Autumn 2009 Issue 20

THE EXPERIENCE

Newsletter of The UK Drug Workers Forum

In this issue:

Date for your Diary:

UKDWF ANNUAL NATIONAL CONFERENCE 2009

13-14 October 2009 York

From the UKDWF Board …..

Hi All,

Autumn is here at last and summer well and truly over**.** What summer you may be asking? Well for those who managed to get away to foreign climes at least, may have seen the sun, albeit for a fortnight only.

But enough of the doom, liven up your autumn and don't miss out on this year's UKDWF Annual National Conference. With a theme of '**Policy in Practice: Achieving Positive Client Outcomes**' we have a packed programme of presentations, workshops, exhibition and new this year are our 'Question Time Debate sessions' and lunchbreak filmshows, all designed to inform, educate, share experiences and provoke thought and discussion. The event will focus on successes and overcoming barriers to achieve the best result for our drug using clients. The full programme is provided in this issue, together with an overview of our presenters.

Places are getting booked up quickly, so don't delay, get your booking in and join us in York for an action-packed event.

We look forward to seeing you in York in October.

Best regards,

The UKDWF Management Team

UKDWF SEEKING ADDITIONAL BOARD MEMBERS

The UK Drug Workers Forum Annual General Meeting will be held at the York Conference on Tuesday, 13 October.

Anyone interested in finding out more about the work of the Forum and how you can get involved as a Board Member should come along to the AGM or download a nomination pack from the website – www.ukdrugworkersforum.org

The UKDWF Board of Trustees (2009-10):

Mick Fowler (Chair), Loretta Johnson (Vice-Chair), Nigel Atkin (Treasurer), Viv Evans (Board Member), Dave Pennington (Board Member), Nadeem Mirza (Board Member)

Office: Gill Kennedy - info@ukdrugworkersforum.org - Tel: 01904 898069 - Fax: 01904 898715

Lethal Treatment for Society's 'Disorder of Choice'

Norman Lamb's response, as reported by the Telegraph last week, to the latest rises in drug deaths released by the ONS, was that: 'The Government's punitive policies and heavy-handed rhetoric on drugs are failing.'

I agree but not in the sense I think that he means. This government's drug policy has proved punitive in one thing alone - in its lethal 'liquid handcuffs' treatment policy.

This is not quite the war on drugs that most people anticipated. Missed by the newspaper headlines' preoccupation with last year's 20% rise in cocaine deaths was the 16% rise in methadone deaths - deaths that have risen 74% since 2004.

Given the amount of methadone now sloshing around the country and in our prisons too, courtesy of the National Health Service, this might have been predicted.

Government targets ensured the doubling of GP prescribing between 2003 and 2008 and a massive threefold rise in spending on the green gloop. They ensured the NTA's boasts for retention in treatment - 127,000 'clients' in 'prescribing services' by 2008 - dominantly on methadone scripts. Retoxing 'clients' on methadone purportedly to stop them dying of heroin overdoses on leaving prison or maintaining them in prison permanently on methadone with lip service paid to psycho-social support, is but the latest gospel we are meant to accept.

In some of England's rural DAT areas methadone deaths are now level pegging heroin deaths. In Edinburgh they outnumber them. If such deaths were occurring in any other population group as an apparent outcome of medical intervention there would be a demand for a detailed enquiry and for an immediate suspension of that treatment until its findings were forthcoming.

The reverse is the case. Official resistance to acknowledging the perverse outcomes of a multi billion pound 'command and control' treatment policy is the order of the day. One DAT coordinator said to me despairingly, "The government's policy has been creative only in meeting targets and has trained drug workers accordingly. No wonder methadone deaths are going up".

The problem is that alongside the relentless drive to meet spurious 'retention in treatment' targets, official 'clinical guidelines' routinely encourage incremental increases in methadone doses to 120 mls a day. This, instead of providing a stepping stone to abstinence or a window of opportunity to changing lifestyles (the original idea behind methadone programmes) has both set the bar to recovery and exposure to risk even higher. Clients find it easier to have their prescribing amounts raised than they do to have them lowered - allowing them to 'score' off their prescribers; to reinforce their illicit drug use and destructive lifestyles.

One senior drug worker told me: "...because of the high doses prescribed some chemists are dishing out massive doses of methadone - the Home Office guide is no more than 500ml in one go but I know some are going beyond this - which has all sorts of problems when it comes to leakage into the illicit market....
"Talking to police colleagues, it is common for them to have intelligence on trading methadone for money or heroin or any combination thereof outside of chemists. Often clients get their methadone, get straight for the day and then go onto to commit crime to buy heroin (or sell some of their methadone)."

This state of affairs is down to government's misdiagnosis of the problem in the first place. First is their failure to understand that with addictive behaviour, more is rarely enough; second is their mistaken conviction that addiction is a chronically relapsing disease rather than a voluntary choice and a recoverable condition; third, is their confused and ethically dubious idea, stemming from the Prime Minister's Strategy Unit, that 'gripping' high harm causing drug users (HHCU's) in treatment will reduce crime. It has not and it won't.

For anyone who wants to understand why the government, so many medics and many other well meaning people have got it all so very wrong I suggest they turn to Gene Heyman's recent publication, *Addiction: A Disorder of Choice*. He convincingly refutes the idea that once an addict always an addict. He also refutes the idea that addiction is a disease. He attributes the first misdiagnosis to the study of clinical treatment results (addicts quit outside the purview of clinics); and the second to the misinterpretation of genetic influence. "We inherit genes; we do not inherit behaviours". Genetic influences do not preclude choice - otherwise no addict would ever recover.

He brings to bear biographical, epidemiological, ethnographic and clinical research on his analysis all of which lead to the same conclusion that addicts are not compulsive drug users - they *choose* to keep using drugs and they can - and do - choose to quit. He shows that choosing to engage in self destructive and socially destructive behaviour is not so surprising given our culture today. He shows that the 'maladaptive choice' of drug abuse is similar to other maladaptive choices of excessive consumption. Too much of what we like now against the longer term costs. Voluntary behaviour is not rational.

The wide acceptance of illicit drug use since the 1960s, a lack of prudential rules, individualism and relational breakdown (marriage is the anti drug relationship - in the US 60% of drug abusers are single compared to 25% who are married) have set the cultural scene for a scale of behaviourally toxic addiction wider than we have previously known.

Applying this analysis we can see why in the last ten years in this country the government has made matters worse. Its imposition of 'treatment' has tipped the balance further in favour of addiction and maladaptive choices. Its interventions have proved more a hindrance than a help.

The best social data, Heyman confirms, shows that addicts are more likely to recover without, rather than, with conventional treatment. He confirms what many of us have known - that AA and NA and the programmes they have influenced are superior to conventional treatments; that this is a function of what they do - not a function of the individual characteristics of those who chose to stay on the programme. His data and his analysis confirm that both *hope* and *alternatives to drugs* are what are needed for someone to stop quitting. AA, NA and their various offshoots offer both. The government has offered neither.

Research on drug use implies that individuals repeatedly make choices that are not in their long term interests, nor in the interests of those around them and which they themselves often regret and want to escape from. It is deeply disturbing that government policy is putting these people at further risk by contributing to their drugs cocktail and by protracting their drug using 'careers'. We can only hope that a new administration will move quickly to reverse this state of affairs.

Source: www.cps.org.uk
Article by Kathy Gyngell,
Research Fellow, CPS
& Chair of the Centre's Prisons and Addiction Forum

Comments:

- I predict a riot!

  There will be all sorts of side issues raised about what you are saying here, and why their expertise is better than yours as I know I have been saying the same things myself for years and felt the wrath. I agree with every single clear and concise word you say here. I am sure knickers will be twisted over and over around the genetics/disease thing, with Heymans work, and as you subtly point out he does not deny genes can play a part but he says the evidence points to them not determining addiction, that environment and setting (the sum total of non hereditary influences - peer group and culture particularly) being more important - so change those conditions - show people how they can change their decision making and that it will ultimately be more rewarding and you will help people get better. Exactly my own experience when I saw others who had recovered for the first time and my family continue into active addiction.

  Well done and thank you for the lack of bullshit or rhetoric we so often see during this debate.
  Also thank you so much for speaking for those who seek help and those of us who got it and are told by so called experts, i.e. drug workers that we are not really "that type of addict" referring to their clients, that type that cant recover!

  In all my years of staying clean (12) and watching thousands of others get and stay clean i have yet to meet the type of addict they refer too. Best wishes and stay well in the truth that you speak when the backlash hits. In gratitude and admiration of your courage.

- First of all it's dreadful that methadone deaths are outnumbering heroin deaths in Edinburgh and other regions. Surely this has more to do with the way the methadone is being prescribed rather than the actual prescribing of it? The reason for people being on higher levels of methadone (>60mls) is that from this level it increases the person's tolerance and therefore reduces the risk of them overdosing on other opiates if they use. If supervised correctly in the chemist this works, and reduces deaths. On doses under 60mls this does not work, and so if you are still using heroin then of course your worker will be less willing to reduce your methadone to an untherapeutic dose.

  Also, you make the point that we need to be getting away from the disease model of thinking about addictions - I wholeheartedly agree - but AA and NA and other 12-step groups that you mention all subscribe to the disease model. There are plenty of good services where I work that work within the social learning model, and I think these types of services deserve more recognition in the media.

  I work with people and arrange their methadone prescriptions, and I use this work as an engagement tool to instil hope and present alternatives to drug use, whilst keeping the person safe and less likely to die from overdose while still using. There are plenty more like me, and so I am tired of hearing one sided arguments about the evils of methadone/12-step/abstinence/harm reduction* (delete as necessary) treatment when what is needed is a more rounded debate about how to improve services for people. We need to ensure that methadone is supervised appropriately and used at therapeutic doses, alongside effective psychosocial interventions.

UKDWF ANNUAL NATIONAL CONFERENCE 2009

13-14 October 2009 - Park Inn Hotel, York

DRUG WORKERS UPDATE 2009 – Policy in Practice: Achieving Positive Client Outcomes

ATTENDEES FREE PRIZE DRAW

All conference delegates will be entered into the Prize Draw free of charge.

Prizes:

- Two prizes of a 12-week rehab place for allocation by the winner to one of their drug or alcohol clients *(Prize donated by TTP Recovery Communities)*
- Two prizes of one free place at the 2010 UKDWF Drug Workers Update Conference for the full conference including accommodation and meals *(Prize donated by the UKDWF)*

One of each of the above prizes will be drawn on each day of the event.

CONFERENCE PROGRAMME

Tuesday, 13 October				
10.30-12.30	**PLENARY SESSION 1 – POLICY IN PRACTICE**			
	• **NTA and Drug Workers: The Way Forward** – Paul Hayes			
	• **The Family Role in Recovery** – Viv Evans			
	• **A Look at Distance Travelled and the ETE Agenda Within Drug Treatment** - *Steve Hamer*			
	Panel Q&A & **Day 1 Raffle Prize Draw**			
12.15-14.00	Lunch, Exhibition and Film Showls			
	'QUESTION TIME' DEBATES			
12.15-13.15	**Harm Reduction and Abstinence** – Led by Loretta Johnson & Tom Kirkwood			
12.45-13.45	**Prison and Community: Bridging the Gaps** – Led by Chris Ashley, Name tba & Nino Maddalena			
14.00-15.15	**WORKSHOP SESSION 1**			
	1 Integrated Offender Management Systems	**2** EXASS Net: Experiences from Moscow and Budapest	**3** Understanding the Transition Needs of Young People Entering Adult Substance Misuse Services	**4** Education to Employment
15.15-15.45	Tea and Exhibition			
15.50-17.00	**WORKSHOP SESSION 2**			
	5 Alcohol Arrest Referral Pilot Outcomes	**6** Diversity &Engagement	**7** Addiction Support in the Horseracing Industry	**8** A Shared Experience
17.15-17.45	UKDWF Annual General Meeting			
Wednesday, 14 October				
09.00-10.20	**PLENARY SESSION 2 – SUPPORTING CLIENTS**			
	• **Sharing Information Between European Member States** – Thomas Kattau			
	• **Recovery and the UK Drug Treatment System: Key Dimensions of Change** – Ian Wardle			
	• **Sport as an Intervention** – Eric Noi			

	Panel Q&A			
10.25-10.50	Coffee and Exhibition			
10.55-12.10	**WORKSHOP SESSION 3**			
	9 Integrated Offender Management Systems	**10** EXASS Net: Experiences from Moscow and Budapest	**11** Understanding the Transition Needs of Young People Entering Adult Substance Misuse Services	**12** Education to Employment
12.15-13.10	Lunch, Exhibition and Film Shows			
12.45-13.00	**Exhibitor Presentation**: Maintaining Continuity of Treatment via Case Management Systems – Business & Decision Ltd			
13.15-14.30	**PLENARY SESSION 3 – DRUG WORKERS UPDATE**			
	• **Findings of the DIP Review** – Peter Grime			
	• **The Changing Role of the Drug Worker** – Carole Sharma			
	• **Title & Speaker tba**			
	Panel Q&A			
14.40-15.55	**WORKSHOP SESSION 4**			
	13 Alcohol Arrest Referral Pilot Outcomes	**14** Diversity &Engagement	**15** Addiction Support in the Horseracing Industry	**16** A Shared Experience
16.00-16.20	**FINAL PLENARY SESSION**			
	Questions, Closing Remarks and **Day 2 Raffle Prize Draw**			

COSTS

Item	Members	Voluntary	Statutory	Total (£)
You may book an 'All-Inclusive Package' from the following options:				
A. Full Attendance (All-inclusive) (Arrive Monday, 12 October, depart Wednesday, 14 October - includes dinner, bed and breakfast, coffee, lunch and tea each day)	£520	£555	£620	
B. Full Attendance (All-inclusive) (Arrive Tuesday, 13 October, depart Wednesday, 14 October - includes dinner, bed and breakfast, coffee, lunch and tea each day)	£420	£455	£520	
Or book items individually according to your requirements (the one-day conference fee includes coffee, lunch and tea):				
One Day Conference - Tuesday, 13 October	£160	£180	£210	
One Day Conference - Wednesday, 14 October	£160	£180	£210	
Bed & Breakfast - Monday, 12 October	£90	£90	£90	
Bed & Breakfast - Tuesday, 13 October	£90	£90	£90	
Dinner - Monday, 12 October (3-courses)	£25	£25	£25	
Dinner - Tuesday, 13 October (3-courses)	£25	£25	£25	

If you haven't yet booked your place, do so now as places are filling up fast. Download the full programme, information and booking form from: www.ukdrugworkersforum.org. Or alternatively, email us at info@ukdrugworkersforum.org or telephone 01904 898069 and we can send the information to you.

We look forward to seeing you in York.

THE WAR ON DRUGS HAS FAILED

Latin America remains the world's largest exporter of cocaine and marijuana. We need a new, global approach to this problem.

It is time to admit the obvious. The "war on drugs" has failed, at least in the way it has been waged so far. In Latin America, the "unintended" consequences have been disastrous. Thousands of people have lost their lives in drug-associated violence. Drug lords have taken over entire communities. Misery has spread. Corruption is undermining fragile democracies.

And, after decades of over-flights, interdictions, spraying and raids on jungle drug factories, Latin America remains the world's largest exporter of cocaine and marijuana. It is producing more and more opium and heroin. It is developing the capacity to mass-produce synthetic drugs.

Continuing the drugs war with more of the same is ludicrous. What is needed is a serious debate that will lead to the adoption of more humane and more effective strategies to deal with the global drug problem. Earlier this year the Latin American Commission on Drugs and Democracy, which I co-chaired with the former president of Colombia, César Gaviria, and the former president of Mexico, Ernesto Zedillo, released the first high-level statement ever to endorse harm-reduction generally and decriminalisation of marijuana specifically.

The core conclusion of the statement is that a paradigm shift is required away from repression of drug users and towards treatment and prevention. The challenge is to reduce drastically the harm caused by illegal narcotics to people, societies and public institutions.

To move in this direction, it is essential to differentiate between illicit substances according to the harm they inflict. The status of addicts must change from that of drug buyers in the illegal market to that of patients cared for in the public health system. Police activities can then be better focused against the drug lords and organised crime.

The shift towards harm-reduction efforts and decriminalisation has already begun. Recently, a landmark ruling by Argentina's supreme court and a law passed by Mexico's Congress have for all practical purposes removed criminal penalties in those countries for the possession of small amounts of drugs for personal and immediate consumption. Colombia was the first country to take this step. A decision by its constitutional court in 1994 scrapped penalties for private consumption. Bolivia and Ecuador have liberalised their drug laws. Change is also imminent in Brazil. The chief justice of our highest court made a public appeal for clarification of the differentiation between drug user and drug dealer. A current ambiguity in the law effectively opens opportunities for police corruption and extortion. Brazil's legislature is about to consider a new law to remove penalties for the consumption of small amounts of marijuana.

This is consistent with the broader trend in Europe: the Netherlands decriminalised years ago; Portugal followed in 2001, stressing that criminalisation drove resources away from treatment and deterred people from seeking help for addiction – the number of people using drugs before decriminalisation was higher than afterwards. In the United States, backing for decriminalisation and treatment alternatives to prison is growing, but has still not achieved a critical mass of support and momentum behind traditional – failed – punitive policies remains strong.

There is still a long way to go. The trend towards decriminalisation for possession helps to empower a public health paradigm. It breaks the silence about the drug problem. It enables people to think in terms of approaching drug abuse in a way that is not first and foremost a matter for the criminal justice system. Reducing the harm caused by drugs goes hand in hand with reducing consumption.

Repressive policies towards drug users are firmly rooted in prejudice, fear and ideological visions, rather than in cold and hard assessment of the realities of drug abuse. The approach recommended in the commission's statement does not imply complacency regarding narcotics and their purveyors. Abuse of drugs is harmful to health. Abused drugs undermine a user's decision-making capacity. Needle-sharing spreads HIV/Aids and other diseases. Addiction can lead to financial ruin and abuse of family, especially children.

To be credible and effective, decriminalisation must be combined with robust prevention campaigns. The profound drop in tobacco consumption in recent decades shows how public information and prevention campaigns can be effective when they are based on messages that are consistent with the experience of those they target.

No country has devised a comprehensive solution to the drug abuse challenge. And a solution need not be a stark choice between prohibition and legalisation. Alternative approaches are being tested and must be carefully reviewed. But it is clear that the way forward will involve a strategy of reaching out, patiently and persistently, to the users, and not the continued waging of a misguided and counterproductive war that makes the users, rather than the drug lords, the primary victims.

By: Fernando Henrique Cardoso (president of Brazil from 1995-2003)
Source: www.guardian.co.uk

RELEASE – SNIFFER DOG CAMPAIGN REACHES HIGH COURT

Release is taking legal action against the British Transport Police (BTP) for breach of human rights, unlawful search and trespass to the person, regarding the use of sniffer dogs to detect drugs.

Release Executive Director, Sebastian Saville was stopped and searched by the BTP at Camden Town underground station in June 2008 following a positive indication by a sniffer dog. Mr Saville had no illegal drugs in his possession. All information gathered by Release shows that sniffer dogs are wrong approximately 75% of the time. Despite this startling level of inaccuracy, a positive indication by a sniffer dog currently gives the police reasonable grounds to proceed with a personal search.

The action, which is being taken on pro bono by 1 Pump Court barristers, is to challenge the continued erosion of civil liberties, as law abiding members of the public are prevented from going about their daily business as a result of an indication by a dog.

The Police and Criminal Evidence Act 1984 states that police may not stop and search an individual on grounds of reasonable suspicion based on personal factors alone unless there is a reliable supporting source of intelligence or information, or some specific behaviour by the person. Since Sebastian's behaviour was in no way suspicious, and dogs themselves are not reliable indicators, it is claimed that he was therefore unlawfully detained and searched. Release argues that these actions constituted a breach of Sebastian's fundamental human rights to freedom of movement and respect for private life, as well as constituting a trespass to his person.

The case is expected to reach the High Court later this year. If Sebastian and Release are successful in their claim, the police will be forced to desist from using sniffer dogs for the detection of drugs.

Source: www.release.org.uk

EVENTS

- **UK Drug Workers Forum Annual National Conference 2009 'Policy in Practice: Achieving Positive Client Outcomes' - 13-14 October - York**

  Annual National Conference of the UK Drug Workers Forum. Aimed at all workers in the drugs field, the event will address current issues, new developments and best practice relevant to professional practice. **Contact:** UK Drug Workers Forum - Tel: 01904 898069, Fax: 01904 898715 Email: info@ukdrugworkersforum.org Web: www.ukdrugworkersforum.org

SEE FULL PROGRAMME – PAGES 4-5

- **Society for the Study of Addiction Annual Symposium 2009**
  Theme: Service-user involvement young people and families. What does the AERC do?
  12-13 November 2009, York. **Contact:** www.addiction-ssa.org

JOBS

- **NIGHT SUPPORT WORKER, Hrs: 16.45-09.15 (6 nights per month) £6,375**
  Streetscene, Southampton
  Based within a substance misuse centre in Southampton, duties include supporting the service users and dispensing medication. Candidates should have an NVQ Level 2 in Social Care or equivalent experience of residential care, administering medication and be computer literate.
  Closing date: 25 September 2009. **Email:** angiehg@streetscener.org.uk

- **MANAGER, £32,845-£36,053, DEPUTY MANAGER, £27,773-31,556**
  Bosense Farm Community Ltd, Cornwall
  To develop and manage a new service for residential drug and alcohol detoxification in West Cornwall.
  Closing date: 2 October 2009
  Application form and full job description: Tel: 01736 850006, Email: sibs@bosencefarm.com