Developing the Alliance

For many service users, the Alliance has not only provided a lifeline to better treatment, it has given them skills, knowledge and the inspiration to get back into mainstream life and employment. Daren Garratt, the Alliance's development manager, tells DDN why the work of this small but dynamic organisation is more vital than ever.

When I first became aware of Bill Nelles and the then Methadone Alliance at their inaugural conference at the Purcell Rooms in the late 90s, they encapsulated everything that I had become involved in drug work for: they were a respected, proactive and influential professional body that placed the health, dignity and well-being of drug users at its core. They were not afraid to highlight, address and tackle the injustices, inaccuracies and misguided, blinkered, and occasionally downright dangerous opinion-based practices that were allowed to pass themselves off as accepted drug treatment programmes at that time. They fought to ensure that the evidence-base informed and influenced substitute prescribing, and not an individual's moral viewpoint or received wisdom. They wanted to prove that drug users and health and social-care professionals could work together as equals to improve the conditions that many users (and workers) found themselves locked in, and bring greater cohesion, benefits and stability to society as a whole. And they were successful. Who wouldn't want to be a part of that?

I'd come to the attention of the Alliance largely due to the work I'd done as DAT Coordinator in Walsall, West Midlands. I was fortunate enough to work for, and with, a DAT that embraced and encouraged the philosophy of harm reduction, and understood that our main duty of care was the preservation of life, and that we should take every step to prevent the unnecessary transmission of diseases and other avoidable drug-related harms. This was a DAT that had as its chair of the joint commissioning group a wonderfully pragmatic, no-nonsense director of public health who came out with the immortal line, 'when it comes to public health, there's no such thing as morality' (apologies Sam, if I've misquoted you!). So in 2001, as a fresh-faced idealist (I would say 'romantic', but I'm from Dudley), adapting to my first few months of employment, I was allowed to introduce citric acid sachets when it was still technically illegal, supported in developing emergency response protocols with the police, coroner and ambulance service, and tasked with coordinating a peer-led, Injecting Drug User (IDU) Research Project, where current or ex-IDUs would be trained in research methodology by Staffordshire University, and paid to conduct research into the nature of IV use in the borough. They were good, exciting, effective days, culminating in a major DAT-organised Harm Reduction Conference at the Bescot Stadium (home of Walsall FC), at which Bill Nelles was invited to be our keynote speaker.

There was, however, a distinctly noticeable sea change in the air. The government had produced a white paper proposing that DATs and Crime and Disorder Reduction Partnerships (CDRPs) merge, and duly established a consultation process. Unfortunately, when the consultation process was complete, and the vast majority of DATs had responded saying that although closer working arrangements would and should be welcomed and encouraged, full mergers would be unfavourable, largely unworkable and possibly even detrimental, we were told that we'd either misunderstood or been misled. The question now was no longer if we should merge, but how.

So now my role became one of enabling two vitally important, yet largely aesthetically alien, bodies to breathe as one. My role became one of ensuring the chief executive of our PCT got his star rating. My role became one of establishing effective, robust data collection and transfer systems that allowed the NTA to hit the targets they were tasked with. My role appeared to have less and less to do with supporting users or improving the wider well being of our communities. My role was, to me, about keeping people with much more important titles and much bigger salaries than me in employment. My role was lost.

And then, as if from nowhere, an angel in an off-white t-shirt and grey, sloppy-Joe jogging bottoms spoke to me, offered me a path and delivered me from limbo. I was saved!

And I did feel saved. I felt – and will always feel – honoured, humbled and proud to serve the Alliance, because I know what the Alliance does, I know what the Alliance has the ability and talent to do, and I know that we need the Alliance possibly more now than ever before.

I have known friends grow in the user involvement movement and facilitate workshops at National Conferences thanks to the 120ml methadone maintenance script that the Alliance helped them secure – scripts that, two years previously, would have been unthinkable.

I have seen users attend our practical advocacy training courses, overjoyed, and sometimes overawed, that they've finally met Alan Joyce; a man who, in their own words, saved their lives.

I have had the privilege to work alongside dedicated, enthusiastic, NHS employed (read 'paid') user involvement and advocacy workers who achieved stability thanks to the Alliance's intervention, and developed their skills, knowledge and professionalism thanks to the Alliance's volunteer and mentoring programmes.

I have had the honour of standing shoulder to shoulder with the Alliance's Chair, Dr Chris Ford, as she has worked with users to improve services and fought for the rights of drug users. I'll reiterate: who wouldn't want to be a part of that?

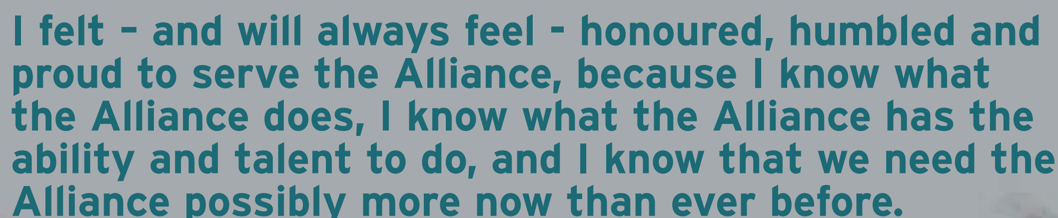
But for all the Alliance's international reputation and sterling work, it's been achieved with a minimal staff team operating on a shoestring budget built on unsecured, short-term, hotchpotch financial agreements. We need to secure, expand and develop our national model of advocacy so that we can devise, support and manage four tiers of local, regional and national advocacy provision and ensure that all users, regardless of their geographical area, have the opportunity to access peers who have the ability, knowledge and professional backing to negotiate and secure individualised treatment programmes, doses and modes of administration that are right for them.

We need to secure, expand and develop our volunteer provision and helpline programme in order to ensure that users have access to the employment opportunities they want, and the evidence base they need.

We need to secure, expand and develop our management team, not only in relation to our core strategic and operational areas, but crucially, in our advocacy training and active provision.

We need to find effective avenues to impart knowledge around supporting, training, mentoring and coordinating user involvement initiatives, and we need to formalise our ability and unique position to devise, conduct and disseminate research proposals from a user perspective, with user-relevant outcomes in mind.

It is, however, difficult to achieve the achievable with a salaried staff team of three, six part time volunteers, a one day a week user-researcher coordinating the random control tests into injectable opioid treatment, and no substantial, dedicated, long-term financial investment.



This is a story no different to the one that every charitable organisation has to settle down to bed with, and it's an accepted fact of life that small, voluntary organisations have to invest most of their time and energies into keeping themselves afloat, often to the detriment of the proactive work that they're seeking funding for.

In the case of the Alliance, the worry is that we will become so bogged down in bid writing and money chasing that it will supplant our coalface work and activism, on which we've built our reputation and helped turn so many lives around.

This cannot be allowed to happen. Not in an increasingly punitive and coercive state-controlled system that puts users in the very real and unnecessary position of facing a jail stretch, should they dare to use on top of their sub-optimal, ineffective dose.

Not in a society and culture that allows three policemen to dump a known 25 year old 'drug addict' (and, coincidentally, mother of three, daughter of two) in wasteland, on 'another force's' patch, in the middle of winter, undiscovered for three months, and for there to be no charges brought against them because, 'no expert evidence had been brought forward to explain questions such as whether heroin addicts should be referred to a doctor or what obligations the police have when releasing people from custody without charge in towns where they do not live.' (*Daily Telegraph*, 19 April 2005).

Not when people's lives are being arbitrarily and willingly lost and destroyed in a game that seeks only to win the political and moral high ground.

Our aims and objectives are simple. We want to support those currently in drug treatment, those who have accessed drug treatment in the past and those who may access drug treatment in the future. We will do this by:

- establishing the right of people receiving treatment to be consulted about changes that concern them and to participating in the making of decisions relating to their care
- providing accurate information, advice, and support to people receiving prescribed drugs for the treatment of their drug dependency and educating users about their rights to effective treatment
- providing advocacy and representation to people receiving poor care, and helping improve their situation and their experience of treatment
- lobbying for prescribing practices that are validated as 'evidence-based' by reputable scientific bodies and ensuring that drug users are actively involved in the debate about their treatment and care at every level
- supporting 'drug-of-choice' prescribing regimes where these would clearly benefit the individual
- providing a structure through which users can address the needs of their own community
- promoting a harm-reduction approach to the treatment of drug use

We've come a long way, but there's still a long way to go. The Alliance is here for the long-haul.

For training or other admin queries, please contact Ursula Brown on 020 7713 6222 or email malliance@btconnect.com
The Alliance Helpline : 020 7837 4379
Noon to 4pm Mon-Fri
www.m-alliance.org.uk