COUNTDOWN TO CONFERENCE – 20 FEB

DDN
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DDN Drink and Drugs News

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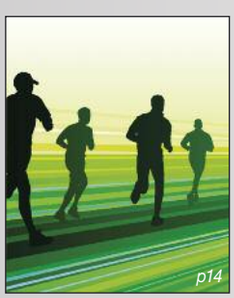
Precious rights

Let's keep our ideological battles in context

In Russia, people who use drugs have no human rights, says Anya Sarang of the Moscow-based Andrey Rylkov Foundation in this month's News Focus (page 6-7). The stark reality of this is that there is no opioid substitution treatment, few needle exchange programmes, and little harm reduction of any kind – and rising rates of HIV and hepatitis C. There is not even any hep C treatment available for people who inject drugs, more than 70 per cent of whom are infected with the virus. Efforts of other countries to influence the Russian government come to nought as 'the rest of the world is wrong'.

So whatever our battles back home, let's at least be grateful for dialogue, both with politicians and with those to whom we are ideologically opposed. There are some diverse, indeed starkly opposing, views in this month's issue, but it is heartening to hear Mat Southwell's view in the profile interview (page 16) that 'there are figures on both sides of recovery and human rights/harm reduction who share views and are looking for points of connection and trying to collaborate.' Let's celebrate these points of connection at *Make it Happen!* on 20 February – call us or visit our website for your last chance to book. We're looking forward to making this the best service user involvement conference yet. See you there!

This issue



FEATURES

REGULARS

NEWS IN BRIEF

DEADLY DRINKING

Vodka consumption is one of the main reasons why a quarter of Russian men die before the age of 55, according to a study of more than 150,000 people over the course of a decade by the Russian Cancer Research Centre, WHO and the University of Oxford. 'Russian death rates have fluctuated wildly over the past 30 years as alcohol restrictions and social stability varied under presidents Gorbachev, Yeltsin, and Putin, and the main thing driving these wild fluctuations in death was vodka,' said Professor Sir Richard Peto of Oxford University. *Alcohol and mortality in Russia: prospective observational study of 151,000 adults at www.thelancet.com*

METH MESSAGE

Although methamphetamine remains a 'minor player' on the European drug scene, it has the potential to cause 'significant' harm 'even at a relatively low prevalence', according to a new report from EMCDDA. While there are longer-term entrenched patterns of methamphetamine use in the Czech Republic and Slovakia, increased rates of use are also being reported in Germany, Latvia, Greece, Turkey and Cyprus, says *Exploring methamphetamine trends in Europe*. 'New injection trends' among groups of gay men in London and elsewhere (*DDN*, April 2013, page 6) is also a 'phenomenon that requires close monitoring', it states. *Report at www.emcdda.europa.eu*

HOME GROWN

More needs to be done to address the growing problem of domestic drug consumption in Afghanistan, according to UNODC. The country saw a record opium crop last year (*DDN*, December 2013, page 5) and now has more than a million opiate addicts, a 'national tragedy' according to UNODC executive director Yury Fedotov. 'For too long the threats of illicit drugs, crime and corruption have been neglected in efforts to shore up the security and stability of Afghanistan,' he said. 'We need to ensure that these issues are made national priorities.'

DRY DAYS

Nearly 17,500 people signed up for last month's Dry January, says Alcohol Concern – four times as many as the previous year. 'Many participants are telling us through social media that this month has been a life changing experience for them,' said the charity's director of campaigns, Emily Robinson. 'They've had lightbulb moments about the way they drink and why. We're incredibly proud to be able to help people make changes which we hope will have a lasting, positive impact for them.'

Government bans below-cost alcohol sales

Legislation banning the sale of below-cost alcohol is to come into force in April, subject to Parliamentary approval, the government has announced.

The Home Office has issued guidance on the ban, which was first announced last summer following a consultation on the government's alcohol strategy (*DDN*, August 2013, page 4). The announcement angered many health campaigners who had instead wanted to see a minimum price per unit of alcohol.

Below-cost sales bans are seen as an unsatisfactory compromise by organisations calling for a minimum unit price, as well as unnecessarily difficult to calculate. 'Cost' is defined as 'the level of alcohol duty for a product plus value added tax payable on the duty element of the product price', says the guidance. According to the document, a 440ml can of 4 per cent lager could not be sold for less than 41p, or a 9 per cent can for less than £1.16. A 70cl bottle of 37.5 per cent vodka, meanwhile, would cost at least £8.89 and a 750ml bottle of 12.5 per cent wine £2.41.

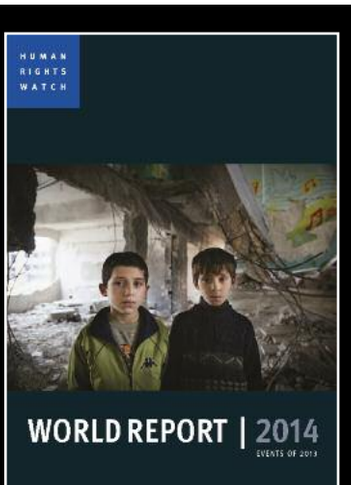
The government's response to its alcohol strategy consultation also dropped plans to ban multi-buy promotions, and businesses will still be able to offer 'buy one get one free' deals as long as the total purchase price 'is not below the aggregate of the duty plus VAT permitted price for each product comprised in the package'. The ban will be enforced by local authorities, trading standards officers and the police, although the guidance recommends that 'enforcement officers only check the prices of heavily discounted alcohol products' rather than all alcohol on sale at the premises.

'The idea that banning below-cost sales will help tackle our problem with alcohol is laughable,' said Alcohol Concern chief executive Eric Appleby. 'It's confusing and close to impossible to implement. On top of this, reports show it would have an impact on just 1 per cent of alcohol products sold in shops and supermarkets, leaving untouched most of those drinks that are so blatantly targeted at young people. The government is wasting time when international evidence shows that minimum unit pricing is what we need to save lives and cut crime.'

Guidance on banning the sale of alcohol below the cost of duty plus VAT: for suppliers of alcohol and enforcement authorities in England and Wales at www.gov.uk

'The idea that banning below-cost sales will help tackle our problem with alcohol is laughable.'

ERIC APPLEBY



KEEP WATCHING: The 'devastating costs' of the current approach to drug control – in 'lives lost to violence, people subjected to long prison terms, barriers to health, harm to families and communities, and damage to the rule of law' – are continuing to mount, says Human Rights Watch's *World report 2014*. 'It is time to chart a new course,' says the organisation, which last year adopted a policy calling on governments to look at alternative approaches to the drug trade, including the decriminalisation of personal use and possession. *Document at www.hrw.org*

Shake up at Drinkaware over industry links

Alcohol education charity Drinkaware has announced 'radical' changes to its governance arrangements and a number of new appointments, following an independent audit of its effectiveness. The industry-funded charity has long been the subject of criticism over its perceived lack of independence.

Drinkaware has published a formal response to the 2013 audit, which was overseen by Guy's and St Thomas' NHS Foundation Trust chair Sir Hugh Taylor. The audit was critical of the charity on a number of issues including lack of an evidence base – 'both to inform what Drinkaware does and to evaluate how it does it' – and perception of industry influence, 'resulting in a suspicion that Drinkaware is not truly independent of the alcohol industry'. It also described 'weak stakeholder engagement', leaving the organisation isolated within the wider alcohol harm reduction community, and lack of clarity over its mission and purpose.

'Drinkaware is seen by non-industry stakeholders as lacking independence from its funders, and some are sceptical that it truly wishes to encourage responsible drinking behaviours,' said the audit document. 'Industry stakeholders are aware that these perceptions exist and are frustrated that their efforts to meet their corporate social responsibility obligations are undermined by Drinkaware's lack of credibility with the public health community.'

While recognising the 'inevitable tensions' facing an organisation 'with the remit and funding base' of Drinkaware, the report wanted to see 'substantial changes' to the way it operates – in terms of funding, governance model and the way it carries out its core activities. It called for a restructuring of the board to include more lay trustees and the development of more positive relationships with non-industry stakeholders and health organisations.

Drinkaware now states that 'almost all of the auditors' recommendations have been accepted and have either been implemented or are in progress', including commissioning independent research to inform strategy, improved transparency and forging new relationships with the public health sector. It also says that, while trustees have approved changes to the organisation's governance – including a smaller board with no specific quota of industry professionals – the audit 'found no specific evidence of inappropriate influence'.

Former Department for Work and Pensions permanent secretary Sir Leigh Lewis has been appointed as the new chair, and there are also three new trustees. 'The announcement of our formal response to last year's audit and the major changes in the governance of Drinkaware represents its "coming of age",' said outgoing trust chair Derek Lewis. 'The new board structure and governance arrangements represent best practice in not-for-profit organisations and will ensure that Drinkaware is equipped to play an increasing role in tackling alcohol harm in the UK.'

Independent audit panel chair Sir Hugh Taylor called the developments – in particular the new governance arrangements –'very positive'.

Government to opt out of EU directive on new drugs

The UK government will opt out of the European Commission's proposals for a directive and other regulation on new psychoactive substances, it has announced.

The government 'strongly disputes' the conclusion of an EU Commission impact assessment that around 20 per cent of new psychoactive substances have a legitimate use, said crime prevention minister Norman Baker in a written statement. The EU's proposals would also 'fetter the UK's discretion to control different new psychoactive substances, binding the UK to an EU system which would take insufficient account of our national circumstances', he stated. The government is currently conducting its own wide-ranging review into the laws relating to new drugs (*DDN*, January, page 4), with the conclusions to be announced in the spring.

'New psychoactive substances pose a significant global challenge and the decision to opt out should not in any way be considered to diminish our commitment to tackle this issue,' said Baker. 'We are looking at a range of options including legislative ones to enable us to deal with the dangers many of these substances present even more speedily and effectively.'

Meanwhile, police in Scotland have issued a warning about a batch of tablets in circulation containing para-Methoxyamphetamine (PMA). The tablets, which are being sold as ecstasy, are pink with a 'Superman' logo on one side and ® logo on the other.

As PMA can take longer to have an effect than MDMA, the risk is that people take repeat doses in the belief that the drugs aren't working. The substance was linked to deaths and hospitalisations last summer (*DDN*, August 2013, page 5), prompting the Department of Health to issue a health alert. Scottish police and health services have also issued warnings about red 'mortal kombat' tablets featuring an image of a dragon, following the recent death of a woman in Glasgow and four other people being hospitalised.

NEWS IN BRIEF

POOR PERFORMANCE

Actors pretending to be drunk were served in more than 80 per cent of bars targeted for test purchases, according to a new report from Liverpool John Moores University's Centre for Public Health. 'UK law preventing sales of alcohol to drunks is routinely broken in nightlife environments,' says the study, published in the *Journal of Epidemiology and Community Health*. *jech.bmj.com*

IMPROVING PICTURE

A new report from the AVA project aims to provide an updated picture of the number of women's aid refuges in London that provide access for women who use drugs and alcohol or have mental health issues. A 2002 survey revealed that just 13 per cent provided automatic access, while a further 48 per cent said they 'sometimes' would. Using freedom of information requests, the report found that most boroughs now include some level of requirement to support women with drug and alcohol and/or mental health problems, with only two actively excluding them. The document wants to see clear policies on working with women with these needs, a more comprehensive approach to risk assessment, and training for all refuge staff involved in the assessment of referrals. *Case by case: refuge provision in London for survivors of domestic violence who use alcohol and other drugs or have mental health problems at www.avaproject.org.uk*

IN HARM'S WAY

Laws and policies and their 'justificatory social constructions and stigmas' are responsible for worsening avoidable harms around illicit drug use, according to a report from Youth RISE and INPUD. 'Understandings of drug-related harm and effect within the context of a criminalising paradigm are predominantly moral' – rather than empirical – says *The harms of drug use: criminalisation, misinformation and stigma*, which studies the 'social, legal and linguistic' contexts of drug use. *Available at www.youthrise.org*

COMMISSIONING COUNSEL

Public Health England is developing a national framework for commissioning HIV and sexual health services, the agency has announced. The aim is to provide local authorities, clinical commissioning groups and the NHS with practical advice and best practice examples. A draft document for consultation will be available in April, with the final resource due in the summer. *www.gov.uk*

OLYMPIAN STRUGGLE

While the run-up to the Winter Olympics has seen outcry over Russia's anti-gay legislation, less has been said about the country's treatment of its drug users. *DDN* reports

With the Sochi Winter Olympics now on, the eyes of the world's media are on Russia. In the run-up to the games, much of the press focused on the country's legislation banning the 'promotion' of homosexuality and the rising levels of homophobic rhetoric and violence that followed, leading some people to call for a boycott of the games. Less has been written about the plight of another of the country's marginalised groups, however.

According to Harm Reduction International's most recent *Global state of harm reduction* report, there are an estimated at 1.8m injecting drug users in Russia, more than 37 per cent of whom are infected with HIV, while opioid substitution therapy remains steadfastly unavailable.

'The government thinks that the main threats to the country are gay propaganda and opioid substitution treatment (OST), things like that – that they contradict our traditional values and we should oppose them,' Anya Sarang of the Moscow-based Andrey Rylkov Foundation for Health and Social Justice tells *DDN*. 'OST is still unavailable and government opposition to it remains very vocal and strong.'

Given the weight of international evidence, how does the Russian government justify its position on OST? 'Basically they say that it's a bad idea to replace one drug with another, and that substitution therapy is not effective,' she says. 'The chief narcologist of Russia says we don't need this therapy and instead they put a lot of effort into naltrexone programmes and all kinds of antagonist treatment. Naltrexone is much more expensive, but they say it's the Russian way to treat addicts. But even these programmes are very few, and go in the face of clinical trials – if they are available they're very expensive and so not many people can afford them.'

Although there are some harm reduction services operating in the country, they remain 'politically marginalised', says HRI, with national drug policy depicting needle and syringe exchange programmes as 'a threat to effective drug control'.

'There are a few needle exchange programmes,' says Sarang. 'We managed to keep funding from the Global Fund [to fight AIDS, Tuberculosis and Malaria] for this, but I don't even know how many of them are still working. Our organisation runs its own needle exchange, needle distribution programme and street outreach work in Moscow, but we get nothing from the Russian government – the funding comes from the Open Society Foundations, the Levi Strauss Foundation, people like that. It's all private foundations, as well as some remaining money from the Global Fund project, but now Russia isn't even taking the money from the Global Fund, so I don't know how long that will keep running.'

In fact, the government's antipathy towards harm reduction even extends to attempting to ban the Andrey Rylkov Foundation from publishing information about methadone on its website and passing an order to close down the site a couple of years ago, a move described as 'totally unacceptable' by Human Rights Watch (*DDN*, June 2012, page 5). 'They still don't like it,' says Sarang. 'We went to the national courts but they ruled in support of the Federal Drug Control Service that we cannot place any information on methadone on our website – even information from UN agencies like WHO or UNAIDS. It's very oppositional to the international position on substitution treatment.'

Despite the harassment, however, the foundation manages to keep the site going, alongside its outreach and other work. 'We just had to move the website hosting from a Russian provider to an American provider so we still keep all this information, but now they have a new internet law which basically allows Russian officials to block access to any site they don't like. They haven't done it to ours yet but it's possible, and without any legal procedure. So I'm not sure how long we'll be able to provide this.'

The consequences of the government's policies are becoming increasingly stark, however. According to UNOWED, the Russian Federation, US and China account for almost half of the people in the world who inject drugs and are living with HIV (21 per cent, 15 per cent and 10 per cent, respectively), while Russian health watchdog the Federal Surveillance Service for Consumer Rights and Human Welfare says that more than 54,000 new HIV cases were registered between January and September last year alone, up more than 7 per cent on the corresponding period in 2012. Unsurprisingly, nearly 60 per cent of the new cases were the result of injecting drug use, and the Russian Federal AIDS Center states that the country now has the fastest-rising infection rates in the world.

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ANYA SARANG

The numbers are especially troubling given that HIV infection rates are falling in much of the rest of the world, with a 33 per cent drop overall since 2001 (*DDN*, October 2013, page 5). 'They're managing to control the numbers due to scaled up prevention efforts and access to treatment, but in Russia the numbers are still rising,' she says. 'The majority of people who are getting HIV are drug users and if you don't have harm reduction programmes and needle exchange programmes then there's no prevention.'

"you should treat your HIV but before you start your medication you should do something about your drug use." But because there is no access to substitution treatment, no rehabilitation centres, no help, people go away and they get lost and they come back only when they're dying.

'If you don't provide adequate drug treatment then it's impossible to treat people with HIV, so when the government says, "everybody who wants medication can get it", it's hypocrisy,' she continues.

strategy there's no mention of human rights, and even if we talk to human rights organisations in Russia they're not really interested in drug users.' And there's no mention of harm reduction in the strategy either, presumably? 'Harm reduction is mentioned, yes, but it's mentioned as a threat. The strategy is based on the principle that there should be a zero tolerance approach.'

Given how isolated the Russian government's position has become, is there anything that the international

'If would be good if they didn't give health officials and drug treatment officials the money for these trials for antagonist treatments, for example.

'American researchers come to Russia with their clinical trials because no one's really interested in naltrexone in the US. They pilot their studies, the Russians receive huge funding and then the Russian officials present it as the Russian way of treating drug addiction, as some kind of miracle treatment. Of course everybody understands that it's nonsense. OK, it's

In Moscow... HIV prevalence was below about 14 per cent, but the prevalence studies documented up to 75 per cent in the city of Biysk.

'Treat hepatitis C? It is cheaper to bury.' Activists draw attention to hep C outside the Ministry of Health on Rakhmanovsky pereulok in Moscow.

And as there are increasingly few prevalence studies being carried out among drug users it can be hard to even establish the real extent of the problem, she says. 'Russia is so huge and it depends on the region. In Moscow the last estimates, around four years ago, were that HIV prevalence was below about 14 per cent, but the prevalence studies documented up to 75 per cent in the city of Biysk, in Altai Krai, and in Samara Oblast it was above 60 per cent. But I think the average number is still just under 40 per cent.'

Even the government's claims that it is addressing HIV by providing medication such as antiretrovirals to anyone who needs them should not be taken at face value, she says. 'A couple of years ago I was interviewing a large number of drug users for a WHO project and we found that, to have adequate access to medication, the doctors were saying,

'Theoretically it's true but they're not able to get through this labyrinth of bureaucratic procedures to start treatment, and they're not able to even maintain their HIV treatment because they go into drug relapses.'

The figures for hepatitis C infection among people who inject drugs also make grim reading, standing at more than 70 per cent according to recent estimates. 'In some places it's even above that – approaching 90 per cent – and hep C treatment is not available in Russia at all,' she says. 'Or it's available, but only to the few people who can buy it – it's very expensive – and even then not to drug users. With HIV at least some people have treatment, but with hep C it's a really bad situation.'

One fundamental root of the problem is that, in Russia, people who use drugs have no human rights, she states. 'If you take the national drug

community could realistically be doing to put pressure on them? 'I don't know if it's even possible to influence them,' she says. 'They have a strong standpoint in the international arena, they are very powerful and basically they can do whatever they want. Even at the high-level UN meetings on human rights they present substitution treatment as a threat. The government's position is basically that everyone in the world is wrong, and they are right and that they should use this strong repression and base policy on zero tolerance with no regards to human rights or the health of people. This position is not changing, and there's no flexibility.'

One thing she would like to see that could potentially make a difference, however, is for western clinicians to stop engaging with medical and clinical trials in the country, she states.

one medication option, but it's never been the most effective, and even if they do the clinical trials of new preparations they should compare them to the gold standard addiction treatment, which is substitution. So it's not very ethical to do this in Russia.'

As well as providing more grounds for the Russian government to oppose substitution treatment, the main motivation is 'basically economic', she stresses. 'It's a very corrupt public health policy. If they're being fed by their colleagues from the US and wherever with this clinical trials money, and they're selling this expensive, not very effective medication, then of course they'll keep doing it. So it would be good if at least on a professional level there was a change of position from the western researchers using Russia for this purpose.'

en.rylkov-fond.org

LONDON CA

As London treatment service Blenheim celebrates a milestone anniversary, **Jo Palmieri** looks back at 50 years of social action affecting the drug and alcohol field

This year Blenheim, one of the UK's leading substance misuse charities, celebrates 50 years of delivering drug and alcohol treatment services across London. Blenheim is the successful merger of three organisations – The Blenheim Project, established in 1964, CDP (Community Drug Project) established in 1968 and CASA (Camden Alcoholics' Support Association), established in 1977.

Much has changed since the early sixties when The Blenheim Project was first working with young 'drifters', drawn to west London for empathy and shelter. Back then, local volunteers were encouraged to provide overnight accommodation in their own homes for those young clients who had nowhere to go. Eighty per cent of clients were under the age of 30 and most of the young people who attended The Blenheim Project were uncertain in what they wanted, half-convinced that they would remain drifters, simply seeking a hot cup of tea and the clothing and luggage store. It was a challenging time for the professionals too.

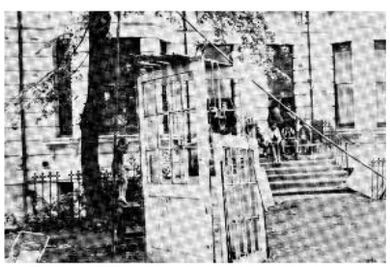
'I am not sure that we really knew what we were doing when we set up the Community Drug Project,' says Gerry Stimson, now director of Knowledge Action Change. 'What we did know for certain was that there was an increasing number of people in the area who were injecting drugs, and problems connected with drug injecting in and around Camberwell Green.'

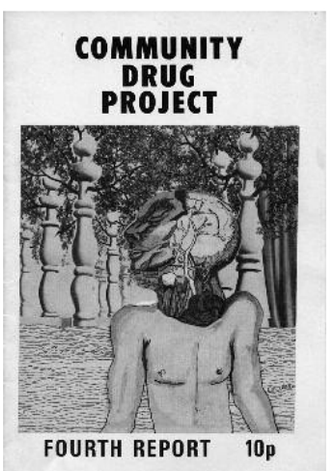
Individually the three organisations were known for their 'caring, compassionate and tolerant' approach by the local communities and the professionals who supported and funded their work. Across the decades they have also been recognised for their innovation and responsiveness to local need – CDP was the only agency still running an injecting room in the '70s, CASA delivered the first specialist services for the older drinker in the '80s and The Blenheim Project opened the UK's first crack day programme in the '90s.

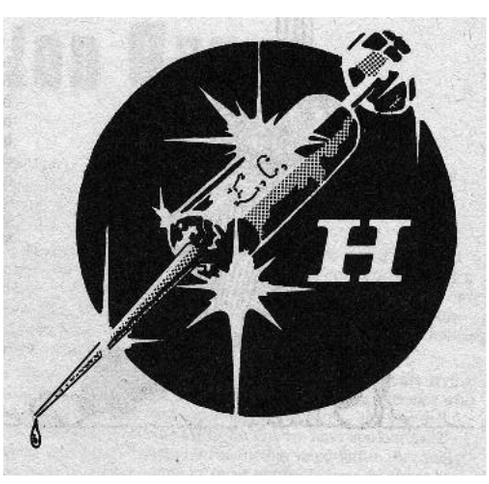
Blenheim is now one of the fastest growing charities in the UK, supporting over 9,000 people a year across London. Its staff are not only recognised for their professionalism in delivering recovery treatment services but also for their commitment to campaigning and influencing policy, as highlighted last week by Baroness Hayter in the first of their 50th celebratory events, at the House of Lords.

'For 50 years Blenheim, CDP and CASA have been proactive social change organisations, rooted in the day to day challenges facing those with alcohol and drug problems, their families and local communities,' she said. 'As Blenheim enters their 50th year of social action they are committed to continuing to be a loud advocate for those with the most complex needs in society today. Campaigning and advising the main decision makers is indeed a key and significant part of Blenheim's work.'

The celebratory event was attended by renowned professionals in the field,







'For 50 years Blenheim, CDP and CASA have been proactive social change organisations, rooted in the day to day challenges facing those with alcohol and drug problems, their families and local communities.'

BARONESS DIANNE HAYTER

LLING

service users, commissioners and supporters. Speakers included minister for crime prevention, Norman Baker, who acknowledged there was more to do in tackling psychoactive substances and recognised the impact of alcohol use: 'We will continue to challenge the alcohol industry to raise its game,' he said. Blenheim's CEO John Jolly responded that Blenheim would 'continue to act as a critical friend' to government.

Blenheim also chose this celebratory event to launch *London Calling: Voices from 50 years of Social Action*, a book which not only tells the history of Blenheim through the voices of those who have been involved since the sixties, but also the story of the development of the drug and alcohol sector in the UK.

'It's the story of how, together, we built the best drug and alcohol treatment system in the world, set within its historical and political context over the last 50 years,' said Jolly. 'It is a celebration of the commitment of the thousands of people who have given their time, skills and energy to help those struggling with drugs and alcohol problems over the past five decades.'

A constant over the 50 years has been Blenheim's commitment to listening and responding to service users. Tim Sampey, a former Blenheim service user and now chief operating officer of Build on Belief (BoB), is also featured in the book. BoB runs the largest peer-led weekend service in London and is now an independent service user charity.

'Without Blenheim's willingness to support something untried, without their courage to agree to our total independence and without their patience to put up with our wild enthusiasm and occasional unorthodox ideas, there would have been no seven-day-a-week provision and no Build on Belief,' said Sampey. 'Blenheim has truly demonstrated what service user involvement can and should be.'

Jo Palmieri is former director of business, innovation and skills at Blenheim.

For more information about Blenheim's services, to purchase a copy of London Calling or to become a Friend of Blenheim go to www.blenheimcdp.org.uk and www.blenheim50.wordpress.com.

Tim Sampey will be speaking at Make it Happen!, the national service user involvement conference on 20 February – visit www.drinkanddrugsnews.com for booking details.

TIMELINE

1959 11 per cent of reported addicts are under 35 years of age.

1964 40 per cent of reported addicts are under 35 years of age. The Blenheim Project is born.

1968 Drug Dependence Units (DDUs) are established to treat heroin addiction.

'In the whole of the UK in 1968 there were only 2,240 heroin addicts known to the Home Office (under the informal notification scheme) and 1,091 patients at drug clinics,' says Gerry Stimson, emeritus professor, Imperial College London. (The 2009-10 NTA report on drug use prevalence estimated that in England there were 264,072 opiate users, and 193,575 people were receiving treatment by their 2012-13 drug treatment report.)

1970 Government funding to the voluntary sector is £2.5m, rising to £35.4m by 1976. (That figure had increased to £11.8bn in 2010/11 according to a report by *Third Sector* magazine.)

1972 The number of cannabis users in the UK is estimated at 1m. (Department of Health figures in 2009 estimated that to have doubled, but the number has been in decline since then.)

1976 CDP becomes the last agency to close its injecting room. The Blenheim Project's open-door policy gives way to an appointment system.

1977 The first Narcotics Anonymous (NA) group meeting is held in the UK.

1980 The growth of illegal drug use accelerates rapidly across the UK.

1982 Conservative secretary of state for social services, Norman Fowler, announces the first funding initiative for drug services, the Central Funding Initiative (CFI). Initially £6m is available, in short-term grants.

1986 GPs now prescribe for 48 per cent of heroin users.

1989 There are now 323 dedicated drug services in England. Drug users become 'problem drug takers' instead of 'addicts'.

1991 Criminal Justice Act. Drug using offenders are sentenced to community-based treatment orders for the first time.

1994 Blenheim opens the UK's first crack day programme.

1995 The government launches the white paper *Tackling drugs together*, a new three-year drug strategy. Drug Action Teams (DATs) are created in each health authority area.

1997 The first UK drugs czar is appointed by the government to 'co-ordinate' the 'war on drugs' strategy.

2002 Home secretary, David Blunkett announces the government's intention to reclassify cannabis from class B to class C.

2004 The Cabinet Office publishes the *Alcohol harm reduction strategy for England*.

2007 *Safe, sensible and social. The next steps in the national alcohol strategy* is launched.

2008 New government drugs strategy. New measures for 'coercing' drug using benefit claimants into treatment.

2012 National Institute for Health and Clinical Excellence (NICE) publishes NICE guidelines and public health outcomes, with recommendations for alcohol treatment services. Blenheim, CDP and CASA merge.

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

The idea that the existing policy on drugs in this country, and almost everywhere in the world apart from Colorado and Uruguay, is a self-evident failure is not a truth that is self-evident to me. In particular, the 'war on drugs', and the notion that it is being 'lost', is a cliché that helps to shut down thought rather than encourage it... Legalisers sometimes say that it is jolly confusing that cannabis is illegal in theory but that the police tend to concentrate on more important things in practice. It's a compromise. It is so sensible that it is the most common legal position all over the world: illegal but not stringently enforced for small amounts. It is intellectually unsatisfactory, but it is winning. The people who want to change it have to make a better case.
John Rentoul, *Independent*, 7 January

I am worried because I think of legalisation as a symbol. A symbol that the world has become more accepting of living a mediocre life... the more we accept pot and other distractions as perfectly normal, the more we are accepting mediocrity.
Elad Nehorai, *Guardian*, 7 January

If marijuana is now deemed OK in Colorado – and dispensaries will open soon in Washington as well, the other state that approved legal marijuana at the end of 2012 – what message does that send to Mexico and others fighting the war on drugs largely on America's behalf?... As a father I am not thrilled to see marijuana consumption encouraged. What I surely do welcome, however, is the opportunity for the first time to test in practice the argument that legalisation will do more to diminish violence in America's immediate neighbour and points south than any amount of militarised prohibition.
David Usborne, *Independent*, 8 January

There's no one simple and definite solution to substance abuse but the argument for deterrence is not one. If millions want to drink, smoke, snort and swallow then they will, whether it's expensive or not, whether it's legal or not. If the government wants them to stop, it needs to give them greater reason to; a reality they don't want release from.
Chris Jackson, *Independent on Sunday*, 26 January

If the country is supposed to get upset because no gun-toting, drug-peddling gangster is safe on the streets any more then forget it... Gangsters who live by the gun – even those who throw them away when the police close in – should expect to die by the gun. They are vermin whose drug pushing threatens every decent family in the land and if the police happen to take a few out as they clean up the streets then so be it.
Chris Roycroft-Davis, *Express*, 10 January

[David Cameron] tried to pin the blame for Britain's drinking culture on the last government, which is fair enough, up to a point. Yet at the same time as Mr Cameron condemns deregulation of alcohol and gambling, we learn the extent to which his ministers, too, were lobbied by the alcohol industry... While Labour should shoulder some of the blame, the government needs to treat addiction to alcohol and gambling – often affecting the same people – as a national emergency.
Jane Merrick, *Independent*, 8 January

LETTERS

'We are keen to make take-home naloxone available to all high-risk drug users in Peterborough and provide training for service users and their families.'

COMMITTED TO NALOXONE

Regarding Neil Hunt's opinion piece, 'A matter of life and death' (*DDN*, December 2013, page 18): as the service provider for Peterborough, we are in absolute agreement that naloxone should be available to service users, especially high-risk service users such as those leaving prison and those accessing the needle exchange. We fully appreciate that naloxone is a potentially life saving drug and with minimal training – we provide it to service users and their families on a case-by-case basis.

CRI provide the integrated recovery service in Peterborough, which incorporates prescribing interventions and we have not been aware of any contact made with our service, or with our Peterborough commissioners, in relation to take-home naloxone. Had we been contacted, we would of course have made the drug available. We are keen to make take-home naloxone available to all high-risk drug users in Peterborough and provide training for service users and their families.

Our services in Sefton and East Lancashire are an example of this. Peer mentors, high-risk service users and their families were identified and trained. Naloxone is also made available in the needle exchange, so it is available to people who were not engaged in treatment. Within the first year of the scheme, we had notification from the local ambulance service that the availability of take-home naloxone had saved three people's lives. We also had several reports from service users, who provided anecdotal evidence that through the use of naloxone, drug-related deaths had been avoided.

We, and commissioners locally, are committed to ensuring that Peterborough has a similar service provision for take-home naloxone and are currently making this available to all high-risk service users across the city.

If the author of the article would like to discuss this further or hear about our success with naloxone in other parts of the country, please do not hesitate to contact us.
Alison Snelling, services manager, CRI Aspire, Peterborough

GET CERTIFIED

Adfam and FDAP have jointly developed a competency-based certification for practitioners supporting families affected by drugs and alcohol. Adfam brings years of experience of working with both families and practitioners to the creation of this unique certification scheme, and FDAP its expertise as the professional body and membership organisation for the substance misuse sector.

Currently FDAP provides

certification and accreditation services for drug and alcohol practitioners and counsellors, and accredits university courses which prepare counsellors. We urge those who work with families to consider this process of certification to demonstrate their competence in this area.

The Adfam/FDAP Drug and Alcohol Family Worker Professional Certification provides practitioners with a range of benefits including:

- *A professional competency-based certification mapped to appropriate National Occupational Standards.*
- *A role profile and a code of practice to work to.*
- *Ongoing support from FDAP/Adfam, including priority invites to events.*

This certification is offered at the registration level. Practitioners will, as a minimum, require their employers to attest to their competence in each of the National Occupational Standards outlined in the role profile. They will also be required to develop a portfolio of continued learning to allow them to demonstrate continued professional development in order to re-accredit after three years.

It is in both practitioner and service's interest to adopt practices which demonstrate a commitment to providing high quality services to the people and communities they serve. Ensuring practitioners remain competent and continue to develop their skills is a major component of quality management.

In this ever more cash-strapped environment with funding being reduced across the board, services are being re-tendered with contracts being awarded to new employers. It is therefore important that practitioners demonstrate the quality of their practice and services demonstrate to commissioners that the systems they utilise provide quality-assured services which effectively respond to the changing needs of the client group. This certification system will support quality management, drive continued professional development for practitioners and assist the commissioning process.

The accreditation costs £75 for three years, and includes a year's membership of FDAP. For more information please see the FDAP website, www.fdap.org.uk or ring on 0207 234 9798.

Carole Sharma, chief executive, FDAP

PERCEPTION OF DOORS

CRI's drug service in Wellington Street, Hastings is, I am sure, a good service but that is not the message sent out by weary signage and a tatty door with peeling paint. Austerity is no excuse. Number ten Downing Street knows how important a symbol a front door can be. It keeps replacement doors. When one door is in need of a refurbishment, a new door replaces the old one immediately. I do not suggest for one moment that CRI can afford to do that, but a lick of paint costs little. When the Hastings service was run by Addaction, when I was in charge of communications – including building signage – the organisation believed that the portal through which frightened and stigmatised clients passed was important. It says you are valued and you are respected. Doors are important.

Rosie Brocklehurst, former director of communications, Addaction, St Leonard's on Sea, East Sussex

POOLING RESOURCES

I work for a drugs and alcohol service in Greater Manchester and I'm aware that our team is receiving increasing numbers of referrals for Polish men who speak and read very little English. I'm looking at translating some of our promotional and therapeutic materials (such as drink diaries) into the Polish language. I'd like to hear from other services that may already have undertaken such an exercise – with a view to pooling resources. If you'd like to get in touch please contact me at alan.alker@nhs.net – any attached translated documents would be appreciated.

Alan Alker, team manager/clinical nurse specialist, Pennine Care Trust Drugs and Alcohol Service, Ashton-under-Lyne.

We welcome your letters...

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

POST-ITS FROM PRACTICE

A tale of two drinkers

The challenge of Dry January meant different strokes for different folks, says Dr Steve Brinksman

As the role alcohol plays in ill health and social dysfunction is increasingly in the spotlight, the whole SMMGP team decided to support Alcohol Concern by taking part in Dry January. It would be fair to say that it was anticipated that it would be harder some of us (*ie* me) than some of the others.

I decided that the best approach for me would be to tell as many people as possible that I was taking part, thus feeling compelled to complete it. One of the knock-on effects was that one of my GP partners and his wife decided to join in. I also had several interesting conversations with patients including one with an older lady who said, 'Oh, I didn't realise you were an alcoholic and needed to dry out.' Hopefully she now understands a little more about the concept of dependence.

Frank had an appointment about his high blood pressure. He was taking medication for this and we were discussing adding in another tablet. He is a self-employed plumber and has always admitted to drinking 'a lot' at weekends and 'a few' during the week. That said, when work was busy he would sometimes go three or even four days without a drink. Now in his mid-40s he had watched his weight go up with his blood pressure, especially after he stopped smoking three years ago. He was surprised when I suggested he consider Dry January, but faced with the prospect of more medication he somewhat begrudgingly agreed it might be worth a go.

Linda, on the other hand, brought up her plan with me to participate in Dry January. She told me a friend at work was intending to sign up to the campaign and she thought she would too. She had a stressful job with a firm of solicitors, had lost her driving licence due to drink-driving 12 months ago and had been seeing the local CBT counselling service for anxiety and depression over the past few months.

This led to a deeper exploration of her drinking habits: she arrived home from work and immediately had a large glass of wine, followed by a couple more during the working week and probably twice this at the weekend.

She had gone a couple of days without a drink earlier in the year when she had flu but said she felt really ill and had been retching and shaky which she blamed on the virus.

An AUDIT (alcohol use disorders identification test) score of 28 supported my view that she probably had a degree of physical dependence, and after some persuasion she agreed to see our alcohol counsellor rather than attempt Dry January. She has done well and over the course of January she has cut back to about half a bottle of wine a day and towards the end of the month has even managed a couple of dry days. She is now focused on getting her licence back and is starting to think that her life might be better without alcohol.

As for Frank he came in looking great, he had lost 4kgs in weight and his blood pressure was back under control. I had thought he might struggle but he told me he had stopped going to the pub and started going for a run: 'I'd like to do a marathon, Doc. It's quite addictive this running, you know.'

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

HELPING HANDS

Jenni Parker **tells DDN about the Aurora Project Lambeth, a social enterprise that offers volunteer-led peer mentoring to people in treatment**

THE AURORA PROJECT LAMBETH is situated in a quiet office on Stockwell Road in Brixton, south London and was set up three years ago by a group of service users from Lambeth. The project is an independent, not-for-profit social enterprise that is governed by a board made up of service users, local residents and professionals.

The idea behind the project was to offer peer support and mentoring to individuals in treatment for their substance use within the borough, and to promote the belief that those in recovery have much to offer their local communities. It aimed to challenge the stereotype that drug and alcohol users are a burden on society.

The board was successful in securing £110,000 worth of funding from the local primary care trust and the project continues to be funded by the Lambeth local authority. Two years ago I joined the organisation as their only paid member of staff. My challenge? To streamline the project's operations.

I worked closely with the directors and three service users, who gave their time to the project on a voluntary basis, to recruit volunteers who had been through treatment themselves and were in recovery. We then trained them to be peer mentors and matched them to clients referred to us by the Lambeth Alcohol and Drug Treatment Consortium.

'Our volunteers offer clients the chance to speak to someone who has been there and done that.'

The biggest challenge at this stage was finding volunteers to give their time, but two years on we have a team of 30 trained volunteer peer mentors. One Aurora Project Lambeth volunteer, who joined us six months into his own recovery, said of his experience, 'My time at Aurora Project Lambeth has been one of the most positive, inspiring and fulfilling times of my life.'

My role involves the ongoing support and management of our volunteer team – ensuring they get a good volunteering experience during their time with the project and ensuring that they provide a great standard of support to others.

Our volunteers offer clients the chance to speak to someone who has 'been there and done that'. They give practical advice and information on a variety of topics, as well as motivational support and encouragement, whether through attending groups, appointments or meetings. Our volunteers offer clients their time, which is something that they seem to value the most – time to work things out, to talk, to be heard.

'It's not clinical,' said one client of her interaction with an Aurora Project volunteer. 'I know she understands and she's been through the same thing.'

In addition to ongoing one-to-one peer mentoring, we also offer clients the chance to come along to our art group, which is facilitated by a trained artist who is in recovery herself. This group allows them to meet and support each other, as well as adding structure to their day-to-day lives. It helps to raise self-esteem – and is also a way of just having fun!

Last year we achieved the approved provider standard, a national quality standard awarded by the Mentoring and Befriending Foundation. This standard was awarded to us because we proved we offer an outstanding experience for our volunteers, supporting them in their roles and in helping them to access further education. It also recognises that our volunteers are trained thoroughly for their role, that the organisation is governed exceptionally well and that we are offering a much needed and effective service for our clients.

There have of course been teething problems along the way. We have learned that although we are an independent organisation, it is vital to have the buy-in and support from the Lambeth Treatment Consortium, ensuring communication channels are always open. We have also learned that offering a high level of support to our volunteers is paramount when asking people in recovery to work directly with clients, many of whom are still living chaotic lifestyles. We do this by offering them clinical supervision, support from staff and ensuring that the volunteers support each other.

The Aurora Project Lambeth continues to grow and has become embedded in the local community.

Jenni Parker is the service delivery manager at Aurora Project Lambeth.
www.auroraprojectlambeth.org.uk

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HOWF

David Best, **Tracy Beswick**, and **Merce Morell** explain how their new online outcome measurement tool assesses progress on the recovery journey

With recovery now the dominant model for alcohol and drug treatment, commissioning and research in both England and Scotland, there is a clear need to have an accessible, simple-to-use method for mapping recovery achievements in and out of formal treatment. This article introduces the REC-CAP (short for recovery capital), a new instrument that provides frontline staff with an easy-to-complete assessment of a client's recovery functioning, and can become a useful component of recovery-oriented care planning. In addition to locating the client within a recovery framework, it will also provide an organisation with objective measures of changes and gains made by recoverees during and after formal treatment.

In both Scotland (Scottish Government, 2007) and England (Home Office, 2008), public policy has seen a radical shift in focus and emphasis away from drug and alcohol interventions targeting crime and blood-borne disease to a more optimistic model based on individual wellbeing, quality of life and active engagement in the community. This transition to a recovery approach echoes the evidence from the mental health field where recovery has been shown to be characterised by a clutch of linked characteristics – connectedness, hope, identity, meaning and empowerment (collectively, CHIME; Leamy et al, 2011).

While the transition to a recovery model has provided much-needed hope and belief to addiction professionals, policymakers, family members and those with addiction problems, it also provokes a significant challenge for the science of addiction, around the measurement of success. Although there are a number of tried and tested outcome measures – the Addiction Severity Index (ASI) and the Maudsley Addiction Profile (MAP) to name but two – they have both emerged out of a pathology model where the aim of treatment has been the reduction of acute symptoms and adverse life consequences. They are not suited to the measurement of a growth of wellbeing and positive achievements as would be needed to track a recovery journey. What the REC-CAP does is to address this omission and so create a measure of growth that can continue long after acute treatment needs have been addressed, and which measures wellbeing and engagement in society.

RECOVERY CAPITAL

The key to this dilemma is addressed in an article by White and Cloud (2008) who concluded that long-term recovery is much better predicted on the basis of strengths than on the management and reduction of pathology symptoms. This builds on work previously done by Granfield and Cloud (2001) who used the term 'recovery capital' for the first time to refer to the resources available to an individual to support their recovery journey. Elaborating on this, Best and Laudet (2010) categorised recovery capital as containing three dimensions:

- ***Personal recovery capital*** *represents the skills, capabilities and resources a person has that includes such things as self-esteem, resilience and communication skills.*
- ***Social recovery capital*** *is the central component of recovery capital and includes the level of social support the person has, a network of support for their recovery and their commitment to and engagement with the support network.*
- ***Community recovery capital*** *is the resources available in the community, consisting of the quality of treatment services, but crucially the availability and attractiveness of recovery communities and champions.*

The three levels of recovery capital are assumed to exist in a complex and interactive dynamic, where improvements in one area have positive knock-on effects in the others.

'Long-term recovery is much better predicted on the basis of strengths than on the management and reduction of pathology symptoms.'

However, much of the work on recovery capital in the addictions field has been largely theoretical and it was really with the production of a measure that this changed. One of the authors of this article, along with William White, a research consultant for Chestnut Health Systems and a leading recovery figure in the US, and Teodora Groshkova from the Institute of Psychiatry, worked together to produce the Assessment of Recovery Capital (ARC: Groshkova, Best and White, 2012). This is a validated and accepted research tool currently used in a number of countries that measures personal and social recovery capital, and which has been shown to

AR HAVE YOU COME?

be associated with positive treatment outcomes (Best et al, in preparation).

SO WHAT IS THE REC-CAP?

We have taken elements of four established engagement, outcome and recovery measures to create a flexible online recovery mapping measure that can be linked to both care planning and review, and to recovery management outside of treatment services. The four elements are:

- ***Basic recovery enablers:*** *Measures of key life issues mapped using elements of the Treatment Outcome Profile (TOP). These are not regarded as elements of recovery capital (and so are not shown in the REC-CAP star) but are seen as key issues to address to facilitate the recovery journey.*
- ***Treatment motivation and engagement:*** *Measuring desire for help and treatment engagement for those in treatment using the Client Evaluation of Self and Treatment (CEST).*
- ***Recovery capital:*** *Divided into separate sub-scales for personal and social recovery capital, and measured using the Assessment of Recovery Capital (ARC).*
- ***Recovery community engagement:*** *Involvement in social groups supportive of recovery, assessed on the Recovery Group Participation Scale (RGPS).*

These combine into five measures that are all scored out of 20 – treatment motivation, treatment engagement, personal recovery capital, social recovery capital, and community recovery capital.

Entering the scores creates a visual map of recovery wellbeing as shown in the accompanying illustration.

What is unique about the REC-CAP is that it is entered online and will automatically populate the graph above – initially to show how the person compares to other clients from that service – and so identify what strengths and resources they have for their recovery journey. However, in all review completions of the REC-CAP, the graph will show their own change in wellbeing, providing the person in recovery (and the worker) with a measure of growth in recovery capital.

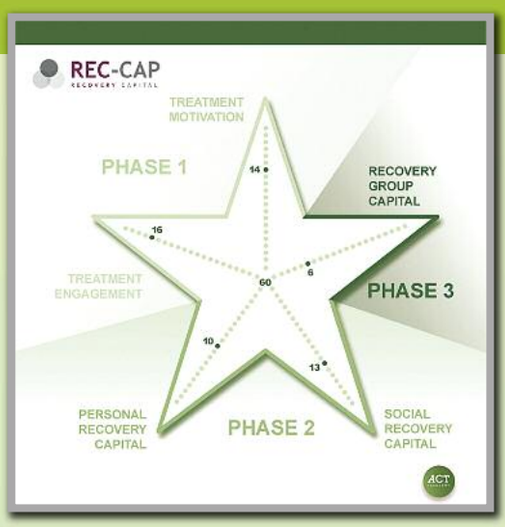
Being a mapping system that is completed online, there is no paperwork, no data to be entered by harassed admin staff and no delays between completing the form (the initial form takes around 30 minutes and the review less than 10) and observing the scores. The online system is structured so that the results are available as soon as the last question is answered. This is a recovery outcome system that is flexible and easy to use, and one that minimises the burden on staff and on clients. We are currently exploring ways in which it can be linked to services' existing databases.

As a result, it has real application as a clinical recovery tool – where the worker and client complete the REC-CAP in a treatment session, they have immediate access to the results in the form of a graph or a printout of the scales. It provides immediate feedback on strengths and gaps, representing a genuine commitment to partnership recovery working for agencies and their clients. The REC-CAP is basically a client-level assessment that is collaborative and shared in supporting and developing recovery journeys and pathways, but it can also be used as a performance management measure in services to assess progress in enabling clients' recovery journeys.

The REC-CAP system is now up and running, with a full worker manual and training pack and an IT support system in place to enable its immediate application either in DAATs or agencies.

LOOKING TO PARTNER

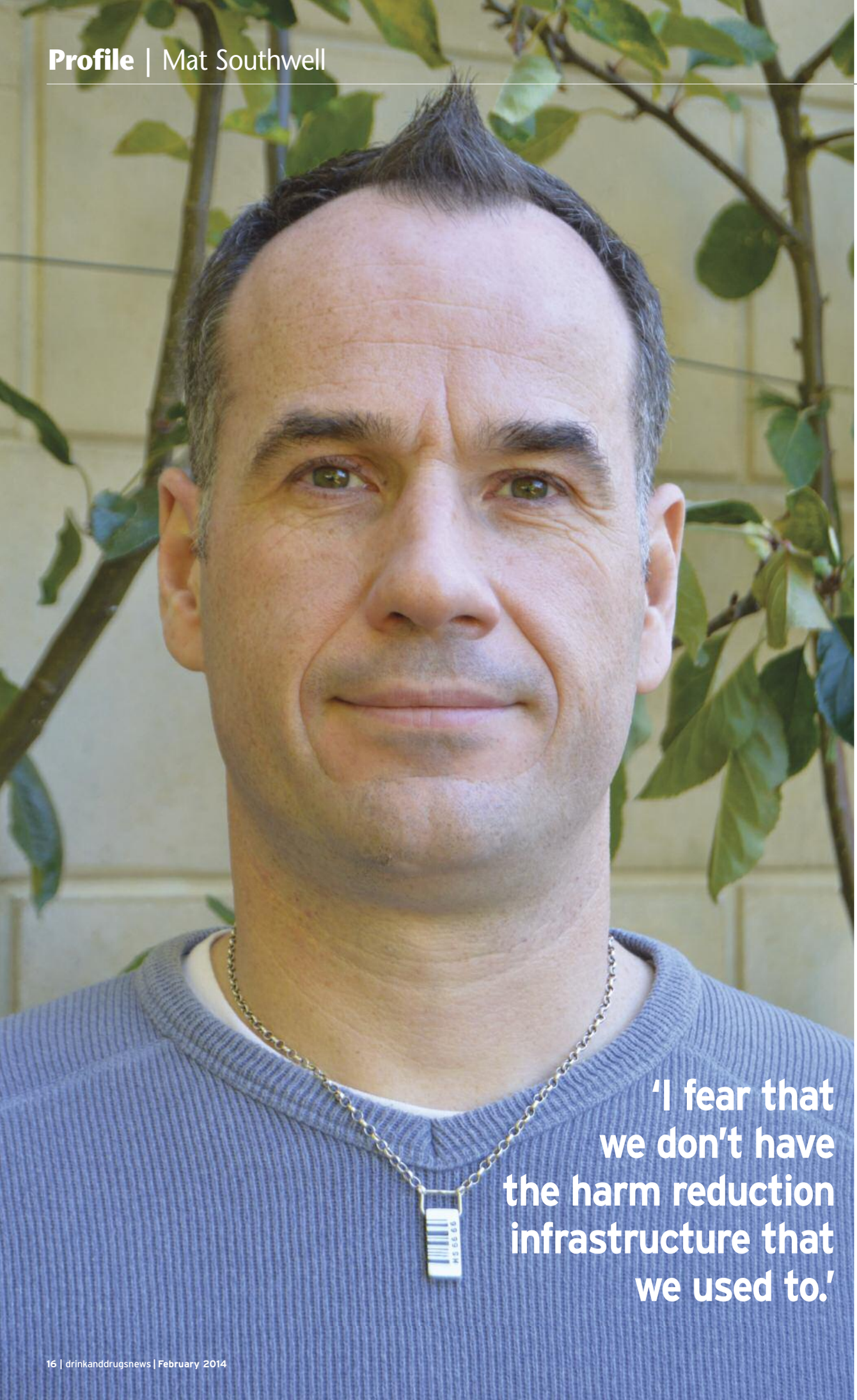
We are looking for agencies to partner with us in testing the REC-CAP, which is based on reliable and valid measures of wellbeing and recovery. It would provide an agency with an opportunity to pioneer an innovative recovery oriented approach to client management and to work in collaboration with us.



Visual map of recovery wellbeing

The REC-CAP is unique – it is one of the first tools that will help to maximise the recovery potential of clients and introduce an evidence-based recovery assessment into the care planning of clients that starts but does not end with formal treatment. If you would like more details on the REC-CAP or would be interested in working with us as an early adopter of the REC-CAP tool, please do not hesitate to contact us at info@actrecovery.co.uk.

David Best, is director, ACT Recovery; head of research and workforce development, Turning Point, Melbourne and associate professor of addiction studies, Monash University. Tracy Beswick is director of operations and Merce Morell is director of resource management at ACT Recovery, www.actrecovery.co.uk



'I fear that we don't have the harm reduction infrastructure that we used to.'

on the frontline

Mat Southwell talks to **David Gilliver** about how things have changed over his three decades of work in advocacy and harm reduction

'I didn't know that wasn't what you were meant to do in the drugs field,' says Mat Southwell of the participative approach he adopted when he first started working in the sector. 'It was what I'd learned, so when I came to London I just automatically worked with people in the same way.'

An early HIV worker in the late 1980s, his introduction to the field was volunteering for an HIV centre and helpline established by the gay community in Brighton. He moved to London to work as an HIV counsellor and went on to become professional head of service for East London and City Drug Services, an organisation he'd helped to build up.

'That participative approach was also partly because I didn't really know very much about methadone and that sort of stuff – that wasn't my background in drugs, so I had to ask people,' he says. 'So there was partly a pragmatism to my participative model and partly a philosophical commitment, but it opened up a whole array of different work that allowed us to constantly respond to new drug trends and issues, because we were working with people on the frontline of the east London drug scene which was where many of the new trends hit.'

He also developed the showcase Healthy Options Team (HOT), which 'really gave me the credibility in the field', he says. 'It was what I brought from working with the gay men's organisation where my director was a gay man living with HIV who was also a social worker, so I really got that model of community organising. This is where I started to get involved in championing responses to issues like HCV prevention and injecting, crack, heroin chasing, dance drugs and, most recently, ketamine.'

*****

Although his career in the field has in many ways been defined by the struggle for the human rights of people who use drugs, for the first ten years it was defined by their health, he stresses. 'In that acute period of the UK's HIV epidemic we saw 60 people die of HIV when we cared for them in east London. The consequences of that public health crisis were very real for us. We really felt we were fighting to stop our community from being decimated.'

Despite being an activist deeply opposed to Margaret Thatcher, the irony, he says, was 'living through an era where she created an environment that we could do work in that was incredibly innovative and very pragmatic, involving drug users, building collaborations with GPs and moving away from the traditional addiction model. We did some amazing work, and services really flourished.'

At that point he wasn't publicly known as a drug user – although he was employing several people who were – but by the end of the 1990s he'd decided it would be more beneficial to 'stand publicly' as someone who used drugs. 'The problem is that it's always the people on the margins who are forced out into the open because of health or legal or other issues, and I wanted to make a choice to politically stand in solidarity with those people and fight alongside them,' he says. 'Of course when health crises arise we have to respond to them but we wouldn't be in this health crisis – at least not so deeply – if it wasn't for the stigma and discrimination and criminalisation.'

Although the NTA period that followed meant new investment, it also brought 'stifling bureaucracy', he feels, 'and this fear of actually talking about what works. And we've now crashed into this recovery period which is fundamentally ideologically based. The irony for me as a global advocate is that I go around the world teaching people as a technical support provider how to do the British model while we reverse away from it as rapidly as we possibly can. I really worry about what the implications of that will be.'

The UK is 'naïve' if it feels insulated from major problems with HIV and other blood-borne viruses, he believes. 'There was a second spike in the HIV epidemic here that coincided with crack arriving, and it was only really because we had good harm reduction and treatment services in place that it didn't become a more fully fledged epidemic. We could get an outbreak linked to legal high injecting, for example, and we'd be very ill-equipped to deal with it. What seems like a trickle of a problem to start with can suddenly become a really big problem if you don't manage it. And I fear that we don't have the harm reduction infrastructure that we used to – the lack of fixed site needle exchanges is quite shocking.'

He's also involved in HIV issues on a global scale, working as the International Drug Policy Consortium's (IDPC) drugs and HIV consultant, a role that focuses on advocacy between drugs civil society and the United Nations Office on Drugs and Crime's (UNODC) HIV team. Does he get the impression that the UNODC is beginning to open up a little more, after years of what many people perceived as intransigency?

'In the last year or so we have seen an opening up, whereas historically UNODC was very reluctant to talk to civil society,' he says. 'Through some robust advocacy from civil society we've managed to force an engagement. There were discussions around the selection of which countries UNODC would be working in and what the priorities for those countries would be and civil society took part in that conversation. Are we 100 per cent listened to? Absolutely not. Do we have fully aligned positions? Absolutely not. But at least we're talking to and working with each other, which is a huge step forward.'

A lot of people worried when Yury Fedotov took over as UNODC head (*DDN*, 19 July, page 5), but he hasn't proved to be as hardline as many feared. 'I think the thing to remember about Fedotov is that he's a skilled diplomat – he understands how to manage the system. I wouldn't be naïve around him, but I think the neglect of the drugs and HIV agenda up until about a year ago was causing such concern – not just within civil society but also with UNAIDS and other UN partners – that it just became unsustainable.'

Part of the initial worry about Fedotov was that he was Russian, a notoriously hardline country when it comes to drugs policy, and with catastrophic consequences in terms of HIV (*see news focus, page 6*). 'I think the climate is changing, with America shifting position and all the experiments around drug policy – the problem is the entrenchment in places like Russia, who seem to have a complete disregard for human life. People who use drugs are seen as part of that outsider group that are treated appallingly. They're using scapegoating as a strategy, and drug users are one of the groups being scapegoated.'

The challenge is to maintain a watchdog function on Russia while at the same time trying to counteract the country's influence on its neighbours, he believes. 'You try to then get more progressive drug policy and harm reduction practice pushing in, and that's where UNAIDS and UNODC have both said "let's start focusing on priority countries so that we actually work in fewer countries but demonstrate how the work should be done." By putting more resources into some countries you get case studies to show that you can shift the epidemic, which then hopefully drives more domestic funding.'

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In terms of that international engagement, his latest venture is Coact, a technical support agency with nine consultants he's running alongside business partner Tam Miller. 'The aim is that we go around the world teaching people harm reduction, drug user organising and drug treatment. All of us are ex or current drug users but we also have a dual professional background in drugs or HIV so it's very much this function of bridge building – as well as standing up for the drug user community I also hold onto my identity as a drugs worker very proudly. One of the things we're trying to do is help build bridges so we can all work together more effectively.'

When it comes to working together, does he feel that some of the old barriers between recovery and harm reduction are finally starting to break down – are things a little less polarised? 'I think there are figures on both sides of recovery and human rights/harm reduction who share views and are looking for points of connection and trying to collaborate,' he says. 'There's a whole lot of people who are trying to respond very healthily. But I think there's a smaller group of recovery people who are much more politicised and fighting a whole political agenda that has bugger all to do with science. I get frustrated when people claim that I'm being divisive by critiquing those people. For me it's about saying that these people are denying our human rights.

'When the government's own evaluation of recovery says it doesn't work then we're saying, "back your claims up",' he continues. 'Our claims around harm reduction and humane drug treatment are well evidenced. This is where I feel that the recovery movement at its worst moves into being something like a cross between an evangelical church and a National Socialism rally, where if you object then people say "you're letting all us down by not agreeing" or "you're in denial". If that's the level of debate then we move into a different type of engagement.'

Mat Southwell is partner in Coact and associate consultant, drugs and HIV, at IDPC. www.co-act.info.

Room at the ta

'I will never make apologies for being emotive about something that affects us all,' said Noreen Oliver MBE, opening *Creating Recovery*, The Recovery Group UK's conference in London last month. The conference's strapline was 'funding opportunities for building abstinence recovery communities' and the politicians were there to tell us why 'recovery' now meant 'drug free'.

'It's about getting people as far from drugs as we possibly can,' said work and pensions secretary, Iain Duncan Smith. 'It's all about giving people a chance, but with the discipline and determination to move people into recovery.'

Rosanna O'Connor of Public Health England stressed that there continued to be 'high ministerial interest' in this agenda, but warned that drug treatment money was likely to be squeezed even further now its 'quasi ringfence' had been removed, with community care funding 'a particular challenge'. A rehab survey had confirmed a solid basis for local authorities to continue investing in them, but holding LAs to account would be 'slightly more difficult'.

'These are challenging times with funding constraints and potential disinvestments. We all need to up our game,' she said.

Lord Benjamin Mancroft, chair of the Addiction Recovery Foundation and a peer in the House of Lords for 27 years, who had beaten his own addiction, was unequivocal that recovery meant abstinence, and that those who disagreed did so because they did not understand.

'The healthcare profession can't cure addiction,' he said. 'Doctors do not understand addiction – it's not in their radar.' The problem, he said, was that 95 per cent of healthcare was provided by one organisation, the NHS, controlled by doctors. That organisation was 'the most dangerous dealer in the world', for prescription drugs.

'After 30 years of very careful observation, I understand abstinence and substitute prescribing. But I have never met anyone who's benefited from substitute prescribing for any but a very short length of time,' he said.

Christian Guy, of the Centre for Social Justice, brought the discussion back to equality and giving 'every person in the country the choices we would want for our families.' We should all agree that people should be given the choice to get drug free and stay drug free, he said.

The climate was becoming tougher without money, with more than half of local authorities cutting money for rehab.

'As much as we hate to believe it, politics does matter,' he said. 'But it's not just about money, it's about lack of ambition for too many people in the system.'

We also needed to know what recovery looked like in later life, he said, as this group were in danger of being forgotten and written off, with the attitude 'keep them quiet' and 'put them in shooting galleries where the rest of us can't see them.'

With 'more people in rehab for alcohol than drugs', we were also not good enough at treating the root causes of the 1.6m people trapped in alcohol addiction.

'Rehab is a chance to live again and surely that's what recovery is about,' he added. 'Let's go out with renewed determination to finish the job and give people that chance.'

Camila Batmanghelidjh, founder of Kids Company, warned of the need to 'stop simplistic narratives of blame' that were affecting children and young people. Of the 36,000 young people, children and vulnerable adults KidsCo supported every year, 81 per cent arrived addicted to drugs and 90 per cent of them had been introduced to drugs by their immediate carers.

'Potentially, this country it sitting on an emotional and public health timebomb in the way that it's not paying attention to the urgency of care for the most vulnerable,' she said. 'We should be thinking about the emotional health and practical living circumstances of our children.

'We tend to think about recovery across the whole spectrum in "siloed" ways, but often people's difficulties are complex and multiple and they have continuous challenges as they go through their recovery programme.'

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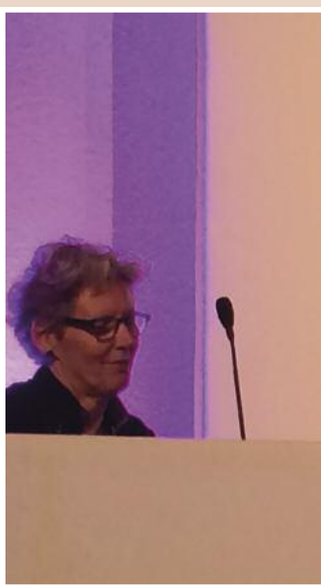
Against this backdrop of political, strategic and economic anxiety, there was a strong message of optimism and a proactive climate in the audience, many of whom had come to demonstrate their active recovery. 'There's a hell of a lot of power in the

'I will never make apologies for being emotive.'
NOREEN OLIVER

'These are challenging times... We all need to up our game.'
ROSANNA O'CONNOR



'The healthcare profession can't cure addiction.'
LORD BENJAMIN MANCROFT

'Visible change happens when we harness strength'
STUART HONOR

able?

Last month's Creating Recovery conference was as much about establishing the criteria for 'recovery' funding as about celebrating recovery, as ***DDN*** reports. Photos by **Simon Brandon**, courtesy of RAPt

room – share what you've got,' urged Noreen Oliver.

'Whenever someone in the public eye talks of their recovery, it inspires others to do the same,' said Chip Somers, chief executive of Focus 12, as he introduced former client Russell Brand (whose large white German Shepherd dog leapt onto the speakers' desk, much to Rosanna O'Connor's surprise).

'I want this message of abstinence-based recovery to reach everybody,' said Brand. 'Addiction seems like such a hopeless condition when you're using. Because of support from other addicts I've got a chance.'

The only way to get people to 'stay clean' was through support and a sense of purposefulness and togetherness. There was still demonisation of a section of society, but 'till we have a compassionate approach we won't solve the problem,' he said.

Stuart Honor of The Basement Recovery Project (TBRP) demonstrated the power of 'social contagion' in creating recovery communities. 'We are stronger in shoals,' he said. 'The number of people in your network correlates with personal and social recovery capital.'

TBRP's recovery community centres gave opportunities to create long-term pathways, and the graduates – 'community builders' – thrived on giving peer support. 'Visible change happens when we harness strength in the community,' he said. Abstinence was just a necessary part of this process: 'You have to turn off the water to mend the plumbing.'

Kevin Kennedy – Curly Watts from *Coronation Street* – echoed this view of recovery in sharing his story. As his acting career had begun to rise, so did his drinking – 'I drank because I liked it. I enjoyed the pub, the camaraderie – until it all went wrong.

'In 1997 I thought I'd discovered the secret of the universe – the morning drink,' he said. After being sent by Granada to rehab, he began attending AA meetings 'because I thought I was being watched by the press'. But he learned to love the 'humble scout hut' because it was keeping him well.

'This is a shame-based illness – the only way out of it is abstinence,' he said. While on holiday he visited a dry bar and came home determined to set one up in his home town of Brighton. 'What better way to show off we're in recovery,' he said. 'It's important we change people's view of what recovery's about.'

Having an acceptance of the recovery culture was 'crucial' in prisons, said RAPt's chief executive, Mike Trace. RAPt's answer to building recovery communities was to have large peer networks, he said, supporting people to make the emotional changes that helped them to make progress. 'The "what happens next?" is our biggest headache,' he said – making sure they had recovery capital in good quality accommodation, friendship networks and employment prospects.

Russell Brand, RAPt's newest patron, underlined the need for mutual support.

'There's a currency of kindness,' he said. 'We only stay well by helping other people to stay well.

'Abstinence-based recovery is bloody hard,' he added. 'We're all in this together.'

The other important element of the conference was to look at funding opportunities, including the Give It Up Fund, launched by Russell Brand and managed by Comic Relief.

Gilly Green of Comic Relief explained that with £500,000 raised to date, the fund aimed 'to promote abstinence-based recovery, increase access to treatment, help sustain long-term recovery and reduce stigma towards those with addictions.'

Applicants could present a clear vision for a recovery community, using effective local partnerships, for a grant of up to £70,000, or could apply for the small grants programme, which would fund smaller activities with up to £5,000.

Further opportunities were offered by Dominic Ruffy of the Amy Winehouse Foundation, who said their organisation – already involved in a schools programme in partnership with Addaction – could offer grants for projects on recovery.

'Be creative,' said Noreen Oliver. 'Think of all the things out there built by service users. Work with agencies in partnership, tap into community assets.'

Carl Cundall of Sheffield Alcohol Support Services (SASS) had an encouraging message for those who thought a drug-using or dealing past might blight their opportunities. You have a CV of transferable skills, he said, such as excellent networking and problem-solving, being highly motivated and being able to manage people effectively.

That was one of the many benefits of recovery, he said – 'it gives you the opportunity to watch people transform their lives.' **DDN**

'The "what happens next?" is our biggest headache.'
MIKE TRACE

'We only stay well by helping other people to stay well.'
RUSSELL BRAND

'...the secret of the universe – the morning drink'
KEVIN KENNEDY

hebron trust
Hebron House, 12 Stanley Avenue, Norwich, Norfolk NR7 0BE

FEMALE CARE COORDINATOR

Hebron Trust is a registered Christian charity providing a specialised residential rehabilitation programme for women with serious drug and alcohol addiction. Our programme is abstinence based, centred round the 12 steps and combines a mixture of group work, psychosocial interventions and practical and vocational activities.

We require an experienced counsellor to develop and coordinate delivery of our care treatment programme within the Trust ethos and treatment philosophy. You will lead and manage a small team, require knowledge of the 12 Step model and be able to deliver group facilitation. Management experience with a minimum of Diploma in Counselling or equivalent is essential.

Please contact Mo for further details and an application form on 01603 439905 or email mo@hebrontrust.org.uk.

Closing date: 21 February 2014

GOR: Exempt under the Equality Act 2010 Sch.9 Part 1
We welcome applications from all sectors of the community.

Expressions of interest

OXFORDSHIRE COUNTY COUNCIL

THE PROVISION OF A LOCAL RESIDENTIAL DETOXIFICATION PROJECT FOR ADULTS WITH PROBLEMATIC SUBSTANCE MISUSE

Oxfordshire County Council (CPU785)

Oxfordshire County Council Public Health Directorate are seeking expressions of interest from organisations interested in providing a medically assisted Residential Detoxification Project for adults, aged 18 years or over, with problematic drug and or alcohol addiction resident in Oxfordshire from a facility located in Oxford city. These premises are managed under a separate agreement by St Mungos.

The project will provide 10 beds and will be a clinically managed residential detoxification service providing an intensive treatment programme that combines medically assisted withdrawal/detoxification and evidenced based psychosocial individual and group interventions. The service will offer a programme for a maximum of 12 weeks with flexibility for intensive shorter stay, assisted withdrawal programmes of 4 to 8 weeks for those who are assessed as suitable.

Embedded within the medical detoxification plan and psychosocial interventions will be a 7 day programme of activities and positive healthy lifestyle programme, to meet the goals identified with the service user during the assessment and the care planning process.This contract may also include support services for a 5 bed move on accommodation.

It is expected that the Contract will commence on 1 October 2014, and will be for a period of 3 years, with possible extensions of 1 year plus 1 year. Please note TUPE will apply to this contract.

Please express your interest via the "opportunities" function on the southeast business portal **www.businessportal.southeastiep.gov.uk**.

Oxfordshire County Council will not be bound to award any contract under this tender process.

Tender documents will be issued to all interested parties at a later date. If, however, you have any general questions regarding this service please contact Sarah Roberts, email **sarah.roberts@oxfordshire.gov.uk**

INVESTORS IN PEOPLE

TENDER OPPORTUNITY:

Invitation to Tender for the Provision of Recovery Focused Integrated Substance Misuse Community Services for the Isle of Wight

The Isle of Wight Council invites tenders from suitably qualified organisations for the provision of Recovery Focused Integrated Substance Misuse Community Services for the Isle of Wight. The contract is to run from 1 October 2014 for a period of 3 years with the option to extend for a further period of up to 2 years at the sole discretion of the Council.

Tenderers should be able to demonstrate the knowledge, innovation and ability to deliver substance misuse services to meet the needs of our local population. This will include adult, young persons and criminal justice services.

This service will be outcome focused and will deliver a recovery based journey through treatment. The contract will have a payment by result element.

The expected allocated budget for these services is in the range of £1.2 to £1.4 million per annum.

It is intended to hold a Bidders Event on 7 March 2014 at the Council offices on the Isle of Wight subject to interest. The aims of this event are to explain,

- *The service that we wish to commission*
- *What we are looking for from interested parties*
- *The calculation method for Payment by Results*
- *How the bids will be evaluated.*

A more detailed advert can be viewed at: **www.iwight.com/contractopportunities**

Tenders can be submitted by completing a Tender pack which is to be returned by no later than 14:00 Hrs on the 31 March 2014.

The tender reference is PH/1305/T01 and the pack can be obtained from: Email: lucy.mclaughlin@iow.gov.uk

ISLE of WIGHT COUNCIL