

Re: 'Harm Reduction is not a ticket to recovery'

Am I missing something here or does Roy Fisher simply not understand what harm reduction is (*DDN* letters, 27 June). He thinks *DDN* supports a harm minimisation model as a form of 'recovery' which I take from his letter he doesn't agree with. Although *DDN* has recently featured an article on a rehash of an old 12-step faith based programme, 'recovery' is not a term I have ever heard used in the harm reduction field, nor have I ever heard anybody claim it is a form of recovery. Harm reduction is about reducing drug related harm (the name is a bit of a giveaway). He then goes on to state the 'bleeding obvious' that users find it hard to control their drug use and says 'I cannot subscribe to the theory that people given time and a methadone prescription will eventually sort themselves and the real danger here is that many service users die in the contemplation mode'.

Let me make it simple for you Roy, methadone does sort some people out. Try getting out and meeting some people who are alive because of methadone or maybe even reading some research. Second, it is not passing through a stage of Prochaska and DiClemente's theoretical model that kills people – it is overdoses and blood borne viruses. Harm reduction's primary purpose is to reduce deaths caused by these and other factors. Harm reduction in Britain started in the 1980s because treatment services and the old concept based therapeutic communities were totally abstinence based (including my own service, Lifeline). They had woeful success rates, even among the few who chose to go along to them and were as much use as a chocolate fireguard when faced with the threat of HIV amongst injectors. A harm reduction philosophy has never precluded helping people stopping or supporting people who want to be abstinent, but it recognises that many fail and are at increased risk of overdose and sharing if they go back to using. I agree with one thing that Roy Fisher says: 'whilst at work we must work within a framework of giving the service users choices'. Harm reduction, in the form of needle exchange, safer use information, methadone and other prescribing

'A harm reduction philosophy has never precluded helping people stopping or supporting people who want to be abstinent, but it recognises that many fail and are at increased risk of overdose and sharing if they go back to using... Harm reduction, in the form of needle exchange, safer use information, methadone and other prescribing options should be part of the choice on offer to everyone, even in those services that spend their time challenging addiction "in a respectful manner".'

options should be part of the choice on offer to everyone, even in those services that spend their time challenging addiction 'in a respectful manner'.

Michael Linnell, Director of Communications, Lifeline

NTA: Don't underestimate the value of continuity

I have just returned from the NTA conference to launch the new treatment effectiveness strategy, which was edifying and raised my expectation for 'service user participation'.

BUT – at the final Q&A I managed to get in a question ('today has been very encouraging, but isn't it pointless when, every three years, you throw everything that's been done up in the air and insist the contracts for alcohol and drugs services go out to tender?') in a plea for stability for service users on their 'journey'. The answers were so dismissive that it made me think that Saul Bellow was right when he said 'a great deal of intelligence can be invested in ignorance when the need for illusion is deep'.

Politicians, and funding authorities for that matter, require evidence that they're getting 'value for money' but are clueless as to what 'value' is. It is only the service user who understands the true value of the service he receives, and it can't be measured.

When an addict, be it alcohol or drugs, and goes into treatment, he soon realises that he's going to be forced to make some radical changes

to his way of life. This requires even more difficult changes in his way of thinking. These changes will mean making many difficult choices, and to do that he will need the help of someone he can trust, somebody who is non-judgemental and free of dogma, to work out all of his options with him, and give him a better chance of making the best one.

It's a long and difficult journey, made easier by the help of many and various caring people. But being bereft of any self-worth, let alone self-confidence, it may take a little time to establish a rapport with the practitioners at his service; but when he does, a bond is created that is to become the foundation on which he will base his road-map for the journey to 'being normal'.

With his support structure in place, he is up and running, ready to make some of those difficult choices. With his mutually drawn-up care-plan and needs assessment in place, peer support around the corner at his first 'day course', there is light at the end of the tunnel. With services, some of which he had never heard (like-auricular acupuncture), there to help him, he can be forgiven for being optimistic about his future sobriety. Unrecognised by all, including himself but more ironically by those insistent on measuring outcomes, something very subtle has happened to our friend. Since 'detox' he has not been fighting his problems alone. He's had counselling and advice from people who are caring and supportive, and peer support that is empathetic from colleagues on the same journey as he

is. This compassion, for someone on their own, is probably the closest they have been to being loved for a long, long time. This can have a great deal of influence on the effectiveness of 'recovery'. Measure it if you can!

Meanwhile, back at the PCT, 'the system' is (thanks to our politicians) ready to kick away the support under our alcoholic/addict, and rubbish all the PCT's efforts to meet its meaningless targets. It is time for the contracts for alcohol and drugs services go out to tender. 'Patient needs' driven NHS..?

Now with a new service provider, and not knowing if same professionals, whose trust and support were the foundation of his fight back, will still be there for him, our friend may be forgiven for coming to the conclusion that he had been right all along – he wasn't worth it. Hopefully he'll have become strong enough to start again.

Surely it's not beyond the wit of the PCTs to forego this so called 'modernisation' when it is damaging to the patient. Providers, GPs, DAATS, commissioners – all have their corners to defend, what chance, or choice, does the service user have? I can't help thinking that, with the help of service users' experience, a service, provided by a consortium of existing providers working together, using the 'Models of Care' protocols already in place, would not only produce 'best practice' but also 'best value'.

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Email your letter to claire@cjwellings.com. Letters may be edited for reasons of length and clarity.