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Drink and Drugs News

7 February 2005
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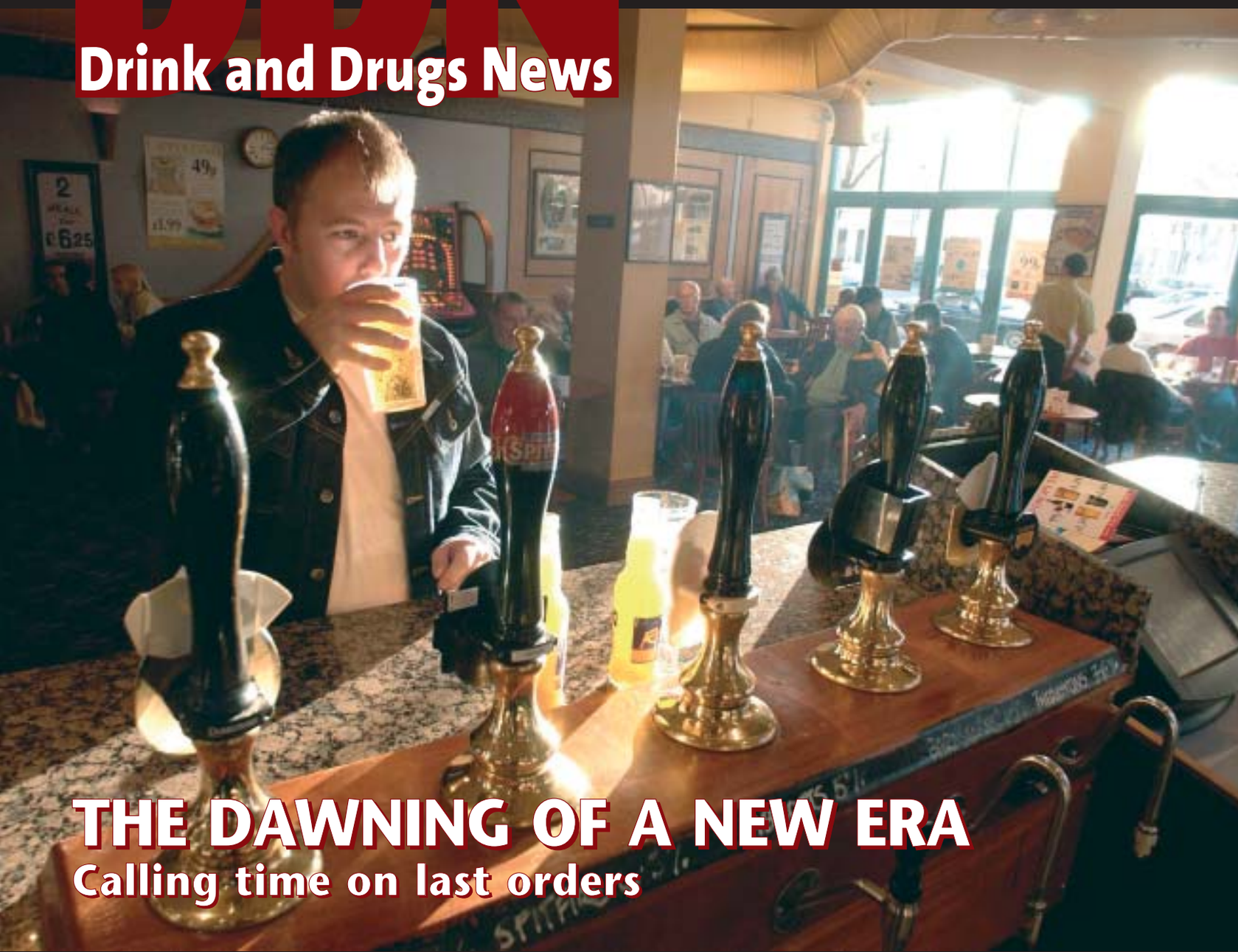

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Needle exchange
Up close in Glasgow

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RELEASE

Drink and Drugs News

7 February 2005

Editor's letter

The page about health risks from our drinking epidemic seems to have dropped out of the government's alcohol strategy, so we've devoted a few of our own pages, this issue.

In case we start to believe that binge drinking is only about the Saturday night lads down the pub, we've considered who else might make up the staggering statistics on alcohol related illness. Surprise surprise, most of us can manage to binge quite easily in our own homes, without so much as the radio on.

The statistics on alcohol-related harm are staggering, and the symptoms make uncomfortable reading. If you try the online questionnaire on Alcohol Concern's 'How's Your Drink?' website, you'll probably think that the diagnosis is wrong. 'Surely I'm not a problem drinker? I only have a few to wind down – most nights.' Yet the truth is that most of us don't have a clue how much we drink, and are apt to confuse every beer or glass of wine with a little light relaxation. The moves to reclassify the unit system to reflect today's larger measures are at least an attempt towards clarity – but the rest of alcohol policy seems drowned in confusion. Through all of this, the resounding note of concern through our alcohol features in this issue should surely merit steering the debate away from crime and back into health.

April Shaw of the Scottish Drugs Forum picks up the needle exchange debate started by Prof Neil McKeganey last issue, to give service users' views on what works for them, and some of the barriers to treatment (page 13).

We'll be looking at the workforce that makes up the drink and drugs field in the next few weeks, so if you fancy telling us how you started in the field, please get in touch.

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In this issue

Afganistan: every reason to keep up opium supply

ALL 32 PROVINCES of Afghanistan are now growing opium poppies, professor of international drug policy, Cindy Fazey told delegates at Release's 'Drugs University' conference.

Prof Fazey, of Liverpool University, explained the country's 'perforated borders', which made an escalating supply impossible to control.

2004 had been a record year for opium production, and narcotics had become the main engine of economic growth. A harvest of 4,200 metric tonnes had been produced, despite bad weather reducing yield by 28 per cent. A good summer could increase this to 7,000mt this year.

A look at the figures demonstrated the appeal of growing opium poppies. Opium was worth $4,600 per hectare in 2004, against $390 for wheat. The British government had offered just $1,235 per hectare not to grow poppies.

Opium exports were up 22 per cent in value and gross trafficking profits up 69 per cent, explained Prof Fazey. Farm profits were down, but trafficking profits up: was this down to better organisation, or not losing as much to confiscation?, she asked.

Stopping the trade was proving impossible. Incentives to farmers didn't work. Labs could easily go underground and operate in smaller, mobile units. Traffickers, warlords, tribal chiefs and farmers would unite and fight to protect their income – going on past experience they'd win, said Prof Fazey.

Other campaigns were proving disastrous. Using fungus and herbicides destroyed other crops, and substituting other crops was not a viable option. Oil and gas were a key reason for governments stalling: Afghanistan needed to be kept stable, without threat of war, to enable pipelines to run through the country.

Beyond politics and economics, 'why would a peasant go to earning half their normal income?,' asked Prof Fazey. There was no evidence to suggest that the uncontrollable supply would be tackled effectively.

BBC presenter Mishal Husain chairing Release's fourth Drugs University, alongside Director, Sebastian Saville. 'Drugs – The Politics, Philospohy and Economics' attracted international speakers and featured an exclusive video interview wtih Dr Alexander Shulgin, the 'godfather of ecstasy'. A varied selection of parallel sessions involved service users and drugs workers in discussions such as a doctor's dilemmas when prescribing for heroin users.

Ex deputy drug czar gives insight on tolerance

WHAT'S THE LOGICAL FORM of tolerant policy?, Mike Trace, former deputy drug czar and now director of RAPT, asked delegates.

The vast majority of people who possessed an illegal drug were not touched – so should we get harder or softer on those who are caught, said Mr Trace.

Some countries were demonstrating their reduced faith in the criminal justice system, through downgrading the 'zero tolerance' approach. Others were moving towards a health focus, realising users needed help.

While the trend might seem to be becoming more liberal around the word, globally this was not so, said Mr Trace. Africa, Asia and the former Soviet Union were all looking to strengthen their drug policy and there was a split in Europe and Latin America.

European Union drug strategy was quite balanced, according to Mr Trace. Minimum and maximum penalties for drug trafficking had been agreed, and new substances were being added to the list of drugs that needed to be controlled.

The international community was trying to get a unified stronger framework, he said. Many European countries, including the UK, had introduced policies that aimed to be more balanced, with less of a criminal justice approach.

The UK change to cannabis classification had had a lot of attention, but was only doing a milder version of what many other countries were doing. Mr Trace commented that he was not yet in a position to say whether reclassification had had an effect or not.

In answer to Dr Chris Ford's question from the floor: 'how could you have a ten-year drug strategy that doesn't involve health?', Mr Trace replied that 'not one minister was interested in public health and drugs'.

Racism and control of underclasses colour drug policy

RACISM has been evident throughout the history of drug control, said Professor Craig Reinarman of the University of California.

Intent could be difficult to discern, as 'white people walk around with an invisible knapsack of privileges', said Prof Reinarman.

Racist fears were exploited in many drug laws. 'Crack babies' were almost all Afro Americans, whose mothers had had their children taken off them. Arrests were, in many cases, about the social control of the underclass.

African Americans were much more likely to be arrested and sent to prison than white people, and there were now more black Americans in the criminal justice system than in college, according to Prof Reinarman. There were disproportionate arrests of Muslims in France and Aborigines in Australia, he added.

Many methods for eradicating drug crops were racist, in their blatant disregards for the health of people living in the target area. The US had 'sprayed herbicides on swathes of the Andes that are the size of England', said Prof Reinarman.

More inprisonment and lower drug prices equalled failed strategy. Unless we began to think and act differently, drug policy would continue to be about colour.

Drug wars tended to be racist in their consequences, if not in their intent. Drugs were interwoven with other public policy, and needed to be considered alongside, he told delegates.

Prison numbers rise dramatically

IS SENTENCING WORKING – and are we incarcerating the right people?, Eric Sevigny of the University of Pittsburgh asked conference.

As the UK was undergoing a major review of sentencing, there were important opportunities to influence policy, he suggested.

Incarceration rates had increased dramatically – six-fold in England and Wales over the last 10 years, to one person in every 709 residents; and tenfold in the US. One in every 139 US residents was now incarcerated, and drug offenders had contributed substantially to the rising prison population. Crack cocaine accounted for seven out of ten drug offenders in US prisons, and almost a quarter were in prison for their first drug offence.

Analysing the seriousness of many incarcerated drug offenders, Mr Sevigny concluded that very few were 'kingpins' in the drug trade.

Addaction gets brewery partnership for schools pack on alcohol misuse

ADDACTION has found funding to develop a resource pack for schools on alcohol misuse, through a partnership with an international brewery.

SABMiller has given £60,000 to the drug and alcohol treatment charity, to roll out the 'Know Limits' pack to schools. The pack was developed by The Cornwall and Drug Agency (CADA) and piloted successfully in the local area.

Peter Martin, Addaction's CEO, said his charity had recognised the value of this 'fantastic and comprehensive educational resource for children and young people' that would also be useful for teachers delivering public health and social education (PHSE) in schools. Addaction had approached the brewer to engage them in considering alcohol risk, education and responsibility, from the treatment sector's perspective.

In the run-up to the alcohol strategy, Addaction had made public its view that the drinks industry must share the risks for society.

Sue Clark, Corporate Affairs Director of SABMiller said the company supported underage drinking prevention initiatives, drink driving prevention campaigns and life-skills education.

'We deemed it appropriate to begin to consider how we could extend to the UK the work we do around the world to support education in trying to prevent misuse.'

The pack aims to help young people in any youth setting make informed choices about alcohol, and will address the lack of quality education materials specific to alcohol, according to Addaction.

Many heroin users lead 'ordinary lives'

A STUDY OF HEROIN USERS that claims the drug can be taken without jeopardising health or holding down a job, has been contested by many drug workers and agencies.

David Shewan and Phil Dalgarno from Glasgow Caledonian University conducted a four-year study of 126 long-term heroin users. Most of the 'ordinary people' studied were married and employed, and none were in treatment. The majority had gone through higher education, showing that a class A drug user can achieve educational qualifications comparable to non-drug users, according to the researchers.

The findings revealed that although there were many heroin users with problems, there were also many who led a normal life.

'Some drug-related negative health and social outcomes had occurred on a lifetime basis, but ongoing problems were rare and heroin was not a predictor in either context,' said Dr Shewan.

The researchers stated that they were not saying heroin use was safe, but had aimed to investigate the largely unexplored area of controlled drug use.

Psychological and social factors that came to light from the study could help to inform theory and practice in dealing with addiction, they suggested.

The study is published in a week when the new Metropolitan Police Commissioner said cocaine use was commonplace among the UK's middle classes, who were apt to 'drink less wine and snort more cocaine', provoking further debate on which drugs are deemed 'socially acceptable'.

'The researchers stated that they were not saying heroin use was safe, but had aimed to investigate the largely unexplored area of controlled drug use.'

Getting drunk 'positive experience' for young

INCREASED CONFIDENCE, escapism and 'something to do' are among the main reasons for young people getting drunk, according to a survey released this week by the Joseph Rowntree Foundation.

Getting drunk was seen as normal and acceptable, and closely linked to the influence of friends. Confidence in social and sexual situations was given as the main reason for drinking, and getting drunk was seen as a bonding experience, making it easier to make friends and talk to someone they liked. There was generally a very positive image associated with getting drunk.

Harmful outcomes were acknowledged by the 64 interviewees, aged 14 to 17. Most of these were health related, and included instances of intoxication and drug-taking, alongside regretted sexual experiences, and injuries sustained through accidents and fighting. They were also more prone to risk-taking, through walking home alone at night, daring behaviour and pranks, and dangerous driving.

Some of those questioned admitted using alcohol as an excuse for socially unacceptable behaviour.

www.jrf.org.uk/knowledge/findings/socialpolicy

Latest research

Weblinks for these documents can be found in the research and guidance section of our website, drinkanddrugs.net

The impact of mandatory drug testing in prisons
Review of evidence re MDT accuracy and effects. Home Office – Jan 2005.

Effective and cost-effective measures to reduce alcohol use in Scotland
Literature review of measures for reducing alcohol use. Scottish Exec – Jan 2005.

Integrated care pathways guide 7: Care of people with drug prob/s in general hospital settings
Seventh in series of guides on Integrated Care Pathways (ICPs). EIU (Scotland) – Jan 2005.

Reducing deaths - a resource for A&E staff
Guidance for A&E staff on reducing deaths caused by illicit drugs. NTA – Dec 2004.

Evaluation of the Scottish Prison Service Transitional Care Initiative
Interim evaluation of SPS transitional care arrangements. EIU (Scotland) – Dec 2004.

Providing for the Housing Needs of Drug Interventions Programme Clients
Briefing for those involved in throughcare and aftercare services. Home Office – Dec 2004.

An evaluation of a brief intervention model for use with young non-injecting stimulant users
Evaluation of brief intervention with stimulant users. NTA – Nov 2004.

Effect of waiting time on clinical outcomes in opiate users
Research study on waiting time and outcomes. NTA – Nov 2004.

Dual diagnosis in a primary care group (PCG)
Research and guidance on dual diagnosis in primary care. NTA – Nov 2004.

Residential Detoxification & Rehabilitation Services for Drug Users: A Review
Review of evidence re detox and rehab. EIU (Scotland) – Nov 2004.

Hidden Harm - Scottish Executive Response
Action on children & young people affected by drug use. Scottish Exec – Nov 2004.

Extending empowerment – involving service users and carers
Guidance on involving service users and carers in treatment. NTA – Nov 2004.

Drugs Use and Begging - A Practice Guide
Guidance on services aimed at drug users who beg. Home Office – Nov 2004.

Reconviction Following Drug Treatment and Testing Orders
Study of post DTTO reconviction rates. Scottish Executive – Nov 2004.

café culture or catastrophe?

The government's major initiative to tackle binge drinking has focused on increasing licensing hours to reduce the cost of alcohol-fuelled crime. Yet what happened to the experts' bank of evidence on drink-related ill health – and why doesn't it inform the strategy?

The government's definition of a binge-drinker has focused on the under 25 year old male, drinking in a group on Friday and Saturday nights. It's hardly surprising then, that strategy is dominated by law and order, and reducing the costs of drunken brawling, violence and property damage.

Last month, Culture Secretary Tessa Jowell and Home Office Minister Hazel Blears announced tough new penalties for those found drunk and disorderly – and for premises that sell to the drunk or under age customers. The scale of alcohol licence fees will change to reflect the size of the pub, and premises within 'alcohol disorder zones' will be expected to contribute to the cost of policing.

Tessa Jowell said the new licensing laws were about making 'our towns and cities safe for all, not a free for all'. Hazel Blears said the proposals went 'hand in hand with [the government's] drive against anti-social behaviour and disorder on the streets'.

The pub trade associations, meanwhile, have been busy reassuring a tabloid-provoked public that 24-hour licensing will not represent mayhem round the clock.

'Most businesses will seek to take the opportunity to serve customers at a suitable time for them, and to say otherwise is inaccurate and sensationalist,' says John McNamara, chief executive of the British Institute of Innkeeping.

Stories about 24-hour drinking are a fairytale, according to the British Beer and Pub Association.

'Our latest survey of more than 30,000 pubs shows that not a single pub will be open for 24 hours,' says Mark Hastings, Director of Communications.

'What pubs are looking to apply for is an extra couple of hours on Friday and Saturday nights. We will have a much greater choice after 11 o'clock. At present the only option is to go to a noisy nightclub or late bar.'

While there are obvious concerns about the charges on pubs implied by the Alcohol Disorder Zones, the BBPA is keen to demonstrate proactive 'social responsibility initiatives' and is credited in the government's report with developing a code of practice for owners and operators on banning irresponsible drinks promotions.

So we've had plenty of input from a drinks industry worth more than £30bn a year. But where is the mention of escalating health risks from 24-hour drinking?, ask the medical experts, called to advise government on the Alcohol Harm Reduction Strategy. Members of the advisory panel have spoken out publicly about the disappearance of their scientific evidence – evidence that pointed to a rise in alcohol-related disease and mortality in other countries that had extended their licensing hours.

Professor Colin Drummond, professor of addiction psychiatry at St George's Hospital Medical School, said that detailed research on controlling alcohol problems by making it less affordable, did not appear in the published report.

The minister with responsibility for licensing, Richard Caborn MP, said on BBC's Panorama programme, 'what I want to see is the drinks industry getting in with local authorities to develop the local economies'. So how have economics led the government's strategy, when the UK's most eminent and well-respected scientists have signed up to the view that we are a nation drinking ourselves to death? Epidemiologist Sir Richard Doll, Griffith Edwards, professor of addiction behaviour at King's College, and Sir Michael Marmot, professor of epidemiology at University College London, have all warned against presenting the Mediterranean 'drink day or night' model as a safe alternative to the rowdy city centre version of binge drinking.

Last November, Adrian Levy and Cathy Scott-Clark, writing in The Guardian, reported that Sir Richard Doll 'had advised Blair that deaths from liver cirrhosis, a prime indicator used to measure alcohol-related harm, had risen in Britain over 30 years by a staggering 959 per cent among men aged between 25 and 44, and 924 per cent among women of the same age'. The only reference to liver cirrhosis that had made it through to the Prime Minister's report, was a specific statistic relating to chronic drinkers.

How much evidence do we need that binge drinking is not the preserve of a young, male minority?

Long term health damage from heavy drinking

by Jonathan Chick, Alcohol Problems Service, Lothian Health,Edinburgh

Several body systems begin to fail due to repeated sessions of drinking of over 8 units in a session, and/or the cumulative effects of regular consumption of 4 units/ day (women) and 6 units a day (men). These levels seem low to many drinkers, and indeed some health professionals. But they indicate the levels at which an increased chance of failure of one or more body systems begins to be seen. Many people who develop long-term harm are, of course, drinking far above those levels.

Some diseases such cancer related to alcohol (mouth, throat, gullet), and brain haemorrhage are usually seen in people who smoke as well as drink heavily. Some are related to poor nutrition along with heavy drinking, such as nerve damage and brain damage. Diseases such as liver cirrhosis and inflammation of the pancreas can occur in people who otherwise have healthy lifestyles.

Hospital data for the UK show a steady increase in recording of all types of alcohol-related diseases in the past 20 years. Doctors' greater awareness probably cannot account for all the increase in the figures.

We have fairly good data in UK on liver cirrhosis due to alcohol. Death due to alcoholic liver disease has doubled in the UK in the past decade. The average age at which death happens from this condition has moved to 10 years earlier i.e. about 40 rather than 50 years old, than 20 years ago. Some deaths from alcoholic liver disease are now occurring in people in their 20's. These changes are presumably related to the earlier start of heavy drinking in the last decade in British youth, as well as to overall higher consumption. Some argue that the consumption of alcohol in the UK (figures for which are derived from alcohol sales tax data) have not increased sufficiently to account for the increase in alcoholic liver disease, and hospital admissions for alcohol-related illness. However, people who work with heavy drinkers hear stories that make them suspect that there has been a big increase in the consumption of non-taxed alcohol, via the English Channel, or diverted illegally.

Some use the term 'a time bomb' – as a society we will pay heavily in the next two decades for the changes in drinking we have witnessed since 1990.

'In the UK, Lloyd George introduced "opening hours" during the First World War. He felt that one of the most serious obstacles to increasing the output of munitions was heavy drinking by the workforce. Factory owners, who made so much profit out of the war, were in complete agreement.'

Then...

A long-term affair: some historical perspectives on alcohol

➔ The first non-distilled alcoholic beverages were made inadvertently, due to natural fermentation.

➔ The first beers were produced in Egypt 5,000 to 6,000 B.C. The earliest written law, the Code of Hammurabi, written in Assyria in 2225 B.C., set forth rules for the keeping of beer, wine shops and taverns. The earliest reference to distilled spirits appeared in China about 1,000 B.C.

➔ The traditional Jewish view was that wine was a creation of God and was therefore naturally a good thing that should be used by man, but not to excess.

➔ Plato was greatly concerned about the drinking habits of his countryman and wrote down rules for symposia, which were, in reality, drinking parties. He wrote: 'When a man drinks wine he begins to be better pleased with himself and the more he drinks the more he is filled full of brave hopes, and conceit of his powers, and at least the string of his tongue is loosened, and fancying himself wise, he is brimming over with lawlessness and has no more fear or respect and is ready to do or say anything.'

➔ The fall of the Roman Empire has been blamed on wine – it was stored and fermented in lead containers and contained an additive with a high lead content. Most of the nobility who drank wine suffered from lead poisoning, of which mental instability is a symptom.

➔ Taverns and ale houses established in Britain in 8th century – priests were not allowed to enter.

➔ Some things have not changed much over time. Peter of Blois was reputed to have said after the Norman conquest: 'You know that the constant habit of drinking has made the English famous among all foreign nations.'

➔ Distillation started to make its presence felt in the UK in the 16th century. The gin epidemic hit London streets in the early 1700s. Consumption of distilled spirits increased from 500,000 gallons in 1684 to 3.5 million by 1727 and, despite higher taxes, to 19 million gallons in 1742. Distillation of grain was banned and consumption dropped to 4 million gallons by 1782.

➔ In the 18th century, alcohol was seen as a good thing, but drunkenness and social disorder were not. With the coming of the industrial age, drinking was less tolerated because of work performance and safety.

➔ Colonial Americans were also hearty drinkers, and alcohol played a large part in their lives. The importance of alcohol to colonial Americans was represented in language. In 1737, Benjamin Franklin published a Drinkers Dictionary, which included more than 235 terms to describe the drunkard.

➔ Consumption levels increased to prodigious levels in the years after the War of Revolution, but dropped precipitously between 1830 and 1860. This decline can be attributed to the temperance movement.

➔ A massive propaganda campaign was carried out by the temperance movement. This was fuelled by concern of middle classes over urbanisation and immigration, as well as a religious revival sweeping the U.S. Total abstinence from alcohol was identified with middle class respectability of the 'native American'. Drunkenness was described as a sinful behaviour and a moral weakness.

➔ A Prohibition party was formed and their vigorous campaign led to the 18th Amendment to the US Constitution in 1917. Prohibition became law in 1919. The temperance movement also grew in Britain.

➔ The weight of public opinion was not behind prohibition. Alcohol continued to be produced and distributed to satisfy public demand. By 1930, more than 500,000 Americans had been arrested for drink offences and sentenced to a total of more than 33,000 years' imprisonment. More than 250,000 illegal stills were confiscated. The arising black market encouraged the involvement of organised crime and more than 700 gangland assassinations occurred during prohibition.

➔ Respected public figures, including many politicians in Washington, broke the prohibition law. Al Capone commented: 'I make my money by supplying a public demand. If I break the law, my customers, who number hundreds of the best people in Chicago, are as guilty as I am. The only difference between us is that I sell and they buy. Everybody calls me a racketeer. I call myself a businessman. When I sell liquor, it's bootlegging. When my patrons sell it on a silver tray on Lake Shore Drive, it's hospitality.'

➔ Prohibition was repealed in 1933.

➔ In the UK, Lloyd George introduced 'opening hours' during the First World War. He felt that one of the most serious obstacles to increasing the output of munitions was heavy drinking by the workforce. Factory owners, who made so much profit out of the war, were in complete agreement.

➔ The King offered to give up drink if it would provide an example for workers. But the King's pledge was not a success, partly due to the fact that certain politicians and public figures would not do the same.

➔ Lloyd George introduced the Defence of the Realm Act, which greatly reduced the availability of alcohol and introduced the British system of opening hours.

...and now

How drunk can you get for a tenner?

➔ The cost of drinking has fallen dramatically over the past few years and a quick trip around the country reveals the plethora of promotions offering the opportunity to get completely annihilated for less than £10.

➔ You could begin your nationwide budget bar crawl to oblivion in Weston Super Mare where the Stars nightclub entices punters in with a £9 door charge and then all drinks just 1p! This could be followed with a night in one of the hundreds of '£1 a pint' pubs such as Green Jacks in Lowestoft with their £1 a pint lager available all day, every day.

➔ If your hangover allows, it you might want to party the night away at Tivolis in Rotherham where your £10 buys you entrance to the club and free drinks all evening.

➔ After all these alcohol fuelled nights a jaunt to genteel Canterbury might be in order to sample jugs of 'Frosty Todger' cocktails for just £9, which could come in handy if you were to visit Glasgow where a bar has allegedly been running the promotion: 'All you can drink; until you need the loo!'

Turning a blind eye to boozed-up Britain

We're all in agreement then: binge drinking is unacceptable. But who are the nation's binge drinkers – and will the new licensing laws come anywhere near scratching the surface of the problem? Years of experience on both sides of the fence have made Norrie McKechnie somewhat sceptical.

Alcohol offending problems are going to increase whether the hours stay the same, open all night, or you closed them completely. The government seems to be trying to manage the problem rather than get to the source of it.

This is about ingrained attitudes and a society where being drunk, falling around and making a prat of yourself is considered funny, where you have radio DJs talking about getting 'lashed' and 'bladdered' at the weekends and laughing about it. Imagine if they made jokes about themselves injecting smack on live radio. You almost need a politically correct language to change people's conception of being drunk. Unfortunately children see parents drunk; it's on television constantly in advertising; it's cheap and available; and it sedates and kills inhibitions, bringing Dutch courage to today's insecure youth. It also brings aggression, rage, anger, hostility then violence, as we know only too well.

You get a clue into binge drinking problems when you look at the binge drinkers of the future, the children. At the moment they are binging on junk food, hence the problems with obesity. (Maybe they should open McDonalds and Kentucky Fried Chicken 24 hours, then the kids wouldn't binge as much.) But soon they will be experimenting with alcohol and various types of drugs and in the case of alcohol they will not only get the oral gratification associated also with eating and smoking, but they will experience, probably for the first time in the lives, the sedative effects of alcohol. It's this sedative effect, combined with enhanced feelings of confidence and the reduction in inhibitions that makes alcohol so dangerous to many people.

What is suggested now is that very few pubs would open 24 hours, but instead open to perhaps 1am. That must be the worst possible scenario as regards binge drinking – and what is the point in having a bill that no-one is going to use? Most people I talk to, police and other workers, and even people not connected with the caring business, do not see the need for this bill, as most of the people who would want to be out at night are young drinkers.

One police inspector told me about an incident on Sky TV's *Booze Britain*. You had a group of young men sitting at a table, and a barman with a tank on his back, and in the tank was a mixture of drinks, very potent stuff. This barman was going round each lad in turn and spraying a powerful mixture into their open mouths. Like baby sparrows in a nest, the lads were getting massive amounts of alcohol into their system in one go, and were choking most of the time – this happened regularly during the evening. At the end of the evening, the bill was £800 between them. This sort of madness will still go on whatever opening times are. Is this your caring drinks industry?

This bill is not going to stop binge drinking, and will definitely worsen alcohol abuse generally, just as rigid measures have not cut down drug taking. Neither free reign nor imposing restrictions works with people, both are too extreme. Just look at the failed attempts encouraging people to stop using their cars, or the rise of mobile phones. They have woven them into the pattern of their lives; some of them would find it hard to stop, even if they wanted to.

Then there is the suggestion: 'be like the French and their café society'. The problem with that, is that a massive amount of French people suffer from 'delta alcoholism' – they drink regularly every day with control, but have an inability to abstain. The new word for this is 'normal alcoholism', and the crunch is that the French have one of the worst records of serious alcohol related liver problems in the world. So they die in their droves, but do it quietly and without offending and causing political waves. Is that what we want to be like, and admire? In Scotland, where hours are more relaxed than here, alcohol related deaths have doubled, 70 per cent of violent crime is alcohol related, and there has been a fivefold increase in hospital admissions due to alcohol illness.

Apart from the usual offending carnage of binge drinkers, there is a huge rise in 'civilised alcoholism' and it is showing up in my work already. A typical case of this is Mr and Mrs J. They both have full-time jobs and have never offended at any time; they have families and own their home. They would never for a second remotely consider themselves to have alcohol problems or be like those hooligan binge drinkers. They are not hooligans, but they drink more, or as much, as binge drinkers. They are part of a new civilised 'wine culture' brigade, who drink wine every evening while making the dinner, and also during and after dinner. They are never very drunk and rarely take time off work. They don't fight or vomit in the street, but on average they drink over 100 units a week.

They have convinced themselves wine has no alcohol in it, and only look on going out to the pub (which they do over and above the wine) as having a drink. Mrs J is drinking nine times over the safe limit for women every week, and it's beginning to show, but she never blames the alcohol. There are nine units in one bottle of wine, so even just one bottle a night would be 63 units a week, which is still four times the safe limit for women. This pattern is being repeated up and down the country in millions of homes and has already started to cause major health concerns, especially with women's liver problems. This again will cost a fortune to the health service.

'This is about ingrained attitudes and a society where being drunk, falling around and making a prat of yourself is considered funny, where you have radio DJs talking about getting 'lashed' and 'bladdered' at the weekends and laughing about it. Imagine if they made jokes about themselves injecting smack on live radio.'

There are always going to be people that drink too much, eat too much, and watch television too much, so it's naïve to think everyone who drinks is capable of making informed and proper judgements on their drinking habits. A great majority of the people that come to our service do so because they find it very difficult to stop drinking once they start, and I am not just talking about chronic alcoholics. This compulsion, and inability to only have one or two drinks are the dynamics behind binge drinking. The pubs and homes are the theatres in which it's played out.

I never realised how passionate I felt about 24-hour opening, and the sadness generally about the lack of funding for community based alcohol abuse projects. Doing our work is like trying to move a ton of coal with a spoon, and the more we move, the bigger the pile gets.

Norrie McKechnie is an alcohol counsellor in the south west. He is an ex-alcoholic, and has 12 years' experience of working in prisons.

Lesley's story: part 1

A habit that started with a few glasses of shandy turned into 'drinking to oblivion'. Lesley retraces her steps to tell DDN about her nightmare days of playing hide and seek with social services, as her life spiralled out of control.

For as long as Lesley can remember, alcohol was part of her family life. She recalls camping trips during her childhood where her parents would spend time in the pubs allowing Lesley a glass of shandy. By the time she was 18, Lesley would frequently go to pubs with her friends. She remembers making sure that she had one drink more than everybody else, especially at closing time.

Lesley's first long-term personal relationship lasted three years and she was devastated by the break up. She began to drink heavily, two or three bottles of wine a day – 'drinking to oblivion'. She continued to drink this way for a year until she went back to work.

When Lesley was 29, she began dating Steve. They were drinking every night, in the pub straight after work until nine or ten o'clock. When Lesley's father fell ill, she gave up work to help her mother look after him. Her mother was an alcoholic. She kept her mother company drinking, sometimes from lunchtime. 'She deserved it, having to look after my father and I was keeping her company – my excuse.'

When her father died, Lesley and her mother hit the drink hard. Within 18 months, her mother also passed away. Again, Lesley's drinking escalated. 'I was completely off my rocker all the time.' She cannot remember exactly how much she was drinking at this time – cans of cider and lager, made up with half a bottle of whiskey a day.

Lesley continued drinking chaotically until she was 37 years old when she gave birth to James. This prompted her to look at her drinking. She slowed down, having a couple of cans in the evenings. Her partner continued to drink heavily.

When James started nursery, Lesley would meet her friends in the afternoon in the pub. She was drinking with people who drank like she did. She continued to drink in the evenings as well. Her drinking further escalated. Social Services became involved and James, aged seven, was taken into care.

Lesley tried detoxing three times in a local psychiatric hospital. She also tried numerous home detoxes. However, she had no intention of staying off the alcohol. 'I'd just give my body a break and go back out there... I'd no intention to stay off it... let my liver recover and be nice to Social Services and they'll give me James back.'

She was sober for six months when Social Services gave James back to her. However, although she had cleaned up she had not changed her way of thinking. She attended a harm-reduction agency, where she was encouraged to control her drinking. 'It was giving me licence to drink, wasn't it? You know, as long as I show up on time... it was good.'

James was home six months when Steve had a stroke. He was diagnosed with brain cancer and given five weeks to live. Lesley looks back at this as a wonderful licence to drink. She visited Steve in hospital every day while under the influence of alcohol. Two cans in the morning for breakfast for courage and two cans to drink during the visit – hidden in the toilets. Steve was in hospital for four months before Lesley was allowed to take him home. At this point, she was drinking cider, as lager was no longer giving her a quick enough kick. She then had to take Steve to chemotherapy every day.

'[Leslie] started to try and control her drinking. She also tried changing her drinks. She tried to rationalise that she couldn't be an alcoholic because she drank whiskey and Martini, not only cheap lagers and ciders.'

Social Services took James off Lesley again. Her friends volunteered to foster him and Lesley was allowed supervised contact once a week. Inevitably, Steve had to go into a nursing home. When he died, Lesley weighed just six stone. With Steve gone and James in care, she felt as if her life had collapsed and began to question, 'What have I got to live for?'

Steve's funeral was on a Friday and Lesley went into the local psychiatric hospital on the following Monday to detox. Her detox lasted ten days. Once again she turned to alcohol. She didn't feel guilty, she didn't feel anything. To her, 'a detox was just a detox'.

She started to try and control her drinking. She also tried changing her drinks. She tried to rationalise that she couldn't be an alcoholic because she drank whiskey and Martini, not only cheap lagers and ciders. She drank from long glasses, decided to have only one drink before tea – but tea kept getting earlier – and was grateful for the invention of Coca-Cola (you could hide so much in it!) She started to take valium in the morning if she did not have alcohol, in order to avoid withdrawal symptoms.

Lesley was now spending most of her time on her own. She described herself as 'a poor helpless little waif with nothing going for her' at the peak of her drinking.

'I didn't care, I couldn't be bothered. I was dirty. I didn't bother washing. Didn't bother eating. I was the person no one wanted to talk to. Even my drinking friends, the majority of them had deserted me. I was an embarrassment. I was very, very lonely. Very lonely.'

Next issue: Lesley comes back from the brink

A day in the life of...

Mark Farrell, assistant manager at a London 'wet' hostel

Hopkinson House is a wet house, which means people can bring alcohol onto the premises. There are 21 single rooms downstairs, 11 single rooms on the second floor and four self-contained flats.

When we get referrals from the borough of Westminster, we meet the person to see if he or she suitable to move in. We don't have a huge amount of criteria and we're pretty flexible.

When someone comes into Hopkinson that has an alcohol issue, we try – and don't always succeed – in helping them to try and cut down on alcohol and start using their living skills. Then we see if they could take on extra responsibility.

I come in at 9.30am and go straight into the duty office to see if have been any disruptions in the night, or any exclusions. I pick up the major incident reports if there are any, and familiarise myself with what's gone on, especially on a Monday morning. Things do tend to kick off more on a weekend.

Sometimes we have to exclude a service user if they've created a problem, for up to 48 hrs. This means they're asked to give back their keys and leave the project. It normally happens on a weekend, as there's no management in after Friday evening. It sounds awful, but it's almost like a short sharp shock. If someone's been here eight months, gets into a big argument and is excluded for the weekend, they tend to forget what it's like back out on the street.

We also sometimes get abandonment. If people have been long term living in the street, they can't adjust. They come in and we give them every type of support we can, but if they don't want to be inside, they just leave. It can be entrenched in somebody that they've lived out on the streets so long, that they're streetwise and know how to get by.

'The level of drinking isn't as high as you might think. People imagine when they think of a wet hostel that everybody's lying on the floor, frothing at the mouth with 23 cans of Tennant's Extra. It's just not like that.'

We only take people who are street homeless or in very short stay night shelters and get referrals from various outreach services. We're not direct access; sometimes local police think they can pop people at our door at 11pm and we can take them in.

I'm often at referral meetings in the afternoon. Everybody has a six-weekly review, just to see how things are getting on. Then it's dealing with any referrals that have been faxed over. We have an average of four or five referrals a week, of which three or four might be suitable.

We ask our residents to pay £30 a week. That's £25 a week for food and £5 service charge. It's a lot more than some other places ask, but we provide a bigger service. Everybody has their own room with a locked door, and two cooked meals a day.

We also run extensive leisure and recreation facilities here. They're all service user led, and include shiatsu, acupuncture, karaoke, a video night, bingo, and parties for Burns night and St Patrick's Day. They're well attended and give a real feeling of community.

Individual cases can be really inspiring. We had a guy in here last year for 18 months. He'd witnessed his brother being blown up next to him in the Falklands war, and had only been back a few months when his wife died of cancer. This was the catalyst for him starting drinking, as he just couldn't handle it. So he was sleeping rough when he came in here and we had issues with getting him to cut down.

We supported him in getting in touch with members of his family he hadn't seen for years. The upshot is that he got back with his first wife, is living in Kent and due to get remarried.

It's an inspiration if somebody cuts down on their alcohol levels. We have a service user in at the moment, who's had a history of coming in the winter and stopping a couple of months over the worst weather, then going outside again. For whatever reason he's decided to change his life around. He moved from the first floor to one of the self-contained flats a few weeks ago and everything's going really well.

As the day unfolds I take it as it comes. One of the managers, depending on what we've got on that day, tries to fit in going to the handover meeting of early to late staff, which takes place 2.30 to 3.30.

We operate an open door policy here. Any service users that are up on the second floor, or any of the staff, can just come and knock. I like the fact that we're visible. If staff are stressed out by something, they should be able to just come up and let off steam. At the end of day they're front line staff, and will know much more about the service users.

If people get drunk in wet areas, we just have to manage it as best we can. They'll still drink to the levels they always have. If somebody falls asleep in their chair, we just leave them, we don't say they need to be back in their room. We let them sleep it off.

People here are on benefit and that has an effect on drinking levels. They're quite ordered, in that they know how much they've got and know how much they can drink. Yes, they've got little arrangements between themselves – Bert will say to Joe 'I've got my money today, you don't get your money till Thursday, I'll buy you a drink till then..'. But the level of drinking isn't as high as you might think. People imagine when they think of a wet hostel that everybody's lying on the floor, frothing at the mouth with 23 cans of Tennant's Extra. It's just not like that.

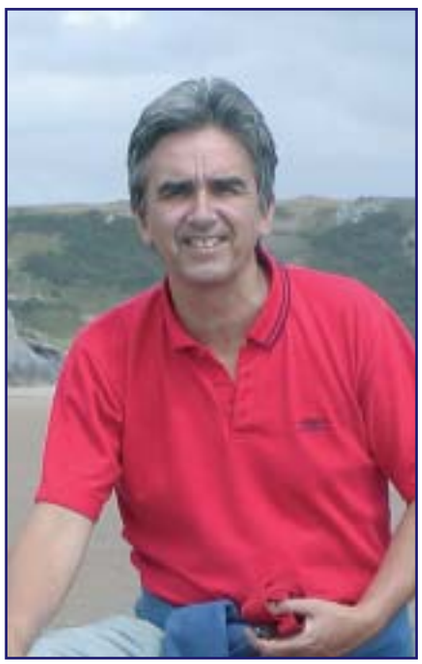
I like to pop downstairs, because I enjoy the interaction. You can get the odd one that can be difficult as they often have dual diagnosis mental health problems, but it keeps it interesting.

Every day is different.

Mark Farrell is assistant service manager at Hopkinson House, an Equinox care centre.

Alcohol dependence

In the latest of his background briefings, Professor David Clark looks at the nature of alcohol dependence



There has been a considerable scientific effort over the past three decades in to identifying and understanding the core features of alcohol and drug dependence. This work really began in 1976 when the British psychiatrist Griffith Edwards and his American colleague Milton M. Gross collaborated to produce a formulation of what had previously been understood as 'alcoholism' – the alcohol dependence syndrome.

The alcohol dependence syndrome was seen as a cluster of seven elements that concur. It was argued that not all elements may be present in every case, but the picture is sufficiently regular and coherent to permit clinical recognition. The syndrome was also considered to exist in degrees of severity rather than as a categorical absolute. Thus, the proper question is not 'whether a person is dependent on alcohol', but 'how far along the path of dependence has a person progressed'.

The following elements are the template for which the degree of dependence is judged:

Narrowing of the drinking repertoire. A normal drinker's consumption and choice of drink varies from day to day and week to week, with the drinking being patterned by varying internal cues and external circumstances. The dependent person may drink to the same extent whether it is workday, weekend or holiday, irrespective of whether he is alone or in company, and whatever his mood. With advanced dependency, the drinking may become timetabled to maintain high alcohol levels.

Increased salience of the need for alcohol over competing needs and responsibilities. As dependence advances, the person gives priority to maintaining their intake. Their partner's distressed complaints are ignored, income is used to support their drinking rather than provide for the family, and the need for drink may become more important for the person with liver damage than consideration of survival. A person who used to have moral standards now begs, borrows and steals to pay for drinking.

An acquired tolerance to alcohol. A given amount of alcohol will have a smaller effect on the dependent person than on a naïve drinker due to changes in brain function arising from repeated consumption of alcohol. Tolerance is also shown by the dependent person being able to sustain an alcohol intake and go about their business at blood alcohol levels that would incapacitate the non-tolerant individual. However, in later stages of dependence this tolerance declines and the drinker is incapacitated by quantities of alcohol that he could previously hold easily.

Withdrawal symptoms. These vary from a mild shaking of the hands in the morning through to convulsions and the life-threatening illness of delirium tremens (confusion, hallucinations, tremor). As dependence increases, so does the frequency and severity of the symptoms. Symptoms of withdrawal may occur during the day as blood alcohol levels drop. The four key symptoms are tremor, nausea, sweating and mood disturbance. A person may wake in the morning with soaking sweats, or they may vomit in the morning. In the early stages, a person may feel a 'bit edgy', but as dependence develops, they may experience terrible agitation and depression, or may show phobic reactions. Other symptoms include muscle cramps, sleep disturbance, hallucinations, and grand mal seizures.

Relief or avoidance of withdrawal symptoms by further drinking. In the earlier stages of dependence, the person may feel at lunchtime that the first drink of the day 'will help me straighten up a bit'. At the other extreme, a person may require a drink every morning before they can get out of bed. They may try to maintain steady alcohol level which they may have learnt to recognise as being comfortable above the danger level for withdrawal.

Subjective awareness of compulsion to drink. The person may become aware of their ability to lose control: 'If I have one or two, I won't stop'. They may start to experience and express their craving for alcohol. Cues for craving include the feeling of intoxication, incipient withdrawal, mood or situational cues (e.g. seeing a drinking friend). They may constantly think about alcohol when experiencing withdrawal.

'There is no signpost to a person becoming dependent. Whilst a severely dependent person is easy to recognise, it can be difficult to detect a problem in the early stages.'

Reinstatement after abstinence. If a severely dependent drinker is abstinent for a year and then attempts to return to social drinking, it is likely that within a few days they will be back to an intensity of withdrawal experience which had previously taken many years of drinking to develop. Dependence has a memory.

There is no signpost to a person becoming dependent. Whilst a severely dependent person is easy to recognise, it can be difficult to detect a problem in the early stages. Clearly, it is essential to be able to diagnose early problems, before drinking gets out of hand and there is a precipitous decline in the quality of life that accompanies increasing dependence.

In the latter stages of dependence, there may be a rapidly mounting intensity of morning distress, appalling shakes, suicidal thoughts, and delirium tremens. Gross and incapacitating intoxication becomes common. The person is intoxicated after a couple of drinks, there is a gross and repeated amnesia (they may disappear for several days but not remember where), and there are desperate attempts to avoid withdrawal by topping up. Drinking makes the person very ill – this is partly due to mounting intensity of morning distress, but also due to various alcohol-induced physical problems (e.g. liver disease). Psychiatric disorders may become common at this stage.

Credit for competence

In the second of our series to give a working knowledge of the Drugs and Alcohol National Standards, Trevor Boutall explains DANOS-based qualifications.

DANOS – the Drugs and Alcohol National Occupational Standards – describe the standards of performance expected of all those working in the drugs and alcohol field and the knowledge and skills they need to be effective in their work. They can be downloaded free of charge from www.DANOS.info.

Over the past year and a half, Skills for Health has been working closely with the National Treatment Agency for Substance Misuse (NTA), the Drugs Strategy Directorate (DSD), Alcohol Concern, DrugScope, the National Assembly for Wales, educationalists, employers and service users to develop a strategy to give credit for competent performance to DANOS standards through nationally-recognised qualifications.

National and Scottish Vocational Qualifications (NVQs/SVQs)

The first of these qualifications, just launched by awarding bodies like City and Guilds, Edexcel and the Scottish Qualifications Authority (SQA), is the NVQ or SVQ in Health and Social Care level 3.

This qualification can be widely used across the health and social care sectors as a certificate of competence. It is ideal for those working in the drugs and alcohol field who do not hold a professional qualification. Experienced staff will not need to do extensive training – they will find that, through the NVQ/SVQ, they can get accreditation for their prior experience and learning.

All candidates, wherever they are working, are required to take four common core units:

- Promote effective communication for and about individuals
- Promote, monitor and maintain health, safety and security in the working environment
- Reflect on and develop your practice
- Promote choice, well-being and the protection of all individuals (those working with children and young people take an alternative unit: Promote the well-being and protection of children and young people).

To complete their qualifications, candidates select four optional units – from a choice of 40 DANOS units – which are most appropriate to their work role.

A project worker, for example, might choose the following units:

- Support individuals who are substance users
- Assess and act upon immediate risk of danger to substance users
- Carry out assessment to identify and prioritise needs
- Contribute to planning, monitoring and reviewing the delivery of service for individuals.

A counsellor, on the other hand, would choose a different set:

- Contribute to planning, monitoring and reviewing the delivery of service for individuals
- Counsel individuals about their substance use using recognised theoretical models
- Help individuals address their substance use through an action plan
- Counsel groups of individuals about their substance use using recognised theoretical models.

For details of local centres offering the NVQ/SVQ in Health and Social Care level 3, contact the relevant awarding bodies:

- City and Guilds www.city-and-guilds.co.uk
- Edexel www.edexcel.org.uk
- SQA www.sqa.org.uk

'There are over 300 training courses and qualifications linked to DANOS on the Learning Resources Database... Most of these focus on developing students' underpinning knowledge and skills.'

Federation of Drugs and Alcohol Professionals Accreditation

Following a pilot process at the end of last year, the Federation of Drugs and Alcohol Professionals (FDAP) is about to launch its new Professional Certification scheme, which is also based on DANOS, but goes further than the NVQ/SVQ.

To become a Certified Drug and Alcohol Professional, practitioners will need to demonstrate their competence in 10 core DANOS units. The first four of these are identical to the NVQ/SVQ core, the additional six being:

- Relate to, and interact with, individuals
- Promote the equality, diversity, rights and responsibilities of individuals
- Support individuals who are substance users
- Assess and act upon immediate risk of danger to substance users
- Make use of supervision
- Carry out assessment to identify and prioritise needs.

To be certified under the scheme, practitioners will also need to demonstrate they are competent in at least one additional specialist unit, selected from a choice of a further 14 DANOS units.

For more details of FDAP's Drug and Alcohol Professional Certification scheme, contact FDAP at www.fdap.org.uk .

Other DANOS-related training and qualifications

There are over 300 training courses and qualifications linked to DANOS on the Learning Resources Database on www.DANOS.info. Most of these focus on developing students' underpinning knowledge and skills, rather than assessing whether they can actually perform competently in the workplace.

However, a number of Higher Education Institutes (HEIs), such as Bath, Leeds and Leicester universities, are currently exploring ways of integrating the assessment of workplace performance into their substance misuse qualifications, and the National Open College Network and the NCFE awarding body will be reviewing their drugs and alcohol qualifications this year.

2005 will see a growth in the choice of DANOS-based qualifications suitable for practitioners at all levels, including a new Continuing Professional Development Award, being developed by Skills for Health in partnership with awarding bodies, to help those with professional qualifications but no experience in the substance misuse sector quickly to get up to speed and prove they can work competently and safely to meet service users' needs.

Next Month: DANOS-based Recruitment, Development and Retention – the Middlesbrough Experience.

Views from the street

Provision of needle exchanges in Glasgow has tripled during the last seven years – but are service users getting what they need? April Shaw shares results of a survey that highlights some of the gaps and barriers in services.

Glasgow Involvement Group (GIG) carried out a snapshot survey with a sample of 76 injecting drug users (IDUs) in Glasgow in September 2004 on existing needle exchange (NX) services and blood borne virus (BBV) information within Glasgow.

GIG is a volunteer group of ex/current addiction service users who are recruited, trained and supported to undertake activities that will impact on the planning and delivery of services. The structured questionnaire used in this study was designed by GIG in collaboration with Scottish Drug Forum's User Involvement Team. The sites from which the IDUs were recruited were chosen by GIG members with knowledge of the street scene in Glasgow.

The Glasgow area has increased its NX provision from eight in 1997 to 24 in 2004; this increase was regarded positively by the respondents in this study. Although access to NXs, including numbers of NXs and opening hours were good for the majority of respondents, they identified a number of gaps and barriers in the provision of NX services. Among these gaps was the continuing lack of spoons, acidifiers, filters and water ampoules used in the preparation process.

The main barriers to Glasgow's NXs for this sample of users included police presence, fear of losing their methadone prescription and stigmatisation. Barriers differed according to the type of NX. Stigma and police presence presented barriers to pharmacy access; fear of losing a prescription was the main barrier to treatment based NXs. In addition, 'lack of privacy' was an impediment to many of the pharmacy NX users. Alternative sources for obtaining sterile equipment suggested by the respondents included mobile NXs, vending machines and home deliveries.

GIG sought to explore the respondents' views and experiences on safer injecting information and BBVs given the rising numbers of IDUs infected with Hepatitis C (HCV). The findings suggest there is a lack of information regarding safe injecting practice and injecting techniques. Only four people said they had ever been shown how to inject safely; however when asked, two-thirds of respondents stated they would access safer injecting training whilst three-quarters would access overdose training. Less than half the sample had received information on BBVs.

Respondents were asked whether they had been tested for BBVs and the outcome of the test. Almost three-quarters had been offered a BBV test, most frequently through statutory health and prison services. While one third of the total sample had received a positive test result for HCV, only eight people reported being offered post-test counselling despite Department of Health guidelines that state 'Injecting drug users... who seek testing should be offered well-informed advice and should be made aware of the implications of a positive test... those who test positive will need advice on ways of minimising the risk of transmitting infection to others.' It has been reported elsewhere that there is currently no consistent policy regarding screening for HCV in IDUs and that there is widespread variation in the provision of testing.

'Distribution of paraphernalia should be re-examined in light of the 2003 Amendment to Misuse of Drugs Act that allows services to widen provision to include acidifiers and spoons... Further impetus should be given to proposals to allow the widening of the supply of sterile water.'

The results obtained in this study suggest that the respondents' knowledge of BBVs is not impacting on their injecting behaviour even among those who have tested positive for HCV. Among those who did test positive, almost one quarter had shared needles within the last month, whilst almost two-thirds had recently shared paraphernalia. Nevertheless, as other research has shown and as this sample reported, many crucial factors can impinge on safer injecting practice, most notably withdrawals, not having needles/paraphernalia of their own and convenience of access to clean injecting equipment.

The study has raised some important points for discussion about NX provision, including the continued provision of needles and syringes, as well as the potential increase of 24 hour access. Innovative ways to achieve this have already been mentioned in this study, including vending machines and outreach schemes. Distribution of paraphernalia should be re-examined in light of the 2003 Amendment to Misuse of Drugs Act that allows services to widen provision to include acidifiers and spoons. Given the clear desire among the sample for increasing the supply of both needles/syringes and paraphernalia, further impetus should be given to proposals to allow the widening of the supply of sterile water by NXs and other non-clinical treatment workers. Furthermore, increasing access to sterile equipment and paraphernalia will be required if injecting cocaine use becomes more prevalent.

It is also clear that a consistent policy of BBV testing and counselling needs to be developed; less than a third of the respondents who tested HCV positive were offered post-test counselling. This would provide a valuable opportunity to engage with IDUs and offer information and counselling to help reduce risk behaviours and the spread of infection among the wider IDU population.

In essence, needle exchanges provide a valuable service for injecting drug users and for some users this may be their main service contact, particularly for those not in treatments. It is therefore essential that the role of needle exchange providers, both addiction service and pharmacy based, are provided with the resources to widen the distribution of all necessary injecting equipment and paraphernalia. Moreover, the direct and indirect costs of blood borne viruses are potentially huge, and as such, needle exchanges can play a vital role in the supply of information on both safer injecting practices and BBVs.

April Shaw is research officer at the Scottish Drugs Forum.


Extreme measures

'Buddhism, at the moment, is quite fashionable and I daresay many of those who work in the field would be quite receptive to this form of detox. However, I have found a high level of discrimination by workers towards programmes (such as 12 step) that include spirituality as an essential element of overcoming addiction.'

Responses to 'Extreme Measures' (DDN 24 January)

I think this method of detox is totally viable, but I agree with Dr Ford that the follow up can be the downfall – much the same as detox in this country. Wherever a person goes for detox, whatever wonderful surroundings they find themselves in, they still have to return to the same old shit.

An element of the Thamkrabok detox which may differ from rehabs in this country (I'm not sure) is the spiritual side; it sounds like participants have the option of engaging their spirituality to an extent that they choose. I recently attended a conference including a speaker who discussed 'substance misuse and spirituality', and I felt that he addressed a lot of vital issues that are ignored within the substance misuse field. Unfortunately, speaking with one or two other workers at the conference, this section was quite ill received.

Buddhism, at the moment, is quite fashionable and I daresay many of those who work in the field would be quite receptive to this form of detox. However, I have found a high level of discrimination by workers towards programmes (such as 12 step) that include spirituality as an essential element of overcoming addiction. Likewise many Christian organisations do a huge amount of work with people dealing with addiction and these are often dismissed by workers because they are Christian. I am not a Christian, and I am not religious, however I think that the loss of personal, and possibly communal, spirituality has had a huge impact on many social problems including substance misuse. In my experience clients of addiction services are far more open to exploring their spiritual side and gaining strength from this than workers are – and services should be geared to clients' beliefs and wishes, not workers'.

Bernice Shepherd, Substance misuse worker at Cardiff YOT

I was interested to read the article on the detox programme offered at Thamkrabok Monastery.

I am currently working towards UKCP registration in Core Process psychotherapy (a Buddhist-oriented approach that combines western developmental theory with Buddhist psychology). I work with clients in private practice as well as offering a voluntary service at Clouds Families Plus in Salisbury. I have personal experience of how alcoholism can dominate family life and lead to a host of problems including trans-generation addiction, post-traumatic stress disorder, long-term mental illness and at worst, suicide.

Buddhism as a practical way of life centres on relieving suffering, one of the causes of which is the attachment to craving – or addiction. The way out involves a commitment to self-enquiry through regular traditional meditation and awareness practices, and the cultivation of compassion towards oneself in mind and body – a holistic approach. It's possible to benefit from a Buddhist way of living without accepting it as a religion, which explains its growing popularity in the west.

If the detox programme at Thamkrabok could be linked up with follow-up therapeutic support to help cultivate awareness and compassion, craving and attachment may not disappear, but there is the potential for recovery and health in the long-term. The recovery cycle, when accessed, can be stronger ultimately than the cycle of abuse. So I'd like to send my thanks and appreciation to the monks at Thamkrabok and the East-West Detox workers – I wish you well with the ongoing work.

Florence Hamilton, by email

WD-40 no answer to clubbers' coke

Having read an article in *The Times* on 19 January entitled 'WD-40 adds coke-busting to its list of handy household chores', I cannot understand how any national newspaper can publish such a dangerous activity to unsuspecting members of the public.

They mentioned the fact that it congeals and semi-dissolves the powder cocaine and renders it virtually unusable, but then state that people have continued to attempt to use it, which then induces a nose bleed and I'm sure severe pain. This cannot be seen as best practice or a way of safely reducing cocaine use or crime reduction in any shape or form. It is archaic and dangerous. If this is seen to be acceptable why not put vomit-inducing chemicals in alcohol. This would certainly reduce the amount of people binge drinking on a weekend or become dependent on alcohol. Maybe add a little bit of WD-40 to tobacco, it would certainly make the tobacco burn quicker and the smoker would have less time to inhale all the nicotine in the cigarette. It won't matter that it may burst into flames and scar their faces.

Cocaine dependency or compulsive use of cocaine is a problem faced by many communities around this country. It is illegal and can be dangerous to the user, but this is not the way forward in treating this kind of problem. As *The Times* also stated, many different people from all walks of life use cocaine as a recreational substance. If traces have been found in The House of Lords' lavatories and 'hotels used by delegates at party conferences, this goes to show even the people that debate and pass the laws of this country feel there is a place for recreational substance use in this society.

I very much doubt the pubs or clubs that this practice is being done in, advertise that such a procedure is happening and this group of people are at risk of damaging their nasal passage more by snorting WD-40 than from snorting the cocaine on its own. We definitely do not know how snorting WD-40 and the chemicals it contains will react in our bodies. This is also too close a connection to inhaling solvents and gases, which are a known instant killer.

Anthony Atkins, Drugs Worker, Surrey

Hep C and needle exchange – the truth is out there

Professor Neil McKeganey (*DDN*, 24 January) rightly alerts us to the failure to adequately control hepatitis C but simply says there is a 'lack of knowledge' of the effectiveness of needle exchange. True, there isn't as much as we would like but there is some - enough to form the basis of a four-part series in Drug and Alcohol Findings starting in issue 8 and ending in the latest issue, issue 11. This comprehensively reviewed the British data (and it is inadequate) after presenting a series of international case studies showing why needle exchange has failed with hepatitis C but also how it can succeed. The final part of the series pulled together the threads in the form of the limitations which threaten viral control and the practice ingredients which hold promise for the future, presenting a revitalised agenda for needle exchange commensurate with the challenge of hepatitis C. The overall conclusion was that 'Inadequacies stem from the under-resourcing and marginalisation of this work which leaves it unable to match the size of the task ... Exchanges can only realise [their] potential if they no longer have to constrict themselves due to shortsighted financial restrictions, community opposition, and misplaced morality, or deliberately choose to tie their own hands.'

Mike Ashton
Editor Drug and Alcohol Findings
Drug and Alcohol Findings is available through Alcohol Concern, 020 7928 7377

10 February - Leicester
Alcohol, Bingeing and Crime: Practical Responses
Organised by Perpetuity Conferences. A one day conference. Topics discussed include: enforcement campaigns, arrest referral schemes, the impact of the new licensing legislation, the role of the alcohol industry and sobering up units as an alternative to police cells. Perpetuity Conferences –
w: www.perpetuitygroup.com.
t: 0116 221 7775
e: conferences@perpetuitygroup.com

21-22 February – London
National drug treatment conference
Organised by Exchange Conference in association with The Alliance. A two day annual event. Keynote plenary sessions, parallel workshops, discussion, paper presentations and fringe meetings. Essential for drug workers, drug activists, criminal justice workers, prison healthcare staff, clinicians, researchers, policy makers, service providers and commissioners. Contact Monique.
t: 020 7928 9152
e: moniquetomlinson@wdi.co.uk
w: www.exchangesupplies.org

23 February – London
Arrest Referral - Full Speed Ahead?
Organised by Spotlight. This conference sets out the challenges ahead for those involved in commissioning, managing, delivering and monitoring arrest referral work. Speakers from the Government, Home Office, Drugscope, Addaction, CRI, Coca and the Institute for Criminal Policy Research, King's College London.
w: www.policyspotlight.co.uk/conferences/pdf/psl-arrest.pdf
t: 0870 351 8720
e: bookings@policyspotlight.co.uk.

24 February – Liverpool
2nd Perspective on Cannabis Conference
Organised by HIT and Liverpool John Moores University. This conference will bring together internationally renowned experts to share their knowledge and perspectives about many cannabis related issues. Topics include: Cannabis and severe mental illness: is there a link?, Communicating with heavy, frequent cannabis users; the impact of long-term heavy cannabis use; Developments in the treatment of cannabis related problems in Australia and Cannabis education and young people: the Australian experience.
t: 0870 990 9704
e: cannabis@hit.org.uk.

24-25 February – Manchester
UK Hepatitis C Awareness & Prevention Conference
Organised by UK Hepatitis C Resource Centre and Mainliners. Among the topics to be explored are projects to raise awareness, including England and Scotland's Health Departments' public and professional awareness activities, and key prevention issues such as progressive harm reduction approaches including injecting rooms, prescribed heroin, current issues surrounding sexual transmission and needle stick injuries. Workshops will seek answers to questions on case finding, prevention and screening.
t: 020 7378 5495
e: dkeys@mainliners.org.uk
w: www.hepccentre.org.uk.

24-25 February - London
Combating Drug & Alcohol in Workplace Conference
Organised by Business Forums International. Two day conference and exhibition on services and products to support corporate strategies on tackling drugs and alcohol in the workplace. Contact BFI –
e: djames@bfi.co.uk

14-15 March – Cardiff
3rd Annual Tackling Drugs Supply Conference & Awards
Organised by Home Office and Calder Conferences. The aim of the conference is to identify, promote and recognise best practice among police forces in tackling drug supply. The presentations of the winning nominations allow delegates to share innovative approaches in tackling drug supply. In addition, the event aims to acknowledge and celebrate the good work that is being undertaken throughout the country.
w: www.calderconferences.co.uk/cardiff_page.asp#
t: 020 7273 3886
e: Brian.Hanrahan@homeoffice.gsi.gov.uk

Please email details of your events to:
office@fdap.org.uk

HAMPSHIRE DAAT
Drug & Alcohol Action Team

Drug Intervention Programme Service

Hampshire DAAT are seeking written expressions of interest from providers with proven experience in delivering criminal justice substance misuse treatment services for the provision of the Hampshire DAAT DIP service which will include:

- offering a throughcare (including Arrest Referral) and aftercare service to drug users entering the criminal justice system at any point
- providing a 24/7 point of contact offering support, information and contact details, options, DIP team appointments and other appropriate services for all DIP clients.
- providing a Drug Treatment and Testing Order (DTTO) service, or it's replacement, and linking in with Prolific and Priority Offender (PPO) schemes.

The Service will be required to commence on October 3rd 2005 to operate throughout the Hampshire wide DAAT area (this excludes the unitary areas of Southampton, Portsmouth and Isle of Wight).

A restricted tendering procedure will be followed with the criteria for award of the contract to be:

- Supplier track record of and commitment to the provision of substance misuse treatment services
- Supplier capacity and capability
- Economic and financial standing

Written expressions of interest must be received by **18 February 2005**. Upon receipt a pre-qualification document will be sent to all interested parties to be completed and returned by the **4th March 2005**.

Tender packs will be sent to providers selected to tender during the week commencing the 7th March for return by the **8th April 2005**. Presentations will take place during the week ending **22nd April 2005**.

To register your interest please contact Pat Hall, Hampshire DAAT, Capitol House, 12-13 Bridge Street, Winchester, Hampshire. SO23 0HL.

PROCUREMENT OPPORTUNITIES

Drug Intervention Programme Service

safer portsmouth

Portsmouth City Council on behalf of the Safer Portsmouth Partnership is seeking expressions of interest from providers with proven experience in delivering criminal justice substance misuse services for the provision of the Portsmouth City DIP Service which will include:

- Arrest referral, throughcare and aftercare services
- 24/7 point of contact
- Drug Treatment and Testing Order service (or its replacement)
- Prolific and Priority Offender scheme including low threshold prescribing

The Service will be required to commence on 3rd October 2005

Closing date: 25th February 2005

For full details on how to apply please visit www.portsmouth.gov.uk/procurement

For assistance with access telephone Procurement Services on 023 9283 4994 quoting the above title.

Portsmouth CITY COUNCIL

dasl
drug and alcohol service for london

Drug and Alcohol Service for London is an innovative agency working across London to provide a range of services to people experiencing problems with alcohol or drugs. We are currently seeking to employ:

WOMEN, DOMESTIC VIOLENCE AND SUBSTANCE MISUSE WORKER

Section 7(2) E Sex Discrimination Act Applies

£24,792 pa for 35 hrs/wk (Ref: 04/22)

Funded to 31.03.07 by the Association of London Government (ALG)

You will provide counselling, brief intervention, advice, advocacy and support to women with substance misuse problems due to a previous/current violent relationship and to women experiencing substance misuse related domestic violence in Newham, Tower Hamlets and Redbridge. You will also deliver appropriate training to local professionals, raising awareness of substance misuse and domestic violence. A background in drugs, alcohol, domestic violence work and demonstrable training skills are required.

Closing date: 5pm 28.2.05. Interviews: week commencing 7.3.05.

DTTO DAY PROGRAMME WORKER

£24,792 pa for 35 hrs/wk (Ref: 04/21)

DASL has two Structured Day Programmes (alcohol or drugs), incorporating skills and therapy groups, alongside complementary therapies. The Drug Treatment & Testing Order Programme is a new service and you will help establish it, planning, facilitating and documenting groups; planning the DTTO programme; assessing clients; drug testing and working in a care-planned approach. Experience of working in the criminal justice system, an understanding of substance misuse and related issues is required, as well as extensive experience of running, planning and documenting groups in a similar context.

Closing date: 5pm 28.2.05. Interviews: week commencing 7.3.05.

PART-TIME YOUNG GAY MEN'S SUBSTANCE MISUSE WORKER

£4,958 for 7 hrs/wk (Ref: 04/19)

You will be responsible for providing information on substance use/misuse problems and substance misuse services to all gay male projects in East London. You will also provide a programme of outreach and development work to these projects including offering training, consultation and resources to equip workers with an understanding of the particular needs of young gay men and the skills necessary to improve their work with this client group. Some evening work will be required. Training experience as well as experience of working with young gay men in a community setting will be required.

Closing date: 5pm 4.3.05. Interviews will be held on: 17.3.05.

All posts are eligible for Enhanced Disclosure by the Criminal Records Bureau.

For an application pack (paper/electronic packs available) contact DASL, Capital House, 134-138 Romford Road, Stratford, London E15 4LD. Tel: 020 8257 3068, email: jobvacancies@dasl.org.uk quoting job title and reference number.

DASL is committed to the principles of equality of opportunity for all. ***Registered charity 299535***

South Manchester Primary Care Trust NHS

Alcohol Arrest Referral/Primary Care Alcohol Linkworker

Nursing grade F or equivalent

Full Time 37.5 hours per week

Manchester Community Alcohol Team (CAT) is a citywide service managed and employed by South Manchester PCT. Working as part of the CAT this role involves prevention and early identification of alcohol problems, assessments, planning interventions and care management of people experiencing problems associated with their alcohol use from primary care and criminal justice settings. You will have a minimum of one year's experience of working with people with alcohol problems preferably in the community. This role provides an opportunity to work with a high level of individual responsibility, whilst being a member of a forward thinking team. The service has a strong commitment towards the professional development of its staff.
For an informal discussion contact Darren Hill, on 0161 611 3663

For an application form and job details please either telephone 0161 862 9315 (24 hour answer phone) or e-mail ApplicaR@manchester.nwest.nhs.uk giving your full name, address and quoting job S/AAR/267.

Closing date: 18th February 2005.

Hounslow Primary Care Trust NHS

Hounslow PCT and London Borough of Hounslow

DAAT Co-ordinator/ Programme Manager

£31,347 - £33,642 depending on experience
Have a REAL say in Drug Strategy

As an integral part of a small, pro-active DAAT you will have a real voice in the implementation of national drug strategy in the London Borough of Hounslow.

Among other projects you will take the lead in setting up the new Young Peoples Substance Misuse Service and offer professional support to its manager. You will also have the opportunity to develop innovative projects to further enhance the work that the DAAT and its partners are delivering.

As well as this, the DAAT Co-ordinators duties will include chairing various groups, reporting to central and local government departments, liasing with our partners and assisting the Joint Commissioning Manager in delivering the local implementation of the National Drug Strategy.

Hounslow is a diverse, multi-cultural borough with good transport links and this post offers a unique opportunity to be really involved in creating something new.

You will have at least two years' experience of working in the Drug and Alcohol field and experience of partnership working. Experience of working with young people with substance misuse problems would be an advantage. You will be able to select whether you are employed on NHS or Local Authority terms and conditions of service.

So if you are up for the challenge and want to find out more about the post please call Simon Gunn on 020 8583 3015.

To apply for this vacancy, please visit www.jobs.nhs.uk and enter Job Ref: 687-SM-129, please note that we only accept on-line applications. If you experience any difficulties in applying via the website please contact Recruitment on 020 8321 2216.

Closing date: 21 February 2005.

Staff benefits include a final salary pension scheme; childcare support; access to housing schemes; staff discounts and personal development and training opportunities.

We are committed to diversity in the workplace, equality of employment and the promotion of flexible working. All disabled applicants who meet the minimum criteria for the job will be invited to interview.

Some posts will be excluded under the Rehabilitation of Offenders Act 1974 and will be subject to disclosure. If relevant, candidates will be informed of this at the point of being invited to interview.

DDN Drink and Drugs News

Get the latest vacancies direct to your inbox. To register email us at jobs@fdap.org.uk

East Lothian Drug and Alcohol Action Team

Project Leader

(The PETE Project)
(Pathways to Education, Training and Employment)
(Temporary for 2 years)
£22,398 – £24,396

This is an exciting opportunity to lead a new project, helping people who have experienced substance misuse problems to find routes into education, training and employment.

We are looking to recruit a suitably qualified and experienced person to develop and lead this innovative project, based in Musselburgh, East Lothian, and jointly funded by the Big Lottery Fund and East Lothian Drug and Alcohol Action Team.

The project will work with stabilised individuals, developing personal action plans, and using personal development funds available to the Project.

The Project Leader will be highly motivated, with experience of working with people with substance misuse problems, and a proven record of working effectively in partnership settings. He/she will be committed to helping people with drug and alcohol problems to 'make a difference' in their lives, and to leading a project which produces real outcomes.

The Project will be temporary, for 2 years, in the first instance.

*Further information about this vacancy is available on the recruitment pages of East Lothian Council's website, or contact the Recruitment Line on **01620 827825** quoting Ref. No. 5494CMS to receive an information pack.*

Closing date is 14th February 2005.

www.eastlothian.gov.uk/vacancies/index.htm

Heart of Birmingham Teaching NHS
Primary Care Trust

One of only 30 UK PCTs with teaching status. Heart of Birmingham is harnessing the power of people. By recognising everyone's potential, we can make progress in improving the health of the diverse local community we serve.

progress through people

A focus at the heart of the community

Community Drugs Co-ordinator

Fixed Term Contract or Secondment - 12 months

£25,871 - £27,969 pa

37 hours a week

Summerhill Day Centre

If your ability to network across professional and institutional boundaries is combined with awareness of the diverse needs of a multicultural population, this influential appointment represents an exciting developmental opportunity; particularly if you're currently working in the treatment field and want to gain experience in a more community orientated role.

As a focal point for our activities in the Ladywood area, you'll establish both formal and informal relationships on the ground with agencies involved in tackling drugs - improving signposting and access to services, and working with the community to develop our capacity to provide a response to drug use.

This will involve you in the creation of a Ladywood Drugs Forum and the identification of funding sources for a range of drugs projects. Importantly, you'll also liaise with many sections of the community to gain an understanding of needs, then work with treatment providers to ensure they are met.

We'll be looking for a professional qualification in social work, probation, mental health or youth and community work, plus two years' relevant experience. Alternatively, you could have at least five years' experience in a drug and alcohol treatment setting. Whatever your background, you will need excellent communication skills, an understanding of community development techniques, and up-to-date knowledge of therapies, treatment and aftercare programmes relating to drug use.

For further information please contact Ian Mather on 0121 224 4633.

For an application form please visit our website www.hobtpct.nhs.uk contact the Human Resources Department on 0121 224 4676 or email HR.Recruitment@hobtpct.nhs.uk quoting reference 30/05.

Closing date: 22nd February 2005.

The Trust is committed to Equal Opportunities in Employment

www.hobtpct.nhs.uk

addaction

The leading drug and alcohol charity.

Helping individuals and communities to manage the effects of drug and alcohol misuse.

To apply please call Kelly Berkeley on 020 7017 2723 or email k.berkeley@addaction.org.uk quoting the appropriate reference.

Closing date: 28 February 2005

Addaction is an equal opportunities employer.

Charity no: 1001957

established 1967

www.addaction.org.uk

Project Worker

Impact Young People's Service

£19,300 - £25,300 pa • North London **Ref: ADD LA17**

Impact offers drug prevention and early intervention work with vulnerable young people, aged 11 to 21 years, who live in the boroughs of Camden and Islington.

Your role will be to provide young people with packages of care and treatment to enable them to address and overcome substance misuse. You will offer advice, information, support and referral when needed, and offer counselling to service users. You should possess good communication skills and a proven background in the drug or related field. Experience of working with young people is also required.

EXCITING NEW PROJECT.

The NEXT project is a new and unique, post-treatment service for ex-drug users who think they may want to work in the drug field. We are recruiting two full time training staff to join our team in order to develop and deliver this project. While both roles will involve delivering foundation training, guided support and experiential group work, each will have its own additional focus:

Training and Assessment Worker

£22,800 - £24,900 pa • London EC1M **Ref: ADD LA18**

You will be responsible for gaining referrals into the programme and for assessing the suitability of potential participants.

Training and Employment Liaison Worker

£22,800 - £24,900 pa • London EC1M **Ref: ADD LA19**

You will be responsible for developing links with education, training and employment agencies and will ensure that participants will be able to take advantage of 'move on' opportunities to maintain a drug and alcohol free lifestyle.

Successful candidates will ideally have a background in the substance misuse field and will have the ability to design and deliver training material. Additionally, will have a good understanding of issues facing drug misusers.

Association of London Government

EUROPEAN UNION

All applicants are expected to have an understanding of equal opportunities and the ability to work effectively with people from a range of culturally diverse backgrounds is needed for all posts.

Hatton Chase recruitment & training

Project Officer

(Enhanced Arrest Referral Officer) Based in North West London

You will be required to promote awareness of the Arrest Referral Scheme with police officers and other criminal justice agencies and to provide an initial assessment in order to determine the most appropriate intervention. You will also be required to provide harm reduction/risk reduction advice to clients who have been referred to the scheme. You are required to have at least 6 months experience working in a substance misuse service provision. It would be desirable if you have experience in a criminal justice setting. This role is a Temp to Perm position for which the permanent position is paying £20,000 and £27,000 YOU MUST HAVE AN ENHANCED CRB CHECK

Project Officer

(lead for stimulant/crack services)

You will be required to provide advice and support to the organisations clients. You will be expected to deliver stimulant/crack specific interventions and services to clients. You will also be required to provide training and presentations to other service providers. You must have one years experience in a substance misuse provision and specific knowledge relating to stimulant/crack users. This is a Permanent role paying £25,000 and £31,000

6 x After Care Workers and 5 Project Officers

(based in East London)

A large substance misuse organisation requires several after care workers to work within a newly formed day programme. Some experience in substance misuse is required. The job description is still being reviewed but if you are interested please forward your CV for further details. Salary is between £20,000 and £27,000

Care Manager (Rehabilitation Centre)

You will be responsible for managing a 15 bed rehabilitation unit. It is important that you have 2nd stage rehabilitation experience. This exciting opportunity is based in Pinner in Middlesex. You will responsible for managing four staff members. The salary for this vacancy is £27,000 - £34,000

To enquire about any of these roles, contact 020 7463 2068 or email your CV to drugmisuse@hattonchase.co.uk

Advanced Counsellor Training for established counsellors

PROMIS
Counselling Centre
7-11 Kendrick Mews
London SW7 3HG
Tel: 020 7581 8222

1 to 1 Group therapy Psychodrama
Thursday evenings, 6.00 p.m. to 7.00 p.m.
£30.00 per session **Dr Robert Lefever**

THE PRIORY CLINIC NOTTINGHAM

Bank Therapists

We are currently recruiting bank therapists for holiday and sickness cover. Successful applicants will have:

- Minimum 2 years experience in a substance misuse setting
- Experience of facilitating group therapy
- A good working knowledge of 12 step addiction work
- FDAP accreditation or similar

Please contact Audrey Lowery, Clinical Services Manager on 0115-969-3388 for further details and an application form.

department for
education and skills
creating opportunity, releasing potential, achieving excellence

Tackling drugs

Consultant Advisors to support the Government's national drugs strategy for young people

£365 per day

The Department for Education and Skills, supported by the Home Office and Department of Health are seeking to engage a number of consultants based across the country. Working directly with local authorities and others they will support their delivery of the Government's national drugs strategy for young people in 30 'high focus' local authority areas.

The consultants will help local children and young people services and drugs and crime partnerships work together to plan and implement effective drugs prevention, early intervention and treatment for young people and their families. They will work with local authorities and other partners first to identify the challenges they are facing in providing effective services. They will then support them in taking action to improve planning, commissioning and front-line delivery of services, to implement the national drugs strategy for young people and to build capacity for sustained improvement. This may include more focused work to support specific delivery areas such as assessment and case management arrangements.

Consultants will be based locally but, depending on where they live, will work with local authorities on a regional basis. In doing so, they will liaise closely with the appropriate Government Office regional teams. The work will be done on an individual basis or as part of small consultant teams, depending on the needs of the local area.

Applications are sought from experienced individuals who have:

- a good understanding of the workings of local authority children's services, with particular experience of drug misuse services; experience of inter-agency working across early years, health and family social care;
- a sound knowledge of effective organisational structures and change management;
- expertise in quality assurance and improvement;
- a good working knowledge of project management principles and business planning;
- strong negotiation and interpersonal skills.

In return the DfES is offering the opportunity to work at the heart of public sector challenge and change. Successful applicants will be engaged in a contract for service at a flat rate of £365 per day, for up to 60 days a year, depending on the level of experience and knowledge - although a minimum number of days cannot be guaranteed. Contracts are expected to commence from April 2005 and run until March 2006, when they will be reviewed.

For an application pack, including a skills specification and details of conditions, please contact Ross Tomlin on 020 7273 4932 or e-mail ross.tomlin@dfes.gsi.gov.uk

For more information regarding these opportunities, please contact Rhian Stone on 020 7273 5730 or e-mail rhian.stone@dfes.gsi.gov.uk

Closing date for applications is 27 February 2005 and interviews are expected to be held in March.

THE DFES IS COMMITTED TO BEING AN EQUALITY OF OPPORTUNITY EMPLOYER AND APPOINTMENTS ARE BASED ON MERIT IN OPEN AND FAIR COMPETITION. ALL APPLICANTS ARE TREATED EQUALLY REGARDLESS OF AGE, DISABILITY, ETHNIC ORIGIN, GENDER, MARITAL STATUS, RELIGION OR SEXUAL ORIENTATION.

edp
EDP drug & alcohol services

EDP Drug and Alcohol Services is a vibrant, forward thinking organisation committed to evidencing the highest standard of service provision and outcomes for those that use our services.

Head of North Devon Adult Services

- **Ref: 29/04**
- **Hours: 35 Per week**
- **Salary: (NJC Scale 37-40 - £27,370-£29,865)**
- **Holiday: 25 Days rising to 30 Days**
- **5% employer contribution pension**

EDP Services in North Devon is a non-statutory provision providing tier two and tier three support to adults across a wide, mainly rural, area. We are looking for an effective manager who can both consolidate the work of a relatively new service and drive it forward in line with local and national strategy.

You will be strongly committed to the highest standard of professional practice and partnership working. You will have experience of the substance misuse field, day-to-day management of staff and project management. In return we will provide you with the appropriate training, supervision and support as well as the opportunity to further your career by working for a leading Devon drug and alcohol service provider.

Closing Date: 22 February 2005 *Interview Date: 1 March 2005*

For an application pack please write enclosing an A4 SAE (£1.01) to *Georgina Burford, Human Resources Assistant, EDP – Drug & Alcohol Services, Dean Clarke House, Southernhay East, Exeter, EX1 1PQ* or alternatively email *recruitment@edp.eurobell.co.uk* quoting the reference number.

For an informal discussion contact *Lucie Hartley, Director of Client Services*, on *01392 666723* following receipt of job pack.

EDP – Drug & Alcohol Services always welcome applications from people with experience in the field of substance misuse, please send your CV to *Georgina Burford, Human Resources Assistant* at the above address.

EDP is committed to equality of opportunity, aiming for the widest possible diversity in its workforce drawing recruits from every part of the community. In accordance with the Police Act 1997 this posts is subject to disclosure through the CRB. A criminal record is not necessarily a bar to employment in these posts.

INVESTORS IN PEOPLE UK