



Recovery Academy CIC

Recovery Growth and Transformation

Second annual Recovery Academy conference 2011

South Hall Conference Centre, Edinburgh

Tuesday 27th September 2011

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**In Association with Scottish Drugs Recovery Consortium
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Welcome

Welcome to the Recovery Academy Conference 2011! After many months of planning, we are delighted that so many people have registered from all over the UK and further afield. Today's programme complements the knowledge transfer from our conference in Glasgow last year and the programme has been enhanced by feedback from the delegates in 2010. All our speakers and workshop facilitators have shown great enthusiasm for today and we thank them for their support during the planning and commend them for their desire to share their knowledge to peers and professionals, supporting the growth of the recovery community. We hope that today develops your thinking through a dynamic programme and networking opportunities as you consider what your role is in supporting the reality of recovery.

We would encourage you to attend one of the open mutual aid meetings which are being held at lunchtime, to take your time to informally meet the students who are presenting posters, talk with the exhibitors and admire the Scottish Drug Recovery Consortium *Recovery Through the lens* photography display. We encourage you to stay to the end of the conference when we will be presenting a prize for the Poster Presentation, announcing the Recovery Champion award and we have a quotes competition, which you can find in your pack, the prize being a signed copy of *Tackling Addiction: Pathways to Recovery*.

We would like to thank the Scottish Drugs Recovery Consortium for their support in the organising of this conference and in particular Linda Swift. We also thank those organisations who bought exhibition space, the students who have prepared such high calibre poster presentations and those who will lead the open mutual aid meetings. This conference booklet is designed to be an accompaniment to the workshop presentations, but we also thank those contributors who have also provided us with additional articles. The articles are the ownership and opinion of the respective authors.

As the recovery landscape shifts and changes, we hope that this conference will confirm that the Recovery Academy remains stalwart and committed to demonstrating recovery from addiction, and to mapping the resulting growth and transformation in individuals and communities. We invite you to see this conference as a reflection of the RA ethos - as an open and participative process, reflecting the warmth, humility and strength of those in recovery, and providing the basis for a science that is based on the art of recovery.

On behalf of the Recovery Academy Directors, have a wonderful day!!!

Grace Ball
September 2011



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Conference Programme

When	Who	What	Where
0845	Registration / Early Bird	Walking With Wulf.	Meet at the registration desk in the Foyer of South Hall.
1000	Conference opens	Rowdy Yates, conference chair.	South Hall Main Hall
1015	Reg Hall	Scottish Drugs Recovery Consortium.	
1045	Dr George De Leon Clinical Professor of Psychiatry at New York University School of Medicine	The Recovery movement: What can be learned from therapeutic communities for addictions.	
1115	Prof Jo Neale Professor in Public Health Oxford Brookes University	People often say that recovery involves repairing a spoiled identity, but is this idea really helpful?	
1145	Break	Refreshments	Kirkland Room
1215	Assoc Prof David Best Monash University Australia	Readiness for recovery – inspiring exits from treatment to a better place.	South Hall, Main Hall
1245	Rebecca Daddow Royal Society of Arts	Whole Person Recovery.	
1315	Lunch Optional open mutual aid meetings start at 1345: SMART and NA for 30 mins.		Lunch: Kirkland Room SMART: Abden drawing room NA: South Hall, Rm 3

1415	Rowdy Yates & Jo Neale	Two hour afternoon research methodology masterclass <i>How to investigate and report grassroots recovery</i>	South Hall, Main Hall
	Workshop A		
	A1/ Marion Logan	Developing, delivering and evidencing Recovery in Scotland	Abden House Drawing Room
	A2/ Jason Gough	Patient Opinion. Supporting the client voice	Salisbury Green, Bryce Room
	A3/ Michaela Jones	Influence of Maslow & hierarchy of needs within Recovery	South Hall upstairs small meeting room (VIP room)
	A4/ David McCartney & Andy Rome	Does community rehab work? LEAP treatment outcome study.	South Hall Meeting Room 3
	A5/ Simon Jenkins	Recovery - it's an inside job.	Salisbury Green Drawing Room
Refreshments and Workshop B			
1515	B1/ Brendan Georgeson:	Comorbidity and recovery	Salisbury Green, Bryce Room
	B2/ Mark Gilman:	You alone can do it but you can't do it alone.	Abden House Drawing Room
	B4/ Stephanie Morrison & Margaret Hannah:	Tools and supports when initiating and supporting person-centred recovery journeys.	Salisbury Green Drawing Room
	B5/ Matthew Kidd & Carl Cundall:	Peer support/communities of recovery.	South Hall Meeting Room 3
Back to South Hall			
1615 - 1630	Stephen Bamber RA President	Recovery Academy CIC prize giving Close of conference	South Hall, main hall

Diversity is the Key Strength of the U.S. Recovery Movement Keith Humphries

U.K. recovery advocates often ask me what has made the U.S. recovery movement so successful. I find that the easiest way to answer this question is to recognize that there have been many recovery movements in the U.S. before that fell apart. What did they lack that the current movement seems to possess?

One could point to many things, but I believe the chief advantage of the current movement is its diversity. I mean diversity partly in the usual sense of a movement having members and national leaders who represent the full range of races, sexes, ethnicities and religions. Many prior recovery movements (e.g., the Keeley League) were entirely composed of white males, or even more restrictively of Protestant white males. A movement that rules most of the population out from participation is not going to grow and thrive over time, and will lose its moral standing as reformist because of its own evident internal prejudices.

But the modern U.S. recovery movement's commitment to diversity goes beyond concerns about the demographics of the membership. Equally important is the movement's embrace of diverse pathways to recovery. It wasn't always this way.

For years, when I would be on the radio or television to talk about my research on Alcoholics Anonymous, I would receive nasty letters and emails later telling me how stupid I was for saying good things

about AA. The typical letter said something like *"I tried AA and it didn't work. What worked for me is X and that's what you should be recommending"*. "X" was different across these letters, what was constant was the idea that the letter writer's own pathway should be followed by everyone else. This phenomenon was not unique to AA, when I would give talks about SMART Recovery, methadone maintenance, faith-based treatment programs, cognitive-behavioral psychotherapy or any other pathway to recovery I would get the same reaction from at least some people who had recovered in a different way, which they considered the only right and proper way.

Fortunately, people in recovery eventually realized that if that didn't start hanging together they would hang separately. The formation of Faces and Voices of Recovery as an integrative, diverse organization was critical, as was "national summit on recovery" in which people who had recovered in different ways stood on stage and said that they honored the recovery of people who had walked a different road. People who had recovered through Christian evangelical programs, 12-step programs, medications and psychotherapies stood shoulder to shoulder for the first time, and felt the power that comes when you stop attacking your own and start working together for a greater cause.

Whether the U.S. recovery movement can continue to grow in size and influence depends largely on how well it can continue to nurture a shared sense of "unity in diversity". And from what I see and hear in my many visits to the U.K., that same sensibility will be critical for recovery



activists here as well. It's tremendously hard work to create and maintain a space in which very different people can feel a sense of kinship and shared mission, but in my mind the work is worth it because it's the only way a movement can direct its attention and power outward and thereby change the society in which it exists.

Keith Humphreys is a Professor of Psychiatry at Stanford University and was Senior Policy Advisor at the White House drug policy office under President Obama, during which time he helped develop a White House office on recovery. The ideas in this paper are his responsibility and were originally presented as part of a longer keynote address at the UKRF Recovery Conference in Cardiff, Wales on 9 September 2011.

Colin Wilkie-Jones Moving Towards a Recovery-Oriented System

eATA and its members have had a long association with the recovery movement. I am therefore delighted as its Chief Executive to be a member of the Recovery Academy.

Across Great Britain, politicians, policy makers, service commissioners, providers and service users are, at long last, waking up to the fact that we should be raising our aspirations to demand that recovery become a reality in our communities. To this end the Scottish and English Governments have laid out compelling and credible visions for the future of their respective systems. The challenge for us all now is to make these visions come alive.

Central to this will be an acceptance by us all that there are many recovery pathways, all of which are equally valid as long as they are work for the individual. Given that no two recovery journeys will be the same, it is imperative that local areas provide a range of services which can be tailored to meet user needs. At a minimum, these should include:

- Harm reduction services that act as gateways to a wider recovery system
- Prescribing services that work with individuals to stabilise them in times of crisis, provide them with time to consider next steps and motivate them to make further progress
- A range of detox services
- A choice of residential treatment modalities and abstinence-oriented community services
- Truly recovery-oriented services for those opiate users for whom medically assisted recovery or long term planned maintenance would be most appropriate.
- Community aftercare and recovery 'check-ups'
- Integration with primary healthcare services, such as GPs and mental health
- Partnership work with reintegration services, such as education, employment and housing.

I would argue that any local system that does not offer the above cannot truly call itself a recovery oriented. Nor can a system that does not support and facilitate access to a variety of mutual aid pathways and other types of peer engagement and support. 'I can't but we can' and 'Nothing about us without us' being very pertinent rallying calls in this regard.



A key paradigm shift will be to move from an acute care to a chronic disease model in the treatment of addiction. In particular viewing addiction as a condition which, for the vast majority of people, will require ongoing management and accepting that relapse, whilst not inevitable, does often happen and should be seen not as a failure of the individual or the system, but as an error or learning experience resulting from the acquisition of new unfamiliar behaviours. It is also vital that we don't kid ourselves that we can deliver kind of change required overnight, as it is likely to take years. Nor should we be satisfied with rebranding everything previously referred to as treatment as recovery and bolt on a few extra bits and pieces – we should be aiming for long term transformational change from the bottom-up.

As great endings almost always start from small beginnings I would urge each and every one of you, as a first step, to play your part and engage with commissioners, providers, service users and people in recovery in your local communities in a 'big conversation' about the nature of addiction and recovery and the implications for your local services. We do after all 'make the path by walking it'.

A Postcard from Melbourne Assoc. Professor David Best

Since I have moved to Melbourne, I have been asked a number of times by people from home where the Australians stand with the recovery agenda. I would not be presumptuous enough to answer for the whole country but I will give a provisional answer for Melbourne and Victoria. There is a strong harm reduction philosophy in

specialist services that generally regards recovery as an 'abstentionist' agenda and so is reluctant to embrace or discuss this idea. However, this does not mean that there is no support or engagement – after all, in Australia as everywhere else in the world, lots of people have been recovering since long before the advent of specialist treatment provision. Unsurprisingly, there is also a tradition of both mutual aid and 12-step based rehabilitation services, although without a common voice or clear articulation. As we move towards an initial Recovery Academy seminar (on the 12th of October), there are three primary groups of 'allies' who will enable and support this process.

1. People in recovery – there are several visible and influential 'recovery champions' in the city including the Recovery Foundation and Self-Help Addiction Recovery Centre (SHARC). The latter is particularly interesting as it houses the main service user representative organisation, APSU. It also includes a private hospital largely, the Malvern, that is largely staffed by people in recovery
2. Individuals and groups involved in the mental health recovery movement – as in the UK, recovery has achieved earlier 'legitimacy' from academics and professionals around mental health where some of the principles and philosophies have gained significant traction. Here the opportunities for alliance and joint working are clear – and welcome.
3. Policy makers – as this was also going to be a core part of my role, the openness from the Victorian Department of Health was both surprising and welcome. The concern



about an 'episodes of care' commissioning model combined with the drive towards a new coherent policy has led to an opening to establish a recovery model across the AOD (alcohol and other drugs) arena.

So where is the opposition? As is always the case, this will come from the vested interests whose contracts and careers are threatened. But it is a 'can do' country and at the moment my honeymoon period is extending as a result of the commitment to improve in specialist staff, the energy of my colleagues and the opportunities for innovation and collaboration from my colleagues at Turning Point and in the wider AOD sector.

As a postscript to the postcard, I have just completed reporting on our North Wales recovery and treatment effectiveness project – and there are signs that recovery is making a difference. In addition to some amazing peer work, the attitudes of treatment staff have changed in an astonishing way reflecting in improved engagement and recovery capital in their clients.

A hierarchy of needs?

Michaela Jones

Can people engage effectively with treatment, sustain their recovery and attain the holy grail of reintegration unless their basic needs are being met? Do we fail to recognise that many of those affected directly and indirectly by substance misuse are not currently having their biological and physiological needs fully met?

Anybody with even a passing interest in psychology will have come across Maslow's Hierarchy of Needs, and his assertion that that the most basic level of needs must be met before the individual will strongly desire (or focus motivation upon) the secondary or higher level needs.

The concept of "better than well" is gaining increased currency in the recovery movement, Maslow described this as metatmotivation,¹ the determination to exceed the scope of basic needs and to aspire to constant growth and development. Individuals who are metamotivated have moved beyond deficiency needs or D-needs (esteem, friendship and love, security, and physical needs) and become focused on being needs or B needs. What Maslow characterises as "the desire to become more and more what one is, to become everything that one is capable of becoming."²

Has the focus on treatment of 'addiction', rather than a wider understanding of the factors surrounding addiction, led the field to build a system on insecure foundations? And in our desire to be aspirational, are we forgetting that meeting D-needs represents the building blocks of recovery?

References

¹ Goble, F. The Third Force: The Psychology of Abraham Maslow. Richmond, Ca: Maurice Bassett Publishing, 1970. Pg. 62.

² Maslow, Abraham. Motivation and personality. Harper and Row New York, New York 1954 pg 92



Initiating and supporting person-centred recovery journeys

Margaret Hannah

The 21st Century finds us living through a period of unusual change of the kind that only comes along every few hundred years. In the space of a relatively few years the ideas which guide our efforts, the actions in which we are engaged, our view of the world, of health and wellbeing and all that goes with it change beyond recognition. We call this a Change of Age. In such times it is still necessary to take effective action, a need compounded by the pace of change, the complexity of the challenges and uncertainty about outcomes. With the help of insights generated by International Futures Forum, we have begun to innovate in ways that appear to be making a real impact in people's lives.

We want to share some of these insights and provide some evidence for one innovation in particular (Kitbag) which shows promise as a way to initiate and support person-centred recovery journeys. Kitbag supports people to discover and develop their own innate capacities for growth and healing. This work starts with ourselves as recovery practitioners. During the workshop, you will have the opportunity to try Kitbag for yourselves.

Is it really helpful to argue that drug users who want to recover need to repair their spoiled identity?¹

Jo Neale

Researchers from the UK and US have argued that drug users have a 'spoiled identity' and must restore a 'normal' or 'unspoiled' identity in order to recover. In Scotland, for example, a study of seventy drug users showed how individuals who wanted to stop using drugs first had to realise that they were exhibiting characteristics that were unacceptable to themselves and to others and that their identity had been 'spoiled'. They then had to want a new identity and lifestyle, have a vision of a renewed future and believe that change was possible (McIntosh & McKeganey, 2001).

Linking recovery to repairing a spoiled identity is appealing for a number of reasons. First, drug users often try to explain away previous misdemeanours in terms of a past 'spoiled identity' that contrasts with a new clean self. Second, drug treatment services, and particularly twelve-step programmes, routinely encourage individuals to destroy their negative identity rooted in the drug world and to establish supportive social networks that will sustain a positive new self. Third, restoring a normal or unspoiled identity is consistent with current policy goals of re-integrating drug users back into mainstream society. And fourth, the argument that recovery is about repairing a spoiled identity is relatively easy to explain and understand.



The importance of drug users establishing a 'non-addict', 'normal' or 'unspoiled' identity has been linked to the sociologist Erving Goffman and his book: *Stigma: notes on the management of a spoiled identity*. Common sense, however, suggests that people do not tend to have completely 'spoiled' (or 'unspoiled') identities. Life is much more complicated than this. Instead, aspects of an individual's identity (rather than whole identities) might be 'damaged' or 'spoiled' at particular moments in time and in particular situations. Labelling drug users as 'spoiled' is simplistic, misinformed and derogatory. It also suggests that the only way to not be spoiled is to stop using drugs completely. What then of those individuals who reduce or stabilise their drug use or engage well with treatment or harm reduction services? Are they still 'spoiled'? Explaining recovery in terms of repairing a spoiled identity also implies that individuals can simply stop using drugs. Yet, in the real world there are lots of complex physical, psychological and social reasons why people continue to use. Additionally, society will often continue to label and stigmatise individuals as spoiled even though their drug use has ceased.

On closer inspection, the argument that recovery requires individuals to repair their spoiled identity is weak. Indeed, there are likely to be other more useful ways of explaining and describing what happens when people stop using drugs. It is not possible to cover the many possibilities here. However, another book by Erving Goffman, *The Presentation of Self in Everyday Life*, seems to provide a better alternative. In this second book, Goffman argues that identity is not a fixed characteristic but more like a theatrical performance. In other words, identity

emerges from how we perform or behave when we are interacting with other people. People can have multiple simultaneous identities. Furthermore, those identities can be changed or adapted at any moment in time and in different situations.

By focusing on the performative aspects of identity, we can see that individuals are not simply 'a drug user' or 'a non drug user' or a 'spoiled' or 'unspoiled' person. They might also have other identities: a person trying hard in treatment, a caring parent, a considerate friend, a hard-working employee or simply kind-hearted person. It is not necessary to be totally abstinent in order to have a positive presence in the world. In every new social encounter, it is possible to be thoughtful and considerate, make amends for a past negative action and project a more positive self. The idea that individuals have multiple identities which they can change (even if this is only in small ways) in different situations is more complex than the argument that all drug users have spoiled identities which they must repair in order to recover. Nonetheless, it offers more possibilities for personal development within recovery and stops us from labeling all drug users as spoiled people unless and until they become totally drug free.

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- Goffman, E. (1963). *Stigma: notes on the management of a spoiled identity*. Harmondsworth: Penguin.
- McIntosh, J., & McKeganey, N. (2001). *Beating the dragon: the recovery from dependent drug use*. London: Prentice Hall.



¹ This entry summarises key arguments from a recently published paper: Neale, J., Nettleton, S. and Pickering, L. (2011) 'Recovery from problem drug use: what can we learn from the sociologist Erving Goffman?', *Drugs: education, prevention and policy* 18(1): 3-9.

You alone can do it but you can't do it alone.

Mark Gilman

Since the last Recovery Academy conference in 2010 we have come to realise that treatment and recovery are places that exist in every community in the UK. Treatment may take the form of a single handed GP providing pharmacotherapy. Recovery may take the form of two people in a church basement with an AA Big Book, a coffee pot and a resentment. With this in mind we continue to build bridges between treatment and recovery. Our bridges need to be well signposted and go both ways. Some bridges will need to be big because they have to span a wide gap. In the UK, the bridges from orthodox medical treatment services to 12 step mutual aid will need to be bigger than the bridges to SMART Recovery. This is because UK treatment services tend to find it easier to link to SMART Recovery because they have CBT in common.

In the US, the reverse is more likely to be true because their treatment services often have the 12 steps in common. There is a lot of misunderstanding that could be helped if we simply admitted that we are all exploring uncharted territory. We have never been here before. We have had recovery in a form that we would recognise

today since AA was formed in 1935. Methadone maintenance came to the UK around thirty years later in 1965. With some notable exceptions, treatment and recovery have never attempted to work together in a systematic wholesale way in the UK. As treatment professionals and recovering and recovered people come together, we have to find a common language and a way of communicating respectfully. It reminds me of our new trading relationships with the "BRIC" countries of Brazil, Russia, India and China. The success of much of UK export business will rely on how well it relates to the 'BRIC' countries. The success of treatment will similarly depend on how well it relates to the recovery communities. In other words, how we come together to Build Recovery in Communities (BRiC). Successful relationships require a sound working knowledge of each other's culture. Understanding cultural differences and promoting cultural sensitivity will help ensure that communication across borders is effective and that business transactions are successful. It's the same in our work. Treatment and recovery have their own cultural standards of being, thinking, and acting. These cultural differences strongly influence our values and communications with each other. What may be considered perfectly acceptable and natural in a recovery setting may be considered confusing or even offensive in a treatment setting. For example, someone may be subject to a level of personal challenge in a recovery setting that would be unacceptable in a treatment setting. Recovery often requires a culture of risk taking. In order to fly you've got to leave the nest. Many treatment systems have evolved within a risk-averse culture. In treatment settings we focus on individuals



and our treatment interventions are rooted in individualism. But we also know the damaging effects of social isolation. Recovery is fundamentally about the collective: I can't but we can. Those of us who work in treatment settings need to work out how we operationalise one of the core values of the recovery world – you alone can do it but you can't do it alone. What does this mean? Where does it come from and where is it taking us?

Everyone needs a Mentor

Matthew Kidd

It's best not to ask "when does someone with addiction problems need a peer mentor?" but instead "when doesn't someone need a peer mentor?" To those immersed in active addiction, either treatment resistant or in treatment through the criminal justice route, peer mentors can provide a reason to change. Peer Mentors can make recovery desirable in a way most professionals can not. Peer mentors can't be accused of having "not been there" and they can openly disclose the costs of their addiction and the benefits of their recovery.

When people begin to enter the contemplation stage peer mentors can help to meet the individuals esteem needs, to help convince them they are worthy of a better life. They can help the individual discover and articulate their motivation for recovery. When people begin to take action peer mentors are arguably needed the most, helping the individual access the support and the resources they require. As all of a sudden one big problem, in the form of addiction and where the next drink or hit is coming from, turns in to a hundred and one smaller problems such as bills to pay,

shopping to buy, isolation, feelings of loneliness and inadequacy. It's easy to feel overwhelmed at this stage and the importance of a guide you can trust and relate to cannot be underestimated.

A peer mentor can help someone access mutual aid groups, virtual recovery communities and even those who don't feel comfortable engaging with either. A good peer mentor will be aware of many different sources of support and can inform people of these without influencing them. When people are looking to sustain their recovery a peer mentor can be there to guide and advise as they face common barriers and obstacles, as they try to learn how to manage urges and cravings, as they look to tackle the hundred and one problems mentioned earlier. Perhaps more importantly, a peer mentor can advise that a lapse doesn't have to mean a relapse. They can help the individual overcome any subsequent guilt and shame and encourage them to re-engage with support networks they might have been afraid to go back to.

The route from service user to volunteer is a well trodden one, it is a route than can bring as much frustration as it can satisfaction. At this stage a peer mentor can convince you that it is worth persevering with. Again; they will have overcome many of the common barriers and obstacles and can offer a living, breathing example of someone who has made the transition.

So to conclude, if you are thinking about peer mentoring in your locality you should be asking "why shouldn't we have peer mentors" because you'll find a much shorter answer to the question of why you should incorporate them. The following is



taken from “Linking Addiction Treatment and Communities of Recovery” by William White and Ernest Kurtz - A Primer for Addiction Counselors and Recovery Coaches, Representative Functions of Recovery Community Volunteers:

1. Offering themselves as “living proof” of the reality of recovery and the transformative power of recovery.
 2. Sharing their recovery status and, when well-timed and appropriate, their recovery story.
 3. Serving as a recovery lifestyle consultant, sharing practical tips on living as a person in recovery within one’s family, school or workplace and larger community.
 4. Helping staff and paid peer-support specialists guide the client/family into relationships with one or more local or virtual communities of recovery.
 5. Providing support (e.g., information, transportation) and advocacy to each client/family to facilitate access to needed recovery services.
 6. Providing face-to-face, telephone and email communications for purposes of monitoring, recovery coaching, and, when needed, early re-intervention.
 7. Training family members (or persons in recovery) to run family education seminars and family support groups.
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Does rehab work?

David McCartney

If reports from the sector are accurate, then it looks as if residential rehabilitation services are not being commissioned or accessed as much as they might be. The refrain of “there’s no evidence that it works” is often heard, but is it true? Does residential rehab work or does it not?

One of the challenges with answering this question is the lack of evidence we have in the UK on the matter generally. However there is some evidence. Another issue is what does “work” mean? You’d think with decades of residential rehabilitation provision in the UK that we could look to a robust evidence base for the answer. We can’t. We might also want to know what elements of rehab are most important.

DORIS and NTORS, two large UK treatment outcome studies, had elements of residential rehab embedded in them, but even here it’s hard to draw robust conclusions. What constitutes success? For residential rehab, abstinence is usually one of the goals, but DORIS (Drug Outcome Research In Scotland) and NTORS (National Treatment Outcome Research Study) had different definitions of abstinence, neither of which would fit comfortably with the philosophy of a typical rehab. The DORIS study in its three year outcomes found that those achieving abstinence improved across a range of outcomes compared to those who were maintained on prescription opiates. The study also found that those recruited from residential treatment settings achieved abstinence at three times the rate of those in community treatment programmes and five times the rate of those in prison based



treatment. As the authors acknowledge, the nature of a cohort study makes the attribution of causality problematic.

Abstinence might be one goal, but recovery is not to be defined simply in terms of drug or alcohol use. There are issues around quality of life, citizenship, the fulfilment of potential and improvements in social, financial and relationship domains of life. And while we're on the matter, what about housing, education, employment and parenting? Trying to decide what things to measure and how to do it provides a headache for researchers. We had this dilemma at a treatment and rehabilitation service in Edinburgh: the Lothians & Edinburgh Abstinence Programme (LEAP). Set up as a quasi-residential rehab and funded as a Scottish Government pilot, we knew at the outset that we needed to have a robust evaluation in place. We looked at what was available in terms of outcome measurement tools. They all seemed quite pathology focussed, detailing the absence of negatives in folk's lives rather than measuring the positives that recovery brings.

With the advice of our evaluators (Figure 8) and that of Dr David Best, we elected to use the Addiction Severity Index (ASIX) as our main tool. Validated and used in studies around the world, it measures changes across a range of domains. Our team had to be trained in how to administer the questionnaire and then each of us were assessed for accuracy and consistency. We used the tool at baseline in a cohort of 145 patients and our evaluators followed them up at 9 months, 15 months and 27 months.

What did we find? Well, going through community treatment at LEAP is

associated with significant reduction in alcohol and drug use (and total abstinence). The effect is related to time in treatment with those completing doing better than those leaving early. We were able to demonstrate reduction in injecting behaviour too showing that abstinence oriented treatment and harm reduction may exist as comfortable bedfellows. The improvements were sustained over time, even though this client group were no longer in treatment. We showed that clients' quality of life improved, as did the quality of their relationships. There was a reduction in legal problems. Economic situation was slower to improve, but at the 27 month mark there was evidence of progress with this and mental health too. Those attending aftercare, mutual aid and doing volunteer work did better than those not taking part in these activities, suggesting that these may be protective and should be promoted in treatment services.

This study demonstrates that it is possible to do research in rehab settings, that in this holistic, integrated model of treatment, substantial and significant improvements were seen and that these were sustained. We plan to publish the study in detail in due course. We're seeking funding to help us continue to follow this cohort over time which we hope will allow policy-makers greater confidence in understanding what works in those seeking abstinent recovery.

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Duelling in Dual Diagnosis

Brendan Georgeson

Earlier this year I was asked to present at the Recovery Academy 2nd annual conference in Edinburgh on recovery oriented systems of care for those experiencing dual diagnosis. However dual had been misspelt duel. I was about to correct it when I realised a duel or fight is often what the dually diagnosed experience when trying to access help. The solution to conflict in the field has long been known i.e. an integrated approach 'Effective treatment needs to be evidence-based and provide an integrated response..... service users often have difficulty in approaching mainstream services. It is therefore vital to engage with them in a meaningful and positive way to work towards long term recovery' (Turning Point, 2007). The pathways to dual diagnosis treatment should have long been in place, but according to the Themed Review by CSIP (2008) they haven't and therefore difficulties leading to conflict still arise. Not meeting the threshold for services, different thresholds and misunderstandings, who decides what is dual diagnosis and workers fear of the unknown. Some people with dual diagnosis can experience a great deal of interpersonal

conflict in their life as a matter of course (Mathew et al 1999). For some the conflict may come not as a result of the service user's transference, but as a result of workers counter transference (Najavits 2001).

Service users and workers alike often report of the bouncing between mental health and substance misuse services. The solution to this has long been known i.e. an integrated approach and the means to do it long been proposed in the Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide i.e. joint commissioning arrangements between mental health commissioners and drug action team commissioners (Department of Health 2002). The pathways to dual diagnosis treatment have should have long been in place - all local and health authorities should have a dual diagnosis strategy with clearly defined guidance and areas of responsibility and a lot should also have link workers and dual diagnosis champions. In short over the last 5 years the frameworks for action have come a long way, certainly in Bristol where the majority of service users that the St James Priory work with, so why is it still a fight? For example it's still not possible to get joint funding to place a service user in our dual diagnosis service. We have had to explain to a number of potential referrers the referral routes in as they aren't known. We expect our residents to be declined mental health services which is why we stopped referring them years ago and set up our own dual diagnosis specialism through sheer frustration at a process that felt futile. These issues are developed in detail in the workshop and solutions based on experience offered. In conclusion there



are many different reasons for the duel in dual diagnosis.

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Recovery - it's an inside job

Simon Jenkins

"Recovery is freedom from active addiction".

I like this definition because it is a simple description of a complex condition. I believe addiction is a chronic relapsing condition that affects the whole person, is contagious, and left untreated, ultimately fatal. I also believe that Recovery is contagious, and that: "I alone can do it, but I can't do it alone". People do not generally recover in isolation. Any recovery should engender such elements as: hope,

aspiration, asking for help, honest self appraisal, insight, open-mindedness and a willingness to change. It is a movement from being served to being of service to others. When I reflect on my own personal recovery I am aware that it is constantly evolving and changing. How I describe it now is very different to my earliest experiences. I am now clear that - as during my active addiction - recovery has little to do with drugs, including alcohol, even though it was all about that when my recovery began. My first exposure to recovery was in a residential treatment centre, where I met a group of people, ranging from those desperate to stop using drugs, to those who were indifferent, but complying with the regime for their own reasons. I quickly worked out that recovery wasn't possible for me, because it seemed so far from my experience of constant drug use.

I had spent a lifetime comparing my insides with other people outsides. I had felt trapped inside my own prison by my addiction, yet I was always an outsider wherever I was. I never felt a part of anything. What happened over a period of weeks was that I came to believe that freedom from the drugs that had controlled my life for so long was actually possible, as I was meeting people for whom that was a reality. These people were just like me, had used drugs just like me, but were moving on with their lives in a way that I truly wanted to emulate. This is what I mean by 'contagious'. This raises another feature of recovery: momentum. Recovery is not about moving away from anything, it is about moving towards something. One of the best features of the 'New Recovery Agenda' is that it is focussed on moving towards health, happiness, fulfillment,



social inclusion, community involvement. This movement needs to be continuous I also think that this gives an opportunity to move away from the deficit model, with all it's talk of drugs, and addiction and the harm caused, to an asset focussed recovery, with all the opportunities that brings for engagement with family, community and wider society. Recovery Now are consultants who specialize in advising drug treatment providers and services how best to work with mutual aid organisations. We believe that Recovery is an experiential journey, and that the traditional Treatment services provide only a part of the information and resources recovering people need to continue their life journey. To quote a well used analogy: 'If Recovery is a train journey from Edinburgh to London, then treatment is the taxi to the station.' We believe that abstinence is key to a continuing recovery, though not necessarily at the absolute beginning of the journey. We believe everyone - with the right support - can find freedom from addiction. We have worked with a variety of funding and treatment services, and are currently working with a leading London Treatment Provider. Our brief is to deliver training focused on Recovery Championing and embedding Mutual Aid into their services. We also regularly participate in meetings with Government and Mutual Aid Groups, helping to reshape the Recovery landscape.

Jason Gough Engagement & Support Officer. Patient Opinion Limited

Patient Opinion (www.patientopinion.org.uk) is a not-for-profit social enterprise, and is the first independent national patient/service user feedback system in the world. Patient Opinion treats feedback as a collaborative tool – allowing staff to work with patients/service users to improve standards of care. We aim to harness the experience of service users and carers to transform health services, making it easy and safe for anyone to give feedback about healthcare, and channel it to the people who can use it to make services better.

The benefits are clear, and are signalling a step change in the way professionals engage with service users, so much so that in July, the House of Commons Health Committee's report was published, stating that there was "*great value in providers constantly viewing the comments left about them on websites such as Patient Opinion*", and recommending that organisations embrace "*tools that allow patients and service users to give feedback anonymously and that can demonstrate that changes have been made to service provision based on feedback received*".



Book reviews

Rowdy Yates

What follows here is a copy of a brief article I did for our Departmental Newsletter here in University of Stirling. It's a contribution to a regular column called Desert Island Books. The idea is that people in the Department will list 5 books that most tellingly have affected their work/lives. I have to say that choosing just five was really hard and it meant that I had to miss out some serious contenders like John Davies' "The Myth of Addiction", Jay Steven's "Storming Heaven" and Brian Inglis' "Forbidden Game". So

Yablonsky, L. (1965), Synanon: The Tunnel Back, New York: Macmillan

I first read this in 1970. I'd come off heroin four months before and a group of five of us were trying to build a sort of Alcoholics Anonymous for heroin users. Somebody found Tunnel Back in the public library and I think we kept it out on loan for about a year! To this day I can't remember who ended up paying the fine! In the book, Yablonsky – a social anthropologist, then recognised as a leading authority on US gang culture – describes a visit to Synanon, the first US therapeutic community for heroin users. At that time, the established view was that heroin addiction was incurable and yet here, Yablonsky found a fiercely independent community of ex-users who were not only maintaining their sobriety without professional help, but contributing to society in a very positive way. Yablonsky was so impressed that he stayed in Synanon for months. Our little group was just as impressed with Yablonsky's record of that stay. It was as if somebody had come into our group and said, "Well, if you're really serious about

this stuff, here's some things you could do". It became the bible of our group and, later when we set up Lifeline, now one of the UK's largest drug treatment agencies, it was the foundation of much of what we did in the early years. For me, Tunnel Back represents almost everything I believe in about recovery and it gave me strength when I needed it most.

Peele, S. and Brodsky, A. (1975) Love and Addiction, New York: Taplinger Publishing

This book I read as soon as it was published. A friend had recommended it and she wasn't wrong. Peele and Brodsky view addiction as a normal behaviour that has veered out of control and they compare it with dysfunctional human relationships. I think it was probably the first book I ever read which analysed addiction in a way that made sense to me and echoed what I knew from my work. Years later, after I came to Stirling, I undertook a study looking at recovered addicts who had been sexually abused as children. One of the researchers we used was a psychotherapist to trade and remarked to me that the relationship they described with their drug(s) of choice sounded exactly like their relationship with their perpetrator. I remembered Peele and Brodsky and pulled it off the shelf. It still reads absolutely true as an understanding of addictive behaviour all these years later.

De Leon, G. (2000) The Therapeutic Community: Theory, Model and Method, New York: Springer Publishing Company

In the world of drug-free therapeutic communities, George De Leon is the nearest thing we have to a Pope! A psychology graduate who was making a living as a well-respected jazz player, De Leon saw at first hand the impact of heroin



addiction amongst the jazz musicians he played with. Many of his fellow musicians found sobriety at Synanon and when a similar facility – Phoenix House – was established in New York, he became its first Director of Research. This is a hugely comprehensive book and a labour of love. De Leon systematically describes the drug-free therapeutic community and its origins. He sets out the fundamental principles of the approach describing his notion of community as method as, “The purposive use of the community to teach the individual to use the community to change themselves.” Last year I chaired a working party for the Royal College of Psychiatrists (Community of Communities Project) to develop a set of service standards for drug-free therapeutic communities. During that time, De Leon’s book was absolutely invaluable and rarely left my side.

Bridgeland M. (1971) Pioneer work with maladjusted children, London: Staples Press

Maurice Bridgeland taught at Lendrick Muir School, Rumbling Bridge, Kinross-shire from 1962 – 67. Lendrick Muir was a special needs school much influenced by the work of A. S. Neil, David Wills and others in the early therapeutic school movement. He went on to lecture at University of Liverpool where he wrote this fascinating history of that early work. I came across this book quite by accident and simply couldn’t put it down. For me, it placed the whole story of the drug-free therapeutic community into an historical context. Bridgeland describes the work of David Wills in setting up the Hawkspur Camp (a self-governing, self-built community for

“maladjusted” children) and the impact this had, both on the approach to juvenile delinquency and upon residential care and schooling. Perhaps most compelling are the chapters on Homer Lane and his Little Commonwealth settlement before the First World War. Lane, a US woodwork teacher developed what might have been the first true therapeutic community with a mixed population of family units, a token economy system and levels of self-governance which were unheard of at that time. Always treated with distaste and distrust by the UK authorities, Lane was eventually refused an extension to his visa following a scandal which many believed to have been orchestrated by the authorities themselves. W. H. Auden wrote:

*“Lawrence was brought down by the
slut hounds*

Blake went dotty as he sang

Homer Lane was killed in action

By the Twickenham Baptist gang.”

Young, J. (1992) Songs They Never Play on the Radio: Nico, the last Bohemian, London: Bloomsbury

I chose this one just because it’s a really good read. Well written, Young gives the reader a real insider’s view of the world of the addict during the final tumultuous years of the life of Nico, former doyen of the Velvet Underground. It’s fairly gritty stuff and Nico doesn’t come out of it all that well. But at times it is uproariously funny. The discussion between punk poet, John Cooper Clarke and his sidekick Echo, about the relative merits of brown versus white heroin wins my prize for the funniest passage of addiction-related literature hands down! Thoroughly recommended.