INSIDE: SPRING RESIDENTIAL TREATMENT DIRECTORY

DDN
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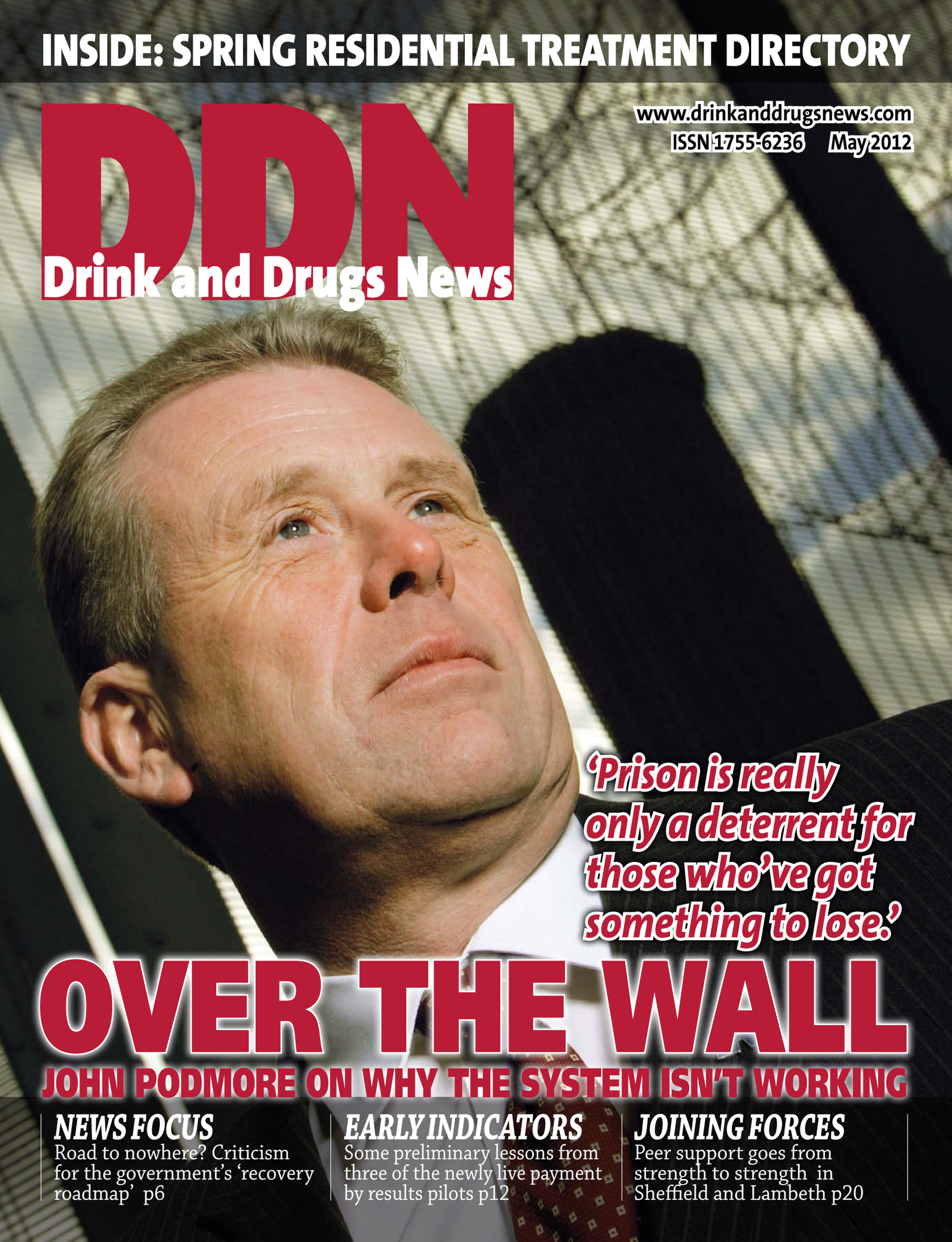

'Prison is really only a deterrent for those who've got something to lose.'

OVER THE WALL

JOHN PODMORE ON WHY THE SYSTEM ISN'T WORKING

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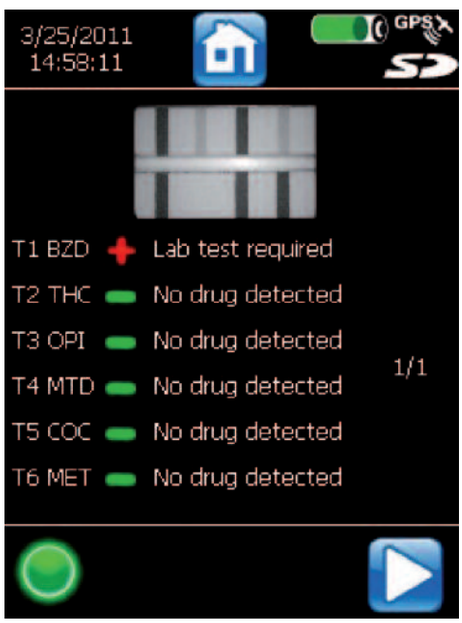

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DDN Drink and Drugs News

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Road to ruin?

Challenging government's recovery roadmap

The government's 'roadmap' for a recovery-based treatment system has rung alarm bells with many respected organisations in the field, despite its declared principles of 'wellbeing, citizenship and freedom from dependence' (news focus, page 6). Opposition goes beyond drug and alcohol treatment to those working in wider public healthcare settings. There is deep-seated worry for clients unable or unsuited to reaching the abstinence goal and those for whom stigma has already provided hurdle after hurdle to the healthcare that the rest of the population takes for granted. These criticisms are not made lightly and we can only hope the government listens to criticism of a 'dangerous' policy whose 'impact will be measured in lives lost'.

Another expert commentator features in our cover story (page 8). John Podmore's 25 years as a prison governor and inspector make him a qualified voice on why our prisons aren't working – particularly for those who fall victim of the remand system, a cruel way of dealing with drug, alcohol or mental health problems. His aim in writing the book was to stimulate debate and provoke change. Let's hope he gets a hearing.

And in the middle of a packed issue, we hope you find our centre-page pullout residential treatment directory useful. You can also find it online at www.drinkanddrugsnews.com with our other free resources.

This issue

FEATURES

REGULARS

News in Brief

HEP STEP UP

The Hepatitis C Trust is joining forces with Addaction to improve efforts to tackle the virus, with a shared member of staff delivering a training programme to 600 frontline workers. Around 2,000 people thought to be at risk will be tested and referred to specialist secondary care. 'We are excited to be working in partnership with such a large organisation as Addaction,' said Hepatitis C Trust chief executive Charles Gore. 'This is an enormous opportunity to reach tens of thousands of people at risk of hepatitis C. With so many people yet to be diagnosed in the UK, this partnership could make a major difference.' The trust has also won a £25,000 GlaxoSmithKline IMPACT award for its 'outstanding contribution to improving health' and 'significant impact on policy makers, both nationally and internationally'.

HEROIN EVIDENCE

The EMCDDA has issued the first 'state-of-the-art overview' of research on heroin-assisted treatment, studying evidence from Europe and further afield. Supervised use of medicinal heroin could be an 'effective second-line treatment' for heroin users who fail to respond to other interventions, says EMCDDA. 'New heroin-assisted treatment is an issue that has attracted much attention, controversy and often confusion', said EMCDDA Director Wolfgang Götz. 'We hope that this report will help policymakers and practitioners draw their own conclusions about this type of treatment within their own national context'.

New heroin-assisted treatment available at www.emcdda.europa.eu

BEREAVEMENT STUDY

Researchers at the University of Bath have received a grant of more than £450,000 from the Economic and Social Research council for a study of families who have lost loved ones to alcohol or drugs. The team will carry out in-depth interviews with families and consult with practitioners and policy makers to help develop guidelines for people working to support bereaved family members. 'At a time when substance misuse related deaths are increasing and support for bereaved families lacking, the study will address a significant gap in understanding and addressing the needs of this group,' said researcher Dr Christine Valentine.

SOREK SWANSONG

Drinkaware chief executive Chris Sorek is leaving the charity at the end of next month, after three and a half years in the post. 'I will miss being part of Drinkaware and am incredibly proud of what the charity has become,' he said.

New synthetic drug detected in EU 'every week'

New psychoactive substances were detected in the EU at the rate of approximately one per week last year, according to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Forty-nine new drugs were officially notified for the first time through the EU early warning system (EWS) in 2011, the most ever reported, according to the *EMCDDA-Europol 2011 annual report*.

All of the new drugs were synthetic, with 23 new cannabinoids – used to produce drugs such as 'spice' – and eight new synthetic cathinones. Five new chemical families of cannabinoids were detected.

'New drugs ('legal highs') have become a global phenomenon which is developing at an unprecedented pace,' the report states. 'The speed at which new drugs appear on the market – reflected not only in the sheer number of substances, but also in their diversity and in how they are produced, distributed and marketed – challenges established procedures for monitoring, responding to and controlling the use of new psychoactive substances.' Forty-one new substances were reported in 2010 (*DDN*, June 2011, page 5) and 24 in 2009.

The European Commission (EC) is proposing stronger EU legislation on new psychoactive substances, which would enhance monitoring and risk assessment of substances as well as improve alignment of the laws relating to drug control, product safety, consumer protection and medicine to cover 'the wide variety of substances that emerge'. The legislation would also enable 'a faster response to the emergence of substances', potentially through increased use of temporary bans on those deemed to pose 'immediate risks'. The legal high methoxetamine – or 'mexxy' – recently became the first substance to be banned in the UK under a temporary class drug order (TCDO) (*DDN*, April, page 4).

'The simple fact is that a dangerous game of roulette is being played by those who consume an ever-growing variety of powders, pills and mixtures, without accurate knowledge of what substances they contain and the potential health risks they may pose,' said EMCDDA director, Wolfgang Götz. 'We must continue to enhance Europe's ability to detect and respond quickly and appropriately to these developments. This requires networking and the sharing of information and it requires greater investment in forensic analysis and research'.

Report available at www.emcdda.europa.eu

Minimum alcohol pricing could 'push people to black market'

The introduction of a minimum price per unit of alcohol and ban on multi-buy promotions could lead to a surge in potentially dangerous black market alcohol, according to the Local Government Association (LGA).

Although the LGA is in favour of giving local health authorities the power to intervene in licensing conditions, it has expressed concerns at other aspects of the government's alcohol strategy, announced earlier this year (*DDN*, April, page 4). Focusing on affordability fails to address the root causes of binge drinking, it says.

Illicit alcohol is an increasingly lucrative area of operation for organised criminal gangs (*DDN*, August 2011, page 6). Tests on bottles of fake vodka seized by trading standards officers reveal 'alarming' levels of methanol, says the LGA, which could potentially cause blindness or death, and other industrial chemicals used in pesticides and cleaning fluids have also been found. Trading standards officers in Southampton recently found 35 bottles of fake Jacob's Creek wine, with 'Australia' misspelled on the label.

'We are concerned that targeting cheap alcohol could push people to the black market and cheaper drinks,' said chair of the LGA's Community Wellbeing Board, Cllr David Rogers. 'When drinking counterfeit brands, you can never be sure what you are putting into your body. People who think they are getting a bargain could end up making themselves blind or even drinking themselves to death. National gestures like minimum pricing and banning multi-buy discounts will only go so far in deterring binge drinking and don't take into account the varying issues in town and city centres across the country. We need to see councils given the powers and flexibility to tackle problems locally.'

Scotland's Alcohol Minimum Pricing Bill has been amended at stage 2 of its passage through the Scottish Parliament to include a 'sunset clause' to allow minimum pricing provisions to expire after six years if they are seen as having been ineffective. The new clause addressed concerns that minimum pricing had not been tried elsewhere, said health secretary Nicola Sturgeon.

Meanwhile, a survey by Alcohol Concern Cymru reveals that 77 per cent of Welsh publicans support a minimum price per unit. More than 60 per cent expected their business to decline in the coming year, with most blaming cheap supermarket promotions.

'Landlords are telling us that it's unfair that they are blamed for so many of the alcohol-related problems in society, whilst supermarkets are allowed to continue to sell heavily discounted alcohol,' said Alcohol Concern spokesperson Mark Leyshon.

'A minimum price would set a baseline price below which alcohol could not be sold. This would leave pub prices largely unaffected, but would stop supermarkets and off licenses selling very cheap alcohol.'

'We can't arrest our way out of the drug problem', says White House

The US government has launched a new drug strategy, which it says will prioritise public health and recovery-based principles over law enforcement.

The Office of National Drug Control Policy's *2012 Drug control strategy* is guided by 'three facts', says the White House – 'addiction is a disease that can be treated; people with substance use disorders can recover; and innovative new criminal justice reforms can stop the revolving door of drug use, crime, incarceration and arrest'.

At the moment, one in four American prisoners are incarcerated for drugs offences (*DDN*, March, page 9). The new strategy, however, will divert non-violent drug offenders to treatment rather than prison and improve youth outreach work. The strategy contains more than 100 specific actions to reform US drug policy through 'innovative and evidence-based public health and safety approaches'.

'Outdated policies like the mass incarceration of non-violent drug offenders are relics of the past that ignore the need for a balanced public health and safety approach to our drug problem,' said director of national drug control policy, Gil Kerlikowske. 'The policy alternatives contained in our new strategy support mainstream reforms based on the proven facts that drug addiction is a disease of the brain that can be prevented and treated and that we cannot simply arrest our way out of the drug problem.'

The strategy has been criticised by some organisations advocating drug law reform, with Bill Piper of the Drug Policy Alliance writing on the *Huffington Post* that 'while the rhetoric is new' the government remained committed to 'punitive approaches'.

President Obama, however, told the recent CEO Summit of the Americas in Colombia that it was 'entirely legitimate to have a conversation about whether the laws in place are ones that are doing more harm than good in certain places'. While legalisation had the capacity to be 'be just as corrupting if not more corrupting than the status quo', he said, he was 'a big believer in looking at the evidence [and] having a debate'. Dealing with demand in a more effective way was central to tackling the issue, he stated, as well as addressing the economic and structural issues in countries where drugs were grown and produced.

Drug strategy at www.whitehouse.gov

Overhaul consultation for NDTMS

The NTA has launched a consultation on its proposal to amend the data collected by the National Drug Treatment Monitoring System (NDTMS) to make sure it remains 'relevant to the delivery of specialist substance misuse interventions for young people'.

The amendments – which would be effective from April next year – include improving the recording of specialist interventions and their settings and the risk factors and outcomes for young people, removing unnecessary data items and updating how information relating to hepatitis C and B is captured. 'We are keen to have input into this process and we are committed to listening to the views of the field and responding to them appropriately to ensure the amendments are practical and achieve their aims,' says the agency.

A new online bulletin has also been launched by the Department of Health to support the eight new payment by results (PbR) pilot sites and their provider organisations, as well as provide information for anyone interested in developing local models.

Meanwhile, chief executive of Brighton and Sussex University Hospitals NHS Trust, Duncan Selbie, has been named as chief executive designate of Public Health England, which takes over responsibility for drug and alcohol treatment services from next April. 'I do not in any way underestimate the challenge this represents,' he said. 'By getting this right, I believe Public Health England will make a unique and extremely positive contribution to the public's health alongside local government and the NHS.'

NTA consultation at www.nta.nhs.uk/yp-dataset-2012.aspx until 25 July

PbR bulletin at recoverypbr.dh.gov.uk

See our feature on the new PbR pilots on page 12

REVVING UP FOR RECOVERY!

A new partnership project launched by East Coast Recovery will see people in recovery working at Andy's Garage in Lowestoft, Suffolk, and being trained up in all aspects of running the business. East Coast Recovery's growing recovery community already includes a picture framing business and well-established recovery café, among many other projects.

More information at www.eastcoastrecovery.co.uk

News in Brief

UNEXPLORED TERRITORY

A new report from UKDPC, *Charting new waters: delivering drug policy at a time of radical reform and financial austerity*, examines how areas will be able to achieve the aims of the drug strategy at a time of structural reform and substantial cuts in public spending. The speed and scale of reforms could undermine many of the gains from a decade of investment and risk delivering poor value for money, says the report, which is based on 14 months of interviews, surveys and workshops with frontline staff and policy makers. Improved co-ordination and integration between public health and criminal justice agencies is necessary, it says, alongside a 'nationally managed and coordinated resource for authoritative evidence' and a balanced approach to drug-related enforcement activity. *Available at www.ukdpc.org.uk*

NAILING IT

A new DVD to provide prisoners with information about drugs and alcohol has been produced by the Young Offenders Institute at HMP Portland in Dorset in partnership with Avon and Wiltshire Mental Health Partnership NHS Trust, Weymouth College and the Princes Trust. *Nailed*, which will be shown to young offenders as they leave prison, came about because the offenders felt the drug and alcohol information they had access to was of poor quality. The film was written, shot and edited by the prisoners, with technical help from Weymouth College media students. *See page 8 for our prisons feature*.

SEARCH STATISTICS

Police stopped and searched nearly 1,300,000 people and/or vehicles in 2010/11, 8 per cent less than the previous year, according to figures released by the Home Office. Forty-six per cent of all stops and searches were carried out by the Metropolitan Police, and overall stop and searches under Section 1 of the Police and Criminal Evidence Act (PACE) – which gives the police the power to look for drugs, weapons or stolen property – rose by 4 per cent to 1,222,378. Nine per cent of those searched were arrested, with 37 per cent of arrests for drugs, and drugs accounted for around half of the items most commonly searched for. *www.homeoffice.gov.uk*

DERKACZ DEPARTURE

Anton Derkacz has left KCA after 24 years, ten of them as chief executive. He thanked staff and partner organisations for all they have done to empower service users, and was commended by trustees for his passion and commitment. Caroline Felton is interim CEO.

ROADMAP FOR PEACE?

Organisations have been voicing their opinions of *Putting full recovery first* – the government's 'roadmap' for the creation of a recovery-based treatment system. And they're not positive, reports **DDN**

The government's cross-departmental *Putting full recovery first* document (*DDN*, April, page 4) outlines its 'roadmap for building a new treatment system based on recovery', following on from the 2010 Drug Strategy and guided by 'three overarching principles' of wellbeing, citizenship and freedom from dependence.

The document reiterates the coalition's stated aim of challenging the 'status quo' and bringing 'an urgent end to the current drift of far too many people into indefinite maintenance', which it describes as 'a replacement of one dependency with another'. The creation of Public Health England will allow 'clearer leadership and vision-setting', it says, while payment by results (PbR) will shift the focus of providers 'from process and output to delivering tangible personal and social outcomes' and value for money.

'We do not underestimate the scale of the transformation from a system that has concentrated on engaging and retaining people in treatment to one that is capable of delivering recovery outcomes,' says chair of the inter-ministerial group established to take it forward, Lord Henley. What he may have underestimated, however, is the sheer strength of feeling against the document.

Last month the UK Harm Reduction Alliance (UKHRA), UK Recovery Federation (UKRF) and National Users Network (NUN) wrote to him enclosing a public statement, *Putting public health first*, that forensically takes the government's plans apart, accusing it of setting 'arbitrary, unethical and ineffective' treatment goals, willfully ignoring 'decades of evidence' and endangering the wellbeing of clients. The roadmap, it continues, will 'waste scarce resources' and constitutes a threat to public health in the UK.

The 40 signatory organisations and individuals include some heavy hitters. While the government would probably say it expected some resistance from Release, Transform, Harm Reduction International, SMMGP, NUN and the Alliance – all present and correct among many others from the field – it will be less easy to dismiss the Terrence Higgins Trust, National Aids Trust and the London School of Hygiene and Tropical Medicine as 'the usual suspects'.

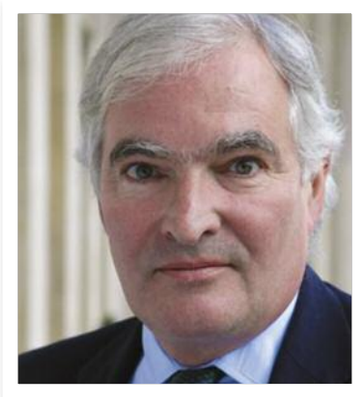
'The UK has one of the lowest HIV epidemics amongst injecting drug users thanks to early introduction of such harm reduction measures as opioid substitution treatment,' said the National AIDS Trust's Yusef Asad. 'We have grave concerns about the impact of the government's change of direction on HIV amongst injecting drug users in this country.' In fact, the encouraging thing about the document,' says NUN volunteer Alan Joyce, is the 'unanimity of the response by virtually every organisation with any expertise in the area'.

If the government was hoping for unqualified support from the UK's recovery organisations it was wrong on that score too. 'Recovery is much bigger than abstinence and we believe that a treatment system founded on notions of "full recovery" will fail to meet the needs of many, put people at risk and generate greater stigma and discrimination,' says UKRF director Alistair Sinclair.

'Abstinence is just stopping something,' he tells *DDN*. 'We have difficulty with the notion of "full recovery", as do many others, including people active within the fellowships. Recovery is a process, not an end state.'

Does he feel the document fundamentally misunderstands recovery? 'The interesting thing is it's 27 pages long and, from memory, has about eight references – I've never seen anything like it,' he says. 'From the point of view of evidencing and referencing it's deeply disturbing – there are no references to the

'We do not underestimate the scale of the transformation from a system that has concentrated on engaging and retaining people in treatment to one that is capable of delivering recovery outcomes.'
Lord Henley



'We have grave concerns about the impact of the government's change of direction on HIV amongst injecting drug users in this country.'
Yusef Azad

literature or best practice within the field of recovery-orientated treatment, and anyone reading it will remain blissfully unaware of the fact that recovery is an established approach within mental health services in this country, and that there's a body of work there.'

The government's 'apparent volte-face' over the use of 'recovery' will mean 'hundreds of thousands of successfully-in-treatment patients having their lives turned upside down', says Alan Joyce, with 'yet another anxiety added to a population already mired in stigma. Many of our membership network whose health, wellbeing, family life and careers are predicated on and sustained by long-term opioid maintenance or substitution therapy would have their lives, recovery and continued employment needlessly put at risk.'

Few employers would allow someone six months to a year off to become abstinent, he adds, 'and that's excluding risk of relapse onto street drugs. Contrary to the belief propagated that drug users in treatment have been force-fed methadone and parked on it indefinitely, many of our members on OST have had to fight hard and repeated battles over three to four decades to obtain and retain a prescribed medication that is essential for them to lead normal, fulfilled lives.' The fear is that, once 'discharged', many would not seek treatment again, he continues, preferring to go back to living 'under the radar, relying on street drugs and the tenderness of the wolves as best they can'.

The roadmap will also increase rates of HIV transmission and overdose, warns *Putting public health first*, pointing to the example of Greece, where HIV transmission rates have rocketed from between nine and 16 annual cases in the previous five years to 190 in 2011, partly as a result of austerity-related cuts in prevention and harm reduction services. The roadmap's bald statement that it will deliver better value for taxpayers' money as 'ultimately payment will be made for full recovery only' also trivialises the complex nature of drug dependence, it continues, with services likely to be tempted to exclude clients they deem unsuitable, adding that imposing a 'one-size-fits-all' abstinence goal on the diverse population of drug users could well contravene medical ethics.

The government pre-empts the negative responses in the document itself, stating that, 'Arguably the greatest challenge is addressing the attitudes and practice of all parties in the treatment system and in creating a culture that genuinely embraces change.' However, a key argument of *Putting public health first* is that 'the roadmap bypassed public consultation yet carries logos from eight government departments', and the letter to Lord Henley extends an invitation to discuss the field's concerns. 'I've yet to meet anyone who's actually contributed to the document,' says Sinclair. 'What the UKRF and others are asking for is consultation.'

'If we are going to completely change our approach to drug treatment, we need to talk to the people who use it – and their families and carers,' agrees Alliance director Ken Stringer. 'I'd like to know how the risk assessment was undertaken for this policy – what's going to be the impact on crime? How will it affect health – and healthcare?'

It also comes at a time when 'some commissioners and providers are already abandoning the evidence base,' he adds. 'We've got huge changes to our local and national health services, and some very confused people out there. This isn't going to help and I am afraid if we are not careful, we could end up measuring the impact of this policy in lives lost.'

Indeed, *Putting full recovery first* is a 'dangerous document', says Sinclair. 'In a time of austerity when services a being cut in the community it seems to be suggesting that through the creation of recovery champions we'll find ourselves in a wonderful state of full recovery. The sort of services that would support recovery in the community are being cut, so I find it difficult to believe that a government that's cutting vital support services is at the same time suggesting that it is supporting recovery.

'It describes itself as a roadmap, but it gives no directions,' he continues. 'I go around the country and there's an incredible amount of confusion around what recovery-orientation is – I encounter very few commissioners or service managers who've had any real guidance. Service users and people delivering services deserve better. They deserve to get reasonable guidance about what recovery orientation actually is.'

Putting full recovery first available at www.homeoffice.org.uk

Putting public health first available at www.ukhra.org/putting_public_health_first

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

I do not know whether this troupe of high-minded MPs has yet commissioned stationery bearing the screamer 'the most starfucking bunch of dullards this side of *OK!* magazine', but if not, I am happy to furnish them with the quote. Chaired by the odious Keith Vaz, whose advance towards the red benches appears to be as ineluctable as it is sensationally ill-deserved, the committee this week followed up its decision to call Amy Winehouse's father to discourse on the cocaine trade with an invitation to Russell Brand to address them on drug addiction. To substitute one genuine expert with a tabloid celebrity may be regarded as unfortunate; to do it twice begins to look like a clear strategy... Brand is not there because of anything he might say. He is there because he will get Vaz and friends on the telly.
Marina Hyde, *The Guardian*, 26 April

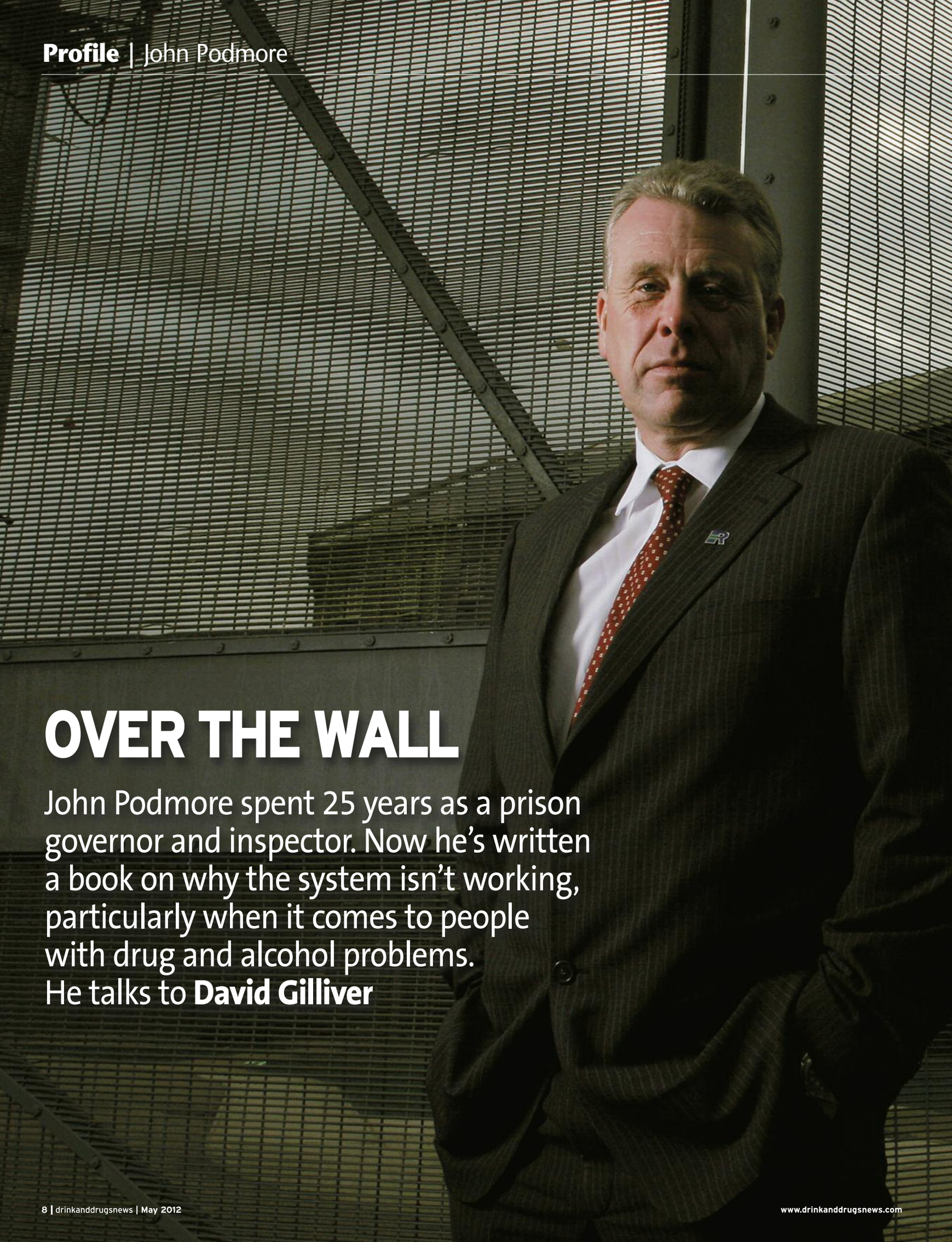
The fact is that drug use is a risky minority activity that most people do not have a taste for. It will stay that way as long as it is against the law.
Kathy Gyngell, *Daily Mail*, 24 April

Consumer countries of the developed world have seen whole communities devastated by epidemics of drugs misuse and crime. Addicts of drugs such as heroin have been marginalised and stigmatised and many otherwise law-abiding citizens criminalised for their consumption choices. But the vulnerable producer and transit countries of the developing world have paid a far higher price.
Nigel Inkster, *The Sun*, 17 April

The pro-crime lobby who run our injustice system have two fixed beliefs. One is that criminals are victims. Their misdeeds are not their fault but the inevitable result of non-existent poverty... The other is that prisons are a waste of money, an 'expensive way of making bad people worse'... They keep the jails we have only because of tiresome public opinion, and because of newspapers like this one that hold fast to traditional ideas of right and wrong, justice and punishment. That is why they deliberately run those prisons very badly – they are pointless, apologetic warehouses, largely under the control of the inmates and full of illegal drugs.
Peter Hitchens, *Mail on Sunday*, 15 April

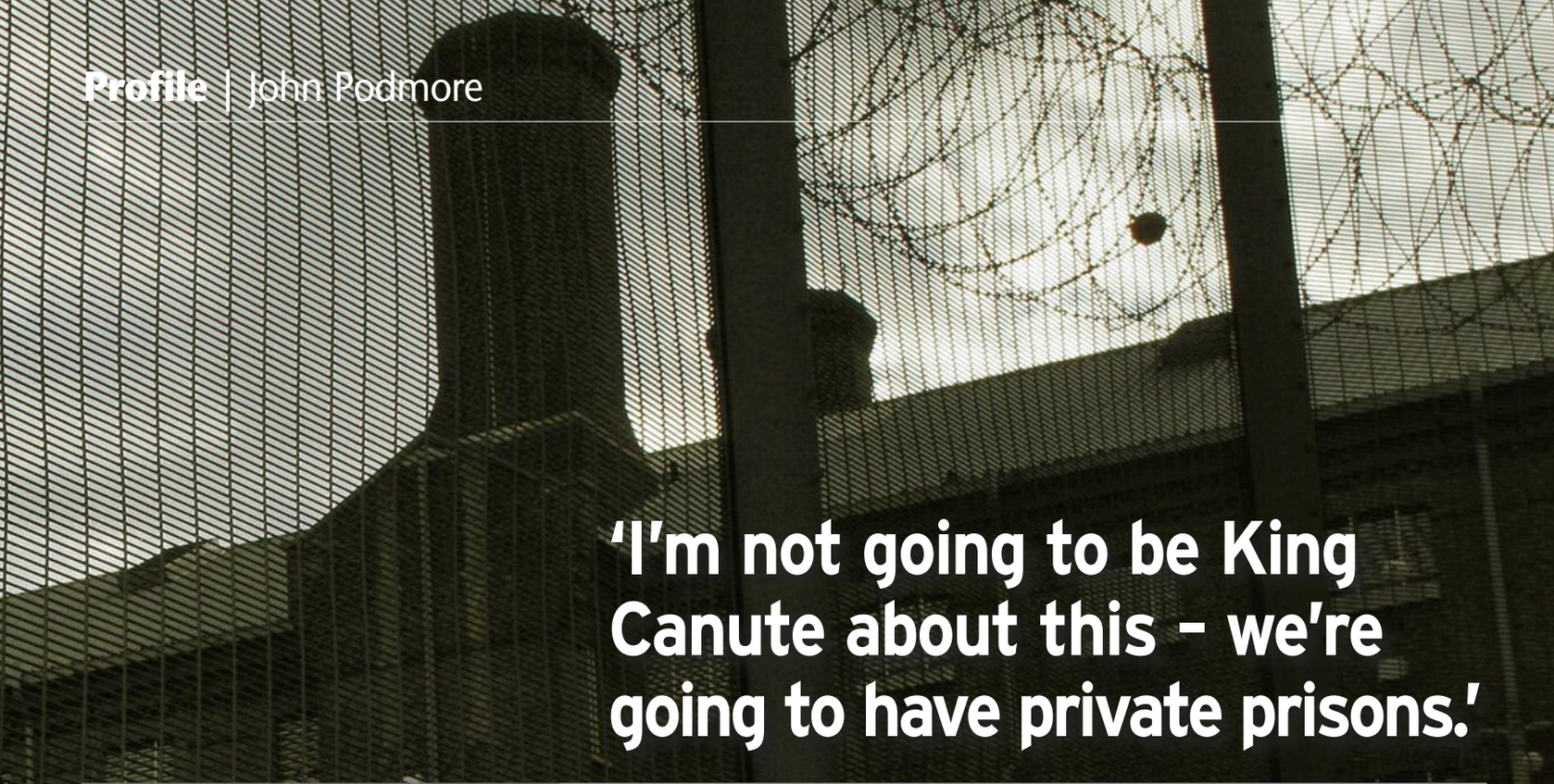
While you witter on about your pet project Mr Cameron, care for society's vulnerable is being systematically taken apart. I don't see anything Big about that. Big Society... it's very apt that when reduced to basics, it's nothing more than BS.
Fiona Phillips, *Mirror*, 7 April

Recently, researchers from King's College in the UK have found that the number of middle aged people who had taken cannabis in the last year has increased tenfold over the last fourteen years. The hippie generation are not keen to give up the weed. Some see no point. They like it and they claim that it is doing them no harm. Excessive use often damages mood, memory and motivation but maybe they don't value these attributes.
Dr Robert Lefever, *Daily Mail*, 13 April



OVER THE WALL

John Podmore spent 25 years as a prison governor and inspector. Now he's written a book on why the system isn't working, particularly when it comes to people with drug and alcohol problems. He talks to **David Gilliver**



'I'm not going to be King Canute about this – we're going to have private prisons.'

'Prison is really only a deterrent for those who've got something to lose,' says John Podmore, author of *Out of Sight, Out of Mind: Why Britain's Prisons are Failing*. While 'prison isn't working' arguments may have become familiar, it's extremely rare to hear them from someone who spent 25 years in the service – as governor of Brixton and Belmarsh and then as an inspector – which is what makes the book so fascinating and its arguments so powerful.

'If I were to go to prison, I've got a lot to lose – a great family, friends, lots of interests and things I love doing, and that's true for most of us,' he says. 'But for a lot of people out there, particularly in the current economic climate, going to prison wouldn't actually mean losing very much. If you haven't got a home you're not losing a home, if you haven't got a job you're not losing a job.'

And, as the book spells out, neither does it stop crime being committed – acting as a networking opportunity for major drug dealers in particular – or people going on to reoffend once they're released. 'You hear all this stuff about "we need to make it tougher and harsher" and so on – well, what we need is a larger section of society having something to lose by going to prison,' he says. 'We've got a huge number of people who are socially excluded, dispossessed and struggling with life, so rather than looking at prison we've got to look at society. That's where we need to put some of the emphasis.'

The book grimly details the systematic over-use of the remand system in particular, especially for people who aren't even likely to get a custodial sentence if found guilty. The result is a world where those with drug, alcohol or mental health problems presenting before the courts for relatively minor offences will be remanded just to keep them off the streets.

'We know – but we won't accept – that we use remand to deal with social problems,' he states. 'That is not a good principle for putting people on remand. The least we can do is say "he's got a problem and needs drug or alcohol treatment or psychiatric support, let's provide that in some kind of supported housing, not a prison". We need to have better, more flexible facilities. The remand system is not the place, and anyway there's no more money – the way the remand population is created, managed and maintained is diverting huge sums away from other parts of the system.'

Government plans to improve the remand process, however, appear to have been shelved, presumably for fear of being seen as 'soft on crime'. Does he have any optimism that things could change for the better? 'No one wants a "rehabilitation revolution" more than I do, but by definition in a revolution something has to be overthrown. I don't see anything major happening, other than privatising a load of jails.'

The book makes a stark warning that privatisation will mean the interests of shareholders coming before those of staff and prisoners. With eight prisons out for contract and up to 20 more expected to be announced later this year, this is 'privatisation on a scale that no country in any part of the world has ever been down the road of,' he states.

'I'm not going to be King Canute about this – we're going to have private prisons. OK, one, let them be more cost-effective – despite what anyone says, there's no real evidence to suggest that private prisons are cheaper. The whole PFI thing should have given a real warning about that. Two, there should be some positive new initiatives in the service, but if you get the private contractors to talk they'll say, "they're not looking for much in the way of initiatives, they just want cheap containment." There is this kind of perception of "private good, public bad" and I'm prepared to listen to the arguments, but in this world of the evidence base, give me the evidence that this strategy is the best one. It's not there.'

What prompted him to write the book? 'It was serendipitous, really,' he says. 'I was planning to leave the service and I was working with the [freedom of expression organisation] English PEN scheme. I was at an event where someone asked if I'd thought of writing a book and said he knew the guy who ran Biteback Publishing and he'd give me an introduction.'

He found writing it both tough and cathartic, and the feedback so far has been 'extraordinarily good', he says. 'It never worried me that people would disagree with me because the whole aim was to stimulate debate, but one of the most gratifying reviews was from [serving prisoner] Ben Gunn in *Inside Time* [the newspaper for UK prisoners]. Ben who, shall we say, is not backward in coming forward in his views of the service said he was "nodding in agreement with almost every page" – although he found himself uncomfortable with that because he's not someone who normally agrees with prison governors.'

Press coverage has also been positive, including – perhaps surprisingly – in the *Mail*. With politicians of all parties seemingly running scared of the press, particularly regarding crime and drugs, does he think attitudes might be changing? 'That's an interesting question, because I had a call the other day from the *Guardian* to tip me off that I was a victim of phone hacking. The information they got on me has been redacted so we don't know when it was, but it may well have been the time I was at Brixton.'

Was that a shock? 'People have asked me why I'm surprised, but it leaves a very nasty taste. It kind of comes with the territory, but I was more disturbed by it than I thought because it's such a personal intrusion. But in general terms, I've found it's easy to blame the media. When you deal with the quality media they just want to know what's going on, so I think if you engage and have a positive relationship with the media it can be mutually beneficial. You've got to be wary of tabloid headlines and all that, obviously, but sometimes you get the negative stuff because there's this kind of media barrier. If you don't offer anything they'll just go off at a tangent and do their own thing.'

As the book points out, this was particularly a problem in the Blair years, which he describes as 'the worst in recent memory'. 'It was dreadful,' he says. 'They were just obsessed with the media and there was no real engagement with what should be done – it was just a case of "we want to stay in power and don't do anything to stop us staying in power". I found that very sad.'

He's also saddened by the way innovation in the system is being killed by risk-aversion and the commissioning process, he says. 'We need innovation and we need change and that's not coming about from the private sector. OK, they're

'We know – but we won't accept – that we use remand to deal with social problems.'

trying to involve Third Sector organisations, but some of the bigger ones like NACRO have effectively teamed up with the large multinationals. The smaller organisations will either get swallowed up or they'll disappear entirely because they can't compete in the new world. You can't say to these small charities that want to get involved in prisons "you'll only get paid via payment by results" because they don't have the capital to put up front.'

While there's a great deal of anxiety about the structural changes to commissioning and delivering drug treatment in the community from next year, there'll also be a huge impact on treatment in prisons. 'It'll be interesting to see where that goes because I think there's a real danger that commissioners will tend to not favour prisons,' he says. 'Brixton is different because you had a degree of coterminosity between the community and the prison, but let's say you're commissioning services in the Isle of Wight. You've got three prisons that hold about 2,000-plus prisoners and very few come from the Isle of Wight and very few will be returned to the Isle of Wight, so is the health authority body – whatever it's going to be called – on the Isle of Wight going to look particularly at the prison population?'

The emphasis needs to be on prison governors forming relationship with the local community and health authorities, he stresses. 'Some governors do that very well, others I'm not sure. The whole commissioning of health and drug and alcohol services is going to be a test of that – when it comes to commissioning time, people are human and if the mutual understanding of need is not there then the prison may miss out on that commissioning process.'

In terms of treatment in prison, the book is a reminder of how much alcohol provision is still woefully lacking. 'There's none, really,' he says. 'There's alcohol detox, and they're beginning to look at commissioning some alcohol services. I don't know what's happening out there in terms of contracts, but I don't think local commissioners are giving any priority to alcohol. It's an absolute disgrace, because we know how much alcohol is related to domestic violence. There's disorder and violence on the streets, but how much is alcohol involved in a whole raft of offending? There needs to be much more long-term investment in alcohol treatment in prison. It's always been the poor relation and I've never understood it.'

What's vital is proper assessment of prisoners' needs as they come into prison, he argues. 'There's always been the emphasis on opiate treatment, but when I was at Brixton crack was the drug of choice. Dealing with people taking crack is more difficult than getting them on an opiate-based programme, so if you're a prisoner coming into Brixton you'll be confessing to opiate misuse rather than stimulant misuse because you know they'll give you something, you're going to get a prescription.'

It's widely felt that mandatory drug tests (MDT) are, to say the least, an unreliable measure of levels of drug use in a prison and, as the book describes, reasonably easy to fake. The prison service, however, 'clings to them', it says, partly because they can count towards bonuses and appraisals.

'According to MDT statistics, drug use in prison is either reducing or staying the same,' he says. 'Now if you can find me any problematic drug user coming out of prison who says that's the situation, I'm a Dutchman. What I would advocate is to send in an independent body – or send one jail to randomly drug-test another – and if the figures are the same as the MDT, then fine. But that's never been done. There's been no independent, external verification of MDT so what's the evidence to suggest they're accurate? The most important thing is to go and talk to people who've just come out of jail, or prisoners in jail – they'll tell you. There's also research around people's first opiate use being in prison, and we really ought to be acting on that.'

The book goes on to describe many prisons as having an 'institutional antipathy' towards organisations like NA, justified partly on security grounds. Does he get any sense that attitudes are softening? 'External organisations generally – charities, voluntary bodies – still struggle to get into prisons and get access to prisoners. Again, it comes down to the evidence – we spent £150m on CARATs but where's the evidence that CARATs works? All I know is that getting someone in from NA to meet with prisoners on a Wednesday night certainly won't do any harm, and it will get a message out to the prisoners that we are interested in this.'

In terms of making the system work – and, of course, the welfare of those in the system – the transition from prison to community is particularly crucial, especially with the much-increased risk of overdose. 'There's a phrase they use in the states about 'drop kicking' people into the community, and that's what we do. Keeping people in prison is relatively easy. Getting them out and keeping them out, is the difficult bit. But we become obsessed – and measure the success of our prison system – by people not getting out when the emphasis of that success should be on getting people out such that they don't come back.'

As everyone knows, however, reconviction rates remain stubbornly high, as much as 70 per cent for young offenders. 'The most optimistic statements you'll get are "rates have gone down from 56 per cent to 55 per cent". If you had a factory making cars and half the cars broke down after six months, you'd close the factory down. If we really had payment by results we'd close down the entire prison system.'

These days he's a freelance consultant and has just returned from doing some work with New York's Columbia University. 'Most of my contemporaries are on a thousand pounds a day doing work for Serco and so on, but needless to say they won't touch me with a bargepole,' he laughs.

He entered the service after being a teacher for eight years. 'I had a young family and I wasn't earning very much and getting bored and disillusioned, and I came across an advert one day and thought "that looks interesting". Twenty-five years later here I am.' How does he look back on his career? 'I've enjoyed it. I think my problem was I enjoyed working in jails but I was a bit of a fish out of water when I wasn't in jail, apart from when I was inspecting, where you can make a significant contribution to getting things done. But working at Brixton was the highlight.'

So which countries are closest to getting it right? 'Everyone says Scandinavia, and they are the nearest. In Norway to be a prison officer you need two years' training to degree level. And what we need here is a long-term strategy, rather than just "how can we save money in the short term?"'

***Out of Sight, Out of Mind: Why Britain's Prisons are Failing* is published by Biteback**

Photo: TSL Education and many thanks to Neil Turner, neil@dg28.com

POLICY SCOPE

What's next for Payment by Results, asks Marcus Roberts **in his first regular column from DrugScope**

UNCHARTED TERRITORIES

Payment by results 'pilots' for drug and alcohol recovery 'went live' on 2 April – as *DDN* readers will no doubt be aware if they are involved with services in Bracknell Forest, Enfield in London, Kent, Lincolnshire, Oxfordshire, Stockport, Wakefield or Wigan. Others who may not be involved in the eight pilot areas have their own reasons to be concerned about payment by results (PbR).

Elsewhere some commissioners have developed their own schemes and the government has encouraged others to join them. Other PbR initiatives are also impacting on the drug and alcohol sector, including DWP's 'work programme' and PbR in the criminal justice system. PbR is emerging as the centrepiece of the coalition government's approach to public service reform.

Writing in the *Guardian*, Oliver Letwin, the cabinet office minister who has led on PbR, explained that the basic principle was that 'where vulnerable users can't exercise choice for themselves, the government should specify the result it is seeking, and then pay the providers of the service if, but only if, they achieve the result'.

Drug rehabilitation is particularly suitable for PbR, he claims, because 'we have been pouring billions into it over the years – with appallingly low rates of successful recovery', and, he believes, this situation can be turned around if 'providers of drug rehabilitation are being paid their full fee only if they get drug users properly off drugs'. The Audit Commission has recognised that 'PbR can provide sustained incentives for providers to improve outcomes, and to find new ways of doing so. It can encourage new ideas, new forms of service delivery and new entrants to service provision'.

Having been involved with the Department of Health's co-design process for the PbR pilots, I can testify to the thought and energy that civil servants and local commissioners have given to addressing potential pitfalls and problems. It should also be stressed that the PbR outcome framework is broader than Oliver Letwin's comments in the *Guardian* might suggest – there are two further 'domains' alongside 'free from drugs of dependence' – 'reducing offending' and 'health and wellbeing' (including cessation of injecting, hepatitis B vaccination and access to housing). Nor does the first domain simply pay out on 'abstinence'.

But there remain significant grounds for caution and concern, particularly as PbR is implemented in a rapidly changing and financially challenging environment. The Audit Commission warns that 'schemes that make a large part of the payment dependent on performance are, for the most part, untested and their overall effectiveness is not yet proven'. This echoes an earlier UKDPC report, which concluded that 'the approach being taken to payment by results in recovery is going into uncharted territories and is effectively a social experiment with a particularly vulnerable group'.

The government says that PbR has the 'potential' to improve the performance of drug and alcohol services. It is now about actual delivery, consequences (intended and unintended) and... results.

Marcus Roberts is director of policy and membership at DrugScope, www.drugscope.org.uk. *See page 12 for our feature on PbR pilots*

LEGAL LINE

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

CAN WE STOP THE CONSTANT POINTLESS POLICE SEARCHES?

READER'S QUESTION:

My son and his friends get stopped and searched by police at least a few times a week. The officers often say it's because they can smell cannabis on them, but they have never found anything on my son. He feels like he's being targeted and I'm starting to think it might be because he is a young, black male in an area where there is a lot of crime. Is there anything we can do to stop this?

KIRSTIE SAYS:

Your son should make a complaint about the frequency he is being stopped and searched, and the fact that there do not actually appear to be any grounds for this (based on the fact that no drugs have ever been found on him). A complaint can either be made to the inspector at the police station where the officers are based, or to the Independent Police Complaints Commission (IPCC).

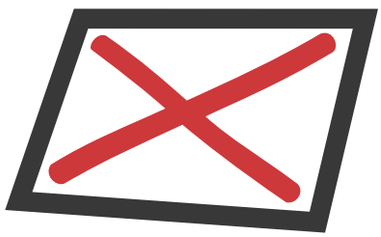
Many people are not comfortable making the complaint at the police station because they worry about any investigation being independent. However, even if the complaint is made to the IPCC, issues of this type are often referred back to the relevant police station for local resolution. If the decision at that level is unsatisfactory the IPCC can still be contacted.

Each time your son was stopped and searched he should have been given a form confirming this, which will include details of the officers performing the stop and search. This will be particularly important if it is the same officers that stop your son each time, as this may support that he is being targeted by them. There may be potential for an action against the police for harassment.

I understand that it must be frustrating for your son each time he is stopped and searched unnecessarily, but he must try to remain calm. Any hostility on his part may be misinterpreted by the police and lead to more serious action being taken. It is important to cooperate with the officers at the time and make any complaint about their actions after the event. Each time your son is stopped he should make sure he records the officers' names/badge numbers and as much other information as he can to assist with the future action he wants to take.

You do not mention if your son has been mistreated in any way, for instance subjected to a strip search in a public place, but if this has occurred this should form a separate complaint as well as part of the general one. It may also be possible to take legal action against the police in this situation, and it will be important to get details of any potential witnesses for this.

Email your legal questions to claire@cjwellings.com
We will pass them to Kirstie to answer in a future issue of DDN.
Release is conducting research into the disproportionate policing of drugs offences. For more information on this issue call 0845 4500 215.



The government's PbR pilots are now up and running. **DDN** hears how things are going so far

A YEAR AGO, Bracknell Forest, Oxfordshire and Wigan were among the eight areas chosen to pilot a payment by results (PbR) approach to drug treatment (*DDN*, May 2011, page 5). As the pilots only went live last month it's too early to assess any impact on levels of reoffending or drug use, but some interesting lessons are already starting to emerge.

Your area was chosen based on the ideas you put forward. Could you briefly outline what those were?

Jo Melling, director of Oxfordshire DAAT: We have redeveloped the whole treatment system, embedded alcohol intervention and treatment within it, and introduced not only payment by results to the recovery contract but incentive payment to every contract. All services were competitively tendered.

We've also redesigned police custody-based interventions with Thames Valley Police and commissioned an independent local area single assessment and referral service (LASARS) with a 75 per cent contract value, 25 per cent PbR element, provided by Aquarius. There's a harm minimisation service, with 70 per cent contract value and 30 per cent PbR element provided by Oxford Health in partnership with OASIS, and we've also commissioned a recovery service, on a 100 per cent outcome basis provided by Lifeline.

Jillian Hunt, DAAT manager and commissioner at Bracknell Forest: We based our approach on appointing a single prime provider with a contract that is 100 per cent PbR. As a small unitary authority we have a strong record of partnership working to maximise resources and, about two years ago, the police in Bracknell Forest set up a regular operation called Ladybird, which has been instrumental in reducing levels of crime. It adopts an assertive outreach approach – joint visits are made to offenders who have disengaged with services, and it's been successful in getting people back into treatment. Our model extends this approach to all of the people using drug and alcohol services.

David Gray, prolific offender and drug intervention strategy manager at Wigan: The intention was to look at whether financial incentives can drive performance and help achieve the sustainable recovery that we wanted. It's part of a much wider remodelling of our services.

It's obviously still early days, but how would you say the process is working out so far?

JH: It only went live on 2 April, however our LASAR has been undertaking all of the assessments since mid December and that's working very well. Many of the people who were in treatment already and have been reassessed using the new recovery-focused approach have commented favourably on the process and said that it has made them feel more involved in their own care.

What key lessons would you say you've learned, that might be useful to other areas?

JM: PbR is complicated in terms of ensuring that the complex needs of clients are met, whilst setting outcomes that can be measured and are sensible for the client group we're dealing with. Having overarching outcomes seems simple, but turning that into, one, a good quality service and, two, a contractual payment is not an easy process.

JH: One of the major lessons is not to underestimate the time it takes to reassess the people who are already in treatment. Your LASAR and providers need to work together to explain not only the benefits of the reassessment but also that people have to have it done. For some people that is of concern because it's change and they may not actually want recovery at that point. Keeping the people in services in the loop is crucial to ensure a smooth transition.

DG: You need to look at things from your local area aspect – what your relationships are like, the profile of your clients – and understand what you want to incentivise and how you want to do it. Also, give yourself plenty of planning time – a lot of people might just rush into it and end up incentivising activity rather than outcomes.

Any mistakes that people should avoid?

JM: Many! It's been a huge learning curve in terms on turning aspirations into reality, and I know more about the legalities of NHS contracting than I ever wanted to.

PbR is designed to boost value for money and affordability. Is there any evidence so far that it's doing so?

JM: I think PbR is actually about improving outcomes – it is for me. As a commissioner I think we serve only two overarching aims – the best quality services for the service user and the best value for money for the taxpayer. I know that sounds very grand but when you break it down, that's what we need to be achieving. It's too early to say if PbR can improve that.

JH: Again, it's too early to tell. However Bracknell Forest has set its own tariffs and has developed a client complexity profile modelling tool outside of the national model, which takes into account all of the domains that have impacted on a person misusing drugs and alcohol. The tariffs have been set so that the prime provider should have sufficient resources to meet every individual's needs. Early indications in terms of the people already in service are that a saving will be made without reducing the quality of the service and ensuring that the financial risks to the prime provider are minimised.

DG: With the context we're working in – the new funding arrangements and public health coming over to the local authority – we need to better evidence performance and the effectiveness of substance misuse services. A significant question is how we can support individuals with entrenched substance misuse problems towards recovery, and I don't even know if we'll have all the answers in a year or two's time, but a big part of our evaluation is to look at whether a PbR approach could contribute to positive outcomes for clients and for us to understand the wider impact on services and service users.

In other areas where PbR has been introduced – such as mental health services – it's taken years to develop, yet the time frame to get the pilots up and running was fairly tight. How did you find the process, and of co-designing the system with the government's team?

E THE RESULTS

JH: Originally the intention was that the pilots would be running from October 2011 but it was quickly recognised that this timescale could not be kept, particularly in the case of areas like us who were retendering all of their services. The co-design process has had some ups and downs, one being the agreement of all parties on the final outcomes, but we got there in the end. On the whole, the process for the pilot areas has been good because we've had the chance to learn from each other.

DG: The real advantage is that you get to link and work with the other pilot areas, so you're coming at things from a similar mentality and you can work through the processes like that. That's an opportunity you don't get every day – you might liaise with neighbouring boroughs, but to go and spend some time looking at different ways of doing things and different models gives you ideas outside of the PbR aspect. But it is a pilot at the end of the day. Some work, some don't.

But PbR is controversial, with concerns that it will lead to the cherry picking of clients with lower levels of need.

JM: The system needs to be designed to take out cherry picking. It's not impossible to do, it just takes some thought. Also, when people talk of cherry picking it's assuming that everything is perfect now – I'm sure some service users may say differently.

JH: Having an independent LASAR who retains responsibility for the treatment outcomes process reduces the risk of cherry picking. The client profiling that we do means that the prime provider should receive adequate resources in respect of even the most complex people. A percentage of each person's tariff is also paid up front when someone is taken onto the caseload, in order to ensure that the prime provider has an incentive to work with them. Also, if you have a mature relationship with your provider and they are committed to the recovery agenda, why would they turn people away?

'Give yourself plenty of planning time – a lot of people might just rush into it and end up incentivising activity rather than outcomes.' David Gray

'When people talk of cherry picking it's assuming that everything is perfect now – I'm sure some service users may say differently. ' Jo Melling

DG: We're doing it on a cohort basis, which is different to a lot of the other areas. Because we've profiled it in that way, services can't ignore the high complexity cases because there are targets associated with that. I'm not saying it won't happen – with any system there's always going to be an element of it, even with non-PbR systems, but that's how we've managed to reduce some of the risks.

What's been the level of input from service users and families?

JM: Every step of the way, service users were involved in the original concept and every element of the process thereafter including in all the commissioning – we have service user representation in every level including the DAAT board. It was our service users who were one of the drivers for change.

JH: One of the people on the project board was in recovery and was involved in the tender process from start to finish – she was particularly good at asking questions about involving people in service development. We have a strong family and friends group in Bracknell Forest who were kept up to date on developments.

DG: We're working with the existing providers so for some of the elements we already had a single point of contact that was working well. So while there's an awareness this is happening, service users shouldn't see too much difference in terms of how it actually translates.

At the DDN conference, some service users expressed fears that PbR could mean them being 'kept on the books' of services and held back. What would you say to them?

JH: Quite the opposite. The whole reason for focusing on recovery is to move people on. We see payment by results as an opportunity to work with people and help them to achieve their full potential.

LETTERS

'What is undeniable is that the scientific evidence shows that drug treatment provides value for money. Taxpayers get back more than they put in, through reduced crime, better public health, and successful outcomes for individuals.'

VALUE FOR MONEY

Your correspondent Pat Trowbridge makes a fair point about measuring value for money (*DDN*, April, page 11), but the NTA has never undervalued the benefits of drug treatment. The issue is that academics have disagreed about the numbers.

The Centre for Health Economics at York University estimated that every £1 spent on treatment saved £9.50 in 2004. This was based on the NTORS research commissioned by the Home Office, and balanced the cost of treatment against savings made in crime and healthcare costs.

NTORS studied mainly heroin addicts between 1995 and 2000, before the recent expansion of services. Subsequently, in the light of the rise in crack and cocaine users, and the growth of treatment for drug-misusing offenders, the Home Office commissioned an update.

DTORS (2009) estimated that £2.50 was saved for every £1 invested, but used a different methodology and acknowledged, 'It is not possible to conclude that drug treatment is now less cost-effective than it was at the time of NTORS'. However, the National Audit Office accepted the £2.50 for every £1 cost-benefit in a report (2010) that concluded treatment was improving and supported by robust evidence.

What is undeniable is that the scientific evidence shows that drug treatment provides value for money. Taxpayers get back more than they put in, through reduced crime, better public health, and successful outcomes for individuals.

Meanwhile, the NTA has been interrogating the wealth of information collected over recent years, in conjunction with the drugs data warehouse project at the Home Office, to make its own assessment of value for money. We intend to publish a report on this shortly which will demonstrate how investment in treatment continues to improve health, reduce crime and put individuals on the road to recovery.

Paul Hayes, chief executive, NTA

WALK IT LIKE YOU TALK IT

This year's recovery walk, which is to be held in the city of Brighton & Hove on 29 September, was officially launched on 11 April [*see picture below*]. The mayor gave us a fantastic speech, which you can find on our new website – www.recoverywalk2012.org.uk

You may be wondering why a 'walk' has to be launched. Well, the event will be the culmination of a project that has been running since around August last year. We wanted this walk to be completely peer-led, and a group of people in recovery have been doing some amazing work in developing this project, and thereby developing their own skills, knowledge and connections (otherwise known as recovery capital).

Alongside the planning, negotiating and banging of heads against various walls that typifies organising such events, the group have been working to an asset-based approach that has seen them forge new and interesting allies and partnerships. People are really very interested in what we are doing here – not just the celebration of recovery and tackling of stigma, but the overall approach of empowerment and mobilisation.

The lasting legacy for Brighton & Hove will be an established, visible, vocal and independent recovery community. That's the long game. But what about the walk itself? Have a look at the website for the route. In Preston Park, we will be holding an event with musicians/comedians etc (there are plenty of those in Brighton – and in recovery too!). There will be stalls for various groups to display their wares, open meetings, get-togethers for activists, guerrilla recovery coaching, kiddies' areas, it's all going to be there.

The theme is creativity. This is not only apt for Brighton, but for recovery too. We believe that creativity is an important part of rebuilding ourselves, and our communities. Just like there are many pathways to recovery, so there are to creativity. So we want you all to get creative and bring your banners, kites, badges, t-shirts etc along on the day to show us, and each other, that recovery is a reality in all corners of the UK.

So the launch is for all of you really, to say 'let's start getting together and getting creative'. We are in discussion with Brighton Museum to run a concurrent exhibition of artefacts from the old temperance movement that was very active in the city. We are also making a documentary and getting a steel band together. We want recovery choirs, artists, jugglers and magicians to come and celebrate with us. The general public of Brighton & Hove will see that people and communities can recover, given time and understanding. Come, and be 'part of'!

Brian Morgan, UKRF director and chair of the UK recovery walk steering group

GOOD CAUSE

Service user group Sussed are looking at putting on a sponsored walk from Bedford to Cambridge on 30 June. This is one of the many ideas that they are putting together to mark the Eastern region recovery month, and they are looking for sponsorship from any organisation that would like to support their work in their local area.

The walk is 30 miles and will be setting off from Bedford Corn Exchange

at 9am. This will be another cross-county event, with Cambridge champions meeting the walkers at the other end. So far there are nine walkers, six from the group, one from the local DAT, one from Bedford Housing Link and one other supporter of the group. All money raised will go back into the group to enable them to continue their work in promoting recovery in all its forms in the local community.

We have been asked by their rep to see if anyone would be interested in sponsoring the group for a small amount, thus supporting the group to continue operating in their local community. Any support to secure the group's future would be appreciated.

Kevin Jaffray, open access project worker, Addaction, Bedford
Email: k.jaffray@addaction.org.uk

SHOP SOILED

I read with interest Dr Chris Ford's description of her local pharmacist in her column in the April issue of *DDN* (page 11) and once again marvelled at the quality of the joined up working in her local area. I only wish my experience of pharmacies was similar.

While Dr Chris's pharmacist is 'part of the team, a vital partner and not just someone who dispenses the medication', I have found from personal experience the opposite can be the case. My local pharmacist sees themself just as someone who dispenses medication, albeit very grudgingly. Far from being a 'welcoming place without stigma' my local pharmacist treats me with a level of stigma usually only reserved by sweetshop owners for school kids lurking around the penny chews section. I keep expecting to see an 'only two junkies may enter this shop at anyone time' sign appear on the door any day now.

Time spent in the shop is kept to an absolute minimum, with as few words exchanged as possible, and the barely disguised aim of getting the 'dirty junkie' out of the shop as quickly as possible before any nice 'normal' people come in.

Like Dr Ford's pharmacist I am sure there are many fine practitioners providing a valuable service, but sadly I don't think my experience is untypical. Optional training is only taken up by those who are sympathetic in the first place, so why not make the courses compulsory and have a service user-led first-hand account of the dangers of stigma at its core?

Name and address supplied

INEXPERT WITNESS

I know we need a celebrity to provide information on anything these days, and any TV programme worth its salt has to have a famous face involved to validate it, from 'Hot air ballooning with Bill Wyman' to 'Town planning with Trevor McDonald.' This now extends beyond the world of entertainment to politics where Mary Portas saves our shops, *Location Location*'s Kirstie solves the housing crisis and Dale Winton probes the murky world of badger baiting... probably.

There seems no area left where a genuine expert's opinion carries enough weight. Despite the fact that you might have devoted your life to studying and working in that field, your views are not going to be heard unless they are backed up by a media personality.

I see this has now been adopted by the drugs field, where we had the Russell Brand select committee show this month.

While Russell may have won his own personal battle with addiction, his experience is far removed from that of most people. Russell's repeated insistence that what we need is more abstinence-based recovery, while ignoring any other possible form of treatment, including dismissing methadone maintenance as 'state sponsored opium addiction,' was incredibly unhelpful.

When asked about decriminalisation and harm reduction he started with the caveat that he really didn't know anything about it, then proceeded to waffle at great length.

While a bit of 'stardust' might sell a TV show and introduce an audience to a subject, surely we don't need to adopt this practice to engage with MPs on drug treatment?

Alan, by email

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.

Post-its from Practice

The price of drink

Alcohol can pervade personal and family life, says Dr Chris Ford

With tears of joy Noel thanked me for supporting him through yet another alcohol detoxification and said he accepted that he had needed something more than just the detox.

I've known Noel for about three years. He is 62 years old, has always worked as a builder, has been married for 40 years and has two daughters. He has also lived with an alcohol problem, but didn't view it as a problem from his 20s to his 50s – he had always got to work on time and all his fellow workers drank at the same level. Then problems began to develop. He started to have odd days off work and his health deteriorated.

When I first met him he said he had never revealed his drinking habits to a doctor before and had never asked for help. At that time he was drinking 13.6 units of 4% beer a day (95.2 units a week,) and two litre bottles of 40% vodka (80 units) a week, adding up to 175.2 units a month, and his intake gradually increased. He had used AA on and off over the years and had found it helpful, but was too ashamed to attend meetings at the moment. He had tried to stop himself a few times over the past months but said he always became violently sick. He always came to appointments with his wife and she confirmed his history and said she had persuaded him to come and see me.

At that time we talked about alcohol dependency and the options Noel had for treatment. Even giving him all the evidence, he said he just needed some tablets to help him through the withdrawals and he would go back to AA. He didn't want work to know and could only take ten days off. His wife said she would support him and he completed the physical part of the detox fairly easily, but he stopped coming to see Mel, the practice counsellor, after a few weeks.

Noel came back after a few months, saying he had relapsed after a drink at a family wedding. He asked for 'some more of those pills' and he would then 'get out of my hair' and stop bothering me. We again went through the evidence and options but he declined all additional support.

This cycle was repeated twice more, until he presented late last year. He now accepted he had a problem and he was powerless to do it alone. After going through the choices again, he decided on an inpatient detoxification and a 12 week abstinence day programme at EACH, which he started early in the new year. I saw him a few times during those weeks and each time he was bursting to share what he had done. The programme covers life skills, motivation, anger management, help with employment and housing, support – even a gym session.

Four weeks after completion of the programme Noel is still having counselling, still attending AA, and is still alcohol-free – one day at a time. As so many people have said before, recovery is seldom a single event contained within a set period of time. Each person is different and needs to find their way and this can't be dictated by health professionals or government policy. Some people need more help than others; some need no help. It is usually incremental and, as with Noel, can take place over many years.

Noel knows he is one drink away from going back to alcohol and all its problems. Excessive alcohol is so often the condition patients don't want to mention and doctors don't want to uncover for fear of what to do. Although we have improved about asking in general practice, we still have a long way to go.

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

BE THE CHANGE YOU WANT TO SEE

PRIDE IN RECOVERY

Haringey drug and alcohol service users, commissioners and staff are working together to reduce stigma and support recovery, writes **Laura Pechey**

BACK IN JULY 2011, Haringey Drug and Alcohol Action Team (DAAT) and local drug and alcohol services started thinking about how we could work together to promote recovery locally. As a first step, the DAAT set up a recovery champions group made up of staff and service users from local drug and alcohol services, and chaired by the local DAAT strategy manager, Marion Morris. The group set out to develop a shared understanding of recovery and to use this to reduce stigma in the wider community – and it agreed from the offset that, since recovery is self-defined, it does not necessarily entail abstinence from all substances.

We looked around to see what other areas had done and found a host of great initiatives but no resources that we could use to support our work locally. So producing recovery-focused resources was identified early on as a priority. Once we were armed with these resources, how would we get the message out there? Inspired by the success of other 'pride' movements and events, such as Gay Pride, we decided to hold a 'Recovery Pride' week.

What would the collective symbol of a Recovery Pride movement look like? What does recovery mean to our service users? We asked 32 service users from across all eight local services for their ideas for a recovery logo and slogan. The sessions were lively, funny and poignant with service users sharing their personal experiences and creative ideas.

Barnet Service User Group (BSUG) and Haringey DAAT judged the entries and selected two standout winners. Bringing Unity Back into Community (BUBIC) service users spoke about how taking control of your substance use felt like 'unmasking yourself'. Taking inspiration from Mahatma Gandhi's famous call to 'be the change we wish to see in the world', Drugs Advisory Service Haringey (DASH) service users devised a motivational slogan for people at any stage of treatment or recovery: 'be the change you want to see'.

To record some more personal accounts of recovery, we also invited service users to write about their journey to recovery and turned the eight winning stories into a powerful book, Recovery Pride: Stories from Haringey. 'Rhyme of Recovery,' one of the winning entries, concluded:

It was no fun to be a mess, and all the stress that brings,
But when I walk, I'll walk from here with a whole new set of strings,
I've gone from feeling that in life I really just can't cope,
To knowing that above all things, in life there's always hope.

As well as working with service users to express what recovery means to them, the recovery champions group also put together a template for best practice in recovery for professionals. Using feedback from service user consultation and staff ideas, we put together the Recovery Pride Charter, which invites drug and alcohol services to make four key recovery pledges. More than 50 professionals from Haringey and across the country have signed up so far. When asked to comment on the charter, one respondent said simply: 'At last'.

So now we had a recovery logo and strapline, proudly displayed on pens, bags, and t-shirts; a charter; and a book of recovery stories. We were ready for Haringey Recovery Pride week from 26 to 31 March. And what a week it was – 16 events were attended by more than 500 people in 11 locations!

We launched the Recovery Charter and started giving out recovery materials on stalls run across the borough. Cllr Dilek Dogus, cabinet member for health and adult services, opened an awe-inspiring exhibition of service users' artwork, which ran throughout the week at Wood Green Library. Services held their own special events, including a 'What about me?' day for friends and families, a community café, a cycling event around Finsbury Park, a garden-seeding afternoon, and a 'Recovery Soundscape'.

At the end of the week, more than 200 service users, their friends and families, and professionals gathered together as a community for a lively celebration event. Winners of the story, logo and slogan competitions were awarded their prizes by Cllr Bernice Vanier, cabinet member for communities, and Alison Keating, London manager of the National Treatment Agency (NTA). People in recovery spoke movingly of their experiences and we were enthralled by the premiere of *The Tale of Too Many*, a theatre performance organised by Katrina Lahmann, Dual Diagnosis Network, and created by service users from across services.

We couldn't have hoped for a more wonderfully positive celebration of the work done by service users and professionals locally. As we take time to catch our breath we are already planning next year, which we hope will be entirely service user-led and even more successful as a result.

You can join our campaign by signing up to the Recovery Pride Charter: https://www.surveymonkey.com/s/_RecoveryPrideCharter_X2FZYBH

If you have any questions or comments about Haringey's recovery work, please contact Marion Morris marion.morris@haringey.gov.uk

Dr Laura Pechey is the brief interventions and development manager for HAGA, Haringey's local alcohol service. www.haga.co.uk

Ben Websdale in front of his 'Tales from the Ghetto' and other examples of service user artwork.

'HOPE IS INFECTIOUS'

DISC's recent recovery conference gave plenty of inspiration on long-term change, writes **Sue Semple**

'This conference will hopefully inspire you and provide a new focus on recovery and delivering recovery-focused services that people want and need,' said Avril Tully, executive director for drug and alcohol services, opening DISC's recent recovery conference in Leeds.

Chief executive Mark Weeding spoke about people realising their potential and how it was part of DISC's vision to help support people in recovery back into society and into our communities.

'Hope is infectious and that's the message we need to pass on to our service users,' he said, before introducing peer mentor Steven Ellis. Steven told his inspiring personal journey to recovery, supported by DISC and a passion for art. Seeing him on stage now it is hard to believe that Steven had a 12-year heroin addiction supported by an extensive criminal background.

'I had a life and DISC helped me to rebuild it,' he said. 'Despite being four years abstinent from drugs, I still see myself in recovery. It's a lifelong journey.'

Mark Gilman of the National Treatment Agency (NTA) gave a motivating speech demystifying some of the 'Zen' around recovery for everyone.

'We can achieve things together that we could never do on our own,' he said, describing the 'five ways of wellbeing' strategy – connecting with people, being active, giving something back, learning and taking notice. 'If we as workers can support individuals to focus on those elements, they will see an improvement in their wellbeing. Everyone is passionate about something, find your passion and focus on it,' he added.

Rebecca Daddow, senior researcher at the Royal Society for the Arts (RSA) presented the RSA's 'integrated person' work, around helping to support whole person recovery and discovering untapped potential, as well as their work on 'recovery capital' to sustain recovery. Evaluation had shown the extent to which recovery and access to recovery capital at social and community levels were contagious, spreading positive messages through networks.

She also discussed the role of the GP within the recovery process and how, as a first port of call for someone seeking help, they could be an effective catalyst to someone's recovery journey. 'It is crucial that GPs are aware of the potential importance of their role in recovery. They are often the gateway to a much broader system of recovery support,' she said.

Last to speak was Professor Keith Humphries of Stanford University in the US, delivering a presentation on 'circles of recovery', and what science could tell us about peer-led and managed recovery organisations. The strong messages from Keith's presentation were that recovery was a small investment for a massive public health gain. He spoke of the effectiveness of mutual aid in recovery and how small changes in support could have a massive impact on recovery. This included introducing people to mutual aid groups and the concept and importance of assertive outreach – a key part of DISC's recovery programmes.

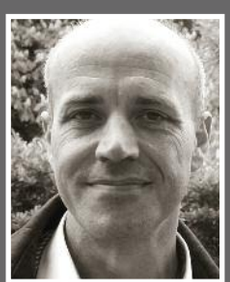
Summing up, Mark Weeding said: 'Recovery is real for anyone who is willing to make an effort to achieve it.'

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

VOICES OF RECOVERY

STRENGTH IN NUMBERS

Recovery is about celebrating differences as well as common bonds, says **Alistair Sinclair**



I'm writing this on the train to Brighton (I spend a lot of time on trains) where I'm going to meet with the planning group for the 2012 UK Recovery Walk, which will take place in Brighton on 29 September. You'll be hearing from the group in this column over the summer but if you want to see what's planned check out the recovery walk website at www.recoverywalk2012.org.uk.

It'll be quite a day – people from all over the UK getting together to make recovery visible, challenge stigma and discrimination, celebrate the strengths, assets and diversity that support recovery, make new friendships and have some fun. Everyone who supports recovery in the community is welcome.

'We make the path as we walk it' is the UK Recovery Federation's motto and that's what we've been doing; getting together with people to talk, share, connect, learn and make the path. We've supported UK recovery walks in Glasgow and Cardiff, delivered conferences with the recovery community and kicked off a recovery seminar programme that has taken us all over the UK.

In April we delivered a recovery seminar in a prison for the first time, as part of Kirkham Prison's recovery week, and we were in HMP Edinburgh on 4 May, exploring passions and strengths and supporting people to find their own way toward greater wellbeing. You'll hear from some of the people involved in the Kirkham recovery seminar in the next 'Voices of Recovery' column and I'll also be reporting back in the next issue of *DDN* on the 'People's Conference' which took place on 21 April, organised and delivered by the Lancashire Recovery Community.

The UKRF has many friends who come from many different places and with very different personal definitions of recovery, reflecting its diversity. In these times when terms like 'full recovery' are being bandied about in government papers, the UKRF falls back on its Recovery Principles. I'll finish with them:

1. **Recovery lies within individuals, families and communities and is self-directed and empowering.**
2. **Recovery lies within our 'connectedness' to others, is holistic and has many cultural dimensions.**
3. **Recovery is supported by peers, families and allies within communities.**
4. **Recovery involves the personal, cultural and structural recognition of the need for participative change, transformation and the building of recovery capital.**
5. **Recovery involves a continual process of change and self-redefinition for individuals, families, organisations and communities.**
6. **Recovery challenges all discrimination and transcends shame and stigma.**
7. **Recovery emerges from hope, gratitude, love and service to others.**
8. **There are many pathways to recovery and no individual, community or organisation has the right to claim ownership of the 'right pathway'.**
9. **Recovery exists on a continuum of improved health and wellbeing.**
10. **Recovery transcends, whilst embracing, harm reduction and abstinence based approaches and does not seek to be prescriptive.**
11. **Honesty, self-awareness and openness lie at the heart of recovery.**
12. **Recovery is a reality and contagious.**

Alistair Sinclair is director of the UK Recovery Federation (UKRF)

Out in the COLD

In April's issue we focused on families to underline the need for appropriate support. In direct response, **Maureen Roberts** told us of her harrowing experience of coping with prejudice on top of grief when she lost her son Scott

There's nothing out there for families during the grieving process. Drug users are stigmatised in life, and sadly that happens in death as well. No excuses are accepted and everything has to be their fault. Scott became drug free apart from methadone, which, like anything else, the doctor gives you to maintain your health. I take Warfarin and view that in exactly the same light.

When Scott was refused a prescription over a bank holiday weekend and when one receptionist decided he couldn't be seen, it was like signing his death warrant. How can a professional not know that a five-day window where somebody doesn't have any methadone can result in them dying?

He rang the out-of-hours service and so did I – we were willing to do anything. Between us we made five calls, but they didn't ring back. We're still waiting for that call.

At the mention of methadone he'd become 'that kind of patient'. He was discriminated against in life and he and his family were stigmatised in death. If somebody had said to him, 'if you have symptoms you can call this number', it wouldn't have happened.

There's been no acknowledgement that this was a man who played a big part in our lives. He had everything going for him. I used to say to people, 'your love for your kids is unconditional, but some days it's OK not to like them'. But we'd gone way past that stage. Scott was working hard, he was maintaining his own life. He'd got two kids who were well adjusted, and in their late teens and twenties at the time of his death. He'd got everything going for him.

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When Scott died I knew he hadn't died of heroin. But I had the police telling me I had to accept that that was what had killed him. Because I was always honest about Scott, I said I believed he'd got methadone off the black market a week before his death, but that it was watered.

Then they came back a few days later and accused me of moving all the

drugs paraphernalia after he'd died. By this time somebody must have looked at him and realised there were no puncture marks, but it didn't stop the police from shouting at me.

I knew that he'd died – it was like a sixth sense. My husband went in and found him. I was outside on my knees, absolutely hysterical. If I'd have gone into that flat I'd have barricaded us both in and I would have tried to make him better. Nobody would have taken him away.

Because he died suddenly, everybody had excuses as to why it was his own fault. The coroner actually said, 'well we all die in the end anyway'. I wanted the out-of-hours service to come to the inquest just to say why they had taken the steps they did, but they were never called. The blame was firmly put on Scott, that he'd done something that had caused his death. But he'd done nothing to deserve it – he'd gone past the stage of being reckless.

My world just fell apart. I'd seen him every day. Every day I'd put my arms round him, every day I'd kissed him. Every day I told him I loved him. Then suddenly I had to accept that I wasn't going to see him again.

By this time I'd got all this rubbish going on with the police, who thought they were justified in their behaviour because I was the mother of a drug user. So anything the family said was suspect.

In my area there was nothing to help me, nowhere appropriate for me to go. I tried normal bereavement counselling, and got as far as saying Scott's prescription was withdrawn, and that his tolerance had fallen to his methadone, and this person sat looking at me as if I was speaking Mexican. They didn't know what a script was, didn't know what methadone was.

So I made contact with a service 60 miles away, which really saved me. But I had to go there on the train every week – and then I had to come home and deal with the emotion.

It's the absolute desperate situation you find yourself in. I've got a stone in a bit of ground that says that was my son. That's it. I can't touch him, I can't help him, I can't do anything.

People used to say, 'you lost your son – what did he die of?' When I told them they'd look at me as if I'd got five heads. 'He took drugs? He was an addict?' But no, he wasn't an addict when he died.

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One of the really hard things for us was when the pathologist report came through the post. It told me his brain was normal and it told me the contents of his stomach. It told me his heart was enlarged. I stood there reading this and the realisation hit me that he'd been cut into bits. Nothing had prepared me for that. No one had told me that the autopsy report would be quite detailed.

And there was nobody I could go to who could tell me why this had to happen – why the receptionist of the out-of-hours service decided that Scott shouldn't be referred on. This wasn't about blaming somebody, but what I'd hoped was that by making someone look at it, it'd stop someone else's mother from being on her knees.

I became very critical of the industry that's sprung up, putting people into abstinence-based services. As soon as you do things that services disapprove of, you become seen as codependent or an enabler.

When I first took Scott to services I realised this was a hamster wheel. I became critical of services and wanted to know 'why are we having three strikes and we're out?' You get these 'tough love' people who say 'let them go lie in the gutter'. If someone can do tough love, great – but don't throw stones at me because I can't.

People used to think I was a nice woman, but this turned me into a dragon. I live in the shitty end of addiction. I live in a world where people get their child or their house taken off them because they're on heroin. When somebody's walking around with their belongings in a bag, how can they get their act together? I want people to be able to access a good honest service and find services that have a bit of compassion for the families.

Scott worked and did everything expected. But someone pulled the carpet from under him. He didn't die of drugs, he died of prejudice. DDN

FAMILY MATTERS

A PARENT'S VITAL ROLE

Families need to be involved throughout treatment, says **Joss Smith** in her first regular column from the family support charity Adfam

'Families need to recover too' has long been our argument within the discussion over what recovery means. The debate about recovery continues to rumble on in some arenas and we are concerned to ensure that the needs of families are present. Adfam believes that family members are real assets in encouraging loved ones to enter treatment and achieve sustained recovery. In order to do so safely and appropriately, however, they need to recover too.

Family members (whether they be parents, partners, grandparents) have often been through their own journey of emotional, physical and financial harms while coping with the substance user in their lives. They deserve to be given the time and support to grow strength and rebuild their own relationships. It is through this investment of time and support for family members that we will truly be able to maximise their positive influence on their loved one's recovery.

It is crucial that we do not see these two elements – support for families in their own right and their involvement in treatment – as separate; they are entirely connected and indeed mutually supporting. Investment in involving family members in treatment while neglecting the existence of the family members' own needs may be counterproductive and can undermine even the best of intentions. It still seems amazing that when trying to support people into recovery, little or no attention is paid to those who have the most affecting relationships on the drug or alcohol user.

We know that people in recovery say that their family is the biggest factor in their motivation to change and maintain that change. In fact a recent survey conducted by Phoenix Futures highlighted that 70 per cent of their residential service users reported that their mum was the main family member they stayed in contact with and 50 per cent went on to cite their mum as the main support in their recovery. Yet nationally we still invest little in supporting mums and other family members who have been so affected by the substance using behaviour of their loved one.

Over recent years we have seen a huge improvement in the responses of drug and alcohol services to the needs of parental substance users. The last few months have seen a lot of focus on 'troubled families' and the ongoing emphasis on safeguarding issues, which must of course be addressed appropriately and swiftly. However, by focusing so heavily on troubled families and the needs of children, we are in danger of reducing the conversation about families to focus solely on those considered troubled, or those children affected by parental substance users, and neglecting others who have been affected and the significant resource they could be.

This would be a great shame and an opportunity missed – not just for the family members or their drug or alcohol using loved ones, but also for the treatment system. We risk missing a vital part of the puzzle while promoting recovery: families deserve recognition of the problems they have faced and the valuable place they could hold in their loved one's recovery process.

Joss Smith is director of policy and regional development at Adfam. www.adfam.org.uk

PEER POWER

Can you balance the needs of a peer-led recovery service with the requirements of good governance and practice? Yes, says **Carl Cundall** of the Alcohol Recovery Community

Back in 2006 a small group of rehab residents from Sheffield Alcohol Support Service (SASS) complained about the lack of peer support during their alcohol treatment. This feedback was the start of something big and provided the inspiration to what has turned out to be a very successful Alcohol Recovery Community (ARC).

Now in its second year, the ARC, funded by the Big Lottery and based at SASS, provides support for people in alcohol recovery using a model based around daily activities built on four key areas – health and wellbeing, lifestyle and independence, peer support, and training and volunteering. The results have been astonishing. Out of 134 clients, 76 per cent have shown a reduction in their drinking or continued abstinence and 80 per cent have reported benefits to their health and wellbeing.

ARC is an innovative project, breaking new grounds in supporting people to move on from their addiction, and we feel it's working. Historically SASS has always provided treatment support for alcohol addiction in the form of brief interventions, counselling and residential rehab. But from our own experience we knew that clinical treatment alone does not always stop people from drinking in the long term. We provided some peer support groups that were working really well but service users often told us that it was the social isolation that was a significant factor in any relapse.

When you remove an addiction such as alcohol it leaves a huge gap in a person's life, especially if they have been an entrenched drinker. Previous relationships and social activities have revolved around the addiction and many users have been out of work for long periods of time. ARC's effectiveness comes from using peer support in the traditional sense of mutual aid, but also combining it with social and recreational activities, including volunteering, the opportunity to be in the company of other people on a similar journey and the support of friendly, accepting and skilled staff and volunteers.

The challenge has come from ensuring that the ARC has stayed true to the values of peer support – being led by the service users, but also ensuring risks are managed and outcomes are met for the funder. SASS has achieved this by handing over service design and most delivery to its volunteers, who are all themselves in recovery. For example the idea for their modelling club came from a discussion in a SMART Recovery meeting, where someone had discussed how the act of making model aeroplanes had really helped them avoid the urge to drink through a diversionary activity. Other service users and volunteers liked this idea and now run a social model club on a Saturday. SASS provides the venue and the equipment but the group is entirely led by its members.

SASS has taken this concept one step further by using volunteers in recovery to provide face-to-face support for their more vulnerable service users through recovery coaching. Volunteers in recovery complete a ten-day accredited programme of training that teaches them skills around boundaries, counselling and relapse prevention. Once they have completed this they are then matched up with clients who are in the earlier stages of recovery and assist them to develop their recovery capital. This has proved to be a winning formula as it allows the volunteers to use their own life experiences to help others, but through techniques that are regarded as industry best practice, therefore minimising the risk to the service users sometimes associated with peer support groups while strengthening the support available.

Bowled over: ARC members in action

We are very lucky at SASS to have an in-house training social enterprise called Waypoint, which can deliver tailor-made training to our volunteers. In addition to high quality training, we also provide all volunteers with an in-depth induction, mandatory support and supervision. This is extended to external clinical supervision for the recovery coaches. So for us this combination of supervision and training, along with handing over large parts of service delivery, ensures ARC clients are getting the best support and opportunities to move on from their addictions, while minimising the risks to the organisation.

SASS does not claim that service user changes are solely due to attendance at the ARC, but responses made by service users have shown the ways in which this combination of a sense of community with real opportunities to move on has had a positive impact on the lives of recovering alcohol users.

SASS will be sharing their findings at their annual Recovery in the Community conference on 13–14 September. For more information contact carl.cundall@sheffieldass.org.uk

Carl Cundall is manager of the Alcohol Recovery Community (ARC) in Sheffield

LEADING LIGHTS

Lambeth's new peer support service is taking shape through the Aurora Project, a team enterprise with service users at its heart. **DDN** reports from the launch

'We wanted to put peer support at the heart of what we do'

KENNY GREGORY, substance misuse joint commissioner for Lambeth

Service user involvement has always been at the heart of what we do – every year we do a service user audit. Six years ago we first mentioned peer mentoring in Lambeth and got an external agency to deliver it on our behalf. Then we set up system change pilots with money from the NTA and tried to set up a peer mentoring service with young offenders.

Towards the end of 2009 we had to re-tailor our drug and alcohol system. We had less money but had to deliver more. We wanted to put peer support at the heart of that and came up with the idea of our service users delivering this themselves, not putting it out to tender.

The service users really stepped up to the task, organising themselves into a management board and working hard to get the product off the ground with business plans and assessment forms. The level of professional work amazed me.

The volunteers, service users and drug and alcohol treatment services showed what we could do when we invest in recovery capital, all using their experience to inform and improve. The system was brought into action by committed individuals who used their own time to get involved.

We're expecting this kind of work to grow over the next few years and for them to grow their own projects and ideas. The Sanctuary Club, Aurora and The Network Club are all service user initiatives. Aurora is one of the key projects at the heart of the recovery transition.

'Today's clients will be tomorrow's volunteers'

DUNCAN CAIRNS, director, Aurora Project

Funding was always a barrier. As people on the service user council got stronger and put more time and effort into it we formed a social enterprise – a not for profit company – with a management made up entirely of service users.

Last March we became incorporated as a company and got our building. We had to start recruiting volunteers and thought it would be hard, but we were blown away by how many people wanted to join us.

It's quite phenomenal that you can run a service on the goodwill of others. It's about mutual aid – about people who have been through addiction being able to help others. The amount of time and effort people are willing to put in for others never ceases to amaze me.

We don't pay volunteers, but we offer education and training. People who are our clients today will be our next volunteers. Some go on to be professionals in the field. It shows how people are prepared to put something back into the community.

'It's about bridging the gap for service users'

ANGIE, peer mentor

After 23 years of addiction I wanted to help others. When I was out there I didn't know help was available.

When I was using I worked with service users for six years. Now I'm clean it's about knowing how to help them in a more beneficial way. It's about having the communication skills to help them open up, and to work out why they're not engaging. It's also about bridging the gap between them and their key worker.

I needed to learn boundaries. One of the biggest things is learning empathy and compassion. But as peer mentors we can put people in touch with the needle exchange, outreach services, the drop-in centre – whatever they need.

'Our peer mentors go above and beyond'

JENNI ALEXANDER, peer mentor coordinator

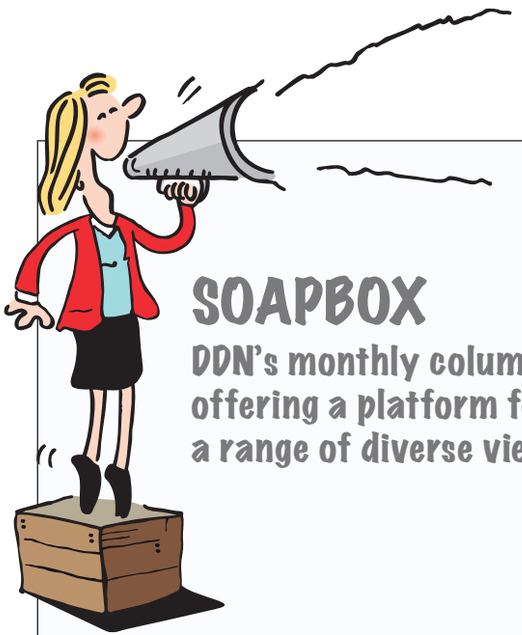
Peer mentoring gives support to the client, whether it's accompanying them to the doctor or services, linking them to social activities, or accompanying them from detox to rehab. We also offer support through small practical steps, such as filling out forms. Clients can be very vulnerable at these stages and the feedback on the service has been fantastic.

I've come from a background of managing volunteers from all walks of life. But I've never worked with a team as dedicated, passionate and enthusiastic as this one.

Our new team of volunteers starts extensive training at the end of May. They have 13 to 15 training sessions and have to show commitment. They also need to be very patient. Some will study for a diploma in health and social care alongside their peer mentoring.

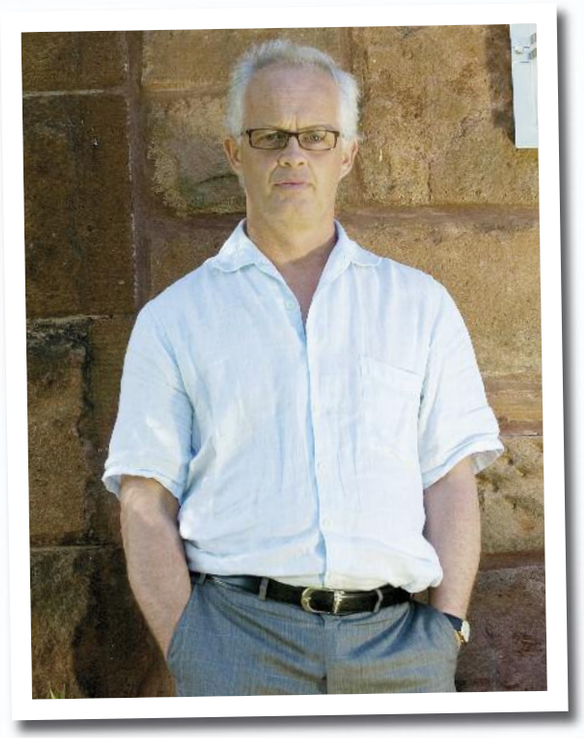
As they've gained confidence our peer mentors have gone above and beyond what's expected of them.

Contact the Aurora Project at support@auroraprojectlambeth.org.uk



SOAPBOX

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



CHALLENGING THE HIGH PRIESTS

A major culture shift is needed to change the universal religion of drug taking, says **Neil McKeganey**

According to a recently released survey, drug use has become virtually endemic within the UK nightclub scene. Global Drug Survey, an independent research group, has just reported the results of its largest ever survey of 7,700 UK clubbers. Carried out conjunction with *Mixmag* magazine and the *Guardian* Newspaper, 75 per cent of those questioned had used ecstasy in the last year, 64 per cent had used cannabis, 62 per cent had used cocaine, 51 per cent had used the former legal high mephedrone and 41 per cent had used the veterinary tranquiliser ketamine. Worryingly, 15 per cent said that they had taken a white powder without even knowing what it was.

If anybody thought that drug use is the preserve of the poor, the results of the *Mixmag* survey tell a different story, with nearly a third of those questioned earning in excess of £30,000 a year. Drug use, it seems, is alive and not so well in the UK club scene, with 86 per cent of those questioned saying that in their view drugs made a good night even better. In the *Mixmag* survey 45 per cent of clubbers had bought their drugs on the internet. These are people with a deep interest in pharmacology and the capacity to pay for the products put before them.

In the 1980s illegal drug use typically centred around four drugs – cannabis, LSD, heroin and cocaine. The list of drugs now being consumed is bewildering in its length and variety. Between 1997 and 2010 there were 150 new drugs identified by the European Union's drug abuse monitoring centre in Lisbon. In 2010 there were 41 new legal high drugs identified by the monitoring centre (see news story, page 4). Governments across the world are struggling to keep up with the ingenuity of chemists developing these substances and the speed of the internet in taking the products into a global market.

The finding that a significant number of young people had consumed a drug without fully knowing what it was reveals a fundamental change in their attitudes to drug use. Whereas in the past many people confined their drug use to one or two substances, what we are now seeing is not so much a culture of poly drug use but a staggering willingness to consume substances whatever the drugs involved.

The lack of interest as to what is actually in the drugs that are now being sold is a feature of their marketing. With names such as ivory wave, meow meow, white magic, sparkle and spice, that convey nothing of what the drugs contain, what is being sold here is a lifestyle uplift to the mundanity of everyday living.

The survey shows there is a clear need for club owners and the police to reflect on their respective approaches. It is probably the case that the police have less penetration into the world of the clubs than they need to, but there is also a major responsibility that needs to sit at the feet of club owners and managers. The results of this survey do not show that the drug use was necessarily occurring within the clubs themselves – however the link with clubbing is clear cut and unarguable, and there is now a case for club owners to consider using the technology of drug testing to refuse entry to those who are using drugs. The goal of a drug-free club should also become an important part of the licensing system.

The findings of this survey are also a wake-up call to those working in the field of drug prevention. For years this has involved informing young people of the risks of the drugs they may be offered, and which they may be tempted on occasion to take. The findings of this survey suggest that such words of caution have not only fallen on deaf ears, but have been overtaken by a generation that has integrated drug taking into the very heart of its leisure activities.

At the moment drug taking is the perfect activity in a culture that has elevated the realisation of personal wants and desires above all else. For as long as our culture gives such absolute priority to the notion of doing what one wants, whatever the consequences, it is all but impossible to imagine a time when the level of drug use within the club scene and elsewhere will be substantially reduced.

As we face a future of increasing financial difficulty it may be that we will see a cultural shift in which less and less emphasis is placed on the importance of meeting the needs of the individual and greater importance is given to helping others to realise their goals. In the face of such a shift, drug use may come to be seen as an anachronistic hangover of a past cult of individualism. Equally though, in the face of a bleak economic future, we may seek more and more ways of blocking out the reality of a world where the chemists have become the high priests of a new universal religion.

Neil McKeganey is director of the Centre for Drug Misuse Research, Glasgow

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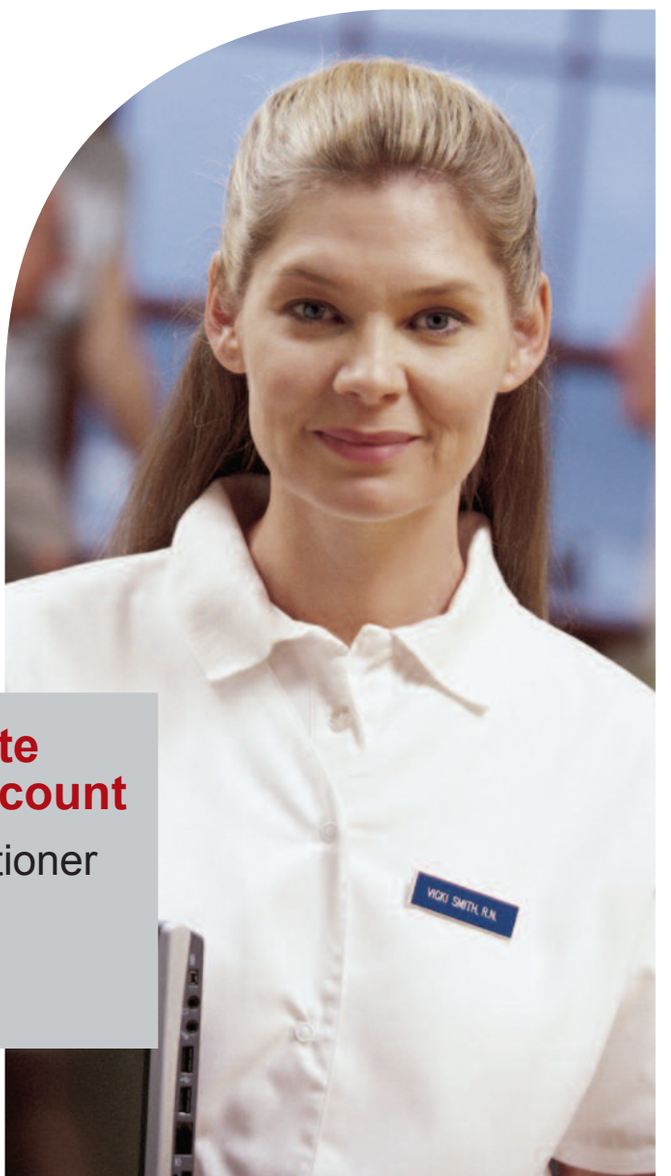

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INVITATION – EXPRESSIONS OF INTEREST

NHS Gloucestershire

GLOUCESTERSHIRE DRUG AND ALCOHOL TREATMENT & RECOVERY SERVICES

NHS Gloucestershire (Gloucestershire Primary Care Trust) as lead commissioner and current host of the Gloucestershire Drug and Alcohol Team (DAAT) invite expressions of interest from suitable and experienced service providers for the provision of Adult Community Drug and Alcohol Services throughout the County of Gloucestershire serving a population of approximately 593,500 residents and also for the provision of Prison Drug and Alcohol Treatment Services at HMP Gloucester.

Gloucestershire's Drug and Alcohol Action Team (DAAT) currently commission Adult Substance Misuse Treatment services (including both drug and alcohol and treatment services) on behalf of Gloucestershire Stronger Safer Justice Commission (GSSJC). This partnership is the accountable body for the DAAT and is a multi agency strategic partnership for Gloucestershire.

PROVISION OF COMMUNITY DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICES

Commissioning intentions are for a new design of a recovery focussed, outcome based, integrated, comprehensive Drug and Alcohol treatment and recovery system for Gloucestershire. The contract is expected to be for a period of 3 years with an option to extend for two further periods, each of twelve months duration by mutual agreement with the Provider from the date of contract award.

The following services are presently included in this procurement and providers will ensure seamless and accessible pathways for service users. Please note the list below is purely indicative and full details relating to services required will be provided at the Invitation to Tender (ITT) stage.

- *'Tier 2' Harm Reduction, low threshold, needle exchange, etc*
- *Community Alcohol services*
- *'Tier 3' Structured clinical prescribing*
- *Psychosocial interventions*
- *Recovery oriented, reintegration 'wrap around' services including floating support and accommodation based*
- *Community Criminal Justice Services (DIP and DRR)*
- *Abstinence based services*
- *Inpatient services*
- *Aftercare.*

The resources, range and depth of skills needed to provide the services are such that it is the expectation of NHS Gloucestershire that organisations will collaborate to form a consortium in order to bid, with a lead organisation becoming the main contracting party with the Trust. However, this does not preclude a single provider bidder offering all the resources and services.

NHS Gloucestershire reserve the right to require groupings of contractors to take a particular legal form or to require a single contractor to take primary liability or to require that each party undertakes joint and several liability.

PROVISION OF DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICES WITHIN HMP GLOUCESTER

A new integrated Drug and Alcohol Service will be provided according to the needs of the prisoners at HMP Gloucester. The new service will incorporate clinical and psychosocial service (previously IDTS clinical and CARATS). The contract is expected to be for a period of 3 years with an option to extend for two further periods, each of twelve months duration by mutual agreement with the Provider from the date of contract award.

Key elements will include:

- *Recovery oriented clinical treatment including harm minimisation and prescribed interventions*
- *Evidence based individual and group psychosocial interventions*
- *End to end planning and case management between the prison and the community.*

Please note the list above is purely indicative and full details relating to services required will be provided at the Invitation to Tender (ITT) stage.

A Memorandum of Information and Pre-Qualification Questionnaire relating to this procurement is available from NHS Gloucestershire. To obtain a copy, please e-mail: paul.wilkinson@glos.nhs.uk.

The closing date for expressions of interest is 5pm on Tuesday 12 June 2012.

The closing date for submission of Pre-Qualification Questionnaires is 12.00noon on Friday 22 June 2012. Suitable candidates will then be requested to submit formal tenders. It is anticipated that the service will commence in April 2013.

TENDER EVENT

Swindon Borough Council

SWINDON DRUG TREATMENT AND RECOVERY SERVICE TENDER MARKETING EVENT

Swindon Borough Council Drug and Alcohol Action Team invite potential service providers to attend a suppliers engagement event, where plans to re-commission a Borough wide Drug Treatment and Recovery Service will be outlined.

The event will be held on

Friday May 25th 2012, 14:00 – 15:30

Committee Room 6, Swindon Civic Offices, Euclid Street, Swindon, Wiltshire SN1 2JH

This event is an opportunity to inform service providers of our competitive tendering intentions and for commissioners to gauge potential provider interest, take views and answer questions. More details of the procurement model and scope of services will be given at this event.

To confirm your attendance, please send an email containing your contact details to: Mussah Dube-Manungo, Mdube-Manungo@swindon.gov.uk (01793 466506) by May 18th.

Places will be allocated on a first come first served basis and your booking will be confirmed upon receipt. We are limited to a maximum of two representatives per potential provider organisation.

If you wish to discuss the content of the event prior to May 25th, please contact Chris Stickler, Strategic Manager Substance Misuse on 01793 466066 or cstickler@swindon.gov.uk

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Delayed intake possible in October 2012 or January 2013.

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+44(0) 116 229 7590

drugalcohol.dl@le.ac.uk

Distance Learning
Foundation Degree
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Lewisham

EXPRESSIONS OF INTEREST

TIER 4 SERVICES & DAY PROGRAMME FRAMEWORK

Lewisham Drug and Alcohol Action Team (DAAT), on behalf of Lewisham Council and Lewisham Primary Care Trust, is looking to appoint a range of providers under the following categories ('lots') for a 4-year period.

Lot 1: Structured Day Programmes (non abstinent & abstinent)
To undertake a range of interventions in relation to a structured day programme format for individuals with a primary drug problem (may also use alcohol) or now abstinent.

Lot 2: Residential Rehabilitation Programmes (abstinent drug and/or alcohol)
To undertake a range of interventions and approaches e.g. 12-step; therapeutic communities, cognitive based, behavioural, social learning, eclectic/ integrated, faith-based, skills based, single gender establishments.

Lot 3: Residential rehabilitation day programmes or quasi residential rehabilitation day programmes (drug and/or alcohol)
Where treatment is provided at a different location to accommodation, to provide a range of interventions and approaches for abstinent clients including aftercare provision.

Lot 4: Residential Programmes and/or residential rehabilitation day programmes drug and/or alcohol (miscellaneous)
To provide a range of more specialist interventions in addition to rehabilitation e.g. for people on court orders such as DRRs and tags; mother and baby; family interventions; people who may require medical support such as those with mental health problems, people with physical disabilities or health problems: people with learning difficulties; younger adults (16+); detox facilities; residential stabilisation.

Expressions of interest are sought from suitably qualified organisations that can demonstrate the knowledge, innovation and ability to be included in a framework to deliver these services to meet the needs of a diverse population. Providers may apply for one or more lots.

The term of the framework will be from August 2012 for four years, during which time contracts will be spot-purchased from the framework.

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

Expressions of interest should be made by **Tuesday 29 May 2012**, and completed tenders must be returned for receipt by no later than **12 noon, Wednesday 6 June 2012**.

PARENTAL SUBSTANCE MISUSE WORKER

£27,723 – £36,474 incl. (SWCG)

Fixed term contract until March 2014. Ref: CC/023

Wandsworth DAAT are seeking a dynamic and energetic person to support parents who may be using drugs and/or alcohol by working between Children's Specialist Services and the new Integrated Drug and Alcohol Service (IDAS). The post is jointly funded by NHS South West London and Children's Specialist Services and will be employed by Wandsworth Council.

The post has three key areas of work:

1) *Assessment and early intervention with substance misusing parents referred to Children's Specialist Services*
2) *Support staff in the Wandsworth drug and alcohol treatment system to work effectively with parents, families and Children's Specialist Services*
3) *Promote a 'whole family' approach and support the 'Troubled Families' agenda in the borough*

The aim of the post is to reduce the impact of drug and alcohol misuse on parent's capacity to look after their children. The post has a significant role in assisting the Council to respond to the requirements of the 'Hidden Harm' agenda as well as respond to identify and response to needs of parents with drug and alcohol misuse issues.

This challenging and exciting position presents an ideal opportunity for someone who is keen to move into a developmental role but still maintain their clinical knowledge and skills.

A professional social work or nursing qualification or equivalent is essential for this post alongside experience (Full-time or Part-time) of work within the substance misuse field. Appointment is subject to an enhanced CRB check.

If you would like further information on this post, please contact Teresa Hills 0208 871 8933 or email thills@wandsworth.gov.uk

Please apply online at www.wandsworth.gov.uk or for an application pack with information pack, please telephone 020 8871 7241 between 9:00am and 5pm, Monday – Friday.

Closing Date for all applicants: 28/05/2012
Interviews: 21/06/12

THE BRIGHTER BOROUGH Wandsworth

NHS South West London

West Sussex County Council

Local Partnerships Promoting Recovery for Drug and Alcohol Users

Tender for the Provision of Recovery Focused Substance Misuse Services in HMP Ford

West Sussex County Council, on behalf of West Sussex Drug and Alcohol Action Team (DAAT) and commissioning partners, invites expressions of interest, from both individual organisations and consortia, for the provision of the above named services, to be delivered in HMP Ford, West Sussex, a category D prison within the prison estate.

Suitably qualified organisations able to demonstrate the knowledge, innovation and ability to deliver substance misuse services in the prison environment and meet the needs of its diverse population are encouraged to express an interest in the work. The successful service provider will be expected to deliver a service that is equitable and sustainable and can demonstrate a best value approach as defined by the Government.

The outcome focused Substance Misuse Service will bring together clinical and non-clinical interventions, previously IDTS and CARATs respectively, for drug users and specific provision for primary alcohol users. The successful provider will be expected to deliver a recovery-based service through comprehensive substance misuse services to those presenting to the service and develop appropriate treatment packages and recovery plans for these individuals.

It is anticipated that the contract will be awarded in July 2012 with a start date of the 1st October 2012 and will run for an initial term of three years until the 30th Sept 2015, with optional two twelve-month extensions. During the three-month transition period the successful provider will need to ensure full security clearance of all personnel to be employed on the contract.

This tender is being managed electronically and therefore to obtain further details of the requirement and to submit a tender response you should, if not already done so, register your organisation online via the West Sussex County Council eSourcing portal at: westsussex.bravosolution.co.uk

Once registered you should follow the links to current opportunities and the relevant project, as titled.

If you have any queries, you should use the messaging facility within the portal in the first instance or send an e-mail to Contracts@westsussex.gov.uk marked for the attention of Jez Rumsey and titled "Substance Misuse Tender" in the subject box.

The deadline for submission (publication) of tenders is 1200 hours (noon) on Friday the 18th May 2012.

OPPORTUNITY FOR INCLUSION ONTO AN APPROVED LIST, FOR DRUG & ALCOHOL RESIDENTIAL REHABILITATION SERVICES

southend onsea BOROUGH COUNCIL

Southend on Sea Borough Council, on behalf of the ***Southend DAAT***, is inviting expressions of interest from experienced rehab providers for inclusion onto the Council's Approved Provider's List for the provision of Drug & Alcohol Residential Rehabilitation services to young people and adults.

The aim of this service is to ensure that people with drug & alcohol addictions are supported in a way which enables them to:

- ***Achieve lasting recovery from drug and / or alcohol dependence***
- ***Develop the skills required to reintegrate into their community***

We are seeking a range of Providers that can deliver rehab services including, but not limited to, women only services, services for people under 18 years of age, for people with a dual diagnosis, for those with an alcohol only problem and those with extensive and current involvement in the criminal justice system, as well as more 'mainstream' Drug & Alcohol rehab services.

Supporting the Council's drive to increase choice for individuals and promoting the self directed support initiative, this Approved List, will ensure that service users and their families, are provided with a choice of experienced and quality approved care providers, across the country.

Southend Borough Council envisages inviting a maximum of 12 providers onto the Approved List. Current levels of rehabilitation service referrals equate to approximately £120k per annum. Please note that this Approved List will be made available to other Local Authorities.

If you wish to be considered for invitation onto this Approved List, please contact Suzanne Clark, to request the necessary documents.

Address: Corporate Procurement, 2nd Floor, Civic Centre, Southend-on-Sea, Essex, SS2 6ER.
E-Mail: procurement@southend.gov.uk
Phone: 01702 534026
Fax: 01702 215110

Closing date for document requests is 12.00 noon on Friday 29th June 2012.
Completed Approved List documents must be returned by 12.00 noon on Friday 6th July 2012.

ISLE OF WIGHT YOUTH TRUST
1 St. John's Place, Newport, Isle of Wight, PO30 1LH

THE WORKS PROJECT MANAGER

Full time – £29,216 per annum

Established in 1983, the Isle of Wight Youth Trust has a proud history of providing counselling services to young people aged 25 and under, as well as providing information and support services to parents, carers and others. 'The Works' is a project run by the Isle of Wight Youth Trust that specifically works with young people aged 18 – 25 years who are committed to addressing, reducing and ultimately ending their own alcohol and/or drug use.

The Works has a vacancy for a Project Manager to continue to lead and develop the service. The ideal candidate will have knowledge and experience of addiction and treatments, including knowledge of 12 Step recovery methodology, and have direct experience of working with young people with alcohol/drug misuse issues. The ability to empathise generally with young people is essential.

The project is funded by The National Lottery through The Big Lottery Fund, Lloyds TSB and through private donations, and has secured funding until 31 March 2014 in the first instance.

For an application pack, please e-mail info@iowyouthtrust.co.uk or call 01983 529 569 or for more information, please call Eileen Monks (Director of the Isle of Wight Youth Trust) on the number above.

The closing date for applications is Friday 18 May 2012

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SENIOR PRACTITIONER – STRUCTURED DAY PROGRAMME

£26, 073 (Full-time, permanent). Ref: DDN SDC SP

The ideal candidate will be an enthusiastic and organised leader with good communication skills and the ability to shape the future of our structured day programmes. You will be supervising a dynamic groupwork staff team delivering a range of programmes working with active drug users and those who are abstinent. You need 2 years experience of working with problem drug users, extensive group work experience and the ability to supervise others. *Funded by Safer Bristol, Crime, Drugs and Alcohol Partnership.*

Safer Bristol

Closing date: Noon, Thursday 24th May 2012
Interview date: Friday 1st June 2012

PEER SUPPORT WORKER – COORDINATOR

£26,073 pro rata. Ref: DDN PSW CO
(Part time, 23 hours per week with 12 months initial funding)

This is a superb opportunity to expand and develop our established Peer Support Project. We are seeking a vibrant and enthusiastic person who will have a good understanding of the needs of volunteers and of current best practice around managing and supporting them. The Peer Support Coordinator role is an interesting and challenging opportunity for someone who wishes to provide meaningful & fulfilling opportunities to drug users to help them in building their Recovery. The successful candidate is responsible for the recruitment, training and support of peer volunteers. It is hoped that this will become a permanent post subject to funding. *Funded by Comic Relief.*

FUNDED BY COMIC RELIEF

Closing date: Noon, Thursday 24th May 2012
Interview date: Thursday 31st May 2012

For further information please contact Justin Hoggans, Manager, Structured Support Services. Tel: 07973 421 023.

For an application pack please contact Angelo Curtis, quoting the job reference. Tel: 0117 987 6004. Email: recruitment@bdp.org.uk

We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation. No CV's agencies or publications.

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Closing date: 5pm 25 May 2012
For an application pack please contact Joanna Clarke
joanna.clarke@thomasonline.org.uk Tel 01254 584662

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- Building relationships with commissioners
- Supporting service providers in implementing the programme
- Presenting to joint commissioning groups
- Training practitioners and recovery champions

We are looking for a dynamic, enthusiastic and outgoing person who is passionate about widening people's access to technology-enhanced recovery. You can be based anywhere in the UK, but must have direct experience of working in the substance misuse field in some capacity. A willingness to travel and driving licence are also essential.

To discuss the role, please contact Glyn Davies on 0161 834 4647. Or to apply, email your CV with a covering letter outlining your experience to gdavies@breakingfreeonline.com. **The closing date for applications is 25 May 2012.**

www.BreakingFreeOnline.com