SIMPLY THE BEST – BETTER THAN ALL THE REST

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'For a long time I believed that I didn't deserve anything better than the situation I was living in... I don't believe in myself and nobody else believes in me.'

IN IT TOGETHER

JOINING FORCES TO TACKLE STIGMA HEAD ON

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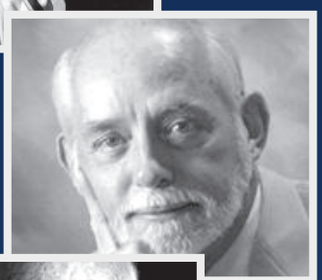
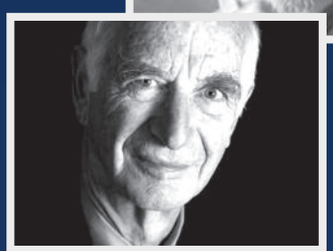

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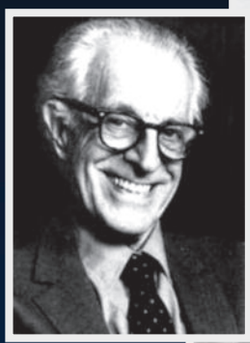
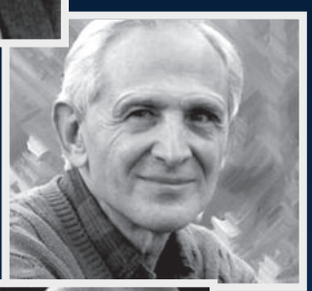
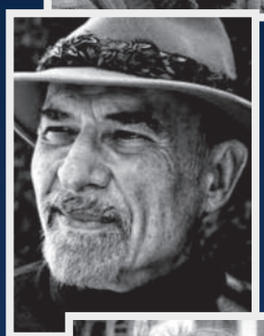

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Editorial – Claire Brown

In it together

Stigma is a challenge we must tackle head on

We must have all experienced stigma at one time or another, but for most of us it's a passing irritation to be batted aside with a swift putdown. Our cover story – and much of the rest of the magazine this month – is a reminder that for many it's not so easy, and that we should stand up for our client group. We must fight for the survival of NHS addiction services, Clare Gerada told GPs at their recent Cardiff conference (page 10), while in this month's Soapbox (page 23), Ken Stringer warns that some parts of our treatment system are simply unravelling. It's not going to get easier for a much-maligned client group in the near future.

But there are areas of progress that should help motivate. A pilot project with London hostels has helped residents discover their strengths and escape 'revolving door syndrome' (page 18), while peer support initiatives in Bristol are giving positive outcomes to older drug users. The effects of people power cannot be underestimated as Alistair Sinclair reports from a Lancashire recovery event (page 16) – a powerful demonstration that the negative experiences of stigma we heard on page 9 can be transformed with the right peer support and professional empathy. Public health minister Anne Milton acknowledges in News Focus (page 6) that payment by results is not just about the money. Let's hope her colleagues believe her.

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FEATURES

REGULARS

THROUGHOUT THE MAGAZINE: COURSES, CONFERENCES AND TENDERS

News in Brief

MONEY MATTERS

Drug treatment provision in England prevents almost 5m crimes a year and saves the public purse £960m, according to a report from the NTA. *Estimating the crime reduction benefits of drug treatment and recovery* is based on conviction records, self-reported offences and official treatment statistics. 'It is well established that getting drug-dependent offenders into, and through, treatment cuts crime,' said chief executive Paul Hayes. 'Now we can confidently estimate how much that is worth to the taxpayer, to individuals and to society.' *Available at www.nta.nhs.uk*

DANGEROUS DISCHARGE

More than 70 per cent of homeless people are being discharged from hospital back on to the streets, according to a report from Homeless Link and St Mungo's. NHS staff need to identify people who are homeless or at risk of becoming homeless and involve key partners like outreach teams, local authority housing departments and hostel staff immediately, says *Improving hospital admission and discharge for people who are homeless*. 'The findings from this report are extremely disappointing,' said Homeless Link interim chief executive Matt Harrison. 'Failing to meet homeless people's health and housing needs is costly to individuals, but also to the NHS as life on the streets means they continue to be readmitted to hospital. No one should be discharged from hospital to insecure or inappropriate accommodation.'

FELLOWSHIP FUNDS

The Winston Churchill Memorial Trust is offering a travelling fellowship to someone with an interest in alcohol-related health and continuity of care. The £6,000 grant will cover travel, accommodation, expenses and insurance for around six weeks overseas. *More information at www.wcmt.org.uk*

GANG WATCH

A new video designed to help address gang-related crime has been launched by young people's charity Catch-22, featuring ex gang members and their families talking about how they've managed to turn their lives around. Watch it on the *DDN* site at: *www.drinkanddrugsnews.com*

Scots pass 'landmark' alcohol minimum pricing bill

The Alcohol Minimum Pricing Bill has been passed by the Scottish Parliament, 18 months after the previous Alcohol etc (Scotland) Bill had its provisions for minimum pricing removed. The bill represents a 'landmark moment in Scotland's fight against alcohol misuse' said health secretary Nicola Sturgeon.

The bill sets a 50p minimum price for a unit of alcohol as a condition of licence, although a 'sunset clause' has been added to allow the provisions to expire after a period of six years if they are considered ineffective (*DDN*, May, page 4). However, according to a modelling study by the University of Sheffield, the first year following the introduction of a 50p minimum price would see 1,600 fewer hospital admissions in Scotland and 60 fewer deaths, as well as around 3,500 fewer crimes. This would rise to 300 fewer deaths annually and 6,500 fewer hospital admissions after ten years.

The 50p price was equivalent to the 45p price set two years ago after taking account of inflation, said Ms Sturgeon, and would see the price of a 2-litre bottle of Tesco Value dry cider rise from £1.69 to £4.20 and 70cl of Glen's vodka from £11.29 to £13.13. Many 'name' brands will be unaffected, however.

Alongside measures to tackle irresponsible promotions and quantity discounts, minimum pricing would help to create a 'cultural shift' in Scotland's relationship with alcohol, Ms Sturgeon stated. 'It has been a long road to get to where we are now and we have worked hard to convince those who were in doubt that this was the right policy for Scotland. This policy will save lives – it's as simple as that. It is time to turn the tide of alcohol misuse that for too long has been crippling our country. Minimum pricing will kick-start a change by addressing a fundamental part of our alcohol culture – the availability of high-strength low-cost alcohol.'

Implementation of the policy will start in April 2013 at the earliest, while the British government also recently committed itself to minimum pricing with the publication of its alcohol strategy (*DDN*, April, page 4).

'This decisive move stands to make a significant impact on alcohol health harm and alcohol-related crime in Scotland,' said Alcohol Concern chief executive Eric Appleby. 'With minimum pricing due to be introduced in England and Wales, the government in Westminster should follow Scotland's lead and set the minimum price to at least 50p to make a real difference.'

Meanwhile a new report from researchers at Oxford University claims that cutting alcohol consumption to just over half a unit per day – equivalent to a quarter pint of beer – would save 4,600 lives a year. Current government recommended limits are 3-4 units per day for men and 2-3 for women.

The researchers used a mathematical model to assess the impact of changing average consumption on deaths from 11 conditions including coronary heart disease, stroke, cirrhosis of the liver and five cancers, concluding that just over half a unit a day 'was the optimal level of consumption' among current drinkers. 'A couple of pints or a couple of glasses of wine per day is not a healthy option,' said lead author Dr Melanie Nichols.'

The government has also named ten communities that have successfully bid to share £1m funding to tackle binge and underage drinking. The areas – whose bids set out how community-based approaches would deal with local problems – are Bury, Chelmsford, Cornwall, County Durham, Lincoln, Maidstone, Moseley, Newcastle, Shropshire and Wakefield.

University of Sheffield study available at www.shef.ac.uk/scharr/sections/ph/research/alpol/research/scotland

University of Oxford study published in BMJ Open at bmjopen.bmj.com

North East tops alcohol treatment table

The North East has more under-18s in specialist alcohol treatment than anywhere else in England, according to figures released by Balance, the North East Alcohol Office.

Six hundred under-18s were in treatment in the North East in 2010-11, accounting for around 7 per cent of all those receiving treatment in the region.

While the England average for under-18s in treatment is 59 per 100,000 population, the North East figure is double that at 118 per 100,000. Balance wants to see more done to protect children and young people from exposure to alcohol, particularly through advertising and marketing, an area where it says the government's alcohol strategy (*DDN*, April, page 4) is 'weak'.

The organisation is also concerned that many people in the North East see excessive consumption as a social and cultural norm. 'Our region is drinking too much from an early age driven by alcohol which is too affordable, too available and too heavily promoted,' said Balance director Colin Shevills. 'It is particularly concerning as here in the North East we have the highest rate of 11 to 15-year-olds who drink in England and the highest rate of under-18s admitted to hospital because of alcohol.'

Meanwhile a new report from the Youth Alcohol Advertising Council (YAAC) says that young people are not being protected to the full extent under existing advertising codes. Marketing for leading brands 'regularly breaches' rules prohibiting adverts that appeal to under-18s, says YAAC, which is coordinated by Alcohol Concern. The group has complained to the Advertising Standards Authority (ASA) about the marketing of Lambrini, Smirnoff and Frosty Jack's cider and also states that advertisers are exploiting weaker monitoring of social media in order to appeal to young people.

'If government is serious about tackling binge drinking, then protecting children through full implementation of the existing codes on alcohol advertising is an obvious place to start,' said Alcohol Concern's director of campaigns, Emily Robinson. 'If the alcohol industry insists on bending the rules to target young people and irresponsibly sell more of their product then we need more robust regulation that prevents advertisers from creatively sidestepping the rules.'

www.balancenortheast.co.uk

Spring 2012 report of the Youth Alcohol Advertising Council (YAAC) available at www.alcoholconcern.org.uk

Government signals intention to link benefit sanctions to treatment

The government has indicated that it is proposing to cut the benefits of people with drug or alcohol problems who refuse to enter treatment. The measures would be included as part of the universal credit system, which comes into force in October 2013.

In a speech to an Alcoholics Anonymous (AA) event in Parliament, work and pensions secretary Iain Duncan Smith said that the 'outdated' benefits system needed to be 'more active in helping problem drug users and alcoholics' who were being 'failed' by the welfare state.

Universal credit had the potential to change the system from 'passive to active intervention', he said, quoting Department of Work and Pensions (DWP) figures that approximately 80 per cent of problem drug users claim out-of-work benefits and around 40,000 people claim incapacity benefits with alcoholism as the primary diagnosis.

The government would be outlining its plans 'shortly', he added, and although the speech contained no specific mention of benefit cuts, a 'government source' told the *Guardian* that 'there will be sanctions' if people refuse to seek treatment.

DrugScope said that, while it was wary of 'the prism of unnamed or off-the-record briefings', if true the plans would be a reversal of the government's publicly stated position. The previous government's intention to give Jobcentre staff the power to make people answer questions about drug and alcohol use and undergo drug testing had been abandoned following criticism from the Social Security Advisory Committee, the charity pointed out.

Linking benefits to a requirement to undergo treatment would set 'a dangerous precedent' and would also be against the principles of the NHS Constitution, stated chief executive Martin Barnes. 'There is no evidence that using the stick of benefit sanctions will help people to positively engage with treatment and support their recovery. Indeed, the risk is that people will disengage from support services, potentially worsening their dependency and the impacts on their families and communities.

Alcohol Concern chief executive Eric Appleby said that the 'real answer' to helping people overcome their addiction was to make sure that high quality treatment services were 'fully funded and available all over the country'.

ACMD: Increase naloxone availability

Naloxone should be made more widely available and the government should ease restrictions on who can be supplied with the drug, according to a report from the Advisory Council on the Misuse of Drugs (ACMD).

The government should also investigate how people supplied with naloxone can be best trained to administer it, says *Consideration of naloxone*.

Provision of the World Health Organization-recommended medicine – which can reverse the effects of opioid overdose – reduces drug-related death rates, says the report, but maximum impact can only be achieved if naloxone 'is given to people with the greatest opportunity to use it, and to those who can best engage with heroin users'. It is currently only available on prescription.

Naloxone provision is 'an evidence-based intervention, which can save lives,' the report states. Scotland has already made provisions to make naloxone more widely available, and nine Welsh areas are taking part in a take-home naloxone programme following a successful 2009 pilot. It is already used by the emergency services and has no potential for misuse or dependency, the report stresses, adding that the ACMD is unaware of 'any significant body of evidence' that naloxone provision in the community leads to increased heroin use, as some critics have claimed.

Former ACMD chair Professor David Nutt told journalists at the launch of his new book that the illegal status of drugs like cannabis and MDMA was preventing scientists from properly researching their possible therapeutic use, a claim the Home Office has denied. He was sacked from his post in 2009 for saying that alcohol and tobacco were more harmful than many illegal drugs (*DDN*, 16 November 2009, page 4).

Meanwhile a formal national emergency plan to respond to future outbreaks of infection among drug users is to be developed by the Scottish Government, following a proposal by the Scottish Drugs Forum (SDF) in the wake of the 2009/10 anthrax outbreak.

Report available from www.homeoffice.gov.uk/agencies-public-bodies/acmd

HOIST THE MAIN SAIL!

Service users from Phoenix Futures have begun the countdown to their three-month voyage 1,800 miles around Britain, beginning on 1 August. Sailing the 80ft Tectona will give social confidence as well as sail training. 'That sense of living, working, cooking and discussing our plans together gives a real sense of care – it'll be our therapeutic community,' says Stu Plant. He came up with the idea with Darren Long, whose life was 'changed massively' by an earlier sailing trip (*DDN*, March, page 15). *Phoenix Futures are actively fundraising to give more service users the opportunity to experience a leg of the voyage – to get involved, visit www.phoenix-futures.org.uk or call 020 7234 9762.*

News in Brief

DRUG DRIVING

Drug driving could become a specific offence – with a fine of up to £5,000 and up to six months in prison – under plans to be included in the forthcoming Crime, Communications and Courts Bill. The proposed legislation would cover motorists in England, Scotland and Wales with police – who will need to show that driving has been impaired by drugs in order to prosecute – equipped with hand-held devices for saliva-testing at the roadside.

DOUBLE DATE

Theatre and media company Genie in the Gutter, which was set up by Liverpool's abstinence-based Park View Project (*DDN*, 17 November 2008, page 8) is mounting a production of Jim Cartwright's play *Two* at the Valley Community Theatre on 15 June – *contact alena@genieinthegutter.co.uk for details.* Meanwhile, Liverpool-based relapse prevention and aftercare service The Spider Project is celebrating its tenth anniversary this month. The project uses creative and physical activities to motivate people to achieve their full potential. *www.spiderproject.org*

REZOLVING TO HELP

Addaction has joined forces with Cornish social enterprise ReZolve to help deliver some of its community and environmental projects, with service users helping to recycle and restore items used in ReZolve's work. 'Combining our resources in this way, as well as our shared values and visions will really help ReZolve to grow, helping more people to fully recover from substance misuse problems and to become a positive influence in their local communities,' said Addaction chief executive Simon Antrobus.

HELPING HAND

Russian grassroots harm reduction organisation the Andrey Rylkov Foundation is seeking donations to establish a mobile clinic in Moscow for needle exchange and blood-borne virus testing, and to safeguard services from 'the whims of the government'. Earlier this year Russia's Federal Drug Control Service (FSKN) passed an order to close down the foundation's website, accusing it of carrying material that 'propagandised' drug use, a move condemned as 'totally unacceptable' by Human Rights Watch. *To make a donation, go to en.rylkov-fond.org.*

HOW WILL THE SECTOR ADAPT TO PAYMENT BY RESULTS?

PbR is now a reality, with the eight pilot sites live and the government stating that nearly fifty more areas are either developing pilot plans or intending to do so in the future. **DDN** reports from a recent learning event for treatment providers

'This isn't just about money,' Parliamentary under-secretary of state for public health Anne Milton told delegates at the cross-government *Providing drug and alcohol recovery through payment by results* event in London. 'It's also about the human cost. These pilots allow providers to focus on what they know works. We know that what works in Kent won't necessarily work in Wakefield – each area has different needs and challenges – but there are common threads.'

One of these was housing, she told the event, an area where it was important to 'set our sights higher' as there was a tendency to always focus on homelessness. 'There are also important issues of people moving away from known associates,' she said. 'It's extremely complex.'

Each of the eight payment by results (PbR) pilot areas had put service users at the centre of the models they had developed, she maintained, and were working closely with government to make sure that providers were rewarded in 'complex situations'. There was also the issue of what constituted a 'result', she added, as different clients clearly had different needs. 'It's about recognising that for some people this is an incredibly long journey. For some, it could be a lifetime journey.'

On the thorny issue of cherry picking, she told delegates that 'it's about keeping enough data coming back to us to make sure we can monitor it without it becoming over-burdensome'. A key challenge would be the effectiveness of the monitoring system itself, she said. 'We're working out exactly which questions we need to ask to get the information we need. We've got to be very sure what we're doing. The really important thing is to have the humility to understand that we don't have all the answers – that's why we need to work together.'

When asked about a nationally agreed definition of what recovery was, she replied that it would have to be 'quite broad' and involve service users. 'Recovery for one person isn't the same as for another – there are stages of recovery.' On the risk of smaller and medium-sized charities being excluded from PbR she said, 'We want to increase the size of the market for smaller organisations, and there's a lot of work going on in the Cabinet Office about this. In order to get to where we want, we need a level playing field for big and small providers. We're very, very mindful of this.'

Offending outcomes and health outcomes were inextricably linked, the Home Office's deputy director of reducing offending, Sally Richards, told delegates. 'This is not new. The drug interventions programme (DIP) has brought together criminal justice and treatment systems for the last nine years. We need to build on these key links between the health and criminal justice systems.' The PbR offending outcome would pay providers on a reduction in the average number of offences by more than the historical baseline, she said, which would encourage them to work with offenders. 'You'll have to improve to get the payment. We want to make sure the

'Recovery for one person isn't the same as for another – there are stages of recovery... In order to get to where we want, we need a level playing field for big and small providers.'

Parliamentary under-secretary of state for public health, Anne Milton

approach incentivises you to tackle the people with more complex issues and more complex lives.'

Police and crime commissioners (PCCs) would be elected in November across police forces in England and Wales and would be accountable for how crime was tackled in their area, she continued. 'We see them as having a real opportunity to work with local authority and health providers to make sure health and criminal justice approaches are embedded together, and they'll receive an un-ringfenced community safety fund.' Providers would play a central role in helping local areas to make the case for funding drug interventions to their PCC, she stated.

PbR would also provide a chance to improve continuity of care for offenders from prison to release and on into the community, said deputy director of offender management at the Ministry of Justice, John Hall. It would also mean treatment providers working closely with criminal justice partners to prevent offenders 'falling through the gaps'. Real localism required the shaping of policies around individuals, added head of policy and analysis for disadvantaged groups at the Department of Work and Pensions (DWP), Martin Hill. His department was currently matching DWP benefits records against NDTMS figures, he said, and the results would help to develop and cost new policies.

Delegates also had the chance to hear feedback from the pilot sites. Wakefield's pilot, which went live in April, had been revised from a 100 per cent payment on outcome model, to a 'still challenging' model where 20 per cent of tier 3 contract value was paid on outcome. That meant that over two years, nearly £1.2m would be held back from providers unless outcomes were met, delegates heard – a drugs outcome payment of £549,000 in year one and a drugs and alcohol outcome payment of £632,000 in year two.

Wakefield had nearly 2,000 drug users in treatment and more than 500 alcohol users, delegates heard, along with high levels of multiple deprivation. While the LASARS (Local Area Single Assessment and Referral Service) function would be delivered by existing providers, Wakefield had commissioned an external organisation to develop a LASAR audit tool.

The pilot used central NDTMS-modelled data and the NTA outcome payment tool and 'provided an opportunity to redefine and reshape our services, and shape future policy,' said Jo Rowe of Turning Point. 'There were risks for us – 20 per cent of our payment is now attached to outcomes.'

There was close working with commissioners through the co-design process, she said, and all services were co-located at one site. While the central co-design meetings had run as scheduled and were useful in shaping the pilot's development, the LASAR tool had been a 'great challenge', she said. 'It was very trial and error, but we had feedback from all the providers to make sure we had a process and mechanism that worked really well.' Nonetheless, staff had bought into the design of the model because they were able to ask questions, she said. 'It's all about shifting the emphasis and learning new skills,' added chief executive of Spectrum Community Health in Wakefield, Dr Linda Harris.

'We contributed directly, because we wanted to make sure that PbR helped develop recovery capital,' said Emil Brown of Wakefield service user forum, Recovery 4EM. Participatory appraisal tools had been developed and service user representatives had visited each site to make sure there was a consistent approach. 'We very quickly honed in on the fact that the best method was to get people to feed back on what was good and what was bad about their recovery journey, so we could keep the good and get rid of the bad.'

Access to accredited training courses and adult education had already improved as a result, he said, and there were structured day services focused on developing skills, confidence and employability. There was also more capacity to shape the system, he said, with ongoing service user representation on the PbR board.

Service users had been very specific about the perceived barriers within the system, he said, and were 'very concerned that it didn't just mean they were rushed off' their prescriptions. 'But that's partly because this was something new, as before it had often been "are we just going to be stuck on our scripts – is that all there is to it?"'

FAMILY MATTERS

POSITIVE IMPACT

Looking at the criminal justice system through a family-focused lens would be an investment, says **Joss Smith**

A recent *Guardian* article highlighted the lack of public awareness of the forthcoming Police and Crime Commissioner (PCC) elections, with nearly 80 per cent of the public knowing nothing or very little about the process. The article raised concerns that the limited public engagement could mean those who are likely to vote may be galvanised by extreme opinion and policies. As PCCs will control 40 per cent of the current Drug Intervention Programme budget and all the Safer Stronger Communities budget, their influence on shaping the local criminal justice response to drug and alcohol users and their families will be significant. It is therefore important that in the build-up to these elections that communities and local voluntary, community and social enterprise organisations are influencing the candidates to offer positive strategies and response to drugs and alcohol.

In policy terms, as well as media and public opinion, there appears to be a continuous appetite for a punitive approach to crime. However there is also a parallel argument that prison and punishment just isn't enough when it comes to preventing reoffending, and repeatedly incarcerating people costs a lot of public money. The system needs something more to keep ex-offenders out of prison and making positive changes in their lives; as John Podmore argued in *DDN*, 'prison is really only a deterrent for those who have something to lose' (May, page 8). At Adfam we would suggest that a family-focused lens for the criminal justice system would enable whole families to invest in their future and support the efforts of their loved ones towards positive reintegration and recovery.

There is also an important specific message to inform PCCs about the impact of criminal justice responses to female offenders and their children. Between 2000 and 2010, the women's prison population increased by 27 per cent to 4,267. Although this is a small percentage of the total prison population (88,179 in England and Wales as of 2 December 2011), research suggests that prison impacts disproportionately on women. Women are much more likely to have sole custody of their children, and a period of time in custody can therefore cost them and their children dearly: 17,000 children were separated from their mothers by imprisonment last year, according to a PACT report.

Researchers found that women in custody often have very poor psychological, physical and social health, with women accounting for nearly half of self-harm incidents in jail despite making up just 5 per cent of the prison population. In 2007, a major review by Baroness Corston concluded that most female prisoners shouldn't be in jail at all, with many having disproportionate and inappropriately severe sentences. The PACT study also found that only 9 per cent of children whose mothers were in prison were living with their fathers, half were in care and the others were assumed to be cared for by kinship carers. It is concerning to know that there is no automatic process for tracking who is responsible for the care of the child when their parent is placed in custody, which can lead to some inappropriate caring arrangements.

Obviously influencing local PCCs takes time and energy at a time when many organisations are struggling to survive. However there is a real opportunity to influence and shape the local agenda and its responses to families within the criminal justice system. As local candidates seek to make potentially radical changes, there is an opportunity for them to really hear and understand the positive impact families can play in their local communities.

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

NIT

Tackling stigma is no longer about 'us and them' but a shared opportunity to further the goals of substance misuse treatment and recovery, according to Nottingham service users. DDN reports

'Everyone's affected by stigma, but it can hit you harder when you're from a minority group, or a group that society doesn't necessarily agree with,' says Lee Collingham, who runs Nottingham's Shared Care User Forum (SCUF). 'Hearing that if we don't engage with treatment they'll stop our benefits can make us feel like the bottom level of society.'

Collingham knows first hand about feeling stigmatised. Having started using drugs at the age of 11, he became caught up in a cycle of offending, drug use and short periods of time in prison. After completing a detox and taking various training courses, he began volunteering on his release and experienced the difficulties of competing for paid employment with a substance misusing past and a criminal record.

There have been some energetic anti-stigma initiatives in Nottingham over the last couple of years, involving substance misuse and mental health, including the award-winning Stamp Out Stigma campaign, which led to service users being employed as peer mentors. The local Healthcare Trust and the crime and drug partnership continue to give much-needed support, and an annual dual diagnosis conference goes from strength to strength. But the reasons to tackle stigma haven't diminished in the slightest, says Collingham, particularly relating to healthcare, which initially drove the campaign.

'People going into A&E with drug and alcohol related illnesses such as DVTs and liver cirrhosis often get separate treatment because of their lifestyle choices,' he says. 'People have been discharged at 3am and told to make their own way home, and often because they are looking chaotic, they are treated like the bottom end of society.'

Such attitudes still permeate the workplace and affect promotion prospects, despite high profile work by the UKDPC, DrugScope and Release. 'You still get the reaction that you can't leave anything near us or it'll go missing,' says Collingham. 'And when you apply for a job, even when you know you're best qualified for it, you don't get it because you're not judged on your actual standards.'

While stigma campaigns have been mainly directed at professionals, the public and media, he says that it should be about changing service users' attitudes as well. 'It's about the attitude of everybody, not just "us and them". A lot of false messages and prejudices are being spread by users. They might get a bad keyworker or it might be something as straightforward as a personality clash – but they're very likely to go and tell every single person about it. Then that window of opportunity to work together is gone.'

The latest initiative he has been involved with is a film, made by service user reps from Nottingham with the help of Let's Build, a healthcare trust partner organisation. The finishing touches are still being put to the DVD version, which will be sold to try and recoup its production costs, but it has already won the 'best film' award at the recent RCGP conference in Cardiff, collected by Collingham. The next step will be to push for service user led training for practitioners, pharmacists, police and job centre staff, to give them better understanding of addiction.

Collingham felt greatly encouraged that the work was acknowledged at the GPs' event and pleased to be able to mention SCUF, the fledgling Shared Care User Forum that he runs to help improve relations between service users, shared care workers and GPs. It was also a moment to reflect how far he has come personally – a much healthier looking Lee than the version in the DVD, with new teeth and confidence – stepping up to the platform to give an acceptance speech.

There is still a long fight ahead to change attitudes towards people experiencing problems with drugs and alcohol, and this drives him to keep badgering for more support locally. 'But the relationship between healthcare and substance misuse isn't what it was ten years ago – a lot of the historical problems aren't there,' he says, with a note of genuine optimism. 'And we need to get that message across. It's not about us and them – let's do it together.'

'Hearing that if we don't engage with treatment they'll stop our benefits can make us feel like the bottom level of society.'

LEE COLLINGHAM


Bruce


Matt


Alison


Lee


Charlie

JUDGEMENT DAYS

Nottingham service users were filmed explaining how stigma affected them. The story is of damaging and painful experiences, as these excerpts show

WHAT DOES STIGMA MEAN TO YOU?

Bruce: Being misunderstood, alienated, stereotyped, categorised – very much looked down upon. It caused me to totally lose my way and took away whatever self-esteem I had.

HOW HAS STIGMA AFFECTED YOUR LIFE?

Matt: Whilst in hospital in 2008, I was recovering from a really serious infection in my lung. The nurse stigmatised me a lot by saying she was sick of having to care for addicts. That people who needed life saving treatment had to wait... and to overhear that was really quite awful.

Alison: People were pointing fingers... in the end their judgement overtook and I lost my confidence and had to stop working. From a family point of view, my sister particularly was so angry with me... She never forgave me.

Lee: After having come through recovery, having done rehab and years of voluntary work, I was fortunate enough to get paid employment. I never hid my history, but unfortunately it worked against me because I was stereotyped as a junkie... when it came to promotion for jobs that I was more than capable of doing, I was passed over.

WERE FAMILY AND FRIENDS AFFECTED BY THE STIGMA YOU EXPERIENCED?

Alison: I thought I had friends, but then when I really was in trouble, they just completely disappeared. And even though I'm now better, I phone them and they don't want to know.

HOW DID THIS STIGMA MAKE YOU FEEL?

Matt: It made me feel little, you know, small and unwanted and not cared about and just generally a lesser citizen than anybody else.

Charlie: For a long time I believed that I didn't deserve anything better than the situation I was living in... I don't believe in myself and nobody else believes in me.

DID STIGMA STOP YOU DOING CERTAIN THINGS?

Bruce: The shame was so overwhelming that I drew back from making any positive moves. I drew back from getting into recovery for a long time. It's a very debilitating feeling, and it just stopped me from making any progress.

Charlie: I denied myself things. If I had some money from work that was left over after bills, I wouldn't go out and treat myself to anything, because I wouldn't feel I deserved it.

WHY DO YOU THINK PEOPLE GET STIGMATISED?

Lee: Mostly, just from being different – because you don't necessarily fit to the public stereotype of what somebody should be. And if you're slightly out of that box, people tend to notice that and pick on that. They don't realise what effect that has on people's confidence, their mental health.

HOW CAN WE CHALLENGE PEOPLE TO CHANGE THEIR ATTITUDES?

Bruce: I think we could all benefit if we start looking at stigma, start to understand exactly what it means and just how hurtful it is and how negative it is.

Matt: You've just got to try and make people understand that despite what we've done or what we do, we are still people and deserve the same amount of respect as anyone else.

Alison: Education. No one chooses to be an addict... We need to teach people to be a bit more tolerant.

Charlie: The best thing you can do for someone is listen and make sure they know there is help available if they need it.

Lee: Not accepting it, rather than just saying nothing about it, trying to ignore it... people should be challenged for their behaviour. It could have a massive effect on someone's recovery.

Film stills courtesy of Crocodile House, www.crocodilehouse.co.uk
The film was a joint project between Let's Build (www.letsbuild.org.uk) and service users from Nottingham City Dual Diagnosis Forum **DDN**

NO NEAT FORM

'The government has spent £3bn on moving the deckchairs around the Titanic... Are we going to fight for NHS addiction services? They'll become extinct if we don't.'

Professor Clare Gerada, RCGP chair

'We need to step back and realise this is about people,' said Dr Mel Bagshaw, opening the GPs' 17th national conference on managing drug and alcohol treatment in primary care, in Cardiff City Hall. This year's theme was 'Right treatment, right time, right place' and she told delegates: 'Everyone has their own journey. We're often pressurised to put people through treatment too quickly.'

Professor Clare Gerada, RCGP chair, took the platform fresh from her very public fight against 'a meaningless nonsense of a reorganisation' of the NHS.

'The government has spent £3bn on moving the deckchairs around the Titanic,' she said. 'They're dismantling the health service at a time of phenomenal political change.'

It was not all bad news, she told GPs. 'You're here because you care… but go away with thoughts not of the nonsense of the last 18 months. It's about what we must all do – delivering kindness to patients and working collaboratively together. We must never talk about patients as tariffs, but as people.

'Are we going to fight for NHS addiction services?' she asked, adding 'they'll become extinct if we don't.'

John Strang said that clinical work was becoming too automated and believed that the recovery agenda needed rebalancing, with the patient at the front.

'The government is putting full recovery first – but the danger is that anything shorter than full recovery has no value to it,' he said. 'It's about talking to the individual and saying "what's the greatest you can achieve?" We need to prompt reflection and change in our patients.'

Recovery was personally defined, he said, but the debate had suffered from polarisation in the last couple of years. 'It's a sloppy debate – an assumption that abstinence is the same as recovery. How did we get to this situation?'

We should look for synergies across modalities, he suggested, and 'nurturing individuals' aspirations at a level they can achieve.'

'We're looking at addiction treatment in a far too technological manner,' added Professor Jim Orford of Birmingham University. Furthermore, a short treatment timescale expected results in three months.

'This assumes treatment is the single most important thing in a person's recovery. It ignores social networks and family groups,' he said.

In a debate about Payment by Results (PbR), Dr Gordon Morse said, 'we have to be careful about these bean counting exercises. We need to be looking at health, housing and lives – what's important to the person.' He quoted renowned psychologist Stanton Peele – 'Give them a home, give them a job, they're sorted' – and added 'these are the most important things you can do for people.'

Fulya Yahioglu, commissioning manager at Enfield DAAT reported positive progress in achieving flexible options during their PbR pilot. 'We've tried to ensure there's choice and we haven't pushed abstinence,' she said. 'We try to ensure people have the best outcomes possible.'

'But how does PbR fit into the primary care model?' asked Dr Steve Brinksman, clinical lead for SMMGP. 'We've fought for years to get more drug and alcohol treatment in primary care. Are we being asked to step back?'

Glenda Daniels, manager of Oxford Users Team (OUT), responded by drawing attention to how changes to local GPs' contracts were directly affecting patients' lives: 'Some users are now being asked to take longer journeys to

NULA

Amid anxious speculation about tightening budgets and structural change, the message that treatment and recovery must be at the patient's own pace came over loud and clear at this year's GPs' conference

services in the city. I find it amazing that anyone thinks this is OK.'

Kate Halliday led a session looking at key issues for primary care treatment. She talked about wide-sweeping changes in England and a feeling of 'moving into the unknown now' without the monitoring – and the protection – of the NTA.

'There's lots of retendering, creating uncertainty,' she said, pointing to a need to 'rebalance the system'. 'We need to ensure we present a balanced and holistic model of care. In some cases we've seen people having to sign agreements that they'll be off drugs in three months.'

Removing ring-fencing from drugs budgets would mean coming into competition with every other area of public health, she pointed out, and clear care pathways, strong leadership, good data gathering and effective communication with commissioners would be needed more than ever: 'We need to say what we're doing and why it's good, or we'll be overlooked.'

Her fears were voiced by Alex Boyt, Camden user involvement officer, who commented: 'We've just lost £600,000 from our pooled treatment in Camden. We'd love to be able to focus on kind and intelligent care, but there is some panic. The money is linked to abstinence – it's a harsh environment.'

A panel discussion around 'is it OK to use on top of your script?' provoked conflicting views. But the personal experiences of two ex service users, Jimi Grieve (agreeing with the question) and Glenda Daniels (disagreeing) both demonstrated the value of a collaborative and long-term approach to treatment.

'They mended me but it was a long journey,' said Grieve. 'But the most important thing was, I remained in treatment and made it work… treatment needs not to be punitive. You learn from it and crack on. I was lucky – I had good support and open conversation.'

'I couldn't imagine going on any further,' said Daniels, describing her lowest point of enforced detox and feeling that she had lost everything. 'What got me through was my relationship with my GP.'

Two GPs who took the conference platform at the end of the day demonstrated that they understood completely the need for reaching recovery on individual terms, as they had experienced fighting addiction themselves.

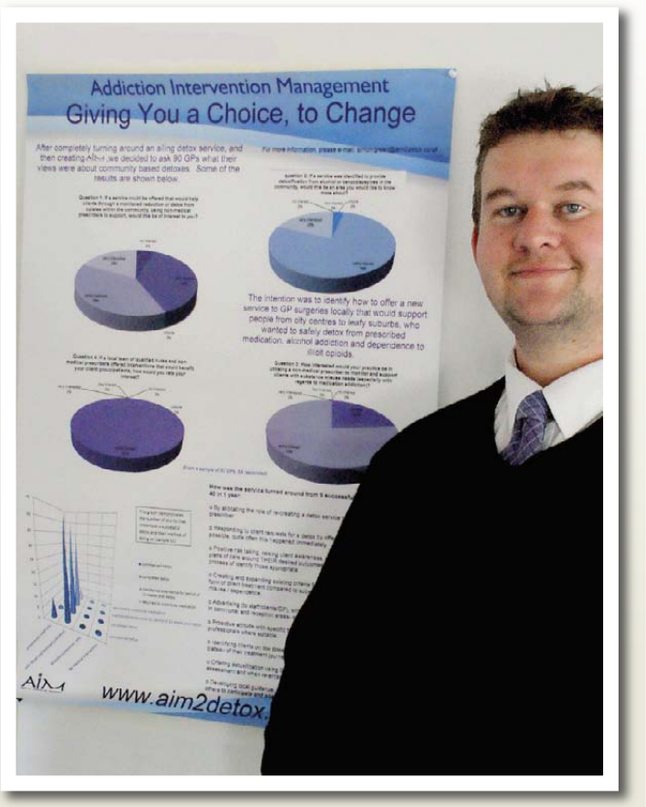
Dr Michael Blackmore tried every variety of drug in his youth and had gone from being a 'legend in [his] own head' to a 'social hand grenade'. Later, as a GP with addiction, he had to take time off work to work on himself.

'It was a journey to get back to work,' he says. 'I did ten months in an unpaid post and did part-time work as a JHO [junior house officer] for the humility.' Being accepted for a post of portfolio GP have him the chance to demonstrate that he had turned 'a massive negative into a huge positive'.

Dr Ian Scott told how, as a high achiever, his addiction hit him hard as a moral failing. He described how he used the framework of mutual aid, through many 12-step meetings.

'I'm not religious but it was a spiritual process – self-recovery, working on unhealthy behaviours, then maintaining the process and carrying it forward,' he said.

Summing up the conference, chair Dr Stephen Willott said the latter two doctors had demonstrated how easy it was for anyone to get life out of kilter. He recalled Clare Gerada's words from the morning session – that patients aren't commodities or tariffs – and said the day had underlined John Strang's belief that there was no neat formula for recovery, 'but that the patient needs to be at the front of this, moving to a better place'. **DDN**



SIMON GREEN OF ADDICTION INTERVENTION MANAGEMENT (AIM) displays his winning entry in the conference poster display. The poster showed the results of independent research with GPs in the Midlands about their views on community detox provision, their experiences with patients addicted to over-the-counter medicines, and how they viewed having non-medical addiction specialists in their surgeries to support them with medicine addiction. The research snapshot showed success with community detox involving one-to-one nursing interventions, and reported that GPs would welcome additional expertise and support in the surgery. www.aim2detox.co.uk

TALKING THE SAME

Older drug users are likely to respond very well in group settings when surrounded by their peers, says **Rachel Ayres**

There have been repeated calls for the development of services for older drug users for more than a decade now. In response, the Bristol Drugs Project (bdp) established an 'older drug users' group which has now been running for two years. Originally funded by a grant from St Monica Trust and researched through a qualitative survey of older users, it is now an established part of the weekly timetable at bdp.

The group is well attended and staff are enthusiastic about it, but although it has positive outcomes it stubbornly refuses to fit into any particular therapeutic model. Consultations with founder members established that what people wanted the most were unstructured sessions with a strong sense of building trust, community and shared experience. The group has the feel of a facilitated self-help group – it's informal and the role of the facilitators is to follow the lead of the group rather than set tasks or guide discussions.

Practicalities are important. The group takes place around a large table with hot drinks and snacks on offer, and auricular acupuncture is always available, delivered by an older member of bdp's peer support volunteer group. The facilitators comprise two members of staff – one male, one female – and a member of the council of management who is also an ex-service user. Two are 60-plus and one much younger, and having a range of experience and age in the facilitator team has real advantages and is appreciated by participants. Among the comments we've had are 'it feels non-hierarchical. I can talk to staff if I want but I can also talk to my friends here', and 'it's easy to ignore advice from professionals when you're my age, but I do listen to them'.

Reducing isolation and making new social networks were identified as key objectives in the development phase, and members talk enthusiastically about relationships that have grown via the group. 'We keep in touch during the week, sometimes meet up for a coffee,' said one. 'If I don't turn up one week I know someone will ring me to see if I'm OK,' commented another. There are 45 participants currently on the 'regulars' list, with 10-15 turning up each week and a text or phone call system reminding members to attend.

In line with other studies, early interviews with potential participants flagged up loneliness, isolation, shame and lack of confidence around seeking help for typical age-related health complaints as key issues for the group. Founder members were also clear that they did not want to attend 'yet another drug-treatment' group. 'If I had to come along and just do work on my drug use I wouldn't bother,' one told us. Another said, 'A lot of us have had years of those sort of groups in the past and they clearly haven't worked. Here I can talk about meeting other people of a similar age with substance use problems with a view to addressing some of these issues,' and adding that 'it's very important that older service users have a safe place to go and get together'.

Sitting around the table, drug and alcohol use is certainly is not the main subject of conversation. Topics range from current affairs and personal circumstances, to benefits and health issues. Depression and anxiety are discussed regularly. 'The group is really understanding about my depression – no one tells me, "oh you shouldn't feel like that, you have a lovely family",' said one group member. 'I try to follow a more positive way of life,' another told us. 'I used to dwell on the past continuously, now after talking about my depression a lot in group I try to look to the positive things and the future.'

Participants feel that the confidence to discuss substance use comes slowly and that change in substance use is most likely to happen when other things are in place. 'I like talking about current affairs,' said one. 'When I feel less lonely I use less and things seem better'. 'I was on 60 ml, now I'm on 22 ml and switching to Subutex next week,' said another. 'Talking it through gave me the confidence to try it. My other experience of detox was prison. It was awful – thought it would put me off for life.'

While those who want to make changes are encouraged by the group, there is understanding of those for whom change or detox still seems distant. One participant told me that over his year in the group he has quietly reduced from 8-4 mg subutex. 'I do talk about [subutex script] but I can share everything, my family problems,' he said. 'I will detox eventually but not planning anything definite at the moment.'

Outcomes questionnaires show a high level of improvement in many areas for individuals – almost all participants report an improvement in psychological health status and a reduction in isolation, which they attribute to being involved with the group. Most respondents also report significant changes in drug and alcohol use. Of ten attendees at a recent meeting, nine had not been thinking about reducing medications before starting in the group, but all reported either reductions in – or cessation of – 'on top' use, and reductions in prescribed medication. All said that the group had played an important part in boosting confidence to achieve this.

The facilitators also act as advocates – members have been accompanied to hospital appointments, a work tribunal and detox assessments, and have been helped to find opticians and dentists and advised about pensions. There's also been regular help around filling out DLA forms, applying for bus passes and setting up email accounts.

It's known that detox may need to be slower in older age and that pain relief for other complaints may need to be increased, and facilitators routinely talk to GPs and shared-care workers on behalf of participants to discuss slower reductions or changes in pain control regimes. There are occasional outings to help reduce isolation which are enthusiastically attended, as well as popular

LANGUAGE

'Facilitators notice some significant differences in working with older people. They comment on the strong sense of personal responsibility, lack of external attribution... and readiness to develop new friendships.'

evening walks by the sea at Clevedon and visits to Westonbirt Arboretum. On top of this there have been bowling events and a memorable barbeque on the beach at Weston-super-Mare.

Facilitators notice some significant differences in working with older people. They comment on the strong sense of personal responsibility, lack of external attribution, regular discussions about fear – of stopping, or using, or getting old – and readiness to develop new friendships. Participants talk animatedly about what they value in the group, with comments like 'it takes me out of my loneliness'; 'it's a comfortable relaxed atmosphere, no pressure to attend'; 'it's a community and the underlying factor is trust'; 'I get a lot of pleasure from coming, my wife reminds me [to attend] each week'; 'the group perks me up – gives me some positivity' and, 'being around people, having the opportunity to ask for advice if I'm struggling with anything'.

Being in an age-specific group is absolutely vital to all participants, with comments like 'we just all understand…there's no bragging about what you've done, it doesn't matter any more' and 'I feel calm and safe in this group because of the age group which does not exist anywhere else'.

So what happens if a member turns up intoxicated? It just doesn't happen. In the words of one member, 'for us it's about friendship, community and family. You respect it'. **DDN**

If you're interested in starting a group for older drug or alcohol users contact Katie Jacobs, Bob Fisher or Paul Osterley at Bristol Drugs Project: Info@bdp.org.uk

Rachel Ayres is volunteer manager at Bristol Drugs Project

Post-its from Practice

Nurturing hope

Gender sensitive care is needed, says **Dr Chris Ford**

Women start using drugs for a variety of reasons. Often, like Maria, they have started drugs and/or alcohol as a coping mechanism.

WHEN I SAW MARIA for her routine appointment last week, she asked me to mention her in this column – she thought she had done really well and wanted everyone to know it. So I cast my mind back to the first time I had met her over eight years ago when she was four months pregnant. She was battered and angry, and demanded in her strong Dublin accent that I gave her methadone.

Maria told me that day that she had left her abusive partner and fled to London with her baby. She could no longer take the abuse, even if it meant leaving her family and home. She pleaded with me not to involve social services, but I explained it was better to have them on board early as support. We were lucky that the allocated social worker understood what was needed and the local hospital has a great specialist midwife, so Maria was supported throughout the remainder of her pregnancy.

She settled on 80mg of methadone and wanted to reduce, but each time she tried she became less stable, so we agreed to revisit this when the baby was a few months old. Maria took to motherhood and bonded well with her baby daughter, but every time I gently probed for information about her past life, she clammed up and became angry.

Over the next few years she told me her story – born to alcoholic parents, youngest of five siblings, in and out of care, abused by an uncle who would 'look after' her while her parents went to the pub, and escaping at 16 to an older man who drank and started to hit her from the day they were married. Maria began using heroin as a way of coping and the violence intensified when she became pregnant.

Since leaving she has continued to flourish and remains on methadone while pursuing her recovery. Her daughter is eight years old and doing well, she has a part-time job in the kitchens of her daughter's school and has started to go to NA. She is thinking about reducing her methadone but doesn't want to upset what she sees as her recovery.

Women start using drugs for a variety of reasons. Many have been abused and more than average have been in care. Often, like Maria, they have started drugs and/or alcohol as a coping mechanism. Many have been the victims of domestic violence. One in four women will have experienced domestic violence in their lifetime and women victims are 15 times more likely to misuse alcohol and nine times more likely to have problematic drug use. We must be aware of women's vulnerability, and nurture hope and purpose in their lives.

Maria has come a long way on her journey of recovery and she has taught me many things. She may have further to go but if, when, and how, is for her to decide. At the moment she feels she has done well – and I agree!

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

ENTERPRISE CORNER

SEEING THE BIGGER PICTURE

Does the government 'get' entrepreneurship? asks **Amar Lodhia**

WITH THE UK IN A DOUBLE DIP RECESSION, our government's answer to the country's own recovery journey has been one of austerity. I often have to explain to government officials (local and central) the value of 'entrepreneurialism' – supporting people to 'make their own jobs' in the current climate and how enterprise skills support transition into employment – something they generally understand, but often just don't know how to implement and drive across departments.

Harvard professor Josh Lerner argues that the flaws of governments are partly down to bad programme design and implementation, but also a result of dumb, often corrupt, policy-making and that, more often than not, governments simply 'don't get' entrepreneurship.

I think Lerner may have been a bit harsh, but he has a point. I had the pleasure of sitting down with Lord Young at Downing Street a few weeks ago. Lord Young is the force behind initiatives like StartUp Britain and now the enterprise loans for young people, where every young person from the UK aged 18-24 will be entitled to a business start-up loan. Although the £10m allocated to this will only provide loans to 10,000 young people when there are 1m unemployed, this is a great start and it is reassuring to know enterprising people like Lord Young are advising the prime minister and making change happen.

One of the problems I see is that this central message of entrepreneurialism is often preached but not practised by the government, locally and centrally. Let me give you the most prominent example of what businesses do wrong during the 'rainy days'. The most likely cuts to be made are to the things that drive the business, such as marketing, training and staff. This has also been true for government. Even local government can often make the mistake of cutting expenditure which may seem like a 'luxury' but in fact is central to the entire delivery of outcomes within a service. Why does this happen? In short, because the big picture is not seen.

If entrepreneurs ran the country, would they handle things differently? Yes they would. There is a lag time in seeing the effects of policy decisions, so how long – with all the changes being made – will it take for us to see any change in our economy and a turnaround in our country's woes? And can we wait that long?

The department that costs the taxpayer the most is the Department of Work and Pensions (DWP). The idea of transferring the risk through a 'payment by results' model is arguably quite a candid way of designing service delivery and paying only for hard outcomes. Following the recent demise of A4e and the government ending their Work Programme contract, we already know that the prime providers are incentivised in way that promotes quick cash generation on outcomes to meet their cash flow targets. So will they support a recovering drug addict who has not worked in the last 15 years, and at the age of 40 is unemployed and finishing treatment for substance misuse who may take longer to work with?

The worry is, if our leaders spend any more time in making fundamental errors and cutting funds to 'bread and butter' activities and not running the country like a business, we could potentially find ourselves in a worse state than we are already by 2015.

I'd love to hear your views. Email me at ceo@tsbccic.org.uk and follow us on Twitter @TSBCLondon using *#DDNews*

Amar Lodhia is chief executive of The Small Business Consultancy (TSBC)

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Hatred against those receiving benefits is out of control in Cameron's Britain. The Tories transformed a crisis of capitalism into a crisis of public spending, and determined that the most vulnerable would make the biggest sacrifices.
Owen Jones, *The Independent*, 18 May

What Duncan Smith proposes comes too late in the long alcoholic cycle (20 years for most addicts). The kind of people he has in mind (few, one suspects, will be Eton/Oxbridge educated) have an array of problems. Adding one more – acute poverty – will not make them 'pull themselves together'. It is more likely to be straws and camel backs.
John Sutherland, *The Guardian*, 24 May

A 50-pence-a-unit minimum alcohol price will probably make a major difference to lifestyles in the Rab C. Nesbitt zones. Mr Cameron envisages something similar for England, although the minimum price would be a bit lower, possibly to take into account all the extra taxes English drinkers have to pay to subsidise the Scottish ones.
Steve Doughty, *Daily Mail*, 28 May

This minimum price meddling by politicians is futile. Northern Europeans are prone to binge-drinking in a way that southern Europeans are not. Ask the Scandinavians! Alcohol is massively expensive there, yet alcoholism remains a serious problem... I doubt it'll have any other effect than to make life more difficult for the poor, give a boost to smuggling and lead to a drunken invasion of England, which will do the reputation of Scots and Scotland no good at all.
Simon Richards, *Daily Mail*, 14 May

It's foolhardy to expect that those who have to fill with booze the empty space inside themselves will be deterred by having to pay a little more for it.
Alexander Boot, *Daily Mail*, 17 May

Minimum pricing is a result of a national moral panic about alcohol, which follows on the trail of moral panics about tobacco and obesity, which are created by the tabloids and their beloved pictures of girls vomiting into gutters with their skirts hitched round their waists; there is a whole crocodile of moral panics, squeezing its way into Downing Street as more important issues are ignored.
Tanya Gold, *The Guardian*, 15 May

Why shouldn't people be allowed to make the choice to live the way they want? The world is full of self-righteous, issue-obsessed busy-bodies who want to bully us out of our pleasures. You can't have a glass of wine, eat a couple of sausages, drive a petrol car or water your garden without someone telling you that you're damaging yourself or the planet. And most of it is just nonsense.
David Thomas, *Daily Mail*, 10 May

I know from experience that what seems like harmless boozing in the company of similarly thirsty contemporaries can develop into alcoholism. But I also know from experience that 12-step dogma can leave people trapped in a situation in which they define themselves by their addictions.
Damian Thompson, *The Telegraph*, 17 May

Blenheim CDP

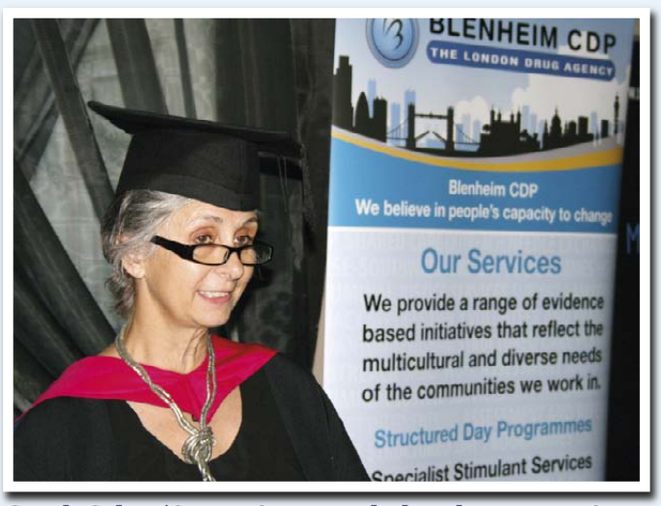
Blenheim CDP's managers have just graduated from the Chartered Management Institute (CMI) level 5 Diploma in Management and Leadership – a new course designed to draw out their skills and talents as inspirational managers and leaders. At a special graduation ceremony in London the team explained what the experience has meant to them

TAKING THE LEADERSHIP CHALLENGE

'When I was first tasked with finding an appropriate qualification for managers, I experienced frustration and despair at the lack of relevant and inspiring courses,' says Jo Palmieri, Director of Learning and Development at Blenheim CDP. Meeting trainer Alia Taub from Management Focus Training Solutions changed all that. Over the next few months they worked out a course that would test knowledge, skill, reflective practice and be just as relevant to the wider health and social care field – and would result in a recognised global qualification.

'We wanted managers to be stretched and apply their learning to their work,' says Jo. The 100 per cent pass rate showed that their investment in an accredited course paid off. 'We now have 11 more motivated, competent and bonded managers,' she says.

'The course was designed to include the latest topics around management,' says Alia, who was course tutor for the programme. 'We designed an assessment process that used different skills, from project development to presentations. Managers were faced with challenges and now have the skills, resources and knowledge to face situations they wouldn't have tackled before.'



Sarah Cahn: 'Our written, verbal and presentation skills were all assessed and, for me, it was the variety of assessment methods that made it special, unique and rightly challenging.'

'Many organisations only develop the technical skills of their people, without developing their leadership and management,' says Chris Roebuck of the Chartered Management Institute (CMI). 'Leadership is about convincing people that you know what you are doing and that they can trust you. As well as technical experts we have to be leaders.'

Laraine Start had been a manager at Blenheim CDP for eight years when she embarked on the diploma course.

'It made me think about my strengths and weaknesses,' she says. 'It taught me about management styles, change management and the need to read every context differently. It also taught me that learning styles are endless.'

'It made me question myself and step back,' she says. 'Being a figure of authority is not just about telling people what to do. It's about being a cheerleader –someone to encourage them and take risks for them.'

Sarah Cahn was amongst the last managers to sign up for the course and admits to hanging back initially. But the attractions of a 'fantastically visual course' soon won her over and made her realise that her dyslexia was not a barrier.

Presenting the graduation certificates, the Lord Mayor of Westminster, Councillor Angela Harvey, said she was inspired by the team's work in making a difference to people's lives.

'The work you do has real meaning for us all,' she said. 'I applaud everything you do and hope that you'll be continuing your learning journey.'

BECOME A FULLY QUALIFIED MANAGER

The Diploma in Management and Leadership is a 14-day programme of study held over ten months, in central London and costs £2,700 for study in 2012/13. It is designed for those who are current managers, or those who are aspiring managers, and gives an opportunity to progress to Chartered Manager status through the CMI.

For further information and application forms, contact Jo Palmieri, Director of Learning and Development, Blenheim CDP, 66 Bolton Crescent, London SE5 0SE. Tel: 07949 924351 or 020 7582 2200. Email: j.palmieri@blenheimcdp.org.uk

The visiting professor

A key figure in shaping Obama's drug policy, Keith Humphreys is now working with the coalition government. He talks to **David Gilliver** about politics and polarisation

'What I like is that you see everything about people,' says Keith Humphreys of his 25 years in the addictions field. 'You see hope, despair, love, death, transformation, struggle for control. And it relates to every area of public policy.' The Stanford University professor of psychiatry and behavioural sciences is spending five months in London as an honorary professor at King's College, as well as doing policy work for the UK government. And on the subject of policy, he believes that polarised debates about prohibition and legalisation should take a back seat to scientific evidence of what works.

'Extremes make good PR,' he says. 'That's true of a lot of issues. Everybody's saying things are far simpler than they actually are. One the one hand, if it's just a question of suppressing [drugs] sufficiently, then they're not being honest about the downside costs of that, particularly in my country where 25 per cent of prisoners are there for drugs. It's horrible. But on the other hand you have people saying legalisation would solve everything. Ask those people how happy they are with the health contributions of the tobacco industry, because that's what a legalised industry is.'

He points out that legal pharmaceutical drugs are the leading cause of overdose in the US, undermining the argument that overdose rates would fall if people could check the purity of the drugs they were going to take instead of being dependent on the black market. 'I hear that all the time, but the evidence is that it doesn't impact overdose rates,' he says. 'And in terms of the crime argument, the

drug with the biggest link to crime is alcohol. There's just no free lunch, unfortunately. Legalisation works in theory, but any theory will beat reality.'

He's speaking as someone with experience at the highest level, having been senior policy advisor at the White House's Office of National Drug Control Policy (ONDCP). What was that experience like? 'Really enjoyable,' he deadpans. 'That's a lie. It was gratifying, but very hard. I gained 15 pounds, I developed reflux, I was working all the time and didn't see my family – all that stuff is non-negotiable cost. It really beats you down, and – getting back to the polarisation – you do get exposed to a lot of ugliness.'

He's immensely proud of what was achieved, however, having been involved in the landmark Affordable Care Act for healthcare reform. 'We got full coverage of alcohol and drugs treatment and screening in there, which is really important,' he says. 'Getting 30m people, a lot of them poor, covered was a really big deal. I never thought I'd see it in my lifetime. And also changing the drug strategy – the previous one didn't even mention Aids. So getting that back in, with needle exchange and naloxone distribution.'

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The *2012 national drug control strategy* (*DDN*, May, page 5) promises more money for treatment and prevention as well as an intention to divert non-violent drug offenders away from the prison system. It also signals a new direction in criminal justice, he says – a harm reduction approach towards policing itself.

'You're always going to have drugs, but you need to change how you think about markets,' he explains. 'Drug markets destroy the quality of community life, because they're violent – much more so in the US than here. So when you're policing, your haul shouldn't be ten people for possession – what you want is the most violent people, and you need to make it publicly known that the way to attract law enforcement attention is to be violent. You bring in all the gang members and say, "these two guys went to prison because they shot people. If none of you shoot anybody, you won't see us again. But if *anyone* in your gang shoots anybody we will come after you for overdue library books and parking fines, so police yourselves. And that works. It encourages the police to think about their work differently – they're incentivised to not go after the easy busts.'

Nonetheless, there's been a depiction of Obama as a 'drug warrior' by some – did people have unrealistic expectations? 'He's considered a drug warrior by one end of the spectrum, and a complete softy by the other,' he says. 'Don't forget, we reduced the prison population for the first time in 40 years, reduced sentences for crack and cocaine, and we took money from businesses and the taxpayer to provide healthcare for drug addicts. So if you talk to one group of people, we're a bunch of potheads. I think that's the nature of the beast – if you're fairly centrist you're hated more than if you just hew to one end.'

He's consistently argued that what's necessary is 'more and better treatment', as there remains nothing comparable to methadone for people with stimulant problems. 'I've been at this 25 years and if someone had come to me then and said, "doc, I'm strung out on cocaine – what are my options?" my answer would have been the same as today. I have nothing new. We've made huge progress but it remains hard to treat the amphetamine-type stimulants.'

This is another argument against legalisation models, he maintains. 'If you legalise coke and meth the price would drop dramatically, as cocaine's price is about 99 per cent illegality. So let's imagine if the number of addicts *only* doubled – what would we do, if we don't have great treatment options?' And addiction to legal prescription drugs is a huge problem in the US, he stresses.

'It's an epidemic. Something like one per cent of American teenagers have tried heroin, but about 12 per cent – one in eight – have taken OxyContin and Vicodin, and those are sticky drugs. It's really big, and the deaths are still underestimated.'

*****

As well as his work at King's College, he has a special remit to work with the UK government in a cross-party capacity, presenting on science and policy 'to anyone who'll listen,' he says. 'I'm not registered to vote here so I'll talk to everybody. I've never given a briefing to the BNP, but anyone who's not insane and wants to know about treatment, crime, addiction, I can go in and say, "this is what we know, this is the evidence".'

'If it's just a question of suppressing [drugs] sufficiently, then they're not being honest about the downside costs of that... But on the other hand you have people saying legalisation would solve everything. Ask those people how happy they are with the health contributions of the tobacco industry, because that's what a legalised industry is.'
Keith Humphreys

As far as current UK policy issues go, he's convinced that minimum pricing is a good idea. 'If you look at the evidence, people who drink the most are highly price-sensitive, so you're specifically targeting an intervention. But the might of the industry is not to be underestimated. The fact that in the Blair administration alcohol policy was in the ministry of culture and sport says a great deal.'

He's also been a volunteer in the humanitarian effort to rebuild Iraq's psychiatric care system and a member of the White House Commission on Drug Free Communities. What sparked his interest in addiction and mental health issues? 'A friend mentioned this research assistant job,' he says. 'At the time I was flipping burgers for three dollars an hour in college as a psychology major.'

His focus on the evidence base also means that a consistent area of interest has been the limits of research, particularly around the extent to which subjects in medical research differ from patients in everyday clinical practice. 'I'm not the kind of person who's going to come up with a grand theory – I've always been more interested in how we do science practically, to help people,' he says. 'But what I noticed reading a lot of clinical trials was the section on how people got in, or usually who couldn't get in, because you often end up with these very high functioning people. And I thought it might be hazardous to generalise from these fairly stable, mono-problem people, because you're excluding the poor and vulnerable.

'I did a study of who couldn't get in to alcohol trials, and they were disproportionately poor and black. So that's a science issue, a public policy issue, and a moral issue.' **DDN**

INNER STRENGTH

A pilot project in London hostels has been helping to motivate both residents and staff, reports **DDN**

'It works by engaging people on the basis of what their strengths are,' says Suzanne Quinney of appreciative inquiry (AI), the technique of asking positive questions to help build strengths and challenge negative thinking. As co-director of Appreciating People she's been involved in a partnership project with Westminster City Council and Riverside ECHG, 'Back on your feet', which uses AI with residents of the borough's hostels.

The 'Back on your feet' project began at King George's hostel for single homeless men, which has a high proportion of drug-using residents. Quinney co-designed the programme with hostel staff, working with them individually before the training began to give them 'a bit of a flavour that there was a slightly different approach being incorporated'.

The aim was to build on the residents' inner resilience and make them less susceptible to relapse, as well as establish small communities of peer-led support. The key to AI is simply to encourage people to look at things in a different way, she explains. 'It's about discovering more about the strengths we already have and quite often aren't giving enough attention to, or maybe we haven't really registered that we've got them. Sometimes if you ask people out of the blue what their strengths are they don't know, because they've never put the time into it or had that little bit of coaching.'

Residents and staff both participate, which is something that residents value, she stresses. 'It's the equality of the situation – I think that's helpful for everybody. People see a different side to each other that they can then relate to, and it helps them to support each other. One of the questions we ask is 'when have you helped a friend?' to encourage that mentoring side of things. In the case of the staff we'll focus on the strengths of their work.'

Originally developed at the end of the 1980s, appreciative inquiry is an 'open-source' method that has grown and developed over the years. So is it similar to CBT, in that it aims to challenge ingrained modes of thinking? 'People do mention that, but I think they're different in the sense that appreciative inquiry originally comes from organisational development, and has been used in community development as well. It basically allows people to think, "there's an option here for how I see the world".'

Hostel staff started to notice changes quite soon into the project, she says, with residents becoming motivated to get up in the morning and put on clean clothes. Did they start out with a level of cynicism or suspicion that needed to be overcome first? 'Before we began I went and did a little intro session with the residents, so there was a small core of knowledge start with,' she says. 'But on the first day two people left before the afternoon was over. Some people decide it's not for them and that's fine – we don't make anyone stay. But once people decide to stay, they generally really give it as much as they can.'

After the initial work with 12 residents at King George's, 'Back on your feet' has been rolled out to other hostels across the borough. She's now worked with around 40 residents personally, although the staff who've been trained have worked with many more – a training session late last year involved 18 staff from nine different hostels. 'They find their own ways to use it, and their individual clients will respond differently in different settings,' she says.

There's also been a team-building session with the council's rough sleeper team, but funding for the project – which was from a Westminster City Council pot to support training and education – has now run out, she says. 'We've submitted the project for an award and if we're successful we'd like to use that money to do a bit more and to develop it. We've got residents who are keen to do more, and we'd like to roll it out to interested hostels.'

As far as she's aware, 'Back on your feet' represents the only time that AI has been used in this sector. 'I don't know of any others,' she says. 'Internationally it's been used with hostel staff for team building or support – like we did with the rough-sleeping team – but I haven't found anywhere where it's been used with the client group. I think one of the strengths is the personal development it can bring.'

The overall objective was to address the 'revolving door' syndrome, where residents constantly return to care, and the costs associated with it. Have they been able to assess what kind of financial impact it's had? 'Not overall yet, but we did work out the cost of one resident's arrests, prison stays, failed detox and probation curfew with tagging and an ASBO. People are individuals, obviously, but that came to nearly £15,000, and in the following year there were none of those costs. He moved on to his own accommodation, and he's still there.'

Suzanne Quinney will be discussing the project at the Chartered Institute of Housing conference in Manchester, 12-14 June. Details at www.cihhousing.com

'Sometimes if you ask people out of the blue what their strengths are they don't know, because they've never put the time into it or had that little bit of coaching.'

Suzanne Quinney

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BY THE PEOPLE, FOR T

Alistair Sinclair **reports from a genuinely community-led celebration of recovery**

'THE STRENGTHS OF RELATIONSHIPS THAT EXIST IN THIS ROOM WILL BUILD A RECOVERY COMMUNITY IN LANCASHIRE,' said Tom Woodcock, director of Lancashire DAAT, as he opened a recent recovery event in Preston. NTA strategic recovery lead Mark Gilman spoke twice, on *Recovery – a game of two halves* in the morning and channelling the spirit of Jim Bowen in the afternoon. So, two of the 'usual suspects' on the conference circuit – nothing new there? Well, not quite.

Putting aside Gilman's *Bullseye*-inspired presentation in the afternoon (which pretty much brought the house down) this conference took place on a Saturday, and nearly all of the 200 people present in the Free Methodist Church were members of an emerging Lancashire recovery community.

Organised and run by community members, this wasn't the usual professionally generated response to drug issues, addiction and 'recovery'. Instead it was a community-led celebration of recovery, an articulation of a deep desire to challenge the stigma embedded within services and society, and create a place where people could come together to remember the lost.

Following a UK Recovery Federation (UKRF) seminar in Lancaster last November, Dave Higham, a local recovery activist, pulled together a team of community members. Identifying and using community assets, this team turned Dave's dream – an event organised by the recovery community for the community, 'by the people, for the people' – into a reality.

While it was supported by Dave's employer Addaction, and Lancashire DAAT, it was very much a community affair. Speakers Kerry Farrar, Pete Yarwood, Chris Drury and Dave shared their experience of recovery in the community and what it meant to them. Workshops, delivered by people from the recovery community, explored how recovery could be supported and sustained within communities – in prisons, through the use of old and new media, through the challenging of stigma, and through the sharing and support of passions and strengths in families and communities.

There was music, there was celebration and there was remembrance. A sculpture entitled *Remembering the lost*, created by Kelly, another local recovery activist, was a central feature at the event and everyone was invited to contribute to its evolution by offering up the initials of people they had lost. It's planned that this sculpture will be taken to other community-led recovery events and grow as others contribute the initials of those they want to remember, generating links of remembrance between the many diverse recovery communities in the UK.

Time was taken to remember, and this was a very powerful and moving moment on the day. But what was most powerful was the passion for recovery in the room and the diversity of people who'd come along on to connect, share and learn as a community.

There were people present who are active in the fellowships and SMART, people from Celebrate Recovery, a 12-step programme for 'all hurts' run by the Free Methodist Church. There were 'inmates' from Kirkham Prison who attended at the end of a very successful recovery week. There were people from local rehabs and treatment services, harm reduction advocates and recovery leads, and people who follow no proscribed path in defining and maintaining their recovery. It was a day that brought lots of very different people with different definitions of recovery together, all of them with stories to tell and voices to be heard.

Voices of recovery

'I am a recovering addict and have been living in recovery for seven years. I was in addiction for 25 years and was in prison more than I was on the streets between the ages of 16 to 37. I found recovery in prison doing a 12-step programme and have never used since I started the programme.

'I think it's important that recovery is supported out in the community and celebrated; so we can feel proud of what we have achieved and show others that recovery is possible and happening on a street near you.'
Dave Higham, event lead

'The use of hands in the sculpture represents the idea of remembering, the holding of people within our hearts and thoughts. They represent the unity, togetherness, hope and love that I see developing more and more within the recovery community.

'I wanted to remind people of the unity and connections within the recovery community and our unique ability to be of use and to understand those that are suffering with this disease. So that we continue to give our time and effort to helping those that are suffering in recognition that a chat, love shown and a helping hand could save someone from going so far down the road of addiction that they cannot get back.'
Kelly, sculpture creator

'People do recover from addiction, treatment can initiate long-term recovery and people can get well where they got sick...you can do it but you can't do it alone. 'I' can't but 'we' can...transformed people can transform people...recovery can be a fundamental moral existential revolution.'
Mark Gilman, speaker

'Family members get other family members right, we learn from yesterday, get up with a positive outlook and live from today.'
Christine, Al-Anon

THE PEOPLE

'Everybody in this room has experienced stigma. When I was using I was socially invisible, there was no offer of hope, no language of hope. It was a drug worker who was the first person to look beyond the scars, the abscesses, to see a human being... I've experienced it, I've seen that recovery is contagious, built by contact...We need to make recovery more visible, we need to help people understand the nature of addiction and recovery...We need to keep walking the walk together and talking the talk and not accept language that says "you can't".'
Kerry Farrar, speaker

'I'm here to meet people, make connections and have fun, that's what I'm achieving. It's important to show people that recovery is possible, keep motivation up, inspire people.'
Mags, event participant

'Recovery is bigger than abstinence...for me it's about connecting, the five ways to wellbeing, turning your life around and becoming an asset in the community. When you become an asset your life starts to take off...I saw the beginnings of culture change in Kirkham prison this week, the community saw what was in the prison, saw the assets.'
Peter Yarwood, speaker

'The recovery community, it's like a new family, a new circle of friends, meeting people who've been there, had some of the same problems, learning with each other.'
Event participant

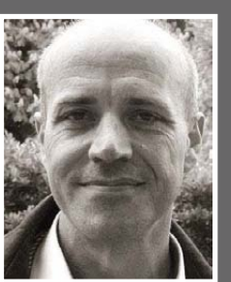
'There are many paths to recovery, many forms of recovery. Recovery involves dealing with a wide range of hurts, habits and hang-ups. Shall we keep doing the same thing over and over again and keep expecting different results or shall we build as a community around our similarities?'
Chris Drury, speaker

'I've been blown away by the power in the room today, you all belong to a community that saves lives.'
Dave Higham, event lead

VOICES OF RECOVERY

RECOVERY ON THE INSIDE

Supporting recovery in prisons can build strong links to life in the community, says **Alistair Sinclair**



I've just been to Birmingham to talk about recovery walks and how the UKRF can support the growth of recovery networks there. Recently we were doing something similar in Edinburgh while delivering two recovery seminars – one in the city centre and the other behind the walls of HMP Edinburgh. This was our second prison seminar after one in April at Kirkham, near Blackpool, as part of Kirkham's 'recovery week'. It was fascinating to spend time exploring the strengths within the recovery community at Kirkham and Edinburgh, and both seminars highlighted the need to support recovery inside prisons and build strong connections between prisons and recovery communities on the 'outside'.

Matt Idle and Mark Shear, ex-offenders with 25 years prison time between them, set up A2nd Chance. They use their experiences of addiction and recovery to support the growing recovery community in Kirkham, helping people prepare for life out in the community. Matt and Mark share their experiences with us:

'We were really surprised by how much we packed into our recovery week at Kirkham, how many different workshops – self-esteem, wellbeing, consequences, victims and family talks, and how many of our recovery mentors shared their experiences and hopes for the future. The impression left on the whole of HMP Kirkham and the Lancashire recovery community couldn't be put into words.

'Was it the shares from the prisoners which made the week, or the families and victims who came along to help people recover – or maybe it was the group of delegates from Parliament? All we know is that the week was outstanding from start to finish. One evening a recovery choir came in. Afterwards we were walking back to our cars and the prisoners were walking back to their cells singing – they were as one, a recovery vessel singing recovery chants. It was one of those many magical moments.

'In the weeks since recovery week the team has been busy with 70 extra applications from prisoners wanting to come onto the recovery billets. The self-help meeting has grown and the prisoners have been building and strengthening their recovery community.

'As A2nd Chance it's great to be part of a very successful and passionate team within HMP Kirkham. We're part of something that in all the years we have been in recovery we have never seen! We can only explain it as real magic, pure love and being part of a community working together. We are ex-offenders and ex-drug users. Our recovery grew with the help of prison mentors and HMP Kirkham staff and has been sustained by our community. This is a prison and these guys have helped us find a purpose in life after years of being lost in addiction.

'We would like to thank the governor Bob McCombe and Donna Morgan for helping people change their lives, and everybody for giving us A2nd Chance. Peace and love and see you at the next recovery week.'

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

POLICY SCOPE

Is there a missing piece in the recovery agenda? asks Marcus Roberts

A GROWING BLIND SPOT

AN INADVERTENT AND UNINTENDED BY-PRODUCT of the focus on recovery may be a lack of attention to the clinical aspects of treatment.

There is now a clear recognition that drug and alcohol treatment should engage with housing, family relationships, meaningful activity, peer networks, recovery champions, etc. However, this should not blind us to the reality that treatment must also continue to be about medicines and prescriptions, HIV and hepatitis, psychiatry and psychotherapy and so on. This is recognised in the *Drug Strategy 2010* – for example, 'prevention of drug-related deaths and blood-borne viruses' is one of eight 'best practice outcomes'. There are, however, concerns that current policy development may be disengaging from clinical aspects of treatment.

For example, it remains unclear how standards of clinical governance and other patient (and staff) rights that are established for services provided or commissioned by the NHS will (or won't) apply to local authorities when the responsibility for drug and alcohol treatment is transferred next April.

NHS patients have rights to treatments recommended by NICE and to a professional standard of care delivered by appropriately qualified and experienced staff, as outlined in The NHS Constitution. The government's Public Health White Paper confirmed that the NHS Constitution applies to Public Health England, but it is not clear whether it will be binding on directors of public health insofar as they are employed by local authorities.

Or consider the development of 'black box' approaches to service commissioning as part of payment by results, with the focus on outcomes, not methods and processes. There is a lot to be said in favour of a more 'hands off' approach from the centre. But what goes on in, say, a doctor's surgery, hospital or psychiatric institution should not be cloaked in opacity, but transparent. As the recent Audit Commission report *Local payment by results* rightly comments 'for some services, it is not innovation that is required but adherence to best practice' and 'in such cases, outcome measures may become less important than input and process measures'. This applies to at least some of what happens in drug and alcohol treatment.

The UK Drug Policy Commission's *Charting new waters*, published in April, highlights concerns that specialist NHS work in drug and alcohol treatment is being squeezed out, partly because it is relatively expensive in austere times. One NHS provider expresses fears that clinical knowledge and expertise that has 'taken a generation to grow' and is essential for 'the best quality high standard care' is under threat – along with clinical leadership, investment in training a new generation of specialists, clinical research and standards of governance.

I suspect this blind spot in the development of recovery systems is more about inattention than intention – and may even be an unintended consequence of the increased (and generally very progressive) interest in the social dimensions of substance misuse problems. But it is a growing concern, and one that is overdue for some focused thought and attention.

Marcus Roberts is director of policy and membership at DrugScope, www.drugscope.org.uk

DrugScope's new 'Building for Recovery' report is available on the DrugScope website at www.drugscope.org.uk

LETTERS

DEFINING RECOVERY

In April the UK Recovery Federation (UKRF) decided to support a response to the government's policy paper *Putting full recovery first* (*DDN*, May, page 6). There are many reasons we did this and some are in the response. However we felt it was important to be clear as to why we decided to be critical of a document that so strongly linked recovery with abstinence.

We believe that 'recovery' is defined and sustained through our relationships and environment within communities. It is, in essence, a social and community activity. To regard 'recovery' as essentially a medical condition – the absence of a drug from our bodies – is to corrupt the reality of recovery. Medical interventions have a role in helping address the physiological and psychological, but, as anyone who has experienced rehab knows, achieving abstinence can be a first step on the way to recovery. It is never the last.

If we improve the quality of our lives, our relationships, employment and housing we will improve our health and wellbeing. If treatment orientates itself to life improvements and works closely with communities of recovery, then abstinence will be a choice that many will make. Self-directed recovery, as opposed to expert-led control, is not only the most ethical but will also embrace and utilise the potential and strengths within all.

The UKRF have principles and values and these sit at the core of everything we do. We believe that this is where recovery-orientation starts; with core values rooted in social justice and equality. We cannot ignore our recovery principles because some people hold different views as to what 'recovery' is. We can only continue to encourage dialogue, work to instill hope and optimism and nurture an inclusive and progressive vision of recovery. Our simple idea – of bringing people together to foster collective and mutual support and learning, resonates with many in recovery. The people who wrote *Putting full recovery* first may be part of our community but they are not its architects. They are certainly not its leaders.

The UKRF want to encourage all those who use drugs, all those recovering and in recovery, all those working to support the reduction of harm and the promotion of recovery – to talk, share and build something better. That's why we signed up to a response that laid out the risks inherent within a closed definition of recovery and invited the paper's authors to participate in a process of dialogue and engagement. We will achieve a recovery-orientated society if we share and learn from all our stories and struggles.

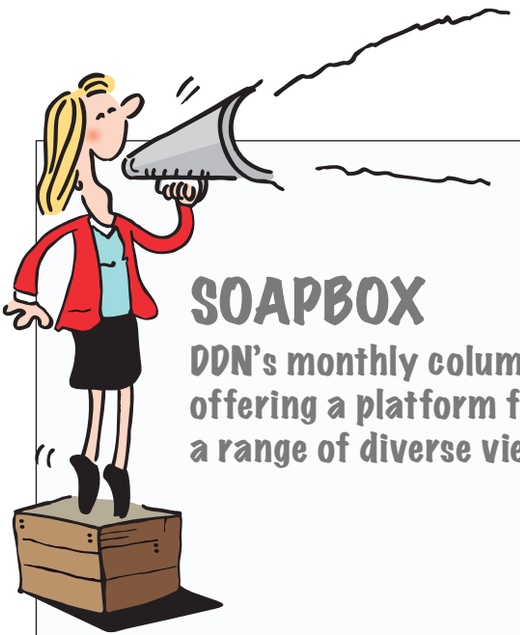
Anne-Marie Ward, Alistair Sinclair, Brian Morgan, James Attwood, Melody Treasure, UK Recovery Federation directors

FINANCIAL KICK-START

Listening to the news the other day I heard an announcement by Lord Young, David Cameron's enterprise advisor, of the launch of a new initiative to provide start-up funding for young people wanting to set up their own business. This started me thinking. Over the last few years we have seen some really exciting innovative attempts to start social enterprises and community interest companies by people in recovery. Many of the projects have been showcased at the *DDN* conference, or featured in the magazine.

Unfortunately there are not enough of them. What would be fantastic would be access to a scheme that provides an honest straightforward loan alongside professional support and advice in return for a viable business plan and the desire to make a venture work. Providing non-judgemental commercial support to enable people in recovery to start small businesses could not just help those people, but also help the drive to kick-start the economy and reduce the benefits bill. People who have battled addiction and come out the other side have demonstrated their resilience and determination. So come on Lord Young, how about providing us with access to some 'recovery capital!'

Andrew Bennett, by email



SOAPBOX

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

FUTURE IMPERFECT

Chaotic and unregulated drug services are not the solution for stable clients, says Ken Stringer

THERE IS SOMETHING ROTTEN AND UNWHOLESOME GOING ON IN OUR SECTOR. This change is not consistent, and not strategically driven in the way we are used to. It seems as though some parts of our hard-won treatment services are simply unravelling – clearly incapable of delivering evidence-based treatment, or maybe just unwilling.

We run a helpline, or rather at the moment due to huge demand we are responding to a backlog of urgent requests for help. We also have an increase in calls referred from FRANK to sort through. Pressure on the helpline has grown significantly, and in direct proportion to funding being reduced (note to self, invoice FRANK). In particular we are seeing increases in calls from workers asking how to respond to direction to engage in bad practice and a massive increase in calls from stable clients experiencing enforced detoxes in the name of 'full recovery'.

This is not consistent across the sector – there remains still a rump of solid quality drug treatment. But the regularity of these calls is depressing – and their increasing frequency challenging. We have been more used to fielding calls about the rigidity and inflexibility of statutory provision, but over the past year there has been a big jump in those we are getting in relation to large national charities.

Perhaps this switch relates to an increase in contracts awarded to this sector and lost by statutory agencies and small local charities. Maybe it's down to the 'over-stretch' of the clinical expertise of these essentially commercial enterprises. To us it seems to show a crisis in clinical governance – one that few appear to have the means or desire to tackle in any meaningful way.

I want to give you a few examples of the sort of thing I am talking about and to show the impact this is having on people – real people who call our helpline. I will not tell you about all of the stable, lower dose clients in jobs with homes and families having services removed in the name of 'recovery'. All that they have to do is find an illicit supply and somehow fund their growing habit for the next year to count as a success. What I will share are some of the more difficult and harder to explain cases of practice being delivered in the name of progress. Also the kind of cases that workers call us about with real concerns about safety. All of these cases come from areas in which longstanding local providers have lost tenders.

Not very long ago we received a call from a homelessness worker seeking support for a vulnerable client. The concern related to a client dependent on both alcohol and opiates who also had a diagnosed bipolar disorder. She had been admitted for an alcohol detox and discharged as homeless. On discharge she was informed that her methadone script was also to be reduced by the drugs service, commencing on the day of discharge, by 10ml per day in what the agency described as 'a planned and appropriate reduction'. We helped the worker access a second opinion for this client – and the agency was challenged directly.

Another case involved contact from the parents of a young woman in her mid-twenties who could no longer even interact with them, having had her 100ml per day script simply stopped with no warning. Another 'planned and appropriate' withdrawal no doubt – or maybe just the response of an agency out of its depth with the level of complexity she presented. The Alliance arranged for her to be fast-tracked back into mental health services.

We also had contact from a service user – a carer for her husband – who is being required to travel over ten miles a day for a daily pick-up after three years of stable weekly scripts. For her, either her support for her husband or her script would have to have gone. We got the weekly script restored by talking directly to the pharmacy – and again the agency were challenged.

I have far too many similar stories to tell now – stories that should shame the services involved.

Government policy is usually stated by these agencies as being behind changes in their approach to clients, the abandonment of the evidence base and of care standards. We had been able to consistently say that this was not government policy, until the publication of the government's 'roadmap to recovery' – *Putting full recovery first*, which essentially gives agencies permission to ignore NICE guidance, ignore Orange Book advice and begin destroying people's lives.

We are now entering a period where poorly governed and unregulated services and the commissioners who purchase them are aiming to mirror their own chaos in the lives of their clients. That's no way to build a road to recovery – more like a road to ruin. Recovery is a word that denotes a means of restoration – for many at the moment, this appears to mean restoration to a state of vulnerability and increased risk of death.

Ken Stringer is chief executive of The Alliance. He will be writing about quality standards in a future issue of DDN

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EXPRESSIONS OF INTEREST

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Community Safety Partnership

ADULT INTEGRATED COMMUNITY DRUG & ALCOHOL TREATMENT & CARE SYSTEM

The Wiltshire Community Safety Partnership would like to offer potential providers the opportunity to express an interest in submitting a Tender for an Adult Integrated Community Drug & Alcohol Treatment & Care System.

The intention is to establish a contract with a sole provider or consortium to deliver a treatment system in line with Models of Care to provide high quality treatment, within defined resources, based on need and by doing so improve access, engagement and throughput.

Expressions of interest must be submitted in writing or by e-mail by **Midday** on **Friday 22 June 2012** to Joe Bowerbank, Contracts Officer, Wiltshire Council, County Hall, Trowbridge, Wiltshire BA14 8LE. **Email: joseph.bowerbank@wiltshire.gov.uk.**

Applicants wishing to express interest in the Tender will be required to complete a Pre-Qualification Questionnaire. Selection at this stage will be based on criteria including financial status, experience and professional expertise. Applicants who meet the criteria at the PQQ stage will be invited to Tender.

The Service Specification, along with further guidance, will be covered within the Pre–Qualification/Tender stage packs.

EXPRESSIONS OF INTEREST

cambridgeshire drugandalcohol action:team

CAMBRIDGESHIRE DRUG & ALCOHOL ACTION TEAM

PROCUREMENT OF SUBSTANCE MISUSE TREATMENT SERVICES IN HMP WHITEMOOR

Cambridgeshire County Council wishes to appoint a contractor to provide Drug and Alcohol Treatment Services within HMP Whitemoor to the organisation located within the geographical boundaries of Cambridgeshire.

Our vision for the provision of substance misuse treatment services is for a single system that is recovery focused and delivered by a single provider, or small number of providers working in partnership / consortia, which will involve all prescribing and non-prescribing drug and alcohol treatment services within HMP Whitemoor comprising of a non-prescribing case management service (currently referred to as DART, Drug & Alcohol Recovery Team), substance misuse (drug and / or alcohol) treatment programmes, IDTS prescribing services and needs led drug testing. The service will be ambitious and inclusive, and will be shaped by the needs and views of local service users, who shall be able to access support at any point within their recovery journey.

It is expected that an initial contract will last for a period of 2 years. The contract will commence on 1st April 2013. The value of the contract is up to and including £550,000.00 per annum dependent on continued funding allocation.

Interested organisations should note that Transfer of Undertakings Protection of Employment (TUPE) will apply. Detailed information around the TUPE requirements relating to this particular contract will be provided at the PQQ Bidders Event.

A PQQ Bidders Event for interested parties will be held at the Ramparts, Shire Hall, Cambridge on Wednesday 4th July 2012 from 10.00 – 12.00.

This procurement is being conducted using Cambridgeshire County Council's e-tendering portal. Interested bidders should register with the following website to access documentation from Friday 8th June 2012 until Friday 27th July 2012.

https://lgss.bravosolution.co.uk/web/login.shtml

More information will be provided via a brief once organisations have registered an expression of interest via the contact details below.

Please register your intention to attend the event via the Bravo Messaging Tool by Monday 2nd July 2012. Places are limited to a maximum of 2 representatives from each organisation.

www.sourcecambridgeshire.co.uk

Applicants should note that all Council contracts are subject to the Freedom of Information Act.

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