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DDN
Drink and Drugs News

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'People looked as we walked through the city and said, "what's that?" I said, that's recovery and I'm proud!'

RECOVERY WALKING

COMING TOGETHER TO DEBATE THE NEXT STEPS FORWARD

Ignorance isn't bliss...

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  Hepatitis C Action Plan for England
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  Drug Misuse and Dependence: UK Guidelines on Clinical Management 2007

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A new era?

Recovery talk draws strength from diversity

A FEW MONTHS AGO THERE WAS MUCH TALK about whether 'recovery' belongs to one group more than another. Those debates still rumble on – particularly when money and politics play a significant part – but the UKRF summit brought all parties to the table to be part of the dialogue (cover story, page 8).

Rather than the all-too-frequent polarised arguments, harm reduction and recovery were acknowledged as traditional bedfellows and the debate moved on to making sure everyone knew the rules of the game when taking debate to a political level. Important to many people who attended the event – and the recovery walk through Cardiff city centre the day after – was the practical discussion about recovery in the context of real life, whether related to treatment and healthcare or more general issues of living and working in the community.

Other articles in this issue reflect recovery in its everyday clothes, from the thriving 12 Café (page 18) to the inspirational LCDP art project (page 14). This isn't just theory, this is maintenance, abstinence, therapy – whatever you want to call it – but most importantly it incorporates a path to wellbeing that transcends any federation, partnership, consortium or concordat you could convene.

This issue

FEATURES

REGULARS

News in Brief

VOLUNTEER VOICES

Adfam has launched an online consultation to help develop a toolkit to encourage volunteering in the drug and alcohol sector. The organisation wants to use the experiences and skills of service users, ex-service users, family members and others who have volunteered in the field – or other sectors – and also wants to hear from those with experience of managing volunteers. *Consultation at www.surveymonkey.com/s/55S267T*

ENERGY AWARE

Drinkers need to be more aware of the possible risks of mixing alcohol with energy drinks, according to a new briefing paper from Alcohol Concern. Some energy drinks contain the equivalent amount of caffeine as five cans of Coca-Cola or a double espresso, says *Mixed messages*, which can mean drinkers may feel alert and not realise how drunk they are, making them more likely to drive or take other risks. They are also more likely to become badly dehydrated. The charity wants to see energy drink producers take more steps to communicate the dangers of mixing their products with alcohol, and for bars and clubs to stop promoting the drinks as mixers. *www.alcoholconcern.org*

REHAB RESOLUTION

A new feedback tool to allow service users to report difficulties in accessing residential rehab has been launched by the NTA. *Rehab watch* allows people to complete a short form, which – with their consent – can be shared with the appropriate commissioner for resolution. *Available at www.nta.nhs.uk*

STREET SUPPORT

Almost half of people who have slept rough have a combined history of substance misuse and institutional care, according to a report from the Homeless Link charity. Seventy per cent had experience of drug and alcohol problems, while 62 per cent had spent time in prison or child care institutions, says *Tackling homelessness and exclusion: understanding complex lives*. The report wants to see more preventative support and greater coordination between services. 'The lives of homeless people are often incredibly complex, so it is vital that the services they need reflect this,' said Joseph Rowntree Foundation chief executive Julia Unwin.

Lib Dems' motion calls for independent drug law inquiry

The Liberal Democrats have passed a motion calling for an independent panel to review the country's drug laws. The *Protecting individuals and communities from drug harms* motion was passed at the party's autumn conference in Birmingham.

The party says it wants to see an 'evidence-based' drug policy in place of the current 'costly and ineffective' one, which, it states, disproportionately affects the 'the poor and marginalised'. The motion calls for a review of the impact of the Misuse of Drugs Act and its legal framework, as well as consideration of reforms based on the Portuguese model of decriminalisation of drugs for personal possession (*DDN*, 11 October 2010, page 6). It also calls for consideration of a regulated market for cannabis.

'We want to ensure the government has a clear focus on prevention and reducing harm by investing in education, treatment and rehabilitation, and moving away from criminalising individuals and vulnerable drug users,' said Carshalton and Wallington MP, and co-chair of the Home Affairs Parliamentary Party Committee, Tom Brake. 'We need proper regulation and investment if we are to get to the root of the battle with drugs. Liberal Democrats are the only party prepared to debate these issues.'

An impact assessment on the Misuse of Drugs Act would, according to Transform, not only be 'eminently sensible' but 'truly groundbreaking'. 'Globally, the tide has turned, and ever more prominent statesmen and women are calling for an end to the failed war on drugs and its replacement with models of legal regulation based on science, public health and human rights principles,' writes Martin Powell on the Transform blog. 'In response, the Tory and Labour frontbenches continue shouting, "drugs are bad for you, ban them" whilst refusing to explore different approaches – even when shown to work in other countries. That is not principled leadership, and looks increasingly irresponsible. The Lib Dem motion is only part of a much broader, growing global campaign for a full review of the war on drugs, and all the alternatives.'

The UK Drug Policy Commission (UKDPC), however, has stated that while it supports the broad thrust of the motion and the call for a review, the motion's assessment of the negative effects of current policy is 'too broad' a generalisation. 'We shouldn't get carried away with saying all UK drug policy is ineffective and harmful,' said chief executive Roger Howard. 'The UK has some harm reduction measures which have saved a great number of lives, including needle exchanges that have led to a much lower HIV-infection rate than in other countries. Access to treatment has improved considerably which has improved users' health and reduced crime.'

See news focus, page 6.

Synthetic drugs second most used

'Amphetamine-type stimulants' (ATS) such as methamphetamine are the world's second most widely used type of drug after cannabis, according to a report from the United Nations Office on Drugs and Crime (UNODC).

While rates of heroin, cocaine and cannabis use remained largely stable in the period between 2005 and 2009, ATS seizures showed a marked increase, says *2011 global ATS assessment*, as – unlike plant-based drugs like opiates or cocaine – they can be manufac - tured anywhere with little financial investment. The UNODC reported 'soaring' levels of ATS production, consumption and trafficking in South East Asia earlier this year (*DDN*, July, page 5), and there are also health concerns around rising rates of injection of ATS.

'The ATS market has evolved from a cottage-type industry typified by small-scale manufacturing operations to more of a cocaine or heroin-type market with a higher level of integration and organised crime groups involved throughout the production and supply chain,' said UNODC Executive Director Yury Fedotov. 'We are seeing manufacturing shifting to new markets and trafficking routes diversifying into areas previously unaffected by ATS.'

'Ivory Wave' to be banned

The substances found in the legal high 'Ivory Wave' are to be banned on the advice of the Advisory Council on the Misuse of Drugs (ACMD), the Home Office has announced.

Desoxypipradrol (2-DPMP) will be controlled under the Misuse of Drugs Act as a class B substance along with structurally-related compounds, so that manufacturers are unable to develop alternatives to avoid the ban. Desoxypipradrol and its related substances had the 'potential to cause harm' said ACMD chair Professor Les Iversen.

The government banned the importation of 2-DPMD last year and gave the UK Border Agency the power to seize and destroy shipments of the drug (*DDN*, 22 November 2010, page 4). An order making the substance illegal will be put before Parliament this autumn, and will also make the benzodiazpene phenazepam a class C substance (*DDN*, August, page 4).

YouTube's alcohol content 'breaks every taboo and regulation'

Alcohol-related content on YouTube breaks 'every social taboo and regulation in the book', according to research by digital marketing agency AccuraCast.

Children of any age can view alcohol-related content on the site, says the company, with an average of 6 per cent of views of adult-orientated content by 13-17 year-olds. This means an alcohol commercial with 10m views will have been seen by around 600,000 children under 17.

Most large alcohol brands now have their own YouTube channel, but the unrestricted nature of the site means children can easily watch alcohol promotions that, although banned by regulators, have been uploaded and 'gone viral'. Although individual alcohol brand channels on YouTube impose age verification boxes they are easy to circumvent, and if users go directly to a video there is no age verification process at all.

'Our research shows that YouTube has lost control of its alcohol-related content and that YouTube alcohol uploads currently break every social taboo and regulation in the book,' said AccuraCast MD Farhad Divecha. 'The watershed that TV imposes on advertising is meaningless on YouTube and the few controls that are in place are simple to bypass. Drinks companies can spend a fortune getting 5m views via traditional media while YouTube can deliver 20m views for nothing.'

Alcohol Concern recently called for advertising marketing to be banned from all social networking and video-sharing sites because of their huge popularity among young people (*DDN*, September, page 4) and has since written an open letter to Facebook following a meeting it had with the organisation. The letter points out that children as young as eight have admitted to setting up profiles on social networking sites that have minimum age requirements, and that access to unregulated 'fan' pages – which can look almost identical to official brand pages – is not age-restricted.

A report from the Joseph Rowntree Foundation has also concluded that online alcohol advertising and alcohol-related images in user-generated content pose 'particular challenges'. Social networking sites have become 'part of young people's drinking culture', says *Young people, alcohol and the media*, with the uploading and 'tagging' of images acting as a way to document a night out or portray a particular identity.

Drinks giant Diageo, meanwhile, has announced that it has taken its multi-million dollar partnership with Facebook to the 'next level', with a commitment to 'push the existing boundaries of social media through co-created experiments leveraging the full capability of the platform'. A study of five Diageo brands in the US had seen sales increases of 20 per cent as a result of Facebook activity, says the company, with Smirnoff now the 'number one beverage alcohol brand' on Facebook worldwide. 'Facebook has been a natural fit for us from day one,' said the company's chief marketing officer Andy Fennell.

Research commissioned by Alcohol Concern has also found a link between the density of off-licences in a given area and rates of alcohol-related harm in under-age drinkers. For every two off-licences per 100,000 population, one under-18-year-old was admitted to hospital for drink-related problems, says *One on every corner*. More off-licences meant more access to alcohol in the home or through friends, as well as more opportunities to 'shoulder tap' – persuading older people to buy alcohol on their behalf. Licensing committees should have more powers to restrict the density of premises, says the report, which also wants to see a new health objective included in the Licensing Act to allow local authorities to refuse new licenses where they see fit.

One on every corner and Facebook letter at www.alcoholconcern.org.uk
Young people, alcohol and the media at www.jrf.org.uk

Foreigners facing drug death penalty

In many of the countries that enforce the death penalty for drugs offences, the majority – or even all – of those facing execution are foreigners, according to Harm Reduction International (HRI).

The 'hundreds, if not thousands' of non-nationals facing, or who have faced, execution in recent years include Americans, Australians, British, Dutch, French, Israelis and Swedes, among many others, says *The death penalty for drug offences – global overview 2011: shared responsibility and shared consequences*.

Thirty-two countries retain the death penalty for drugs offences, says the report, with executions carried out in direct violation of international law. The number of executions each year is likely to be more than a thousand if states that keep their executions secret are included, it says.

HRI understands that around half of the estimated 100 people on Indonesia's death row are there for drug offences, 80 per cent of whom are foreign. This includes citizens of Australia, the Netherlands and the US, while Singapore has executed citizens of Australia and Nigeria in the past ten years. The report also estimates that 53 of the 62 executions for drugs in Saudi Arabia identified in 2007-08 were of foreign nationals. There is also no credible evidence that the policy deters drug trafficking or use, says HRI.

HRI chief executive Rick Lines said the report should encourage governments to 'reflect on their counter-narcotics assistance' to states which continue to use the death penalty for drug offences. 'No government in the world can say with absolute confidence that these laws won't potentially lead to a death sentence for one of its own citizens. What we would not impose at home, we should not expose people to abroad.

'Drug policies must respect human rights, international standards and proven public health measures to be effective. It is simply wrong for a government to try and kill its way out of a drug problem. These killings are arbitrary and morally repugnant.'

Report available at www.ihra.net

News in Brief

COORDINATION CALL

People experiencing multiple needs and exclusions should be supported by effective, flexible, coordinated services, with small teams helping them access the right support, according to a new document. *Turning the tide*, published by the Revolving Doors Agency and the Making Every Adult Matter coalition of DrugScope, Mind and Homeless Link, states that the financial climate means that agencies should find new ways to work together. Around 60,000 adults are being let down by services and facing premature death through lack of understanding and coordinated support, it states.

PEAK PERFORMANCE

Four former drug users from London have completed the tough Three Peaks Challenge, climbing the UK's three highest peaks in 24 hours as part of a programme run by British Military Fitness (BMF). Three men and one woman took part in the scheme, funded by Turning Point and Westminster council. 'The natural high of endorphins through exercise takes away the need to use stimulants like crack cocaine,' said Turning Point substance misuse worker David Parkinson.

INTUITIVE TOOL

A new interactive teaching resource for primary and secondary schools has been launched by Drinkaware. In:tuition is designed to build self-esteem, confidence and decision-making skills among 9-14-year-olds to help them make more informed choices around issues like alcohol. Teachers can also tailor it to include local examples. 'In:tuition empowers young people with the knowledge and self-confidence they need to make lifelong healthy decisions – not only about drinking but about a range of risky behaviours,' said chief executive Chris Sorek.

VETERANS VERSION

A new free support service has been launched for armed forces veterans, serving personnel and their families. The Big White Wall is an online wellbeing service staffed by professional counsellors, and allows users to chat anonymously to people who have experienced similar problems. Many services personnel and veterans experience mental health issues – including substance use problems – and funding from the Department of Health, Ministry of Defence and Help for Heroes will finance a one-year pilot of the service specifically for them.

IS UK DRUG LAW REFORM A REALISTIC AMBITION FOR THE LIB DEMS?

Last month, the Liberal Democrats passed a motion to carry out an impact assessment on the Misuse of Drugs Act, and consider adopting a Portuguese-style model of decriminalisation. Could it happen here, asks **DDN**

ACCORDING TO TRANSFORM, the Liberal Democrats have 'long held the most reasonable, evidence-based drug policy' of the three main British parties, and their recent Birmingham party conference saw them endear themselves further to reformist organisations by passing the *Protecting individuals and communities from drug harms* motion, which calls for an independent panel to review Britain's drug laws (*see news story, page 4*).

It wants the government to 'immediately establish' the panel, which would carry out an impact assessment of the 1971 Misuse of Drugs Act to 'properly evaluate, economically and scientifically' the legal framework for dealing with drugs. As part of this, the panel would consider a reform of the law based on the Portuguese model. This could mean either decriminalisation of possession for personal use or a system whereby possession would remain prohibited but trigger a requirement to appear before a panel set up to determine appropriate education, health or social interventions.

'This is about the fact that the current drugs policy doesn't work... It hasn't stopped drug use and we had a lot of speeches at the conference from professionals who all said the same thing.'

The review would also consider potential frameworks for a 'strictly controlled and regulated cannabis market', and look at how this might work in practice, particularly in terms of impacts on public health and safety – especially regarding children – as well as what impact it could have in terms of tackling organised crime. The Lib Dems also want to see provision of the 'highest quality evidence-based medical, psychological and social services' for people with drug problems, including 'widespread availability of heroin maintenance clinics for the most problematic and vulnerable heroin users'.

The UK Drug Policy Commission (UKDPC) has said that it welcomes the commitment to an evidence-based drug policy and supports the call for a review of the legal framework and 'the general thrust of the motion'. However, it also says the motion's statement that current policy is not only ineffective but actually harmful – and does not represent value for money – is 'too broad a generalisation'.

An impact assessment would also be hampered by the 'glaring gaps in the evidence base', it points out, and warns against needlessly duplicating the work of other independent inquiries. The UKDPC also stresses that the situation in the UK is not one of 'strict' legal enforcement as usually understood, with just 6 per cent of those convicted of possession of a class A drug between 2007 and 2009 receiving a jail term. Those convicted do however have their prospects damaged by a criminal record, it acknowledges.

Nonetheless, while it's increasingly common to see calls for some level of decriminalisation in British broadsheet newspapers, it's likely that the vast majority of opinion in the country remains steadfastly opposed to the idea. While the motion may perhaps look to the Liberal Democrats like one way to try to win back support from some of the people alienated by their coalition with the Conservative Party, how confident are they that they can get an impact assessment carried out, let alone set about changing the law?

'Well, obviously it's now our policy, but it doesn't automatically become part of government policy,' a Liberal Democrat spokesperson told *DDN*. 'It's difficult to gauge at this stage – we don't know how it will pan out – but it's government policy to have a scientific, evidence-based drugs policy anyway, so it's not so at odds with that.'

The Portuguese model, while frequently cited as a beacon of success, does remain controversial, with some commentators querying how much of a positive impact decriminalisation has really had. Neil McKeganey told *DDN* earlier in the year that Portugal had become a 'rallying cry' for liberalisation before the case had convincingly been made (*DDN*, August, page 16), and there have also been reports of increasing rates of drug use among older people.

Portuguese needle exchange team, with client, on the streets of Casal Ventoso. *Pic by Nick Warburton*

'The independent panel will take that into account when it looks into the policy and how it works, and if it's applicable in the United Kingdom,' said the spokesperson. 'That's for the independent panel to take on board. The motion doesn't state that that should be the way forward, just that there should be reference given to that.'

But in terms of whether any of this becomes actual government policy, doesn't a lot of it ultimately – across the political spectrum – come down to 'how will this play with the *Daily Mail*'? The tabloid press aren't very likely to get behind it, are they?

'This is about the fact that the current drugs policy doesn't work,' he stresses. 'It hasn't stopped drug use and we had a lot of speeches at the conference from professionals who work with addictions – whether that's in the NHS or the criminal justice system or elsewhere – who all said the same thing. We need to find ways to make sure the impact of drugs on society is reduced. [The motion] is one way to do that, and we need to make sure that we bring people on board to move forward.' **DDN**

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

It is, of course, quite hard to get accurate statistics on the use of illegal drugs, since even people who aren't the chancellor of the exchequer tend, when they're asked about it, to be a bit coy... Drugs, like stories about Tory politicians and dominatrixes, will always be with us. If we can't get rid of them, we can find ways to reduce their harm. Only a masochistic society wouldn't.
Christina Patterson, *The Independent, 14 September*

We are always told that the authorities have given up on cannabis so that they can be 'freed up' to pursue other drugs, allegedly worse, and the 'evil dealers' who sell them. Since cannabis can unpredictably send you mad for life, I can't see why it is any less serious than heroin or cocaine. But if the authorities have been 'freed up', they haven't taken much advantage of their freedom.
Peter Hitchens, *Mail on Sunday, 3 September*

Here is just one small emblem of the ignorance or callousness of current policy making. Yesterday's public accounts committee report warns of chaos in the new universal credit for families. In the fantasy realm of this policy, 80 per cent of benefits will be claimed online, compared with the current 17 per cent. Yet most poor families have no internet or money for internet cafes.
This neglect of the young makes the financial deficit pale beside the cost of the future social deficit. In unemployment, crime, mental health and social breakdown, the damage done will cascade on, down future generations.
Polly Toynbee, *The Guardian, 12 September*

Crime has moved on since the heyday of the Krays in the 1960s. Guns are now two-a-penny and, as drugs have become rife, old-fashioned villainy has gone out of fashion. You can tell a great deal about a nation from the quality of its crime. Britain used to boast some of the finest armed robbers in the world. It took a lot more bottle to go across the cobbles with a sawn-off Purdey than it does to sell crack cocaine outside the school gates.
Richard Littlejohn, *Daily Mail, 13 September*

True, convicts tipped out of jail, after completing precious little work or education while inside, have dreadful records for falling back into a life of crime – but so do those given risibly soft community punishments... Britain needs stiffer sentences, coupled with meaningful rehabilitation behind bars. Cutting the jail population will only add to society's ills.
Daily Mail editorial, 7 September

The best way to get addicts off drugs is to find treatments that stabilise them. But almost no research is being done because of the government's simplistic view that addiction is not an illness. We need to change this view and increase investment.
Professor David Nutt, *The Independent, 3 September*

LEGAL LINE

'I'M RIDDLED WITH DEBT – IS THERE ANY WAY OUT OF IT?'

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

Reader's question:

I got into lots of debt while I was taking drugs and I didn't deal with it, hoping it would just go away. I'm getting letters from bailiffs and I'm worried they're going to take my belongings. I don't know what to do. Do I have to pay the debts or is the fact I was taking drugs a reason not to?

Kirstie says:

I understand that you are worried about your debts, but there are many things that can be done. Firstly, distinguish between priority and non-priority debts. Priority debts are ones where serious action can be taken against you if you don't pay what you owe, and so should be dealt with before all others. An example of this is rent arrears where you could risk losing your home, or failure to pay your gas and electricity and then have your supply cut off.

Many creditors employ debt collectors, some of whom may describe themselves as bailiffs. Strictly speaking a debt collector is only acting as a bailiff when they have a warrant from the court for a debt where a court judgement has been made against you. It is important to remember not to allow entry from bailiffs into your property. Bailiffs should not generally force entry, but they can enter an open door, or climb through an open window.

The action that can be taken will depend on what stage each debt is at. It is often easier to negotiate with the creditors themselves rather than collection agencies, so you should try to get original creditors to recall accounts from debt collectors where possible.

You can request that debts be written off because of circumstances you were experiencing at the time they occurred, including that you were dependent on drugs. This is more powerful when supported by letters from professionals who can confirm this, perhaps your drug worker or GP. If you were experiencing any other physical or mental health problems, including depression, you should also get letters from any services you were engaging with.

If the creditors won't write off your debts off they may be willing to accept an affordable payment plan. You will need to provide them with information about your income, outgoings and other debts to show your disposable income. Surprisingly some will accept as little as £1 per month.

If you have a large amount of debt you may have to consider other options including a Debt Relief Order (an alternative to bankruptcy in limited circumstances), an Individual Voluntary Arrangement or bankruptcy. Organisations such as the National Debt Helpline and the Consumer Credit Counselling Service can provide more detailed advice on these.

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 debts and drug use please contact the Release legal helpline on 0845 4500 215.

Under the BIG

The recent UKRF event in Cardiff took the politics out of recovery by asking the grassroots – people who were experiencing and working with drug use, harm reduction and recovery – to debate the next steps forward. ***DDN*** reports

'Today is about connecting to each other and creating a space where we can talk,' said Annemarie Ward to a room full of people from diverse backgrounds – and, historically, different beliefs. 'Why are we here? We want to change stuff, and we think that you want to change stuff.'

A year ago the word 'recovery' would be likely to have filtered the audience down to a particular demographic. Today it included faces well known for their work with harm reduction.

The first speaker was Keith Humphries, who has worked closely with the US drug czar. Initially it seemed an obvious choice to ask for an American view; many proponents of a recovery 'movement' over here seem to have been led by the more evangelical version in the US.

But his messages were for wider consumption. 'Just because something works in the US recovery movement doesn't mean it'll work in the UK,' he said. But he drew aspects to his UK audience's attention: 'In the US we have recovery walks and marches all over the country… people used to turn their children away – now they applaud.'

Recovery was now being worked into many aspects of life – recovery schools for adolescents, where pupils could support each other in recovery alongside their studies; recovery housing, run by residents under democratic principles. And, importantly, he said, addiction treatment in the US was now covered under the Healthcare Reform Bill, which wouldn't have happened without constant campaigning by the recovery movement.

Humphries offered lessons from the US experience. Early recovery movements failed because they didn't include diversity. There was racism, sexism and restrictions like 'alcohol only' groups, and hierarchies depending on prospective members' experiences with drugs, needles and prisons. He posed the question, 'what if AA had stuck with the idea that you need to be a white middle class male?' There had to be a 'conscious sustained commitment to diversity' he said. 'There is no wrong way out of addiction.'

Many groups had also stipulated the route to recovery – members had to get better in a particular way, or it didn't count. 'We'll do that again in a heartbeat if we're not careful,' he said.

Debate within the movement was good – 'if it's a fair fight'. 'Fight with respect, fight honourably and fight with a higher purpose in mind,' he said. But beware of stigma outside the group – 'If you want to repress a group you train them to hurt each other… no one outside the community will stop recovery advocates from fighting – they might even cheer them on.'

It was also essential to 'know the rules of the adults' table', he said – how to engage appropriately with decision-makers. 'It's too easy to get overawed, fooled and exploited,' he said. 'We need help to know how to act – and we need to teach people who have been shut out.'

Fellow American Carol McDaid was a founding member of Faces and Voices of Recovery (FAVOR). She echoed the message that there was 'no wrong door to recovery'. For herself it had been through professional treatment, then membership of a self-help group, but with 20m people in recovery in the US, 'we have to create a "big tent" – a way of getting to all of them,' she said.

This big tent had to include family and friends and be inclusive to all kinds of people. It had to include 'principles before personalities' and couldn't 'be diverted by people who think theirs is the only pathway'.

She echoed Humphries' message by saying the way to make sure there was 'nothing about us without us' was by 'having a seat at the table by learning the rules of how the game is played.'

Colin Wilkie-Jones had worked at the Department for Work and Pensions (DWP) but felt he could make a more meaningful contribution to recovery initiatives as chief executive of eATA.

'The government's open to the notion of recovery, but what next?' he asked. Recovery meant different things to people at different times and there was no point in spending money until people were ready for change. 'You have to get used to moving people through a journey – it's a trial and error process,' he said. 'It's really important to remember that recovery is not an end state.'

Short-term interventions were quite different to a long-term recovery plan,

tent

'Recovery transcends harm reduction and recovery-based approaches. We want people to share and build... so many people feel like they're waiting for something that isn't going to happen.'

which needed an integrated model of care and continuous assessments. Healthcare should be about being a 'partner' in recovery, rather than about expert domination, said Wilkie-Jones. '"Nothing about us without us" is absolutely key. We also need to think of relapse not as a failure but as an error in the learning process.'

Alistair Sinclair, joint director of the UKRF with Annemarie Ward, told the conference that the UKRF believed in facilitating connections.

'We are more similar as humans than different – we build from our strengths,' he said. 'Recovery transcends harm reduction and recovery-based approaches.

'We want people to share and build… so many people feel like they're waiting for something that isn't going to happen.'

He identified five ways to wellbeing – 'connect, be active, take notice, keep learning and give.'

Professor John Strang, director of the National Addictions Centre, had been on the UKDPC working group on recovery and the NTA expert group on recovery-orientated drug treatment, both of which acknowledged that recovery should include both abstinence and maintenance approaches and people who were struggling.

'My starting point is that medications aren't everything, but they're important within the whole picture,' he said.

Alongside medications such as methadone, buprenorphine, oral naltrexone and hep C treatment, there were other treatments being studied that could be an incredible step forward, he said, including vaccines for hep C and HIV.

His work had further convinced him of William White's belief that 'how recovery is defined has consequences, and denying medically and socially stabilised methadone patients the status of recovery is a particularly stigmatising consequence'.

Neil Hunt offered a perspective from years of experience working with harm reduction, as a researcher, and as a key figure in the UK Harm Reduction Association (UKHRA). He spoke for the many 'harm reductionists' who wanted to broaden their understanding of what recovery is.

'Was the old harm reduction system right?' he asked, then ventured to answer his own question: 'It had too little ambition – come in, get juiced up with methadone and not much else. It hit the numbers for commissioners.'

He believed the core principles were the same, whether you were in recovery or a harm reduction advocate. 'The aim is to support people's development to the greatest extent possible,' he said, adding that it would be wrong for harm reduction not to promote that. 'We should pick up on any opportunity to support long-term recovery.'

We should be working together to develop full psychosocial support, he said, and urged recovery advocates to work collaboratively with the harm reduction movement to develop recovery oriented integrated systems (ROIS) and to reduce stigma and discrimination.

Sharing his own experience, Brian Morgan of the EXACT Project in West Sussex echoed the need for connectivity.

'Not long ago I had no connections. I was on the streets of Nottingham,' he said. 'Who's defining the boundaries of the recovery community?' he asked. 'Who's allowed to be part of it?'

The challenge of individualising treatment had to go hand in hand with meaningful service user involvement, he said, and there needed to be a shared vision across the drug and alcohol field.

In workshops throughout the day, conference delegates explored different aspects of this shared vision and how recovery could be better worked into everyday life, healthcare and support services.

A clear message to come from the workshops, and the day as a whole, was that delegates believed recovery should be inclusive to all, without stigma to any group, and focused on honesty and self-awareness. There was a long way to go but plenty of willingness to occupy the same space to talk.

'We need to try and mobilise, unify and organise each other,' said Annemarie Ward at the closing session. 'Then we've got a chance of getting funding and building on what we've got.'

A VERY PUBLIC AFFAIR

The third annual UK Recovery Walk took place the day after the conference, a busy Saturday morning in Cardiff town centre, and finished with speeches and celebrations in front of City Hall

'In a sense we're all recovering from something, we all need healing… this walk is about human rights and about getting rid of the prejudice that exists in our society.'
Archbishop of Wales

'My recovery is real, tangible and something I never want to let go of. It's let me live a life full of purpose and meaning, build bridges and be a responsible parent.'
Stuart, volunteer at Recovery Cymru

'We aim to be unbiased and non-judgemental. We want to make people better understand that users are human beings.'
David, CRI mentoring service, Newport

'I came across the world to see this… it's unheard of in Australia. Hopefully this time next year I'll get a recovery walk going in Perth.'
Adam, Australia

'They told me I got everything I deserved – and I have!'
Jamie, South West

'People looked as we walked through the city and said "what is that?" And I said "that is recovery and I'm proud!"'
John Shinholser, McShin Foundation

'Who's going to be in Brighton next year?'
Carol McDaid, Faces and Voices of Recovery

'I was drinking, doing drugs, and lost my family. I was someone no one wanted to know. I was on my own but you lot are my family now.'
Jonathan

'I've been in recovery for nine months. You keep me clean and sober.'
Stuart, Lancashire

'I was just four and a half stone when I went into recovery. I'm back from a relapse but I want to thank you for giving me hope.'
Sharon, Newcastle

'I want to thank you for what you're doing for people you don't know personally. When they read about this a little spark of hope will light in their hearts. They won't know how they will recover, but you will lead them.'
Keith Humphries, professor of psychiatry and research scientist

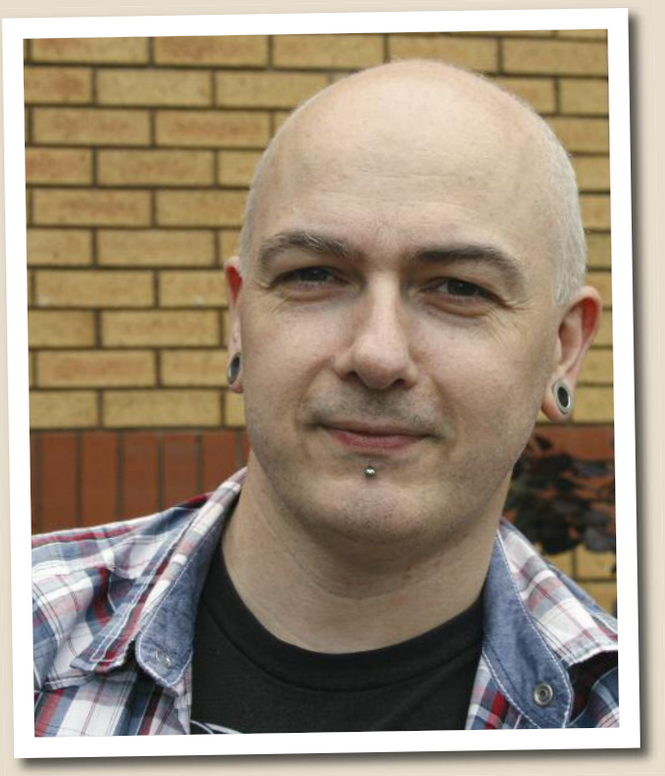
'I am struggling at the moment to know that this can work, but I'm grateful to see so many here today. I didn't have a drink last night and I'm not going to have a drink today.'
John, Newcastle

'One thing I've learned is that I can't, but we can.'
Michaela, Wired In

'Don't forget the families. They're here today to support you and they love you so much.'
Jackie, Ireland

'I was hopeless, helpless and powerless and now I have a life beyond my wildest dreams. You people made it possible.'
Paul, Liverpool

'I know why I do the job when I see your faces.'
Martin Riley, commissioner, Neath Port Talbot



FORGET THE GREAT DIVIDE

'Traditional harm reductionist' Nigel Brunsdon **took part in the recent UKRF recovery summit. He explains why recovery and harm reduction should never be an 'either/or' choice**

AT HEART I'M A HARM REDUCTION KIND OF PERSON. I've spent the last decade working in needle programmes, running a website that provides injecting advice and presenting sessions at conferences promoting harm reduction. For me this work has always had as one of its goals the idea of helping people who want to stop using drugs achieve this. And for the people who don't want to stop, it's been about helping them stay safer and, if I can, 'nudging' them to the idea of stopping at some time in the future.

So the idea that harm reduction and recovery are somehow opposite ends of drugs work has been something I've always found confusing. To me recovery is harm reduction and harm reduction is something that sits perfectly in recovery – even the original ACMD document statement that kicked off needle programmes in the UK had as one of its stated goals 'increase abstinence'.

For some people though, this false dichotomy is an advantage. The press rarely has an interest in stories where people agree that working together is a good way to help people stay alive and healthy. What they want is an element of conflict. This is something that some members of our community – and I include both harm reduction and recovery here – have taken full advantage of to make sure they stay in the public eye. But the other week I attended and spoke at the UKRF Recovery Summit (UKRF11) and was pleased to see that there are so many people who understand that not only would it be a good idea for the two camps to work together, but that it's necessary.

'At heart I'm a harm reduction kind of person... For me this work has always had as one of its goals the idea of helping people who want to stop using drugs achieve this.'

Recovery has many paths to it and I know from experience that a number of those paths are made possible by harm reduction based services, which are, as Stephen Bamber has stated, 'the vanguard of recovery'. Currently drug services are being asked to give more robust evidence that they are helping people make changes and move towards recovery and this is to be welcomed in my opinion – after all it's what I've been doing for years.

Back when I started working in drug services, our area had a ten-month waiting list for treatment. The people coming into the needle programme where I worked got sterile equipment but also received advice and support on reduction strategies and self-detox. I can remember many times when people would stop using drugs without ever needing to engage in 'structured treatment'. But up till now needle programmes have rarely been asked for this kind of data. Instead, all DAATs have been interested in is the number of needles given out – it's almost as if all they think we do is just throw needles at people and never actually talk to them. So yes, I'm all for evidencing the work we do better.

But that's not enough. We need more people from the recovery community to be actively involved in harm reduction. When I spoke at UKRF11 I asked the people attending my session about their experience of overdose interventions in rehabs. I've since asked the same question to other people both online and off. I always get the same kind of answer – 'there was no mention of overdose' or 'there was no overdose advice'.

Previously I've been told that this is because talking about overdose with people in the early stages of recovery is 'difficult', and that it would mean implying that they may return to using substances, which could act as a trigger for using. I do understand this point, but as anyone who understands the Cycle of Change could tell you, there is always going to be a portion of the rehab community that returns to substances.

This is especially true in the early stages of recovery when rehab can be an intimidating place full of strange new situations and difficult questions people have to ask themselves. And it's exactly this situation – people dropping out of rehabs and support services – that poses the greatest risk of overdose. Tolerance is reduced, stresses are high and people often return to the old coping strategy of drug use. Personally I would love to see overdose interventions becoming one of the first things discussed for people entering recovery.

We are losing over 1,000 people a year to overdoses in the UK. This is a number that needs to be reduced and in my mind the only real way we can do that is to all work together. It's not harm reduction or recovery, it's harm reduction AND recovery.

Nigel Brunsdon writes a harm reduction blog called injectingadvice.com which includes a number of tools including a free-to-download Overdose Workshop. He also spends 'far more time than is healthy' using social networks like Twitter to promote harm reduction.

LETTERS

'I have been told that they have deemed me not suitable to work with vulnerable adults... My question is when are ex-service users allowed to move on without judgement and be allowed to forget a past that has made us who we are today?'

WHEN CAN I MOVE ON?

I am writing with much disgust about treatment from a very well known provider. I don't really know how or who to approach about the obvious prejudice and discrimination that exists in a society that, supposedly, this should not be happening in anymore, and which should have moved on from the dark ages.

I have worked in the substance misuse field for the past six years after becoming abstinent eight years ago. I went away and worked within the leisure industry and then decided to work within the substance misuse field. I started successfully with a large organisation and more recently worked within the NHS.

After finishing my fixed term I then struggled to get a position and started doing some labouring. I applied for a job in the field and was successful in my application. I explained that I had a criminal record but that I had not offended for the past eight years, and was informed that my application was successful. Due to organisation checks I waited for three months for my CRB to come back, and was then informed that the offer had been withdrawn due to unsatisfactory checks. This could only be my CRB as I was told I'd been given glowing references from my previous employers. I have tried to get to the bottom of this and have been told that they have deemed me not suitable to work with vulnerable adults; this has come as a big surprise to me as I have been working with vulnerable adults for the past six years with no problems. My question is when are ex-service users allowed to move on without judgement and be allowed to forget a past that has made us who we are today?

This has affected my confidence no end and I have now accepted a job in the leisure industry as a result. I have contacted discrimination organisations and have been told to write to parliament to express my concern. I am writing to *DDN* as I was a regular reader and feel that on behalf of service users and ex-service users I have to ask when does the point come when we are allowed to move on with our lives? I would like to put this to open debate.

Name and address withheld

EMPTY PROMISES

The Liberal Democrat motion to call for a review of drug laws, passed at their conference and reported on your website and across most of the media, is not only a prime piece of spectacularly empty posturing – as they know very well that any such reform has about as much chance of happening as they do of winning the next election – it is also a piece of utterly disgraceful hypocrisy.

Untold wreckage has already been wrought on this country by the Tories, as enabled by the Lib Dems, and we all know there's plenty more to come. If they are serious about wanting to protect 'individuals and communities from drug harms', as they say, perhaps a good place to start would be by not enthusiastically helping to create a culture of absolute hopelessness, with services slashed, support obliterated and young people left with little hope of a decent job, access to higher education or any kind of future at all. Shame on them.

Molly Cochrane, by email

JUDGEMENT DAY

I'm writing in response to the letters from Denis Joe and John Graham (*DDN*, September, page 11) criticising Alex Boyt's article 'Higher Powered' (August, page 12).

It was a well-balanced article looking at what helped him in his own journey with recovery. He was not knocking AA or NA but looking at how it is helping him, while also commenting that it is, in fact, well out of date.

I have attended both organisations' meetings in my own journey to recovery and although I do not use AA or NA now, I feel that both Denis Joe and John Graham are in denial that changes have taken place in this world. Maybe they both need to look at their own approach to their journeys? We have no right to be judgemental towards others' views and the 12 steps clearly state this.

I am amazed that John Graham, as a qualified therapeutic counsellor would be so attacking and judgemental – does he do this with his clients?

As for a relapse being mentioned, I, like everyone with addiction, am always at risk of relapse for the rest of my days in this world. So I ask them both – are their thought processes in condemning such a balanced article in such a judgemental way maybe putting themselves in that category?

Sean Rendell, independent advocate, Hertfordshire

SLOW PROCESS

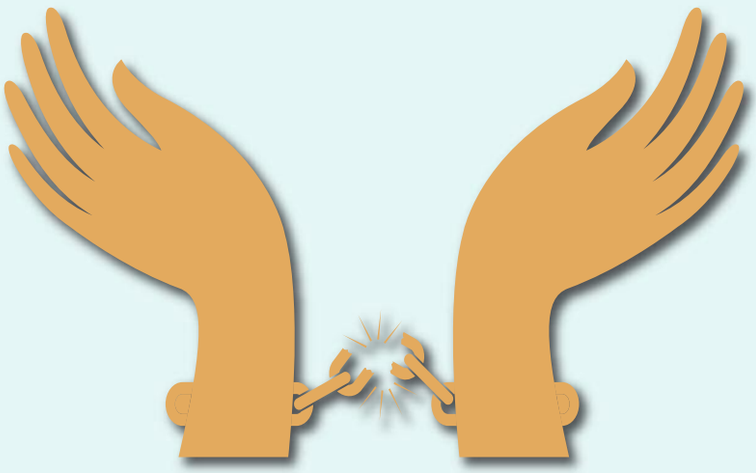
I am the manager of the Mind in Camden Minor Tranquilliser Service, a project that has helped people with addiction to prescribed and unprescribed benzodiazepines for over 20 years.

I was very interested to read your feature about Lifeline Productions' 'Wobbly Stan', an animated film that deals with illicit use of benzodiazepines (*DDN*, September, page 14).
I have since watched the film and found it an informative and humorous introduction to the problems faced by users who take benzodiazepines illicitly.

I was particularly interested in Michael Linnell's comment regarding withdrawal that, 'in terms of the potential implications, you could be looking at an 18-month medically supervised detox with every client coming into our service. That's quite profound'. I agree, and given this need, I feel it is important to highlight that there is little help available for individuals who are dependent on benzodiazepines. Mind in Camden has the only identified benzodiazepine service in Greater London. UK-wide, there is also very minimal provision.

Those of us at the project believe that withdrawal is best done at the user's own pace. In our experience, a slow withdrawal is more effective, both in terms of not resuming use of this medication and of making the process of withdrawal more bearable. We were therefore glad to read Linnell's view about the time that withdrawal can take.

We query the timescale given in current guidelines, where it is stated that withdrawal should not take longer than six months. In our extensive experience, clients who have



successfully and sustainably managed withdrawal have, on average, taken at least a year to do so.

Melanie Davis, minor tranquilliser service manager, Mind in Camden

WHAT ARE WE CURING?

In April 2011 I wrote a blog on Wired-in called 'My random thoughts' about the labelling of addiction as a disease. I did not offer any answers but I was seeking the opinions of other professionals and those who use substances or have addictions.

With this in mind I was interested to read the 'profile' article (*DDN*, September, page 20) on Stanton Peele. He highlights what I believe is a simple mistake we have been making whilst trying to support people through addiction.

Mr Peele quotes the harm reductionists as saying 'the reason we give them methadone is they're constitutionally addicted to narcotics, so let's give them a less harmful narcotic', then comments 'to me that defiles the human spirit. People quit narcotics all the time and therapy should try to assist with that if that's your goal. I'm not going to tell someone they're permanently wedded to a need for a narcotic – it isn't true, and it isn't helpful.'

This is not a protest against the use of substitute prescribing, but serves to highlight the outdated language and terminology, which is still used to motivate people away from addiction. The notion that 'it's not your fault, it's the disease' seems to me to be killing the person with kindness. It would be like saying, 'just accept you are helpless'.

We cannot continue to offer such negativity and still expect results. We have to change beliefs, increase motivation to change and show people that there can be solutions to problems. What is it that we are supposed to 'cure'?

I want to end my letter with one last quote from the article: 'So people take drugs and alcohol because "the disease" compels them to do so, and the cure for that illness is abstinence – which is a funny cure for a disease.'

Mike Benson, young persons substance misuse, Harrogate

WRONG PRIORITIES

It was interesting to note the figures detailed an advert in your last issue for a tender. Apparently £1m is to be spent on drug treatment, and £241,589 on alcohol treatment.

This seemed a tad biased towards drugs, suggesting that drugs are a far bigger and more costly problem than alcohol. Not only did this seem to fly in the face of common sense, it also seemed to fly in the face of evidence. And we all like a bit of evidence-based practice! So I checked my drugs strategy, and apparently alcohol costs the UK £18-25bn per year, whereas drug use costs £15.4bn. It goes on to state that there are approximately 320,000 heroin and/or crack cocaine users, with 170,000 in treatment, whereas it estimates over 1.6m problem alcohol users of which one third (533,333) need treatment.

So how come a service is being commissioned whereby a minority of its users are getting four times as much money spent on their treatment? Answers on a postcard please...

Name and address withheld

THE RIGHT TO CHOOSE

As an organisation we're receiving very mixed reports from service users. Some are describing a situation where they are being very assertively asked, or even told, to choose abstinence as their next goal in treatment. Others are describing refusal of detox or reduction, even refusal to the right for advocacy. The one common factor between many of the cases is the service provider or commissioner taking an authoritarian stance – dictating rather than agreeing treatment options.

At the same time the national dialogue around drug treatment – both inside and outside the field – is becoming increasingly polarised, with both methadone and detoxification used as lazy proxies for the opposing sides. Many of these arguments seem driven less by conscience and more by opportunism. With significant budget reductions probably less than 12 months away, providers and other interest groups are keen to carve out some unique territory in the government's spending plans, it appears, essentially by rubbishing whatever others are doing.

Caught in the middle of this are service users who, depending on location, service provider and, in some cases, even key worker are receiving less than consistent service, and in a number of cases treatment which is without doubt outside both the NICE guidelines and accepted good practice.

The Alliance believes that the content and orientation of treatment provided for substance use is a matter for individual agreement between service users and their clinicians. Service users have a right to access the full range of treatments that can help them improve their quality of life and manage their substance use. Recovery is a matter of personal choice – individuals have the right to define what their own recovery looks like, and to access the services that will enable them to achieve this.

We know that there are a number of barriers to recovery including stigma, discrimination, unequal access to services and restricted treatment options. There are also structural blocks like inadequate or incompetent commissioning, treatment services operating in contravention of national guidelines, and poorly-developed mechanisms for financial gatekeeping, which effectively exclude people from services.

It's our job to promote people's right to access appropriate treatment and support. We all need to be challenging any developments in treatment services, commissioning or government policy that deny this basic right. But we're not naïve, we know we also need to increase public – and political – awareness of the importance of good, respectful, evidence-based drug treatment.

It's also our job to challenge interventions and approaches to substance use which increase stigma, those which say that one kind of drug user is better than another, simply because of the path they choose to recovery, or even the drug they use. As the cuts bite, it is critically important that we do not allow moral or political judgements of people's recovery status to influence their access to healthcare or to permit services to get away with discrimination or operating outside of clinical guidelines, even if they think that they are being incentivised to do so.

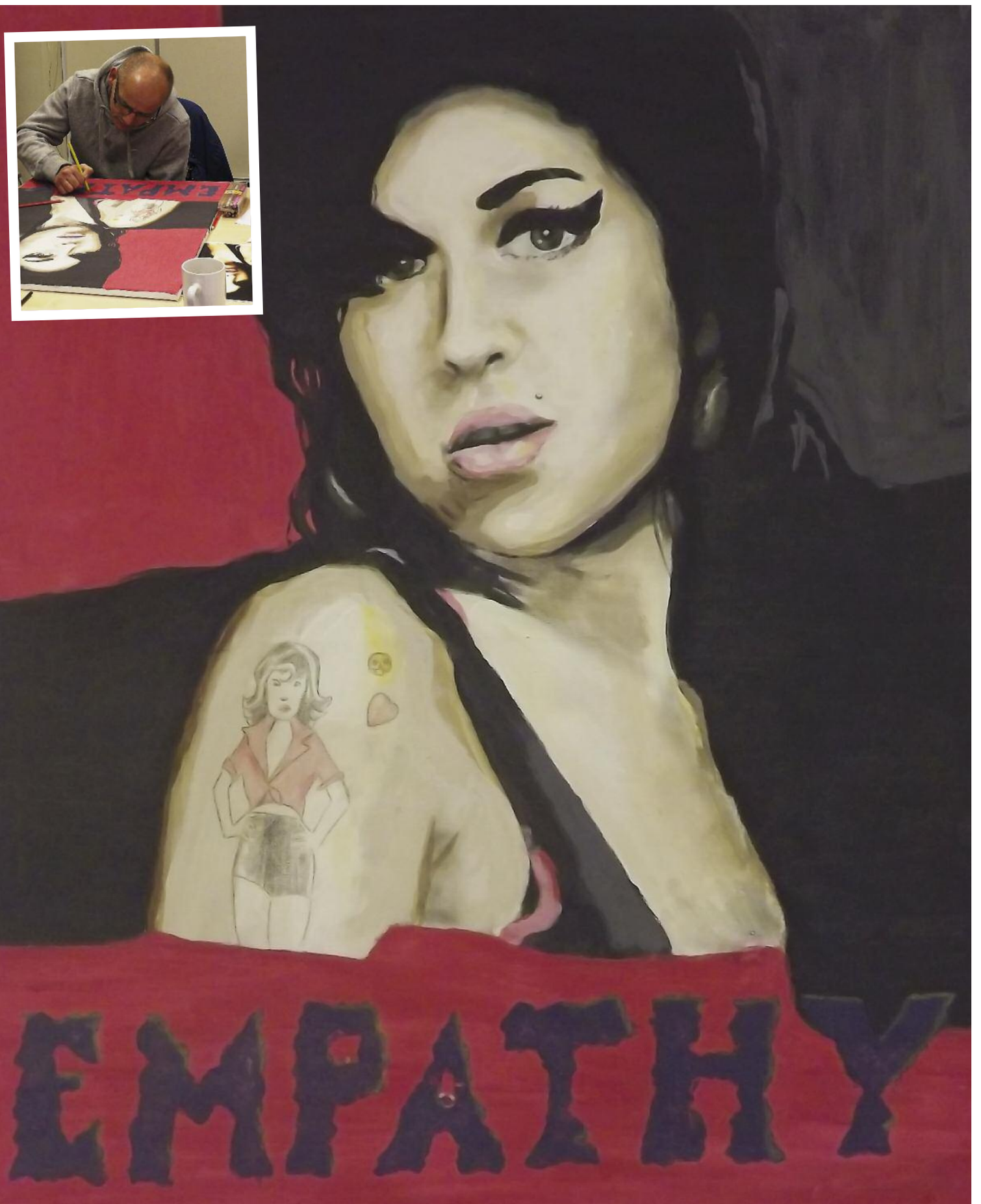
Over the next two months we're conducting a survey – the first of a series – into people's experience of treatment. We want to understand what is going on in our treatment services and how this is affecting people's lives. Currently we want to hear from service users, but in the future we'll be asking workers and clinicians too.

If you can help us better understand what the impact of government policy is on treatment services, please get in touch. You can email us on info@m-alliance.org.uk. If you currently use drug services, please go to our survey page http://www.surveymonkey.com/s/ZH8QTQM or by following the link on the *DDN* website.

Ken Stringer, chief executive, The Alliance

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.


EMPATHY

DRAWING on experience

Steven Ellis turned his drug-using past into a creative journey worth sharing, as **Sue Semple** explains

FOLLOWING CHANGES IN GOVERNMENT POLICY AND THE MOVEMENT TOWARDS RECOVERY-FOCUSED TREATMENT, Leeds Community Drugs Partnership (LCDP) decided to set up two new groups aimed at supporting service users with their recovery. One of these, the art group, is peer led and run by ex-service user and volunteer Steven Ellis, who was taught the basics of art in prison. This inspired him to apply for an art course on release and he is now halfway through a two-year access course at Leeds College of Art.

With his drug taking now four years behind him, Steven is combining his talent and enthusiasm for art with his volunteering at DISC, an independent charity working across the North East, Yorkshire and Lancashire to promote social inclusion. He has brought positivity and a real passion for art to the recovery group in Leeds, which has directly influenced its members' attitudes towards treatment and their aims for the future.

'...it captures your heart as well as your imagination and makes you a better person.'

Steven is running the art lessons weekly, in six-week sessions, and has written the course lesson plans with help from his prison tutors and project workers at DISC. For the first week he asked the members of the group to use magazine cuttings on an outline of a face to express their own personal journey.

'I wanted to get them thinking about themselves and what influences them, what made them the person they are and who they'd like to become,' he explains. He aims to help them to use art as a means of telling their stories to the group, helping them recognise the good and bad within their lives and encouraging them through art to be honest and to work together as a group. 'The group blew my expectations – it's amazing how creative and expressive people can be,' he says.

Steven gets the students working on a scrapbook and diary over the weeks, again encouraging them to document their individual journeys. The artwork, although important to Steven and his students, is almost secondary to the journey to recovery that the students are experiencing. They learn how to express themselves and their thoughts through art, as well as supporting each other in improving their literacy skills by writing descriptions of artwork in their scrapbooks.

'As the art group grows we'd like to encourage more members and inspire more ex-users to let art into their lives,' says Steven. 'Ideally members will continue with their sketches and drawings at home which will hopefully help them with their recovery.'

The group recently worked on a group painting of the singer Amy Winehouse following her tragic death, which will be displayed in the LCDP reception. While drawing and painting Amy, the group discussed addiction and the impact it can have on your life. They found that they empathised with Amy and saw her picture as a way of demonstrating the negative effects that drugs and alcohol could have on us all.

Service users in the art group are at different stages of their recovery journey. Some are still on a prescription, others are six months clean and some have been drug or alcohol free for years, meaning they can provide advice and support to each other.

The group provides an opportunity to develop new skills in art as well as improve literacy and communication. The group is 'peer led' in that Steven tutors them in art, but also in that he provides members with a positive role model and encourages them to become volunteers and peer mentors as he has done.

Members see the groups as an opportunity to meet up with people who are on different stages of their recovery journey, to support others, and to enjoy art as a relaxing activity. Feedback has shown that it has helped improve their confidence and given structure to their day.

'We all support each other – I hadn't drawn anything since school but it has helped me to stay calm and clean,' said one member; while another commented, 'If you're a drug user or in recovery you do nothing with your time – attending the art group motivates me to do something positive.'

Service users who complete the course receive a certificate as further proof of their recovery which often gives them incentive go on into further education, training or employment. Together with a range of harm reduction, prescribing and support services, the initiative is part of LCDP's commitment to helping service users move along the treatment journey towards abstinence.

Sue Semple is media officer at DISC. www.disc-vol.org.uk

'Art was my escape'

After leaving school, Steven had a girlfriend, children and a steady job as a forklift driver for a local company. He was aware of drug taking among his friends but didn't have much experience of it himself. But in his early 20s his relationship broke down and he found himself living back with his mum. He began to take heroin regularly, hiding it from his family.

As time went on Steven became distant from his family and was homeless for a period, with worsening health. In 2008 he was arrested and served most of his four-year sentence at Everthorpe Prison, East Yorkshire.

Steven didn't want to take methadone and became drug-free in prison. He began attending an art course and found the support and inspiration from his tutors at the prison invaluable. Attending the art courses regularly, he was chosen by tutors and inmates as the arts class representative. He saw art as an escape and a big part in 'getting his head right'.

On release Steven wanted to get his life back but found it difficult to get the support he needed. He felt scared and needed help with the most basic of things such as accommodation, clothing and opening a bank account. He received support from the Integrated Offender Management (IOM) service and managed to maintain his motivation and abstinence.

Becoming a student at Leeds College of Art was something entirely new to Steven and DISC took time to prepare him for this change. The first few months were difficult as he struggled with his emotions and feelings that he didn't belong.

He is now is developing a strong portfolio of artwork, experimenting with sculpture and 3D design as well as continuing to produce stunning pieces of traditional drawing and painting. He hopes to go on to study for a fine art degree at Leeds.

Steven feels that art started to make a difference to him in prison, as 'it captures your heart as well as your imagination and makes you a better person'. Art gradually helped to restore his feelings of confidence and self-worth, improving sociability and generating aspirations.

As well as working hard on his art course, Steven has been involved in two community projects and wants to give something back to others. He helped design and paint a wall mural of cartoon characters at Rainbow House in Leeds, a respite home for children with disabilities, and more recently he's been painting a mural for a Princes Trust anti knife crime campaign walled garden – a project being run by Steven's former tutor at Everthorpe Prison to raise awareness of knife crime.

Fixing broken Britain

Acorn Treatment share their vision for integrating people into mainstream society

AT THE END OF SEPTEMBER Acorn Treatment's conference on *Fixing broken Britain* was held in Greater Manchester. The one-day event showcased some of the region's most innovative and effective agencies, and presentations came from providers working in different areas of social care, from prison drug treatment to housing and social enterprise. The conference also drew upon policymakers, politicians and other professionals, with speakers including MP Graham Brady, Mark Gilman from the National Treatment Agency and Michael Ventris from NOMS.

Demonstrating to delegates what the North West could look like if areas commissioned services in a different way, the conference outlined some of the current problems in the UK. For example, Delphi Medical is a consortium of GPs working across the North West in many of the region's prisons and in the community. The move toward GP consortia can be seen as both best value and more effective in terms of long-term treatment outcomes, and one of Delphi's directors, Dr John Richmond, outlined what could be done if commissioners in the criminal justice system and the community really provided an integrated system.

The conference also launched the Can Cook social enterprise project in Greater Manchester. Can Cook is an established and successful social enterprise provider from Liverpool, and the newest project will see a fresh brand of high street vendors in ten cities in the next five years. The model is being piloted in Liverpool and Greater Manchester, providing hundreds of the region's most socially deprived people with an opportunity to start their own business.

Through Can Cook, the emphasis is not only on getting people integrated into mainstream society, but addressing the belief that diet is a public health issue. Every night thousands of people in the UK's major cities miss out on a healthy cooked meal, the Can Cook vendors and studios will provide healthy, fresh and delicious food which will challenge the major high street fast food chains. The Can Cook street vendors will operate out of state-of-the-art kiosks that have been designed by award-winning designer Ilsa Parry. Ilsa has worked with design icon Philippe Starcke and is recognised as one of the UK's most exciting new designers.

The target group for the first cohort are prolific offenders with long-term addiction problems. These are the 6 to 10 per cent of all offenders who commit 60 per cent of all crime across the region. Can Cook believes its emphasis on fine foods, customer service and sales will enable vendors to compete in the major cities in one of the few expanding markets within the service sector.

Acorn Treatment has been described as 'The Priory for the poor'. The charity has been providing high quality treatment and housing to some of the North West's most problematic families and has challenged the standards of drug treatment in the North West for many years, pioneering the movement away from containment and control toward a recovery-oriented treatment system.

At the conference chief executive John Hopkins described the way in which social enterprises, such as Can Cook, could fund free drug treatment for the residents of Greater Manchester. 'Although very different in many aspects, Acorn, Can Cook and Delphi Medical have a common emphasis on challenging standards and providing real outcomes,' he said. 'The theme of my talk was "Challenging the TINA Tendency" (There Is No Alternative). Together all three agencies show there is a real effective alternative to our region's most socially dislocated. The conference provided a showcase for agencies that are making a difference to the North West.'

For more information about Acorn Treatment visit http://acorntreatment.org or call 0161 484 0000.

My cannabis diary

In the final part of his story, Nigel celebrates life without cannabis

I'm glad to say that I now have stability in my life and cannot see myself going back to a life with cannabis in it. But I do have to be aware that I'm an addict, and if I think that I have cracked the illness it could come back to bite me.

I don't worry about relapsing, and writing these columns has helped me to work on my recovery and hopefully bring some awareness that life is waiting for you, and you do not have to simply exist.

Everything I have done in recovery is instilling confidence in me and helping me work through some of my problems and issues. My confidence is growing slowly, but life does become more stable as time goes on.

I am not feeding the addiction but fighting against it and each day I'm learning more about myself. It's not all rosy and I've had my bad days, but the good days far outweigh them. People have told me that you have to have bad days to work through the problems and grow in recovery.

I can also lose my self-awareness and still need it pointing out to me when I let things run out of control. It has been a lot of hard work to get to this point in recovery and I'm continuing to work on installing stability in my life. Yes, I still have issues – but who doesn't on this planet? I don't have cravings or thoughts about picking the drug back up because I have too much to lose for myself, let alone anybody else.

I still have people in my life who have cannabis problems but they remind me of what I was in a previous life and the thought doesn't sit pretty with me at all. I have come so far down the path and picking the first joint up would send me back to my old existence. I have to work at my stability all the time, giving me foundations to fall back on.

This is my final column and I am hoping that my diaries may have helped an addict out there to realise that there is life without the drug, and a professional to help others with cannabis addiction. There is not much awareness of cannabis addiction and I have been inspired by so many people to write these columns when I thought that I couldn't. But I've enjoyed writing them, as I can now reflect on my journey of life.

I'm no longer worried about myself and what the future holds for me, but I do worry about the hidden harms of what my family has suffered through my addiction. I will continue working on my recovery and putting right the wrong things that I did – and my family will be reassured that I am finally on the right path.

With addiction you think that there is a hiding place, but in the end you will hit rock bottom, and I can only hope that you all get the help and support I received. I will continue to try and spread awareness about this drug and hope that my higher power guides me in the right way to spread the word of recovery.

DUEL diagnosis

Brendan Georgeson reflects on the conflicts involved in working with dual diagnosis

EARLIER THIS YEAR I WAS ASKED TO PRESENT AT THE RECOVERY ACADEMY CONFERENCE on recovery oriented systems of care for those experiencing dual diagnosis. Dual had been misspelt duel, and I was about to correct it when I realised that a fight is often exactly what the dually diagnosed experience when trying to access help.

Service users and workers alike often report people being bounced between mental health and substance misuse services. The solution to this has long been acknowledged to be an integrated approach, with joint commissioning arrangements between mental health and drug action teams. All local and health authorities should have a dual diagnosis strategy with clearly defined guidance and areas of responsibility, and many should also have link workers and dual diagnosis champions.

In some areas, such as Bristol, the frameworks for action have come a long way during the last five years. So why is it still a fight? Despite progress, it's still not possible to get joint funding to place a service user in our dual diagnosis service and we have to explain obscure referral routes to potential referrers. We expect our residents to be declined mental health services, which is why we stopped referring them years ago and set up our own dual diagnosis specialism through sheer frustration at the process.

The most common area of the duel has to be not meeting the threshold for services. This can come about for a variety of reasons. Primary care can find secondary services unresponsive and inflexible, while secondary care struggles to target those most in need of specialist skills. One reason for conflict and anger is the lack of shared agreement about who should be referred – a problem that the Institute of Psychiatry (IOP) has tackled by developing the Threshold Assessment Grid (TAG – *downloaded free at http://www.iop.kcl.ac.uk*). The split between healthcare and social care has led to services developing separately, when in reality the dually diagnosed service user can't be split in two, and Andrew Lansley's NHS reform bill failed to unite these two strands. The solution I propose is joint working through co-locating, as described in the Matrix Model (*Psychiatric and Mental Health Nursing, April 2009*).

Another big area of the duel is a basic need for education and refresher training for all workers. So often I have seen perfectly able workers in the substance misuse field de-skill themselves when confronted with mental illness and vice versa. Both sets of workers use the same two basic skills of listening and empathy. Simple knowledge of the agency's policies and procedures will then help you decide what your service can and can't offer and whether onward referral is needed. In Bristol, agencies can do an introductory course in each other's sphere of work and arrange a rotational placement. At the Bristol Drugs Project (BDP) the solution is to have a worker trained in dual diagnosis providing a regular case management group and to upskill workers.

The duel can be described in some cases as an interpersonal one. Some people with dual diagnosis can experience a great deal of interpersonal conflict which can hinder trying to access or sustain treatment. People with psychosis may experience waves of symptoms when self-medicating ceases to be effective and the solution here can be timely medication reviews and advanced crisis planning. We have worked with people whose symptoms were related to stressful events and helped make predictions around crisis points. We also work with people who are detoxing, and in these cases a medication review is needed within a couple of weeks as they adjust to life without drugs, along with support from group therapy and workshops.

Sometimes the duel stems from a worker having feelings of frustration and incompetence. The therapeutic alliance is key to working with service users, but either party can feel rejected when a disagreement occurs. Some try to avoid this conflict by displacing the conflict to an external agency so that distant commissioners, the absent consultant or the unresponsive service become the problem, rather than the unspoken disagreement between worker and service user – a great disservice to our clients. The solution is for workers to be more open about their experiences and for management to have effective supervision policies.

Burnout is another area common in both substance misuse and mental health fields. We have learnt to manage it by assessing the potential of a client's generation of work – for example, at the St James Priory Project anyone with a diagnosed history of personality disorder counts as two clients rather than one, in determining their worker's caseload. We also provide extra support for that worker in the form of a dual diagnosis specialist who is available on call to answer technical questions. Other simple measures include compulsory hour-long lunch breaks.

There are many different reasons for the duel in dual diagnosis, some of which we can change and some of which are out of our control. Merging statutory mental health and drug and alcohol teams would definitely be a quantum leap forward. But the government cutbacks in public sector spending could actually be an opportunity for workers to respond together as a recovery community and seek support from other agencies in their area. Co-locating and personal development are essential in turning the duel into dual.

Brendan Georgeson works at St James Priory Project, Bristol

TASTE of succes

WGCADA's 12 Café has gone from a fledgling peer mentoring initiative to a thriving part of the community. **Cheryl Hancock** shares the story

A few years ago when WGCADA's Neath Port Talbot (NPT) office moved a little further up the road, the chief executive at the time, Norman Preddy, and Martin Riley, the Substance Misuse Action Team (SMAT) commissioner had an idea. If only WGCADA could find a way of buying the property, they could develop a social enterprise grocer shop and café, providing useful training and diversionary activities for clients and volunteers.

A successful application was made to the Welsh Assembly Government for a capital grant and the project took off. First came the hard work of turning the old WGCADA offices into a fully equipped shop and café, with a self-contained flat above. When it was completed, and for the first 18 months, the café was run by service users from NPT mental health day services and was known as the Taibach Community Cafe. The upstairs flat was rented on a short-term basis to WGCADA service users as part of a 'moving on' strategy.

Last year WGCADA secured the peer mentoring project contract, funded by the European Social Fund through the Welsh Government. As the project is focused on helping people gain skills for employment, establishing a social enterprise training café fitted the project extremely well.

Peer mentoring development officer, Saifur Rahaman, began developing the 12 Café business plan. He met and consulted with staff from Communities First, Social Firms Wales, and NPT Council for Voluntary Services and also visited many social enterprise cafés. Late in October 2010, with my previous experience in catering, I was seconded to the Port Talbot office to help progress the development of 12 Café.

Before I knew what had hit me I was busy working on a SWOT analysis and financial forecasts. Many hours of work were put in to developing the framework for the volunteers at 12 Café. The 'fun stuff' followed – developing a menu for the café, contacting catering suppliers and registering our new venture with the Food Standards Agency.

WGCADA's volunteers and service users have been involved with this project from the outset. Their views and ideas have been extremely important and have had a major influence on how the café has developed. With their input, it was decided that the theme for our café would be 'serenity' and within no time at all a small group of volunteers and service users got straight to work on the café's new decor. A very enthusiastic band of volunteers repainted the café from floor to ceiling and a driftwood tree sculpture began to take shape. Volunteers and service users also began donating pieces of art they had made to be exhibited at the café.

12 Cafe started off with 14 WGCADA volunteers and a further two service users from mental health day services with whom we work in partnership. All volunteers attended a one-day basic induction and training day at the café in January 2011. This included barista training, so the café volunteers could all use the coffee machine. One big bonus of the training was that everyone got to have a free cappuccino or latte! The induction training was followed closely by Food Hygiene Level 2 (which included basic infection control and COSHH training) and manual handling and risk assessment training. In true partnership working, this training was provided by Anita Tomaszewski from NPT Social Services in exchange for allowing her Connect to Care and singing workshops (for people experiencing dementia) to take place at the café. The café volunteers also have the opportunity to enrol on any of the work-based NVQs in catering and hospitality in partnership with the Excelsior Plus Project at Bridgend College.

To prepare the 12 Café volunteers for our official opening, a couple of 'pre-launch' days were arranged for WGCADA staff members, and these proved to be a great success. Our doors opened to the public on Tuesday 1 February 2011 and little did we know how fast our reputation would spread.

To date the café has hosted several events. One of the first, organised by peer mentoring, was a curry night for WGCADA staff, volunteers and service users along with staff and service users from partnership agencies. The event was attended by 60 people, so we were extremely grateful for the help of the NPT Tigers – a club run and managed by volunteers for the enrichment of the community through sporting activities and social events – who volunteered to help wait tables for the evening as we didn't have our waiters in place at the time.

One of the events that caused the most excitement was the visit to the café by our patron, Hollywood actor and local boy Michael Sheen. In May we held a Europe Week event, where we had taster tables stocked with tasty delights from

Left – Saifur Rahaman with WGCADA volunteers, and right – the café itself in Port Talbot, which opened to the public in February.

whichever country was being featured that day. The menu changed daily and included French, Spanish, Greek, Italian and, of course, Welsh menus. This event was closely followed by an acoustic evening, where volunteers and service users entertained us with their musical talents. Our Bridgend agency's band The Shed Heads went down a storm, a group of people who couldn't play or sing a note until they joined the music class run by WGCADA's Coastal Project worker.

Our next event was a family evening. Service users came along to the café for the evening with their partners and children, knowing they would be in safe surroundings. More than 20 children attended this event and everyone enjoyed the buffet and magic show, with the children also having great fun getting their faces painted and entering the colouring competition. We have also built up a regular clientele from the local community who enjoy the food, the service and the relaxing 12 Café ambience.

We have also been very busy looking after the environmental side of the business. The café recycles glass, tin and cardboard and is working towards Fairtrade certification. Two of our volunteers have been particularly active on this front and manned a stall at a Fairtrade fayre at a local school, dressed as bananas.

Every day I am blown away by the enthusiasm, commitment and talent of our service users and volunteers. They have all developed skills and confidence as they have progressed through the different café roles, with most also gaining qualifications in food hygiene and some working towards NVQs in customer service and professional cookery. They have developed the café from what was a bare shell to a place that is warm and welcoming – from the comfy sofas to the well-cooked (and very reasonably priced) food. The smiling faces of the volunteers and happy chatter of our customers are evidence of how far it's come.

12 Café has demonstrated what can be achieved when commissioners and partnership agencies work together to identify and fill the gaps in services for our service users. What will 12 Cafe be like six months from now? I have no idea – but what I do know is, if this bunch of volunteers has anything to do with it, it will be sensational!

Cheryl Hancock is 12 Café's manager, based at West Glamorgan Council on Drug Abuse (WGCADA). Join 12 Café on Facebook for news, photos and updates.

Post-its from Practice

Winning smiles

Nice teeth are important for self-esteem, says Dr Chris Ford

I WENT TO GET BOB FROM THE WAITING ROOM. He had arrived over an hour early for his review appointment. When I called him he stood up with the most enormous smile on his face and kept it up as he walked in talking. I asked him how he was and he answered 'very well', still smiling at me with his teeth showing. The penny didn't drop until he said 'did you not notice my new teeth?'

Since Bob started with us just over a year ago he had been trying to get his teeth fixed. The remains of his rotten teeth had been removed about six months ago and he had been awaiting dentures since then. He felt that his rotten teeth seriously affected his self-esteem and he always kept his head down or his hand over his mouth when he spoke. It had been hard for him to find an NHS dentist but when he did, the dentist had been a complete star and made Bob feel that he was worth treating.

'Dental pain may only appear when starting treatment, and if not treated, can lead to relapse.'

People who have used or are using drugs, particularly opiates, have a high level of oral disease and poor access to dental treatment. Dental caries is a complex condition and a number of factors may play a part, including dry mouth caused by the opiates, exposure to sugar, poor diet and poor dental hygiene, while the complex nature of dental pain may be masked by the analgesic effect of opioids prior to engagement in treatment.

Dental pain may only appear when starting treatment, and if not treated, can lead to relapse. Methadone mixture is sometimes blamed for dental problems but it starts well before this and it has been shown that sugar or non-sugared formulas have no significant effect on dental health.

Like Bob, many people feel their poor dentition has an effect on self-esteem, consequently hindering recovery. It should always be included in the assessment and they should be given simple advice on dental hygiene (regular brushing, oral rinsing and the use of sugar-free gum to stimulate saliva production) and explicit advice on how to access dental services in their local area.*

Don't forget that dental health has an important, but largely unrecognised, role to play in the recovery of people who use drugs – not only in the treatment of pain and disease, but also in enhancing people's appearance and self-esteem.

Bob has always worked as a labourer and with his wife has raised three children. He has long harboured a desire to go back to college but had felt too ashamed of his appearance. He finished his review and, with a large grin on his face, listed three goals that were now in reach – he could achieve his desire to become drug-free, he could sign on for that access course he had found, and he could look forward to walking his daughter proudly down the aisle.

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

**Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care, RCGP Substance Misuse Unit (SMU), RCGP Sex, Drugs and HIV Group (SDHIVG), Substance Misuse Management in General Practice (SMMGP), The Alliance*

Writing for r

When one of her identical twin sons suffered a drug-related death, Elizabeth Burton-Phillips detailed her experiences in a book and set up a charity to help other families. She talks to David Gilliver

'I think the biggest mistake that so many families make is assuming it's never going to happen to them,' says Elizabeth Burton-Phillips of her twin sons' prolonged struggle with heroin use. While Simon hasn't touched drugs for almost a decade and is now a successful IT consultant, Nicholas was not so lucky. In 2004, he hanged himself in a hostel following a drink and drug-fuelled argument with his brother, with the coroner recording an open verdict.

Now retired from a 39-year teaching career, she told the twins' story in her book, *Mum, Can You Lend Me Twenty Quid? What Drugs Did to My Family*, and set up the Nicholas Mills Foundation in 2006, now better known as the family support service DrugFAM.

There's no doubt that writing the book would have been a very painful experience, but was it also a cathartic one? 'It was absolutely all about therapy and recovery from the experience,' she says. 'It was written in the first place not with the intention of ever thinking that a book was going to be published, but purely for me to let go of the experience.'

It details how her sons' heroin use led them into bag snatching, shoplifting, dealing and homelessness, and cost them jobs, friends and severe beatings from dealers they'd ripped off. It also almost cost them their relationship with their mother, as their testimonies show how they eventually came to regard her and their stepfather largely as a source of cash for drugs. Drug debts and lost accommodation deposits cost the couple close to £100,000 and very nearly their marriage, and the book repeatedly refers to 'codependency' with the twins' addictions.

'I think inevitably when you are a mum you want to do everything you can to rescue your children from anything that's harming them or putting them in any danger,' she says. 'That is how you get sucked unwittingly into codependency and you become addicted to their addiction, trapped in the cycle. You don't realise it in the first instance and suddenly you're entangled in it, you're out scoring drugs for them or taking them to meet their drug dealers or whatever, and it's part of a process that encapsulates you without you fully understanding what you're doing. It's difficult to get out and re-establish some kind of safety net.'

It's possibly a glib question but, looking back, is there anything she'd have done differently? 'A lot,' she says. 'I would have exercised tough love immediately and I would never have put myself and my husband through the financial losses that we experienced – that, of course, is with the benefit of hindsight. But I would have communicated much earlier with my children about understanding the dangers of drugs and alcohol.'

A recurrent theme of the book is not knowing where to look for support. With the importance of a family-based approach and support for young people now recognised, does she feel that things – cuts notwithstanding – have improved in the years since her son's death? 'Ours was a 14-year experience if you take it until Nicholas' death at the age of 27, and during those years we were running ragged trying to find support for ourselves,' she says. 'There was obviously support for addicts but not much understanding of the trauma that families go through, so I'm actually very heartened that there's been greater recognition of the need for supporting families, friends and carers who are trapped in the cycle, which is principally what setting up DrugFAM was about.'

The charity offers one-to-one counselling and telephone support along with specialised bereavement services. 'One of the things that jumped out immediately was the amount of bereaved families who contacted me,' she says. 'That's why we've got a very, very strong and growing development around bereavement through addiction.'

The charity has just held its third annual bereavement conference and works

ecovery

closely with Cruse Bereavement Services and Adfam. 'Adfam have been brilliant and have given us some excellent training, and we're looking at the possibility of developing a three-way partnership,' she says.

One potential project is a jointly produced leaflet to give people an understanding of the processes that follow an addiction-related death. 'We're thinking of a timeline of what happens to people after they have that dreadful knock on the door. When it comes to losing somebody, many families and partners are obviously very traumatised and don't understand what it means to go to an inquest or a coroner's court. We know of people who haven't even been able to open the envelope from toxicology, for example, so there's a lot of support needed there.'

It's five years since the foundation was set up. Was she surprised by the amount of unmet need that existed? 'Yes – obviously we recognised that up and down the country there were excellent charities and services commissioned by DAATs and things like that, but what we really wanted to do was to open up locally and nationally to people who felt they needed us.'

There's now a national telephone service as well as busy support groups in High Wycombe, Slough and Reading, and help can be tailored to individual needs, she stresses. 'When people phone us in a state we can put them in direct contact with a counsellor who they can go to on a one-to-one basis, anonymously if they like, and if they want to they can go to a group as well. Sometimes you get people who say "I'm not ready for a group", sometimes you get people who want both and sometimes you'll get people who just want to come to a group and listen, and take it step-by-step.'

Her other son, Simon hasn't touched drugs since the death of his brother. 'He doesn't go public any more,' she says. 'It's not many people who lose an identical twin and are able to turn their lives around in the way he has, but he likes to keep a low profile. The media came running after me when Amy Winehouse died and I did some radio and so on, and they wanted Simon to come along but he just feels it's better to be in the background.'

She's spoken at more than 300 events since the book was published. It's now being turned into a play to be performed at the Lighthouse Theatre in Liverpool and the Citadel in St Helens, and the writer has approached Julie Walters' agent to appear in it. Meanwhile the charity is expanding its activities to work in prisons.

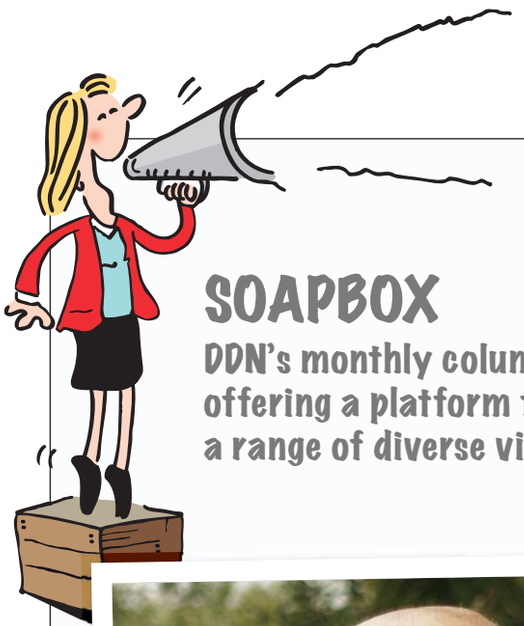
Speaking of prison, what does she make of the calls for some level of legalisation? 'When you've lost a son to drugs it's always very difficult to comment on that without getting very impassioned,' she says. 'But my experience in meeting people in drug rehabs and prisons, and with my own sons, is that decriminalising drugs doesn't necessarily solve anything. I can understand the rationale behind it, but the fact is that all drugs are dangerous. People have choices to make in life, and it's about trying to engage with interventions back in schools to help people understand that if they choose that path it doesn't matter whether drugs are illegal or not, they're going to be very ill. And, let's be honest, it isn't going to put the dealers out of business either, is it?'

What she would like to see on a policy level is some kind of compulsory education programme – for families as well as pupils – about the impact that drugs and alcohol can have on peoples' lives. 'We can tear down the walls of denial,' she says. 'Within the whole country's education system – private or state – there has to be very dedicated education on the subject of drink and drugs. It's not just about giving children lessons in the classroom, it's also about educating the parents and creating the conversations about how easily people can get groomed into it and how easily you can fool yourself that it's OK and it's not going to control you. That's where I'm coming from as an ex-teacher – I'd like to see that become mandatory.' **DDN**

www.drugfam.co.uk

Mum, Can You Lend Me Twenty Quid? is published by Piatkus Books.

'I think inevitably when you are a mum you want to do everything you can to rescue your children from anything that's harming them or putting them in any danger. That is how you get sucked unwittingly into co-dependency and you become addicted to their addiction... You don't realise it in the first instance and suddenly you're entangled.'



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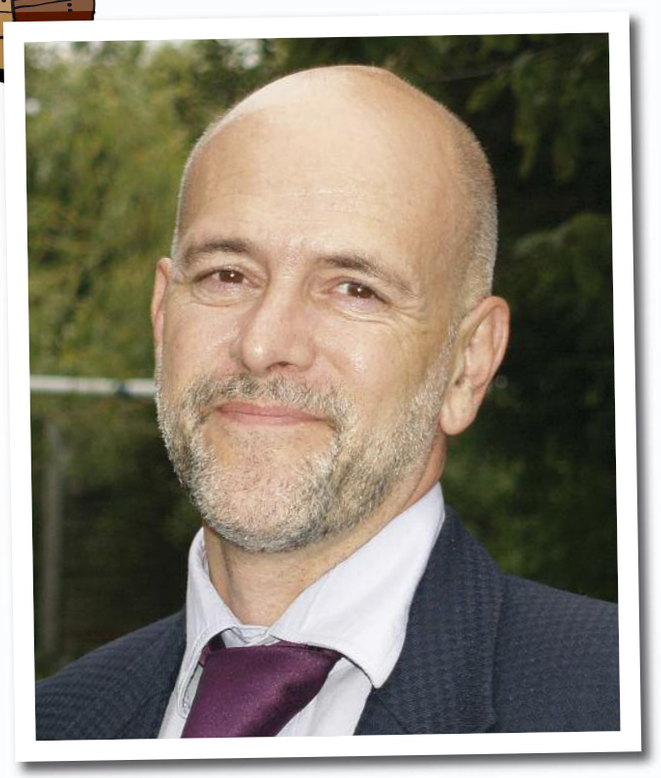

GET WITH THE PROGRAMME!

Payment by results gives incentive for real effectiveness, **argues** Russell Webster

'PAYMENT BY RESULTS' IS AN APPROACH TO FUNDING PUBLIC SERVICES WHICH MIRRORS HOW WE PAY FOR A MEAL IN A RESTAURANT. We typically give a healthy tip if we like the food and service, but demand they take the cost off the bill if it's not what we ordered, or the food is cold or defective in some other way. Organisations providing services under PbR will make a healthy premium if they reduce offending or drug use by more than the norm, but won't get paid in full if they fail to reach their agreed outcomes.

From a government point of view, it's hard to see the downside of PbR – it transfers risk, draws in private investment and ensures that public funding programmes actually achieve their objectives (or the money stays in the Treasury). I'm reliably informed that the 'big hitters' in government are particularly keen on PbR and you can see the evidence across different departments – the £5bn Work Programme is funded by PbR and there are PbR pilots for justice reinvestment, reducing re-offending and cutting the number of nights young people spend in custody. And of course there are eight drug and alcohol recovery PbR pilots.

There is a great deal of criticism of the PbR approach. Some of it is ethical – Polly Toynbee and others see PbR as essentially a Trojan Horse for privatisation of public services. They are opposed to financial institutions making money out of Social Impact Bonds (like the one used to fund the One Project, which provides a resettlement service to prisoners released from Peterborough Prison) and other financial instruments.

Some of the criticism is practical – commentators foresee a wide range of problems. They are concerned that providers will cherry pick the 'easier' clients with lower levels of need. They query whether it is possible to devise accurate outcome measures which are not overly complex and which don't cost a fortune to monitor. They question whether PbR can really foster innovation when agencies are risking their future and the jobs of their staff. In fact, the more PbR contracts are developed, the more concerns emerge.

But I want to argue that the drugs field must embrace PbR if it is serious in building a treatment system which is truly focused on recovery (and not just a rebranding exercise, as Ryan Campbell argued in last month's Soapbox).

Firstly, I think it's important to be honest with ourselves – spending on drug treatment has never been driven by the desire to help drug users. The first wave of investment in the mid-1980s was about halting the spread of HIV; the next big expansion in the early 2000s was about tackling drug-related crime. PbR will also drive money into the drug treatment field (particularly intensive treatment and aftercare) – but only if we can succeed in devising approaches that really help people become drug free, stop offending and rebuild their lives by getting off benefits and (back) into work.

I've been a freelance consultant for over 15 years, and in that time I have evaluated a least a dozen pilot projects which have been highly successful in turning round the lives of drug-using offenders. When these pilots were rolled out nationally, their success was greatly diluted. One of the key factors driving down performance was a focus on narrowly defined activity targets – such as the numbers of assessments (the curse of arrest referral workers and CARAT teams) or programme commencements (DTTOs/DRRs).

PbR may have a lot of drawbacks, but its relentless focus on outcomes in the most brutal fashion (if you don't meet them, you don't get paid) should drive a treatment system that is really focused on helping people get off, and more importantly, stay off, drugs.

PbR has great potential because of one key fact that keeps both government departments and providers honest – they both want to target the people with the most entrenched drug problems who cause the most damage to themselves and society. It's obvious that government wants to target the 'hard cases' because if they recover, they will produce the most savings to the justice, health and benefits systems. But the same is true for providers – the more prolific offenders they help, the more they will reduce 'reconviction events' and the more they will get paid. For once, we have a system with a built-in incentive for real effectiveness. It gives those of us who work in the drugs field and who have been advocating more investment in a holistic, long-term, recovery approach to put our money where our mouth is.

Of course, just like when we go out for a restaurant meal, the proof of the pudding will be in the eating. Let's hope the new treatment provision attracts plenty of Michelin stars and no providers get reported to the Food Standards Agency.

Russell Webster is an independent consultant specialising in substance misuse and crime. He has recently launched a new blog to stimulate debate around the rapid changes in the way we deliver public services – www.russellwebster.com/Blog.

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It is an exciting time to join the prescribing service with many new challenges ahead. Both local and national policy is moving in a new and interesting direction so you will need to be adaptable and enthusiastic for change. You will have line management responsibility and will need to be fully competent in all aspects of BBV minimisation and Hepatitis vaccination delivery.

For further details please contact Sue Hamilton, Area Manager KCA (UK) on 01843 298355 ext 217.

Application forms and job descriptions can be downloaded from www.kca.org.uk Alternatively, you can email recruitment@kca.org.uk or call 01795 590795 and select option three. Please quote reference: 810.

Closing date: 16 October 2011. Interview date: TBC

KCA (UK) is committed to the principles of equality of opportunity for all and welcomes applications from people with experience of substance use or who have had previous problems with substance misuse. Charity No: 292824

www.kca.org.uk

Progressive, Responsive, Effective

INVESTORS IN PEOPLE

N-DAP
Norfolk Drug & Alcohol Partnership

TENDER OPPORTUNITY:

Norfolk Adult Drug and Alcohol Recovery Orientated Treatment System

Norfolk County Council is looking to award a single contract for a Drug and Alcohol Treatment System for adults in Norfolk, which will increase the number of people able to achieve sustained recovery from dependence by providing individual support and treatment packages of care.

The system will be an open access, county-wide system with a single assessment and co-ordination system. Core delivery components will include: low intensity intervention and outreach services; structured treatment services including psychosocial interventions in Norfolk Prisons; volunteering and peer mentoring systems; harm reduction interventions and primary and secondary health care liaison services.

Applicants should view the contract notice published in the Official Journal, reference (290801-2011), at *http://ted.europa.eu/udl?uri=TED:NOTICE:290801-2011:TEXT:EN:HTML*

THE HEPATITIS C TRUST

Outreach Officer – Testing Van

To coordinate and deliver outreach testing and awareness events in hard to reach communities around the UK.

£24,000-£27,000 dependent on experience.

For full job description and application form visit: ***www.hepctrust.org.uk/jobs*** or contact Leila Reid on ***020 7089 6220*** or email ***leila.reid@hepctrust.org.uk***

Closing date – 5pm, Monday 31st October 2011

Charity No: 1104279 and Scottish Charity No: SCO39914

TRAFFORD COUNCIL

TENDER

EXPRESSIONS OF INTEREST ARE INVITED TO DELIVER A RANGE OF PREVENTION, DRUGS AND ALCOHOL AND RECOVERY SERVICES IN TRAFFORD

Trafford Council in partnership with Trafford PCT are seeking applications from suitably experienced providers to deliver one or more of the services detailed below.

THERE ARE THREE CONTRACTS TO PROVIDE

- ***Early Intervention and Prevention*** *– a youth work approach to preventing risky behaviors in young people. Value £400,000.*
- ***Tier 3 Alcohol Service (Lot A)*** *– a single point of contact delivering Hope, Choice and Opportunity to people drinking at risky to dependent levels. Value £300,000.*
- ***Recovery and Abstinence Management (Lot B)*** *– the provision of a structured approach to alcohol and drug recovery with an abstinence based long term aftercare service. Value: £700,000.*

It is anticipated that the contract will be awarded in 2011 with a proposed start time of April 2012. The contract period is 5 years.

For further information please register free on the Council's e-tendering system **"The Chest"** at the following web address: *https://www.thechest.nwce.gov.uk/* Any problems with accessing the information once registered please contact Due North on email: *nwsupport@due-north.com* or telephone: 0845 293 0459.

Documents will be available on the Chest on Monday 3rd October 2011.

Heather Stanton, Strategic Procurement Team, Floor 7 Quay West, Trafford Wharf Road, Trafford Park, Manchester M17 1HH
Tel: 0161 912 1287. Email: heather.stanton@trafford.gov.uk.

DDN DIRECTORIES

Don't miss out on your free listing in the Autumn 2011 edition!

THE RESIDENTIAL TREATMENT DIRECTORY

MONDAY 7 NOVEMBER

The DDN Residential Treatment Directory is back by popular demand! With so many treatment options available, our comprehensive listing aims to give statutory referrers and those seeking treatment an at-a-glance guide to treatment providers across the UK and further afield.

To add or amend your free listing, email directories@cjwellings.com

For details of enhanced listings please contact Ian Ralph on 020 7463 2081

INDEPENDENT COMPLAINTS PANEL MEMBERS

The Portman Group is the social responsibility organisation for drinks producers. We seek to ensure that companies market their products responsibly. We achieve this through operating a self-regulatory Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks.

Complaints under this Code are assessed by an Independent Complaints Panel. The membership of this Panel is diverse, representing a range of backgrounds and experience.

We are seeking to appoint two new members to the Panel to replace people whose term of appointment is ending shortly.

For one of these vacancies, we would particularly welcome applications from those with a health or alcohol services background.

Panel members are required to have sound judgement; good communication and listening skills; a reasonable awareness of alcohol issues; a balanced view of alcohol's role in society; and to be genuinely independent and objective in their thought and approach.

The Panel meets a maximum of eight times a year in Central London.

Members receive an annual honorarium of £3k and are reimbursed for reasonable expenses.

To obtain an information pack, please ring Jo Booth on 020 7290 1460, e-mail info@portmangroup.org.uk or visit our website at www.portmangroup.org.uk.

Closing date: Monday 31 October 2011

The Portman Group is committed to equal opportunities; applications are welcome from all suitably qualified candidates who meet the stated criteria

Portman Group

20 Conduit Street, London W1S 2XW | Telephone 020 7290 1460 | www.portmangroup.org.uk

Substance misuse personnel

Samantha Morris
Solutions Action Management
Founder & Company Director

Sam established Solutions Action Management in 2001 as a result of the ever growing need for specialist, skilled and experienced personnel. Prior to setting up the company, Sam started as a student at WDP where she underwent her Social Work training in conjunction with Brunel University. She then continued to study and work, undertaking her MA in Social Work at The Tavistock Institute whilst working as a Care Manager for Local Authority Substance Misuse Teams. Wanting to make an impact within the field, she took a strategic role and became a DAAT Co-ordinator. In 2001 she decided to work on a freelance basis and undertook needs assessments, CAD projects and interim DAAT roles for various DAAT Partnerships. With a vast network and a growing demand for consultants and temporary staff, SAM (Solutions Action Management) was founded.

Solutions Action Managment continued to develop and is now registered with the Care Quality Commission (formerly CSCI) and now supplies substance misuse nurses alongside social workers, drug workers, counsellors, senior managers and strategic consultants.

With the introduction of AWR (Agency Worker Regulations) this month SAM has been working in conjunction with umbrella companies, legal advisers, clients and candidates to ensure the implementation is seamless and all parties remain fully compliant. If you have any queries regarding the new regulations, Sam is happy to assist.

With many years of experience within the field, Sam and her team feel they are best placed to assist all organisations involved with substance misuse remits, and Solutions Action Management continues to provide excellent personnel to assist all levels of services. With recent developments in the sector, Sam and her team have innovative ideas for fulfilling your organisation's requirements and Sam is always available to discuss your needs.

SAM

Tel: 020 8987 6061 **www.SamRecruitment.org.uk**

DEPARTMENT OF SOCIAL CARE

Rheynn Kiarali y Theay

Adult Mental Health Services

Drug and Alcohol Team

Drug and Alcohol Professional

(Part Time – 30 hours per week) Band: 7
(£32,863 – £43,325 PRO RATA PER ANNUM)
Ref: 167N/11

The Isle of Man is the place to live and work.

- Attractive relocation package
- Excellent air and sea links to the United Kingdom
- Basic Rate of Income Tax 10%, maximum rate of 20%

An exciting opportunity has arisen for a suitably qualified, highly motivated Registered Nurse (Mental Health) with a minimum of 2 years post-registration experience of working within a mental health setting, with a demonstrable level of skills, knowledge & experience related to substance misuse work, to join our busy community based, multi-disciplinary Drug & Alcohol Team.

The successful applicant will deliver a service to people who misuse substances, or have Dual Diagnosis (substance misuse and mental illness) problems; and will take a lead role in the delivery of the Alcohol Treatment Pathway and in the development and delivery of group work programmes, whilst contributing to the optimisation of detoxification provision; as well as being responsible for a caseload of complex clients with severe/dependent substance misuse issues.

In return you will be offered a comprehensive induction package, continued professional development and specific training opportunities to further develop your skills and knowledge in the field of substance misuse.

Please note a police check will be required for this post.

For further information or an informal discussion please contact **Sue Perry, Manager or Martyn Mackie, Clinical Nurse Specialist on 01624 617889.**

Please note all applications must be accompanied by an Equal Opportunities Form.

Closing date for applications: Friday 21 October 2011.

Full application pack and job description can be obtained from: **www.gov.im/jobs** or **recruitment.dh@gov.im** or alternatively, the Office of Human Resources, 2nd Floor, St Andrews House, Finch Road, Douglas, Isle of Man, IM1 2PX. Telephone (01624) 642419 (24 hour answer phone). Please quote the above reference no.

Applications will only be considered on receipt of a fully completed application form.

Please note: If you have not heard from the Department within 6 weeks of the closing date you may assume that your application has been unsuccessful.

Isle of Man Government
Reiltys Ellan Vannin

DEPARTMENT OF HEALTH

Rheynn Slaynt