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DDN
Drink and Drugs News

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HAPPY BIRTHDAY

A DECADE OF NEWS, VIEWS AND DEBATE

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What does the future hold for a treatment sector in a state of flux? p6

AS TIME MARCHES ON
Key players reflect on the last ten years and make their predictions for 2024 p12

PROFILE
Ex-NTA chief Paul Hayes on ministers, markets and money p20

THE CHALLENGE:

GETTING IT RIGHT FOR EVERYBODY

8th DDN national service user involvement conference

We're under no illusions that service user involvement is meeting its toughest challenge yet. The DDN conference will bring together inspiration and ideas from all over the country, to debate what's happening, put forward ideas on surviving and thriving, and gain strength from networking.

Our programme covers meaningful activism, building social capital, the naloxone campaign, alcohol support, tackling BBVs, skills sharing, messages for politicians, practical service user involvement at all levels, therapy zones, and a lot of interaction and debate.

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SMMGP

Editorial - Claire Brown

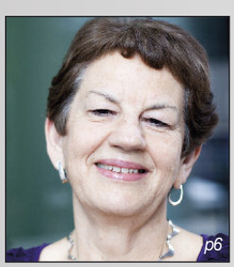
In the beginning...

We look back over our first decade

SO HERE WE ARE, a decade on, at our anniversary issue! Back in 2004, Ian, Jez and I were putting the finishing touches to our very first DDN, feeling excited and not a little nervous at our massive gamble that the sector wanted its own free, fortnightly (as it was then) magazine. The return was instant. By our second issue I was receiving contributions – and we were away. Our free magazine was winging its way to everyone who had an interest in drug and alcohol use and we were being welcomed by a readership whose warmth, honesty and enthusiasm surpassed my wildest dreams.

So how have we fared since those early days? Well I can't pretend it's always been easy – it hasn't. Our fiercely guarded independence and neutrality have meant depending on our advertising to fund each issue – and a glance at pages 12-19 will give clues to how difficult the climate has made that. Sometimes we've wondered if we can carry on bringing you a free magazine, but the whole point of DDN is to make sure it goes everywhere, and not just to those who can afford to pay for it. Times ahead are tough for all of us. But if you value the magazine and want to see it continue, please fill in our online readers' survey, contribute to the magazine, and – gawd bless you – advertise with us, as the adage 'use us or lose us' has never been truer.

This issue



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NEWS IN BRIEF

UNDERCOVER SCANDAL

An undercover 'mystery shopper' investigation carried out by Crisis revealed that homeless people seeking help from local authorities are being turned away to sleep on the streets. People received no help in nearly 60 per cent of cases, including victims of domestic violence. 'This is nothing short of a scandal,' said Crisis chief executive Jon Sparkes. 'On top of the human cost, it is incredibly expensive for society, which has to pick up the pieces.' *Turned away: the treatment of single homeless people by local authority homelessness services in England at www.crisis.org.uk*

NEW DIRECTION

The Liberal Democrats voted to pass a new party policy on drugs 'based on the latest evidence' at their conference in Glasgow last month, including 'immediately' ending the use of imprisonment for possession as well as tightening the laws on stop and search. 'When it comes to tackling crime it is easy to talk tough,' said the party's home affairs spokesperson Julian Huppert. 'But talking tough doesn't deliver results.'

POPPY PROBLEM

Despite a decade-long reconstruction programme and more than $7bn spent on counter-narcotics activity, Afghanistan's poppy cultivation is at an 'all-time high', according to a report from the Office of the Special Inspector General for Afghanistan Reconstruction (SIGAR). 'I strongly suggest that your departments consider the trends in opium cultivation and the effectiveness of past counter-narcotics efforts when planning future initiatives,' special inspector general John F. Sopko wrote to secretary of state John Kerry and other senior US government figures.

PUBLIC SECTOR PRIZE

WDP chair Yasmin Batliwala has been named winner of the Women in the City, Woman of Achievement public sector category award 2014.'There are so many fantastic women working in the public sector, which makes me extremely proud to have won this award,' she said. 'I am dedicated to supporting women's progress in the public sector and ensuring gender equality and diversity, particularly through helping the most vulnerable in society.'

NALOXONE ACTION PLAN

An 'action summit on naloxone' has taken place in London to create an immediate action plan for England 'to cut the red tape which is causing unnecessary deaths'. Dr Chris Ford hosted the meeting, which included CEOs of treatment providers, researchers, doctors, user groups, experts by experience and officials from government departments, and considered ideas and practice from Scotland and Wales. 'It always comes down to people, not policies,' she said, challenging the government's refusal to amend regulations on distributing naloxone until October 2015. *Full report in December's DDN.*

Sharp rise in Scottish drug-related hospital admissions

The rate of drug-related hospital stays in Scotland has increased from 41 per 100,000 population to 124 per 100,000 since 1996/97, according to new figures issued by ISD Scotland. In 2013/14, almost 70 per cent of drug-related stays were associated with opioids and more than 90 per cent were emergency admissions.

The rate of hospital stays increased among older age groups – from 20 to 213 per 100,000 for those aged 40-44 – while decreasing among younger people. Scottish Drug Forum director David Liddell recently stressed the importance of engaging with the country's cohort of older, entrenched drug users (*DDN*, October, page 8).

'The steadily increasing rate of hospital stays related to drug misuse shows that we are fighting a losing battle,' said Scottish Liberal Democrat health spokesperson Jim Hume MSP. 'It is worrying that those from Scotland's poorest communities continue to suffer most from the blight of illegal drug misuse,' he added, stressing that the figures highlighted the need for a 'radical' change in approach to drug policy.

Figures showing a two-thirds increase in the number of take-home naloxone kits issued were welcomed by the Scottish government, however. 'Our world-leading programme for take-home naloxone, alongside life-saving training, sends a clear message that lives matter, and will help those who may not have engaged with drugs services before,' said community safety minister Roseanna Cunningham. 'While problem drug use among the general adult population and young people has decreased, there is still an older group of people who now also face a range of other health problems placing them at increased risk of overdose and death. We are determined to tackle this and support these vulnerable people. The naloxone programme is a key part of this.'

> **'There is an older group of people... at increased risk of overdose and death.'**
>
> **ROSEANNA CUNNINGHAM**

Drug-related hospital statistics Scotland 2014 and National naloxone programme Scotland – naloxone kits issued in 2013/14 and trends in opioid-related deaths at www.isdscotland.org

NICE pill for heavy drinkers

A drug that helps to reduce the craving for alcohol in heavy drinkers has been recommended by the National Institute for Health and Care Excellence (NICE).

Nalmefene has a UK marketing authorisation for the 'reduction of alcohol consumption in adult patients with alcohol dependence', but who do not have physical withdrawal symptoms or require immediate detoxification. The drug – also known by its trade name Selincro – is licensed for use alongside psychosocial support to help people reduce their alcohol intake and 'give them the encouragement they need to continue with their treatment'.

In a new draft guidance document, NICE says that the drug should be available 'as an option' to regular heavy drinkers, with almost 600,000 people eligible for the treatment. It should only be used with patients who still have a high drinking risk level two weeks after initial assessment, says NICE. Final guidance is expected towards the end of the year.

'Those who could be prescribed nalmefene have already taken the first big steps by visiting their doctor, engaging with support services and taking part in therapy programmes,' said health technology evaluation centre director at NICE, Professor Carole Longson. 'We are pleased to be able to recommend the use of nalmefene to support people further in their efforts to fight alcohol dependence. When used alongside psychosocial support nalmefene is clinically and cost effective for the NHS compared with psychosocial support alone.'

The Faculty of Public Health, however, said that while medication was 'one route', there were also 'relatively simple alternatives' such as tougher alcohol advertising restrictions and minimum unit pricing. 'While it is up to each of us to look after our health, government has a responsibility to take action on everyone's behalf when lives can be saved,' said the faculty's alcohol lead, Professor Mark Bellis. 'That's why public health professionals have long been calling for a minimum unit price for alcohol.

'We need to think very carefully about how we use limited NHS resources,' he continued. 'Prescribing nalmefene will increase pressure on the NHS when there are alternatives that would reduce pressure on health services by cutting alcohol consumption. There are always side effects from medication and we don't know yet what the long-term impact will be. That's why we need a clear commitment from government to minimum unit pricing.'

Alcohol dependence – nalmefene, draft guidance document at www.nice.org.uk

‘Millions’ of children exposed to World Cup alcohol marketing

Viewers of the key World Cup broadcasts this summer saw one example of alcohol marketing for every minute of playing time, according to a report from Alcohol Concern. The charity is asking the government to ‘consider whether the harms outweigh the financial benefits’, as the audience included ‘millions of children and young people’.

Researchers studied six matches – two shown on the BBC and four on ITV – including all of the England games, the semi-finals and the final, with the broadcasts recorded and coded according to the number of visual references to alcohol, including logos. They found an average of just under 100 alcohol references per programme, plus ten alcohol commercials when the games were shown on ITV. Around 80 per cent of the references were from electronic pitch-side sponsor boards, with more than two-thirds for official World Cup beer sponsors Budweiser, while the 39 alcohol adverts shown during the four commercially broadcast games totalled more than 12 minutes.

‘It is estimated half the games analysed were viewed by more than one million under-18s,’ says the document, a figure within the existing rules on whether alcohol advertising is appropriate. ‘Alcohol marketing in sport has become so ubiquitous that it often goes unnoticed,’ it adds, and calls for the government to legislate for the phased removal of alcohol marketing from sporting events starting with football.

‘Alcohol marketing is linked to consumption, particularly in under-18s,’ said Alcohol Concern programme policy manager Tom Smith. ‘The volume of alcohol marketing in sport, especially in football which is popular with children and younger people, is enormous. If a million children can be exposed to alcohol marketing on TV and no rules be broken, we should also look at whether the existing rules that are meant to protect our kids are really working.’

The charity has also announced that Professor Sir Ian Gilmore – chair of the UK Alcohol Health Alliance and a former president of the Royal College of Physicians – has been appointed its new president. ‘He will bring an invaluable wealth of knowledge and experience,’ said chief executive Jackie Ballard.

Meanwhile, Public Health England (PHE) has launched its ‘liver disease profiles’ tool which demonstrates stark regional variations, with male death rates up to four times higher in some local authority areas than others.

Liver disease is the only major cause of death that continues to rise in England while falling in other European countries, with 90 per cent of cases caused by either alcohol, obesity or hepatitis B and C. One in ten people in England who die in their 40s now die of liver disease, while Alcohol Concern’s updated ‘map of alcohol harm’ shows that the total number of alcohol-related NHS admissions in England – when inpatient, outpatient and A&E visits are all included – stood at just below the 10m mark in 2012-13.

‘Liver disease is a public health priority because young lives are being needlessly lost,’ said PHE’s liver disease lead Professor Julia Verne. ‘We must do more to raise awareness, nationally and locally, and this is why it is so important for the public and health professionals to understand their local picture.’

New PHE figures on alcohol treatment, however, showed a 5 per cent increase in the number of people in treatment in the last year, with more than 90 per cent waiting less than three weeks. The numbers were encouraging, said director of drugs and alcohol Rosanna O’Connor, but there was ‘much more to do’.

Alcohol Marketing at the FIFA World Cup 2014: a frequency analysis, and alcohol harm map at www.alcoholconcern.org.uk

VALUE FOR MONEY? As DDN went to press, a major Commons debate on the UK drug laws was taking place, the first for 40 years. The debate was secured with cross-party backing by Caroline Lucas MP (DDN, August 2013, page 16), following a 130,000-strong petition calling for MPs to support an impact assessment and cost benefit analysis of the 1971 Misuse of Drugs Act. ‘This debate is not about being for or against drugs reform,’ said Lucas. ‘It’s about making sure we have the best possible laws based on the best possible evidence.’ The same day saw the long-delayed publication of a Home Office report concluding that punitive drug laws failed to curb levels of use. Full report in next month’s DDN.

NEWS IN BRIEF

NO SMOKE

Turning Point has launched smoking cessation pilots in six of its substance misuse services across the country, backed by Public Health England (PHE). Staff will be supported to address smoking with service users and deliver very brief advice (VBA) on giving up. ‘If someone has sought help for alcohol and drug problems, it makes sense that they are given the opportunity to stop smoking at the same time and further improve their chances of a healthy life.’ said PHE’s director of alcohol, drugs and tobacco, Rosanna O’Connor.

BRINK BOOST

Alcohol-free Liverpool venue The Brink (*DDN*, December 2013, page 20) has won in the ‘social change and intervention’ category at this year’s Merseyside Independent Business Awards. ‘It’s our intention to make The Brink a truly self-sustaining business and that means reducing our reliance on grants and donations,’ said Action on Addiction Merseyside’s head of service Karen Hemmings. ‘This win shows that we are a serious business.’

E-ADS

Advertisers will be able to show e-cigarettes in their TV commercials from later this month, under a new ruling from the Committee of Advertising Practice (CAP). Although TV adverts for e-cigarettes are already allowed, the devices are not permitted to be shown on screen. The new ruling specifies that adverts must not target non-smokers or under-18s and ‘avoid containing anything that promotes the use of a tobacco product or shows the use of a tobacco product in a positive light’.

MULTIPLE IMPACT

Welfare reforms are having an ‘overwhelmingly negative’ impact on people with multiple needs, according to a Making Every Adult Matter (MEAM) *Voices from the frontline* report. Among the disturbing findings in *Evidence from the frontline: how policy changes are affecting people experiencing multiple needs* are reports of vulnerable women turning to sex work, subsistence theft or being forced to depend on violent partners after losing their benefits. *Document at meam.org.uk*

SMART IN LIQUIDATION

Trustees of Smart Recovery UK (SRUK) have announced that the charity will cease trading and go into liquidation after a dispute with its US-based licensor (ADASHN) could not be resolved. Their statement said that ‘overall SRUK has been a great success’ and expressed their ‘best wishes and hopes for all those seeking recovery within the UK.’

ONE DIRECTION?

As *DDN* marks its tenth anniversary we take a look at some indicators of what the future might hold

'NOW, MORE THAN EVER BEFORE, drug and alcohol services need to make friends and influence people,' says DrugScope chief executive Marcus Roberts in his introduction to the charity's new *Making the case* resource, a guide to flying the flag for local treatment services in a radically altered landscape.

From before *DDN*'s existence until last year, treatment providers knew there was a central ring-fenced budget set aside and overseen by the NTA (see Paul Hayes profile, page 20), while they now have to compete for the attentions of local directors of public health, some of whom may be sympathetic, onside and committed, and some of whom may have other priorities entirely. 'Localism creates opportunities, but also, in a period of austerity, a real and present risk of disinvestment,' writes Roberts, while Hayes argues that localism might be 'a great theoretical prospect' in opposition but is 'no way to run a government.'

Treatment providers need to be seen to be 'responding flexibly and creatively' in this challenging environment, stresses the DrugScope document, and it details how to persuasively argue the case for services, including using 'big picture' data and demonstrating the wider impact the sector can have. And it's a sector that remains in a 'state of flux', as DrugScope's senior policy officer Paul Anders wrote recently, when urging people to contribute to the charity's latest *State of the sector* research (*DDN*, September, page 8). 'While there was little in the 2013 survey to cause particular alarm,' he said, there was a strong sense that the process of change – relating to both funding and commissioning – 'had only just started'.

Alcohol Concern's updated 'alcohol harm map' (see news story, page 5), meanwhile, shows that the total number of alcohol-related NHS admissions in England – when inpatient, outpatient and A&E visits are all included – almost hit the 10m mark in 2012-13, and while more than half of alcohol-related hospital admissions were to A&E, it was inpatient admissions that were responsible for nearly two thirds of the total cost burden. And it's quite a burden, with the cost of inpatient admissions 'partly attributable' to alcohol standing at £1.3bn on top of the £518m chalked up to those 'wholly attributable'. Then, less than a week later, Public Health England (PHE) launched its liver disease profiles, setting out how the male mortality rate for the disease is now four times higher in some local authority areas than others.

The strain on the NHS from alcohol-related ill health is now 'intolerable', says Alcohol Concern. So how come, despite the stark statistics released in the last couple of weeks, the overall narrative is supposed to be that drinking levels are going down? 'I think because the number of people abstaining from drinking has increased over the last 20 years, so that makes it look like the overall drinking levels are falling,' Alcohol Concern chief executive Jackie Ballard tells *DDN*. 'The reasons for people abstaining can be anything from a choice to do so to religious reasons – and if you look at the alcohol harm maps, the London boroughs with the highest ethnic minority communities are where you'll expect to see a higher percentage of non-drinkers – but there's also, in terms of increasing hospital admissions, a kind of health catch-up. The impact on your health of drinking over guideline limits is not necessarily immediate for most people. It may be immediate if you're binge drinking and collapse on a Saturday night, but for most people it's a cumulative effect.

'We know the figures are going in the wrong direction,' she continues. 'Liver disease deaths are going up, and we're the only European country where that's increasing. So we do have a problem. Whatever the drinks industry figures say about the total amount of alcohol they're selling, firstly they're selling higher strength alcohol and so on, and secondly there's 9m people drinking at levels that pose a risk to their health.'

So now that treatment providers have to compete with the other priorities of directors of public health, are people who need help for an alcohol problem likely to be able to get it? 'We know that we haven't reached even 15 per cent of people who need treatment getting it,' she states. 'There's reasons for that in terms of whether the pathways are clear locally, whether GPs ask people questions about their drinking and refer them to the right place, whether people themselves are resistant to getting treatment – a number of issues. But at the back of all that, yes, there's been a massive squeeze on public spending and treatment is having to fight its corner with all the other demands on local budgets.'

Emli Bendixen/Third Sector

'We know that we haven't reached even 15 per cent of people who need treatment getting it...'

Jackie Ballard, chief executive, Alcohol Concern

One of the arguments for the advent of Public Health England was that it would help to level the playing field between drug and alcohol treatment. Is that happening so far? 'Alcohol is one of the priorities for PHE, and we, through our consultancy and training arm, have been doing a lot of work with local authorities across the country, working with treatment-resistant drinkers, on treatment strategies, interventions and brief advice.

'We are seeing a lot of interest from local authorities and I think that the profile of alcohol is rising – it's not yet on a par with drugs, but it is rising up.'

Making the case: a practical guide to promoting drug and alcohol treatment and recovery services locally available at www.drugscope.org.uk

Alcohol harm map at www.alcoholconcern.org.uk

Liver disease profiles at fingertips.phe.org.uk/profile/liver-disease

Alcohol Concern's conference is on 19 November in London. Details at www.alcoholconcern.org.uk

STAYING ALIVE

Could the recovery agenda be killing people? **Alex Boyt** makes the case from his own experience

In the mid '80s, when I found a prescribing doctor who would take me on, I got offered the short or long script, reducing over two or six weeks. After a detox that largely consisted of hugging the radiator in my cell, I got out of jail in 2004 and found myself begging methadone off people because I was told the waiting time for medication was the best part of a year. A few months later, I was kicked out of my next rehab and got caught up in user involvement. I was so impressed to find the treatment system had woken up, people got the medication they needed, pretty much when they needed, and often at the right dose.

Imagine all those people who no longer had to stand withdrawing on street corners in the winter, hoping the dealer would take £9.40 instead of tenner, because that's what they had left after selling their coat and making the phone call. Imagine all those people who wouldn't have to inject all the wrong crushed up pills and dried blood clots from old works just to get a brief respite from endless withdrawals gnawing at their spirit.

So this was all ticking along nicely. Perhaps some people were getting stuck on methadone and other options were not being explored. But when the push for recovery began to take hold, a number of the people I knew on substitute prescribing started getting nervous. They no longer felt safe: 'Every time I see my drug worker, we have a conversation about reducing my script. Seeing him used to feel like support – now it just feels like pressure.'

Sure I was in recovery now, however you happened to measure it, and so were a few people I knew and liked. But my personal sense of duty was still fighting for those who didn't have the strength, the desire or ability to face the years of neglect, abuse, trauma or the harsh distress of unmedicated reality; those who just needed to be held without judgement by a system of care.

*****

I know from my own experience that pressure to embrace recovery can work for some, but I also know that there are many for whom recovery, especially in its abstinent form, is just too painful, difficult or unattractive. For this lot, often those most at risk from death and disease, the recovery agenda makes services less relevant and safe. People who used to be held by the treatment system are now confronted by goals for integrating into society the moment they make it through the door. I am close to people who won't even consider engaging under these conditions – they'd rather take their chances on the street, and I fear for their wellbeing. All too often they walk into a service, already traumatised and deeply tired, only to be allocated a complex ritual of recovery activities, usually with an implied or overt requirement that prescribing is dependent on engaging.

When successful completions (often code for getting off your script) became the focus, one of our local service managers said 'we have to get them in and out before we get to know them'. I regularly complained to anyone who would listen that 'only when crime and drug-related deaths go up will policy-makers care that some of the most at risk are being failed by the push for recovery.' But somewhere inside I had retained a vestige of trust for the treatment system and hoped that my concerns were misplaced.

However, when the drug-related death figures came out in September my heart sank. I felt so angry, sad and disappointed: in one year a 32 per cent increase in drug-related deaths and 20 per cent of that down to opiates. The government says the cause was likely to be the increased strength of street heroin, but the same stuff hits Wales where there was no increase in drug-related deaths and recovery there is not the driving force it has become in England. With the most at-risk engaging less, and those with their tolerance lowered and facing their demons full on pushed too fast through the treatment system, I worry for their wellbeing. I don't claim to have proof, nor the ability or will to interview the dead or the disengaged, but many I know share my belief that aspects of the push for abstinence are dangerous.

'After a detox that largely consisted of hugging the radiator in my cell, I got out of jail in 2004 and found myself begging methadone off people because I was told the waiting time for medication was the best part of a year...'

The treatment system is of course largely a numbers game, and the need to deliver targets is essential to keep the money flowing for any kind of care to be delivered. I was at a presentation not long ago where the figures for those completing treatment successfully were shown to vary in partnership areas from about 4 per cent annually to 35 per cent. The figures indicate how unhelpful some of the pressures for commissioners and service providers are.

What chance is there that the ideology from central government softens to let people receive the care they need? You only have to note that the ACMD were recently tasked by the Home Office to look at time-limited prescribing to think the chances are slim. Is the recovery agenda killing people? You have to think in places it probably is. My limited hope sits with the good people out there still trying to deliver care in an increasingly harsh environment.

Alex Boyt works in central London as a service user coordinator

VOICES OF RECOVERY

BEST FOOT FORWARD

The volume of activity and appetite for change during September's 'recovery month' speaks volumes about the momentum of the recovery community, says **Alistair Sinclair**

THREE HUNDRED AND FIFTY PEOPLE from around the UK gathered in Leicester on 26 September at the sixth national UKRF event *Creating narratives for the recovery movement: the good, the true and the beautiful*. I've written in *DDN* about Phil Hanlon and his call for a 'fifth wave of public health' (www.afternow.co.uk) and the UKRF event was our first attempt to explore what the 'good, true and beautiful' might actually look like in communities and services.

Fifty presenters in the main room and in ten 'wellbeing zones' (themed around the 'five ways to wellbeing'), shared their thoughts around key action and learning that support the good (values and ethics), the true (learning) and the beautiful.

Material generated by presenters and participants will inform the development of a recovery manifesto for the UKRF – which is grand, but the important thing for us is that the day brought people from services and communities together to share and to connect, generating energy for change. It was a hopeful day and it was, among some other things, our contribution to the 2014 recovery month.

There were 102 events in September's recovery month. It kicked off, a little early at the end of August, with a Fallen Angels Dance Theatre workshop in Salford and a sunset candlelit vigil in Stroud in Gloucestershire. On 1 September, at an event hosted by the Scottish Recovery Consortium, people gathered in Glasgow to 'remember loved ones lost to addiction'. Kaleidoscope in Wales supported activities throughout September under the banner 'My month – my recovery' (something Barry Eveleigh wrote about in last month's *DDN*) and Recovery Cymru held a number of events in Cardiff and Barry.

People in Ireland walked in Dublin on 20 September, while Scotland held its first recovery walk in Edinburgh on the 27th, with North Wales walking the following day from Colwyn Bay to Llandudno. Thousands gathered in Manchester for the sixth UK recovery walk on 13 September and smaller, but no less important, walks took place throughout September in Snowdon, Lancashire, Lewisham, Derbyshire, Loughborough, Leicester, Rotherham, Bournemouth, Bexley and Gloucestershire.

During September *The Anonymous People* film was shown in Worksop, Cheltenham, West Bromwich, Stroud, Gloucester and London, while the Recovery Street Festival toured the country showing in London, Cardiff, Birmingham, Liverpool and Glasgow. A number of lucky

people experienced the 'Dear Albert' film (a documentary filmed over three years around a drugs service in Leicester) at the Leicester UKRF event, which marked the end of a Leicestershire, Leicester and Rutland recovery week which encompassed art exhibitions, flashmobs, a harm reduction café, drama, walks, open days and a picnic.

The Umbrella Café, a dry bar, launched in Manchester on 5 September and they've been putting on really impressive events on Friday and Saturday nights ever since. A focus on fun, creativity and celebration in recovery month led to festivals and parties in Doncaster, Bradford, Burnley, Brighton, Halifax, Hackney, Manchester, Preston, Liverpool, Bournemouth, Cardiff, Henley, Scunthorpe, Norwich and Lanarkshire.

For those who fancied something a bit more sporty there were football competitions, fitness sessions, sponsored cycle rides (from Wolverhampton to Manchester), rambles, mountain climbs, funlympics and some hardy folk even walked over seven days (185.4 miles) from Weston-Super-Mare to Manchester to join the UK recovery walk in Manchester.

But what does all this activity involving thousands of people all over the UK mean? Clearly it means different things to different people, but I think there are a number of core themes that link all these diverse activities and people together. At the heart of all of it is hope; the belief that we can change, we can make things better. When we make recovery visible we're making hope visible and we're locating this hope firmly in the 'core economy'; families, neighbourhoods and communities. At our event In Leicester I think that for a little while people put their 'hats' down and came together as community members. That's what I see at the recovery events I go to.

On a hillside in North Wales on 28 September I listened to 'service users' share their feelings and hopes, and I listened to a commissioner share his. For a brief moment we were a community, a bunch of human beings on a hill. The UKRF will continue to promote a recovery month that celebrates the good, truth and beauty in everyone and the huge strength and potential that exists within communities.

A few days ago in a Westminster meeting about the stigma faced by people with 'substance use disorders' I heard someone say that the 'time wasn't right for a public-facing campaign'. I felt the need to point out that this campaign has already begun. Recovery Month is here. Thousands are already on the move and there are many people, even in these austere dark times, who still have hope.

I think this is where recovery starts. Where we'll end up is down to us; making the path as we walk it.

Alistair Sinclair is a director of the UK Recovery Federation (UKRF), www.ukrf.org.uk

COMMUNITY CHEST

This year's RiTC conference asked what a recovery community could and should mean. *DDN* listened to the debate

'Whether through peer-led and mutual aid recovery initiatives or treatment services, it is agreed that the role of community in addiction recovery is vital. But there seems to be differing visions of what community means… Does there need to be a provider of a recovery community or should we be leaving it to the community itself?'

These were the key questions put to the audience of the Recovery in the Community (RiTC) conference, held by Sheffield Alcohol Support Service (SASS) last month, and to get the debate started, Rowdy Yates, senior research fellow at the University of Stirling, explored the history of recovery groups and their common themes.

Acknowledging that the therapeutic community structure 'teaches impulse control in a safe setting' and 'encourages positive citizenship', he had a message for the 'two main players' – mutual aid fellowships and methadone prescribers: 'Stop calling it a disease. It's a disorder you can recover from.'

'Experts say it's an incurable disease – let's just stop it,' he said, adding: 'We need to be more visible with our recovery. We need to remove employment barriers… we need to remove this stigma.'

A key to this was in encouraging 'recovered addicts' to participate in treatment, and to make activities such as recovery marches more visible. 'We need to see addicts as an asset to the community.' Without such initiatives we were doomed to create a situation where addiction was transmitted down the generations, whereas creating better parents would reduce the chance of repeating the cycle.

SASS's chief executive Josie Soutar then introduced a lively panel discussion called 'hands off our community' to look at ownership, funding and identity of the recovery community, including plenty of comment from the floor.

'Is this the best of times or the worst of times,' she asked.

'In terms of commissioning, it's the worst of times,' said Clive Hallam, drugs commissioning manager at Barnsley DAAT. 'But in terms of people coming through, it's the best of times.' It was important to sustain 'strong creative individuals' and their ideas, he said.

Deb Drinkwater, freelance trainer and co-director of the Dry Umbrella, an alcohol-free bar in Manchester, said it felt like a good time for getting results. 'I've seen a massive change. I've felt like a lone sheep but community development is now seen as a viable model,' she said.

Geoff H, 'a grateful member of AA', felt that it was 'an excellent time for recovery in the community', thanks to the links that were being developed. 'It shouldn't be one size fits all and through links with PHE we've created links throughout the country,' he said.

David Badcock, head of recovery engagement at Addaction, also felt that it was 'a really good time for people to engage with the wider recovery community', which gave 'much better outcomes'. He mentioned the in2recovery website (supported by Addaction and run by Michaela Jones), Addaction's recovery conference and the charity's mutual aid programme to demonstrate that 'the sector has changed and we at Addaction have definitely changed', with a greater emphasis on helping people reintegrate into mainstream life.

'I believe people should be given choice in recovery… We're caught in a corner and driven by the industry – it's a real shame.'

Geoff H

Mark Gilman, strategic recovery lead for PHE, also believed it was the best of times, moving beyond fear-driven treatment to successful treatment in the community, 'where recovery lives'.

Just as the panel agreed on the positives, each panellist was keen that engagement – through such channels as mutual aid – was voluntary and not mandated.

'I believe people should be given choice in recovery,' said Geoff H from AA. 'We're caught in a corner and driven by the industry – it's a real shame.'

'When people are sent, it really bothers me,' added Hallam, who said mutual aid should be used for the right reasons. Badcock added that the lack of choice was his 'lease favourite scenario', Drinkwater said people had to want to change and Gilman compared the mandated aid scenario to that in the US.

The best way forward was for 'the community to take over', according to the panel. Drinkwater's alcohol-free space was powered by hard work and social media, developing organically, with commissioning teams noticing what worked well on the ground.

Badcock also added his vote to initiatives that demonstrated that 'recovery in the community is happening' and showed 'where community knows best'.

LETTERS

'We all know the system isn't working and it is time to stand up and be counted and misbehave...'

TIME TO MISBEHAVE

Listening to *Thought for the Day* this morning suddenly helped me to digest an extraordinary week. Vicky Beeching spoke about how honesty and truth must come first and niceness and love are not always synonymous, so sometimes love requires unsettling the status quo. Laurel Thatcher Ulrich famously wrote: 'Well-behaved women (and men) rarely make history.' Many others and I have been doing some misbehaving over the past week, and we all need to do more!

Firstly there was the first European Conference on Hepatitis C and Injecting Drug Use, which was packed full of people with passion and commitment fighting to improve access to HCV and OST. People put themselves at risk to demand better services. Knowing a little about the oppression in some European countries, I was truly humbled by the user and harm reduction groups working in those countries. Misbehaving and fighting for their rights can easily lead to them ending up in prison.

Then came the Action Summit on Naloxone – again a full room of committed people who want to unsettle the status quo of poor to no naloxone provision in England. How can PHE and DH point us towards localism as a reason for not sending out a clear national message, as hundreds of people die because of the lack of a safe, evidence-based, effective medication, whereas in Wales – where they have it – drug-related deaths have reduced by 53 per cent? Hopefully the newly set-up NAG (Naloxone Action Group) will continue to misbehave and get change.

But sadly there are many too fearful of losing jobs or funding and keeping their heads down. How can DrugScope repeat their *State of the sector* survey with no mention of harm reduction at all (just one brief mention of 'harm minimisation' – harm reduction for wimps). The single mention of naloxone only reinforces the October 2015 date – what about now? It is a licensed medication and at a minimum should (and legally can) be prescribed to everyone who uses opioids, leaves detox or rehab and starts OST. That is the message that needs to be carried. In the survey, there is nothing re access to OST, maintenance, pressure to exit treatment etc and nothing explicit on NSPs, although many of us in the harm reduction group had asked for many of these things to be added after the last survey. If you are doing a state of the sector survey you have to ask the right questions.

From endless emails, posts on SMMGP and other forums, Twitter and phone calls, it is clear that people are being forced into options they are not choosing for themselves. Services are being cut, re-tendering is causing chaos, commissioners are ignoring the enormous evidence base and commissioning services for detox only, and most importantly people are dying. I was first saddened and then angered to get a phone call from a drug worker just after I had listened to *Thought for the Day* to say she was being forced to reduce the methadone by 5mls a day on a very vulnerable patient of hers after he had failed an appointment. She completely understood that this was the most risky thing to do and instead wanted to visit him. I hope she misbehaved and potentially saved his life.

We all know the system isn't working and it is time to stand up and be counted and misbehave – there's lots we can do. We have been lied to, told there's no alternative, no choice, and that you don't deserve any better. To give the last word to Mahatma Gandhi, 'Be the change you want to see'.

Dr Chris Ford, clinical director of IDHDP, by email

WALK THIS WAY?

As someone who has attended the last three recovery walks I was really looking forward to Manchester this year. The walk has always been a massively inspiring event, bringing people together from all across the country to celebrate recovery.

However, I have to say what a disappointment Manchester was to me and my family. Firstly, it was clear that the numbers attending were massively down from Brighton and Birmingham, perhaps even half as many as last year. If it's going to be in Durham next year it's a fair bet that many from the south like me won't be able to attend, so are there going to be even less next time?

I was also really disappointed that this year there didn't seem to be anything to entertain families. I'd travelled up with two young children and had hoped that like previous years there would be something to keep them entertained, but alas there was very little.

Finally, I had travelled up by coach and had spent a fair bit on transport etc which when you're on benefits isn't easy. I had at the very least expected there to be free water as there had been on previous years. Not only were there no free water bottles but I was expected to pay £1.50 for a can of pop! Also last year at Birmingham we had got free t-shirts but this year we were expected to pay a fiver for the privilege.

All this makes me feel the walk has lost its original ethos. It now appears to just be a money-making and promotional tool for the organisers. Perhaps it is time for local activists to reclaim the walk. Maybe we could have locally organised regional walks that involved local people and promoted local groups?

Yours in disappointment,

Charlie Gillespie, by email

TIME TO REFLECT

I am a person in long-term recovery since 1999 and have seen some really good models of delivery in drug services over the years, but also some not so good practice. I believe that service users are experts by experience and are absolutely the best people to work in the field. However, what has bothered me throughout my career is the welfare of service users when they move into long-term recovery and are then employed by a service.

I have seen people be employed when they are clearly not ready and I've seen them relapse and get dismissed or leave. To my knowledge there has never been a national policy on this and agencies just have

their own policies – for some it's six months, others say two years.

Some people can be off work with a serious illness for 13 months or more, but services employ people in recovery after six months? We often forget that a lot of addicts have not had formative years and so need to make up for this and relearn how to live a 'normal' life, for want of a better word. Some people may not agree with me and say they are ready, and I appreciate that this is a subjective matter. However, I think that after treatment and recovery there should be a 'time to reflect' period. It would put ex-service users in a much better position to become a practitioner if they spent two years doing this, in my opinion.

Agencies have a moral and professional duty to protect people they employ and should have rigorous systems and policies for this. Sadly this is quite often not the case and service users are put on a pedestal as a promotion for the wonderful work the service has done, or for stats on how many ex-service users they proudly employ.

We should be looking to embed guidelines nationally so commissioners and strategic influences are on board and it becomes part of the tendering process at the very least. You could argue that just because it's an ex-service user they have the right to be treated the same as any other employee and I would agree, but I think the process for 'time left' services needs to be looked at properly.

I am not naïve enough to think that this has not been discussed a thousand times before, but with the current climate of the recovery movement across the UK and with organisations such as the UKRF, as well as localised movements and SU involvement, surely it is time to put this on the agenda again in a bigger, better way.

Steve Loxley, by email

GAMBLING SUPPORT

I have recently come across your excellent online magazine and I am particularly interested in recent coverage of disordered gambling.

Betknowmore UK was launched as a social enterprise earlier this year, and our mission is to develop and deliver support, education and information services to address problem gambling and addiction. We recently launched our first Gambling Support (GaMS) hub in Islington, which will be a base to deliver our services initially across north London. We have had a lot of interest in our services from a wide range of organisations as diverse as HMPs and premiership football clubs. This includes a number of drug/alcohol agencies and we are currently planning to develop and deliver our services to DASL in east London and Cranstoun in north London. We have also had interest from Addaction and WDP. This is an area we are very much planning to further develop and work in partnership with current service providers.

More details can be found on our website: www.betknowmoreuk.org

Frankie Graham, director/project manager, Bet Know More

MISLEADING FIGURES

The headline on page 4 of your October edition ('England and Wales see sharp rise in drug deaths') is misleading. England saw a rise of 21 per cent in deaths from drug misuse, from 1,492 in 2012 to 1,812 in 2013. In Wales, by contrast, there was no change in the number of drug misuse deaths in 2013 compared with the previous year, with 135 deaths recorded in both years. Discussion on the reasons for the diverging patterns of drug misuse deaths over the past few years, in your magazine and the wider community of those involved in substance misuse policy and practice, would be of great value.

Chris Emmerson, information analyst specialist, health protection, Public Health Wales, Cardiff

Our headline was misleading, as there was no change to the number of drug misuse deaths in Wales, but the ONS report does state: 'However, mortality rates from drug misuse were still significantly higher in Wales than in England.' DDN

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity – please limit submissions to 350 words.

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

The state can only do so much. Most of us aren't alcoholics. We just drink too much. With every drink, we make a decision. We need to make different decisions. But the state can shape attitudes and it can legitimately do so, citing the costs and losses that result when it does little or nothing. The state can do more without being accused of nannying. And it should.

Hugh Muir, *Guardian*, 3 October

How unrealistic of NICE – the body that decides which life-saving drugs the NHS can afford – to suggest anyone who drinks more than two large glasses of wine a day should be prescribed a pill costing £3 on the NHS by their family doctor... NICE needs to be disbanded – it's not fit for purpose.

Janet Street Porter, *Mail*, 6 October

Our collective consumption has come under fire from NICE (possibly the most exasperatingly contradictory acronym ever coined). This august body, which normally preoccupies itself with the illogical restriction of life-saving cancer drugs, has decided to interfere with our right to a family life that's pleasingly fuzzy.

Judith Woods, *Telegraph*, 4 October

Macmillan's Sober October campaign seems to have been brewed on the very idea that not drinking should be some publicly declared, universally admired, valiantly fought battle. Something to scream from the social media rooftops and compensate with sponsorship... We have become so used to drinking, eating, buying and downloading ourselves into a state of milky infant satiation that we have started to see self-restraint as something worth writing home (on Facebook, Twitter, email circulars) about.

Nell Frizzell, *Guardian*, 1 October

Given the percentages, it follows that everyone knows someone who has taken drugs. And the chances are that most of us know someone who acknowledges that they've had problems with drugs. In addition, it's not unlikely that we've fallen victim to a crime committed by an addict funding his or her habit. The point is that drugs cannot be safely categorised as a niche activity or a passing fad. They are as much part of modern life as food banks or farmers' markets.

Andrew Anthony, *Observer*, 5 October

A long and expensive international PR campaign has fooled a willing elite (many of them drug abusers themselves) into believing that cannabis is safe when in fact it is one of the most dangerous drugs there is. So we shut our minds to all the evidence of the terrible harm it can do – even highly publicised killings by cannabis abusers.

Peter Hitchens, *Mail* on Sunday, 26 October

Colombians would dispute the claim that [Stephen] Fry repeated on *Newsnight*: that, with cocaine consumption, 'I'm the only person I hurt'. For them, a long line, more of blood than of powder, links the smallholdings of Cauca or Antioquia to the toilets of Soho clubs. Cocaine-driven conflict in Colombia has cost 220,000 lives. The same upheavals displaced about 4.5m people from their homes... Self-righteous spliff-puffers who believe that their beloved herb stands on higher moral ground than cocaine should know about the Vietnamese children trafficked into Britain to work as slaves on cannabis farms.

Boyd Tonkin, *Independent*, 3 October

What has the past decade meant to you and your role? What have been the most significant changes to the sector? And what will happen next? You gave it to us straight

MY, HOW YOU'VE CHANGED!

'WE'VE BEEN RIDING A CHEMICAL CAROUSEL'

IT'S ONLY WHEN YOU STEP BACK from the day-to-day hubbub that you realise what a chemical carousel we've been riding for the past decade in this world of drugs.

In 2004, cannabis was regraded from class B to C after three years of wrangling from the first announcement. In 2005 the then Tory leader Michael Howard vowed that if his party won the next election,

they would put it back to B and accused Labour of being soft on drugs. They didn't win, but Labour in turn asked the ACMD to reconsider the classification once again. The ACMD resisted the political and media clamour for another change, but couldn't in 2007 when Gordon Brown, the in-coming PM, declared his intention to reclassify whatever the evidence. At the same time, the police were uncovering previously unsuspected numbers of cannabis farms across the country; from a position in 2002 where the imported/home grown ratio was about 75:25, by the late noughties the situation was reversed. Yet all the evidence showed that cannabis use was falling. Who was/is consuming all this cannabis? We still don't really know.

Other drugs were showing a similar trend; we began to experience an ageing heroin population, and the use of other drugs such as MDMA, amphetamine and cocaine were not at the levels of the 1990s. Other drugs were apparently tailing off in popularity, but were causing real problems for those who carried on using – ketamine being the prime example.

But overall the stats were going in the right direction. It was the quiet before the storm. In 2009, say hello to mephedrone, synthetic cannabinoids and the whole dust storm caused by the advent of new psychoactive drugs, which still swirls on. The internet has been the game changer in this dynamic flux. And not just for buying drugs whose actions mimic club and other recreational drugs. We now have an array of performance and prescription drugs available at the click of a mouse – all driven by a well-embedded worldwide connected industry of retailers, wholesalers and chemists.

Down at the sharp end, the drug treatment field has undergone some seismic shifts – moving from a political focus on harm reduction and crime prevention to recovery, accompanied by a removal of ring-fenced funding, ferocious contract-culture and a cliff drop in public spending. The UK drug treatment system has been hailed as world class in its comprehensive coverage, its adherence to the evidence base and its basic humanity and pragmatism. No doubt new drugs will come and go and the arguments for and against law reform will rage on. But our real concerns must be for the future of services caring for our most vulnerable citizens. One can only hope that in ten years time we are not looking back and mourning what we have lost.

Harry Shapiro, director of communications and information, DrugScope

'LACK OF FUNDING WILL HAVE A MASSIVE IMPACT'

PEOPLE'S NEEDS are becoming much more complex, with increased mental health issues, general health concerns, and higher levels of medication. We've seen the use of new drugs such as legal highs, an increase in ketamine use, and in the last ten years an explosion of alcohol problems. There's also a time-bomb with gambling and gaming.

With many rehabs closing, there is a move towards recovery, but it involves a less skilled workforce as community providers especially look to volunteers and support workers. There's been more domination by big national community providers as contracts tendered are for the whole service and not the separate parts. We're going the way of the few big supermarkets. By 2024 we're likely to have one or two dominant market players and just a handful of specialist providers.

The lack of funding coming will have a massive impact and set the whole field back decades, with rises in crime and deaths due to addiction. I'm sorry to paint a bit of a bleak picture, but this, unfortunately, is how I see it.

Brian Dudley, chief executive, Broadway Lodge

'The internet has been the game changer in this dynamic flux.'
HARRY SHAPIRO

'There's... a time-bomb with gambling and gaming.'
BRIAN DUDLEY

'It isn't just drug use among the young that is changing.'
GERVASE MCGRATH

'PATTERNS OF USE ARE CHANGING'

ADDACTION HAS GROWN as a result of market changes in the last ten years. We've quadrupled staff numbers since 2004 and expanded our remit into more clinical work. Our staff now includes pharmacists, 100 former NHS nurses and 20 doctors as a result of the contracts we've won.

The staff profile has also changed. The numbers of former service users volunteering as recovery champions have grown and service users influence the entire organisation, including senior leadership.

During this time the sector has moved from an exclusively harm reduction model to a greater emphasis on recovery. The approach in 2004 was about getting people into treatment, whereas now it's about getting people into recovery. There is more regulation in the sector now, most notably the Care Quality Commission, which we welcome. There's also been a move from NHS to local authority commissioning.

The landscape of substance use is changing. We have a legacy of opiate users stuck in treatment, although opiate use itself is reducing. There is an ageing population of people used to using a variety of substances but for the young, the pattern of substance use is changing with the prevalence of stronger cannabis, and new psychoactive substances creating new challenges for treatment providers.

However it isn't just drug use among the young that is changing. More people drink at home and the context is no longer social; it has more to do with isolation and loneliness. So the way we live our lives is also having an impact on the way we use substances and the damage they can cause.

There is also a growing acceptance of substance misuse – three or four generations of people have grown up in a world that uses drugs, and so the decriminalisation/ legalisation debate will rumble on. In addition to illegal drugs, we will probably be facing up to the legacy of inappropriate prescribing in primary care.

Services will integrate professional staff with recovery services staffed by volunteers. The commissioning landscape is changing, with increased emphasis on social value and community-led recovery. Following the pattern of our broadening remit, I predict we will increasingly be engaging with other services like housing and mental health.

Gervase McGrath, director of UK operations, Addaction

'WE'VE CHANGED FOCUS IN SCOTLAND'

OVER THE PAST TEN YEARS, SDF has seen changes in its focus. There has been a great concentration on improving the quality of service response; reducing the numbers of drug deaths, including pushing for the national naloxone programme and supporting implementation; ensuring an effective user voice; and innovating means of helping people with a history of drug or alcohol problems into employment.

Recovery as a key concept and discourse has been an important change during this time. Initially in Scotland there was an over-emphasis on abstinence, taking us back to an era when the focus was on people who were 'motivated to change'; a narrow focus on the individual and not wider societal inequalities and poverty. Thankfully, we've returned to a balanced approach – recovery and harm reduction are dovetailed and not separate. Competing approaches, eg naloxone, are recognised as a step towards recovery.

In England there seems to be a more fractious relationship between the evidence base and what government would like. Sticking to evidenced-based approaches and not ones driven by moralistic views is a challenge – such as UK government requests to explore time-limiting methadone.

Going forward, we'll see challenges dealing with an ageing group of users, with services working closely with wider care services designed for older people.

In terms of trends of drug use, how will problems manifest themselves? We see significant problems with new psychoactive substances, but this covers a range of compounds with differing effects and issues. We know that if the needs of vulnerable young people aren't adequately addressed today they will become, sadly, the service users of tomorrow.

David Liddell, director, Scottish Drugs Forum (SDF)

'I HOPE THAT QUALITY WILL WIN THE DAY'

I HAVE BEEN PRIVILEGED to be involved in the regulation of the treatment sector over the past ten years. It all began in Weston Super Mare where, as head of inspection, I had to make sense of the concentration of treatment services in the area.

I was constantly bombarded by services who told me in no uncertain terms that they were not 'care homes', but something entirely different. The legislation in the Health and Social Care Act 2008 created a new regulation, which described services

'We'll see challenges dealing with an ageing group of users.'

DAVID LIDDELL

'My hope for the future is that quality will win the day.'

DAVID FINNEY

as 'accommodation for persons who require treatment for substance misuse'. Unfortunately CQC chose not employ someone to coordinate the implementation of this regulation and, as this had become my passion, I took early retirement and sought to assist services as an independent consultant. Sadly, in my view, CQC implemented this inconsistently for the first five years. However they have now decided that a policy manager for substance misuse is needed and a separate nationally recognised inspection methodology is being developed.

The last decade has seen the passing of some long-standing residential rehabs to be replaced by newer ones. Regulation has also been extended to many community-based services, many of which are doing an excellent job. My passion is that services are run respectfully and with a central focus on the needs of people using the services, with recovery as chief aim. My hope for the future is that quality will win the day and the new rating system introduced by CQC will highlight where there is good, and even outstanding, practice among treatment providers.

David Finney, independent social care consultant

'WALES NOW HAS THE BEST ROUTE OUT OF ADDICTION'

KALEIDOSCOPE BEGAN its own rehabilitation by establishing itself in Wales ten years ago. What we saw when coming to Newport were huge waiting lists for treatment and a lack of support for people with drug and alcohol use in many parts of the country.

Today we see Welsh-based organisations forgetting past rivalries and coming together and sharing best practice. This has best been shown by the establishment of Drug and Alcohol Charities Wales (DACW), which ensures there are Welsh solutions to the problems of substance use. Innovation has flourished, be it through Peer Mentoring (an ESF Funded Scheme) which saw hundreds of people with drug and alcohol issues obtain work; Change Step, which is a unique project supporting veterans; the development of computerised dispensing systems in our major cities; and the establishment of social enterprises for service users. Wales is fast becoming the best country in the UK to be in when looking for a route out of addiction, when it used to be the worst.

I am worried that the uniqueness of treatment in Wales will be replaced by the huge English or international companies in ten years' time, peddling average drug services at cut-price costs. In Wales, service users have grown in confidence. In Gwent, *The Voice* service users group works closely with the local providers and is actively involved in how treatment works. Its voice is heard because management is close enough to hear, and is near enough to meet with. As DACW has shown, with drug services in a small country, networks with

trust can be formed which simply would not happen with large faceless organisations.

Positively, I do see a change in legislation and the re-emergence of harm reduction. The Welsh Government policy of a drug and alcohol strategy is an example where all mind-altering substances are looked at rationally and not, as in the case with the UK government, on ill-informed legislation governed more by the *Daily Mail* than by the experts on the subject.

Martin Blakebrough, chief executive, Kaleidoscope Project

'MISTAKEN PARADIGM STILL DOMINATES RESEARCH'

A STRIKING ASPECT of treatment research from the past ten years is the realisation forced on Project MATCH researchers: that after the most sophisticated research of the most highly technically specified therapies ever seen in alcohol treatment, their therapists were in essence doing nothing different from the faith healers and witch doctors of 'primitive' societies – providing a culturally accepted route to recovery which gave clients permission to activate their pre-existing resolve and resources. What was critical was cultural fit, and the status it gave to the intervention and to the therapist. It was an example of the creation of new understandings from the rubble of a massively expensive and unexpected failure – in this case, to match different psychosocial therapies to different kinds of patients.[1]

Underlying most research is a very different preferred message – that we have found treatments that work because they embody the right psychological technology to treat a techno-medical disorder of the body and mind. The car is not working; as long as the technician uses the right spanner on the right nut and turns it in the direction and by the amount specified in the manual, then it will be restored. Despite what (in The No. 1 Ladies' Detective Agency novels) Mma Ramotswe's mechanic husband likes to believe, it matters not at all how the technician talks to the car, whether he loves or loathes it, shows respect or disdain, and the car itself plays no part in the process.

For substance use, this profoundly mistaken

‘In Wales, service users have grown in confidence.’

MARTIN BLAKEBROUGH

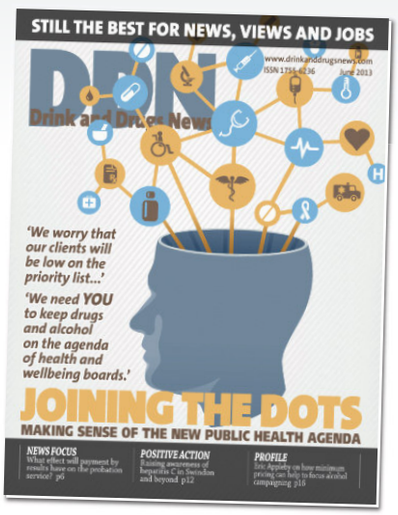
‘Evidence-based relationships must take their place.’

MIKE ASHTON

‘Local government is now in the lead.’

ROSANNA O’CONNOR

paradigm should have been shattered by the ‘failure’ of Project MATCH, but it still dominates research. In psychotherapy generally, things have decisively moved on with the American



Psychological Association’s recognition that evidence-based relationships must take their place alongside evidence-based treatments:[2] ‘It reflects an inexorable, evidence-based recognition that the relationship is a common denominator that brings diverse clinicians together.’[3]

1 http://bit.ly/ZYN2pW;
2 http://bit.ly/1FSXPmW;
3 http://bit.ly/1DXlXml

Mike Ashton, editor, Drug and Alcohol Findings, http://findings.org.uk

‘A LANDSCAPE WITH CONFLICTING PRIORITIES’

THE NATIONAL TREATMENT AGENCY had strong political support during the past decade for its very clear mission to improve the quality and quantity of drug treatment. We actively supported local areas, set targets, asked challenging questions and introduced a recovery ambition.

As Public Health England, we have a much broader interest in alcohol and drugs, in prevention, treatment and recovery and in health inequalities. Local government is now in the lead; we support them through reflecting their performance back to them, promoting the evidence and providing bespoke support to them and providers to deliver safe and cost-effective services. Some things remain constant, but the landscape is now more complex, with conflicting priorities and an un-ring-fenced treatment funding pot.

Substantial investment expanded the sector massively; many more people started treatment quickly and stayed long enough to see real health benefits. The introduction of ambitious evidenced-based prison treatment helped close the gap between prison and community drug treatment.

The centrality of links between effective treatment and crime reduction was a key driver and the emphasis on recovery introduced greater ambition, ensuring a positive shift towards more active and personalised treatment, often harnessing and enhancing mutual aid and peer-led initiatives. During this time we developed a world class data system and accumulated evidence of what works, so our guidance and support is now well developed and highly regarded, with the system delivering much improved outcomes.

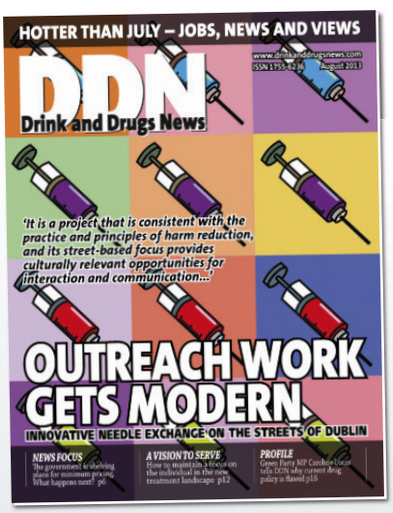
Of late, the most significant development has been the transfer of commissioning to local authorities, with the loss of partnership commissioning and protected funding.

Who knows what the sector might look like by 2024, but hopefully it will be responsive to new populations of users, valued by local authorities, health and criminal justice partners and the public. It should certainly be more aligned with broader services – training and employment, housing, families, mental and sexual health – better integrated with local initiatives, and most importantly, seen to be delivering first class outcomes for the whole community.

Rosanna O’Connor, director of alcohol and drugs, Public Health England (PHE)

‘TEN YEARS AGO IT WAS ABOUT GETTING EVERYONE ON A SCRIPT’

I HAVE WORKED in the drug and alcohol field for the past ten years and have seen a dramatic change in not only our way of working but also in the types of drugs used. When I started, it was a case of getting everyone on a script and keeping them there. It felt as though the government believed that if drug users were on a script then crime would disappear (of course it never did). The only therapy was one-to-one key working, which on its own proved not to work for many.



The emergence of recovery started a few years ago and appears to have blossomed. Sadly not enough staff were trained in it and still few are – it’s always been a case of just running with it. Group work and

'Group work and peer support have gone from strength to strength.'
SUE ANDREWS

'A very welcome change has been... more integrated services.'
LORD VICTOR ADEBOWALE

peer support have gone from strength to strength. The ever-changing legal highs are now a real problem and I believe that we will need to change our way of working with clients who use them.

The one thing I hope not to see widespread in the drug and alcohol field is payment by results, which I was unfortunate enough to work with for a short period of time. This was appalling and put price tags on people's lives.

Sue Andrews, drug worker

'INTEGRATION WITH PUBLIC HEALTH WILL BE THE NORM'

TURNING POINT has been delivering services for 50 years this year. In 1964, founder Barry Richards launched a small non-profit organisation called Helping Hands – the UK's first attempt to help those with alcohol problems, by using a community based, residential programme.

Barry Richards was breaking new ground and that's what we are still trying to do. It's enabled us to grow from what was effectively a small single-issue charity to a leading social enterprise now employing more than 3,000 people and operating over 200 services in the areas of substance misuse, learning disability, mental health, primary care, employment, criminal justice and community commissioning.

Over the past ten years we have kept growing and developing, increasing our expertise around complex needs and dual diagnosis. A very welcome change over the past decade has been the move to more integrated services, which bring together drugs, alcohol, criminal justice, and young people's support.

The recent move of substance misuse back into local authorities, as part of public health, is also positive, although it presents challenges for providers to ensure we're demonstrating clearly the community benefits of investment in us. The benefit of this move is starting to come to fruition through the broadening of traditional substance misuse services to include public health priorities, such as the launch of smoking cessation pilots in six of our substance misuse services.

Integration will be the norm by 2024, so we'll no longer be talking about drink and drugs and mental health but more readily talking about 'public health', with commissioning reflecting comorbidities. Health and social care are intrinsic elements of an equal society and in order to fix them we need to foster collaborative thought and practice.

The bulk of investment should be in prevention and the importance of education and early intervention in the substance misuse sector should not be underestimated. I hope that by 2024 we're investing in services that reach at-risk individuals earlier so that intergenerational problems cease to exist.

Additionally I'd hope that the stigma associated with alcohol and drug dependency and dual diagnosis, which often prevents people from seeking help, would be vastly reduced, so that more people know and accept that sustained recovery is possible for anyone.

Lord Victor Adebowale, chief executive, Turning Point

'FAMILY SUPPORT SERVICES ARE FORCED TO COMPETE'

TEN YEARS AGO Adfam was an organisation which focused its work on direct support for families affected by substance misuse in the criminal justice system – we had services in several prisons in London and we also had a national helpline.

With funding changes, taking account of new political and economic structures and constraints, we became an umbrella organisation in 2008 and now provide indirect support to families and the practitioners who work with them, via our website, regional support team and policy and campaigning activities.

The word 'family' appeared twice in the 2002 government drugs strategy; it was included in the title of the 2008 strategy. The need for family support will probably never go away, but the current economic climate means that support services are increasingly being squeezed and forced to compete with large providers for funding.

By 2024 the drug sector may be comprised of a few, large treatment providers with family support included or just tagged on. This ignores the need for support for families whose loved ones are not in

treatment. There will be a much larger recognition of the needs of families, achieved through a community led movement, not dissimilar in character and influence to the user recovery movement.

Vivienne Evans, chief executive, Adfam

'THINGS CAN ONLY GET BETTER!'

LIKE MANY ORGANISATIONS in this field, WDP has grown significantly over the past ten years. We now provide more services to a larger number of users over a wider geographical area. Quality remains a key component of our service, reflecting our staff team who are always prepared to go that extra mile.

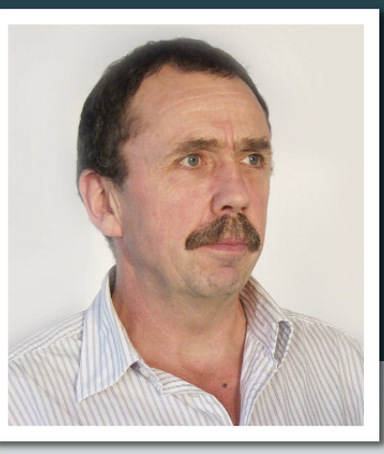
There have been a number of significant changes

'The word "family" appeared twice in the 2002... drugs strategy.'

VIVIENNE EVANS

'The public perception of illicit drug misuse is starting to shift.'

YASMIN BATLIWALA



'We have supported more than 100,000 people in the last ten years...'

MARK WEEDING

in our sector over the past ten years. The nature and type of drug use is changing, with legal highs becoming increasingly common and a reduction in individuals using heroin and cocaine. There are greater numbers of ageing users presenting with more complex health problems than perhaps ever before.

On the positive side, the public perception of illicit drug misuse is starting to shift. It is slowly being seen as a healthcare issue, rather than as a criminal one. The politics of alcohol has also come into play, with government ministers willing to talk, albeit cautiously, about the links between the price of alcohol and its abuse.

There will be important changes ahead that will impact on the planning, commissioning and delivery of services resulting in a very different landscape of service provision. The reality is that it is likely there will be fewer specialist treatment services available – 'choice' of service by the user, which has been systematically eroded, will become even more so.

The resident government, regardless of political persuasion, is likely to be amenable to discussion on UK drugs policy – not because it wants to, but because it has to in order to keep up with current thinking. This may lead to the state regulation of illicit drugs becoming a possibility.

The substances misused will continue to change and the dynamics of treatment versus prevention will be played out in the public arena. The short-term future appears somewhat bleak, but strangely this gives cause for optimism: things can only get better!

Yasmin Batliwala, chair, WDP

'WE'LL BUILD ON SUCCESSES'

THIS YEAR DISC IS CELEBRATING 30 years of being at the forefront of service delivery to those facing the most challenging circumstances.

We've expanded from a charity focused on training to the development of our current organisation – one of the north's most successful charities, with over 400 staff, 100 volunteers and peer mentors, and an annual turnover of £16m. We're committed to supporting people and communities to achieve their goals and helping people reach their potential.

Our anniversary has caused us to reflect on what we've achieved. We can look back on some amazing successes; contracts won, jobs created and partnerships improved. But what we really care passionately about is the number of people, year on year, whose lives we've helped to improve. Through initiatives developed by DISC, we have supported more than 100,000 people in the last ten years alone.

We're an innovative organisation and we are constantly developing diverse ways to meet the needs of current and future service users. By investing in new programmes, developing new partnerships and leading with innovation, we will continue to support healthy communities to bring about change and provide inventive services to help those with problems of alcohol and drug addiction overcome challenges in their lives.

Mark Weeding, CEO, DISC

'WE'RE IN A SOCIAL INEQUALITY WAR'

THE PAST TEN YEARS have seen remarkable changes: the years of expansion in drug treatment, the stall, then a chill wind of austerity biting in many areas.

The massive influx of cash driven by the Blair government's wish to reduce drug-related crime came hand-in-hand with what the Scots call the 'English disease' of targets, data collection (forms, damn forms!) and increasing performance management by commissioners. The NTA quango, with its `delivery assurance' role and armed with `toolkits and guidance' pushed the sector hard and fast with a mantle of assumed power (all 'fur coats and no knickers'!).

The bubble was burst by a groundswell of people in recovery (rightly) wanting more, and a new coalition government wanting something different. The vibrant recovery movement is a fabulous legacy of this decade, but growing stigma against those who cannot reach abstinence is a deeply worrying sign of a society that increasingly disapproves of all state dependence.

By 2024 there will be a lot more old people: one in three over 65 by 2015 and increasing at 4 per cent a year. There will be less money – with a per capita spend on health and welfare less than the USA by 2018. My cynical self thinks this will drive funding to 'mandated groups' only (eg the elderly and children) OR those

doing the most harm to others – where interventions are cost-effective. Our 'lifestyle diseases' may be left to 'mutual aid', web-based health intervention, volunteers and a postcode lottery of services.

I sincerely hope we don't have another heroin epidemic or a new methamphetamine epidemic. I hope synthetic drugs become even less moreish and cannabis CBD levels rise. Who knows, maybe we will follow the USA on cannabis, as we have in obesity.

In 2024, I aim to still be around, championing the cause. We are not in a drugs war, we are in a social inequality war – and we need more troops.

Annette Dale-Perera, strategic director: addictions and offender care, CNWL

'The vibrant recovery movement is a fabulous legacy of this decade.'
ANNETTE DALE-PERERA

'We're seeing significant mental health concerns, psychosis...'
MONTY MONCRIEFF

'STEEP CHALLENGES FOR THE GAY DRUG-USING COMMUNITY'

TEN YEARS IS A LONG TIME in drug treatment. In Antidote – London Friend's specialist service for lesbian, gay, bisexual & transgender people (LGBT) – some changes have been quite astonishing.

Our data from a decade ago shows most clients experienced problems using alcohol and cocaine, with a handful having partied too hard on ecstasy. Generally though, most people managed their party drugs reasonably safely.

We had already heard rumblings from other major cities that crystal meth was a-coming. The mainstream media sprang into a panic predicting the next pandemic, but for the most part it never came. Quietly though, away from view in private houses, crystal was making itself known among a small group of gay and bisexual men.

Fast forward a decade and it's become one of three main problems we deal with – the others, GHB/GBL and mephedrone, having similarly appeared as if from nowhere. A typical user tells us how they 'slam' (the colloquialism for injecting, perhaps coined to avoid associations with IV drug use) and attend weekend-long sex parties with several other men.

Of course, gay men, sex and drugs are hardly strange bedfellows, but a decade ago you partied and maybe then fell into bed if you'd got lucky on the dancefloor; now the norm is to get app-y on smartphones where 'chemsex' is readily found on 'dating' sites without even needing to leave the house.

The fallout is harsh: we're seeing significant mental health concerns, psychosis, and a group of previously stable men whose lives, relationships, jobs and housing are falling apart around them. Men whose self-esteem has plummeted. Men who are contracting HIV as heterosexual infections are falling.

It's been a challenge for us to adapt to new drugs and trends, such as slamming, that were never common within our communities. As these patterns make their way into mainstream services it's important for them to consider how to meet this challenge too. Our recent report *Out of your mind* has some resources to support this.

Monty Moncrieff, chief executive, London Friend

'HANG ON TO USER-LED INITIATIVES'

TEN YEARS AGO, KFx was in its terrible twos. Using the waybackmachine I can see how, in some respects, things haven't changed. Cannabis had been reclassified and the ACPO guidance was the source of much discussion. As housing providers were still concerned about the fall-out from the Wintercomfort Trial, I was busy with housing and drugs policy work, which still remains an issue today. The legal issues still haven't been addressed.

GHB had earlier been made a controlled drug, but since then GBL emerged as a successor and ten years on we're dealing with a slew of newer psychoactive compounds.

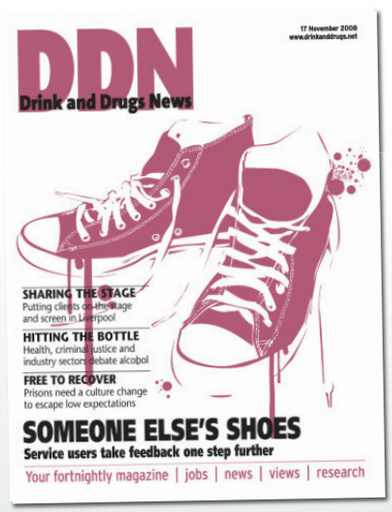
Ten years ago, the paraphernalia laws were slowly being amended, allowing distribution of acids and other paraphernalia. It's taken a further decade for the law on foil to be amended. The farcical nature of the paraphernalia laws forms part of my safer injecting training. Sadly over the past couple of years, there has been a sharp decline in requests for this course. I hope that in ten years time we aren't paying a huge price in injuries and infections from not ensuring staff delivering injecting interventions are adequately trained.

More than 1,000 workshops and 16,000 participants later, I think my passion for and interest in the subject hasn't dimmed. Sadly, not all the organisations that I worked with ten years ago still exist, and have perished in the new world of competitive tenders. A huge change therefore has been a reduction in the number of small, local service providers and a growth in larger national ones. In sharp contrast to the increasingly corporate nature of provision, the grass-roots emergence of user-led initiatives has been amazing and inspirational to behold. Ensuring that this does not in turn become incorporated, co-opted and neutered will be one of the key challenges in the next ten years.

Kevin Flemen, KFx

'SOCIETY DOESN'T TAKE ADDICTION SERIOUSLY'

GOOD THINGS HAPPEN, progress is made, people do get good help and lives are transformed. Whatever the turn of the political and funding wheels and the system they drive have taken, over the last ten years that has undoubtedly been the case. Whether the good has happened because of the system or in spite of it, I am not so sure.



The bad also happens both because of systemic flaws and in spite of them. Progress is thwarted and undermined as too often we take two steps forward and then a couple or more back. Just as we seem to be getting somewhere the operating environment

'Grass-roots emergence of user-led initiatives has been amazing.'
KEVIN FLEMEN

'Empathy for addicted people remains in pretty short supply.'
NICK BARTON

'It took four years... naloxone is now being distributed'
LEE COLLINGHAM

changes, the seeds of progress are ploughed up and obstacles strewn in our path. That's when we're not getting in our own way and tripping ourselves up for one reason or another.

I could explore changes to funding and political structures, degrees of workforce competence, the adequacy of investment in research and whether sufficient priority is given to families. I could discuss recovery and treatment modalities and the tensions between them and examine the commissioning and providing relationship and more.

But I think the fundamental problem is that unlike other life-threatening conditions we simply do not yet as a society really take addiction seriously in its own right. We only address it because of its costly nuisance effect. Empathy for addicted people remains in pretty short supply.

It's not treated like every other major life-threatening ailment; cancer, diabetes, heart disease, for instance. Why? The answer is stigma. Society looks at our client group through the lens of the consequences of addiction and projects conveniently onto it. It loses sight of the people; the human beings.

Until, as a society, we adjust our way of looking at addiction and thereby remove the stigma, we will never properly understand it or be able to respond in a fully rational way that moves beyond the kind of uncoordinated tinkering that characterises much of what we do now.

Once we have done that we can begin to look bravely at the question as to why addiction flourishes in our society in the first place. Maybe in another ten years we will have got there.

Nick Barton, chief executive, Action on Addiction

'THE HEART OF THE MATTER'

WITH THE HELP of supportive commissioners, Nottingham's service users have made sure they're now at the heart of decision-making.

May's meeting of Nottingham's Recovery Forum celebrated ten years of meaningful service user involvement. Over the years the forum has had numerous names, but the function has always been the same – not only for service users to feed into the commissioning process, but also development of services, as well as being a catalyst for many members to go on to paid employment, and not just in substance misuse and mental health.

As was recognised quite early on, clients in recovery, be it on medication, in aftercare or not even engaging, have many complex needs and it was decided other groups would be set up with active user involvement at their heart.

Through the Recovery Forum (and its various names) other forums have become established, such as the Dual Diagnosis Forum (DDF), Alcohol Service Users' Forum (ASUF) and Substance Campaigns User Friendly – formerly Shared Care User Forum – (SCUF). These forums were set up not only to give shape and input into needs assessments, service provision and delivery, but also to give participants a time to check in with their peers for things such as self help and support, as well harm reduction and awareness education and access to training.

The forum and its members have always been integral to anything that has happened within substance misuse in Nottingham City and several members sit on various steering group and strategy meetings and working groups.

One thing that has been key to the Recovery Forum's success is its desire to do partnership work with all the agencies and support services within the city to ensure not only cost effective, but also successful, services that are fit for purpose.

Members of the group have been involved with various agencies producing DVDs around needlestick injuries, safe returns and overdose response, and have produced consistent award-winning work around stigma.

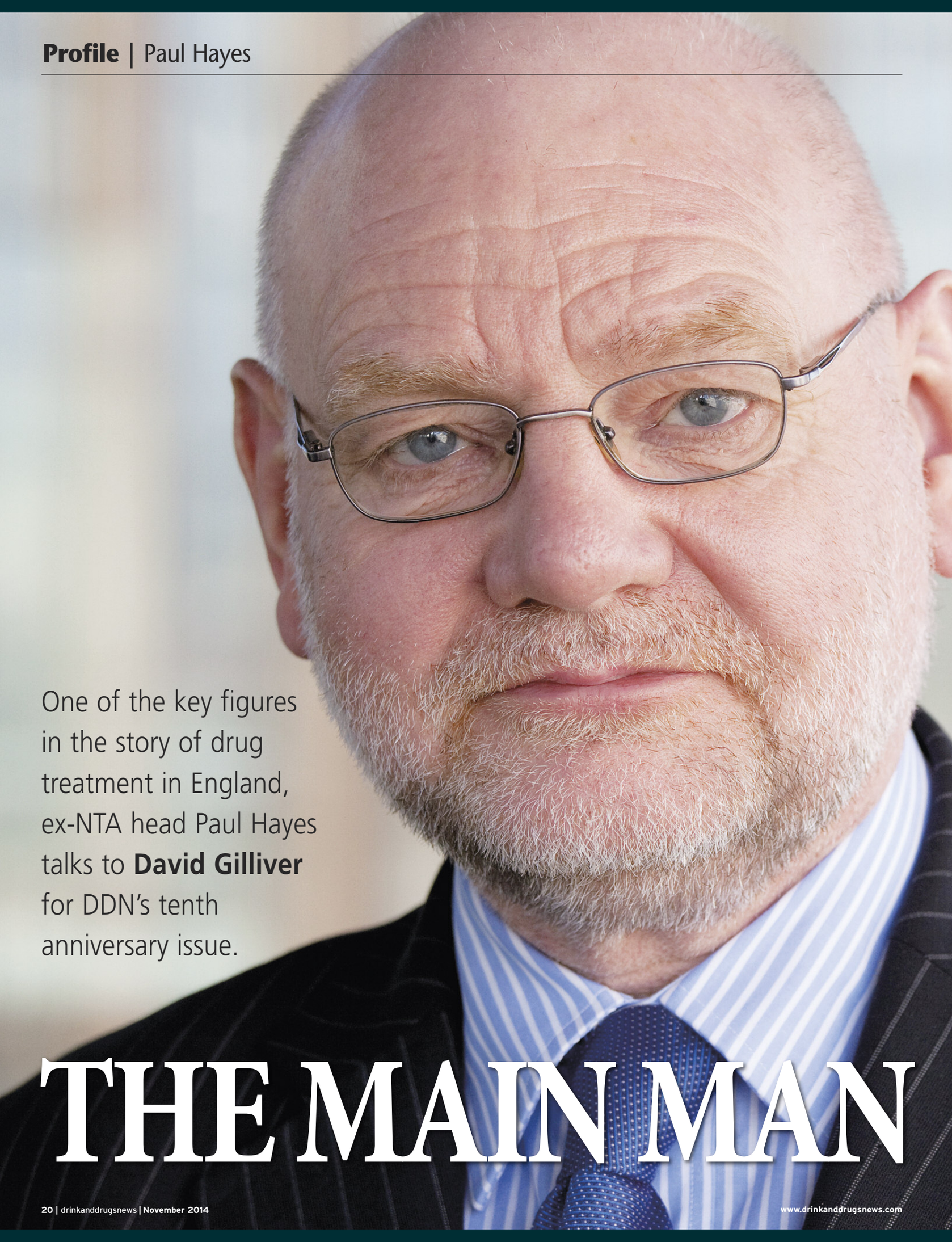
Members of the forum were involved when it came to relocating and rebuilding our current detox unit to become a state-of-the-art unit called The Woodlands, whose statistics speak for themselves. The building and fittings are still as new three years on as when it was built – all down to service users and staff respecting the environment.

The Recovery Forum continues to be at the forefront of what is done in Nottingham's treatment system, and in November last year two organisations came together for 'Recovery Rocks' (DDN, January, page 10) where more than £400 was raised to provide food parcels at the homeless drop-in.

Although it took four years and many meetings – as is often the case with strategic stuff – it was because of the service user relationship and power that naloxone is now being distributed, with 64 kits being issued since it was launched in December last year.

Among many many other things besides The Woodlands and the provision of naloxone, service users are where they should be – at the heart of what's happening, thanks to a forward-thinking commissioning team, a dedicated involvement worker and a committed group of service users refusing to be pushed aside and ignored.

Lee Collingham, service user activist, Nottingham



One of the key figures in the story of drug treatment in England, ex-NTA head Paul Hayes talks to **David Gilliver** for DDN's tenth anniversary issue.

THE MAIN MAN

Paul Hayes was chief executive of the NTA from its inception in 2001 until the agency's functions were taken over by Public Health England last year. He now works with a range of voluntary sector organisations including DISC, the Cyrenians and Family Action and is an honorary professor at the London School of Hygiene and Tropical Medicine.

Prior to the NTA he'd worked in the probation sector for almost 30 years, and was chief executive of the South East London Probation Service when he was asked to put himself forward to be chief executive of the new organisation.

What attracted you to the NTA job?

'There are two aspects. I'd led on drug and alcohol policy for the Association of Chief Officers of Probation for a number of years and I was working in Southwark when the first heroin epidemic hit, so I was acutely aware of the change in the environment – it was an issue that I was confronted with on a daily basis.

I was given a job developing drug policy for the probation service in London, and then when I became a chief I was given the national brief, so I'd worked in drug policy for many years before the NTA was created, and it was put to me that this might be a good thing for me to do. On a less positive note, the probation service was being restructured at the time and my job was being abolished, so in personal terms it wasn't much of an ask – it was either the NTA or the dole.'

The NTA improved access, cut waiting times, oversaw reductions in drug-related deaths. How big was the difference it made to treatment in this country?

'Immense, absolutely immense – I firmly believe that. If you go back to the Audit Commission's 2002 report, *Changing habits*, it describes the treatment system before the NTA was created. People waiting months, very early drop out, and what you got was what that particular service believed in – one of the things that report talks about is inconsistency in treatment and how it's belief-driven rather than evidence-driven. But the most important thing really wasn't the NTA, it was the money.

The Blair government chose to invest an awful lot of money in drug treatment. Central government spend went up from £50m a year to about £400m – that was the direct spend, the criminal justice money was on top of that – and the real reason for the creation of the NTA was that Jack Straw, who was home secretary, basically didn't trust Alan Milburn, who was health secretary, to spend the money on drugs if it was just given to DH. They wanted a new outfit to ride shotgun on it, so they created a quango jointly owned by DH and the Home Office primarily to oversee the money.

We then decided to take on a best practice, performance management, commissioning oversight role to achieve that, but that wasn't set in stone and it was actually very difficult to achieve, because we cut across a lot of the pre-existing assumptions about how things should operate, within both health and the criminal justice system. We had to fight quite a lot of Whitehall battles, battles with the health bureaucracy and the criminal justice system and local authorities, in order to create that space. But a lot of that comes back to the money. If you're dangling cash around you're given an awful lot more licence than if you're not – "we want you to do all this new stuff, by the way here's 400m quid to do it". That makes life a lot easier.

So the performance management stuff was important, the leadership stuff was important, identifying best practice was important. But without the money, and the government's commitment to spend the money – Gordon Brown's money, Tony Blair's leadership – we wouldn't have got anywhere.'

Do you think Tony Blair's contribution is something that's acknowledged?

'Everybody hates Blair, but I think there may be different views in a different generation. From my point of view, leaving foreign policy aside and just focusing on drugs, the drug treatment sector does owe Blair a great debt – the central direction we got, particularly as a cross-cutting issue. Drugs wasn't important enough to any one of the government silos to actually deliver it. It wasn't important to DH, which is why Norman Baker's call for drug policy to go to health would be a mistake, in my view – it doesn't kill enough people and it doesn't make enough people sick. As far as they're concerned, drugs is very small beer, and it's smaller now because it's largely been capped off. It's nowhere near as significant as tobacco, obesity, alcohol, cancer, dementia – if you're running the NHS, how much attention are you going to pay to drugs?

If you're running the Home Office you're rather more interested because of the drugs/crime link, but it's still not top of your list of priorities – it's one thing among many. If you're interested in welfare dependency then it plays a role, but unless you're Iain Duncan Smith it isn't going to be near the top of your list of priorities either. So it matters at about the 5 per cent level to about half a dozen different departments, but not enough to any of them to really give it some oomph. The only point in our system where cross-cutting issues really come to matter is at the centre of government – at No.10 – because that's the only place where they have to own all these different 5 and 10 per cents that stack up to being a real issue.

So you needed not only the money, but a government that was structured to drive things from No.10, and that was how Blair did stuff. Obviously all of that – targets, performance management – became deeply unfashionable, and I think it's very interesting that Nick Clegg is now saying he's taking mental health seriously because he's imposing targets on the system. The Lib Dems and the Tories spent years castigating the previous Labour government for too much focus on targets and bureaucracy, so I think it's very interesting that they're now learning – as most governments do – that localism and absence of central direction is a great theoretical prospect in opposition but it's no way to run a government.'

Overall, what do you think the NTA's main legacy will be? You've mentioned before that it might well be the National Drug Treatment Monitoring System (NDTMS).

'I think it is, and I think it's important that that's been retained in Public Health England, because you need to know what you're doing, to account for what you're spending your money on, how many people you're treating – heroin users or ketamine users. The world changes and you need to keep abreast of that – are you doing as well

with men as with women, are black people getting a fair shake, is the North East performing as well as London? If you're not asking yourself those questions then you're not really able to address what's going on and improve it, and you're letting service users down. And unfortunately, in order to do that, you've got to do boring stuff like keying in information, and it has to be collected in a consistent way.

James Brokenshire, when he was on the front bench in opposition, read out the NDTMS definition for waiting times, I think it was, basically to take the piss out of it, and all the Tory backbenchers were laughing their heads off. Well, five years in they're still using it.'

On that note, how much of a change did you see when the coalition government came in?

'Much less than anyone expected. There was a change in attitude – the NTA immediately became the enemy within, because we weren't 'their' NTA. The important thing from our point of view was to hold on until PHE came in, because it was 'their' Public Health England. So PHE, even though it continued the same policy, was a good thing, whereas the NTA was a bad thing.

But this happens to all governments – all of sudden you're in charge of stuff. You've got a set of ideas you picked up from think tanks, you come into government and instead of being able to make broad statements about you'll do this and do that, all of a sudden what you think and what you say actually matters and you've got civil servants saying, "here's the reasons why the other lot did these things that you spent the last five years saying were stupid." You start looking at them and you go, "maybe it wasn't so stupid after all – maybe there's a reason for that. We still think bits of it are bonkers or ideological, but other bits of it maybe make more sense."

So what you can do is say to them, "you want more people to recover – here's the sensible way to do that. You want that to happen at the same time as drug-related deaths not going up, as keeping a lid on crime, here's the bits of what the other lot were doing that it makes sense to keep, and here's the bits you could sensibly change."

We were able, with an awful lot of help from some very, very smart civil servants in the Home Office and DH to get the key ministers to see that it was actually in their departmental interest, and in the interest of the country as a whole and of service users, to keep much more of the existing package than anyone would have dreamt they were going to keep from the simplistic IDS/Centre for Social Justice pre-election line. The other thing that helped was that IDS didn't play his cards very well within government and wasn't able to persuade Andrew Lansley and Theresa May to go down his route.'

How many of those achievements of the NTA under threat now, do you think?

'To an extent, everything's under threat. NDTMS isn't under threat instantly –the solidity of it was exemplified I think when Oliver Letwin agreed that it would be used as the basis for the payment by results pilot, so instead of being vilified it was co-opted. How long PHE continue to invest in it, and exactly where it goes, is another matter.

But there are significant signs of disinvestment from local authorities. Some of that might be legitimate – seeking better value – because investment in the sector went up so rapidly that it's impossible to say that it's all been as well spent as it should, but there are limits to how far you can actually cut back. People will want to readjust between drugs and alcohol, people will want to spend on what I've previously called "narrow public health" – most of the benefits around drugs accrue in terms of crime, welfare dependency etcetera, which historically have never been very important to public health. Locating public health in local authorities should make it easier to make that argument, but there is a sense in which that success that you've acknowledged is largely invisible in the media and political circles.'

I was just about to come on to that.

'So you've got Nick Clegg and his "failure in drug policy on an industrial scale" stuff, and while that's the default position – while the left think we've got a failed war on drugs that will be solved by decriminalisation or legalisation, and the right think we've got a wrong-headed harm reduction-led policy when we ought to have abstinence – the only thing they can agree on is that we're going to hell in a handcart. Which is the opposite of the reality.

I gave a lecture to a group of criminology students recently and the only thing they were interested in were the numbers I started off with, about the improvements in the system, the decline in use and the crime reduction. They were gobsmacked, they had no idea. They were saying, "What are your references for this?" and I said, "It's the ONS – this is what the official figures say." People just don't know. It's so locked into the media assumptions that it's failed, and in a sense it becomes a sort of proxy space for left and right to have an argument. I think it's even the case that because it's working, because we're not at the state of crisis we were at in the '80s with HIV or the '90s with escalating crime, to an extent that enables people to go back to their ideological corners and throw hand grenades at each other. If there was a real problem they'd roll their sleeves up and get it sorted.'

Do you think all that polarisation is starting to ease off at all?

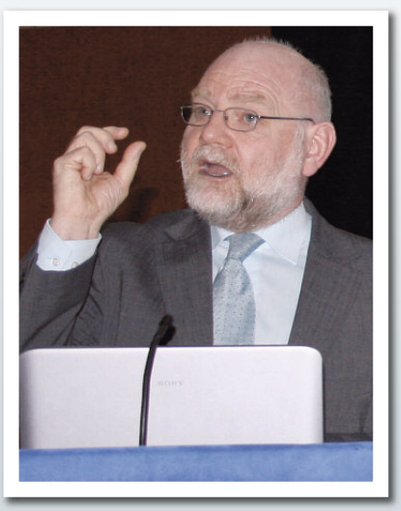
'I think the polarisation in the sector – the harm reduction/abstinence wars – has calmed down. There's still an appetite in bits of government to re-ask the question about time-limited methadone, for example, which in my time they asked four times and always got the same answer. They keep hoping they'll finally find someone to tell them what they want to hear, but the evidence remains the evidence.

What hasn't calmed down is the ideological stuff about the legal status. But what I think will change things dramatically is what's happening in Colorado, funnily enough. I think that will actually harden opinion against changing the law, because now we're starting to ask detailed questions about how does a market work and how regulated can a market be. So rather than being theoretical these issues become real. I think people are very dubious about where Colorado's going to lead.'

With the involvement of big business and so on?

'Absolutely. I don't think there's a space in between prohibition and marketisation – that's my gut instinct. You might be able to get there in Uruguay, when you've got government control of supply – a political impossibility here – but not in a

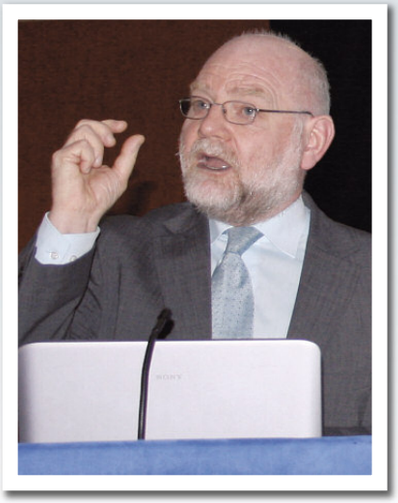
'The left think we've got a failed war on drugs that will be solved by decriminalisation or legislation, and the right think we've got a wrong-headed harm reduction-led policy – the only thing they can agree on is that we're going to hell in a handcart.'



European-wide free market. What is the space that enables you to have something that's marketed but exerts real pressure on the producers not to maximise their market? We try to do it with tobacco, with alcohol but, particularly now with social media, I don't know how you'd prevent viral marketing and so on. How do you stop bigger and bigger entities operating in the market and trying to get the number of people using their product up, when at the moment it's falling?

To come back to Clegg and his "failure on an industrial scale", you only need to adopt a radical policy like decriminalisation if you think the thing's not working. If you think it is working then you need to look at the harms that come from prohibition and address them directly, rather than running the risk of doing more dramatic things.

'If you think drug use is a cause of poverty then you don't have to think in terms of redistributing wealth, and for a party of the right that's a nice comfortable place to be. If you believe that poverty causes drug use, that suggests you need to do something.'



We lock up only small numbers of people for cannabis possession – 500 a year, according to official figures – and they only go for two or three weeks, but it does seem crazy that we're locking people up at all for simple possession. But if the consequence of getting rid of that is cannabis being marketed, then when use goes up, harmful use goes up, as night follows day. The debate is really about what are the negative consequences of prohibition, and how we can minimise them. You can keep things illegal and not lock people up. You can keep things illegal and stop the police using it as an excuse to give a hard time to young black men. You can stop a conviction for cannabis blighting someone's employment opportunities by changing the Rehabilitation of Offenders Act. You can actually address the harms that flow from prohibition without legalising.

But as you soon as you begin to legalise I think you're running a real risk of slipping away from something that's a very inefficient market – that doesn't maximise its clientele – towards a market that's seeking fresh users all the time. And it won't be the Richard Bransons and the Russell Brands who'll be using, it will be people who are in and out of our prisons and our psychiatric hospitals, it will the most vulnerable people who are most likely to succumb. I also fear the market may escalate very quickly, like we're seeing with gambling.'

As it's the tenth anniversary issue of DDN, what do you think have been the most significant changes in the sector over the last ten years?

'In 2004 the treatment system's expansion was well in train, but I think the biggest thing has been the re-focus away from expansion and getting people in, to trying to improve the offer for people when they are in, and trying to strike that delicate balance between holding on to people for as long as you need to and working with them in order to maximise their opportunities to recover. Improving practice to do that is a really big ask.

Eventually we were successful in getting the clinicians to recognise that they weren't being ambitious enough on behalf of many of their patients. That's now accepted, and the stuff that John Strang led on was very helpful in that – finding a clinically appropriate space where we can actually protect people and give them a platform for them to recover. The big question for me, and this is something the ACMD have been looking at, is that we need some benchmark for what good looks like. How many people can you actually expect to recover? There are no really solid international comparators.

If you talk to the Americans, for example, they say, "well, no one's really got to the stage you're at in England" – a system where the vast majority of people who need to be in treatment are in treatment, a system that can get people in quickly and hold on to them – so nobody else knows. Without some sense of what good looks like, we'll always be vulnerable to being told that it's not working.

As a slight corrective to that, what I'm not sure of is the extent to which we focus too much on the drug and not enough on the person. There's a group of people in society who've been dealt a not very good hand – they've been born into families with difficulties, born into cities and regions with very poor employment prospects, they've been let down by the education system, they've got mental health problems. If they're the majority – which the evidence suggests they are – of the population addicted to heroin and crack, then maybe the issue we should be looking at isn't how many people we can cure, as such, but how do we actually manage a population that will continue to struggle with life, only one of whose problems is actually focused on their drug and alcohol use?

So it might actually be that the number of people you can expect to recover isn't a product of the drug they're using, but of the society they're living in and the economic and social disadvantages that they suffer within that society.'

Which is a much bigger issue to try to tackle.

'And for the current government, particularly, a much more challenging prospect than to say drug use is a cause of poverty. If you think drug use is a cause of poverty then you don't have to think in terms of redistributing wealth, and for a party of the right that's a nice comfortable place to be. But if you believe that poverty causes drug use, then that does suggest that you need to do something about redistributing wealth and maintaining investment in public services.'

So finally, what do you think the sector might look like ten years from now?

'This might sound peculiar, but I think the optimistic scenario would be that the sector is still dominated by a diminishing cohort of heroin users who haven't yet recovered, and they haven't been topped up by new cohorts either of heroin users or users of some substance as yet unknown that's arriving from some lab in India or China that wreaks new havoc. If we've got a diminishing number of heroin users left over from the epidemic of the '80s and '90s and a system that's flexible enough to continue to provide services to that cohort and respond to the probably smaller numbers of people succumbing to dependency on other drugs as they emerge, and that frees up money to provide better services for alcohol users, that would be the golden scenario.

I see not reason at all, structurally, why we shouldn't be able to do that. But the big proviso, of course, is money. If there's not enough money retained in the system to do that then we come back to competing priorities in the NHS and local government. Which, at the risk of sounding like a stuck record, is why you need the broader perspective. If you're not thinking crime, worklessness, child protection – if you're just thinking narrow health – then you're not going to want to make the investment.

But I was very disappointed and shocked to see the recent big increase in drug-related deaths, and we need to watch that like a hawk. It might be a blip, it might be something about the recording, it might be a consequence of the end of the heroin drought, but we need to be looking at that. And if that's followed by an increase in use, when those numbers come out, then I think all bets are off.' **DDN**

Three sector stalwarts, who were there at the start, look back at the birth of DDN

BACK IN THE DAY...

IN THE BEGINNING...

When they threw everything into DDN I thought they'd taken leave of their senses, says ***Simon Shepherd***

BACK IN THE EARLY SUMMER OF 2004, as director of FDAP, I'd agreed to meet two people from a public health magazine to discuss the idea of a special issue on substance misuse. We were due to meet in a hotel in Brighton, where I was based and they were covering a conference, but I couldn't find them (it turns out they'd been just around the corner!). It was a lovely day and on the way back to the office I stopped for lunch by the beach. While I waited, they called and asked if they could join me there. I agreed but it soon became clear their company wanted money for their special issue, and that was never going to happen!

As I got up to leave, they asked if I thought that there was a case for a regular magazine specifically about substance misuse and distributed free across the field. I sat down again. A couple of hours later we'd sketched out the bones of what it might look like, we'd even thought of a name, *Drink and Drugs News*, but in truth I couldn't see how they'd make it work and didn't really expect to hear from them again.

When Claire and Ian called to say they'd decided to quit their jobs and throw everything into *DDN* I thought they had taken leave of their senses – but they were convinced they could make it work, and I agreed to help.

Although we held regular meetings over the summer, I was astonished, when the first issue came out, by the magazine's overall quality and the range of issues it covered. It's amazing to think that all that was ten years ago now and, given the challenges they faced, that the magazine has not only survived but thrived in that time.

It's hard to over-state the impact that *DDN* has had. While the Labour government set up the NTA in 2001 and committed significant funding to treatment, there really wasn't much of a field back then. The sector was riven between two seemingly intractable camps, those committed to harm minimisation on one side, and the abstinence-based camp on the other, and there was little sense of substance misuse work as a profession.

While I am not pretending that all is now rosy in the garden, there is a clear sense of the sector as a profession, and a shared identity which extends across the field as a whole. They obviously didn't do it alone – I'd like to think, for instance, that FDAP played at least a small part itself – but *DDN*'s very existence, its comprehensive coverage of all aspects of substance misuse treatment, its commitment to editorial neutrality and the evidence base, and the outstanding quality of its writing, have all played a huge role.

The success of *DDN* is of course all down to Claire and Ian, but I am glad we did eventually meet that day, or perhaps it would never have happened...

Simon Shepherd, former chief executive of FDAP (now chief executive of The Butler Trust)

A POST-IT FROM PRACTICE

DDN started at a time of change, remembers ***Dr Chris Ford***

I CAN'T BELIEVE that *DDN* has been around for a decade – and haven't they done a good job! I first met Claire at a conference just before publication of the first edition of *DDN*. We got talking and I instantly liked her. I was amazed that she hadn't worked in this area before but she seemed to get it and there was born a great ongoing relationship, both with Claire and then the rest of the team.

DDN started at a time of change and the magazine always kept us abreast of the changes. They always tried to present all sides of the argument, even at times when I wished they would be more biased! It was really exciting times for treatment in general practice (with the number of GPs involved in care of people who use drugs rising from below 1 per cent in 1994 to over 32 per cent of practices in 2012. This change was helped by the birth of SMMGP in 1995 (a network to specifically support primary care practitioners when there was nothing), our annual conference now in its 20th year, and RCGP training courses.

Claire and the team have always been a 'can do' lot – as a 90-year-old once told me 'no such thing as can't, you just take the 't' off!' So when I suggested a column about treating people in general practice called 'Post-its from practice', they were up for it. Then when the Alliance wanted to get to more people, the joint service user involvement conference was born, and is now in its eighth year.

Although often uphill, everything seemed to be advancing until a government change, bringing with it a philosophy change. Recovery, as with any positive change and self-defined journey, is wonderful and we have always promoted that. But contracting services that provide 'one size fits all' and dramatically cutting budgets is not congenial to person-centred care, which for me is the only way possible. Set that in a climate of destroying the NHS and general practice, increasing privatisation of all treatments and the madness of constant re-tendering, and it feels a difficult time at the moment.

But I'm an optimist and there are so many amazing people both using and working in the sector I feel confident that things will again improve.

Thank you *DDN* for being there!

Dr Chris Ford, retired GP and clinical director of IDHDP, www.idhdp.com

'It's hard to over-state the impact that *DDN* has had... there really wasn't much of a field back then.'

SIMON SHEPHERD

'They always tried to present all sides of the argument, even at times when I wished they would be more biased!'

DR CHRIS FORD

'One of my favourite activities was writing an educational column, Background Briefings, for *DDN*. It was fun and stimulating.'

PROF DAVID CLARK

REFLECTIONS

*A letter from **Prof David Clark**, author of our hugely popular series of Background Briefings*

DEAR CLAIRE AND IAN,

Firstly, a huge congratulations for *DDN*'s tenth birthday! Can you fly me back for cake and champers?

Do you remember approaching Simon Shepherd (FDAP) and me (WIRED) all those years ago and asking whether we thought the *DDN* concept would work? Our answer was brief – 'Yes!' – and our enthusiasm obvious. Not that you needed much encouragement. You saw a niche and have taken *DDN* to where it is today.

I'd started WIRED (later Wired In) as a way of empowering people to overcome substance use problems at the end of the millennium. I left a successful 25-year neuroscience career and started working with real people.

I knew that quality information and education was key to helping people recover and to improving addiction treatment. I knew that we needed to create hope and connect people.

My colleagues and I started the news portal Daily Dose in 2001 and over the years a variety of other Wired In community based initiatives – personal stories, research, an online recovery community (Wired In To Recovery). Sadly, we always struggled for funding, so were limited in what we could achieve. Mind you, I'm very proud of what the Wired In team (Lucie, Kev, Sarah and Ash) achieved.

One of my favourite activities was writing an educational column, Background Briefings, for *DDN*. It was fun and stimulating. I still remember Claire's calls saying the deadline was an hour away! I was touched by the amount of positive feedback I received and still have each briefing in my study drawer.

Gosh, we had some good times then, didn't we Claire and Ian? You were a very stimulating duet to work with... but I sometimes had to watch my health in the evening!

When I look back, the real highlight for me during this time was seeing people recover from their addiction. Their joy and gratitude was beautiful! So many of these people overcame great adversity... and then went on to help other people. Amazing!

They were exciting times and I feel really proud being part of that early recovery advocacy movement in the UK. Mind you, they were tough times as well, because there was shit flying around. The addiction care system is very resistant to change, in part because of vested interests. Ironic really, when people working in and overseeing the system were being paid to help people with addiction problems change their behaviour!

For those of you wondering what I am doing now, I took early retirement from Swansea University in 2006 and moved to Perth, Australia in 2008. Last year, I started Recovery Stories (www.recoverystories.info) and Sharing Culture (www.sharingculture.info). The latter is focused on helping indigenous people in Australia (and further afield) overcome historical trauma and its consequences.

I am very excited by this latter project. It will be my toughest challenge, but I know that my close colleague, filmmaker Michael Liu, and I can make something happen if we can attract funding. I am appalled at the way that indigenous people in Australia are treated – and what they still go through – and I am very determined to help make a difference. They are beautiful people and their culture special.

Maybe I can do another *DDN* Background Briefing one day?

Professor David Clark's Background Briefings are available in our back issues at www.drinkanddrugsnews.com

Many things have changed over the last decade for the DDN team – staff, premises, and even the introduction of canine office mascots. But after ten years, everything still comes together on the magazine's press day.

ALL IN A DAY'S WORK

It's half past eight in the morning on the last Thursday of the month – the lights go up, the kettle goes on, and things are kicking off for another *DDN* press day.

Throughout the last month, the team has been pulling together the different strands of the magazine, all the while juggling a number of other projects – some related to *DDN*, and some completely distinct from it.

Claire, Kayleigh and David have been working on the editorial features, Ian and Annie have been pinning down advertising leads, and Jez has started the designing process for the upcoming issue.

Today is the culmination of all of this effort – but there's still plenty of work to be done. Jez prints out the features he has already created on Quark Xpress, and David gets to work proofing them for grammar, factual errors and anything else that is out of place.

Claire uses the morning to read and edit any editorial that has come in past the deadline, as well as summarising her thoughts on this month's issue for her editor's letter. There is always some zero-hour fact to be checked or author headshot to be chased in – and Kayleigh's morning is usually spent tying up loose ends.

Meanwhile, Annie updates the mailing list – removing addresses that no longer need the magazine, and adding new subscribers. After ten years, *DDN* is still a free, self-funded publication, but we do ask that organisations pass copies around and share the magazine to help us keep costs down.

When Jez isn't creating editorial pages, he and Ian work together to set adverts, so that our advertisers can see a proof before we publish the magazine – we want to offer everyone who advertises with *DDN* the best customer care we can provide.

'The DDN bunch has always been a small team, so press days usually entail a fair bit of multi-tasking for everyone.'

Lunchtime arrives, and we've still got a long afternoon ahead of us – what's on the menu can make or break the day. Publishing pups Ziggy and Bella go for a much-needed run (they've had an exhausting day of supervising the office, after all) and owners Claire and Ian pick up the team lunch order from the local sandwich shop on their way back. The team dig in to well-deserved sandwiches – the only quiet part of the entire day.

The afternoon rolls on, and Jez prints out the last few pages of the magazine to be proofread by David. Kayleigh is the next in line for the proofing process, making any changes that need to be made to each article, and giving them a second read-through.

Amendments to adverts are made – occasionally we get a last minute booking that we weren't expecting, which is always a good problem to have. Ian creates an ad list for every issue, so that he knows what advert will go on what page. He works with Claire to decide what size each issue will be, depending on how much advertising we get and how much editorial there is, and finally Claire creates a flatplan for each person to work from.

We've always been a small team, so press days usually entail a fair bit of multi-tasking for everyone. No hands are left idle, and it's important that we keep our channels of communication open so that, even with several plates spinning at the same time, no mistakes are made.

When all the editorial pages have been proofed and corrected, Claire has her final check through them before she signs off the editorial – Jez can then prepare them to be sent to our printers.

The day draws to a close, and the *DDN* team breathe a sigh of relief... until the next morning anyway, when the advert pages of the magazine are also finalised and prepared to be printed. Ian will take adverts right up until the end of the day – we depend on advertising to fund every issue, so every advert counts. Our accounts whizz Chrissie will then create invoices for all of our advertising clients, and get them out of the door with a hard copy of the magazine.

In the afternoon, Annie makes recruitment and tender adverts live on the website – being featured online is part of the package when someone buys a print advert. Kayleigh prepares the editorial features to go up on the *DDN* website after the weekend – along with the virtual magazine – just in time for when the printed magazine will start landing on the desks of our faithful readers.

And just as you're opening up your latest issue, we start thinking about the next.

Let us know what you want from your magazine! Visit www.drinkanddrugsnews.com to complete our readers' survey – and for your chance to win a £50 Amazon voucher.

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