Drug Submission 76.

Submission to the

Education and Health Standing Committee

Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia

"Recovery and Recovery Oriented Systems of Care (ROSC)"

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1. Recovery and the recovery model

1.1. In some countries, a major paradigm shift has recently been occurring in the way that society helps people overcome substance use problems.

1.2. Experts emphasise that rather than focus on the problem (addiction) and its negative consequences (social cost model) as society has done for many years, society needs to focus on the lived solution (recovery) and its positive benefits (recovery-based model). Millions of people have overcome serious substance use problems and society must learn from these people to help others find their path to recovery.

1.3. Personal recovery from alcohol and drug problems has been defined as a process of change through which an individual achieves abstinence, improved health, wellness, and quality of life[1].

1.4. Advocates of the recovery model appreciate that a multitude of factors within a person's social ecosystem (at personal, family, community, state, national levels) influence a person as they travel along their path to recovery.

1.5. The recovery model differs from the classical medical model, on which much of addiction treatment is currently based, in that it emphasises empowerment of the person, the importance of peer support, and the involvement of family members in helping the individual and family find recovery.

1.6. Rather than focus on pathology and personal weaknesses and deficits, as does the current treatment approach, the recovery model focuses on the person and family using their strengths and assets to travel a path to wellness and recovery.

1.7. Recovery is not just about symptom management, as is the case of much of treatment today (e.g. most methadone maintenance programmes). It is about the person (re)building a meaningful and valued life, where they can realise their aspirations, be treated with respect and dignity, and contribute to society.

2. Treatment and recovery oriented systems of care (ROSC)[2]

2.1. Ultimately, recovery comes from the person, not the practitioner. However, research has shown that professional treatment can help people manage and even overcome serious substance use problems, although the success of many treatment systems is still limited.

2.2. This relative lack of success is in part related to the fact that society uses primarily an acute care model[3], whilst serious substance use problems are generally chronic in nature. As a result, whilst many people entering treatment may achieve a temporary psychosocial stabilisation, they soon relapse after leaving treatment, in large part

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[1] It is possible to have medication-assisted recovery, e.g. methadone maintenance, so that the person is not abstinent of all substances. However, a current common treatment practice is for people with a heroin problem to be put on a methadone substitution programme without any other form of support. This approach is not recovery-oriented.

[2] In the UK, these are commonly referred to as Recovery-Oriented Integrated Systems (ROIS).

[3] A common alternative to the acute model has been to place people on a long-term (permanent) script of methadone with little or no additional support. This approach has had limited success in helping people overcome an addiction to opiates unless it is part of a recovery programme.

because of a lack of continuing support. Many, possibly the majority of people who enter the treatment system do so on many occasions, resulting in the well-known revolving door phenomena.

2.3. The recovery model recognises treatment as playing an important role in recovery initiation. However, for treatment to impact positively on long-term recovery, a continuum of care, or chronic care model, is needed for people with serious substance use problems, similar to that used for other chronic conditions such as diabetes and heart disease.

2.4. Treatment also needs to be part of a wider system of care helping people find long-term recovery.

2.5. Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilised to sustain long-term recovery for individuals and families affected impacted by serious substance use problems.

2.6. The *system* in ROSC is not a treatment agency but a macro level organization of a community. ROSC focuses on the physical, mental, spiritual and social wellness of the individual and offers person-centered, strength-based, individualised services and support to help the person meet changing needs as recovery unfolds.

2.7. Recovery-oriented services and systems (e.g., treatment, peer support, family, medical, housing, child welfare, criminal justice, education) are integrated, comprehensive, flexible, and outcomes-driven. The integration of the systems offers a fully coordinated menu of services and supports to maximise choice.

2.8. ROSC combine the use of professional services (such as treatment), mutual aid groups (e.g. AA, SMART Recovery) and peer support, as well as a wide range of other support services.

2.9. Peer recovery support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery and enhancing the quality of personal and family life in long-term recovery.

2.10 Peer recovery support services are strengths-based, build recovery-oriented systems and offer hope. They are adaptable across the continuum of care and are distinguished from professional treatment and mutual aid support groups.

2.11. In the recovery model, treatment practitioners often act as a coach, collaborator and teacher to free up the client's innate tendency to heal.[4]

2.12. Whilst the good practitioner brings a good deal of expertise to this relationship which helps 'guide' the person's recovery, ultimately the person himself does the hard work needed for a positive change and enhanced well-being.

2.13. A major way that practitioners facilitate recovery is by helping a person restore, or gain new, recovery capital. Recovery capital is the quantity and quality of internal (e.g. mental health, self-esteem, resilience), and external resources (e.g. family

[4] Medical practitioners also help a person with their physical and mental health problems, as well as supervise the detox process when required.

support, peer support network) that one can bring to bear on the initiation and maintenance of recovery. Recovery capital, or lack of it, plays a major role in facilitating recovery and in maintaining addiction. Facilitation of social inclusion, or community involvement, is key to helping a person find recovery.

3. The new Recovery Movement

3.1. A new Addiction Recovery Advocacy Movement has been developing over the past ten years in America. Key players in this movement include William L White (please see references listed), whose writings on recovery and related issues are seminal, and the organisation Faces & Voices of Recovery.

3.2. Cities and states such as Philadelphia and Connecticut, respectively, are pursuing a recovery revolution and radically transforming their systems of care so that long-term help is provided to people with serious substance use problems (please see reference listed).

3.3. A Recovery Movement has also been developing in the UK over the past few years. There are clear signs that parts of the UK are moving towards a recovery-based approach to helping people overcome substance use problems.

3.4. This movement is leading to new exciting recovery initiatives and to greater numbers of people overcoming substance use problems. In the UK, hope is growing in communities massively impacted upon by substance use problems, communities where the treatment system has had little ambition other than to maintain opiate addicts on substitute prescriptions like methadone.

3.5. The treatment system in the UK has been lacking in hope – with many practitioners never having seen anyone recover. This picture is changing dramatically in some parts of the country. The impact of the Recovery Movement in the UK can be evidenced by reading the blogs on Wired In To Recovery community (www.wiredin.org.uk), an online community we launched in November, 2008.

3.6. The mental health field in the UK, US, Australia and elsewhere has also been moving towards a recovery approach, from the early 1990s in the US.

3.7. The recovery agenda could bring about a much needed bridging of the gap between mental health and addiction care systems, which have often acted independently to the detriment of people looking for support from these systems.

3.8. The addiction Recovery Movement has sadly not developed in Australia and there are no ROSC to help people overcome substance use problems, despite ROSC being used in the mental health field. [There are some recovery-oriented treatment services in WA, such as the Fresh Start Recovery Programme].

3.9. The Recovery Movement is first and foremost a civil rights movement. There is a considerable amount of prejudice, discrimination and stigmatization of people with addiction and mental health problems in society. These are key barriers to recovery.

3.10. It is also important to realize that people with mental health and/or addiction problems should not have to overcome their problem to be included in mainstream society. In fact, inclusion in mainstream society can facilitate a person's path to recovery.

4. Changing to a recovery-oriented system of care

4.1. As indicated earlier, cities and regions in the US and UK are changing their systems of care for addiction (and mental health) services. It has been accepted in these countries that such changes cannot involve a mere tinkering at the edges of current systems of care – they require a complete transformation of the system. The fact that this has been happening in different places, with increasing numbers of people overcoming substance use problems, shows it is possible to change systems.

4.2. We need to develop treatment systems in WA that do not just focus on heroin users – which is the generally the case at present – but also helps people who have developed problems with other illegal drugs, alcohol, prescription (e.g. benzodiazepines) and over-the counter drugs (e.g. opiates), and solvents. Most treatment systems are not geared up to, and are not helping, people with these sorts of problem anywhere near as much as it should.

4.3. Moreover, we need to be doing much more to help the families and friends of people affected by substance use problems – this group has many serious problems of its own, caused by the person (e.g. partner, child, sibling) with the substance use problem. It must also be emphasised that families often fall part when an individual member finds recovery, because it is unable to adapt to the new situation. Minimal help is provided for this sort of situation.

4.4. New treatment systems must portray hope (the first key element of recovery) and stop blaming its clients for its own shortcomings. As an example, there is now so little hope in large parts of the UK treatment system, amongst clients, staff and commissioners. Clients are blamed if they relapse, even when the treatment they are being offered is so obviously inadequate. [For what other medical/social problem are clients blamed for showing the symptoms of their disorder?] Some staff are talking about addiction as 'a relapsing condition' almost as a mantra, adding to their clients' problems by reducing their self-belief, resilience and most importantly hope that they can overcome their problems. The same must not be allowed to happen in Australia.

4.5. In making the changes to a ROSC, we need to be very careful in making such changes and involve people at all levels of the system in the process. We must not abandon the good in the system we have, it must be integrated into the ROSC. We must not leave our workforce – many of whom are doing excellent work following the remit they have been given to help people - feeling threatened and insecure. We must be aware that many managers and workers will say they are already operating a recovery-oriented system, when in fact they are not. Many will suddenly become recovery experts (to get funding), when they are not. We must avoid in-fighting between the so-called abstinence and harm reduction approaches, when in fact both are part of the recovery-oriented approach.

4.6. There is a considerable amount of work that is required to change systems of care and this will take years, but benefits can occur relatively quickly. Moreover, it must be emphasised that we do not need to start from scratch in developing ROSC, as others have gone before us. The Recovery Movement is very strong in the US and there is much we can learn from those people who are involved. The UK Recovery Movement has been growing at a very fast rate, at a rate that has surprised key people in the US. Our developed ROSC in WA and elsewhere in Australia may well

not be identical to those in the US or UK; they will be shaped by people here in WA, even when we have the guidance of our colleagues elsewhere.

4.7. In developing ROSC, it is important to remember the key factors that are essential for facilitating recovery from serious substance use problems. These factors, some of which overlap in some ways, are:

- Hope (a sense that things can and will get better
- Empowerment (sense of own capability and power, helping others)
- Understanding (of problem and ways it can be overcome)
- Enhanced motivation (want and believe one can change)
- Goal attainment (learn to set and attain reasonable goals)
- Supportive relationships (people who believe in you)
- Shared experience (learning from people with similar difficulties).
- Finding a niche (valued social roles through meaningful activities)
- Identity change (regaining pre-addiction identity or new identity)
- Manage symptoms (ongoing personal care, actively using services & support)
- Fighting stigma (both external and internal [enhance self-esteem])
- Risking vulnerability (by removing one's masks and being authentic)
- Self-responsibility (take responsibility for and control own life)
- Identity change (regaining pre-addiction identity or new identity).

5. Key material

William L White, historian, advocate and researcher, has many seminal pieces of writing, which must be read for a person to gain full insights into the recovery agenda. Amongst other material, I have provided details of two key books in the mental health field, written by Larry Davidson and colleagues.

5.1. Key monographs and papers

Links to the following six articles can be obtained at:
http://www.williamwhitepapers.com/books_monographs/monographs/
'Recovery Management' by W. White, E. Kurtz & M. Sanders
'Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches' by W. White & E. Kurtz
'Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright)' by W. White
'Recovery management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices' by W. White
'Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation' by W. White
'Recovery-oriented Methadone Maintenance' by W. White & L. Torres

'Recovery-Oriented System of Care: A Recovery Community Perspective' by Pennsylvania Drug and Alcohol Coalition
http://www.facesandvoicesofrecovery.org/pdf/White/rosc_community_perspective_2010.pdf

'The Role of Partnership in Recovery-Oriented Systems of Care: The Philadelphia Experience' by R. Lamb, A. Evans & W. White
http://www.facesandvoicesofrecovery.org/pdf/White/2009PartnershipPaper.pdf

5.2. Key books
'Slaying the Dragon: The History of Addiction Treatment and Recovery in America' by W. White
'Pathways from the Culture of Addiction to the Culture of Recovery: A Travel Guide for Addiction Professionals'
http://www.williamwhitepapers.com/books_monographs/books for above two books.

'A Practical Guide to Recovery-Oriented Practice' by L. Davidson, M. Rowe, J. Tondora & Maria J. O'Connell
'The Roots of the Recovery Movement in Psychiatry: Lessons Learned' by L. Davidson, J. Rakfeldt & J. Strauss
Check www.amazon.co.uk for above two books

5.3. Key websites

www.williamwhitepapers.com
www.wiredin.org.uk
www.facesandvoicesofrecovery.org

5.4. Some key film material

William White on recovery
http://www.fead.org.uk/video171/William-White-SFF-May-2009.html

Professor Keith Humphries
http://www.fead.org.uk/video169/Professor-Keith-Humphreys:-SFF-Presentation-on-Recovery-May-09.html

APPENDIX 1

6.1. In this Appendix, I have provided information from a key document, 'Recovery-oriented system of care: A Recovery Community Perspective' written by the Pennsylvania Drug and Alcohol Coalition, in order to provide you with further information.

6.2. This information focuses on the proposed Guiding Principles and Elements of a Recovery-Oriented System of Care (ROSC). These Principles and Elements are being used to help transform the addiction and mental health care system in Pennsylvania, so that it is based on recovery and a chronic care model of care.

6.3. Please note, I've taken these Principles and Elements as written in the original document, other than altering paragraphing and maintaining numbering to help your referencing and make it easier to read.

GUIDING PRINCIPLES

6.4. "As in any system, there are Guiding Principles that are the ideals or code of conduct that defines the system's core values and priorities. Guiding Principles filter through every aspect of a system clearly identifying the moral values embedded within the system.

6.5. Guiding Principles are the fundamental beliefs that guide the operation of a system throughout its life in all circumstances, irrespective of changes in its goals, strategies, type of work, or the top management."

6.6. Those values that form the Guiding Principles of a ROSC include the following beliefs about recovery:

6.7. There are many pathways to recovery

- Individuals are unique with specific needs, strengths, goals, attitudes, behaviors and expectations for recovery. Pathways to recovery are highly personal, and generally involve a redefinition of identity in the face of crisis or a process of progressive change.

- Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources, which provide support for recovery.

- The pathway to recovery may include one or more episodes of psychosocial and/or pharmacological treatment. For some, recovery involves neither treatment nor involvement with mutual aid groups.

- Recovery is a lifelong process of change that permits an individual to make healthy choices and improve the quality of his or her life.

6.8. Recovery is self-directed and empowering

- While the pathway to recovery may involve one or more periods of time when activities are directed or guided to a substantial degree by others, recovery is fundamentally a self-directed process.

- The person in recovery is the agent of recovery and has the authority to exercise choices and make decisions based on his or her recovery goals that have an impact on the process.

- The process of recovery leads individuals toward the highest level of autonomy of which they are capable. Through self-empowerment, individuals become optimistic about life goals.

6.9. Recovery involves a personal recognition of the need for change and transformation

- Individuals must accept that a problem exists and be willing to take steps to address it; these steps usually involve seeking help for alcohol and other drug dependence.

- The process of change can involve physical, emotional, intellectual and spiritual aspects of the person's life.

6.10. Recovery is holistic

- Recovery is a process through which one gradually achieves greater balance of mind, body and spirit in relation to other aspects of one's life, including family, work and community.

6.11. Recovery has cultural dimensions

- Each person's recovery process is unique and impacted by cultural beliefs and traditions. A person's cultural experience often shapes the recovery path that is right for him or her.

6.12. Recovery exists on a continuum of improved health and wellness

- Recovery is not a linear process. It is based on continual growth and improved functioning. It may involve relapse and other setbacks, which are a natural part of the continuum but not inevitable outcomes.

- Wellness is the result of improved care and balance of mind, body and spirit. It is a product of the recovery process.

6.13. Recovery emerges from hope and gratitude

- Individuals in or seeking recovery often gain hope from those who share their search for or experience of recovery. They see that people can and do overcome the obstacles that confront them and they cultivate gratitude for the opportunities that each day of recovery offers.

6.14. Recovery involves a process of healing and redefinition for self and family

- Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.

6.15. Recovery involves addressing discrimination and transcending shame and stigma

- Recovery is a process by which individuals, families and communities confront and strive to overcome discrimination, shame and stigma by advocating for self and others.

6.16. Recovery is supported by peers and allies

- A common denominator in the recovery process is the presence and involvement of people who contribute hope and support and suggest strategies and resources for change. Peers, as well as family members and other allies, form vital support networks for people in recovery.

- Providing service to others and experiencing mutual healing help create a community of support among those in recovery.

6.17. Recovery involves (re)joining and (re)building a life in the community

- Recovery involves a process of building or rebuilding what a person has lost or never had due to his or her condition and its consequences. Recovery is building or rebuilding healthy family, social, spiritual and personal relationships.

- Those in recovery often achieve improvements in the quality of their lives, such as obtaining education, employment and housing. They also increasingly become involved in constructive roles in the community through helping others, productive acts and other contributions.

6.18. Recovery is a reality

- It can, will, and does happen."

ELEMENTS

6.19. "The elements of a system, much like the Guiding Principles, are rooted in the very core of the system's values. They are the individual components that make up the whole. The elements of a system are those smaller parts that are similar to the larger system in that they can be described as common in value, behaviors and identity. Therefore, the elements of a ROSC broken down into their individual parts have recovery as their fundamental ingredient. These elements are:

6.20. Person-centered

- A ROSC is person-centered. Individuals will have a menu of choices that fit their needs throughout the recovery process.

6.21. Participation inclusive of individuals and families in recovery

- An essential characteristic of a ROSC is the importance it places on the participation of people in recovery in all aspects and phases of the care delivery process, including financial support for individual and family involvement.

6.22. Family and other ally involvement

- A ROSC acknowledges the important role that families and other allies can play. Family and other allies will be incorporated, with the permission of the individual, in the recovery planning and support process. They can constitute a source of support to assist individuals in entering and maintaining recovery.

- Additionally, systems address the prevention and early intervention, treatment, recovery and other support needs of families and other allies.

6.23. Inclusion of the voices and experiences of recovering individuals and their families

- The voices and experiences of people in recovery and their family members contribute to the design and implementation of ROSC. People in recovery and their family members are included among decision-makers and system-level monitoring.

- Recovering individuals and family members are prominently and authentically represented on advisory councils, boards, task forces and committees at the federal, state and local levels.

6.24. Promoting access and engagement

- Each person who seeks services should be afforded every opportunity to access appropriate addiction treatment and recovery support. A ROSC promotes access to care by facilitating swift and uncomplicated entry and by removing barriers to receiving services (i.e. no wrong door).

- Engagement involves making contact with the person (as opposed to their disease), building trust over time, attending to the person's stated goals and needs and, directly or indirectly, providing a range of services in addition to clinical care. This involves linkages.

6.25. Linkages

- For many individuals, recovery sustainability is not achieved through short episodes of treatment currently authorized by funding entities or through sporadic participation in self-help programs. There is often a misconception that individuals can remain in recovery without additional services and support.

- Linkage to recovery support services can serve to expand the capacity of formal treatment systems by promoting the initiation of recovery, reducing relapse, and intervening early when relapse occurs (Kaplan, 2008). Participation in these services will enhance long-term recovery outcomes, regardless of involvement in formal treatment.

- It is also critical for individuals and families to be connected to ancillary forms of support to address additional needs that directly affect the recovery process (housing, employment, medical care, etc.).

- By collaborating with a wide range of service and resource providers, individuals will gain access to a wider array of resources critical to the recovery process.

6.26. Individualized and comprehensive services across the lifespan

- A ROSC offers a menu of comprehensive services which are individualized, stage-appropriate, and flexible across the lifespan. Systems will adapt to the needs of individuals, rather than requiring individuals to adapt to them. They are designed to support recovery across the lifespan.

- The approach to alcohol and other drug-related issues will change from an acute-based model to one that manages chronic diseases over a lifetime.

6.27. Systems anchored in the community

- A ROSC is nested in the community for the purpose of enhancing the availability and support capacities of families, intimate social networks, community-based institutions and other communities in recovery.

- These systems should establish and maintain effective formal and informal linkages throughout the state to connect individuals and families to clinical, community-based and recovery support services.

6.28. Ensuring continuity of care

- A ROSC offers a continuum of care, including pre-treatment, treatment, continuing care and recovery support. Individuals should have a full range of stage-appropriate services from which to choose at any point in the recovery process.

Partnership-consultant relationships

- A recovery-oriented system of care is patterned after a partnership-consultant model that focuses on collaboration, and less on hierarchy. Systems will be designed so that individuals feel empowered to direct their own recovery with safety being a paramount concern.

Strength-based

- A ROSC emphasizes strengths, assets and resiliencies.

Culturally responsive

- A ROSC is culturally sensitive, competent, responsive and aware of recovery language. There is recognition that beliefs and customs are diverse and can impact the outcomes of recovery efforts.

Responsiveness to personal belief systems

- A ROSC respects the spiritual, religious and/or secular beliefs of those they serve and provide linkages to an array of recovery options that are consistent with these beliefs.

Commitment to peer recovery support services

- A ROSC provides opportunities for ongoing participation of peers in the planning, implementation, and delivery of services throughout the full continuum of care.

Integrated service

- A ROSC coordinates and/or integrates efforts across service systems to achieve an integrated process that responds effectively to the individual's unique strengths, desires and needs.

System-wide education and training

- A ROSC ensures that concepts of recovery and wellness are foundational elements. Training, at every level, will reinforce the tenets of recovery-oriented systems of care.

Ongoing monitoring and outreach

- A ROSC provides ongoing monitoring and feedback with assertive outreach efforts to promote participation, motivation and reengagement in order to continually improve the system.

Outcomes driven

- A ROSC is guided by recovery-based processes and outcome measures. These measures will be developed in collaboration with individuals in recovery.

- Outcome measures will reflect the long-term global effects of the recovery process on the individual, family and community, not just remission of biomedical symptoms. Outcomes will be measurable and include benchmarks of quality of life changes.

Research-based

- A ROSC is informed by research. Additional research on individuals in recovery, recovery venues and the processes and phases of recovery, including cultural and spiritual aspects, is essential. Research will be supplemented by the experiences of people in recovery.

Adequately and flexibly financed

- A ROSC must be adequately financed to permit access to a full continuum of services, ranging from detoxification and treatment to continuing care and recovery support.

- The service delivery system will be flexible enough to provide the establishment of an array of programming around long-term recovery support to augment those already provided within our drug and alcohol service system.

End stigma and discrimination

- A ROSC works toward the eradication of stigma and discrimination. Stigma and discrimination toward individuals and families seeking treatment and recovery will be eliminated and no longer serve as barriers in obtaining necessary services or progressing in their recovery.

Promote the highest level of autonomy

- A ROSC promotes the highest degree of functioning and quality of life for all individuals in our system. The system recognizes that individuals may need to learn new skills to survive in the larger society.

- Success at an expanding array of life tasks and the assumption of new or enhanced roles in the community as they are defined by the person in recovery over time, both derive from and contribute to sustained recovery.

- The system provides emotional and financial resources, social support and skill building opportunities for individuals to achieve their individual goals (CSAT, 2005).

- The elements of any system are the heart and soul that goes into its creation. The elements are what maintain the integrity of the system.

- As in any system, precious parts can be lost over time if those monitoring the system are not vigilant and focused on the true purpose of the system.

- Therefore, it is essential that the elements are reviewed frequently, especially during system transformation and change and that special care is taken to always maintain their authenticity."

BRIEF CURRICULUM VITAE

Professor David Clark

Summary

David Clark is Director of Wired In, an Emeritus Professor of Psychology, and a dedicated addiction recovery advocate. Wired In is a unique initiative that is empowering individuals, families and communities to tackle substance use problems. It maintains the Wired In online recovery community (www.wiredin.org.uk), conducts a range of community activities (e.g. personal stories, research, film), and has run a leading information portal on drugs and alcohol, www.dailydose.net. David has written a highly respected bi-weekly education column for a leading UK magazine, and is also well-known for his engaging blogs. He is currently writing a book on recovery and researching for a documentary film. Prior to moving into this field ten years ago, David was an internationally renowned neuroscientist, having trained with a Nobel Laureate and been the recipient of a number of awards for his research.

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Career of Professor David Clark (highlights)

2010 – Present: I am writing a book and researching for a documentary film on addiction recovery (the latter is being developed with local film-maker Michael Liu, who has previously had a short film shown at the Cannes Film festival)

2008 – Present: I am Director of the Wired In online recovery community. This unique web community comprises personal stories, articles on key issues, blogs, discussion, tools, links to key resources, film clips, and latest news on recovery and related issues.

The recovery community provides an environment in which people can learn from each other and provide mutually beneficial support. Role models show that recovery from addiction is possible, and illustrate the multitude of paths to recovery. The articles provide key information for people to better understand recovery, addiction, treatment, and a range of other matters. The people's journalism is a strong source of recovery advocacy and is suggesting solutions to improve our system of care for people with substance use and mental health problems.

The community has over 1700 members, over 350 of whom have been blogging, generating over 2500 blogs! I write articles (70+) and blogs for the website, edit content written by our community members, and edit film clips for our film archive on Vimeo, which links to our recovery community.

2005 – 2008: I wrote a regular educational column (Background Briefings) for the bi-weekly magazine Drink and Drugs News, the leading publication in the field in the UK. I produced two personal story films and a film on heroin use by young people, both filmed and edited by Cardiff film-maker Jon Kerr-Smith and Wired In member Lucie James. They also filmed and edited material focusing on the views and experiences of people travelling the road to recovery. This material has been edited into clips for the film archive we have developed on Vimeo

2005 - 2008: I was chair of the Professional Certification Advisory Panel for the Federation of Drug and Alcohol Professionals (FDAP), the leading UK professional organization in the field in the UK. I was also External Examiner for the Clouds/Bath University Foundation

degree on 'Addictions Counselling', the first degree of its type in the UK. These roles have allowed me to help improve professional standards.

2000 – 2010: I have been Director of Wired In (formerly WIRED) throughout this time. Our small team has been empowering people to tackle substance use problems. Wired In aims to:

- Provide information and tools that help people better understand and use the options they have to overcome the problems caused by their own, or a loved one's, substance use;
- Develop and maintain online and real world recovery communities that help people find their pathway to recovery, and receive and provide support, and act as a forum for recovery advocacy;
- Develop education and training packages that help improve the quality of treatment and support services in the community;
- Help reduce prejudice towards people with substance use problems and their families, to create a society that better facilitates recovery from substance use.

Wired In has established an outstanding reputation, nationally and internationally, through a wide range of activities. We have a strong and trusting relationship with drug and alcohol users/ex-users, family members, practitioners, commissioners and leading addiction recovery experts. Our Advisory Board comprises world leading researchers and practitioners, including the leading recovery advocate William L White.

Specifically, our achievements to date include:

- Establishing and maintaining the Wired In online recovery community, www.wiredin.org.uk, comprising people who provide content, act as recovery advocates, and provide mutual support.
- Publishing a unique collection of Personal Stories that enhance understanding of addiction and recovery, act as motivational tools, and inform service delivery
- Developing a multi-faceted media library, including filmed Recovery Stories, short movies, and tools to facilitate treatment delivery, support and recovery
- Conducting an innovative research programme, focusing on issues central to improving practice and policy focused on recovery and treatment.
- Developing a recovery support group in Cardiff.
- Running the leading information portal on substance use, www.dailydose.net, for nine years, which had over 8,000 subscribers before it had to close due to lack of funding.
- Developing the websites www.substancemisuse.net and www.wiredinitiative.com, providing a range of content on substance use and misuse.

2000 - 2003: I changed 'career' in 2000 because I wanted to help people overcome substance use problems, and felt that neuroscience was not helping me realise this ambition. I set up WIRED, and the charity Wired International Ltd, with the aim of helping empower people to tackle substance use problems.

I directed a team that carried out a 2-year evaluation of projects funded by the Drug and Alcohol Treatment Fund in Wales, the largest fund for treatment in the country. I conducted other evaluations focused on the activities of local drug and alcohol services.