drink, but it is said that only one in ten stays sober.

The other day I was interviewed for a piece of research and was asked what advice I would give to young people about drinking. As much as I was given time to think, there was no answer. Young people are so disenfranchised from the rest of society, what with ASBOs and constant harassment, that I don't think that a simple existential understanding, employed by someone like myself (an old git), is appropriate. The issue of youth in relation to drink and drugs lies more in the attitudes towards youth that have evolved within our society.

In my day (I never thought I would use that phrase) drinking and taking drugs was something we dabbled in for experimentation. Life had other things to occupy us, not least the security of a job. Adults were expected to intervene if they saw a problem with a youngster (*eg* someone in a pub would tell you that you had had enough). No structure like that exists and I feel that the issue around young people cannot be solved by simply going down the therapy path.

Denis Joe, by email

SYMPATHETIC EAR?

While I have some sympathy with Nigel Chambers (*My cannabis diary*, *DDN*, June, page 23) I do not get a sense that he is taking very much

responsibility for his own behaviour. In my experience substances do not tend to administer themselves and unlike those with a physical dependency, Nigel did have a whole range of alternatives and choices.

This is encapsulated for me in '…I also rolled joints for my break time – I don't know how I got away with it'. I am assuming that Nigel 'got away with it' by being a bit sneaky and not 'skinning up' in public? Did a plant make this decision for him? Probably not.

As an aspiring humanist I believe that this article is Nigel's truth about his relationship with cannabis and that this diary may be cathartic for him. However, I feel that he is seeking to apportion blame which I feel won't help him in the long term, especially as this enforces the idea that he is helpless in the face of this 'terrible drug'.

I feel I want to ask Nigel that if there is blame here, where does it end? His father? The drug? Himself? Big G for creating cannabis in the first place?

Nigel, I feel that it would be helpful for you to live in the present and stop seeking to blame. Instead I would like you to celebrate the positives that you are still alive, well, and due to your experiences, free to make different decisions in the rest of your life. Overall, I wish you well and hope you are happy and content in the choices you are making today.
Tyrone Cole, South Gloucestershire

MAVERICK MISCHIEF

Prohibition is not pointless – it has just never been properly applied. However, I do agree with Paul Flynn that he has other very sound viewpoints on the drugs policies of the last 60 years.

I see him regularly at meetings of the All Party Parliamentary Group on Drug Misuse, and he is right that in his quarter century of Westminster service he has witnessed mainly ineptitude and untutored activity devoted more to PR and vote-catching than to handling the addiction problem.

Unfortunately it is a characteristic of the democratic system that we have a change of political policy-makers every few years, so that newly elected ministers are at the mercy of interests in the drug sector who have been exercising their sophisticated trade practices from well before such ministers were even born.

But we have to give credit for the fact that it is the current government's demand for 'lasting abstinence' that has exposed many of the problems Paul has voiced over the years. Today we have the proof that, apart from 12 steps – which succeeds in some 20 to 30 per cent of cases – the majority of treatments fail to deliver lasting abstinence.

This is because, for 60 years, successive governments have relied on so-called 'advice and guidance' from psycho-pharmaceutical interests which recommend 'habit management' and 'harm reduction' because a cured drug addict is usually a lost client.

It is a well-known fact that, because of accessibility and familiarity, publicans, barmen, barmaids and cellar-men are most prone to becoming alcoholics. For similar reasons, we now know that the staff of hospitals and pharmaceutical manufacturers are more likely to be drug addicts than employees in other trades, a condition the NHS cannot cure.

However, addiction to most substances is curable – but only by the addict himself. This means training him in viable self-help techniques, which have been proving themselves for 45 years across 43 countries and in 169 centres, including those run by prison inmates.

Paul is right that PbR is open to huge misrepresentation. Look at all the new definitions for 'recovered' that have recently sprung up!
Kenneth Eckersley, CEO, Addiction Recovery Training Services (ARTS)

BIG SOCIETY – OR HOT AIR?

In response to your cover story highlighting (or rather promoting) Westminster's new integrated drug service model (*DDN*, June, page 8), it appears that such voluntary and statutory sector collaborations are part of the Big Society agenda being pushed by the Tory government.

Quite apart from the ludicrous corporate language used in the piece ('robust, innovative, cross-fertilised, synergised, neighbourhood mini-systems' and such like) these changes are not being made for the benefit of service users but to save money. Yes, commissioners will talk of 'empowering service users' but in reality this is all about budgets and balance sheets. Whilst I accept that peer mentoring/support and service user involvement is crucial to the delivery of services, there is every possibility that such schemes end up exploiting the very people we are supposed to be helping.

If there are jobs to be done, then pay people decent wages to do them instead of relying on volunteers and dressing it up as empowerment. Whilst it's good to see social workers and other specialists working alongside addiction and recovery workers, nevertheless such 'synergisation' reduces costs, not only in terms of wages but also expensive office space. It would be interesting to see how much money the PCTs have saved from their restructuring and whether this will be redirected into frontline services.

At a recent conference, we were lectured by so-called business academics and PCT policy czars that we should regard ourselves as 'social entrepreneurs' and look towards local business leaders as potential benefactors, to restructure and cut out 'dead wood' and 'rationalise', in rhetoric very reminiscent of the last Tory regime.

This 'Big Society/small government' ideology would have us return to the private philanthropy of the Victorian era, where the burden of responsibility to help society's most vulnerable is placed not upon the political executive who can then be held to account, but upon the 'great and the good' who decide who is 'deserving' of their charity. This attitude is reinforced by TV programmes such as *The Secret Millionaire* and *How The Other Half Live* whereby generous benefactors pick and choose 'worthy causes/cases' to help, based upon their own personal political/moral beliefs.

It is this attitude and culture that must be challenged by those of us who refuse to accept this as a suitable model of care. By accepting the 'Big Society' agenda and using the vocabulary of the business consultant, Westminster Drug Project have actually taken us back to the 80s – the 1880s!
Name and address withheld, Merseyside

DEFINITION OF RECOVERY

'To recover' (*Chambers Concise Dictionary*): 1. To regain one's good health. 2. To regain a former and usually better condition. 3. To get back into position. Of course there is the recovery process, but the aim of recovery is to recover, no?

If I have a cold I hope to recover – no sniffles, weakness and thick head. If I have cancer I want it to be gone, completely – no shadows on the x-ray, no secondaries, no comeback. Name any disease or condition and recovery is either full or partial or non-existent.

Only in addiction do we swallow the fiction that methadone, or the freedom from the principal drug of choice or any other partial solution is recovery. We would be being cheated in any other medical field if we accepted that. So let's at least agree terms before we wander any further down the road to La-la Land where recovery means whatever you or I decide it means.
Andy Holt, Papa Stour, Shetland

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.

CONJOINED COMPONENTS

High quality specialist needle and syringe programmes, with motivated, well-trained staff, are an indispensable aspect of a truly recovery-orientated system, says Kevin Flemen

The drugs field is going through seismic shifts at the moment. Initiatives supporting recovery are the centre of attention and form the kernel of the coalition drug strategy, and looking at some conference programmes, reading some articles and listening to some recovery advocates, one could end up with the impression that there was no place within the new agenda for any harm reduction, and that initiatives such as needle and syringe programmes (NSPs) have all but had their day.

It has to be said that not all commentators developing a discourse around recovery share this view. Notably, Stephen Bamber – author of *The Art of Life Itself* – wrote a paper looking at the ongoing role of NSPs within recovery, but it feels as though such voices are at risk of being drowned out by louder, more strident ones.

To my mind, harm reduction measures – like NSPs – which in turn don't support and nurture recovery, are incomplete, as are recovery interventions that don't include elements of harm reduction. In a fit of holistic whimsy I used the yin and yang to illustrate this point at the recent National Needle Exchange meeting in Bristol (*see report, page 8*).

The importance of NSPs in their own right, and as an integral part of any recovery-oriented system, cannot be overlooked. In their own right they have, unquestionably, helped to prevent an HIV epidemic in the UK among injecting drug users (IDUs), and have reduced the spread of HCV. By providing equipment, advice and support, NSPs have been important in addressing overdoses, reducing injecting-related wounds, supporting access to wound care and looking at alternatives to injecting. In short they have done much – quite literally – to help save life and limb.

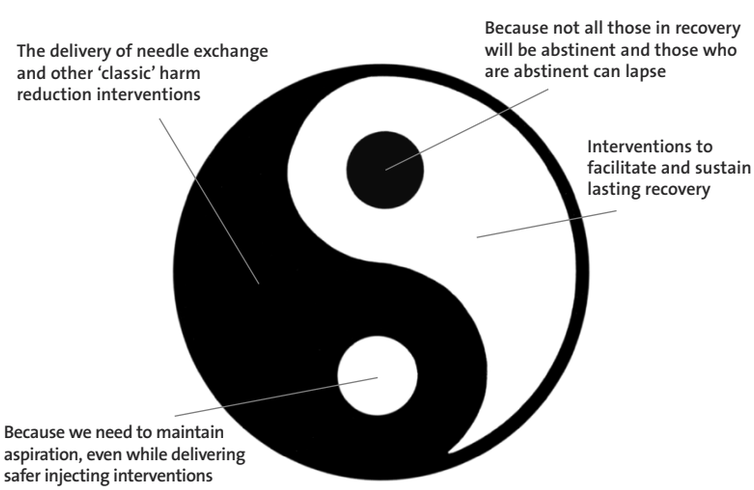
Most needle exchange workers would, however, acknowledge that NSPs – however good they are – can only reduce harm, and not completely prevent it. Given non-sterile drugs, less than ideal injecting environments and limitations in injecting technique and equipment, injectors will still develop complications and the longer injecting goes on, the more likely it is that health will suffer. A move away from injecting towards sustained recovery will obviously remove injecting-related risk rather than simply reduce it – this hierarchy of harm reduction, from aspiration and a reduction of risks such as sharing, on towards cessation, underpinned the ACMD's endorsement of needle exchange in their 1988 report on AIDS and drugs misuse.

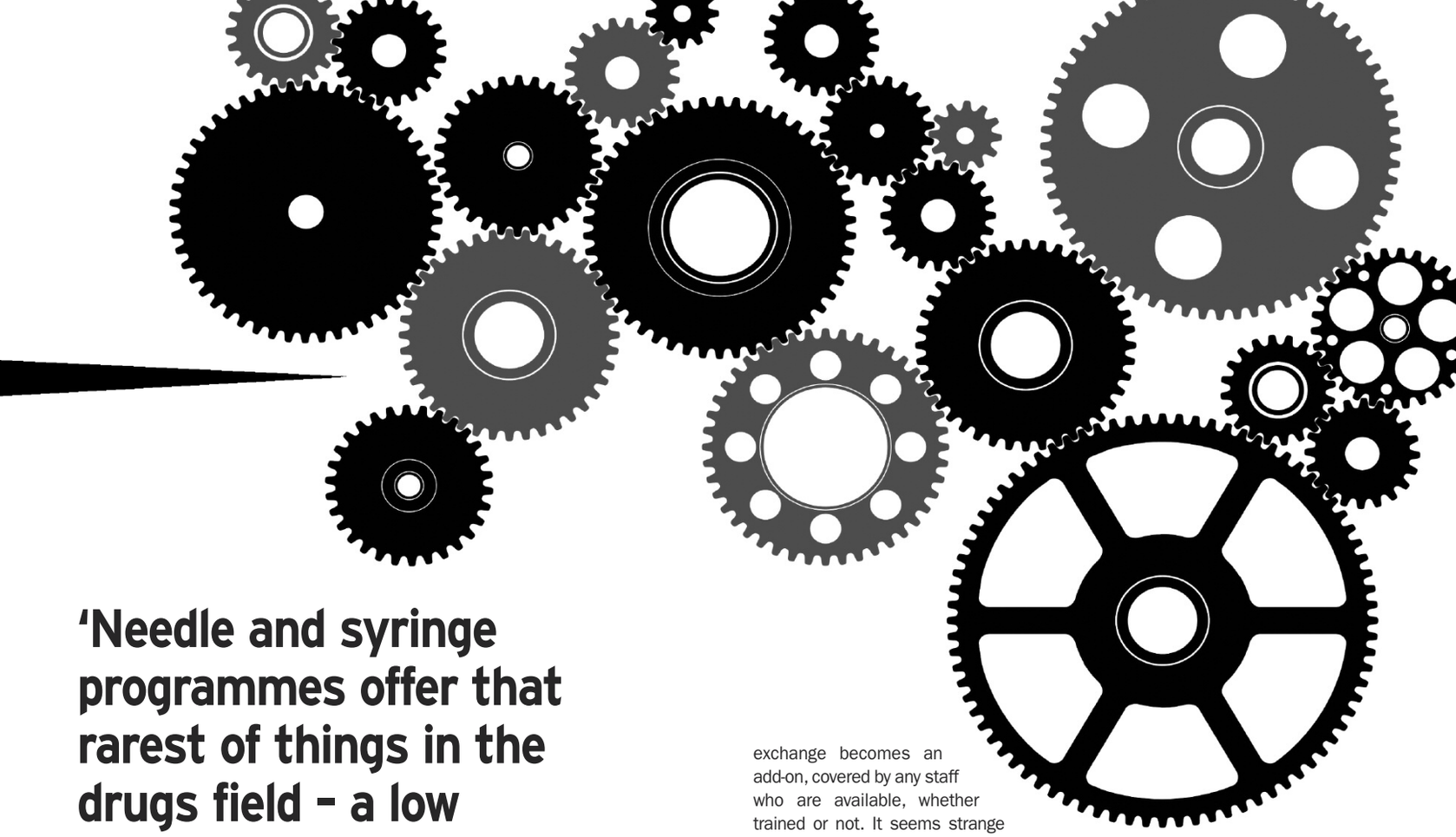
At this point, though, it's important to stress that while NSPs have a specific role to play in reducing harm while injecting, attendance and participation in NSPs can also represent an essential first step on the road to recovery. To attend a needle exchange for the first time and collect equipment is an important step. It may be the first voluntary engagement with professionals in the drugs field, the first disclosure of injecting drug use, and an initial acknowledgement of the risks or negatives attached to injecting and desire to seek help to reduce these risks.

NSPs offer that rarest of things in the drugs field – a low threshold, non-coercive point of access. While the number of access points has increased, many have greater degrees of coercion, for example via the criminal justice system. Others require the person to be further on in the cycle of change, and ready for structured treatment or to stop using.

The use of NSPs can reflect an ongoing inner desire to exercise some control over drug taking and to reduce risk to self. Given that use of NSPs can both reduce harm to injectors and provide a route to other interventions, it seems strange that they are not more widely celebrated among those advocating recovery, and there can also sometimes be a level of 'myopic hindsight' – a clear recollection and celebration of the intervention or person that helped someone stop using or achieve recovery, but less acknowledgement of the interventions that may have helped them stay as safe as possible when they were still using.

It is not, of course, a one way street, and some workers in NSPs are as resistant to recovery as some recovery advocates are to NSPs. NSP workers seek to reduce harm to people who inject drugs, so unwillingness on the part of some harm reductionists to acknowledge that supporting a move towards not using is





'Needle and syringe programmes offer that rarest of things in the drugs field – a low threshold, non-coercive point of access.'

the safest option is unfortunate, to say the least.

Acknowledging the role of NSPs in the context of recovery is well and good, however, but it doesn't acknowledge that not all NSPs are the same and some will integrate better into recovery-orientated services than others. Models that merely provide greater coverage may not be placed to help people move in to treatment.

NSPs should, of course, succeed at providing an accessible service distributing the required volume of equipment to minimise the need to reuse or share equipment. Reviews of the existing evidence by NICE demonstrate the effectiveness and cost effectiveness of NSPs to reduce the spread and incidence of HIV among injectors given sufficient geographical coverage and adequate distribution of equipment. However the same research highlights that simply providing adequate distribution is less effective at reducing the spread of HCV and highlights the need for other interventions, such as support to access testing, HCV treatment and opiate-substitution therapy (OST). On this final issue – the role of NSPs in promoting access to OST – the NICE report highlights the paucity of evidence to demonstrate that NSPs can act as a conduit towards structured treatment.

The lack of this evidence base is hugely unhelpful when it comes to demonstrating the role of NSPs in a recovery oriented integrated system. We know anecdotally that it happens, but there is a dearth of clinical evidence. What we do know, however, points to the quality of the intervention in NSPs being important. Informed, educated and empathetic staff, with space, time and privacy to engage well with their customers are essential. When the NTA reviewed the situation in 2005, some 80 per cent of provision was pharmacy based – in such settings, the NTA noted that face-to-face harm reduction and referral to structured treatment took place in less than 50 per cent of DAT areas who provided information to the study.

There are clearly advantages to a 'mixed economy' of specialist needle exchange and pharmacy needle exchange provision. While some pharmacy exchanges are exemplary, ensuring all staff are trained and that injectors are offered space, time and privacy, this isn't always the case. All too often exchanges are very quick, with little space or time for interaction and by staff who have often had minimal training.

In truth, this is sometimes the case in dedicated drugs services too, where needle exchange becomes an add-on, covered by any staff who are available, whether trained or not. It seems strange that counsellors who may not have had any needle exchange experience are expected to step in to 'cover' needle exchange, while it would be unacceptable to expect needle exchange workers to step in for a couple of counselling sessions were the counsellor on annual leave!

We are in a period of huge upheaval. The colossal financial cuts that organisations are facing come at the same time as the structural changes which will see directorships of public health within local authority control, and all this takes place against the backdrop of the ideological change that is the recovery agenda. The risk in times of austerity is that specialism will be sacrificed for coverage and, in the short term, pharmacy exchange will be seen as the cheapest way of providing coverage.

This short-term economic advantage doesn't recognise the extent to which pharmacy exchanges are less well placed to undertake the additional interventions that specialist services should be able to offer injectors. Given such short-termism, we will struggle to develop NSPs and gain the evidence needed to 'prove' the efficacy of NSPs as a stepping stone to recovery.

What we should instead be developing are NSPs that maximise the quality of interventions. Trained, motivated staff, space, time and privacy are of paramount importance, as are clear, proactive pathways that provide motivation towards, and hand holding into, structured treatment. The latter need to be carefully balanced against overly pushy services that could deter injectors who are not contemplating more structured treatment.

While the role of people in recovery as mentors, advocates, volunteers and workers is becoming more widespread in the latter stages of treatment journeys, it has so far not been so common in arenas such as NSPs. But with properly trained and supported individuals, aspirational representatives of recovery can provide an essential bridge from harm reduction interventions through to more sustained change. Such high quality NSPs, backed up by proper monitoring and evaluation, will do much to demonstrate the cost effectiveness of NSP, not just as a way of preventing the spread of BBVs but as the primary voluntary pathway in to treatment for injecting drugs users.

So the cry must go out to those commissioning services – and those who work or volunteer in any of them – whether harm reduction or recovery oriented: high quality, specialist NSPs, properly resourced and trained, are not a mere add-on or yesterday's game. They are an essential, indispensable aspect of a recovery-oriented integrated system. A failure to recognise this and invest accordingly will see an increase in BBV transmission in the UK, and inhibit our ability to support people to achieve their recovery. **DDN**

Kevin Flemen runs KFx, a service that provides an information website, training and resources to those with an interest in drugs. For more information visit www.kfx.org.uk or email kevin@kfx.org.uk

OFFENSIVE TA

With reoffending rates in Britain remaining stubbornly high, **DDN** hears about a programme in the Midlands that's achieving impressive results through intensive one-to-one sessions with substance-using clients

Ken Clarke's tenure as justice secretary has not been without its controversies, to say the least. One has been his proposed 'rehabilitation revolution' – an attempt to tackle reoffending rates among prisoners and reduce the prison population by 3,000. While the right-wing press might accuse the Tories of going soft on crime, and the left accuse them of trying to privatise the criminal justice system by stealth, most people would agree that something needs to be done to cut Britain's high levels of reoffending – last year the Ministry of Justice revealed that fourteen prisons in England and Wales had reoffending rates of a staggering 70 per cent and above.

Rugby-based treatment agency Swanswell has developed a 12-session pilot programme, *Reducing drug-related offending*, which it says could easily be adopted by other services and rolled out nationwide. The programme uses structured one-to-one sessions focusing on subjects like triggers for offending and how to avoid risky situations, and aims to make clients understand the links between their substance misuse and their offending behaviour.

The amount of money participants spent on drugs fell by more than 70 per cent compared to the period before treatment began, and the organisation says linking illegal drug spend with criminal activity to finance it is a useful way of monitoring reoffending. Swanswell claims that if the programme were adopted nationally the saving to the public purse could be as much as £2.4bn, based on the estimated £15.4bn annual costs of drug-related crime in England and Wales.

'Reducing drug-related offending also ties in perfectly with payment by results... You can demonstrate what you do, and see the rates of success as you do it.'

The pilot began around 18 months ago and involved 360 people with drug problems, around 80 of whom were prolific and priority offenders (PPOs).

'We do a lot of work with PPOs in Birmingham, and also with criminal justice teams, so we were going into probation offices doing our work reducing drug use,' says Swanswell's director of services, Chris Robinson. 'What we realised was that if we combined looking at drug use with offending – if we had something more structured – then perhaps we could make a difference, so with the agreement of probation we said "we'll still come in and do what we need to do, but we want to do it in a more structured way", and they said "by all means".'

The police and probation services were closely involved from the start, and Swanswell made sure staff were fully trained to give them a proper grounding in the programme before it began. Other session themes included harm reduction, analysing the hierarchy of needs, understanding sabotage – 'how you or others might disrupt treatment' – and looking at the 'gains and losses of offending', with overall attendance rates an impressive 73 per cent – 23 per cent more than Birmingham DIP's 'required assessment' (RA) programme.

The completion rate was 67 per cent, almost double that of the DIP RA programme, with quantitative data collected at three-week intervals throughout the pilot and qualitative data gathered by a researcher from Birmingham City University in partnership with the police, probation and DIP. There were also frequent opportunities for clients to provide feedback, with many reporting that they felt less inhibited talking to a Swanswell drug worker than they did talking to probation or police officers.

'After the initial pilot we said we'd have a look at what worked and what didn't and just review it,' says Robinson, with a more central role now planned for carers and clients' social networks. 'We've done a lot more work on developing the stuff that they do in between the sessions – the homework, if you like, the stuff they go away to think about and bring back to the next session.'

The structure of the programme will also be modified, she says. 'It was originally the 12-week programme, but we worked out that it was better to do it as a core of eight sessions which everyone will get, and then tailor an additional four sessions to whatever drug they're using at the time, rather than go to all sorts of drugs that they're not actually using. We're going to be rolling it out on a bigger scale based on what we've learned – we're keeping the 12-week programme but we're making it more focused to the individual.'

Nearly 70 per cent of those invited to join the programme accepted the offer – up almost 20 per cent on a previous Swanswell programme – with 94 per cent rating the sessions either 'good' or 'average'. At the end of the pilot, just over 15 per cent of participants whose case had been closed (176 people) were completely drug free, while a further 5 per cent reported only occasional drug use. While these might not seem hugely impressive statistics on their own, Robinson points out that the sessions' focus is reoffending. 'And don't forget people are connecting with drug treatment services as well,' she says. 'It's tied in with the way services are delivering the recovery agenda, where being drug free is something you should be thinking about at the start of your journey, and that's something I think we'll see go up if we do a bigger pilot.'

The new programme will run for six months, with Swanswell again gathering data throughout. 'We'll be looking at the differences in offending rates and that connection into the recovery model, using a lot more stuff around social and peer groups and getting them into other things after they've engaged with us. Originally you did the 12-week programme and then just sort of carried on with your probation officer, but we're looking at setting up peer support groups and things like that in the community, so there are things to move on to once you've finished the 12-week programme to keep up the good work.'

Reducing drug-related offending also ties in perfectly with payment by results, she believes. 'You can demonstrate what you do, and see the rates of success as you do it.

'What we're clear about is we're not just designing something for use internally – it can be easily replicated in other organisations, so potentially anyone can do it. We can show them how to do it, but we needed to try it out first, which is what we've done. The whole idea is to offer it up nationally when we've finished the even bigger pilot, so we have more of an evidence base, rather than us just saying "yes, it worked really well".' **DDN**

For more information on the programme contact chris.robinson@swanswell.org

ALK

Pictured: Swanswell workers Keisha Dell, senior practitioner, and Stuart Haste, criminal justice referrals and allocations co-ordinator, have been involved in the reducing drug-related offending pilot.

FRANK'S STORY

'I never expected it to lead down the road it did,' says 43-year-old Birmingham resident Frank of his cocaine use, which eventually cost him his house and well-paid job. He was spending up to £400 a day on the drug and drinking heavily at the same time, quickly burning through his £20,000 savings. His employers realised something was wrong and allowed him to take some time off, but he chose to resign and carry on using. He sold his two cars to pay for drugs and allowed his mortgage and bills to go unpaid for months, before things finally spiralled irrevocably out of control.

'One night, while under the influence of alcohol and cocaine, I got in to an argument with some lads on a night out in [Birmingham]'s Broad Street, got in a fight, and basically got arrested, kept in overnight. I just remember waking up, I didn't know where I was – then I looked around, heard keys shaking, people talking, and I thought, "I'm in a police cell. I wonder what I've done?"'

His solicitor informed him that he'd been charged with two counts of ABH and a threat to kill at knifepoint, but that he had a chance to plead not guilty. 'I said no. He said, "are you sure?" I said yeah, yeah, because it started to come back to me what happened. And I thought my life had been such a mess anyway, the fact that I've got myself in this situation now. Words cannot describe how low it was, and going through that at the time, I never thought there was any way out. All I thought was if I was dead I was better off, and I thought that every day.'

In September 2009 he was released on two years' probation and a one-year suspended sentence. His house had been repossessed while he was on remand, and he was now £45,000 in debt, but his probation officer referred him to the Swanswell programme via DIP. 'I've always thought that I had to change, but this time I knew that I had to do it with some kind of help,' he says. 'We had a lot of one-to-ones and covered trigger factors and the cycle of change, and how drugs affected the brain. It was important because when I used to take it, I didn't know what it was actually doing, I just knew it made me feel good. But being able to see it and know what was going on, it gave me a bit more of an understanding and that helped me stop as well.

'I have been studying for nearly a year now and coming to the end of my course. This is what we discussed while under Swanswell – that I could go to college. I feel happy that I'm getting distinctions in all of my assignments and starting voluntary work as well, and this is going to equip me with the tools I need to progress further in the field of being a drug worker.

'After going through the Swanswell programme, and doing my studying, and mixing with positive people, my life has turned right round and I'm actually more confident than I've ever been, because I'd been through something hard and have managed to beat it and get through it. So that shows me my capabilities, and I think the sky's the limit now and I don't think there's much that will stop me going forward.'

'I'm actually more confident than I've ever been, because I'd been through something hard and have managed to beat it and get through it. So that shows me my capabilities'

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Children who watch their parents drinking are twice as likely to binge on alcohol, according to the Rowntree Foundation. But they're also more likely to drink when left unsupervised, its new report warned gravely. So the best way to bring up your kids as happy and balanced teetotallers, we should infer, is to linger in their presence indefinitely, swigging from a carton of orange juice.
Harriet Walker, *The Independent*, 18 June

War on drugs latest. The vicious persecution of innocent dope-smokers continues, or does it? William Marsh, caught with nearly one pound and two ounces of cannabis (worth £5,000), plus a set of scales, received a suspended prison sentence, plus some community service, meaning he was let off, at Liverpool Crown Court. This was despite five previous convictions, including one for cannabis possession. Official guidelines now say this great lump of poison is a 'small quantity'.
Peter Hitchens, *Daily Mail*, 13 June

I would suggest that getting a drug-dealing father away from a little girl whose mother he has battered could be seen only as a positive step, unless you are a law-making Eurocrat who ignores the views of victims and focuses on how to help the cheats who laugh all the way out of our courts.
Frederick Forsyth, *Sunday Express*, 19 June

It is easy to see how Mr Cameron, driven to profess his 'love' for the NHS as if starring in a clinical rom-com, found himself in this mess. The Lansley reforms are merely an acceleration of the silent shift to marketisation, and thence towards privatisation, begun in 2004 by Tony Blair and Alan Milburn. Belatedly, health professionals have raised the alarm, and voters are afraid.
Mary Riddell, *Daily Telegraph*, 6 June

Ah, Lansley. Damp tinder. He is the anti-matter of ignited paraffin. Those physics boffins in Geneva should stick him in one of the vacuum chambers and study him....'We're going to focus on outcomes!' declared Mr Lansley, to all sorts of cheers from the Tory backbenches. Outcomes, eh? Good-oh. They sound our sort of thing. But what does this mean?
Quentin Letts, *Daily Mail*, 8 June

Astonishingly, no one reads history. Cameron and his colleagues have fallen victim to the syndrome that has afflicted every attempt at NHS reform. Those in 1974, 1982, 1990, 1994, 1997, 2002 and 2007 all had the same objective, to devolve power from the centre, restore local professionalism and institutional leadership, and introduce choice and competition. Each did the opposite, by increasing the overhead and raising the tempo of political controversy. Each replicated the mistakes of the last. Yet no one stopped to ask why.
Simon Jenkins, *The Guardian*, 7 June

LEGAL LINE

'CAN I TAKE MY METHADONE ON HOLIDAY WITH ME?'

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

Reader's question:
I am going on holiday to Spain next month and am worried about taking my methadone while I am there. Am I allowed to bring it with me? I can't manage without it but I don't want to get held up at customs – will they take it away from me? Please help.

Kirstie says:
When going abroad with medications there are two issues to consider – the exportation of it from the UK and the importation into your destination. If you are only going on a short holiday you will be able to get through UK customs with your methadone simply by carrying a letter from your prescriber which confirms your personal details, dates of travel, country of destination, the drug prescribed, the dosage required and the total amount needed for the period of the trip. If you are travelling for more than three months you will require a personal licence which can be obtained through the Home Office (www.homeoffice.gov.uk/drugs/ licensing/personal/).

It is recommended that you carry any medication in your hand luggage. However you will still need to comply with the airline's rules on carrying liquids in hand baggage – if the amounts you are bringing exceed the allowances, you will have to put the methadone in your checked baggage. This may cause difficulties if your luggage is lost or delayed. You could speak to your prescriber about the possibility of changing to medication in tablet form for the duration of your holiday so that there are no issues with carrying liquids.

'Every country will have different conditions to satisfy, to enable medication to be brought into the country.'

Every country will have different conditions to satisfy, to enable medication to be brought into the country. Spain requires that the letter from your prescriber must be certified by a Spanish embassy or consulate – you should contact them as far in advance of travelling as possible (http://spain.embassyhomepage.com/).

If you are still concerned about taking your medication with you, there is also the possibility of getting substitution prescribing at your destination. This service is offered widely in Spain and can be arranged through your prescriber. A treatment service near to where you will be travelling to can be located and arrangements made for you to receive medication while you are there. Your prescriber will have to provide all of the necessary information to their Spanish counterpart to ensure you receive the correct treatment.

The requirements for every country will be different, so if you want to travel anywhere else you must check with the relevant embassy or consulate before travel. Some countries, for instance Pakistan, will not allow the importation of methadone under any circumstances.

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

For more information about travelling with medication, contact the Release legal helpline on 0845 4500 215.

Community AC

Despite all the rhetoric and opportunistic allying, the genuine recovery movement will rise from – and be sustained in – communities, says **Alistair Sinclair**

What is the 'recovery movement'? The term is used by all sorts of individuals and groups with a vested interest in 'recovery'. However, most of the 'leading lights' in the 'recovery world' come from treatment, or organisations with very close links to treatment, which raises some important questions.

Is the recovery movement situated within treatment, or is it primarily situated within the wider community? Do we have a recognisable recovery movement, or do we have a lot of very disparate groups and individuals? Recovery communities have existed in the UK for a long time and mutual aid groups can be found in most areas – do these communities and groups self-identify as being part of a recovery movement? Can treatment actually 'build' recovery in the community – is it an either/or proposition? And, if the movement does principally sit within communities, why don't we hear more from voices of recovery in these communities?

There's movement within treatment towards a 'recovery orientation'. However I think there's still limited knowledge of recovery's historical roots within the substance and mental health field, with many unclear as to what recovery means within the context of service provision and within the community. There's still a need to identify and clarify the core values and strengths that underpin recovery orientation within treatment, and significant work required to develop recovery-orientated standards.

What of the wider recovery movement – what is it and where is it? If we accept that the recovery movement is a social/civil rights/grassroots movement that concerns itself explicitly with political advocacy, I think we must also accept that it will only be generated and sustained in communities by people who are recovering and in recovery, and their allies. How wide they stretch these terms will be up to them. Where are their 'leading lights', where are their voices heard? The UK Recovery Federation (UKRF) believes there is a need to find and support new voices within services – because treatment does sit within communities – and within the wider community. We believe it is these new voices – alongside current activists – that will articulate, define and shape the UK recovery movement.

So what is the UKRF doing to support the emergence of a distinct UK recovery movement? Last year I wrote a piece that suggested that while mutual aid (in its widest sense) was a core component of the wider recovery movement, we hadn't established a unified recovery vision and language that was acceptable to all (*DDN*, 13 September 2010, page 14). It's the UKRF view that recovery can only be 'owned' by individuals and communities and they will define its terms. As recovery sits within individuals in their lived environments, and is built through our strengths, passions and connections to others as human beings, there is a need for new community-based recovery networks that will bring people in recovery and recovering, and their families, friends and allies, together.

The formation of new diverse networks – built around strong recovery principles and an asset-based approach – will define and shape the recovery movement, and this movement will find its strength, voice and direction in diverse and inclusive communities. These communities need the active support of recovery-orientated services but will define their own agenda as they identify and develop their recovery capital. In the article we proposed the establishment of five regional recovery networks in the north-west and said that we would be holding a conference in Preston in September, in partnership with the NTA, to promote this, our 'big idea'.

Since last September the 'big idea' has got bigger. Independent of the UKRF, two new recovery federations initiated by Mark Gilman of the NTA – principally through Wiredin – were established in Greater Manchester and Cheshire. The UKRF has supported the establishment of a Merseyside Recovery Network and this network has embraced the UKRF recovery principles (as have the Lanarkshire Addiction Recovery Consortium in Scotland and other groups) and a strength-based approach. Around 40 people attended the last meeting of the Merseyside network, and over the last three months we've focused on the mapping of individual strengths and the assets of local associations and institutions.

This mapping will determine what the network decides to do while at the same time identifying new opportunities within the community for people in recovery and recovering. The next Merseyside Recovery Network meeting will focus on the building of new relationships across the Merseyside area. It's our view – echoed in work by the RSA in its Connecting Communities Project and Whole-Person Recovery Project (*DDN*, 6 December 2010, page 18) – that the facilitation of access to diverse new connections generates and sustains recovery.

The Merseyside Recovery Network brings together people from abstinence-focused traditions, harm reduction and others in recognition of the fact that 'recovery transcends, whilst embracing harm reduction and abstinence-focused approaches and does not seek to be prescriptive' (UKRF recovery principle). The UKRF wants to support individuals within the Merseyside Recovery Network to become recovery community organisers (RCOs) – people trained (drawing on their lived experience) in values-based and asset-based approaches and enabled to support others in the development of new recovery networks and communities.

'Empowerment happens when a person who is seen as the problem begins to see themselves as part of the solution'
Saul Alinsky

The UKRF supported a major event in the south-east in April when recovery community members came together with service providers at the Guildhall in Portsmouth to begin to explore strength-based approaches and the beginnings of new relationships founded on our similarities as human beings. The event, organised and facilitated by people from the recovery community, led to the formation of the South-East Recovery Network, and this network will be hosting the 2012 UK Recovery Walk in Brighton. A smaller-scale event in Bedfordshire took place in June, organised by Bedfordshire DAAT and supported by the UKRF, and a Bedfordshire Recovery Network is now going to be established with SUSSED (a

TION

local service user-led group) at its heart.

The UKRF is also in discussion with recovery community members in the London boroughs of Kingston (RISE) and Camden (Camden Frontline) and presented a proposal for a London Recovery Network at the London User Forum in June. Lancashire will soon have its own recovery network and a north-east recovery network is likely (alongside the east Midlands) in the near future.

The UKRF envisages a time when there will be recovery networks in every region of the UK – every locality, every city and every town. Diverse and vibrant, they will be reflective of their membership, but bound together through shared values, a commitment to the equality and potential of human beings, and the growth of the strengths that every person has.

Recovery networks are growing and they are spreading. People are coming together to support each other, identify and access new opportunities and mobilise for change. With strong social justice principles at their heart, these networks are beginning to connect with each other, often through relatively new media like Facebook. Where once people and communities were isolated and alone they are beginning to reach out past old boundaries to shape new identities and make new friends. The UKRF has forged new links with abstinence-focused and harm reduction focused groups and individuals to facilitate this process. It's a beginning. The recovery networks we see emerging welcome all those who seek to recover – as they define it – and are working to build something new within their communities.

At our conference in Cardiff on 9 September we will bring many people from these networks together to explore how we can continue to support the new recovery movement through the development of new inclusive and diverse recovery networks and the establishment of recovery community organisers. We will also be discussing and debating a UKRF recovery consensus statement that will reflect where we believe recovery lives – within communities and individuals and grounded in a commitment to the challenging on inequality and injustice.

The recovery movement can support agencies in developing recovery-orientated services. We believe recovery networks have a significant role to play in public health responses to unhealthy dependencies in individuals and communities, on individual, cultural and structural levels. However we believe the new recovery networks will principally focus on advocacy for those that are recovering and in recovery and on the building of new cultures of recovery within our communities.

We hope that as many people as possible will stay in Cardiff for the third UK Recovery Walk on Saturday 10 September. We will be celebrating the achievements and strengths of people in recovery and recovering, and the people that support them, coming together in solidarity and friendship. It's our intention that the UKRF conference and the third UK Recovery Walk will play a significant role in celebrating and supporting the many new faces and voices of recovery in the UK. Many of those who come to Cardiff in September will play a significant part in the evolution of the new UK recovery movement. It will rise from communities, and in communities it will be sustained.

We make the path by walking it. **DDN**

Alistair Sinclair is a director of UKRF

Change at the top: Dr Chris Ford with SMMGP colleagues at this year's conference, including new clinical lead Dr. Steve Brinksman

CARRY ON DOCTOR

Dr Chris Ford, star of DDN's much loved Post-its from Practice column, is staying on as a GP but retiring from her post as clinical lead of SMMGP, the organisation she set up 17 years ago. She talks to **David Gilliver**

'It's a job that I've enjoyed absolutely every minute of,' says Chris Ford of her decision to retire as clinical lead of Substance Misuse Management in General Practice (SMMGP), the organisation she set up in 1995. 'I love it to bits, but I've reached 60, I work six or seven days a week, and I felt I needed to make some changes. I've got about four jobs, and this was the one that was taking up the most time.'

She also felt it was 'time to let someone else take over', she says, while the organisation was in a robust state. 'It's a time when we've got a really healthy financial situation, a great team and we're really established. The person who's replacing me is a bit like me, but different enough to really take it forward, so I feel it's really in safe hands. It's best to go at a healthy time.'

She'll stay on as clinical director for SMMGP partner organisation IDHDP (International Doctors for Healthy Drug Policies), and is also keeping her 'day job' as a GP and partner at the Lonsdale Medical Practice in north west London, where she's worked since 1987, a time when drug treatment was something that very few GPs had much to do with. 'The involvement of GPs when I started was 0.2 per cent,' she says. 'There was only me and one other GP in the whole area who actually saw people.'

It was the lack of any real guidance for those that did want to get involved that was behind the decision to set up SMMGP, she says. 'As a GP in training I'd worked in a practice where they'd sort of said "you can look after their abscesses, but don't work with drug users because they're not very nice and it's too complicated". Then at the practice I went to afterwards as a partner I had someone come in in the first week who'd been sent away by the local drug service – he was 16 and he came with his mum. I said, "I'll see if I can help you. What would you like?" He said, "I don't know – I've heard that methadone's helpful".'

It was 'very much a case of he had a problem and we came to a solution together', she says, something that has defined her life as a GP working with people with substance issues. 'He told his friends, and they told other people, and then a whole tranche of people started coming, and there was an immediate trust between us. I didn't try to say "bog off", because I didn't think that was the right thing to do in general practice. I feel incredibly fortunate that I've learned everything off people who use drugs, and also have been trusted by them, so we learned together.'

Her practice began seeing patients deemed too problematic by the local drug service, and a realisation that there must be other GPs in a similar situation led to SMMGP's decision to hold its first conference, at the Royal College of General Practitioners (RCGP). 'That was 17 years ago,' she says. 'We thought we'd have a few mates – you were only supposed to have 60 people in there at that time, but we sold 100 tickets very quickly. We realised we'd really tapped into something and that other people were having the same problems.'

At the time this was partly because 'all the literature was very psychiatric-based', she says, and one of SMMGP's aims is to help develop the evidence base for effective treatment in primary care, alongside promoting training and user involvement. 'SMMGP has always been a network that supports and trains

people, but everyone is equal – we get solutions from each other. No one is seen as the boss or as having more value than anyone else, and I think that's what its energy has been. The second conference was bigger, and the third was even bigger and so it goes on. We also thought that not everyone would be able to come, so we we'd have a newsletter to go with it.'

They hand-wrote and posted hundreds of envelopes containing the first newsletter – a single A-4 sheet put together on her home computer, which has since evolved into the highly regarded *Network* magazine. The next unmet need the

'I feel it's really in safe hands. It's best to go at a healthy time.'

organisation decided to address was for effective training, she says, 'which is where the RCGP certificate in drug dependency part one and part two came from'. She contacted Clare Gerada, now chair of the RCGP council but at the time working in drugs at the Department of Health. 'It was the right person at the right time,' she says. 'She introduced the course and part one is now seen as the standard training for GPs. Something like 14,000 people have done that, and it's very good.'

Having come so far, does she worry about the negative views of prescribing being voiced at the moment? 'We're in changing times,' she says. 'Since the new government, and the new strategy, there is a real swing, but I think we have to see it as an opportunity. If we don't hold on to the recovery agenda and talk about medically assisted recovery as well as abstinence-based recovery, I think we'll lose the game. While there might be some GPs who might stick a prescription out and don't really do much else – there are some people who perhaps haven't had all the input they should have had – we have to be careful that we don't throw the baby out with the bathwater. We have to look at how we can help people to make a change – but that may be medically assisted medication and not necessarily abstinence.'

A crucial issue shaping the debate at the moment is the way data is collected and used, she maintains. 'We're not very good in primary care at data collection, so data collection is being used against us. What's happening is that the NTA and/or commissioners are using data collected under the old system to look at the new system – they're collecting data about apples and using it for bananas or pineapples, and you can't do that. So now you have some people saying "methadone and GPs, bad; abstinence, good", based on absolutely crappy data.'

The wider health reforms and GP commissioning also represent both an opportunity and a threat, she says, and she has anxieties about the potential consequences of increased third sector involvement in the field. 'I'm very much into patient-centred care – I see people as a person, not as a drug, and I have a concern that a lot of commissioners are more worried about cost than quality. I think payment by results could fall into that, with third sector organisations cherry-picking people with problems that can be cured easily. I deal with people with severe, enduring mental health problems, alcohol problems, hep C and so on, and I support them to be as well as they can be.

'So if I was doing payment by results, I wouldn't be paid very much,' she laughs. 'If you start off looking at people as a problem, as baddies who create crime, you're never going to see them as people with health needs.'

It's this that also makes her adamant that the best place to treat people with drug and alcohol problems is general practice. 'If you're diabetic and you got too complex for me I'd send you to a man or woman down the road, but you'd still stay my patient. I think the way people are compartmentalised off to specialist drugs services is really a negative thing – I blame psychiatry. People should be in general practice, with the support of other agencies. I know we can't rewrite history, but we can change it.' **DDN**

Post-its from Practice

Bottling it up

Always ask about alcohol, says Dr Chris Ford

BRITNEY BURST INTO MY ROOM yesterday and before sitting down she said she needed a letter for court, adding 'I'm the victim you know, not on trial!' I replied that she could have her letter but would she mind sitting down to tell me why she needed it. She sat down, instantly becoming a shy, vulnerable, frightened girl, and told me it was her father who was on trial for physically and sexually abusing her. She was due to give evidence that day and could not face seeing him.

Now just 17 years old, the abuse had started when Britney was 12 and continued until aged 15. Leaving home about a year ago, she has been living in supportive housing and sees a support worker and a therapist weekly. She admitted that it was tough and she often felt disconnected. I asked her about drinking and smoking. She casually responded that she drank at least four half bottles of vodka per week and smoked 30 cigarettes a day. Asking her about other drugs she said she would 'never do those'. We worked out together that her units amounted to at least 60 per week and I enquired if she was working on this with her therapist. She answered that no one had ever asked before, therefore she hadn't mentioned it.

Britney went on to say that alcohol was the only thing that made her feel better as she tried to forget. We discussed the pros and cons of drinking and she was insightful about how it might negatively affect her mood.

I asked if she wanted help to address the problem and she said that she would discuss it with her therapist and see how she got on. She asked if she could return if he wasn't able to help and I reassured her that my door was always open.

As a nation our alcohol consumption has been rising for decades and, with that, the harms associated with this consumption. But it's more complicated in young people. The proportion of people aged between 11 and 15 who reported having drunk alcohol decreased, but the amount they reported drinking increased from just over six units per week in 1994 to close to 13 units per week in 2007. Many teenagers are admitted to hospital every year for alcohol-related reasons and in one survey, one in five teenagers admitted to drink driving.

Drinking alcohol can also make teenagers forget about safer sex. Starting drinking as a young person can result in a greater risk of developing long-term health conditions in later life. Deaths from liver disease have risen sharply in the 25-34 age group over the last 10 years and this is thought to be a consequence of increased drinking that had started at an earlier age. Underage drinking can also cause problems with mental functioning, as the brain is still developing.

Britney has been drinking at this level for about a year and seems keen to address this issue, so I'm hoping that she can reverse the damage done so far. I really like her, and view her as a survivor – but I'm so glad I asked the question. How many other young people are consuming unsafe amounts of alcohol, remaining undetected and without support?

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

Questions and Answers

Last issue Derek wanted ideas to help clients quit smoking...

I enjoy a reasonable level of success treating people for their drug and alcohol problems, but the one addiction that the majority of my clients (and many of my colleagues) maintain is to cigarettes. While it is not their primary reason for presenting to our service, I feel I should offer some sort of intervention. Does anyone have suggestions on how to do this and what's available? *Derek, by email*

Natural treatment: I saw this article and thought it useful. It's from *Tips on treating nicotine addiction naturally* by R T Shelly:

- 'Nicotine products can definitely help to reduce the craving and severe withdrawal symptoms you feel when you try to stop smoking. Control the craving without the nicotine with natural cures to quit smoking.
- 'Cold turkey – this good old standby sure won't cost you anything except maybe a bag of candy to pacify the urge to put something in your mouth.
- 'Hypnotherapy – hypnosis creates an altered state of mind causing a person to become more susceptible to suggestion... it isn't for everyone.
- 'St. John's Wort is a natural remedy used primarily for depression, but has been found helpful to control anxiety when withdrawing from nicotine.
- 'Acupuncture can be used as an alternative approach to stop smoking. [It] can help curb withdrawal symptoms and cravings.
- 'Recently, medical science has confirmed that many of the herbs used treating nicotine addiction naturally are effective in helping to control and prevent a range of symptoms as well as the craving associated with withdrawal.'

The article source is http://EzineArticles.com/1649841

Darren Heslin, director, Train To Enhance Ltd, www.traintoenhance.com

Alternative measures: The only way to avoid the health risks associated with tobacco products is not to use them at all. However, in addition to cessation and prevention efforts, some public health policymakers are considering a broader approach to tobacco harm reduction to help those who are unable to quit. This involves pragmatic measures, such as providing safer alternatives to cigarettes.

Using smokeless snus (very popular in Sweden) is acknowledged by several independent health experts to be at least 90 per cent less harmful than smoking cigarettes. Snus is not smoked. It is finely ground moist tobacco that comes either loose or in pouches – a bit like tiny tea-bags – that are placed under the upper lip and held in the mouth for about an hour before being discarded. In manufacturing snus, it is heated in a process similar to pasteurisation. This reduces the formation of nitrosamines – chemicals that are potentially carcinogenic and have historically been found at relatively high levels in other forms of oral tobacco, such as some types of chewing tobacco.

Snus releases about the same amount of nicotine as a cigarette, so it is assumed that some snus users would be defined as being dependent. However, it's the smoke generated from burning tobacco that presents the serious risk to health for smokers. Nicotine is a stimulant, like caffeine, that can cause dependency and has effects on blood pressure.

Snus is banned in the EU, but Sweden got an exception when they joined.

Dr Chris Proctor, chief scientific officer, British American Tobacco

Do you have a question about any aspect of your working life or treatment experiences? Send it to claire@cjwellings.com and let other readers help you

MY CANNABIS DIARY

In the fourth part of his story, Nigel Chambers tries to access drug treatment services

I BEGAN TO REALISE that drugs were a mask, covering up what was going on in my life and the chaos in my head. I had tried to access drug treatment services in Middlesbrough for about eight or nine years, but there was not a lot of awareness out there about cannabis addiction.

I was crying out for help but was turned away by several services because I did not have a crack or heroin addiction and they could not see that I had any issues. I just didn't fit into the criteria that had been set by the system. All they could do was to tell me to go to my GP to see if he could help in any way.

My GP has always known about my story and I have nothing to hide so I told him what had happened with the services over the last couple of weeks. Again there was no substitute for my addiction, so my doctor prescribed me tablets that are prescribed to alcoholics – I was willing to try anything now to get me into recovery. I only took one tablet as I felt they were doing more damage than actually using the drug.

I found another service in Middlesbrough which let me try acupuncture and electric stimulation therapy (EST). I was grateful to be allowed in, but being put into a small room with needles coming out of my ears and electro shock patterns running through my body to my brain was something else. Again I fell out of the service because things were not changing – I was still using cannabis.

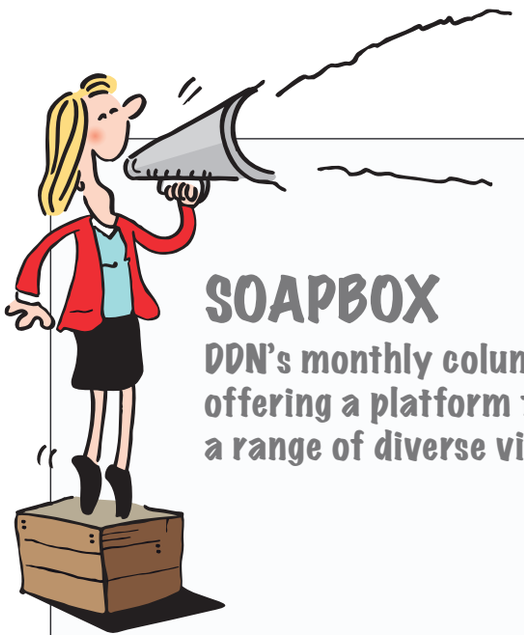
On 24 February 2010 I had hit rock bottom yet again – my birthday, and now a reminder of how my life changed for the better. I got the Yellow Pages out and this time I was not taking no for an answer. After ringing several services I was pointed in the direction of Hope North East in Middlesbrough. I explained my situation and addiction and they asked me to come in.

The hardest part when I arrived was to walk through that front door. Would I be judged or looked down upon? I just didn't know – but I was welcomed with open arms and started attending regular one-to-one and group sessions. The service didn't judge and they didn't expect me to fit any criteria – all they asked was did I need recovery.

I felt so alone back then, but amazingly the people in this service had all been through what I was going through. What I thought would be the next obstacle was attending a group meeting – while I was at the door of the room it felt like I was an outsider looking in, the people in the room were full of smiles and the energy that was in that room was overpowering. It was the last place I wanted to be – I couldn't handle it. But I suppose it was like the saying 'he who dares wins' – and win I did.

As I started hearing all those people sharing what was going on in their lives, my defences crumbled as I knew I was not alone. Finally I had someone to share all my concerns with – I had finally stopped banging on that steel lid to get someone to listen to me. I realised I could continue to work on my path of recovery with the help and support of Hope North East, and I'm so grateful to them. **DDN**

Next month: Nigel fights to regain his family life.



SOAPBOX

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

A HIGHER AIM

The ambition of abstinence is key to tackling drug addiction, says **Andy Winter**

In the last week I bumped into two former clients of Brighton Housing Trust's Recovery Project. The project offers an abstinence-based programme, which provides a route to life without use of illegal drugs or prescribed substitutes.

Rob (not his real name) is just finishing his final exams at Sussex University. He looked well, although stressed and tired due to lack of sleep. The next day I saw Rachel (again, not her real name) who spoke about how much she was loving her new job – she had recently been promoted to become a manager. I remember her 15 years ago when many would have written her off as another 'hopeless junkie'.

One had left the project four years ago, the other more than a decade ago. They have remained abstinent and have turned their aspirations into reality. Both are happy. Both are an inspiration to me and others, showing that recovery from addiction is possible.

In the same week I read the comments of two leaders in the city, with whom I often agree – Caroline Lucas MP, and the head of Brighton police, chief superintendent Graham Bartlett, who have called for the decriminalisation of drugs and a harm-minimisation, health-based response. They said that 'the war on drugs' has failed and that a new approach is needed that looks at the problem from a health perspective, with more prescribing to reduce crime and social dysfunction.

Like them, I am deeply concerned about the high death rate of addicts in Brighton and Hove. However, I was frankly depressed by their proposals, since (apart from the call for formal decriminalisation of private use) they are simply advocating a view that has dominated government policy since at least 1997. It is a policy that has failed. This policy has seen ever-increasing numbers maintained in drug use, with spiralling costs that cannot be sustained in ethical or economic terms.

The coalition government has signalled a fundamental change in approach, although this has yet to be translated on the ground. It says it wants to change the way drug addiction is tackled, with more people with problems diverted away from prison and into treatment as part of what it calls a 'rehabilitation revolution'. Its strategy involves 'championing abstinence' and the Department of Health says its aim is to get users 'off drugs for good'. I support all of this.

The Centre for Policy Studies (CPS) says the current annual cost of maintaining treatment for 320,000 problem drug users is made up of £1.7bn in benefits, £1.2bn for looking after their children and £730m for prescribing the heroin substitute methadone.

A key issue is one of ambition or rather what can now be seen, in hindsight, as a poverty of ambition. Do we think that it is acceptable to tolerate the £3.6bn now spent on treating users with drug substitutes like methadone and keeping them on benefits each year, not to mention the wasted potential of addicts who are maintained in their drug use? Is it acceptable that those who wish to be abstinent are either denied the detoxification facilities they need or have been actively encouraged to use heroin substitutes?

Things cannot improve if much of what we do is to maintain people in their addiction. Clients in the Recovery Project testify that, before entering our abstinence programme and when on maintenance scripts, they 'topped up' with street drugs. There is also an active market in prescribed drugs, which are sold on by addicts supposedly 'in recovery'. Those addicted in this way may not use or commit crime at the same rate, but they are certainly still stuck in the drug-using culture and often acting illegally and destructively.

It is surely ethical that addicted people should be helped to achieve genuine abstinence, since it is only then that healthy relationships, safe parenting, genuinely secure housing, education, training and employment become viable options.

I fully support the call made by the CPS for 'a real transfer of power from large distant organisations to small innovative providers' for rehabilitation. I agree that small units such as the Recovery Project have a better chance of getting addicts off drugs completely, not least because they tend to involve abstinent users in the planning and delivery of services.

Kathy Gyngell, from the CPS, said prescribing methadone to addicts delays their recovery. The CPS states, 'There is one simple measure of success: that of six months' abstinence from drugs.'

As the CEO of an organisation which offers both harm minimisation services and genuinely abstinence-based treatment, I am ambitious on behalf of our clients. I maintain that six months' abstinence is readily achievable and would go a step further. Treatment providers should be judged on whether the client is genuinely abstinent – from all mood-altering drugs – six months after finishing treatment.

Recovery from addiction is possible. Those of us involved in policy-making, commissioning services and delivering treatment have an ethical duty not only to offer safe care to using addicts, but also to ensure that treatment leads, in each and every case, to abstinence. Too many lives depend on it. **DDN**

Andy Winter is chief executive at Brighton Housing Trust (BHT)

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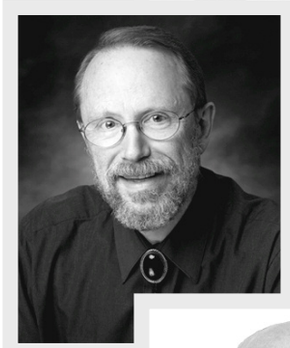
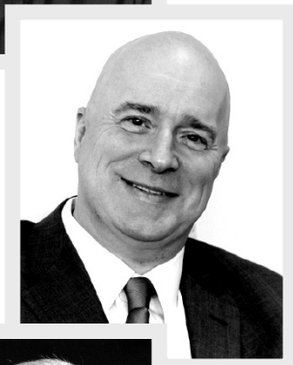
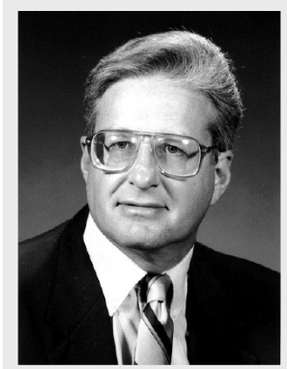
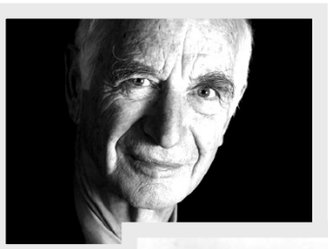


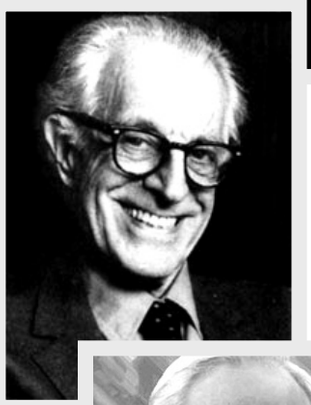


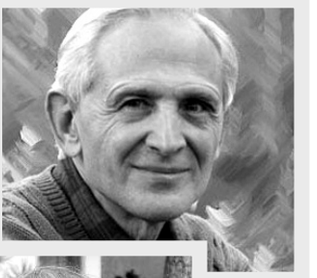


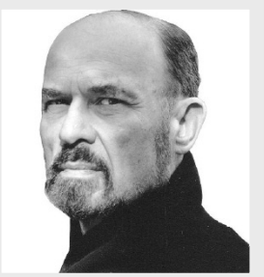
Familiar faces? Familiar names?

Martin Seligman
Christine Padesky
William Miller
Paul Grantham
Donald Meichenbaum
James Hillman
Insoo Kim Berg
Albert Ellis
Peter Levine
Mary Goulding
Irvin Yalom









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