DDN
Drink and Drugs News

16 November 2009
www.drinkanddrugsnews.com

RECOVERY MINDED
Detox is just as much about the psychological as the physical

CHAOS AT THE ACMD
Professor David Nutt talks about his dismissal and his future

'Memories of my childhood conditioning surfaced. If I was "a good little girl", and did what I was told, I would be loved, taken care of, be included.'

OUT OF CONTROL

CAN 12-STEP PROGRAMMES LEAVE ABUSE VICTIMS MORE VULNERABLE?

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The third national service user conference

4 February 2010

Holiday Inn, Birmingham City Centre

DDN Drink and Drugs News

The Alliance

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This is the place

to talk, listen, debate and think about service user involvement. We'll be looking at what's working and what's not, and invite you to share ideas for a brighter and better future.

Featuring the service user group exhibition, video vox pops, push button voting and service user feedback for the **DDN** special report.

Make your voice heard 'Right here, right now!' by joining us for this special day.

Registration: 9.30 – 10.30am

Opening session: 10.30 – 11.35am

- Introduction and welcome – Daren Garratt, The Alliance
- The future of service user involvement, an international perspective – Theo Van Dam, LSD Holland
- The recovery movement in the UK – Jacqui Johnston Lynch

Coffee break: 11.35 – 11.50am

Presentations: 11.50 – 1.00pm

Regional service user led presentations:

- Iain Cameron (NI) – Introducing harm reduction in an hostile environment
- Peter Jones, Avow (Wales) – Volunteer mentoring
- Supporting clients back to work (Scotland) (tbc)
- Specific involvement for alcohol service users (England) (tbc)

Lunch and workshops: 1.00 – 2.20pm

During lunch there will be the option of attending the following 30 minute workshops:

- Setting up an advocacy service – how to, why you need one, what your expectations should be (The Alliance)
- Naloxone – The challenges and the tools to overcome them (Danny Morris, Independent consultant)
- Running a user magazine, website, and member communications (tbc)
- Healthy eating advice from Helen Sandwell, DDN nutrition columnist

Presentation: 2.20 – 2.40pm

- The NTA – Working with service users
- Rosanna O'Connor, NTA Director of Delivery – How the NTA works with service users, families and carers to improve drug treatment

Debate: 2.40 – 3.40pm

Interactive panel debate. This is a chance to question speakers on the issues raised during the day. Using the latest push button voting technology, delegates thoughts and views will be recorded for the special issue of DDN magazine

Post conference: 3.45 – 4.30pm

Optional workshop re-runs, coffee and networking

Plus special guest slot from the new Alliance patron and Britain's 41st best stand-up, TV's STEWART LEE !

Full details and online booking at

www.drinkanddrugsnews.com

or email ian@cjwellings.com for more information

DDN Drink and Drugs News

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ

Editor: Claire Brown
t: 020 7463 2164
e: claire@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Advertising Manager:
Ian Ralph
t: 020 7463 2081
e: ian@cjwellings.com

Advertising Sales:
Faye Liddle
t: 020 7463 2205
e: faye@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
Charlotte Middleton
t: 020 7463 2085
e: subs@cjwellings.com

Events:
t: 020 7463 2081
e: events@cjwellings.com

Website:
www.drinkanddrugsnews.com
Website maintained by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: Aldo Murillo

DDN is an independent publication, entirely funded by advertising.

PUBLISHERS:

PARTNER ORGANISATIONS:

Federation of Drug and Alcohol Professionals

SUPPORTING ORGANISATIONS:

Adfam
Alcohol Concern
The Alliance
ANSA
drugsandalcohol today
EATA
European Association for the Treatment of Addiction
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Editorial – Claire Brown

Off the scale

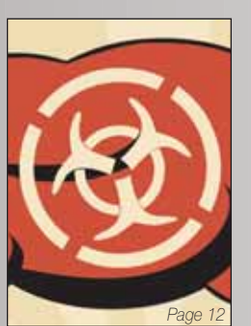
The Prof Nutt row is obscuring the real issues

The row over sacking Professor David Nutt has become intensely personal, to the point where media commentary and the stampede to take sides have obscured the issues at the heart of the debate. But whatever conflicts the home secretary perceived between Prof Nutt's role as ACMD chair and his right to speak frankly about government classification of drugs, the furore shouldn't deter us from confronting the issues he raised (pages 4 and 10). How we perceive drug harms not only affects legislation – as we have seen from former home secretary Jacqui Smith's statement that she needed to take into account public perception in the decision to upgrade cannabis to class B last year – but at a much wider level it affects our use of all drugs, including alcohol. Prof Nutt has become increasingly vocal about his intention to highlight the risks of our 'safe' legal drugs as much as to downplay the relative risks of some illegal drugs – the side of the argument that most popular media have got hold of and which became the big stick with which to beat him.

DDN's readership needs no convincing of alcohol harms, as this issue's news pages demonstrate once again. The Priory Group's survey (page 5) shows an astonishing level of ignorance about safe alcohol consumption limits. Would better education as part of a credible debate on all substances improve this situation? Who knows – it's not clear at the moment whether we will ever get past the government's own scale of harm, which many researchers are condemning as antiquated and irrelevant.

We have to be able to challenge received wisdom, which is why we've featured one of the most popular support mechanisms for recovery, in our cover story. While the 12-step self-help fellowships clearly work for many people, we isolate a particular group for whom they may do more harm than good. We'd be extremely interested in hearing your views.

This issue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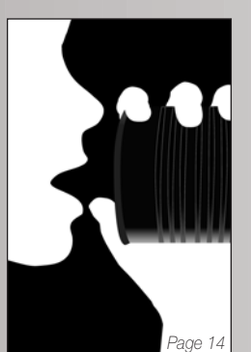
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FEATURES

REGULARS

News in Brief

Alcohol Star

Alcohol Concern has launched a new way of enabling workers and clients to measure progress towards 'soft' outcomes. The Alcohol Star, a version of the Outcomes Star used to measure outcomes for vulnerable people, is a motivational tool that can be used as an integral part of support planning and review. Alcohol Concern chief executive Don Shenker said: 'We now want to test this new version within the alcohol sector in the hope that providers and commissioners can better measure client outcomes.' *Available to download at www.alcoholconcern.org.uk*

Nutt support

Students for Sensible Drug Policy UK has condemned Prof David Nutt's sacking from the ACMD, saying government advisers should be free to give dissenting opinion. Executive director Levent Akbulut said: 'Increasing the criminal penalties for possession of a drug is not conducive to good public health policy. Criminalisation only contributes to the social exclusion and alienation faced by many drug users, nor is it an effective deterrent against their use.'

EU report

EU drugs agency EMCDDA has published its annual report, *The state of the drugs problem in Europe*, giving latest European data and commentary on the drug situation across all 27 EU member states and Croatia, Turkey and Norway. Individual chapters dedicated to specific drugs are complemented by updates on drug-related infectious diseases and deaths, new drugs, emerging trends and the legal, political, social and health responses to Europe's drugs problem.
www.emcdda.europa.eu/events/2009/annual-report

Big drink

Professionals across the South East are being encouraged to share their thoughts and concerns about alcohol. The Big Drink Debate, set up by the Public Health Group South East, is being held in November and aims to develop a coordinated approach to tackling alcohol-related issues across health, community safety, industry, retail and education sector professional networks and services in the region. Two discussion events are being held in Oxford on 19 November and Maidstone on 24 November.
www.bigdrinkdebatese.org.uk

Nutt dismisses ACMD patch-up

Sacked drugs adviser Prof David Nutt has accused home secretary Alan Johnson of 'rearranging deckchairs on the Titanic' following the resignation of three further members of the Advisory Council on the Misuse of Drugs over the government's mishandling of expert scientific advice.

Prof Nutt was removed as chair of the ACMD last month by Mr Johnson after publicly declaring that ecstasy and LSD were less harmful than alcohol and cigarettes. He also criticised the government's decision to re-grade cannabis from a class C to class B as the drug presented only a 'relatively small risk' of a user developing a psychotic illness.

Mr Johnson said that chief advisers could not be seen to be campaigning against government policy.

The sacking sparked a major controversy over the role of government scientific advisers and a number of ACMD members have subsequently walked out in protest. In an attempt to stabilise the ship, Mr Johnson met with the ACMD on 10 November to discuss the committee's future and the appointment of a new chair. He assured members that any advice issued by the committee would be given 'appropriate consideration' and that policy decisions would not be pre-judged.

In addition Mr Johnson said that he would meet with the chair before making a final decision in the event of the government disagreeing with the committee's advice. Members were assured that they would also be given an explanation why their advice had not been taken ahead of any public comment by the Home Office.

But Prof Nutt said that the concessions were only 'moderate'. He added: 'This is progress but it doesn't address the key issue. He has not dealt with my sacking and he is still at liberty to do the same thing in future... It's the old rearranging deckchairs on the Titanic.'

Three ACMD members offered their resignations following the meeting, including psychologist Dr John Marsden, chemist Dr Simon Campbell and pharmaceutical consultant Dr Ian Ragan. Dr Campbell said that he considered his position untenable as the government was forming drugs policy for political rather than scientific reasons. The resignations follow those of Dr Les King and Marion Walker, clinical director of Berkshire Healthcare NHS Foundation Trust's substance misuse service, earlier this month.

Since leaving his post Prof Nutt has vigorously campaigned for the right of scientific advisers to freely comment on certain aspects of government policy. Speaking at an event held by the Centre for Crime and Justice Studies on 11 November he said that he had been upset by his sacking and felt 'righteous anger' in his ongoing battle with Mr Johnson.

Prof Nutt has received support from some quarters, including Labour peer Lord Robert Winston and Liberal Democrat home affairs spokesman Chris Huhne, who said his sacking had been 'disgraceful'. DrugScope's director of communications Harry Shapiro said:

'There are few areas of policy as important but at the same time as difficult, complex and emotive as drugs policy. That is why it is vitally important that government receives advice that is not only evidence based, objective and robust but that that is also public and transparent.'

Shadow home secretary Chris Grayling said the sacking had been inevitable following Prof Nutt's 'ill-judged contribution to the debate'. He added: 'Whilst we backed the original decision, by now I would have expected the home secretary to be able to sit down with other members of the council and rebuild confidence and stability in what they are doing. Quite clearly he has failed to do that.'

See interview, page 10

Parents must shoulder blame for copycat drinking

Parents should do more to stop their children getting into bad drinking habits, according to a new report by the Joseph Rowntree Foundation.

A review of research into how young people learn to drink revealed that parents and representation of drinking in the media had the strongest influence on children's alcohol intake. The report, *Children, young people and alcohol: how they learn and how to prevent excessive use*, concluded that family-based support was the most effective way of encouraging young people to drink responsibly.

Author Richard Velleman, from the University of Bath, said that young people tended to copy what their parents do, rather than what they say. He outlined a number of recommendations to help parents stop their children from excessive drinking, including delaying the onset of drinking, instigating a strong family life and challenging the cultural norm of binge drinking.

The report said that it was 'remarkably easy' for young people to buy alcohol and called for greater restrictions on the purchase by children. It continued: 'The expectation of early drinking is not only held by children themselves and by their parents, but is condoned or colluded with by society as a whole.'

Mr Velleman also rubbished the popular opinion that children on the continent were introduced to alcohol at a young age and asserted that in fact they start drinking at a 'much later age and to drink considerably less' than in the UK. He added: 'Parents need to understand that their behaviour has a strong influence over their children's drinking habits. There needs to be a coherent and co-ordinated plan to reduce the amount of heavy binge drinking in a significant minority of young people in the UK.'

Alcohol Concern chief executive Don Shenker warned that the public acceptance of children's drinking urgently needed be addressed. He said: 'This must be combined with tough action on cheap drinks and those marketed towards underage drinkers if we're to see young people drinking less in future. As the author says, we must simply make it harder for young people to buy alcohol.'

Available at www.jrf.org.uk/publications

Alcohol abuse at 'shocking' levels

Independent mental health care providers Priory Group has warned of a 'shocking' level of alcohol abuse in the UK following the publication of new research last week.

According to a survey conducted by pollsters ICM on behalf of the organisation, millions of people could be putting themselves at risk of alcohol-related violence, health problems or blackouts. It was found that 61 per cent of those questioned had been adversely affected following a night's heavy drinking, with the most common problem being unable to remember what had happened the night before.

More than a quarter of respondents reported arguing with a spouse or partner due to excessive drinking and nearly one in four men admitted having been injured or getting involved in an alcohol-fuelled fight. Forty-three per cent of those aged between 25 and 34 said they had been affected by violence due to alcohol.

A third of respondents reported not being able to remember what had happened the night before and 21 per cent said they had taken a day off to recover from a hangover.

Dr Mark Collins, consultant at the Priory Group said: 'These are shocking revelations, reinforcing the fact that the excessive or inappropriate consumption of alcohol is a massive social and public health problem. The misuse of alcohol can lead to a wide variety of very distressing consequences as has been shown by this survey.

'There is no doubt that alcohol is a harmful drug. It damages both mental and physical health, creates problems for society and is the cause of much violence. It is becoming increasingly apparent that drastic measures need to be taken to address these problems, at national and local level.' The research follows hot on the heels of figures released by the Priory Group last month showing that government safe drinking limits had 'little effect' on preventing excessive drinking in the UK.

A survey revealed that 21 per cent of men and 15 per cent of women regularly drink in excess of the national guidelines. It was also discovered that one in three women and one in five men did not know the recommended weekly number of units of alcohol. Nearly half of those aged over 55 were not aware of safe alcohol consumption limits.

It was also found that the north of England had the highest number of 'over-the-limit' drinkers at 17 per cent, closely followed by Scotland with 16 per cent and the Midlands with 14 per cent. Wales and the South West of England had the lowest excessive drinking rate with just 8 per cent.

Research at www.priorygroup.com

Drugs law specialists Release have launched a pack of playing cards as part of a campaign to highlight the number of prominent politicians who have admitted taking drugs. The deck features a different politician along with their drugs confession on each card and covers everyone from David Cameron to Barack Obama and former home secretary Jacqui Smith. Release said it was 'amazing' how easy it was to locate 52 politicians. The cards are on sale at £4.95 and are available at *www.release.org.uk/shop/playing-cards*

Drug workers' key role to protect children

Drug and alcohol workers have been given a key role in protecting children of drug users who may be at risk while their parents are undergoing treatment, following a new agreement between the National Treatment Agency and the Department for Children, Schools and Families.

Guidance issued to local authority social services departments earlier this month spells out how drug and alcohol treatment workers can help to identify vulnerable children and families. The *Joint guidance on development of local protocols between drug and alcohol treatment services and local safeguarding and family services*, published jointly by the NTA and DCSF, tells staff working with families to alert children's services if they suspect a child is suffering significant harm. It also outlines how a parent's addictive behaviour may affect child safety.

NTA executive Paul Hayes said: 'Questioning what's happening within the families of drug users in treatment is critical for successful treatment outcomes, both for the individual as well as any family involved, and the new guidance for local protocols clarifies when and how to involve children's social care. Entering drug treatment is protective: it protects the individual, their children and wider society.'

According to new figures released by the NTA, 48,703 children were living in the same home as someone newly entering drug treatment in England in 2008/09.

Available at www.nta.nhs.uk

News in Brief

Edinburgh initiative

The Edinburgh Alcohol and Drug Partnership was launched at an alcohol and drug recovery conference in Edinburgh on 10 November. The EADP will lead on the development and delivery of services to tackle alcohol and drug misuse in the city and replaces the Edinburgh Alcohol and Drug Action Team. One of the first tasks for the Partnership will be to develop and implement a local alcohol and drugs strategy. Dr Fiona Watson, clinical director and consultant psychiatrist for the Community Drug Problem Service, NHS Lothian, said: 'The EADP will also be committed to delivering national waiting time drug treatment targets which are being introduced for the first time next year.'

Drug bubbles

A Tayside organisation working to combat drug misuse has issued information in response to a reported increase of a new drug in the region, known as 'bubbles'. Key to Change – a division of local voluntary organisation CAIR Scotland – released findings of research carried out in partnership with Tayside Police, NHS Tayside's public health department and Addaction. Susan Reid, operations manager at CAIR Scotland, said: 'The effects of bubbles are said to be similar to those of taking ecstasy – stimulating feelings of euphoria, energy and happiness.'
www.cairscotland.org.uk/advice.cfm

Inspired Youth

Not-for-profit community enterprise Inspired Youth has launched a campaign, What Do You Know?, shaped by adult service users and aimed at adults and young people to help them break their own cycle of addition. A campaign film and a series of posters can be viewed at www.whatdoyouknowcampaign.blogspot.com

Decriminalisation plan

Think tank Transform has suggested that cocaine could be sold in pharmacies and cannabis in coffee shops as part of a scheme to decriminalise drugs, while reducing crime and improving health. A new book *Blueprint for Regulation*, setting out how currently banned drugs could be regulated, was launched at the House of Commons this week. Author Steve Rolles said: 'Drugs are here to stay, so we have a choice – either criminals control them, or governments do.' More in *DDN* next issue.

CARE? OR CONTROL?

Using personal experiences provided by AA group member Grace, **Sarah Galvani** asks how helpful AA/NA meetings are for women whose experiences of abuse have already left them feeling powerless, controlled and unworthy

Research evidence is clear. The majority of women receiving formal help for alcohol or drug problems have suffered domestic abuse at some point in their lives. A significant number experience ongoing abuse or continue to live with the psychological damage and fear that past abuse engenders. Often it isn't the first time – for some women the abuse started in childhood, continued through teenage relationships and into adulthood.

Domestic violence and abuse is not just about physical assault. It is a range of controlling behaviours that can wear women down until they doubt their sanity, their self worth, their right to make decisions about their body, their thoughts or their friendships. The abuse can be subtle at first and may never include physical acts of violence. Survivors of abuse report how damaging and long lasting the negative effects of psychological and emotional abuse can be. Depression, suicide attempts, flashbacks, and feelings of loneliness and hopelessness are common.

The self-help fellowships of AA and NA offer guidance and support for people facing life without their crutch of alcohol or other drugs, helping people to get in touch with the hope that they can become the people they once were or want to be. They could be perfectly placed to offer a nurturing hand to women coming to terms with both domestic abuse and substance problems. Grace joined the fellowship to take up the offer of the guidance and support and is positive about its role in her own and many people's lives:

'I have great belief in the positive influence it has had on millions of people over the years, it gave hope where before there seemed to be none, and provided a fellowship of like-minded people able to hear strangers speak and take great comfort knowing 'they were not the only ones. The fellowship welcomed me and helped me find a way of coping without alcohol...'

However as her understanding of her experiences with substances and domestic abuse have become clearer, and her sobriety strengthened, she has begun to have doubts about the AA programme's ability to support women suffering domestic abuse.

'It was only as I sponsored fellow women through the programme that I acknowledged how damaging it could be to some people, especially women who had experienced domestic abuse.'

In order to fully 'recover', the AA programme emphasises the need for people to admit their powerlessness, acknowledge their defects, turn their will over to God/higher power, and admit their wrongs and shortcomings, among others. This is particularly concerning for women suffering abuse, many of whom have already had their 'will' broken, their life controlled and have been repeatedly told how

useless they are. Grace's experience of AA highlights how the steps of AA can replicate perpetrators' behaviour rather than support people recovering from it – in Grace's case her experiences included abuse in childhood and adult relationships. Grace found the courage to raise her doubts in her AA meetings:

'When I expressed feelings of doubt about the programme and how it was making me feel, I was told I was in denial, that this was a humbling process. When I talked of feeling overwhelmed with all the things I was trying to do, not drinking, coping with the children's emotions about my drinking, I was told to "hand it over" (to God or my higher power). Once again I felt powerless, not in control of my own life that I had to "do" and "say" certain things to be "accepted" – that someone else's "will" was in control of how my life was to develop. Memories of my childhood conditioning surfaced. If I was "a good little girl", and did what I was told, I would be loved, taken care of, be included.'

For Grace, and women like her, this giving up of her 'will' in order to be accepted by fellowship members had frightening echoes of her experiences of abuse. For those less knowledgeable about domestic abuse, variations of 'I'm just doing it for your own good' are often used by perpetrators to rationalise their controlling behaviour – a pattern that Grace felt was being repeated at times in the group that was supposed to be her main support:

'I did my 12 steps, I acknowledged my "defects" – my "selfishness", "arrogance", and being resentful towards people. I was more than happy to own my defects as I knew I was unworthy, I deserved to be treated the way I had been. I was encouraged to "see and own my part" in many situations, including my experiences of abuse. So when trying to come to terms with my husband's sexual abuse of me, my part was that I had been drinking so did not protect myself. Once again I could blame myself for his behaviour, his anger, manipulation and abuse, I had something wrong with me, I was an alcoholic!'

It could be argued that the focus on 'powerlessness' relates purely to 'powerlessness over alcohol' or 'defects' relating to a woman's behaviour under the influence of substances. Given that research evidence has shown that many women drink to cope with their experiences of abuse or that their substance use is exacerbated by it, the two issues cannot be so neatly separated. And yet, in spite of the personal and research-based evidence, Grace reports how she has not yet heard anyone offering support for victims of domestic abuse in a meeting or challenging women who believe the abuse is their fault:

'I have heard women share their stories about waking up with black eyes and other injuries from their partner, but they always take responsibility for the violence, like it was their fault because they drank or they had been stroppy. I have never heard a woman say that it was wrong for their partner to have been violent with them. It is a "given" that as an alcoholic with "defects" they have a part to play in it. What does this tell us about personal power, choice and responsibility? There is no space to question why a woman drank, they are just alcoholics.'

Grace also reports how men remain unchallenged in meetings about their perpetration of domestic abuse under the influence of substances and reflects on the safety implications for their partners and children:

'I have also often listened to men talk about how alcohol made them violent. Now they don't drink "life is different today". They then go on to reveal behaviours which still come under the spectrum of domestic abuse but as they are not physically violent that's OK then! And what about the partner of this man, the children who have to live with this "reformed" drinker, carrying his badge of "humility", can they question his behaviour? Are they safe now?'

For women whose substance problems have stemmed from or worsened through their experiences of domestic violence and abuse, it is vital that they are believed, valued, and built back up psychologically, emotionally, and sometimes physically. Grace's experience as an AA sponsor has helped her take a different approach to the women she supports:

'Working with other women has given me a different perspective on the programme. I don't feel I have a right to tell another woman that she is arrogant or selfish or feeling sorry for herself. I don't think there is anything wrong with feeling sad about our experiences; this brings much needed empathy for ourselves, something often missing in women who have been abused. If, like me, you find a good sponsor, you can feel understood but I know this is not always the case.'

Because of the self-help nature of fellowship groups, Grace accepts that her experiences may have been different in other groups and that some sponsors, like her, will have greater insight and offer more appropriate support, but she remains sceptical.

'It would depend on the sponsor's knowledge and skills. My experience of some of the people who sponsor is that some are very supportive, but some use sponsoring as a means to "control" through their rigid recital of the "big book". I have heard many stories of sponsors or other "well-meaning AA members" suggesting that a woman will not find peace or "recover" unless she make amends to her husband for their behaviour while drinking."

Set within the context of domestic abuse such advice is inappropriate and unsafe.

In Grace's professional life she has worked in both substance abuse and domestic violence services and is keen to highlight how common the overlapping issues of domestic abuse and substance use are and how important it is for those in supporting roles to acknowledge and support women fully:

'It is really important to remember that many women do not even understand or acknowledge that they have been victims of domestic abuse, especially if they are using alcohol to cope, and may still be living with the abuser.'

However like many of us who have worked in health and social care, when our focus is so firmly on supporting other people we can often fail to recognise our own needs. Grace reflects:

'Even with my knowledge, experience and skills, I got lost and turned to alcohol. In spite of all my professional experience I did not see that it was my reality. It is not just people out there who experience these issues, it's about me as a knowledgeable and informed professional.'

Grace continues to attend meetings and sponsor other women and while she is critical of some aspects of the fellowship, and concerned that her experiences of abuse and those of other women have not been considered or acknowledged within it, she is open to its power to help people. She poses just one key question:

'How can a global multi-cultural programme ignore this issue?'

This article is the first half of a two-part exploration of the overlapping issues of domestic abuse and substance use. Part two (coming in January) will explore the implications for fellowship members and sponsors who support women living with these issues as well as some broader implications for alcohol and drug professionals.

Dr Sarah Galvani is principal research fellow and assistant director at the Tilda Goldberg Centre for Research in Social Work and Social Care, Institute of Applied Social Research, University of Bedfordshire. Contact Sarah.Galvani@beds.ac.uk

'Once again I felt powerless, not in control of my own life that I had to "do" and "say" certain things to be "accepted"... Memories of my childhood conditioning surfaced. If I was "a good little girl", and did what I was told, I would be loved, taken care of, be included.'

'David and his fellow scientists argue that the Home Secretary is sacking his science experts, but he was not sacked for his science... The ACMD advises the Home Office – surely this should have given David the clue that we are not just a science committee.'

ACMD losing the plot

As someone who has served the ACMD for the 9 years (1998-2007) I am very saddened to see its good name dragged through the mud. The council has been involved in some groundbreaking work, such as *Hidden harm*, *Reducing drug related deaths* and most recently its challenging report on hepatitis C. The issue of cannabis, although it dominated airtime, is of minimal importance given the considerable advice given and acted upon by the Home Office.

When David Nutt was appointed chair of the ACMD I was dismayed because I felt he did not have the skills to chair this group. He is a scientist and does not understand how policy can diverge from scientific evaluation. In his personal argument with the government he has got the publicity he craves but could bring down the role of experts from a variety of fields advising in this key area.

David and his fellow scientists argue that the Home Secretary is sacking his science experts, but he was not sacked for his science, he was sacked in his role as chairing a multi agency and expert group. The ACMD advises the Home Office – surely this should have given David the clue that we are not just a science committee.

As someone who works with drug users on a daily basis I valued the opportunity to debate and inform government. It should be noted that not all the recommendations from government are taken on, but the majority are.

Scientists view themselves as a new elite in society, the new popes in a secular society. But most, like David Nutt, do not spend any discernible time with the people suffering from drug misuse issues. To argue that horse riding is as dangerous as cannabis smoking shows his contempt for real debate. He picks up a stat and tries to make a political point. He fails to understand that horse riding is a physical activity, thus in itself more healthy than sitting in one's room smoking a joint and gradually becoming less fit. The point being that one has to look at the facts around an activity not just the activity itself.

I hope that ACMD members remember that David Nutt is not a martyr and that if one wants to resign it is better to do so in relation to true debate rather than personality clashes. I hope that members remember that they are there to provide help in a field that needs expertise and that over the years, with the right leadership, the committee has made a real difference. My anger is therefore at the government for their poor choice of chairman, and at David for proving me right that indeed he has not been up to the job.

Martin Blakebrough,
chief executive, Kaleidoscope

Bad lessons

A school metaphor helps make sense of the recent sacking of Professor Nutt by the home secretary for publicly stating that many illegal drugs are less harmful than alcohol and tobacco. In short, student Nutt was not expelled, as headmaster Johnson claims, for campaigning to change the school policy toward drug use – he was expelled for writing an essay about drugs which made points that the headmaster disagreed with.

Dr Russell Newcombe,
senior researcher, Lifeline Project

World gone mad

I would like to add a few of my own comments in relation to the 'Climate of negativity' (*DDN*, 2 November, page 9).

It seems that the world has gone completely mad. Despite the protests from service users, workers from other partner agencies and our own workers, the decision to withdraw from providing counselling has been made on the recommendation of the NICE guidelines.

It is well known (as well as common sense) that underlying problems more often than not lead us into using mood-altering substances. It takes time and expertise to establish the 'therapeutic relationship'.

What I see happening over and over again is people being discharged from treatment services due to non-compliance. In other words 'do it this way or not at all'. Services are becoming so driven by the 'tick box' approach that they are forgetting we are in the business of helping people recover or discover their lives.

Janice Hooper, via email

Strange bedfellows

The campaign to bash the NTA seems to be creating some new and startling allegiances. The old adage that 'the enemy of my enemy is my friend' would seem to hold true, especially at *Addiction Today*. They produced an online critique of the NTA under the headline 'Dodgy Dossiers of Addiction Non-Treatment' (at www.addictiontoday.org).

What was amazing was one of the sources quoted by *Addiction Today* – a Mr Tony Wilk of New Ways Clinic. This 'clinic' promotes the wholly unproven and highly implausible 'bioresonance' treatment to remove drugs of addiction from the body. Wilk wants to promote bioresonance and does so by knocking all other treatments, including 12-step groups, residential treatment and substitute prescribing.

NTA-knockers are manna to New Ways Clinic and Wilk produced a press release in October on the one-hand to knock the NTA and on the other to try to gain New Ways Clinic more credibility. The press release reached *Addiction Today*, and so they happily quoted 'Tony Wilks of London- and Manchester-based New Ways Clinic' to bolster their denigration of the NTA.

It seems that in their quest to demonstrate the inadequacies of the NTA, it just doesn't matter who you quote or cite or wheel out to support your argument. It seems it is OK to reference a banned company director, who markets a bogus treatment, as long as it has a dig at the NTA. It's somewhat akin to quoting Ponzi scheme fraudster Bernard Madoff to have a poke at Lloyds Bank.

Thanks to *Addiction Today*'s citing of the New Ways Press Release, this now appears third in a Google Search for the clinic. Good going!

Molly Zerowski, Halifax

Opening doors

I was interested to read 'Culture of innovation' (*DDN*, 5 October, page 14). I work within a GP surgery setting in Northampton and we deal with a high volume of clients that are mainly shunned from other GP surgeries for several reasons. We have a high volume of mental health, foreign nationals, substance misuse and violent clients – to name but a few.

We hold ourselves proud to deal with all clients in a holistic way, thinking in zigzags rather than straight lines. When treating addictions we find it is more successful when getting to the core problems and thus dealing with them, rather than leaving the client to immerse themselves in another substance, which does not diminish their problems. However once stable in treatment, we can start looking into their problems and help to get them into the benefit system and housed.

When these simple human needs are met we can then start the work of helping the client to repair the past. I would argue that it is not an expensive funding issue, but one of time. If keyworkers were trained in simple things like the benefit system and community housing, surely a simple phone call to a link person within that field would help the client.

As we are aware, certain clients do not have the ability to address such problems if they are socially isolated and psychosocially immature. Our ethos is to help clients to access health and social care, which ranges from substance,, to personality disorders to the socially unacceptable – and for both clients and us, it works well.

Sue Woodcock, clinical support coordinator, Maple Access Practice, Northampton

We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3.

Cross-party report

Recovery, ISA, and of course the ongoing crisis at the ACMD, dominated the latest meeting of the Cross-Party Group on Drug and Alcohol Treatment and Harm Reduction

The latest meeting of the cross-party group took place on 3 November in the House of Commons. The original agenda involved discussing a briefing paper on the 'recovery movement', submitted by Paddy Costall from the Conference Consortium, and a discussion with Adrian McAllister, chief executive of the Independent Safeguarding Authority (ISA) on how the new legislation will affect employment in the drugs field. The recent news of Professor David Nutt's resignation as chair of the ACMD inevitably led to a late agenda item, to discuss its impact.

Paul Flynn MP started the discussion, saying that, with the honourable exception of the Liberal Democrats, it had been a 'day of shame for parliamentarians and that there had been no humility on the part of any politician that things have gone wrong'. Flynn was concerned that 'the irrational debate we have is being used to stoke up prejudice against the kind of rational debate we want'.

Lord Benjamin Mancroft commented: 'The home secretary is entitled to reject the evidence. While the ACMD does not make policy, it is entitled and obliged by law to offer advice. Politically and morally, if the home secretary rejects the advice, he has an obligation to tell us on what evidence he does so.'

Other members of the group were quick to voice their concern over the circumstances around Nutt's resignation. Andy Stonard from the Conference Consortium was worried that 'the shenanigans that have gone on in the last few days are harming treatment', while Kevin Malloy from KCA asked: 'If evidence can be dismissed so lightly, where does that leave the rest of drug policy?'

The recovery briefing paper looked at how harm reduction fits into the new drive towards a recovery agenda but warned against increased polarisation between abstinence and harm reduction. Kevin Malloy, who presented the paper, voiced the concern that a move back to a 'treatment system based on abstinence might increase drug related death, blood borne virus and drug related harm.' Malloy agreed that services should look beyond methadone maintenance treatment but warned that 'we should look for a rebalance but not a total move to abstinence'.

Professor Gerry Stimson, executive director of IHRA, made the point that 'It's dangerous if you're going to put all money and focus into recovery and abstinence. Harm reduction often involves low cost high impact interventions.' Steve Hamer, chief executive of Compass, said he believed that the polarised debate did not stem from any great ideological differences but 'incompetent implementation of a good policy. People don't know how to access tier 4, and tier 4 is left crying about its lot,' he said.

Adrian McAlister, chief executive of the Independent Safeguarding Authority (ISA) mapped out the exact process the ISA will take when assessing individuals under the new scheme. He sought to allay fears that the new legislation would impact heavily on employment within the drug field, as many volunteers and staff held previous criminal convictions. McAlister explained that, apart from serious sexual offences, there was no instant barring, and each case would be open to appeal. A person's offence could be mitigated by several factors including time since it occurred, and their employment record. There were still specific issues faced by the substance misuse field, especially around volunteers and employees who were not long out of treatment, and McAlister agreed to meet members of the group at a later date to discuss their concerns in more detail.

Recovery paper at http://tinyurl.com/crossparty

Post-its from Practice

Eat, drink and be wary

Drinking and obesity is fuelling a liver disease crisis among the middle-aged, warns Dr Chris Ford

I have known Mrs Brown for over 20 years, having been her GP through her children's illnesses, the collapse of her first marriage and her delight in meeting the love of her life in her forties. She rarely visited me for her own health reasons until her acrimonious divorce, which resulted in high anxiety and insomnia.

She had always liked a drink but the amount she consumed increased during that period. However much we talked about it, she remained convinced that alcohol helped. Her food consumption also increased during that time but she decided she would address both when the divorce was over.

But of course that didn't happen, and she continued to eat and drink when she was happy. She declined counselling, suggestions to try AA and other self-help groups and her weight continued to increase. After a break of about six months she came to see me, concerned about the weight she had put on around her middle. Her friends had also begun asking her when the baby was due – at the age of 59!

Examination showed not only further weight gain, but a swollen liver as well. I asked her again about her drinking and she admitted to half a bottle of vodka three or four times per week, equivalent to 45-60 units a week along with cakes and chocolate bars daily. I suspected fatty liver disease which was confirmed on ultrasound.

Fatty liver disease is not a benign condition and can be caused by either drinking or obesity or both. It is fuelling the liver disease crisis among middle aged people in the UK. The average age of those dying of liver disease has fallen to 60 for women and 58 for men – four years lower for both sexes than 25 years ago.

Liver disease is the only major cause of death that is increasing year on year, with the rate doubling in the last decade. It is already the fifth biggest killer, after cancer, respiratory disease, heart disease and stroke – and it is set to overtake the latter two in as little as two years. It is also a much bigger threat to people in middle age, compared with heart disease and stroke, where the average ages of death are currently 82 and 84 respectively.

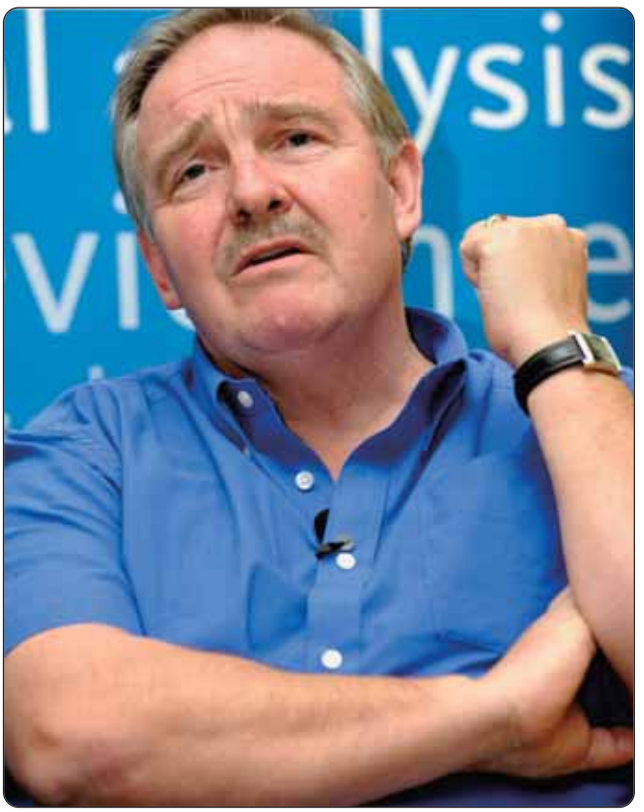
The Department of Health is so concerned that they have appointed a liver disease 'tsar' to introduce a national strategy to combat the crisis. The tsar will decide whether to support liver screening blood tests for all over-40s and a call for more specialist liver doctors.

The impact of alcohol intake on the liver is well known. Last year, 105 people a day were admitted to hospital with a primary or secondary diagnosis of alcoholic liver disease, but many do not realise that obesity is increasingly a cause of liver disease. As many as one in five people now have evidence of non-alcoholic 'fatty liver' disease. More than half a million people in England could end up with obesity-related cirrhosis of the liver, with many of today's obese adults dying in their 60s and 70s with liver failure.

Mrs Brown has managed to stop drinking and her liver function tests have improved, but her weight continues to rise. As such, the risk remains of her dying from liver disease.

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical lead for SMMGP

To become a member of SMMGP, receive bi-monthly clinical and policy updates, and be consulted on important topics in the field, visit www.smmgp.org.uk.



A fortnight of chaos left the ACMD in disarray. As it attempts to regroup, DDN talks to Professor David Nutt, the sacked chair at the centre of the dispute.

Watershed for the ACMD?

THE ADVISORY COUNCIL ON THE MISUSE OF DRUGS and the home secretary have just issued a joint statement on ways of working together collaboratively in future – the government's attempt to patch up a hole that was getting deeper by the day.

Alan Johnson's dismissal of the ACMD's chair Professor David Nutt provoked a storm that shook the independent committee to its core. Five members of the council resigned in protest, with the role and relevance of the remaining members being called into question.

The affair began quietly enough, with Nutt's speech for the Eve Saville lecture in July, which drew media attention when it was published in October as a briefing paper by the Centre for Crime and Justice Studies. Among the detail of the paper, which looked at how to estimate drug harms, Nutt had stated the need for 'proper debate about evidence and drugs – what the appropriate penalties are and why we aren't doing more to deal with alcohol'.

In the course of looking at the drug classification system, he criticised the government's decision to reclassify cannabis to B, ignoring the ACMD's recommendations that it should remain class C.

For this reason, the home secretary accused his chief drugs advisor of undermining the ACMD's scientific independence by lobbying for a change of government policy. 'You cannot have a chief adviser… campaigning against government decisions,' said Johnson.

Nutt reacted furiously, on his own account and that of the ACMD. 'Let me be absolutely explicit about this,' he told *DDN*. 'The lecture was prepared in cooperation with the Home Office. They actually gave me data. We went through the talk and actually orchestrated it in a way that would be interesting, but also what you might call proper political boundaries.' Furthermore, he says: 'I made it very clear that the paper was not presented with my ACMD hat on.'

He adds: 'My anger, which has been boiling up for the last three years has come out… I don't believe I crossed the line.'

He likens his situation to *Alice in Wonderland*, with the home secretary as the Red Queen saying 'the line is where I say it is'.

'He waits till I move and then he draws the line behind me,' says Nutt. 'I've no idea what's going on. I think Alan Johnson was badly advised and that there's a legacy of antipathy towards me. I think Jacqui Smith hates me – she visibly angered when my name was mentioned on *Question Time*. There are people at the Home Office who feel that I should have gone then and are using the chance to get at me now.'

But Nutt is not about to disappear. On the contrary, his sacking has convinced him of the need to build on public interest in the case and examine the issues in depth. 'I'm amazed by how many people have said to me, "thank God, at last someone's talking the truth",' he says.

And that truth, according to Nutt, involves acknowledging that 'alcohol is the big problem at the moment… keeping the price of alcohol so low is clearly having a huge negative impact on public health.

'We've heard so many platitudes that we've got to be hard on drugs, we've got to bang people up. But it's alcohol that's destroying our city centres – that's what's destroying our kids. What we've really got to do is deal with alcohol.'

The media interest has been both help and hindrance, he says, as the matrix of drug harm didn't translate easily into soundbites. Within 30 minutes of doing the *Today Programme* he was on News 24 and the frenzy had not subsided when *DDN* caught up with him just as he finished an interview with BBC Southampton.

'Most interviewers hadn't a clue what I was talking about and were saying "so you think we should all take LSD instead of alcohol?" But what I was saying was, if you want to reduce harm in this country there's no point in worrying about LSD. Focus on alcohol. A lot of the focus on drugs is a way of ignoring alcohol – a sense of doing something, but doing nothing.

'But talk about the oxygen of publicity! I think the landscape has now shifted. At least people know there's one person out there that they can trust, who will tell the truth about drugs.

'People want the truth, they don't want government rubbish,' he adds. 'So I don't see how the ACMD can continue to be viable because no one will trust them. The independent experts will be the people I presume they'll come to.'

And the support from colleagues and the public has given Nutt the confidence to consider turning the humiliation of dismissal into an even sharper thorn in the government's side:

'If we don't get an appropriately independent ACMD, I'm going to found an alternative,' he says. 'A lot of scientists on the ACMD have agreed to join me and I've got a backer who's prepared to underwrite it. So we can actually do it – we can have an independent think tank advisory group.' **DDN**

Overdose management is the icing on a multi-tiered cake, say Stephen Donaldson, Lisette Abrahams **and** Marian DeRuiter

Covering the bases

OVERDOSE MANAGEMENT has traditionally been targeted towards opiate clients, as evidence identifies them as being most at risk. In Surrey, overdose management courses in the community are facilitated by a tier 2 service, the harm reduction outreach team, which reports that a greater number of poly drug users – particularly heroin and crack users – are now attending.

Overdose management groups have been offered for a number of years by Woking's Xchange project, a drop-in and needle exchange service, with good liaison with the tier 3 Windmill community drug and alcohol team to ensure those in need of overdose management skills are referred.

A joint approach between tiers 2 and 3 was initiated to increase the numbers attending the courses and ensure the needs of service users were being met. Many of the staff at the Windmill team have attended a 'train the trainers' session and now co-facilitate the community overdose management courses, while service users also attend the 'train the trainer' sessions, helping them develop into effective peer educators.

This collaborative approach between clients and staff has been very successful – staff find it useful to gain up-to-date information from the clients about the difficulties they face in staying safe, and what combinations of drugs are being used, while for clients the course offers an opportunity to discuss their experiences of overdose openly, sharing experiences with peers and staff.

Tier 4 has traditionally been less likely to be seen as the right environment to offer overdose management, as clients are frequently aiming for abstinence – overdose management could be regarded as conveying the message that they may return to using and not sustain their goals. The other issue is that admissions into Windmill House in Surrey are for all substances, including alcohol, meaning opiate-focused overdose management would not be appropriate for all clients.

Despite these issues, there is strong evidence that those in detox, or who have recently stopped using or drinking, are at increased risk of medical emergencies – overdose or acute poisoning – following a period of abstinence and in an attempt to address this, a joint overdose management group was established in Windmill House.

To ensure inclusivity the focus was on medical emergencies associated with all substance use – the group explored the risks arising from heroin, cocaine, alcohol and prescribed opiate-based medications and benzodiazepines, as well as the risks of combining these. This joint approach between tiers was invaluable, allowing skills and knowledge to be shared to develop a comprehensive package to support clients to reduce the risk of harm in the event of relapse.

'There is strong evidence that those in detox, or who have recently stopped using or drinking, are at increased risk of medical emergencies – overdose or acute poisoning'

Feedback from the group has been extremely positive, with all clients reporting that their awareness of the causes and management of medical emergencies has increased. Clients are actively encouraged to share their experiences of emergencies they have witnessed or experienced for the benefit of others in the group. Those attending the course are also encouraged to pass on the information to family and friends, supporting clients to be peer educators.

So while the tradition has been to focus on opiate clients and their risk in overdose, there is a clear benefit of ensuring overdose management advice is given to all clients irrespective of their substance of choice, especially in tier 4. We would like to hear from other services that have developed similar packages, and their experiences of providing this type of intervention – it would be interesting to know what information services include in their overdose management groups, as a means of sharing good practice.

Stephen Donaldson is substance misuse specialist, Windmill Team.
Lisette Abrahams is exchange manager, Surrey harm reduction outreach team.
Marian DeRuiter is consultant psychiatrist, Windmill Team. Contact the team on 01932 723 309.

Detox is just as much about the psychological as the physical and services ignore this at their peril, argue **Nick Barton** and **Tina Mobsby**

Detoxification is the medically managed withdrawal of, and from, chemicals on which a person has formed a physical dependency. Since it involves medicines and skilful care of the body's reactions to them, it's all too easy to think of the detoxification process as a purely physical matter – a technical, pharmacological intervention – and often one that has to be got out of the way before getting down to rehabilitation and recovery.

Of course it is a biomedical intervention but by no means only that. One might argue that those who approach the management of detox from such a limited perspective betray a lack of understanding of addiction – they miss not only the opportunity to maximise the benefits of the medical treatment to achieve safe and early withdrawal, but they also risk reducing the chances of achieving the broader, longer-term outcome of recovery and wellbeing. It's as well to remember that we are treating addiction, not simply intoxication – that is why a fully integrated approach, with detoxification embedded *within* a psychosocial change programme, makes more sense than the traditional sequence of a discrete medical treatment followed at some point by a psychosocial intervention.

The trouble is that the old separation persists, to a large extent because historic commissioning and funding arrangements effectively keep it that way. There also seems to be a commonly held belief that clients are not ready to experience the one until they have undergone the other. Experience tells us otherwise, and we do a disservice when we underestimate what clients can achieve.

Detox is a necessary process for achieving and maintaining an alcohol and drug free state – a key staging post. The keys to the success of recovery as a whole, however, lie almost entirely in the psychosocial domain. The person undergoing physical withdrawal is in a state of mind that will both affect and be affected by that withdrawal – one that will inevitably have a direct bearing on their engagement with treatment and the process of change as a whole.

Personal psychological dynamics do not slip conveniently into neutral simply because of an intervention occurring at the physical level – withdrawal, like addiction, is a psychological as well as physical process. The patient may no longer be intoxicated but the underlying (partly unconscious) dependent relationship to substances, which is where vulnerability to relapse lies, may have changed little.

Relationship is an important word in this context. Addiction is often best understood as a consuming relationship with a substance or behaviour, and relationships operate primarily in the realms of feeling and thinking. The relationship to mood-altering chemicals is no different. The attachment to alcohol or opiates is not just a matter of the body's acquired dependence on the chemicals to stave off the symptoms of withdrawal – the *thought* of being without them arouses anxiety, from fear of physical discomfort or the prospect of being without them for any length of time, while the thought of imminently obtaining them produces an anticipatory mood elevation or 'buzz' of its own.

Handing over the management of drug intake to someone else involves letting go and is therefore a matter of trust. No matter how much control has already been lost in the addiction, the necessary loss of control in submitting to medically supervised detoxification is likely to cause anxiety.

It stands to reason that the management of withdrawal must take account of the psychological aspects of the relationship – how people feel about the process in general, including the context in which it occurs, and about the particular mode of detox to be applied to them. Indeed, anything that might affect how the person feels about detox needs to be considered. The UK *Orange book* guidelines on clinical management state: 'A full programme of psychosocial support needs to be in place *during* [our italics] detoxification.' While fully endorsing this prescription we should note that it does not suggest what such a programme might consist of, or make any reference to things that might affect the way the process is experienced or how that may influence outcome.

It's also quite a surprise to discover that NICE guidelines on detoxification make no reference to the psychological aspects of this process other than a passing nod to the patient's treatment preference. The guidance focuses solely on the administration of the pharmacological treatment – a serious failing as it ignores the very areas that are the real keys to addiction and critical to withdrawal, recovery and relapse.

Bearing in mind that patients bring to their treatment all manner of mental health issues as well as treatment-specific beliefs, hopes and anxieties – often based on previous experiences – it's wise to discover what those might be and a good idea to ensure that everything relating to the management of withdrawal is as positive as it can be. It's essential for patients to make informed decisions regarding their medical treatment, and sensible not to overplay the importance of the withdrawal process, encouraging a focus on recovery instead. Our view is that this is more easily achieved when detoxification is undergone *within* the context of a psychosocial treatment and recovery programme rather than separately – people are more easily diverted from any tendency to isolate themselves with morbid preoccupations about their physical state.

Everything that goes into conducting that psychosocial programme will have a bearing on the experience of withdrawal and thus engagement with, and completion of, treatment. This will include the physical environment, the staff and organisational culture, the food and other aspects of care. The context needs to optimise the conditions for achieving withdrawal as early but as safely as possible. A collaborative approach helps avoid it becoming a purely 'done-to' experience – if a person feels supported, well cared for and in good hands, it will be easier for them to let go of their attachment to substances in both the physical and psychological sense.

While it's always essential to treat each person as an individual, a sense of shared purpose among the patients may be as important in keeping people on track. The availability of supportive peers at different stages of treatment may also help – patients may draw inspiration from those ahead of them in the process, while in others they may be reminded of conditions they are relieved to have left behind.

The question arises, however, as to whether people should be shielded from all discomfort associated with withdrawal or if there is some benefit to be had from

RECOVERY MINDED

keeping people in touch with one of the realities of addiction. Or should we make it as easy as possible to help the person focus on psychological and lifestyle change instead of physical sensations? Patients puzzle over this and it's interesting that opiate addicts in particular frequently hold the view that it's good for the process not to be too easy.

It's our experience that patients often compare experiences and even, in some cases, compete. If we can minimise potential distractions that might be inherent in managing a wide variety of detoxes in one setting, patients will be able to focus to where it is most needed – on recovery. While it will always need to be tailored to the individual, a broadly uniform approach to managing withdrawal within a particular unit has its merits.

The communications of the staff, whether overt or indirect, are also critical as they give more or less subtle messages that may directly affect the person's experience. The 'therapeutic relationship' should be just that – it sometimes breaks down if, for whatever reason, part-time staff are frequently on duty. Full-time staffing affords much more continuity and consistency of messages, which gives confidence to the patients.

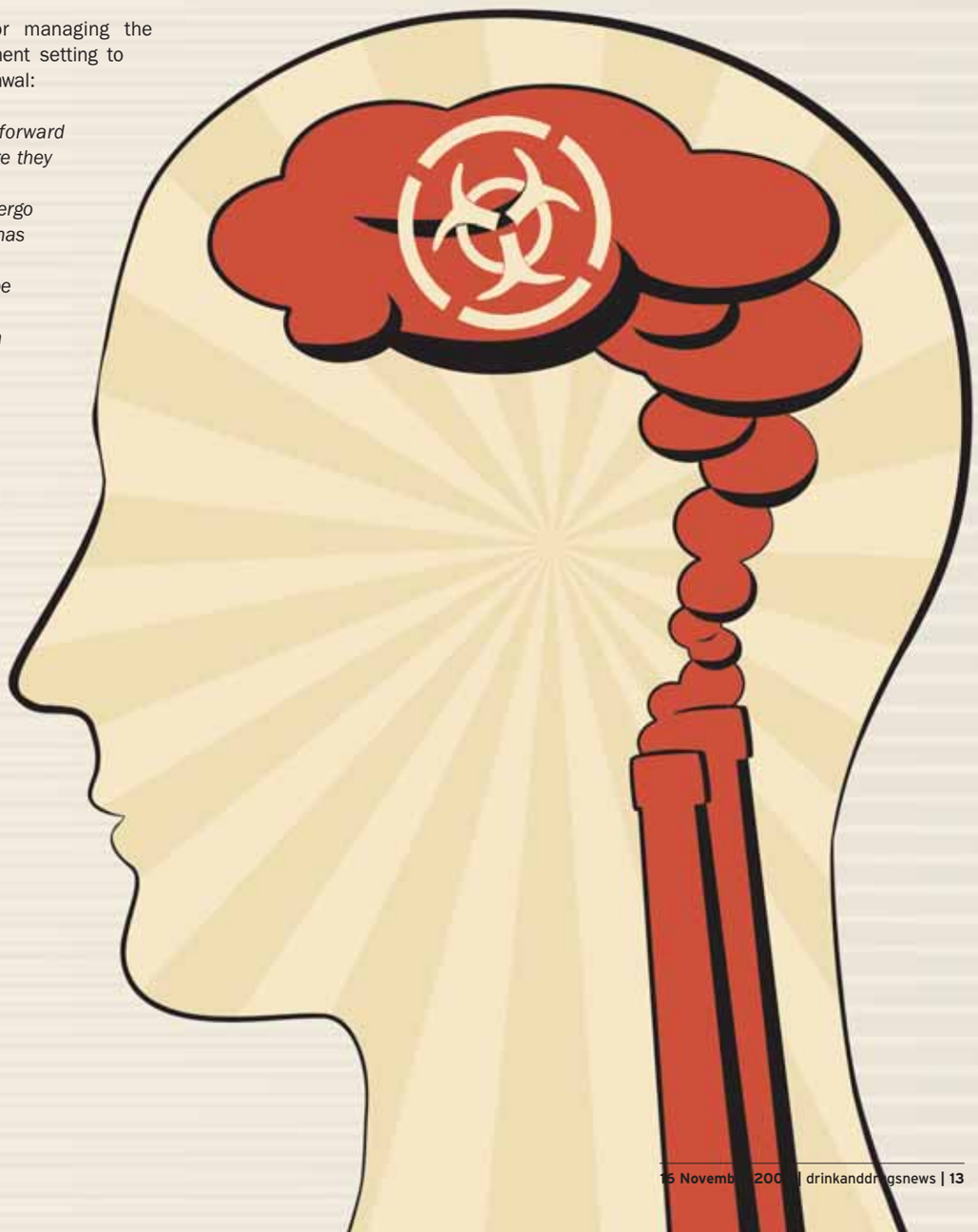
The medical and nursing staff must also be fully in tune with the psychological treatment and recovery programme, working in an integrated and complementary fashion with their colleagues. Patients' lives are so often fragmented that it makes little sense for those treating them to operate in the same way – integration is the key.

Here, then, are our 15 key considerations for managing the psychological aspects of detox in a residential treatment setting to improve the chances of successfully completing withdrawal:

1. *Ensure that people have excellent, straightforward information about the facility and its approach before they arrive.*
2. *Recognise that, in making the decision to undergo withdrawal, a process of psychological change has already begun.*
3. *This step may excite anxiety, which will need to be contained.*
4. *Inform openly, show respect and empathise. Take a collaborative approach.*
5. *Recognise that many patients will have had previous experiences of detox and may hold strong views.*
6. *Foster an approach that takes the drama out of detox. Focus on recovery, rather than withdrawal, from the word go.*
7. *Offer complementary alternative therapies where appropriate.*
8. *Apart from prescribed medication, maintain a well-boundaried alcohol and drug free environment.*
9. *Foster a 24-hour atmosphere that is positive, encouraging, supportive and optimistic.*
10. *Encourage a mutually supportive community spirit among patients.*
11. *The presence of people who are further along in the process can be a great help and encouragement.*
12. *Help people to engage in the psychosocial therapies as early as possible. Do not wait for detox to be completed.*
13. *Ensure staff are confident, knowledgeable communicators and able to mix professionalism with humanity.*
14. *Foster an integrated approach between medical, psychological and other staff.*
15. *While taking full account of individual needs, a regimen that varies as little as possible from one patient to the next can benefit everyone.*

Nick Barton is chief executive of Action on Addiction. Tina Mobsby is nurse team manager at Clouds House

Next issue: Brendan Georgeson looks at community detox



'Detox is a necessary process for achieving and maintaining an alcohol and drug free state – a key staging post. The keys to the success of recovery as a whole, however, lie almost entirely in the psychosocial domain. '

TALK MY LANGUAGE

As a glance back through our letters pages will show, recovery can mean many things to many people. **DDN** reports from a DrugScope conference that aimed to put it all in context.

'It's about giving people hope and not telling them they've been written off by society and are never going to amount to anything.' Chair of the National Survivor User Network, Tina Coldham, was giving a mental health sector service user's perspective on the meaning of recovery to delegates at DrugScope's conference *Drug treatment at the crossroads – where next for the recovery agenda*?

Recovery was a much more long-established concept in the mental health field than in drug treatment, and yet still generated considerable heated debate in that sector, said DrugScope chief executive Martin Barnes. 'Recovery is a term for an approach that many of you have been trying to apply for decades,' he said. 'Treating the person, not the problem.'

All speakers agreed that crucial elements of recovery were housing and employment opportunities. However, while the commitment in the most recent drug strategy to improving reintegration was welcome, barriers to accessing employment and housing remained entrenched, said Barnes. 'When people put themselves forward to treatment they open themselves up to stigma.' The record investment in drug treatment was also based on the link with crime, he said. 'In making the case for funding we risk reinforcing stereotypes and saying that only the politics of fear can convince the public of the case for investment. We shouldn't be naïve about it, but we need to raise public awareness of the complexities of the issue.

'The complex nature of treatment is all too often presented as an "either/or" between harm reduction and abstinence,' he continued. There was now a broad consensus that 'parking people on methadone' was not enough, but treatment services needed to support both approaches, he said. 'Just as there are many routes into drug dependency, so there are many routes out. There's no silver bullet.'

Recovery was about giving 'often chronically excluded people a stake in society and a chance of a new life,' he said. The government's commitment to steering people towards support was laudable, but the fact remained that its welfare reform proposals veered too far towards the punitive, he told the conference. Claimants' refusal to answer questions about their drug use could lead to benefit sanctions, and there was also a proposed power to require people to undergo drug tests (*DDN*, 28 July 2008, page 4). He welcomed the fact that the requirement to undergo treatment no longer formed part of the proposals (*DDN*, 2 November, page 4), but said he hoped the government would 'consider whether drug testing has any place in our benefits system.'

'The people who are clued up and streetwise will get their benefits and go off and do whatever it is they normally do,' said James Sadler of service user organisation DATUS. 'The people who are vulnerable will pay the price. We threaten people with prison and they don't stop using – what makes people think stopping 25 per cent of their benefits will? They'll go off with someone's DVD player instead.'

The system was one that was built to address social harm, he said. 'Once people aren't committing crime or spreading blood-borne viruses, that's it – job done.' Recovery should always be an agenda with key workers, he stressed. 'Recovery is a personal choice, it should be decided by the service user and it's the system's job to facilitate that. Recovery is not reducing your script, it's about rebuilding your life, developing social capital, having a social network that has a

positive – rather than negative – effect on your life. Recovery is only partly about addressing drug use. Drug use is a symptom of a problem – most problematic drug users are medicating themselves to hide from life. '

There was a major crisis in treatment at the moment and two things needed challenging, said David Best, reader in criminal justice at the University of Western Scotland. The first was the concept that 'we're doing well enough on recovery as it is'; the second was that 'no one really recovers', which simply functioned as an excuse to set the bar low.

There was a range of reasons why recovery was described as a pointless goal, he said – "it's not our job", "other professionals outside of the field can't be trusted" and "my clients don't want recovery". The last was 'perhaps the most insulting', he told delegates. 'If you tell someone they've got a chronic, relapsing condition why would they want recovery? What we've offered people is not methadone treatment, it's a methadone filling station. There's no wraparound support.'

Another frequently-cited argument was that the recovery movement was 'abstinence based and oppositional', he said. 'But why is there no recovery movement in maintenance programmes?' It was not that a medicated recovery programme was not possible, he said – it just wasn't being implemented. 'We haven't done anything to generate a long-term recovery process. It's all about symptom management.

'We can only be the supporters of long-term trajectories of change,' he continued. 'The risk with a medicated system is that we medicate through those windows of change.' The recovery movement was not about the management of symptoms, but a long-term process of personal change where key factors were support from partners, having a job, and social relationships.

'The task is one of switching services to something more ambitious, and enabling growth,' he said. 'We need to identify and celebrate all the successes that go on out there.' This meant that the silos of treatment, the voluntary sector and mutual aid could no longer remain as silos, he said. 'We're so caught up in an oppositional model and the flaccid scepticism of entrenched interests who refuse to give up their slice of the pie.'

CEO of Lifeline, Ian Wardle, told delegates that, while he represented the mainstream of the field and David Best's language was more 'challenging and radical', nonetheless both positions found themselves in the same place – 'faced with the most profound financial crisis of our lifetimes.'

The government had shown an 'irrational and schizoid' approach to substance misuse policy, he said, cosying up to the drinks industry on the one hand while punishing minor drugs offences with prison on the other. This meant that recovery had to 'take its place in a real political context.' 'Harm reduction and recovery are profoundly political,' he said. 'To deny that is folly.'

Organisations like his own aimed to transform their practice to identify at an earlier stage the opportunities for transformational change, he said – a key thing here was the workforce. In the best organisations, people from top to bottom were 'absolutely committed,' he said. 'My focus is on how we get our workforce, our management, our systems right.'

Using the resources of the community was 'utterly fundamental', so that people could gradually move out of having 'a career' in services,' consultant psychiatrist in Bromley Assertive Community Treatment (ACT) team, Geraldine Strathdee, told the conference.

So how would people define recovery? 'There are a lot of prescriptions for recovery – this is a warning from mental health,' said Tina Coldham. 'If you Google "recovery in mental health" you'll get all sorts of stuff, but if you take anything from the mental health field, take the fact that peer support is the way ahead.'

'Recovery implies that something still needs fixing, like a car being recovered by the AA,' said Simon Parry of Morph. 'It implies that there's an end point and that "you're not quite there yet", and it smacks of fellowship language as well. But I haven't got a nifty replacement.'

Tina Coldham suggested 'resilience' – 'you still have this issue but you're able to go on with your life' – while James Sadler said 'sustained control' might be more suitable. 'But how you achieve that is up to you. We can't make choices for people about their recovery, because that negates their recovery. If recovery isn't based on personal choice then it isn't recovery.'

'Recovery is not reducing your script, it's about rebuilding your life, developing social capital, having a social network that has a positive – rather than negative – effect on your life.'

DDN Diary Dates

30 November 2009

The NEW Training and Development Directory. If you or you organisation provide training in any area of the substance misuse field, make sure we have all your details for a free listing!

30 November to 18 January 2010

DDN Christmas Break – Following our next issue (30.11.09) DDN will be taking a break from publishing over the Christmas period. Online only advertising options are available throughout this time and you can pre-book advertising space in the first issue back – Monday 18th January, 2010.

18 January 2010

The Residential Treatment Directory
The latest issue of this biannual, comprehensive directory will feature as a 'pull out and keep' section in the first DDN of 2010. Please check, or submit, your treatment provider's listing.

To enquire about any of the above please contact Faye Liddle on 020 7463 2205 or email faye@cjwellings.com

Bournemouth Borough Council

Lansdowne Road

Senior Practitioner

Ref: AT0177, £29,236 - £34,549 includes AMHP increments, 37 hours per week

Bournemouth Drug and Alcohol Action Team (DAAT) is a partnership of statutory organisations, and is the lead commissioner for substance misuse services within the Bournemouth area. We have pioneered the development of a single point of access to substance misuse treatment services through a dedicated Assessment Team.

You will be a member of a forward thinking, multi disciplinary team based within a third sector provider, with responsibility for undertaking assessments, implementing, monitoring and reviewing care plans. You will have a focus on the safeguarding vulnerable children and adults agenda as well as mental health issues that may present with substance use.

Working with service users, carers and other professionals, you will provide support and work towards developing these roles within the team, along with the working practices with partner agencies.

For an informal discussion, please contact Karen Wood, Joint Commissioning Manager on 01202 458740.

For more information, closing dates or to apply online for ANY of our current vacancies visit http://jobs.bournemouth.gov.uk

Alternatively, an application pack may be obtained via:
e. recruitment@bournemouth.gov.uk
t. 01202 454775 or 01202 458838 (24-hour answerphone)

This post is subject to a pay and grading review which may result in a change to the grade and salary.

Closing date: 20 November 2009.

Stonewall DIVERSITY CHAMPION

The Council is committed to achieving equal opportunities and a work life balance. Bournemouth Borough Council does not accept CVs without an application form.

A new alcohol service for Hull. A new job for you.

Action for Change works to support people who have problems caused by alcohol and drug use. Action for Change has secured new funding from NHS Hull to improve and expand the help provided to Hull's residents misusing alcohol.

Service Manager — Hull — £29,650 p.a.

You will lead the delivery and development of the Hull alcohol harm reduction service. The service will provide a range of information and education activities and a range of prevention and treatment interventions, aiming at containing and reducing alcohol consumption levels amongst vulnerable people and the general population in Hull.

You will create an outcome-focussed culture, seeking to constantly improve the service and the performance of service staff.

Project Workers — Full-time / part-time available

£21,952 p.a. (pro rata for part-time) — Hull

You will provide a range of alcohol services across the city of Hull, including 1:1 sessions at Open Access clinics, assessment, brief advice and interventions. Applicants with training experience or qualifications are welcomed.

Administrator — Hull — £15,258 p.a.

You will ensure that the service provides a first class administrative system, undertaking a range of clerical and secretarial tasks to support the work of the team, and providing a welcoming approach to visitors.

To apply, email reception.hh@action-for-change.org. No CVs please. Closing date: 23/11/09.

All posts include 27 days annual leave entitlement, plus 5% pension employer contribution. All posts subject to Enhanced CRB check and required to work some weekends and evenings. Action for Change is an Investor in Volunteers and a Mindful Employer. Action for Change seeks to be an Equal Opportunities Employer, and welcomes applications from all sections of the community.

www.action-for-change.org

Registered Charity No. 1043142
Company Registration No. 2920770

MINDFUL EMPLOYER

@ction for hange

Books about drugs are not just for life...

They're for Christmas

A million titles available at www.ddn.eclector.com

Tackling the harm and impact caused by drugs and alcohol

Cranstoun Drug Services is a non-profit, independent charity and leading provider of specialist services to those affected by drug and alcohol use.

Development Manager

Central Office, Surbiton

£28,353 - £33,328 plus £1,740 OLW

Supporting the Head of Development, this is an exciting new opportunity to take responsibility for the organisation's business development strategy, functions and outputs. You will enhance existing contracts, develop and co-ordinate new business tenders, carry out market research and investigate industry development and competitor analysis.

You will be able to contextualise a comprehensive range of information and incorporate this into presentations and reports. You will also identify new business opportunities and be pro-active and self motivating. Excellent oral and written skills are essential and experience in health care/alcohol intervention is an advantage. **Ref: 536**

To download an application pack visit www.cranstoun.org
Unfortunately we are unable to accept CVs.

Closing date: 18 November 2009.

We welcome applications from all sections of the community.

Working towards equality.

Registered Charity No. 1061582

INVESTORS IN PEOPLE

Cranstoun drug services | 1969-2009 40TH ANNIVERSARY

www.blackburn.gov.uk

Blackburn with Darwen Borough Council has been rated as an "excellent" council by the independent audit commission. This is a real achievement not only for the council but also for our many partners and the local people who work with us to improve their communities. We are a modern, forward thinking council and work hard with our partners to provide good services which make a difference to the lives of everyone living in the Borough.

BLACKBURN with DARWEN BOROUGH COUNCIL

Neighbourhoods, Housing and Customer Service
Joint Commissioning Manager

Blackburn Town Hall, Blackburn, BB1 7DY
Grade I SCP 40 - 44 £33,663 to £37,206 p.a.
Temporary until 31st March 2011, 37 hours per week

The Drug and Alcohol Action Team require a Joint Commissioning Manager who will take the lead on all financial and budgetary responsibilities, conducting and overseeing the key components of the Drug and Alcohol Action Team's commissioning cycle, needs assessment, contract development, service/provision review and performance monitoring.

You will be responsible for working in a multi agency/partnership way within the structure of the local Community Safety Partnership and will be a point of contact for all regional and national bodies such as the National Treatment Agency, Government Office North West and the Department of Health.

You will be required to co-ordinate various standing and time limited development groups within the remit of the Drug and Alcohol Action Team's day to day business as well as taking a lead on the development of a commissioning strategy and organisation of the Joint Commissioning Group responsibilities.

You will also be required to deputise for the DAAT Co-ordinator when required and you will work directly in partnership with the Drug and Alcohol Strategy Manager to ensure effective strategy development and implementation. **Ref No: BB4240.**

Beacon Council

Fostering School Improvement
Fostering Business Growth
Libraries as a Community Resource 2004-2005
Transforming the School Workforce

Closing date: 20th November 2009.

Application forms are available from the 24 hour recruitment hotline on (01254) 585606.

Blackburn with Darwen Council is committed to equal opportunities. Selection, training and promotion of employees are based upon ability.

This post is exempt from the Rehabilitation of Offenders Act 1974. Any offer of employment will be subject to a satisfactory check supplied by the Criminal Records Bureau. The check will include any cautions, reprimands or final warnings as well as convictions.

www.nhslothian.scot.nhs.uk

NHS Lothian

Primary Care Organisation
Lothians and Edinburgh Abstinence Programme (LEAP)

Therapist (Aftercare)

37.5 hours per week **Ref: AW/SUB/374**
Band 6: £24,831 - £33,436

Lothians and Edinburgh Abstinence Programme (LEAP) is a community rehabilitation programme which gives patients the opportunity to achieve abstinence incorporating a holistic approach to their treatment. We are looking to employ an experienced Therapist to work with patients in the post treatment period and to introduce recovery management based interventions. Experience working in a related area and a good understanding of the 12 step model is required.

For an informal discussion, please contact Dr David McCartney on 0131 456 0221.

For an application pack please contact our Recruitment Line on 0845 60 33 444 oremail: recruitment@nhslothian.scot.nhs.uk
Closing date: 30th November 2009.

Stonewall DIVERSITY CHAMPION

Bexley NHS Care Trust

Service User and Carer Involvement Co-ordinator – (Substance Misuse)
and
Data and Information Manager (Substance Misuse)

Band 6
£24,831 - £33,436 per annum (pro rata)
plus HCAS Min £3,339 - max £4,256 per annum (pro rata)

Bexley Care Trust is responsible for commissioning and delivering a range of treatment services to adults who misuse drugs and alcohol. We are seeking to recruit two new posts to further this work and support the delivery of effective treatment.

Service User and Carer Involvement Coordinator (Substance Misuse) (Ref: B 785)
30 hours per week (0.8wte) – flexible working arrangements will be considered. Fixed-term post to 31st March 2011 (extension subject to confirmation of future funding).

Data and Information Manager (Substance Misuse) (Ref: B 786)
37.5 hours per week (full-time post). Fixed-term post to 31st March 2011 (extension subject to confirmation of future funding).

Closing date: 13 December 2009

For further details and to apply, go to nhs jobs, at
www.jobs.nhs.uk

Experienced independent researcher and writer

The Alliance
Taking treatment forward

needed to attend and write up a series of service user and provider consultation events about the personalisation agenda across England in January and February 2010. 25 days work.

Interested parties should send CVs to ursula@m-alliance.org.uk
Closing date: 30th November 2009

On 30 November, **DDN** will be featuring our first **Training and Development Directory** as a pull-out and keep section. If you or your organisation provide training, in any part of the substance misuse field, make sure your free basic listing is included. The deadline for entries is Friday 20 November.

To submit your entry, or for information about advertising and sponsorship opportunities, contact Faye Liddle. t: 020 7463 2205 e: faye@cjwellings.com

LONDON BOROUGH OF MERTON

EXPRESSIONS OF INTEREST FOR PROVISION OF YOUNG PEOPLE'S SUBSTANCE MISUSE SERVICE FOR YOUNG PEOPLE AGED 24 AND UNDER AND THEIR FAMILIES.

Merton council is seeking to invite suitably experienced providers of young people's substance misuse services to bid to deliver specialist support services for local young people. The required service will provide a full range of support and therapeutic interventions for young people using substances at a level that affects their functioning.

The council is looking for an organisation with a proven track record in delivering services for young people and achieving positive outcomes for young people and their families.

The tender is being conducted using the Council's Alito Procurement e-tendering system. The closing date for expressions of interest will be Noon on 16th December 2009.

For further information and application details please write to:

Contracts and Procurement Manager
Children, Schools and Families
London Borough of Merton
10th Floor Civic Centre
London Road
Morden
Surrey SM4 5DX

merton

Addiction Therapist

P/T 30 hrs per week, Woking
Salary £23-25K, Grade 6

The Priory Hospital Woking specialises in the treatment of mental health issues and has an excellent reputation for the highest standard of mental healthcare provision. The Hospital's core services focus on general Adult Psychiatry, an Addiction Treatment Programme and a comprehensive Day Therapy Programme.

We are currently looking for a part-time Therapist to join a team of highly skilled Addiction Therapists providing a 28 day treatment programme to in, day and out patients – the programme runs 6 days a week. Abstinence based 12 step programme is the core of the service.

Candidates will be qualified as an Addiction Counsellor or equivalent and have a minimum of 2 years experience in facilitation of group and individual therapy within the addiction field. FDAP membership or evidence of working toward this is required. Experience with eating disorders and family work is desirable but not essential.

For an informal discussion or for an application form, please contact Joan Bendy in Human Resources on 01483 489211 or email joanbendy@priorygroup.com

For questions about the Addictions Treatment Programme, contact Peter Davies, Addiction Team Leader on 01483 489211 or email peterdavies@priorygroup.com

Closing date: Friday 5th December 2009

All roles will be subject to a successful CRB disclosure at the required level.

We are an equal opportunities employer.

www.priorygroup.com PRIORY

Individual care Innovative services Positive outcomes

Northamptonshire County Council

YOUNG PEOPLE'S SPECIALIST & TARGETED SUBSTANCE MISUSE TREATMENT SERVICES IN NORTHAMPTONSHIRE

Northamptonshire County Council, on behalf of the Northamptonshire Drug & Alcohol Action Team (DAAT), is seeking to procure a Young People's Specialist & Targeted Substance Misuse Treatment Service, and is seeking expressions of interest from suitably experienced and qualified organisations with a proven track record of delivering specialist and targeted substance misuse treatment services to children and young people.

This will be an open access service closely linked to universal and targeted children and young people's services. The service will be required to provide early intervention, psychosocial, pharmacological, harm reduction and family interventions. The successful applicant will need to work with other children and young people service providers in the county.

It is anticipated that the contract will be operational from 1st April 2010, and will be for a period of three years duration, with a possible option to extend for a further two years. This is subject to evidence of need, performance and recurrent funding.

Please go to the following website for further details:

WWW.SOURCENORTHAMPTONSHIRE.CO.UK

This tender is being managed through an electronic process. To request documentation, and apply for the ITT (Invitation To Tender), you will need to register on the Bravo Solution portal:

https://ncc.bravosolution.co.uk/web/login.shtml
Project Reference number: Project_17054 (ITT_28262)

If you have any problems registering on the Bravo website please contact the Bravo support desk on 0800-368-4850.

Please note that questions will only be accepted and responded to via the Bravo Solution portal.

Bidders wishing to submit a response to the tender must do so by 12.00 noon on Friday 11th December 2009.

Portsmouth CITY COUNCIL

Portsmouth City Council is working to tackle substance misuse amongst young people and adults. We have posts available, within our Health Improvement & Development Service and Community Safety Service, aimed at reducing the impact that substance misuse has on the individual, their family and the wider community.

Senior Officer (substance misuse & young people)
Ref No: 1536 Salary: £28,636 - £31,754 p.a.
This post will develop and lead the local plans for young people focusing on the prevention and treatment strategies.

Health Development Officer (substance misuse & young people)
Ref No: 1537 Salary : £26,276 - £ 28,636 p.a.
This post will range from delivery of targeted sessions to working on a 1:1 basis with young people aged 7-16 years.

Alcohol Project Worker
Ref No: 1535 Salary: £22,221 - £26,276 p.a.
This post will work to develop an innovative approach to tackling alcohol misuse working with both young people and parents.

Transition Service Project Manager
Ref No: 1579 Salary: £28,636 - £31,754 p.a.
This post will set up a new substance misuse service for 16-25 year olds.

Drug Strategy Officer
Ref No: 1448 Salary: £22,221 - 26,276 (pro rata)
This post will support our drug strategy, with a particular focus on stimulant drug users.

To learn more about these roles please call 023 9268 8536, or visit

www.jobsatportsmouth.co.uk