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'The 12 steps' powerlessness model distorts our understanding of why people become addicted, downplays the great potential for self-recovery, limits the use of effective treatments, and syphons resources away...'

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DDN Drink and Drugs News

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Tough talk

A challenge to ideology is a call to debate

THE 12-STEP MOVEMENT is close to many readers' hearts and by publishing a critical article about it we do not want to offend the many readers who feel their life is in its debt. But if you disagree with Stanton Peele's assertion (page 8) that the 12-step model should be abandoned because it 'distorts our understanding of why people become addicted, downplays the great potential for self-recovery' and 'diminishes people's sense of their ability to manage themselves and their worlds', please tell us why, as there's much at stake in this debate. While hoisting the flag of caution about blindly following American ideologies, we also hear from Rebecca Daddow (page 12) who shares an exciting approach stemming from a largely American evidence base, which is leading to innovative programmes in prisons and the community, focusing on strengths to transform the prospects of people on the margins.

The worst thing we could do is not to have such debates at all. As Lana Durjava reports from the CND meeting in Vienna (page 7), attended by representatives from UN member states including Russia, Iran and Pakistan, this important forum on drug policy and control was dominated by a 'dialogue of the deaf', where 'members of both camps appeared to be living in parallel words', reducing the exercise to 'ideological ping pong'. Let's keep talking.

This issue

FEATURES

REGULARS

NEWS IN BRIEF

BIG SPENDERS

Drug users in the US spend an estimated $100bn annually on cocaine, marijuana, heroin and methamphetamine, according to a White House-commissioned report from the Rand Corporation. Total expenditure is driven by a 'minority of heavy users who consume on 21 or more days each month', says *What America's users spend on illegal drugs*, and while overall expenditure remained stable in the ten years to 2010, the amount spent on marijuana increased while that spent on cocaine fell – 'consistent with supply-side indicators'. *Report at www.whitehouse.gov*

CRIMEA CALL

The International and Eurasian networks of people who use drugs (INPUD and ENPUD) have issued a warning about the plight of more than 800 clients of opiate substitution programmes in Crimea. Russian president Vladimir Putin and Crimean leaders signed a bill to absorb the peninsula into Russia last month, putting Crimean drug users at the mercy of Russia's 'highly repressive drug laws and deeply punitive approach' (*DDN*, February, page 6). The organisations are calling on the international community to put pressure on the Russian Federation to 'to respect internationally accepted human rights compliant, public health approaches for people who use drugs and allow for the currently running OST and NSP programmes to continue to run in the Crimea.'

HAVE YOUR SAY

The Advisory Council on the Misuse of Drugs (ACMD) is holding an open meeting on 11 April where members of the public will be able to put questions and provide feedback on the council's work. *Details at www.gov.uk/government/news/acmd-public-event-open-meeting-on-11-april-2014*

BRAIN TRAINING

More training for health and social care professionals in recognising alcohol-related brain damage (ARBD) is needed, according to a report by Alcohol Concern Cymru. ARBD covers a range of conditions including Wernicke–Korsakoff syndrome and – although it can be successfully treated if recognised early – is being under-diagnosed, says *All in the mind*. 'When alcohol-related brain damage is on the radar, the focus is often on older street drinkers,' said Alcohol Concern Cymru director Andrew Misell. 'But staff on the front line have been seeing younger people, and other people who don't fit the stereotype of a homeless dependent drinker, coming in with ARBD.' *Report at www.alcoholconcern.org.uk*

MPs demand 'urgent action' on liver disease

The government, NHS and Public Health England (PHE) need to take 'urgent action' to address the growing problem of liver disease, according to a report from the All-Party Parliamentary Hepatology Group (APPHG). A national approach to prevention, early diagnosis and improved service provision is needed immediately, says *Liver disease: today's complacency, tomorrow's catastrophe*.

Deaths from liver disease rose by 40 per cent to 11,000 a year in the decade to 2012, the vast majority of them preventable, says the report. The document renews the call for a 50p minimum unit price for alcohol, as well as for data on all aspects of liver disease to be 'collected, monitored and used effectively on a far more thorough and systematic basis'. It also wants to see PHE and NHS England set 'a clear goal' of eliminating hepatitis C within 15 years.

'Liver disease is the only one of the UK's top five causes of death where death rates continue to rise and there is no national strategy to tackle this,' said APPHG chair David Amess MP. 'Unless urgent and coordinated action is taken now, in less than a generation liver disease has the potential to be the UK's biggest killer. As most liver disease can be prevented, this is a tragic waste of life.'

Meanwhile the government has updated its guidance on banning the sale of alcohol below the cost of duty plus VAT. The ban, announced earlier this year, was branded an 'unsatisfactory compromise' by alcohol health organisations calling instead for a minimum unit price (*DDN*, February, page 4). Alcohol Concern has also accused the government of disregarding the health of the nation to 'protect the interests of big alcohol' after a 1p per pint cut in beer duty and a duty freeze on spirits and ordinary ciders was announced in last month's budget.

'The notion that this freeze is about protecting responsible drinkers is irresponsible spin – alcohol misuse costs us all £21bn a year, our hospitals weigh under the burden of it and our police forces are stretched to the limit because of it,' said Alcohol Concern chief executive Eric Appleby. 'Instead of taking serious, evidence-based action the chancellor has given the alcohol industry the green light to make bigger profits at all of our expense. This freeze makes a mockery of the government's ban on below cost sales, rendering it even less effective than it would have been.'

Deaths from liver disease rose by 40 per cent to 11,000 a year in the decade to 2012

A new report from Alcohol Concern also states that an increasing number of drinks companies are linking their brands to non-alcohol products in order to build brand awareness. Examples cited in *Brand stretch* include Jack Daniel's sauces and Baileys ice cream. 'It's clear that alcohol companies are already topping up their traditional and new media marketing with brand stretching,' said briefing author Mark Leyshon. 'Any attempt to more effectively regulate alcohol advertising will have to take this into account if it's going to make any difference.'

Liver disease: today's complacency, tomorrow's catastrophe at kingsfund.blogs.com

Banning the sale of alcohol below the cost of duty plus VAT at www.gov.uk

Brand stretch at www.alcoholconcern.org.uk

Government announces tougher powers to seize cutting agents

Plans to strengthen powers to seize substances used as 'cutting agents' for illegal drugs have been announced by the Home Office. Under the plans, enforcement agencies will have a general power to seize and destroy 'any substance reasonably suspected of being intended for use' as a cutting agent.

In 2012, more than 7 tonnes of the cutting agents benzocaine, lidocaine and phenacetin were seized, while the Home Office states that animal wormer levamisole has also been found in seized street drugs.

'I am very concerned that, in order to maximise their profits, drug dealers are using cutting agents that may present a hazard to health,' said crime prevention minister Norman Baker. 'People taking these drugs are playing Russian roulette with their lives, as they have no idea what is in them. The action we are taking to enhance the powers available to police and law enforcement agencies will help combat this dangerous and reckless trade.'

Meanwhile, the Department for Transport has announced that the recommended driving limits for 16 drugs have been approved following two consultations (*DDN*, August 2013, page 5). It will be an offence to be over the prescribed limit for eight illegal drugs – including cocaine, cannabis and MDMA – and eight legal ones, including methadone, diazepam and temazepam, with the regulations to come into force in the autumn. An agreed limit on amphetamine will be added to the legislation at a later date, following consultation on the possible impact on people taking medicine for attention deficit hyperactivity disorder (ADHD).

'This new offence will make our roads safer for everyone by making it easier for the police to tackle those who drive after taking illegal drugs,' said road safety minister Robert Goodwill. 'It will also clarify the limits for those who take medication.'

UN drug statement 'an embarrassment', say harm reduction groups

The joint ministerial statement issued at the United Nations Commission on Narcotic Drugs (CND) in Vienna represents a capitulation to hardline states, according to Harm Reduction International (HRI) and the STOPAIDS network of organisations.

Governments from around the world were represented at the commission, which aimed to find ways forward in addressing world drug problems. The joint ministerial statement highlighted 'the importance of health, prevention and treatment, including protection against HIV', said the UN, with United Nations Office on Drugs and Crime (UNODC) executive director Yury Fedotov stating that there was a need to strengthen the public health focus and pursue a 'comprehensive, balanced, scientific, evidence-based approach, fully consistent with human rights standards'.

According to HRI and STOPAIDS, however, the ministerial statement's failure to endorse harm reduction approaches represented a 'capitulation' on the part of progressive governments, with 'lack of coordination, leadership and transparency from the Home Office, Foreign Office and DFID' playing into the hands of hardline countries like Russia. The statement failed to acknowledge that the agreed international target of a 50 per cent reduction in HIV among people who inject drugs by 2015 would not be met, it said, and also failed to condemn 'even the most serious of human rights abuses in relation to drug enforcement', as no agreement on the death penalty was reached.

'The document is an embarrassment for any government that adopts it,' said HRI executive director Rick Lines. 'The UK and the EU as a group have not been forceful enough and backed down on key issues to preserve the "consensus" in Vienna. We are left looking on in frustration as Russian-led efforts to push for regressive language on HIV win through.'

Crime prevention minister Norman Baker, however, said he was pleased that 'we have managed to forge a way ahead towards a global consensus on the need for a modern, balanced and evidence-based approach to drugs policy'. He also used the commission to call on other countries to introduce bans on mephedrone, which was banned and regulated as a class B drug in the UK in 2010 (*DDN*, 26 April 2010, page 4). 'I would urge all countries to take action against this dangerous drug so together we can protect people and ultimately save lives,' he said.

Joint ministerial statement at www.unodc.org

See news focus, page 6, and feature page 7

'We are left looking on in frustration as Russian-led efforts to push for regressive language on HIV win through.'

RICK LINES

Increase in drug-related deaths for older Scots

The proportion of drug-related deaths in Scotland among people aged 45 and above increased from 14 per cent in 2011 to 26 per cent in 2012, according to the latest figures from ISD Scotland.

The report provides further analysis of statistics released last year detailing the country's second-highest number of drug deaths (*DDN*, September 2013, page 5). Two thirds of the 581 drug-related deaths were in the 25-44 age group, with nearly 60 per cent in the country's most deprived areas. Deaths in those aged under 25, however, fell from 12 per cent to 8 per cent. As in previous years, more than three quarters of those who died were male, while more than a third were parents.

'It is encouraging that fewer young people are dying from drugs which is in keeping with wider statistics on drug use in Scotland,' said community safety minister Roseanna Cunningham. 'However, this report also confirms that, in Scotland, we are dealing with an ageing cohort of people with a long legacy of drug use and we must continue to work together to ensure that this vulnerable group, who have been using drugs for many years and who experience other chronic medical conditions, receive the appropriate care and support.'

The national drug related deaths database (Scotland) report: analysis of deaths occurring in 2012 at www.isdscotland.org

NEWS IN BRIEF

AISLE HAVE A LARGE ONE

Displaying alcohol at the end of supermarket aisles increases sales by up to 23 per cent for beer, 34 per cent for wine and 46 per cent for spirits, according to research by Cambridge and East Anglia universities in partnership with MRC Human Nutrition Research. The studies were controlled for price, promotions and number of display locations. 'Although we often assume price is the biggest factor in purchase choices, end-of-aisle displays may play a far greater role,' said study co-author Professor Theresa Marteau.

RECOVERY CASH

Capital funding worth £10m has been distributed to 'recovery-orientated' drug and alcohol services across England, Public Health England (PHE) has announced. Almost 70 awards were made, with amounts ranging from £3,500 to more than £870,000. 'The successful projects range from smaller schemes such as those providing training opportunities to people in recovery, to large-scale schemes such as building new recovery centres,' said PHE's director of alcohol and drugs, Rosanna O'Connor. Among those receiving the money was Weston-super-Mare-based Broadway Lodge, which was awarded nearly £40,000 to upgrade its detox unit (*DDN*, November 2013, page 16). 'We're extremely grateful to receive this money from Public Health England and it will ensure a better quality of service for all our patients,' said chief executive Brian Dudley.

RISKY BEHAVIOURS

Shifting trends in drug use among sections of the gay and bisexual community are causing 'significant' harm to physical, mental and sexual health, according to a new report from the London School of Hygiene and Tropical Medicine. *The chemsex study* was commissioned by the London boroughs of Lambeth – which has the highest prevalence of HIV in the UK – Southwark and Lewisham. 'A vulnerable section of society is using new drugs in new ways that is putting them at serious risk,' said report author Dr Adam Bourne.

WORRYING WORDS

Although alcohol consumption per person across the UK population has more than doubled in the last half-century, the trend 'masks a still more concerning underlying pattern', according to the latest report from the chief medical officer, with an increase in the proportion of the population abstaining from alcohol meaning that 'the increase in consumption per non-abstainer' is even higher. The report also includes sections on prisoner health and health and employment. *Annual report of the chief medical officer at www.gov.uk.*

CONSENSUS POLITICS

As ever, this year's meeting of the Commission on Narcotic Drugs proved a controversial affair. But despite failure to reach agreement on major issues like the death penalty, hears *DDN*, things may be changing below the surface

According to executive director of the UN Office on Drugs and Crime (UNODC), Yury Fedotov, the recent 57th session of the Commission on Narcotic Drugs (CND) in Vienna enabled UN member states come together to strengthen their responses to world drug problems. However it seems the event was characterised more by increasingly entrenched positions than any kind of agreement.

Although held against a backdrop of shifting drug policy – in places like Colorado, Washington state and Uruguay – much of the event's feedback has been negative, with talk of progressive nations giving in to hardline states like Russia (see news story page 5, and comment facing page). Harm Reduction International (HRI) and the STOPAIDS network of organisations even urged the UK government not to sign the joint ministerial statement adopted at the end of the first 'high-level' segment of the event.

However, although that statement may have ended up an unsatisfactory compromise – with states unable to reach agreement on the death penalty, for example – much of what was actually said in Vienna may indicate something of a shift towards a more progressive approach.

'We went to the high-level segment with the expectation of being quite disappointed because the statement was so watered down,' International Drug Policy Consortium (IDPC) executive director Ann Fordham tells *DDN*. 'But it was heartening this time to see countries like Switzerland, Norway and the EU operating as a block being very firm on the need for the abolition of the death penalty.'

Many of the individual country statements in the CND sessions were similarly progressive, she points out. 'Obviously because the joint ministerial statement is a consensus document, their positions were watered down but they did make quite strong statements. All the EU countries were talking about health-based policies, most of them speaking out against the death penalty and many being very frank about the failure of criminal sanctions in deterring people from drug use. That's huge progress. It's unprecedented to have that many countries come out and say we need to decriminalise drug use.'

What was particularly surprising was the position of some Latin American countries, she stresses. 'They were really digging their heels in and being really strong and outspoken. The big surprise for us was Ecuador. We weren't expecting them to be quite so strong but they said "we need to review the UN conventions, they're outdated" – most countries wouldn't go that far. Mexico was also making it very clear that they felt there needs to be an honest and open debate on drug control.'

There remain a significant number of nations maintaining that no debate is needed, however, including, Russia, Iran, Pakistan and others. 'But then you've got Europe who've been strongly basing their drug control policies on health of late and I think they were more open this time about the need for a debate. Then of course we had Uruguay who are on the brink of finalising their cannabis regulation.'

While Fedotov has been dismissive of Uruguay's move, stating that it was 'very hard to say that this law is fully in line with legal provisions of the drug control conventions', Uruguay used the CND to claim that it was within the *spirit* of the conventions as its aim was to ensure public health and security. 'It was interesting to see that dynamic play out, but what was also interesting was that the other Latin American countries aren't necessarily completely supporting Uruguay because they have to be quite careful,' adds Fordham.

'All the EU countries were talking about health-based policies... many being very frank about the failure of criminal sanctions in deterring people from drug use. That's huge progress. It's unprecedented to have that many countries come out and say we need to decriminalise drug use.'

ANN FORDHAM

'I think you have to read between the lines. Obviously we're disappointed, but the global political process does move at a glacial pace and if you're watching closely then you can see the nuances, of which there are many. If you take the cannabis regulation initiatives, in Uruguay and the US states, that trend is irreversible. Vienna is still a very closed-minded, consensus-based model of working that makes progress very limited, but

it's creating a different backdrop to the general discussions.'

But it's at the side events where the real debate takes place, she points out. 'This year they were incredible. Uruguay had an event where they presented their cannabis regulation initiative and I've never seen one that packed, and it wasn't just NGOs in the room – it was mostly government. The US were in there, furiously scribbling notes.'

Scheduling of substances was a central issue, with many countries worried about the proliferation of new drugs. There was a debate around ketamine, which WHO had been asked to review but failed to recommended for scheduling because of the number of countries – particularly in the developing world – that rely on it for anaesthesia.

'That's particularly true for emergency operations in conflict situations because apparently it's very easy, if someone's been shot, to just give them an injection of ketamine and then there's no need for any other complicated anaesthesia,' says Fordham. 'Ketamine's not under international control so you can carry it across borders but if you were to put it under international control, and this is a pretty serious indictment of the international drug control system, it would severely limit access. CND can't just schedule something that WHO has recommended not to be scheduled, but there's this push from countries like Thailand and China, and WHO colleagues are very concerned because many countries would be severely affected.'

Did IDPC's experience of the event alter their expectations for the milestone 2016 UN General Assembly Special Session? 'I'm not sure how hopeful we should be, but it's heartening to see that some countries genuinely no longer have the appetite to just carry on with this charade of a global consensus,' she says. 'There really were some countries that have just had enough of that. Places like Uruguay and also Columbia said that they have a duty to their citizens to do the best they possibly can. That involves looking at alternatives and having countries put that on the table is really important. Where people have come away very pessimistic I can understand that, but you also do have to recognise that those things haven't been said in those rooms before.'

COMMENT

A LITTLE LESS CONVERSATION...

Lana Durjava attended the CND meeting in Vienna and found it woefully short on action, as she tells *DDN*

'The whole convention could be effectively summed up as an endless saga of ideological ping-pong, essentially a dialogue of the deaf.'

LANA DURJAVA

STATISTICALLY SPEAKING, the majority of people who use drugs do it in a recreational and generally functional way. Although motivational forces for any human act are of a complex nature and cannot be reduced to a single component, their drug taking generally seems to have more to do with seeking pleasure than escaping pain.

Since the main focus of my work and research is the phenomenon of drug use that is no longer under control, I was, during my attendance of this year's CND session, primarily interested in learning about practices that are being implemented on a national and international level to address this target group's needs and help make their lives more manageable, more functional and generally less traumatic.

As it turns out, not much is actually done, although there was certainly an awful lot of talking about it. The first casualty of CND-type of conferences that attract a bizarre mixture of prohibition zealots, UN diplomats, treatment providers, harm reductionists and people who use drugs, is probably any sort of terminological consistency. Language was all over the place: drug use, drug abuse, drug misuse and drug addiction often seemed to be interpreted as entirely synonymous terms. Moral notions and intense emotional baggage attached to at least some of these words went mostly unacknowledged.

Discourse creates reality, and this terminological mess offered a pretty good hint of what laid in store for the attendees of the convention. Although there was a certain level of consensus among CND veterans that this year's conference represented notable progress in comparison to those a few years ago, which focused almost exclusively on drug war, the speeches and plenary sessions routinely gave their audience an impression of having stepped into an entirely different historical era.

The whole convention could be effectively summed up as an endless saga of ideological ping-pong, essentially a dialogue of the deaf, with apologists of the drug war and zero tolerance approach on one side and proponents of drug reform on the other. The members of both camps appeared to be living in parallel worlds, half of them promoting the drug war as a raving success, the other half interpreting it as a miserable failure. The speakers' confidence often tended to be in inverted correlation to their knowledge base, and statistics were rather casually adjusted to their current needs.

CND is a political affair, I acknowledge that. But with all the endless talk, it is somewhat hard to come to terms with just how consistently and thoroughly the psychological aspects of the phenomena of drug use and addiction were avoided. If addiction could be primarily understood as a coping mechanism and a compulsive repetition of a once-functional act that is by its essence nostalgic, it would be helpful, but in reality it is not nearly enough to exclusively address social and legal issues around it.

It is undeniable that it would be of great benefit to anyone involved with drugs to change the current drug laws, tackle poverty and generally create more life opportunities, but what remains to be persistently ignored is the vast psychological aftermath of long-term compulsive drug use. I am not talking about brain changes here – although they definitely occur and are a contributory factor. But is rather difficult not to acknowledge that the whole medical paradigm, with its acute lack of compassion and fundamental enforcement of its perspective as the one and only truth, did very little in terms of eradication of stigma and not nearly as much as it would like to claim in terms of general improvement of the wellbeing of people who use drugs.

The lifestyle of persistent preparation of the latest shot, scanning the streets for potential dealers, frantic search for lost veins and eternal checking if the front door is still locked, takes its deep psychological toll. Being originally an act of preservation and essentially an attempt to heal trauma, compulsive drug use ends up to being additionally traumatic, and although the intensity and manageability of the situation correlates with an individual's pre-existing vulnerabilities, this trauma is essentially structural, not incidental.

This is an issue that remains consistently neglected within the current drug policy debates, as well as the vast majority of drug treatment services. And as far as this year's CND goes, it certainly did not accommodate any sort of illusions this will even begin to change anytime soon.

Lana Durjava is a postgraduate student of psychology at the University of Westminster.

A STEP TOO FAR?

'We're doing so well with addiction in the US, we're going to convert Europe.' **Stanton Peele** challenges the received wisdom of the 12-step approach

I recently received this email from a UK addictions worker:

'Stanton, I was in a public health meeting today (well I was until I walked out). The government focus is currently all about facilitating 12-step engagement. I tried to make some kind of stand, and the only progress made was to get an acknowledgement that where people are persuaded to reduce mental health meds, life may be put at risk, and they wanted cases of this to be reported. I pointed out that 12-step fellowships do not work like this or have a reporting structure to facilitate this, but was brushed aside. Anyway, I don't have an ability to work through research or writing on the matter, so I wondered if you have produced a clear (not too long) summary of the potential harms of the 12-step approach with some handy and convincing figures that I can use as part of my rearguard action. I dare say you are busy, but anything would help. Thanks, A.'

Here is my response for people in situations like A.

Many Europeans are aware that we in the United States, home of American exceptionalism, tend to go it on our own, and expect the rest of the world to follow. Understandably, in recent years, Europe has become wary of following us blindly in our overseas adventures (like the invasion of Iraq), the consequences of which haven't been good, or certainly what we claimed they would be. Instead, many European nations prefer to develop their own policies steeped in their own national traditions and values. Good for you!

But the exception to this self-assertion lately has been in the area of alcoholism and addiction. After decades of not rushing down the American route (which is 75 years old) of Alcoholics Anonymous, the 12 steps, and perpetual abstinence as the best – the only – approach to use in the treatment of alcoholism and addiction, a number of European countries have been moving steadily in the 12-step direction (including, as in the quoted mail above, the UK). They are often pushed in this direction by the US rehab industry (called the Minnesota Model), which has a roving group of consultants/lobbyists. This shift is unwise and contrary to Europe's and addicts' best interests.

That the UK and other countries are coming gung-ho now is particularly puzzling for these reasons:

1. The US has often been criticised for its decades-long delay in implementing clean needle programmes, which led to a second wave of HIV infections among IV drug users in the US (primarily minorities) – a public health disaster avoided in the UK, Australia, and virtually all other Western European and Commonwealth nations. Even today, as every public health body in the US and the rest of the world strongly endorses provision of clean

syringes, the US Congress has rescinded government support for this policy, based on America's abstinence fixation.

2. No one in the United States answers the question, 'How are we doing in fighting alcoholism and addiction?' with a wholehearted endorsement of the success of our approach. Instead, there is great soul-searching about every new drug and substance use scare that comes down the road – including, recently, off-label overuse of prescription painkillers and ADHD medications such as Adderall, increased drinking by young women, use of illegal drugs like methamphetamines and heroin, and so on.

3. No one here has great confidence in our treatment modalities. Indeed, AA and 12-step rehab's greatest innovation has been to redefine failures – up to and including death, as in the cases of Philip Seymour Hoffman and Cory Monteith – as proof of its underlying 'cunning, baffling and powerful disease' sales pitch. Yet people simultaneously endorse the strange, religious-based self-flagellation rituals of AA as being a medically efficacious treatment! What's really 'cunning, baffling and powerful' is AA's hold on the American psyche.

4. Recently, through the work of Lance and Zachary Dodes' *The Sober Truth: Debunking the Bad Science Behind 12-Step Programs and the Rehab Industry*, and my and Ilse Thompson's *Recover! Stop Thinking Like an Addict and Reclaim Your Life with The PERFECT Program*, Americans have been presented with some powerful voices rejecting the efficacy of our most popular addiction treatment. Although our books are, in themselves, unlikely to reverse America's ardour for AA and its steps, nonetheless the simple simultaneous appearance of these books, their wide circulation, and their coverage in the media suggest that change is in the air.

As an answer to A's note, let me present the five primary reasons AA and the 12 steps should not be supported among best practices here in the US as well as in Europe. In a quick overview, the 12 steps' powerlessness model distorts our understanding of why people become addicted, downplays the great potential for self-recovery, limits the use of effective treatments, and syphons resources away from pragmatic strategies that help alcoholics and addicts. At a more basic level, it diminishes people's sense of their ability to manage themselves and their worlds, and results in wasteful and often destructive public policies that treat alcoholics/addicts as helpless victims.

1. AA causes us to deny the realities of recovery. The fastest growing body of addiction research shows that most alcoholics and addicts outgrow addiction without treatment. In 2002, the National Institute on Alcohol Abuse and Alcoholism studied 43,000 randomly sampled Americans' lifetime history of alcohol and drug abuse. Called the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), it concluded: '20 years after the onset of alcohol dependence, three-fourths of individuals are in full recovery; more than half of those who have fully recovered drink at low-risk levels without symptoms of alcohol dependence.' Only a quarter had treatment of any sort, and only half of those (13 per cent) actually attended AA or rehab.

NESARC found the same to hold for drug addicts. Gene Heyman has analysed these results and those of three other national surveys of drug addictions: 'Each found that most of those ever addicted to illicit drugs were ex-addicts by about age 30. Moreover, most of those who quit did so without professional help. Follow-up analyses reveal that the high remission rates were not temporary, due to missing addicts or a function of other methodological pitfalls.'

Several longitudinal studies – those following people in the general population – have tracked people who developed alcoholism or drug addiction for years, even decades, and found that 'people mature out of addictions at all ages', and that 'relapse does not appear to be as ubiquitous as one might expect based on estimates from clinic samples.' All these findings lead to 'the view that alcoholism, at least in most cases, represents a changeable habit rather than a brain disease.'

2. AA exaggerates and oversells its success. Dodes cites research indicating that AA works for 5 to 8 per cent of those who participate in the group. But that figure must be compared against the numbers who recover on their own – indeed, several studies comparing alcoholics randomly assigned to AA or left to their own devices found the latter did better on average! And 12-step rehab results are hardly better. According to the Cochrane Collaboration, the prestigious group of scientists that compiles evidence on the effectiveness of various treatments, in the case of the 12 steps: 'No experimental studies unequivocally demonstrated the effectiveness of AA or TSF approaches for reducing alcohol dependence or problems.'

3. AA and 12-step treatment drive out other, often more effective, treatments. Like carp infesting a lake drive out other species, AA and 12-step treatment rule out other, often more effective, approaches. A British group, the Effectiveness Bank, compiles data on such treatments, including motivational interviewing, skills training, social network therapy, community reinforcement approach (CRA) and community reinforcement and family therapy (CRAFT), solution-focused therapy, narrative therapy, purpose-driven therapy – hardly any of which are known, not only to the public, but by treatment providers in the US. They have been thrown overboard due to the myth of 12-step effectiveness and the 12 steps' own imperialistic, take-no-prisoner view of the alcoholism treatment world.

4. AA attacks self-efficacy. What enables people to overcome alcoholism and addiction, particularly considering that most people outgrow it with age and maturity? The single factor most often found in effective treatments is that individuals become more confident of their own strength, sometimes called

'After decades of not rushing down the American route a number of European countries have been moving steadily in the 12-step direction. They are often pushed in this direction by the US rehab industry...'

'self-efficacy' or, more popularly, 'self-empowerment'. AA's central message is of the individual's powerlessness that we all know to be the first step. Then, there is step 3: 'Made a decision to turn our will and our lives over to the care of God as we understood God.' Sound like a sound therapy principle to you? And are you aware of these steps? Step 5: 'Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.' Step 6: 'Were entirely ready to have God remove all these defects of character.' Step 7: 'Humbly asked God to remove our shortcomings.'

These steps do not encourage self-confidence and acceptance of the self – they are not so subtle ways of attacking people's sense of themselves, just like some therapists and group leaders tell people, 'You have had a deep trauma in your life which is saddening and weakening you; what is it?' Everyone has a response to an intrusive question like that, and that answer leads one to a debilitating, self-loathing, or at least a self-pitying, place – not one likely to lead to constructive life changes.

Stanton Peele has been at the cutting edge of addiction theory and practice since writing, with Archie Brodsky, Love and Addiction in 1975. He has developed the online Life Process Program, and has written (with Ilse Thompson), Recover! Stop Thinking Like an Addict and Reclaim Your Life with The PERFECT Program. He can be found online on Google+ and Twitter.

equinox

BUILDING A NETWORK

Charlotte Tarrant explains how Equinox Care's mutual aid groups for cannabis and alcohol misuse have built a network of support for local users

IN 2012, EQUINOX CARE WAS AWARDED TWO GRANTS BY HERTFORDSHIRE COUNTY COUNCIL – one to develop mutual help options for local people with alcohol dependence, the other for individuals who wanted to end or reduce their cannabis use.

The project started in late 2012. The aim was to set up confidential networks in Watford and Three Rivers, which would become self-sustaining by the end of 2013. The cannabis network initially targeted young adults in Watford, aged 18 to 24, whereas the alcohol network targeted professional people in Three Rivers. We found there were many people drinking above safe levels who were not accessing alcohol support. This included people in demanding jobs, commuting into London, who were experiencing work stress and overcompensating with alcohol.

In January 2013, an alcohol leaflet went out to homes and businesses in Rickmansworth, targeting places where professionals accessed services such as hairdressers, newsagents, restaurants, pubs and clubs. Promotion for the cannabis network started in February. With BBC Three Counties Radio, the *Watford Observer* and *My Ricky News* providing supportive local media coverage, notices were also placed on the Three Rivers District Council website.

We put on a stakeholders meeting to network with local and countywide providers, and subsequently, the Equinox project managers met with service providers and attended team meetings, explaining referral procedures. They also met with the community mental health team, GPs, the YMCA and A&E referral workers.

In March 2013, premises for the confidential groups were secured, and in April the cannabis and alcohol groups began in Watford and Rickmansworth, respectively. Location was the key to success, with the cannabis venue proving more accessible. During 2013, the cannabis group grew steadily. A solid core group formed – between six and 14 men and women of all ages attend every week.

They went on to form a peer steering group (which is supported by Equinox but self-facilitating). They have created their own website, www.noneed4weed.org.uk, as well as posters and leaflets, which feature their original illustrations and content. These have been distributed to doctors' surgeries in the Watford area.

Group member Terry needed to give up smoking cannabis due to an emphysema diagnosis. 'I suggested that everyone swapped phone numbers so we could support each other,' he explained. 'So now, anyone who says they are cutting down or quitting, we send messages to support them. It really makes a difference. One of the guys on the group has a dad who is a website engineer, so we also have a cannabis group website with a forum.'

The Three Rivers alcohol group retained the same members each week, but after Equinox's year of involvement ended, the alcohol group ceased to exist. The main learning point has been that the target group of professional people, who were not accessing alcohol support in any form, needed to identify their drinking as problematic first, typically with one-to-one counselling. This might have established the motivation to attend mutual support meetings.

Chief executive of Equinox Care, Bill Puddicombe, explained, 'The argument for working with alcohol users seemed the stronger. There is a long tradition of mutual help proving beneficial in aiding the recovery of alcohol-dependent people.

'As it turned out, the cannabis project was the success. While there are strong indications that mutual help can be successful in assisting with recovery from drug dependency, little of the work that we could find was with cannabis users. Our two local staff, Kathy Young and Jackie Groves, quickly found a group of people in Watford who were keen to end their cannabis use. They moved the group forward with our help. It was always the intention that Equinox assisted in the creation of the recovery community and moved on. Now the cannabis group is self-supporting and going from strength to strength.

'We learned that it is not a good idea to predict who will take up the mutual help offer. Our research had suggested that dependent drinkers, in work and relatively affluent, would find this a more palatable option than local treatment services. In fact they were more drawn to privately funded services, such as counselling.'

Brian Gale, senior commissioning manager for public health at Hertfordshire County Council, added, 'It has been enlightening to see how this initiative has developed. The programme plan was to engage the wider community and then establish the groups on the basis of this engagement, although this meant the group took a long time to establish. On reflection, it would have perhaps been more beneficial to timetable and deliver the group provision for people alongside the programme of community engagement.

'However, overall we are pleased with the establishment of a cannabis group in the area and will be interested to see how this continues to develop over time as a resource for local people.'

Charlotte Tarrant is marketing manager at Equinox Care, www.equinoxcare.org.uk. For more information about the Watford mutual support network email charlotte.tarrant@equinoxcare.org.uk

Recovery should mean focusing on what is strong, not what is wrong – and that's where the ABCD approach comes in, says **Rebecca Daddow**

A PLACE TO THRIVE

Like recovery, addiction is a social issue that cannot be divorced from broader social, economic and political contexts. These are contexts that concern us all and which, for us at Nurture Development, situate issues of addiction and recovery firmly within the bounds of social justice.

I doubt many would disagree. It is rare to find a discussion about these issues without looking to the families and networks that the individual is part of; the economic prosperity of the communities they have come from; the emotional or physical trauma they may have suffered; the opportunities they have for education, training and employment; or an investigation of their wellbeing, physical and mental health. And so on.

It is these issues that reveal the catalysts and journey to addiction for people and will often suggest the likely trajectory of their recovery journey. But they are also the same issues that are pertinent to all of our lives and it is through the mapping of these issues over time that people like Bruce Alexander, as well as our ABCD colleagues, John McKnight and Jody Kretzmann, tell a story of 'the globalisation of addiction' in a post-modern society that promotes individualism, free market economies, competition and professionalisation.

'It is the people, caught in this web of counter-productive systems, who must seek survival in the hopeless spaces available. They react in many ways, just as we would. They strike out in anger, as some of us would. They create productive, phoenix-like new ventures and initiatives, as some of us would. They despair and retreat into addictions, as some of us would. They are normal people in an abnormal world, surrounded by expensive, costly helping systems that are the walls that bound their lives. To defy those walls, they must live abnormal lives – often productive sometimes destructive, always creative.'
John McKnight, The Careless Society: Community and its Counterfeits

This may seem like an odd way to start a discussion about Asset Based Community Development (ABCD), which tends to err on the side of strength, positivity, and abundance. But it is an important layer of context to what follows. Because as we're talking about addiction and recovery as issues of social justice, we propose that we must stop focusing on addiction and recovery, in the same way that we must stop focusing on mental health, rehabilitation of prisoners, domestic violence, or tackling levels of obesity. We must move away from siloed thinking, siloed budgets, siloed cultures and siloed practices and start focusing on how we collectively address the weak communities in which these social ills thrive and build the competencies of communities so that they can reclaim their power in addressing them.

Recovery is only possible in healthy communities, but our communities need to recover too. We need a whole community recovery agenda, not just a whole

person recovery one, that doesn't simply focus on a single issue and offers a radically different approach to the 'four pillars' of traditional responses to drug and alcohol addiction (treatment, prevention, law enforcement and harm reduction) that have ultimately failed.

This is where we suggest that an ABCD approach will add the most value. For us, this approach goes beyond traditional strength-based approaches and promotes citizen-led community building that is independent of service provision and single-issue agendas. The things that people in recovery need to live a full life, for example, are no different to what everyone else needs – positive relationships, job/purposeful activity, somewhere safe and secure to live, and they are no different to the things that are needed to address anti-social behaviour and crime, loneliness and depression or obesity and declining mental health.

ABCD focuses on what is strong, not what is wrong, in individuals and communities. It seeks to enable people to become active contributors to their communities, building relationships and connections with the abundance – both potential and actual – that exists in relationships with their neighbours and in the communities around them.

Our approach to community building is a method for individual and whole community transformation. It is not about building 'recovery communities'. That is not to say that recovery communities are not important: there are some incredible examples around the UK, especially those that have been built by grassroots groups and organisations. But too often these become part of the service landscape. Something happens when they become professionalised, something that means they begin to conform – often without realising it – to the deeply entrenched thinking of the system they are now linked to.

Despite the mountains of data collected about people within the various systems such as benefits, housing and treatment, there is still an incredible lack of evidence about what works, at what points and for whom, when it comes to a number of things including drug and alcohol addiction and recovery. For us, it is not necessarily a question about harm reduction or abstinence. Our money is on healthy, vibrant and hospitable communities that welcome people in from the margins.

It is in community building that individuals in their communities are awakened to their capacity to care for one another, to create safe and hospitable environments, to build resilient local economies and to heal and support people to live fulfilled lives. In doing so, reliance on public services reduces so that their resources are focused only on those things that people and communities cannot do for themselves.

We're using an ABCD approach in our 'learning sites' across the UK to build on the largely American evidence base that demonstrates the power that this approach has across a variety of issues. These learning sites are championed by local leaders who are brave early adopters of an approach that challenges us all to think and behave differently, work in different ways and step into our citizenship.

As part of the development of this evidence base, we'll shortly be embarking on an exciting programme of work across nine prisons and 15 communities in the North West alongside Mark Gilman, PHE strategic recovery lead, and a range of experienced partners from the criminal justice and recovery fields. ABCD provides the ethical and theoretical framework for this innovative programme in a way that is radical and transformational and corresponds with wider PHE and public service reforms, moving beyond a narrow focus on service or system reform. As such it recognises that it is in strong, connected and inclusive communities that recovery thrives and sets out a community building agenda which reaches into the prisons, through the gates and into the heart of communities.

We share our learning regularly through our website and blogs and invite you all to join our journey and be part of the ABCD movement, contributing to our growing understanding about how we can collectively improve social justice.

Rebecca Daddow is recovery and justice lead at Nurture Development, www.nurturedevelopment.org. If you would like to discuss any of the ideas mentioned here, email rebecca@nurturedevelopment.org.

POST-ITS FROM PRACTICE

Different perspectives

No two people are the same – and neither should we expect their treatment to be, says Dr Steve Brinksman

PRIMARY CARE IS A FUNNY OLD WORLD, heading in more or less the same direction as other services with our patients who use drugs and alcohol problematically, but with some major differences.

For a start I never discharge patients; they don't 'exit as treatment completed'. If one issue ceases to be a problem I may well see them for something else. Perhaps this colours my view, but to me getting to abstinence as soon as possible isn't the be-all and end-all. What is desirable is having the person lead what they feel is a normal and hopefully enjoyable life and experiencing the freedom of choice that inevitably provides. Most diabetic or hypertensive patients – despite often expressing a desire to enjoy greater health and wellbeing – don't change their lifestyle so much that they are effectively cured. And while some do make great strides – and that is something to celebrate – I continue at the same time to support those who haven't managed that, because they are my patients.

Over the past couple of months I have seen two men, both in their mid-30s now, who have been in treatment for problematic drug use with us for a number of years.

John had been titrated up to 90mls of methadone before he stopped injecting heroin and crack – a big step forward. He had stayed on that dose for more than a year and had engaged with a local peer support group. Over the past nine months he had slowly been reducing down and then having 'stuck' at 25mls decided to do a lofexidine-assisted withdrawal. Two weeks after this concluded he came for his appointment and we were discussing next steps and what his options were. He decided not to take naltrexone, and he was intending to continue with his mutual aid group.

David had been with us a similar length of time. Twice previously he had stabilised on 60-70mls of methadone and then started to reduce, only to drop out of treatment and relapse. Fortunately on both occasions we were able to get him back into treatment rapidly. This time round he had reduced down to 30mls without mishap and we were discussing where to go from there. He was working, had a stable relationship and was in his own flat. He had been to some mutual aid meetings and felt he wanted to be abstinent in the future but, he said, he suspected that trying to achieve that now might risk what he currently had.

We will continue to discuss David's feelings about this every time I see him and the offer of support to help him achieve abstinence will always be there. Equally, if John should relapse he will always have the option of returning to treatment. Because they are my patients!

As I said – a funny old world, primary care, and one that commissioners and politicians often struggle to understand.

Steve Brinksman is a GP in Birmingham and clinical lead of SMMGP, www.smmgp.org.uk. He is also the RCGP regional lead in substance misuse for the West Midlands.

LETTERS

DRUG-FREE HERO

David Prentice states: 'While the healthcare profession may not have all the answers to "cure" addiction, I'm yet to encounter one type of treatment that can.'

Which is confirmation of Lord Mancroft's statement that: 'The healthcare profession can't cure addiction.' Mancroft doesn't say that addiction cannot be cured – only that it cannot be cured by 'treatment'.

He is right in saying that 'doctors do not understand addiction', and this is confirmed by the numbers of addicted medical staff and the millions of involuntary addicts prescribed into addiction by doctors.

For centuries drugs have been used to try and solve personal problems. But, because of their own addictive properties, they quickly become a bigger problem than the one the individual is trying to solve. When a doctor does something to, or for, an addict in the name of 'treatment', he is trying to take away the addict's own 'solution' to his own personal problem.

So, the only person who can cure substance addiction is the addict himself – as Benjamin Mancroft amply demonstrated in his own case. Seventy to 75 per cent of all addicts have tried to quit, failed and still want to quit. Their problem is not willingness, it is lack of knowledge of effective addiction recovery technology.

But training to achieve lasting abstinence has been available for 48 years, and is today delivered by 169 centres in 49 countries with a 55 to 75 per cent plus success rate. It is however resisted by the pharmaceuticals dominating our health services, who want to see addictive demand diverted to their own substitute drug products instead of being cured.

In many countries Lord Mancroft would be revered as 'a drug-free hero', but in Britain his success in recovering himself to the natural state of abstinence into which he was born, stands in the way of NHS medical treatment proliferation.

Kenneth Eckersley, CEO Addiction Recovery Training Services (ARTS)

COMPETITION TIME

Enter the drugs meter minute competition by 30 September

In April 2013 Global Drug Survey released the first of its drugs meter minutes on what's in pills and powders sold as MDMA. Filmed by Jon Derricott at the forensic toxicology lab at St George's with the fabulous Dr John Ramsey, it's been viewed almost 100,000 times. Since then we've done minutes with various experts on topics as diverse as what's in cocaine, ecstasy pill testing, harm reduction for new drug virgins, PMA deaths, GHB and ketamine bladder.

In 2014 we want to open the door to the huge range of expertise that exists in the field of harm reduction and drug education with the first ever drugs meter minute video completion. The first prize is £750 and free registration to Club Health 2015 in Lisbon, with the runner-up getting £250. All videos endorsed by our expert panel of judges will be offered upload onto the Global Drug Survey youtube channel.

So what have you got to do to win? Easy – produce and submit a video two to six minutes in length on any drug-related topic. Your drugs meter minute needs to be of interest and relevance to people who drink or take drugs. Things that we are particularly interested in are things that

- share knowledge in a novel fashion
- treat the audience as responsible adults
- address important issues and help people make informed choices
- can promote social responsibility and peer intervention
- address the weird and the wonderful

Technical stuff: Your video needs to be filmed in HD with high quality audio. Videos can be sent as SD card or submitted toadam@globaldrugsurvey.com
Closing date: 30 September 2014. Judging panel: Andrew Bennett, Katy McLeod, Jon Derricott, Adam Winstock and Jim McVeigh. Winners will be announced on 15 November.

Please note the videos cannot show drug taking or endorse or promote drug use. Videos that are accepted for publication will be packaged within the usual drugs meter format and carry the drugs meter watermark.

Dr Adam R Winstock, founder of the Global Drug Survey, consultant psychiatrist and addiction medicine specialist; www.globaldrugsurvey.com; www.drugsmeter.com; Twitter: @globaldrugsurvey, @drugsmeter, @drinksmeter

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.

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

The ONS advises a certain degree of caution when it comes to [alcohol consumption] numbers: not surprisingly, there tend to be discrepancies between how much people say they drink, and the quantities they actually put away. It should also be noted that medical problems caused by alcohol are at an all-time high, and all those headlines about rising middle-aged dependency do not come out of nowhere. The 2007-8 crash and subsequent downturn seem to be a factor in reduced consumption, which might undermine claims that Britain has started to see the error of its bacchanalian ways: could it be that we are as thirsty and dependent as ever, but just a bit more strapped for cash?
John Harris, *Guardian*, 21 March

Shaming girls on a boozy night out will not fix Britain's troubles with excess indulgence of alcohol. Education, eradication of poverty, and the minimum unit alcohol pricing are the proper routes. Attacking women for drinking is just as wrong as it for right-wing newspapers to pick on women for wanting careers or for not staying at home to raise children. It's simple, brutal propaganda.
Anna McKie, *Guardian*, 25 March

I've never been randomly stopped and searched by a police officer, but I've met plenty of young black men who have. The experience varies: sometimes officers are almost apologetic, other times full of intimidation and aggression. The evidence shows that black people are significantly less likely to use drugs, and yet black Londoners are six times more likely to be stopped on suspicion of possession. It is difficult to conclude that this is anything but racism.
Owen Jones, *Observer*, 9 March

What is legal now in Uruguay and parts of the US – cannabis production and sales – can still get you sentenced to death in Malaysia, Singapore and elsewhere, or beheaded in Saudi Arabia. Between these polar opposites there can be no consensus and everybody knows it... The death penalty shows that states are now taking sides in the war on drugs; those that respect basic human rights and those that do not. And they cannot work together anymore.
Damon Barrett, *Huffington Post*, 14 March

There is a cat-and-mouse game being played here. As soon as one pharmaceutical compound is identified, catalogued and placed on a schedule of banned drugs, the makeshift labs create another, barely altered but strictly legal. Such activities only make a further mockery of a system already long since discredited.
Independent editorial, 14 March

There is no gang or organised crime currently associated with khat use. When criminalised in other countries, organised crime has, for obvious reasons, stepped in to provide the supply; there's no evidence that demand reduces. In addition, we would be asking the police to enforce a ban that only affects specific ethnic groups – hardly a recipe for good race relations.
Julian Huppert MP, *Guardian*, 31 March

The whole detox

Studying homeopathy led **Tracy Woodward Gagetta** to explore an innovative titration system for drug detoxification, as she explains

After training and working in the fields of mental health and addictions, I developed a dilution titration system to reduce the withdrawal symptoms of and cravings for heroin, while studying for a degree in homeopathy. This was originally a research proposal for my graduating year, but soon developed into a titration for different drug detoxes, called the Tauto-Mod titration system.

The first pilot project was funded by the Homeopathy Action Trust and was a one-day-a-week project in a rehabilitation centre in Luton and a homeless day programme in Slough. After results proved positive for the programme, the detox was then taken on by South Westminster Drug and Alcohol Service (SWDAS) to be used in conjunction with a range of other interventions at the service. Detoxification from opioids and alcohol in this service is carried out under medical supervision, and employs a range of NICE approved drug (allopathic) therapies, with adjuvant evidence based psychosocial interventions. The homeopathic treatment outlined in this article was additional to this.

Since the pilot started at SWDAS in April 2013, 45 clients have taken part in the detox and study. Out of these clients, 60 per cent had self-referred after attending a guest speaker group and hearing about the detox from other clients. Seventy per cent were male and 30 per cent female, with a dropout rate (attending less than three appointments) of six clients in total. Alcohol clients had the highest overall attendance, at 55 per cent. Among all the clients, there was an overall retention rate of 80 per cent for weekly appointments and a successful completion rate of 61 per cent (including those detoxing from the programme, remaining abstinent and/or no longer using the primary drug.) Of those on the programme, nine clients were also on a drug replacement therapy prescription, including detoxing from methadone.

The drugs we detox, and which were included in the SWDAS study, are alcohol, cocaine/crack, heroin, cannabis, methadone, benzodiazepines, amphetamines, methamphetamine, GBL and ketamine.

The Tauto-Mod system adopts a tautopathic approach, which involves the drug or substance that has caused the illness and/or toxicity in the client being prescribed at a high dilution. This system is believed to work in accordance with the 'hormesis concept'.

Hormesis in toxicity involves providing a low-dose stimulation (the drug in high dilution) to cells in order to trigger a restorative process – that is, the compensatory response to damage. It is proposed that these low doses of toxins or other stressors might activate the repair mechanisms of the body. In layman's terms, the Tauto-Mod system works primarily at the cellular level to flush toxins from the body, thus reducing cravings, withdrawal symptoms and long-term toxicity.

The recording of results and the prescribing of the appropriate dilution occurs weekly and is based on whether the symptoms for each drug present as nil, mild, moderate or severe for each titration chart. For example, a client presenting with mostly moderate to severe withdrawal and toxicity symptoms will be prescribed the appropriate tautopathic medication at low dilution. The more amelioration of symptoms recorded in subsequent weeks, the more the dilution of the tautopathic medicine is increased. Clients are recommended in most cases to take a couple of doses daily. This is to ensure they are receiving the full effects of the medication, particularly as most are still using the drug on top of their tautopathic prescription and maybe taking conventional medications alongside this system.

Tauto-Mod involves weekly titration charts that record symptom levels for each drug misused per person. Depending on the level of severity of symptoms, the client is then prescribed the drug at a specified dilution level. The higher the level of symptoms and toxicity, the lower the dilution of the drug. The system titrates upwards only, which differs from conventional methods of prescribing methadone. The premise is that the higher the dilution, the more this method is believed to work on the mental/emotional level once most of the physical symptoms have been alleviated by the lower dilution preparations.

The expectation of the Tauto-Mod detox is that the patient attends weekly appointments to observe and record shifts in symptoms and prescription. This also allows the practitioner to liaise directly with the project workers and medical staff to ensure the best treatment is provided and to flag any risks and concerns, as well as

'The aim is to ensure that the service user can access a holistic treatment system that is tailor-made to their needs, expectations and long-term health goals.'

positive progress. Substance misusers often live chaotic lifestyles, so it is not always possible to see the patient on a weekly basis for a minimum of 12 weeks; however, so far at SWDAS, the attendance rate has been high and surpassed expectations.

This programme also has a second system running parallel to the tautopathic prescriptions. Since the addictions sector is now acknowledging that we must focus on the client's underlying reasons for becoming a substance misuser in the first place, the project also prescribes dilution medications for any associated mental and physical health symptoms, ensuring that the client receives holistic support in their recovery. Mental health issues, such as depression, anxiety, delusions and paranoia, are prescribed for with relevant homeopathic medications. The same follows for any physical health symptoms such as restless leg syndrome, chronic coughs, headaches and constipation. This holistic approach allows the client to develop a sense of overall wellness and attempts to pre-emptively address any reasons why the service user may relapse in the future, such as past trauma and life changing events.

With the aim of rolling this out to other services in south east England and eventually nationwide, I realised I needed help from someone else in the industry and partnered with Mark Dempster, practising psychotherapist, drugs counsellor and author of *Nothing to Declare*. He was very enthusiastic about an 'innovative detoxification system that has limitless potential in the future' and said that 'a titration system fit for purpose which can accommodate the needs of developing drug trends and markets has to be a good thing.'

As the system is not only a clinical treatment programme but also a study, progressive services and boroughs throughout the country now have the opportunity to benefit from our results, helping to obtain more positive outcomes as well as being part of this exciting study. This service has worked well in an integrated health care system and can be accessed at most levels of treatment.

The aim is to ensure that the service user can access a holistic treatment system that is tailor-made to their needs, expectations and long-term health goals. The substance misuse field is finally addressing the issue of long-term methadone maintenance. However, there is still great scope for investigation into complementary and unconventional therapies, their worth to the sector, and the holistic side of treatment.

Tracy Woodward Gagetta is CEO and founder of Restorative Recovery Prescribing Ltd. For more information on the Tauto-Mod system, visit www.recoveryprescribing.com

ENTERPRISE CORNER

BEATING BUDGETS

Forming partnerships helped TSBC stay a step ahead of the inevitable financial constraints, says **Amar Lodhia**

AT BUDGET TIME LAST MONTH TSBC, like many others, had our heads down in spreadsheets, setting our budgets and making plans for the forthcoming year. As soon as the budget was revealed, everyone began looking at how it would affect them in 2014 and beyond – a favourite topic for columnists. Others used the pre-budget frenzy to talk about what they want to see from George Osborne. Indeed there is one interesting idea around the government's Early Intervention Foundation and whether it could be extended from offering help to at-risk pre-schoolers to a wider application – in public health, for example.

For the local authorities we work with, and would like to work with, the budget was already in. The government announced its provisional local government finance settlement back in December 2013 and council sessions up and down the country will have agreed any changes to council tax rates in the past few months. So no crystal balls were required – we already knew that most local authorities were going to be facing tighter budgets and another very difficult financial year in 2014-15. Speakers at the Annual Public Health Conference in February confirmed what many of us already suspected, that drugs spending is the second largest item in public health budgets. And as we know, larger budgets often come under greater pressure when belts are being tightened.

Our overriding concern is how, in such financially constrained times, work will continue to be funded to help the participants we see on our programmes. The answer's not new, but we passionately believe that the answer is to work in partnership – indeed we cheekily asked people what would be the best partnership on Valentine's Day.

For us, it's all about bringing together and working with local public health teams and police and crime commissioners – because the outcomes we can achieve in our employment and self-employment programmes, such as increased abstinence and a reduction in offending or reoffending, relate directly to both the public health and criminal justice agendas. And of course when the successful entrepreneurs from our programme get to the stage of expanding and hiring more staff, we encourage them to give a helping hand to the next generation of service users, creating a truly virtuous circle. With both partners contributing to these programmes, budgets can go a lot further and deliver so much more.

I'm extremely glad that we've just got agreement to go ahead with one such project in Northamptonshire, funded by the county council and the PCC. We'll be delivering our Progress to Success programme helping participants into education, training and, particularly, employment; as well as our flagship E=MC2 course to inspire service users to turn their ideas into a real business of their own. Our worker will be based at The Bridge, a fantastic recovery centre in the heart of Northampton that's doing amazing things helping recovering substance misusers reintegrate back into society.

We'll let you know how we get on.

To enquire more about our work please contact me at amar@tsbccic.org.uk and follow me on Twitter @amarlodhia or @tsbclondon – don't forget to use #DDNews when tweeting!

Amar Lodhia is chief executive of The Small Business Consultancy CIC (TSBC), thesmallbusinessconsultancy.co.uk

As Blenheim celebrates its 50th anniversary, chief executive John Jolly talks to **David Gilliver** about the organisation's future direction and some of the risks facing the field

50 GENT

'We've lost the plot in relation to alcohol and on legal highs we're moving to a position of "if it moves, ban it", pushing people towards ever-more dangerous substances...'

'We all knew each other, it was such a small sector,' says Blenheim chief executive John Jolly of first entering the drugs field in the 1980s. 'It would probably be overstating it to say there were 100 people working in the sector in London.'

As his organisation celebrates its 50th anniversary (*DDN*, February, page 8) he's now been in the field for more than half that time himself, having become interested in drugs issues while working at a children's home – 'petrol sniffing was all the rage then,' he says. His first job, however, was as a police officer.

'I was very young – 19 – and what I discovered very early on was that the bit of the job I liked was the helping people bit, which is a large part of policing that goes unrecognised.' He decided to train as a social worker, working at the London Borough of Newham for a couple of years, before going on to join Release. 'I was working in the courts for social services when the Police and Criminal Evidence Act had just come in, and Newham was one of the pilot areas. So I went to Release as a drugs worker but I also knew as much about the Police and Criminal Evidence Act as anyone else there.'

He joined Release at the time when it was re-launching as a criminal justice and drugs policy organisation in addition to being a helpline provider. 'During the four years I was there we focused on developing a new role as a leading policy organisation around drugs and the law, as well as campaigning and really getting to grips with some of the new drugs that were coming in, like ecstasy, which nobody had heard of very much until the mid-80s.'

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So after almost three decades in the field what does he feel are the most significant changes he's seen? 'I'll be honest, it's the level of services – 25 to 30 years ago there were very few drug services up and down the country. When I started at Release you were only just starting to see the rollout of drugs agencies, so there are huge amounts of more resources and government investment. We really were on a shoestring back then.'

Does he feel that the results of that expansion are under threat now though? 'I think that huge expansion actually carried some risks itself – It's been a struggle to maintain a level of competence in the workforce, for example,' he says. 'But there are real risks now – for the whole of the public sector – and those are that there isn't the money to pay for everything that the public sector needs to do. You don't have to be a rocket scientist to realise there's got to be disinvestment, and there's going to be disinvestment in the substance misuse sector.

'But there are some positives and some negatives,' he adds. 'We've done a very good job in tackling the problems of heroin addiction and addiction across the piece in the UK – if you're not talking about alcohol. We've focused so much on tackling drugs that we've basically let alcohol get out of control. That's the real problem we're going to have over the next 10 or 20 years.'

The idea was that the disparity between drug and alcohol provision was something that Public Health England would be able to address. Is he not convinced? 'Look, we have a real problem with Public Health England, and it's in the title – "public health",' he states. 'You have to look at the philosophy of public health, which is about the needs of whole populations – it doesn't deal with the individual. So, from a public health point of view, I don't care if a few people get ill and die – I worry about whether thousands are dying, and I'm much more interested in stopping the whole population dying before they're 75 because they're obese or drinking heavily. I'm not focused on the needs of somebody who's alcohol-dependent or drugs-dependent – it's much more important that I reduce the alcohol intake of the whole population.'

That this will have an impact on investment decisions is inevitable, he stresses. 'I really characterise it as the needs of the many outweighing the needs of the few. The trouble the current drug and alcohol sector has is that we are set up to work with people with multiple needs – effectively the few – who are heavily dependent, with a whole range of multi-faceted needs that society has failed to respond to.'

So in that case does the treatment sector essentially not even belong in there? 'I think we have a fundamental problem long-term,' he says. 'I've heard people voice this in government already, asking whether drugs and alcohol sit within a public health remit. Well it does in terms of reducing risk but in terms of treatment I don't think it fits at all. My view is that the sooner it can move back to NHS England the better.'

Was getting rid of the NTA a serious mistake then? 'I've always been a keen advocate of the NTA – not necessarily of what they did, but that we need a national treatment agency for drugs and alcohol. Getting rid of it has meant that we don't have an advocate within government for what the Cabinet Office once described as a "wicked problem" – that is, it's hugely important, it impacts on a whole range of crime, health and social agendas but isn't top in any of them, which means it won't get the investment. Health is not going to say, "This is where we need to put our investment" or criminal justice or local authorities, although it has a huge detrimental impact on all of their spending commitments.'

He's expressed concerns in the past about the impact of poor and frequent commissioning, making a case for longer contracts (*DDN*, August 2013, page 20). 'There are some examples of poor commissioning, but it's more about changing the short-termism and increasing the commissioning capacity,' he explains. 'With the changes we've seen recently, for example, many areas just don't have the capacity to commission drug services in any way that's rational, sensible or joined-up. All I'm really saying is that what you can't do is commission organisations like mine for a four-year contract and then every year say, "Actually, we didn't really like what we commissioned – it's not about what you're delivering, but we want to do it differently so we'll re-tender you and then 18 months down the line re-tender you again." Tender something out, tender it for seven years, and have a conversation with your providers about how you're going to change it.'

He's also backed Nick Clegg's call for a debate about drugs regulation. What made him decide to make that statement?

'Well, because why wouldn't you?'

No other major treatment organisations have. 'I worded it very carefully so I wouldn't be hounded from pillar to post, but in fact I've had not one complaint about it. It's quite interesting – I've been working with politicians and every single advisor who's gone in there has said exactly the same. When you're sitting down with policy advisers in government departments, talking to ex-ministers, round the table with three or four ex-chief constables, we're all saying the same thing. And that is, the Misuse of Drugs Act doesn't work.

'I actually think we need to regulate drugs, and we need to do it better,' he explains. 'The reality is we're failing to regulate drugs at the moment and the Misuse of Drugs Act is an excuse for doing nothing. We don't use it as much as we should and bits of it are problematic because they have a negative impact on particular ethnic minorities. It isn't thought through and it isn't rationally linked up – we've lost the plot in relation to alcohol and on legal highs we're moving to a position of "if it moves, ban it", pushing people towards ever-more dangerous substances. It's a disaster waiting to happen. All I'm saying is we need to look at what we want to do, look at it rationally, and come up with a response for the 21st century. Because the Misuse of Drugs Act was written when we didn't have a drugs problem in this country, really.'

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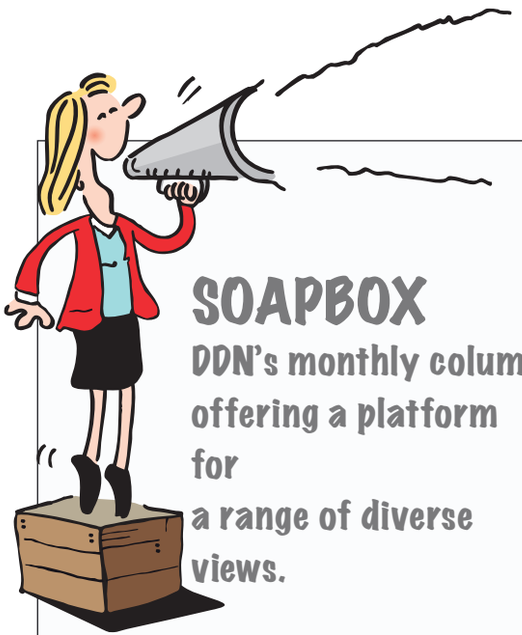
As part of its anniversary, Blenheim is running 50 'recovery story' case studies on its website over the course of the year (*DDN*, January, page 4), partly, he stresses, 'to say, "Look, these people aren't some sort of strange aliens who've used drugs and alcohol – they're mothers, brothers, sisters, the bloke who's delivering your newspaper and maybe the bloke who's giving you shares advice. They're human beings who have a problem and they're no different from you, me or anybody else." That's a message we've been working really hard to give.'

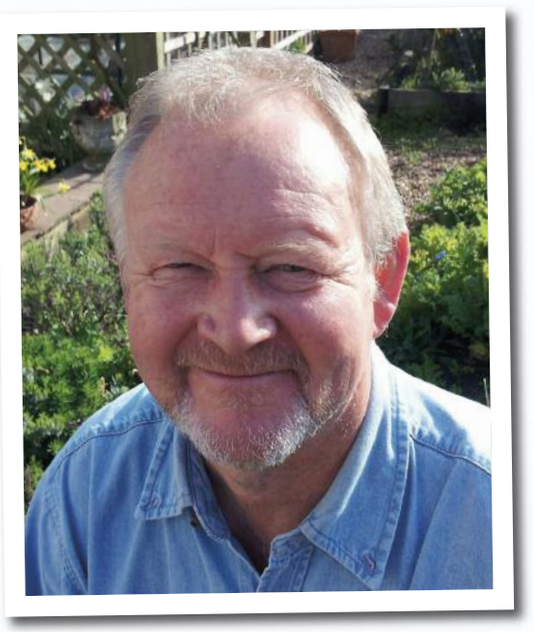
Blenheim has grown to the point that it now helps more than 9,000 people a year. How does he see its future direction? 'For us, it's around quality,' he says. 'We're going to continue to be a service provider and to work with people, and obviously we'd like to work with more, but it's more important to us that we develop long-term relationships with the community and the service users we're working with. We're very clear that we're not just a service provider – we're a charity, we're a campaigning organisation and we also provide services. For us it's all about improving quality of life, campaigning for people who are stigmatised, developing new ways of moving people from dependency to autonomy and looking at how we embed what we do in local communities.

'I would stress that it will be vital for organisations like Blenheim and the sector to really embed ourselves and be part of the communities in which we operate, rather than treatment providers that are dropped in from outside, and I think that's one of the real risks with the commissioning culture. We've worked in some areas for 50 years and we're part of that community, but those sort of long-term relationships are being threatened by the commissioning culture we currently have.' **DDN**



SOAPBOX

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



OPENING DOORS

Drug treatment within custody needs an overhaul, says **Alan Rushmore**

DRUG TREATMENT IN PRISON lacks consistency and is over-burdened and over-complicated by assessment. It need not be so.

Many clients will simply require an assessment of need and possibly a brief intervention. Others may benefit from coursework and/or individual support to confront their offending behaviour. Some will not perceive an issue with their recreational use but may benefit from some information or guidance.

Poly-substance using clients will require more intensive support and involvement with a wider stream of expertise. Others will be on Integrated Drug Treatment System (IDTS) and will need support to withdraw.

Even after 15 years of working 'behind the wire' I am often surprised and impressed by the level of commitment from both clients and colleagues to implement change. Yet I am also saddened by the obstacles and lack of communication thrown up by the prison system or organisations that employ us.

It would be easier if each service provider employed the same assessment tool, and if the client's care plan was reviewed upon transfer. Presently the payment by results culture dictates repetition of assessment, with files rarely transferred with the client. If this were routinely done, clients could be seen promptly and we would have greater continuity of care.

IDTS should be about reduction from methadone and Subutex, not about maintenance. To do this we need to provide the relevant support and guidance and elicit the appropriate community support to encourage self-control and abstinence.

Ideally it would be good to have a national service that enabled prisoners to be met and accompanied to probation, housing providers or rehab. Meet and greet services should be national and not confined to specific service providers.

As drug and alcohol practitioners we need to work closely with our colleagues in healthcare, mental health and discipline. Again, I have been fortunate in that I have always believed that I have worked successfully with my colleagues from other disciplines, but sadly mental health services are often over burdened and under resourced. This has to be rectified as the majority of my clients (and possibly yours) have demonstrated either primary or secondary mental health concerns.

'Addiction does not discriminate but sadly it is only too easy to be criminalised and thereby marginalised...'

Those who work within addiction recovery possess an array of skills. The opportunity to share 'best practice' – a cross-pollination of skills to improve services to clients and to improve dialogue and understanding between custody and community – would be welcomed. DIP teams are actually quite remarkable and have demonstrated excellent practice, but we need to use them more.

Access to alternative therapies and fellowship groups (NA, CA, AA etc) is presently limited and enhanced access would be beneficial. Personally speaking, prison should be about rehabilitation and promoting positive lifestyle choices. Sadly it appears more to be about containment, punishment and retribution.

Our clients are often stigmatised and disenfranchised by their addictions. We should be empowering our clients to confront and take control of their drug use, to rebuild relationships, to access support, to develop trust and enable them to transfer to the community as 'well'.

As practitioners we run the risk of working in isolation. We need to recognise and understand the difficulties and frustrations of working within different institutions and organisations. We need to widen our experience of different environments to make us better practitioners.

We read and hear about 'the war on drugs'. It is not a battle, but it certainly is a struggle to cope with the global pandemic of drug use. Addiction does not discriminate but sadly it is only too easy to be criminalised and thereby marginalised by becoming infected by substance abuse.

'Let's work together, come on, come on, let's work together' to confront the disease of addiction and addictive behaviour. We need to replace use with positive lifestyle choices to enable our clients to make balanced decisions based upon informed choice. By communicating and demonstrating consistency we can encourage empowerment. We're all on the same side.

Alan Rushmore is a drug and alcohol counsellor and therapist

Kairos Community Trust

Counsellor/Group Facilitator

Kairos Community Trust is a registered charity and a leading provider of substance misuse and homelessness services in South London. We are currently looking to recruit a suitably experienced full-time Counsellor and Group Facilitator, with 12-step programme experience. You will be fully qualified to Counselling/Psychotherapy Diploma Level, BACP/UKCP advantageous. The right candidate will also be able to facilitate group therapy and addiction recovery workshops within our abstinence based treatment programme in Nunhead. We offer a competitive salary within a supportive team and a pleasant working environment.

Please address CVs to Tim Penrice, 22 Linden Grove, London SE15 3LF or contact 020 7635 7664.

For more information see www.kairoscommunity.org.uk

Kenward Trust
transforming lives, creating choice

Currently based in Kent and East Sussex, we are a charity that offers people the opportunity to change their lives and reach their full potential.

The Naomi Project in Hawkhurst, Kent offers a female only intensive, structured, (group work based) programme that deals with substance misuse and underlying issues. It is a genuine occupational requirement for female only applicants given the vulnerability of our clients' and type of service provided.

Residential Project Manager (Training can be provided)

Up to £27,229 per annum • Full-time, four days project based, one day Head Office based

With proven experience in developing, promoting, delivering and evaluation of recovery services, this role is extensive and influential and will involve both operational and strategic elements. There is a requirement to participate in the out of hours on call rota across Kenward Trust.

Please send your completed application form with covering letter to Diane Jenner, Head of Human Resources: diane.jenner@kenwardtrust.org.uk
Closing date: 5pm on Friday, 18th April 2014.

All positions are subject to an Enhanced DBS disclosure. Registered Charity no. 1146481. Registered in England no. 7931728.

Expressions of interest

OXFORDSHIRE COUNTY COUNCIL

Oxfordshire County Council Public Health

CONTRACT FOR THE PROVISION OF YOUNG PEOPLE'S SUBSTANCE MISUSE SERVICE

Invitation to Submit an Expression of Interest – CPU 846

Oxfordshire County Council Public Health Directorate is seeking a Service Provider to provide a specialist drug and alcohol service for children and young people in Oxfordshire. The Service Provider shall deliver structured psychosocial interventions for young people misusing drugs and alcohol, or children and young people who are affected by their parent's or family member's substance misuse. The Service Provider will also provide brief intervention and advice for alcohol either on a one to basis or through group work.

The Service operates as an integrated part of Oxfordshire County Council's Early Intervention Service. The Service Provider's specialist drugs and alcohol workers shall be based at the seven hubs (one FTE worker at each hub) and operate as part of the hub teams. The hubs are located in Banbury, Bicester, Witney, East Oxford, Littlemore (Oxford), Abingdon and Didcot.

Interventions will be delivered flexibly by the Service Provider in terms of time and place. Sessions with young people may take place in the hubs or at other locations. Outreach is an important part of the Service and this may include targeted work with young people in schools.

The Service Provider's specialist drugs and alcohol workers shall work with children and young people referred through the standard Early Intervention 'request for service' route. Referring agencies include schools, health professionals, parents and young people themselves.

The Service Provider will be required to evidence a proven track record in the delivery of high quality services of the same nature and must be able to demonstrate excellent, innovative and pro-active skills in working with young people with substance misuse problems (their own or a parent's or family member's).

This is a 3 year contract with the option to extend for a further 12 months in aggregate. The contract will commence from 1st October 2014. The maximum contract value for this Service is £340,000 per annum.

- *The Invitation to Tender will be sent to all Service Providers who express an interest in this Service.*
- *The tender process will be conducted under a single stage procedure*
- *Oxfordshire County Council will not be bound to award any contract under this tender process*

Applicants should note that they will need to register on the southeast portal **www.businessportal.southeastiep.gov.uk** before expressing an interest in the opportunity. Registration itself will not automatically result in an expression of interest being communicated. Please send your expressions of interest via the "Express an Interest" function on this portal.

A provider workshop is provisionally planned for the 1st May from 10-12 in Oxford for organisations expressing an interest.

A fully detailed specification will be issued at the Invitation To Tender (ITT) stage at a later date.

If you have any general questions regarding this proposed service please contact:
Clare Dodwell, clare.dodwell@oxfordshire.gov.uk

If you have any general questions regarding the tender process please contact: Carol Rogan, Strategic Procurement Officer on email: carol.rogan@oxfordshire.gov.uk or telephone: 01865 323731

The closing date for our receipt of expressions of interest is by 12 noon Thursday 17th April 2014.

INVESTORS IN PEOPLE

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BROADREACH HOUSE

Broadreach House is an innovative and dynamic registered charity, offering treatment and support services for men and women whose lives have been adversely affected by addiction. We currently have two exciting opportunities to join our team.

UNIT MANAGER – Longreach (Women only house) – Salary circa £30,000

We are seeking a skilled manager with experience of working in the substance misuse field. You will need to be positive, proactive and flexible in your approach. You will be responsible for the ongoing development and supervision of the team.

To meet the demands of this role you will have:

- substantial management experience
- experience of managing a multi-disciplinary team
- experience of implementing and monitoring appropriate treatment intervention and systems
- proven ability to work in partnership with other agencies and individuals

COUNSELLOR – Closereach (Men only house) – Salary £18-23,000

We are seeking a trained counsellor to join the team at Closereach. The candidate must be able to work within a small team and be an active and enthusiastic member.

To meet the demands of this role you will have:

- experience of working with evidence based counselling skills and practice;
- experience of working in a multi-disciplinary team and of working alone within a supervised framework;
- knowledge of the effects of drug and alcohol dependency;
- evidence of continued professional development.

A relocation package will be considered, if required, for the successful candidates.

At Broadreach we are committed to promoting dignity in the work place and this includes encouraging diversity and equality of opportunity for everyone.

For an application pack for either post please call 01752 566219 and leave your details, stating which post you are interested in or, alternatively, email Liz Fox at liz@broadreach-house.org.uk.

CLOSING DATE: 28TH APRIL 2014

Bournemouth Borough Council

Building Recovery In Communities
BOURNEMOUTH DAAT

EXPRESSIONS OF INTEREST

Bournemouth Borough Council invites expressions of interest from both individual organisations and consortia's for the provision of the following Services:

BOURNEMOUTH ASSESSMENT TEAM SERVICES – £2,200,000 over a five year period;
STRUCTURED DAY TREATMENT – ABSTINENT – £1,750,000 over a five year period;
STRUCTURED DAY TREATMENT – CRIMINAL JUSTICE – £1,000,000 over a five year period;
LOW LEVEL ONE TO ONE PSYCHOSOCIAL SERVICES – £500,000 over a five year period.

Contracts will be for a period of 3 years with the option to extend for a further period of up to 2 years subject to performance and funding. The anticipated start date for services is 1st April 2015.

Organisations must be able to demonstrate good quality service, knowledge, innovation, added value and the ability to deliver recovery orientated services in the community. The successful organisation(s) will also recognise the importance of the wider family and community, focus on a recovery model and social re-integration of Service Users and be required to work as part of a clearly defined treatment system.

Organisations applying should note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 will apply.

In order to register your interest for each Service Providers must register through the Procurement Portal *www.supplyingthesouthwest.org.uk* of which Bournemouth Borough is a participating Council.

Expressions of Interest must be made before **Friday 2nd May 2014**.

PQQ will be available from **Wednesday 7th May 2014. Completed PQQ's** should be returned by **2pm, Friday 6th June 2014** using the Supplier Portal.

SDF Scottish Drugs Forum

TRAINING AND DEVELOPMENT OFFICER

(Harm Reduction and Emergency Responses)

Salary Scale: £30,306 – £33,091 • 3 Year Contract • Based Glasgow

The post has been funded by three Scottish Government Departments in response to outbreaks of infection among drug users – most recently anthrax.

The post holder will undertake a range of work to improve and safeguard the health of drug users with regard to bacterial and other infections. This will include improving the quality of interventions to drug users at risk of infection; improving partnership working between appropriate services and improving the preparedness of frontline services, user groups and SDF to respond to outbreaks of infection among drug users.

Extensive training experience and an understanding of current harm reduction approaches and practice are essential, as are strong communication skills and commitment to a partnership approach. Candidates must show evidence of initiative, resourcefulness and the ability to effectively engage with diverse groups.

An application pack giving a full detailed job description and application form is available. Please contact:
Tel: 0141 221 1175 • Email: recruitment@sdf.org.uk
or download an application pack from:

www.sdf.org.uk

CVs will not be accepted. No agencies.
Closing date: Wednesday 23 April at 12 Noon
(Interviews: Friday 2nd May 2014)
Registered Scottish Charity No. SC008075