From FDAP in association with WIRED

DDN
Drink and Drugs News

25 July 2005
www.drinkanddrugs.net

DIAMORPHINE CRISIS
National problem – local tragedy

TACTICAL TIMING
UK drugs report lost in the crowd

CANNABIS CLASSIFICATION
The crucial questions

LANGUAGE BARRIER
Has FRANK lost its focus?

UKAS accredited drug testing

TrichoTech
Leaders in drug testing

Hair Analysis:

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- Ideal for matching self-reporting with actual drug history before, during and after treatment
- Used by over 120 clinics and hospitals, most local authorities, police and health professionals
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- Simple and quick to collect with high donor tolerance

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UKAS TESTING

TrichoTech is the only UK laboratory to have UKAS accreditation for drug testing hair, saliva and urine. (certificate 2212)

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Drink and Drugs News

25 July 2005

Editor's letter

We've got a packed DDN for you – because there's so much to say before we take a break for four weeks in August.

The crucial issues won't wait. The diamorphine crisis, spelled out in our 27 June issue, is getting worse by the minute for those caught up in it, and it's affecting more than just a handful of patients. The medical profession, user groups and the DAT joined forces months ago in Cornwall, to campaign for swift resolution, and the stalemate is astonishing (page 9). Can anyone shed light on why it's taking so long to get supplies resumed?

This edition's bursting at the staples with pressing policy issues – not least why the government's findings on drug policy effectiveness have been shuffled past us. Steve Rolles from the Transform Drug Policy Foundation raises a challenge for clarity – and where necessary – revision.

On the steadily rumbling cannabis reclassification debate, Neil Hunt offers fresh thought and a useful set of questions to encourage an evidence based approach (page 16).

And we've got lively and thought-provoking contributions from the voluntary sector – energy, enthusiasm and inspiration from T.H.O.M.A.S. (page 15); a call to win public and politicians' hearts and minds from Addaction's Peter Martin (page 12); and excellent intervention and support from FSU Scotland (page 14).

With many and varied messages for teenagers to choose from, our cover story homes in on the government's FRANK campaign that aims to communicate drug safety to young people. As Jonathan Akwue demonstrates, it's not just what you say, but the way you say it.

See you on Monday 5 September – and don't forget to keep sending your news, comments and letters – we're waiting to hear from you!

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In this issue

Media watch

Bad news for fans of psychedelic fungi: a legal loophole that allowed people to buy and sell fresh forms of magic mushrooms has been closed. Although there has been a long-standing ban on dry or packaged magic mushrooms, it did not apply to fresh forms, allowing them to be sold in shops, on stalls and online.
The Guardian, 18 July

Fearing an AIDS epidemic, Iran's theocratic government has dropped a zero-tolerance policy against increasingly common heroin use and now offers addicts low-cost needles, methadone and a measure of social acceptance. Opponents argue that tolerance of life-destroying drugs is simply unacceptable and in the long run breeds acceptance and higher drug use. But in the theocracy's most dramatic rejection of that approach, the ayatollah who heads Iran's conservative judiciary issued an executive order embracing 'such needed and fruitful programs' as needle exchanges and methadone maintenance.
The Washington Post, 5 July

Students may be well known for their love of drinking, but two students from Edinburgh are preparing to deliver a very different message as part of a national campaign. The young filmmakers' advert will be shown to cinema audiences in Edinburgh as part of the Scottish Executive's drive against alcohol misuse. A group of young people are shown staggering out of a bar, before being attacked by zombies, being sick and getting involved in fights. The film has been chosen to front the 'Don't let too much drink spoil a good night out' campaign.
The Scotsman, 14 July

Confusion over the legal status of cannabis may have led young people to believe it is okay for them to use it, according to Fiona Bryson, co-ordinator of the Peer Education Project, which teaches older children to give information to younger pupils. The reclassification of cannabis from Class B to Class C status had left many young people with the impression that possession for personal use was allowed, she said, following the release of figures from Tayside Police showing the number of 11- to 16-year-olds charged with drug offences has more than doubled between 2002 and last year.
Dundee Evening Telegraph, 12 July

A teenage tearaway was given an Asbo ordering him to get drunk and misbehave in a court blunder. An administrative mistake meant the wording of the order – made last February after a string of complaints – reads 'without' rather than 'with'. The error was only noticed when the 15-year-old ended up in front of magistrates again for an alleged breach of the conditions, but as the boy was not technically in breach of the previous order, he has escaped any punishment.
The Daily Mirror, 18 July

Bob Geldof's daughter Peaches, has hit out at claims that she whispered sexually explicit words in to the ear of Babyshambles frontman Pete Doherty, just before he took to the stage at the London Live 8 concert. 'He really plays up to the 'cracked-out loser' thing. He was fine before he went on stage but, once he was there, he transformed into this shambolic drug-addled circus freak,' she said.
The Hollywood News, 11 July

NTA asks service users for 'your say' on treatment

The National Treatment Agency has announced the largest ever client satisfaction survey of drug users in treatment, with the aim of improving effective services and retention rates.

Questionnaires will be sent out between 1 and 5 August to clients attending over 1,000 treatment services in England. Clients will be able to respond by completing an online form on the NTA's website, www.nta.nhs.uk.

Opinion will be invited on care planning, through care and prescribing, as well as treatment services and staff. NTA research manager, David Best, said it was 'an excellent opportunity for service users to tell us what's good or bad about the treatment they are receiving, which, in turn, will enable us to respond by improving and developing treatment services to meet users' needs.' The survey is the latest initiative to give clients a say in planning their treatment.

In its business plan 2005/06, just released, the NTA reports that it has successfully delivered the primary objectives set for its first four years. These include treatment numbers on track to double by 2008; waiting times reduced by an average 9.5 weeks to 2.5 weeks; the drug treatment workforce increased to 10,025, and implementation of Models of Care.

Focus for the next three years will be the treatment effectiveness strategy, launched on 30 June (*DDN*, 11 July, page 7).

Lifebuoy offers rescue to rural drug addicts

A new progressive rehab service has opened in the Wye Valley, close to Ross-on-Wye. It is the latest venture by Lifebuoy to address drug addiction in rural market towns, 'where drugs had quickly proliferated, but where the services needed to help and address the issues had simply not been created,' according to project manager, John Cooper. Programme modules will take advantage of the location, with dry stone walling, painting and decorating and outdoor pursuits.

Cases of liver disease double in almost ten years

Alcoholic liver disease has almost doubled in the last ten years, according to Department of Health figures.

Doctors are treating more people in their 20s and 30s, who are suffering the effects of heavy drinking normally seen in patients 30 years older.

Cases admitted to hospital rose from 10,903 in 1996-97 to 20,779 in 2003-04. The average length of the patient's hospital stay has increased by two days, to nearly two weeks and costs the health service in England more than £71m a year.

The increase is a result of Britain's binge drinking culture, according to the Portman Group and Alcohol Concern, which pointed out that figures contradict trends in the rest of Europe. Health spokesman for the Liberal Democrats, Steve Webb, said figures proved that the government's new licensing laws had been introduced too quickly, with an emphasis on law and order instead of health.

The medical profession warned that figures would get worse if government did not take consequences of alcohol seriously.

Southend's Mayor, Cllr Dandridge samples auricular aromatherapy, on a visit to South Essex Partnership NHS Trust's community drug and alcohol services. The drop-in service offers acupuncture to relieve symptoms of withdrawal, including nausia, cravings, headaches, sweating, muscle cramps and insomnia. Service users also report that it reduces depression and anxiety and can help them back to mental and physical stability.

Training conference – RCGP Certificate in the Management of Drug Misuse

GPs hear impact of social policy on drug users

The latest special interest day in the RCGP's Certificate in the Management of Drug Misuse Training Programme, held in Sheffield on 12 July, focused on social policy and drug users. Speakers gave updates and guidance on pregnancy, childcare, child protection, working with families, housing and benefits. We give a taster of their presentations.

Dr Chris Ford, member of the Substance Misuse Unit Executive Committee and GP adviser to SMMGP, chaired the training day in Sheffield.

'The day was full of energy and commitment, discussing very important and difficult but often neglected areas of work. It was truly multidisciplinary and the highlight for me was Michelle talking about her own personal experience, accompanied by her amazing 15-month-old daughter. She was open and frank about what helped and what didn't, providing us with the opportunity to improve.'

Annie Darby OBE is RCGP's national nurse lead (substance misuse). She gave a presentation about the needs of children who live with drug using parents, based on recent evidence and her experience as a specialist health visitor.

'The needs of children who live with drug users have until recently been low on the alcohol and drugs agenda. The report done by the ACMD in 2003, *Hidden Harm* was aptly named because these children keep their problems hidden, and are invisible to services and professionals. This can make them very vulnerable and isolated.

Many of these children become Young Carers, often caring for the parent and younger siblings. Whilst there are many children who care for a parent with a chronic health condition or disability, and that is always difficult, these children will undertake their caring role in isolation, with no input from agencies or professionals, particularly because of the stigma attached to drug misuse.

As one child said to me recently, who was having trouble with his teacher due to late attendance, "what do I say? I can't say I'm late because my mums a smackhead, so I made something up".

Supporting children and families is essential, and is preventative if we are to stop these children becoming the drug and alcohol users of tomorrow. At present there are very few services in the UK that are specifically focused on the needs of these children, with just a few examples of very good innovative practice.

This has to change, we have to support these children, because at the moment the current situation is best described by a child who told me: "You look after my mum and Dad, but what about me, I'm the one looking after all of them".'

Dr Mary Hepburn, consultant obstetrician in Glasgow, talked about managing pregnancy in women who use drugs.

'Substance misuse during pregnancy adversely affects outcomes both medically and socially. However the drugs commonly used in the UK have few direct effects on pregnancy and most of these adverse outcomes are due to underlying socio-economic deprivation aggravated by the lifestyle associated with drug use. Nevertheless women with problem drug and/or alcohol use have potentially high-risk pregnancies. Their management should therefore be obstetrically led but much of their care can be delivered by midwives. Such women also have difficulties in attending services so it is important that they are provided with multidisciplinary care, preferably community based, that addresses all their problems both medical and social, within a single service.

It is important to introduce social services early in pregnancy but in a preventive and supportive rather than punitive role. If child protection issues are identified these should be dealt with in the usual way. The aim of management is stability rather than abstinence and objectives should be realistic and achievable.

All drug using women should be encouraged to breast feed regardless of drugs used, patterns or levels of use. The women need information about appropriate contraception which should be commenced before postnatal discharge. Although important for all women, continuity in reproductive health care provision is vital for this vulnerable group of women. This will enable them to protect and control their fertility and to have pregnancies if and/or when they choose.

Experience from a number of centres shows that if provided with appropriate services that they are willing and able to use, drug using women will attend early and regularly for maternity care thus giving them the best chance of good outcomes, both medical and social.'

Kate Halliday of SMMGP talked about Hidden Harm in the context of current childcare legislation and policy, and how primary care practitioners should consider responding to the report's recommendations.

'*Hidden Harm* (2003), The Advisory Council on Misuse of Drugs' report has begun to influence the drugs field's approach to our responsibility to the children of drug users. While the report is unequivocal in its assertion that many drug users are good parents, it does establish a clear link between problem drug use and harm to children.

Implications of the new Children Act 2004 may affect practice, together with the influence of Hidden Harm. In future, practitioners in the drugs field are likely to be taking a greater responsibility for assessing the needs of children of their clients, and working with other agencies to prevent the potential harm to children of problem parental drug use.'

Katy Swaine, head of legal services at Release, explained the law and process behind housing and benefits applications, and how the GP's role fits in with that process.

'Problems such as debt, inadequate income and poor housing or homelessness create added pressure for those coping with drug dependency. It can be very difficult for drug users to access the type of professional help that can be required to address these legal issues. Providing accessible legal assistance with these fundamental issues can therefore be key to harm reduction.

The Release legal team has successfully provided legal outreach services within drug projects in London for over 15 years. We are currently under contract with three London drug agencies to provide free legal advice and assistance to their clients. The service is provided by our qualified lawyers, through weekly drop-in sessions and follow-up work back in the Release office. Clients are also able to access us by telephone or email.

The service is intended to cover situations where clients cannot obtain legally aided advice and assistance, and to make it easier for them to access such assistance by providing regular face-to-face contact with our advisors within a convenient, familiar setting.

Many of the enquiries we receive relate to problems with incapacity benefits and housing. Information from GPs and other health and social work professionals is often crucial to the success or failure of benefits and housing applications and appeals.

Housing and benefits problems are regularly grappled with by many drug treatment professionals on behalf of their clients. This is an area of real concern due to the massive impact such problems can have on an individual's wellbeing and their progress in treatment.

Vivienne Evans, chief executive of leading family support agency Adfam, discussed the role families play in supporting and caring for problematic drug users.

'Family' means any person in a close and supportive relationship with a drug user. We need to recognise the importance of the role of families, and that families need support in their own right, not just as the carer of the user. Despite a body of evidence on the impact of alcohol misuse on the family, research into the impact of illicit drug misuse is limited.

There is growing concern about the needs of families affected by drug use and the best way of meeting those needs. Drug misuse affects the entire family and the communities in which these families live. The needs of these families, however, are not well known or documented.

Despite research which indicates that engaging families improves treatment outcomes, arrests declining family health and improves the impact of drugs education, families affected by problems with drugs continue to be at best condescended to or, at worst, actively excluded. Shame, guilt and isolation are common experiences, matched with a constant struggle with the daily trauma of problematic drug use.

Primary care professionals have a key role to play in combating this stigma by promoting the need to support these families and acknowledge their needs, and making appropriate referrals to support agencies.

Is FRANK losing it?

Has the government's FRANK campaign lost its original focus? Jonathan Akwue examines the issues – and the pitfalls – involved in trying to communicate drug safety information to young people.

FRANK is the national campaign that was launched by the government in May 2003 in a flurry of media attention. For once the hype surrounding it appeared justified because although it attracted criticism in some quarters for projecting an image that might only appeal to white men, the television advertisements that were used to launch the campaign broke new ground by successfully using humour to convey its message – a first for a health promotion campaign from the government, and all the more surprising given the sensitive nature of the debate about drugs in this country. A Home Office spokesperson on FRANK explained the rationale:

'Before the campaign was launched extensive research was carried out with young people, parents and stakeholders to ensure FRANK was the most approachable and effective service for people wanting in the facts about drugs.'

You need to consider the style of government sponsored drug campaigns that had come before to appreciate the size of the departure that the FRANK campaign represented. These ranged from the scare tactics of the 'Just say no' campaign featuring heroin addicted 'Zamo' from Grange Hill in the 1980s, to more recent Dance Safely promotions that featured factual, but bland information about drugs. The message was clear – drugs are no laughing matter. FRANK changed all this with TV ads featuring people hugging lampposts on ecstasy, and getting knocked over by curling balls while stoned. The tone was irreverent, tongue in cheek and 'knowing'. They achieved the almost impossible feat for any government campaign of saying 'we know what's going on', whilst underlining the point that taking drugs is illegal, talking about them isn't.

The approach clearly worked. Calls to the FRANK helpline (formerly the National Drug Helpline) went through the roof, and research showed that in the 12 months following the campaign's launch the numbers of young people who recognised the FRANK logo and could recall the ads was as high as 59 per cent.

Despite this early success, more recently – like the characters in its ads – FRANK seems to be losing the plot. There are several contributing reasons for this, the first was the decision made right at the start of the campaign not to control FRANK's brand image.

To ensure that FRANK became known as widely as possible, the government released a resource pack containing FRANK logo templates and press releases that could be adapted for local use. The aim was to create 'viral' marketing campaigns where the FRANK brand could trickle through local networks and become part of youth culture. The problem with this approach was that the people responsible for developing these local campaigns were not likely to be experienced creatives, or even young people, but were more often than not, hard pressed commissioners, or local drug services. This meant that the quality of work produced was bound to vary widely, but all of it would bear the FRANK logo.

FRANK has ended up in a number of places, but with no quality control, the brand has started to lose its unique voice. The annual FRANK national stakeholder awards tries to offset this by promoting the most innovative and well designed examples of

'Recent FRANK Action Updates covering topics such as Substance Misuse in the Workplace provide useful information but also include ill-conceived crossword puzzles and quizzes... The problem is compounded on the website, where

materials bearing the FRANK logo, but as Liz Wakefield of Hey Moscow, the winner of last year's award comments:

'Few DATs have a marketing strategy that sets out exactly what will be achieved and how it will be measured. Little research is done into local attitudes and needs. Promotions are handled by a wide range of people spanning junior to senior, and often people leave and are not replaced for some time. This lack of planning and continuity doesn't match up to the communications challenge, especially when you consider the life changing decisions required by heavy users we want to engage with services.'

Despite attempts to promote good design practice, once the brand genie has been let out of the box, it is impossible to put back in. Can you imagine a major commercial brand letting go of control in the same way?

A second problem with the campaign is that alongside losing its unique voice, FRANK seems to have lost his sense of humour. Recent FRANK Action Updates covering topics such as Substance Misuse in the Workplace provide useful information but also include ill-conceived crossword puzzles and quizzes with questions such as:

Who should you speak to for friendly, confidential drugs advice?
A Your Grandma
B FRANK (0800 77 66 00)
C Your boss
D Bill Clinton

visitors are encouraged to identify their 'Tribe'. Choices include 'Geeks', 'Scallies', 'Gangstas', and 'Townies'. The result is a pointless quiz that tries to recapture that sense of being 'in the know', but fails hopelessly.'

Although admittedly this publication is not aimed directly at young people, by any definition, this is simply not funny. The problem is compounded on the website, where visitors are encouraged to identify their 'Tribe'. Choices include 'Geeks', 'Scallies', 'Gangstas', and 'Townies'. The result is a pointless quiz that tries to recapture that sense of being 'in the know', but fails hopelessly. The government's recently published review of FRANK points to the 1.5 million visits to the FRANK website in the first 12 months, but the same report highlights that less half of young people (47 per cent) believe that the people who work at FRANK really know what they are talking about.

Another criticism levelled at FRANK from the start, was that by choosing the name FRANK, the brand identity would be associated with white males and thereby exclude other sections of the community. Although I understand the thinking behind this argument, I think creating a more 'politically correct' character would have left the government open to the charge of stereotyping minority communities. The key challenge was to see how well could FRANK translate its straight talking, irreverent approach to communicate with women, people from ethnic communities, and other groups. The answer appears to be mixed.

Some of FRANK's campaigns have targeted young women in novel ways (such as the 'ambient media' materials produced for clubs and bars). However, its response to ethnic communities (largely based on translating materials into other languages) has yet to display any real imagination.

Beyond ethnicity, there are question marks as to whether FRANK is communicating effectively with the most socially excluded young people. Research undertaken by In-volve, a national organisation that successfully engages some of the hardest to reach young people, suggested that although many of them could still remember the TV ads, very few of them said they would call the FRANK helpline, and none of them had accessed the website.

So what can we learn from FRANK? I think the government should be congratulated for attempting to launch a credible brand and revolutionising the way that drugs advice is delivered in the UK. However, I think it's also clear that by not carefully managing the brand, FRANK has lost some of its original integrity.

The successes and failures of the FRANK campaign provide several pointers for those of us wanting to communicate health promotion messages to the general public and young people in particular. These can be summed up in three key points.

Recognise the need for authenticity
Essentially each brand is a promise. That promise must remain consistent at every point of contact, as this is what makes a brand authentic. By not prioritising communications or establishing a quality measurement system at a local level, the government has allowed FRANK's authenticity to diminish. You don't know what FRANK you are going to come across these days, and that is a major problem.

If you are going to try to be funny – be funny
Humour is a great way of communicating, but it can be a high-risk strategy. We've all met people who think they are funny but aren't – we generally avoid those people. Advertisements are no different. Ill judged attempts at humour, or trying to be on the level with 'youf' culture can backfire dramatically.

Be honest
Recognise the fact that many young people consider drugs cool, and telling them not to take them isn't. Communicate honestly with your target audience. That was the strength of the original FRANK ads. The best ones were those that expressed an essential truth about drugs in an exaggerated (and humourous) way. Whenever you begin diluting the truth to accommodate more socially acceptable messages, your audience will switch off.

Despite the criticisms, the Home Office remain convinced that the FRANK campaign is working. Their spokesman points out that:

'Since its launch in 2003 there have been over 6 million visits to the website and nearly 900,000 calls have been made to the helpline. In addition to this FRANK has seen fantastic support from stakeholders with over 5000 registered for the campaign at www.drugs.gov.uk and 92 per cent of them happy with the service FRANK offers.'

Whatever your view of FRANK, it is clear that communicating effectively with diverse audiences takes a lot of thought, skillful planning and implementation. Given the importance of the message, it is critical that the same level of creativity is given to promoting public health messages as that which goes into the selling of commercial products. After all, a tin of baked beans won't save your life, but a well-timed message, delivered in the right way, just might.

Jonathan Akwue is business director for In-volve and strategic communications adviser to the Federation of Black and Asian Drug & Alcohol workers. He has over 10 years experience of working in the creative industries and the social care field. In that time he has developed a wide range of campaigns aimed at 'hard to reach' groups. He has recently launched Rat Park; a new communications agency that develops marketing strategies in line with the principles outlined in this article. If you would like to find out more about Rat Park's approach, you can email him at akwue@in-volve.org.uk.

Re the effectiveness strategy:

Although I applaud the NTA for trying to tackle quality, I feel they have again missed the target. As an aim, bringing down waiting lists was helpful and was successful in some areas. But it had negative effects in many others, where treatment was reduced to enforced detoxes to keep waiting lists down and removed choice from many.

Increasing capacity was also helpful, as an aim – but not if this capacity was achieved by poor care, burnt out workers and underdosing. Aiming to increase retention is useful, but is this possible in a system that has retention rates varying between 21-98 per cent? Oh, you say – who has retention figures of 98 per cent? That for me is another problem of the strategy – it does not mention the role of primary care. We are different – we tend to retain people wherever they are 'on their journey' in treatment. Many people are still registered from birth to death, sometimes (even in London) with the same GP; if not, usually with a small number, whether they are drug users or diabetics.

Our retention figures for the whole of the year (not 12 weeks which seems to me to be an extremely short time) for drug users was 98 per cent and none of these were just 'sitting on a methadone script'. Some were on maintenance but changing over areas of their lives, some were undergoing or had completed detox and others were in day programmes; BUT all still remained registered with us wherever they were on their 'journey'.

We have close and valuable links with housing, open access services, the local care and assessment teams and back to work schemes, all of whom we could not do without, BUT we remain the key agency for that person. Is their commitment to helping people on their journey through treatment other words for throughput, enforced abstinence (I totally support abstinence by choice with help – but enforced, no) and a return to thinking of the 1980s?

Another anxiety about the strategy being launched at the same time as Blunkett announcing that drug users need to go into rehab or their benefits will be stopped, and a continued push on the criminal justice agenda, is: are we also moving towards the US model of drug treatment? My role as a doctor is, by involving the patient in all decisions and at every point, to help people improve their health and well-being, whether they have asthma, heart disease or a drug problem – not to punish. People who use drugs are like other people and cannot be wrapped into nice little parcels and shunted around from one place to another.

I worry there appears to be an implicit drive against long-term treatment. I am struck by how the strategy is couched, with the phrase 'abandoned on maintenance' at the forefront. Good methadone maintenance treatment is anything BUT an abandonment. Is the concern really – and perhaps legitimately – about the financial cost of potentially long-term treatment for hundreds of thousands of people? I am worried about how assertive patient management (towards reduction, towards abstinence, towards work, towards whatever) could destabilise patients, if that is what is being proposed.

Dr Chris Ford

Wanted: advice from other service user groups

Recently you have run a few articles on service user groups.

Myself and a few others are in the process of attempting to form an SUG (we're ex-service users of ARC in Manchester). At present we are trying to establish our aims and objectives and a constitution for our group.

At present we have no name, a few keen members and the will to succeed in this venture.

I would be very interested to hear from other SUGs as we would like to learn from the experience of others.

We would benefit from a little guidance for our fledgling group and would like to be added to the subscription list for other groups' magazines. We need to maintain our group's enthusiasm, and have a basic desire to establish connections with others.

We realise from your articles that in time we can acquire funding, training and influence, but at present I/we would appreciate any advice on group cohesion, direction and longevity so we may soon find a voice and one day may be heard.

David Jones, Manchester

If you are involved with a service user group and can give David any advice, please contact him at david-jones1@amserve.com or write to him c/o DDN at the address in the front of the magazine.

Comment

Clinical supervision is much-needed and overdue, says Sue Fletcher

Clinical supervision is a formal process of professional support and learning which enables practitioners to develop and enhance their future practice, knowledge and competence assuming responsibility for their own practice (Vision for the Future, DoH 1993)

Preparation and training for clinical support is seen as essential, the ability to provide and participate is not an innate skill and it does have to be learnt (Good Practice Guide 1998)

As a substance misuse practitioner working with young women in a custodial establishment, my work colleagues and I often requested clinical supervision. It was not available then and for countless workers remains unavailable now.

Yet put a group of workers together and invariably the subject is often under discussion, ask staff whether they would like clinical supervision – undoubtedly the answer is yes. Ask how many actually receive it, and the answer is 'very few'.

Substance misuse workers – whether they are working in the community, in custodial settings or in rehabs – are usually working within a turbulent environment. As we are all aware, sessions with clients may contain disclosures on physical abuse, sexual abuse, child protection issues, self-harm, destructive behaviours, mental health, dual diagnosis, homelessness, domestic violence, indeed there are a myriad of issues, which may be raised. There may also be times when the worker feels compromised or could be subjected to grooming. We encounter complex issues on a daily basis working with vulnerable clients, whose drug and alcohol use is controlling not only their lives but also their families, often resulting in hidden harm. The content of our work and the impact on our workers must surely determine the need for quality supervision with a qualified supervisor.

I believe that substance misuse workers should be given the recognition that as professionals, who working alongside their health and counselling colleagues within the care profession, they are entitled to, and should be offered clinical supervision.

There seems to be a clear division of opinion around clinical supervision, what it means and what it offers. I am now employed as a manager and I want to ensure we have the means for staff to access this service, whether we call it clinical supervision or clinical support.

I do not mean line management, which again leads to misinterpretation – many believe that staff are receiving sufficient supervision. I believe both should be available, and without doubt the clinical supervisor's role should be independent of the line management role.

We tend to work in multi-disciplinary settings and I myself am aware of a team employed by different agencies. Within that team some staff receive clinical supervision and others do not, determined by who employed them. Is this the way to achieve truly effective multi disciplinary team working?

I would say this highlights precisely why we need to raise the issue and ensure that no matter who you work for, clinical supervision is included in your contract of employment.

Certainly there are cost and time implications, but ultimately if it results in employees feeling valued and supported and helps prevent staff burn out, it will only be beneficial.

Supervision provides a protected time where staff can reflect on their practice enabling them to develop their knowledge. By this means, they can maintain and improve the quality of care for clients in a confidential environment. I feel this echoes our ethos for our clients – protected time during which we can explore and discuss their wellbeing within a confidential setting.

It is now time for a national supervision strategy, offering clear guidance to ensure a standardised approach across both statutory and non-statutory agencies.

Sue Fletcher is substance misuse manager, Juvenile Group, at Bullwood Hall, Cookham Wood and Downview

UK Diamorphine shortage: an unfolding tragedy

Since the Department of Health announced a critical shortage of injectable heroin in December 2004, hundreds of patients have been left waiting, in agonising circumstances. Sally Cook, Rupert White, Alison Owen and Adrian Flynn spell out what it means for clients in their area, and express their overwhelming frustration at being stuck in a crisis without any sign of a resolution.

Since the factory of the main UK manufacturer shut down production of injectable diamorphine at Christmas, any remaining supplies have largely been reserved for the hospitals. As a consequence there has been an unprecedented shortage in the community, which has impacted most on heroin users receiving injectable diamorphine as a treatment for their heroin dependency.

According to the NTA (2003) there are 450 such individuals across the country. Because injectable diamorphine as a treatment is reserved for those who have not responded to other interventions, although 450 is a relatively small number, it includes the most disadvantaged and psychologically damaged drug users in the country, and therefore, arguably, some of the most vulnerable individuals in the UK. In addition, heroin use by any one of these individuals has the potential to affect many others.

In Cornwall there were 51 individuals receiving diamorphine by injection. As described in a letter to the journal *Addiction* (forthcoming), nearly all (43) were converted to methadone within a few days of the supplies running out. A brief survey of these clients carried out two months later demonstrated that side effects and withdrawal problems during the conversion, which persisted despite dose adjustments, were apparent in 41. More importantly it revealed, perhaps not surprisingly, that 35 of the 41 had relapsed or increased their heroin use substantially.

Converting the majority of these clients to diamorphine tablets improved the situation somewhat, but because of a lack of guidance and support from the centre, and a lack of transparency from the manufacturers themselves, it was, and continues to be, extremely difficult to plan safe and effective treatment. In particular there has been no indication of when, or even if, supplies will return to normal, and the small supplies that are being made available are insufficient to provide the stability that is the key to good prescribing to substance misusers.

The whole episode has been like watching a tragedy unfold, a tragedy that was almost certainly preventable, and yet we have felt powerless to do anything. In Cornwall we have written to magazines and journals, lobbied the NTA and recently held a service-user meeting, which was the best attended meeting of its kind that we have ever had. In fact there were not enough chairs in the building to seat all those who attended. The atmosphere in the room was one of high emotion, and the meeting was nearly an hour and a half long. After the meeting a petition was signed by clinicians, relatives and patients of the drug-team in Cornwall, which has been sent to the local MPs. Service-users also shared anecdotes and stories, and agreed for them to be included in this article.

One woman who had been living independently and working part-time having been stable on diamorphine for a number of years, told us she had relapsed quickly into heroin use when the supplies dried up, and contracted botulism. She subsequently lost her job and her accommodation. A couple in their thirties with one child had been stable for around five years and having not bought heroin during this time, had managed to save £2,500. When they both relapsed they lost all their savings, and are now nearly £10,000 in debt. A single mother at the meeting told us that despite having considerable psychiatric problems requiring admissions to hospital she had been heroin free for two years, but that since the diamorphine shortage she has had her child taken into care, and spent all her savings. Another explained that having been free of street-drugs for two years, she had lost her job and been dismissed from her college course. A man having been stable for four years explained that he had relapsed, and had not only lost his part-time work and college course, but that he'd been banned from having contact with his son, and had more than one admission to hospital from infections resulting from groin injecting.

The impact that the diamorphine crisis has had cannot be over-estimated. There is no doubt in our view that whilst, in Cornwall, there are may be two or three clients who have apparently coped with the shortage, the remainder have not. Discussions with colleagues outside of Cornwall also suggest that the problems are not just local in nature. Despite this, and despite our efforts, we are still no closer to knowing when, or even if, the supplies will return.

Sally Cook is service user representative; Rupert White is consultant; Alison Owen is community psychiatric nurse; and Adrian Flynn is specialist registrar, at Cornwall Drugs and Alcohol Team

Because injectable diamorphine as a treatment is reserved for those who have not responded to other interventions... it includes the most disadvantaged and psychologically damaged drug users in the country, and therefore, arguably, some of the most vulnerable individuals in the UK.

What No.10 didn't want you to know about UK drug policy

Earlier this month the government attempted to withhold part of a report that would have highlighted a dramatically failing UK drug policy, according to the Transform Drug Policy Foundation. Shouldn't we be putting reform before the government's fear of embarrassment? asks Steve Rolles.

Live 8 weekend witnessed a hugely significant drug story breaking, one that in any other week would have dominated the news, but that sadly was eclipsed by the momentous and tragic events of that week (Live 8, G8, winning the Olympics and the London bombings).

The story concerned the partial release of a 2003 report from the Prime Minister's Strategy Unit (titled: *Phase 1 – understanding the issues*) which provided a detailed economic and social analysis of international and domestic drug policy, showing how attempts to prevent the production supply of drugs (into the UK) had failed historically, would never succeed and was actively counterproductive. The emergence of the report into the public domain has immense implications for everyone in the drugs field.

The most sensitive part of the report, the second half – primarily concerned with supply controls – was subsequently leaked to the *Guardian* who published details of the complete report on 5 July, making the complete report available online (see below).

In summary, the report details:

How efforts to reduce crop production have failed historically, explaining why they are ineffective and will remain so:

'Western influence in production areas is limited because a drugs economy thrives where the rule of law has failed, or where international norms have been breached.' (p.60)

The historic failure of attempts to reduce drug trafficking (and related money laundering), explaining why they will not be any more effective in the future:

'Over the past 10-15 years, despite interventions at every point in the supply chain, cocaine and heroin consumption has been rising, prices falling and drugs have continued to reach users. Government interventions against the drug business are a cost of business, rather than a substantive threat to the industry's viability.' (p.94)

How prohibition has failed to reduce use of the most problematic drug use – specifically since the Misuse of Drugs Act became law in 1971:

'Over 3 million people in the UK use illegal drugs every year, with more than half a million using the most serious drugs.' (p.5)

'The use of high harm causing drugs has risen dramatically over the last 30 years.' (p.38)

How prohibition creates high levels of property crime. This analysis is focused specifically on problematic users of heroin and cocaine – drugs that are both highly addictive and, because of prohibition, highly expensive:

'Heroin and/or crack users cause harm to the health and social functioning of users and society as a whole, but users also commit substantial amounts of crime to fund their drug use (costing £16bn a year).' (p.2)

'Drug use is responsible for the great majority of some types of crime, such as shoplifting and burglary' (including 85 per cent of shoplifting, 70-80 per cent of burglaries, 54 per cent of robberies). (p.25)

It further demonstrates how this crime will always be created by the underlying economics of the completely deregulated illegal drug market. When increasing numbers of users have to pay street prices grossly inflated by prohibition, the exploding levels of crime described in the report are inevitable:

'The high profitability of the drugs business is derived from a premium for taking on risk, as well as from the willingness of drug users to pay high prices.' (p.66)

'profit margins for traffickers can be even higher than those of luxury goods companies' – (cites Gucci as an example). (p.69)

The report goes on to show that even if supply side interventions were more successful, the result would be increased prices that could force addicts to commit more crime to

support their habits:

'There is no evidence to suggest that law enforcement can create such droughts.' (p.102)

[but even if they could...] 'price increases may even increase overall harm, as determined users commit more crime to fund their habit and more than offset the reduction in crime from lapsed users.' (p.99)

The Prime Minister commissioned the report in late 2002 from his personal strategy unit of policy experts based in No. 10, still smarting from highly critical reports on the failure of UK drug policy by the Police Foundation (2000), and the Home Affairs Select Committee (2002). The report was presented to the Prime Minister and a small number of cabinet colleagues in July 2003 and is, as described above, a detailed guided tour of the failures of supply side prohibition. It does not, however, contain any advice or policy recommendations, limiting itself purely to analysis and critique.

What happened next remains somewhat cloudy. It appears that John Birt, one of Blair's unpaid strategic advisors, took the findings from the phase 1 report (with which he was not involved) and produced phase 2 which contained the policy recommendations that then went on to become the basis for the Drugs Bill 2005. The Phase 2 report, or 'Birt report' remains under wraps, but some details have emerged. Acknowledging that government could do nothing about drug supply, Birt opted to focus on demand (and crime) reduction amongst the 'high harm causing users' of heroin and cocaine through a roll out of coerced treatment administered by the criminal justice system.

The report raises a series of important questions. Transform's requests for the release of the document under the Freedom of Information Act were denied on the three part basis that: it compromised national security, it contained advice to ministers, and that it would compromise the ability of ministers to freely discuss sensitive policy issues. The report, when it finally emerged, clearly contained no information that compromised national security and no policy recommendations or advice to ministers.

It appears to have been withheld primarily because it was politically embarrassing – revealing that a major plank of UK drug policy, one that the government pours enormous political, military, policing and financial resources into – is a counterproductive failure, and will remain so. The release of the first half of the report unannounced on the Friday evening before Live 8 also appeared to be a – reasonably successful – attempt to bury and embarrassing story, as noted in a *Guardian* editorial titled 'burying bad news' (5 July 2005). Transform have complained to the Parliamentary Information Commissioner about the timing of the release.

This whole saga does not inspire confidence in the drug policy-making process. It demonstrably lacks transparency, critical analysis is suppressed, and it puts the views of non-experts such as Birt above those of Select Committees or expert NGOs. Anyone who reads the report will be mystified at how the analysis could ever have been twisted into the ill thought through, populist mess that was the Drugs Bill.

Transform believe that drug policy should be led by evidence of effectiveness not political expediency. We now know that the government clearly understands what many reformers have been saying for years; that supply side prohibition has failed. That they continue to enthusiastically support it should seriously concern everyone in the drugs field.

Steve Rolles is information officer at the Transform Drug Policy Foundation.

Further information, including briefings, media links and the report are in full at their website: www.tdpf.org.uk

Methadone and beyond notes from the Alliance

Too many hard-working employees are suffering discrimination because of their past drug use or their need for a regular script, says Daren Garratt, the Alliance's Development Manager.

In this edition of *DDN* there is a letter from Simon in Brighton raising the issue of past drug-user status and future employment options (Q&A, page 19). This remains a pertinent, problematic obstacle for many users, despite the fact that there is no two-year rule in national policy, and employment has been identified as a key aspect of the NTA's treatment effectiveness strategy.

In fact, at the recent launch of the new strategy, the NTA explicitly stated that:

'[it] is designed to deliver a more dynamic treatment system by focusing on service users' "treatment journey", together with a focus on an individual's holistic needs (including housing, employment) to maximise the benefits of treatment.'

This is a laudable and long overdue addition to the drug treatment experience, but the question remains as to how truly effective this aspect of a user's journey can reasonably be, when so many potential employers (both within and outside the drug treatment field) continue to adopt discriminatory, socially exclusive employment policies.

And even if we do see a welcome, necessary cultural shift that enables and encourages the reintegration of users into the workplace, what policies and procedures are going to be implemented that protect and support them once they're in gainful employment?

Will long-term methadone maintained users find that their care plan is immediately revised, and that they'll now be deemed motivated and trustworthy enough to be reduced from daily, supervised consumption, to a weekly pick-up at a time that's most convenient for them?

Will ex/current service users and non-problematic users have the confidence to know that their employers will defend them from gossip, conjecture or anonymous complaints should they arise? Too many effective, dedicated drug-using workers face having their careers destroyed in this field because a lot of employers are too quick to respond to unfounded, anonymous allegations concerning an individual's perceived/assumed lifestyle choices, relationships, friendships and professional conduct; whether ongoing or firmly in their past.

Sadly, we receive many calls from workers who have found themselves unreasonably, and possibly even illegally, under investigation or suspended from work on the basis of these allegations, with no thought or consideration given to the possible motive behind such a complaint. Personal and professional jealousies are largely the root cause for the majority of these unfounded, and often untrue, anonymous actions, yet these can be regularly overlooked, in favour of a swift, guilty-until-proven-innocent investigation procedure that simply underpins and reinforces the 'once a junkie always a junkie' attitude that the majority of users still have to live and deal with on a daily basis, often from the very people who are paid to care for and support them.

Treatment will undoubtedly become more effective as our culture evolves to embrace the NTA's aim of a fully integrated, holistic package of care, but we need to look beyond the easy win, quick fix gestures, and ensure that any programmes that seek to support a user's social reintegration into the workforce are successful, sympathetic, sustainable and supportive.

What next

for the voluntary sector on drug strategy?

Following the buzz created after the recent NTA's effectiveness conference, Peter Martin, CEO of Addaction looks at some threats ahead and calls for a united stand by the sector.

A few days after the National Treatment Agency held one of its most stimulating conferences my morning newspaper informed me that the so-called 'War on Drugs' had been lost. I was surprised to be told that all our efforts and improvements since the updated drug strategy of 2002 counted for nothing. It was particularly demoralising because the field is now moving on to improving effectiveness following major increases in numbers of people entering treatment and the reduction of waiting lists.

Of course, I don't always believe what I read. The 'War on Drugs' was never a helpful phrase. It stigmatises our vulnerable clients. Unfortunately, the 'War on Drugs' is a blanket phrase that fails to make a distinction between policy and outcomes on supply and policy and outcomes on treatment and prevention. It lends itself easily to headlines such as 'War Lost'.

Perhaps we will always be faced with blanket and negative interpretations while good news does not make headlines and there is no capacity for complexity on the news pages. But we ignore these biased interpretations at our peril, because the real battle we face is the winning of hearts and minds of public and politicians on the importance of drug treatment.

We need to instill a profound understanding of treatment and how it works in those who sit in judgement upon us. In the run up to the end of the current drug strategy in 2008, this is more critical for our success than ever.

And the basis for the 'War Lost' story? Two newspapers had applied quite understandably, under the Freedom of Information Act, for the Strategy Unit report on drugs, which was then issued in an allegedly truncated form on a Friday when the news desks have thin cover. This aroused suspicions and stung newspapers into retaliating.

Yet, only a week before Addaction had issued a release that showed that client numbers in its treatment services had risen by a startling 30 per cent in one year. Needless to say, this did not make national newspaper headlines and wasn't even covered except in specialist and local media. I can't help asking if this is a manifestation of a media guilty of suppression by neglect? Even a brief letter sent to the *Guardian* on 5 July, pointing how 'good news' about drug treatment is ignored, failed to make the letters page.

And we had good cause to complain. The Strategy Unit report was two years old and based on statistics pulled together three years ago, and was focused on supply. We have already known for three years that tackling increasingly sophisticated supply has its limitations in isolation. So what's new? On supply there has to be a global response. But headlines don't distinguish between different aspects of strategy. Again we see a perfect example of the clash between government and media over agenda control that erases from the picture the drug treatment practitioners on the ground, as if our work and our successes counted for nothing. It means that old news is often treated as if it were new when its suits the media, while good news on drugs strategy is largely confined to the copy-tasters waste basket.

But we must never be deflected.

Government focus on treatment shifted in 2002-3. There was widespread acknowledgement that although government should certainly not abandon its contribution to addressing worldwide supply and should continue to disrupt local markets, ultimately, progress in drugs strategy comes from investment in treatment.

Now government wants treatment to work faster and better. We can do without rhetoric exchanged above our heads like so many rounds of gunfire, in order to score points. This bias against understanding means truth is the loser.

But we are a resilient sector. What distinguishes us is our commitment to the client – the vision and values that drive us. Yes, of course, we work within constraints, many of them short-sighted. But we work within the system we have and try to improve it. It is not simply a job. If we ever lose sight of that, we are lost.

The NTA is now engaged with the voluntary sector, which is good news. The dynamism of the NTA conference was palpable. It was good to hear from GPs at the conference. They have such an important role to play in engaging clients to change. It was great to hear Dwayne Simpson from Texas who was so involved in the massive data project – the USA DATOS reports – on what works to improve effectiveness. It was good to hear Ian Robinson from EATA on the difficulties we have had with payments and contracts; the excellent Simon Shepherd, the passionate Viv Ahmun, and the articulate voice of Lifeline's Ian Wardle.

But many people leaving the conference were saying – yes, very good, but how do we get there?

One of the first things we must do is come together as a sector to make representations to remove barriers to effectiveness. Policymakers may think that by simply pronouncing on a strategy and establishing goals, we all somehow become fully enabled to

arrive at that goal.

We know what hampers us and it is up to us to seek help to clear the route ahead. Together we are more likely to be heard at the national level, and now is the time to leave our silos and put aside everything that separates us.

Caroline Flint the former Home Office Minister now has an important role at the Department of Health, and will be linking in with Paul Goggins at the Home Office. This is very good news as both ministers have excellent experience and commitment to drug treatment. At the regional level, we must also come together to explain our work.

Motivation is key. Motivating the client and motivating the workforce goes hand-in-hand. But we must also motivate those in government and the regions who know that hard choices need to be made between funding provision for different services at the local level.

In the third term of this government, there is a gathering momentum on joined up policy. The ship is moving full steam ahead.

Many of us are aware of the Local Area Agreements, which will place funding under the control of local authorities. LAAs are currently being rolled out, and could threaten the future for innovative programmes and those services that are not part of the Drugs Interventions Programme. We have gone beyond talk. Changes are happening now.

Whether local funding will continue for some types of service will depend on how we measure up on effectiveness. While we try to develop training and workforce retention and implement all that is required to engage clients in treatment well beyond that pivotal three-month period, we will be under the spotlight. If we fail, some services could be cut off mid-stream without a paddle.

Methadone is another issue we must look at. It was good news to hear consensus within the NTA's effectiveness agenda about improving assessment and consistency of dosage for clients. This will help initial retention and stabilisation.

But the 2003 Strategy Unit report referred to earlier, places methadone within a list of drugs at a cost per head of £67 per week. With approximately 150,000 people currently engaged in some form of treatment, it is important to remember that methadone is a substitute drug, and that it costs the state at least half a billion pounds a year to deliver. There are undoubtedly some people in government who faced with different priorities will look at alternatives to this spend.

What has been a jigsaw of policy is beginning to form a clearer whole picture.

More than 50,000 of the 2.64 million on incapacity benefit, are registered as having drug-related illnesses. There is a strong possibility that the Department for Work and Pensions will propose in their Green Paper to cut the benefit of those drug users on Incapacity Benefit who refuse treatment. Using benefits as a lever to move people into work was applied under the New Deal. The thinking behind this DWP initiative is no different. The implications are enormous.

Greater employment and housing opportunities are two key factors required for reducing re-offending among ex-prisoners, as was indicated three years ago by the Strategy Unit report. At the same time, the sustainability and the rightness of long-term methadone maintenance prescribing is beginning to be challenged inside the treatment sector and within government. Every pressure to move people into rehabilitative treatment is likely to be used. Effectiveness once clients leave the travelator and get through the door is our task.

Most of us who understand addiction and dependency and believe it is possible for many clients to make profound changes in their lives, are fully behind the NTA's effectiveness strategy. We fully support prescribing regimes to help move clients on. I shall say that again – to help move them on. But as ever we must not be supine in playing our part nor remain quiet about any elements of policy that lack fairness or may be construed as being inhumane.

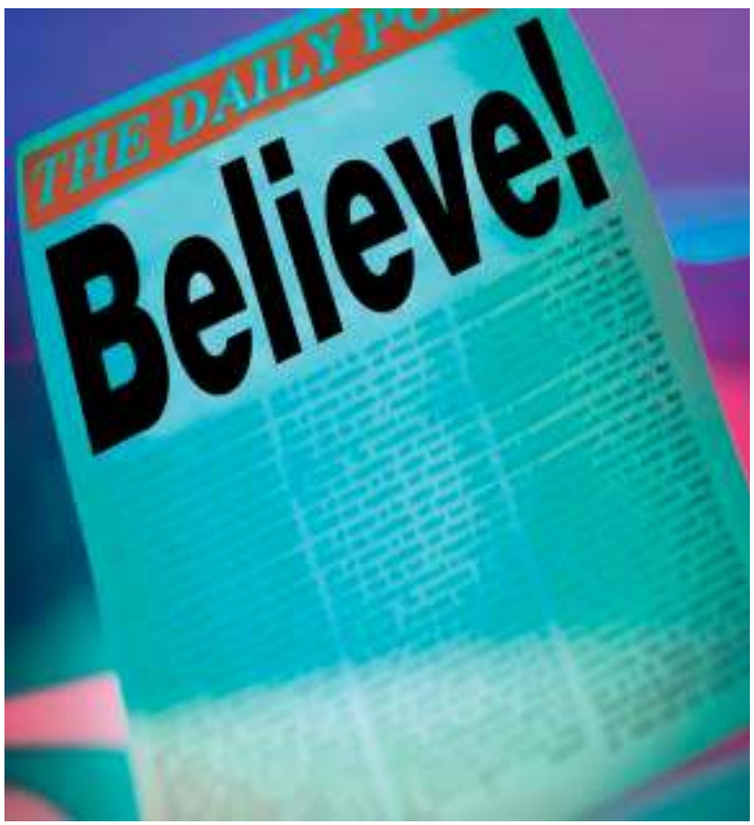
Having long-term aspirations for the client and being needs-led does not mean we are focusing on our own needs as providers. But it does mean motivating clients and being ready for the client when they want to change.

This is where our expertise and focus on the client must lead us to find solutions to some of the big threats and big changes ahead. Whether it is through building abstinence routes into methadone prescribing or by ensuring we have the full complement of workers who are motivated and competent to deliver on the effectiveness goals, we must ensure we are part of the solution or we will be marginalised.

I have no doubt that in the challenging economic environment ahead, methadone delivery because of its valuable uses and its impact on reducing the levels of blood-borne viruses, will continue. But delivery must improve and new processes and models found to stop keeping people forever and a day in stasis, when it is right to do so.

We have to ensure that the voluntary sector remains a crucial part of drug treatment delivery and on-going success. We must also persuade the media of our successes and determination.

Real effectiveness must not be endangered because of self-interest and lack of aspiration. We cannot fail, or we will risk wasting all the human potential that we have strived so hard to release in all our clients.



'Perhaps we will always be faced with blanket and negative interpretations while good news does not make headlines and there is no capacity for complexity on the news pages. But we ignore these biased interpretations at our peril, because the real battle we face is the winning of hearts and minds of public and politicians on the importance of drug treatment.'

Scotland's Family Services Unit lightens the load

Gentle intervention and support can be the only way to get drug using parents to accept help. DDN talks to Grant Sugden about reaching families in need.

Offering practical support in an informal style is our way of gaining the trust of families struggling with a drug or alcohol problem, says Grant Sugden of the Family Services Unit in Scotland.

The FSU has been active in Scotland for more than 30 years and has rooted projects in some of the most challenging areas, to seek out marginalised children and families. Last year, the Harbour Project in Edinburgh and the Hearth Project in West Lothian, were established specifically to support children and families affected by drug and alcohol use.

The unit's 'softly softly' approach involves working with a whole range of other services. Referrals might come from social work, housing, health visitors, drug services or education, and the FSU links back into these services to make sure the family has ongoing support, matching their needs with local expertise.

From the outset of making contact, the FSU takes a 'whole family approach', explains Sugden, who joined with a background in children family social work. This means looking at the whole spectrum of needs, from the day-to-day practical considerations, such as helping mums with timekeeping, to coaxing a child with a drug-using parent to share their anxieties and build their self-esteem.

'A lot of our work is helping parents to make changes to their own lifestyles, helping them with parenting skills,' says Sugden. 'We find a lot of parents we're working with are not able to organise their lives enough to even get their children up in the morning for school.'

Domestic chaos is a familiar companion to drug use, and Sugden and his colleagues draw up achievable goals to try and instill a sense of routine and responsibility.

'We draw up a work plan with the parents that identifies very clear and specific goals,' he explains. 'We outline what our responsibilities are to them – and what we expect them to do as well. Research shows that's the best way to work with parents who have got problems.'

Such simple but structured intervention can make a huge difference to cases like the mum with a long-term heroin problem, who was on a methadone script but began buying extra on the streets. When her child was referred to FSU he was in his first year at primary school, but much of the time she was unable to get him up in the morning.

'So one of the first bits of work was to help her to get up in the morning, so that her son's school attendance would improve. We discussed with her what you do the night before, have you got an alarm clock, those kinds of things. And then we went in each morning and actually helped her to get into a routine,' – gentle support at the beginning, says Sugden, which might turn into visits three or four times a week, until over time she learns to manage. The support might need to be intensive at certain stages, but it's a case of being responsive – stepping up when beckoned and retreating when self-sufficiency catches on.

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FSU doesn't deal with the parents' addiction directly, but the support and encouragement often takes them a step closer to drug and alcohol services. 'Putting in a link is something we've been pretty successful at,' says Sugden. 'We make sure everyone knows what everyone else is doing, and that services are co-ordinated.'

Being a voluntary organisation can make a bond of trust easier to establish, Sugden has found. The fear that often lingers around social services' power to take their children away can often make a dialogue more difficult. The FSU takes time to look at the parents' strengths as well as their support needs, giving them confidence to ask for help where they need it. They are sensitive in approaching parents who often deny their children have noticed their drug use.

'They'll say their child's not affected by my drug use,' says Sugden. 'We'll have to work on the issue – "well I think your wee girl might know more about this than you think she does… let us work with you to look at how we can improve things a bit".'

The bond of trust is equally essential in dealing with their children, addressing the fear and isolation they often feel. From the network of FSU projects, such as the Harbour Project in Edinburgh and the Hearth Project in West Lothian, have sprung support groups that encourage children to share their experiences of living with a parent with a drug problem from the 'safe base' of an environment containing others in the same situation. 'They realise they are not the only one,' says Sugden.

Building a positive school experience for these children is another important mission. The FSU works closely with school staff and does individual work with each child to help them deal with any difficulties they are having at school or in the community.

FSU team meetings often provide additional inspiration. Qualified in health, education or social work, the current team comes from a range of backgrounds – a range that can really help in dealing with a client group that is traditionally difficult to engage with. 'Having the different approaches to draw on has been really helpful in allowing us to be a bit more imaginative,' Sugden explains. Discussing cases and sharing experiences can offer up new ways of linking services and engaging clients – and it certainly seems to be working. Last year the Harbour Project engaged with 90 per cent of referrals, and the team is proud of their high take-up rate.

'I think we achieve that by being very flexible,' says Sugden. 'We won't just visit a family once, we'll keep trying until we can get someone in. We'll do what feels most comfortable, we'll speak to the professional that's referred the case and look at how we can be as successful as possible for the family.'

With that level of commitment, it's not surprising that parents in a chaotic and stressful situation decide to accept the offer of some helping hands.

A directory of FSU services is at www.fsu.org.uk. Visit the FSU Scotland section for more on the Harbour and Hearth Projects. **DDN**

Today's challenge for the third sector

Voluntary services have a vital part to play in injecting energy, enthusiasm and inspiration into a treatment pool that is exhausted by target-driven demands, says Rev Jim McCartney.

As a third sector strategist developing services for hard to reach groups within the criminal justice system and drug treatment sector, I am acutely aware of the important role the 'not for profit sector' has in public service reform. We can no longer solely rely on the public sector to deliver the essential programmes that can radically make a difference to our communities.

Public sector policy makers can create big ideas but the difficulty is often found in converting the theory into practice. At the same time the private sector is driven by productivity, economic growth and profit, thus leaving the third sector, traditionally known as the voluntary sector, to liberate disenfranchised people who have been given the contemporary term 'hard to reach groups'.

In 1993 I formed a church based group to reach out to homeless people; twelve years on, evolution has resulted in it being a specialist provider of drug treatment and resettlement support for ex-offenders. Today the organisation is working in partnership with HMP Preston and HMP Lancaster Castle as it provides a holistic support to prisoners who have multiple complex problems that are chronically inter-related with their drug and alcohol misuse. This is achieved through an intensive programme of support and accommodation when prisoners are immediately released into the community. It also has a multi agency dimension when people graduate from the scheme. Most importantly it provides a therapeutic base to construct the re-building of trust, confidence and manageability of life; hence contact with the individual within the prison is an essential element of the pre rehabilitation and resettlement process.

T.H.O.M.A.S. (Those on the Margins of Society) has taken a lead in multi-agency work. In 2000 we formed a multiparty think tank that included representatives from the Prison Service, the Probation Service and Lancashire Constabulary. This gave birth to a successful resettlement model that has been preserved for five years and was cited by the government as a good practice in its SEU Report 'Reducing Re-offending by Ex-offenders' (2002).

It is interesting to see how the public sector's national drug treatment intervention strategy is only now coming to implement shared and co-ordinated care. One of the significant advantages of T.H.O.M.A.S. is that it is influenced by the 'third way'. This is not an abstract philosophy but a pragmatic approach with the premise that each individual can fundamentally be a builder of the common good within our society.

Even those debilitated by prison and substance abuse can change their lives with shared endeavours and mutual goals. This is achieved, in the words of Etzioni, by developing the concept of mutuality and diminishing the role of voluntarism. These are two distinct variables. The former is embedded with the innovative desire to encourage each individual to be part of the strategic development. This becomes eminently more attractive than the latter, where people volunteer to help people in need and often leave them in need.

At the moment I'm in the process of opening a new unit for rehabilitated drug users who are totally drug and alcohol abstinent. The aim is to enable our service users to establish a pathway and preserve a position within an educational, training or employment setting before they move out of the unit. For this to be successful each person will need to take ownership for the development of the scheme. In the words of Patrick Devlin, 'society means a community of ideas. For society is not something that is kept together physically; it is held by the invisible bonds of common thought'.

The public sector is exhausted and overburdened by the target driven demands, emanating from the government bureaucracy that has a tunnel vision understanding of what constitutes effective community development. Therefore micro organisations that have come to birth by the pooling of local knowledge and human resources become inspirational projects of entrepreneurial ability and dynamic operations.

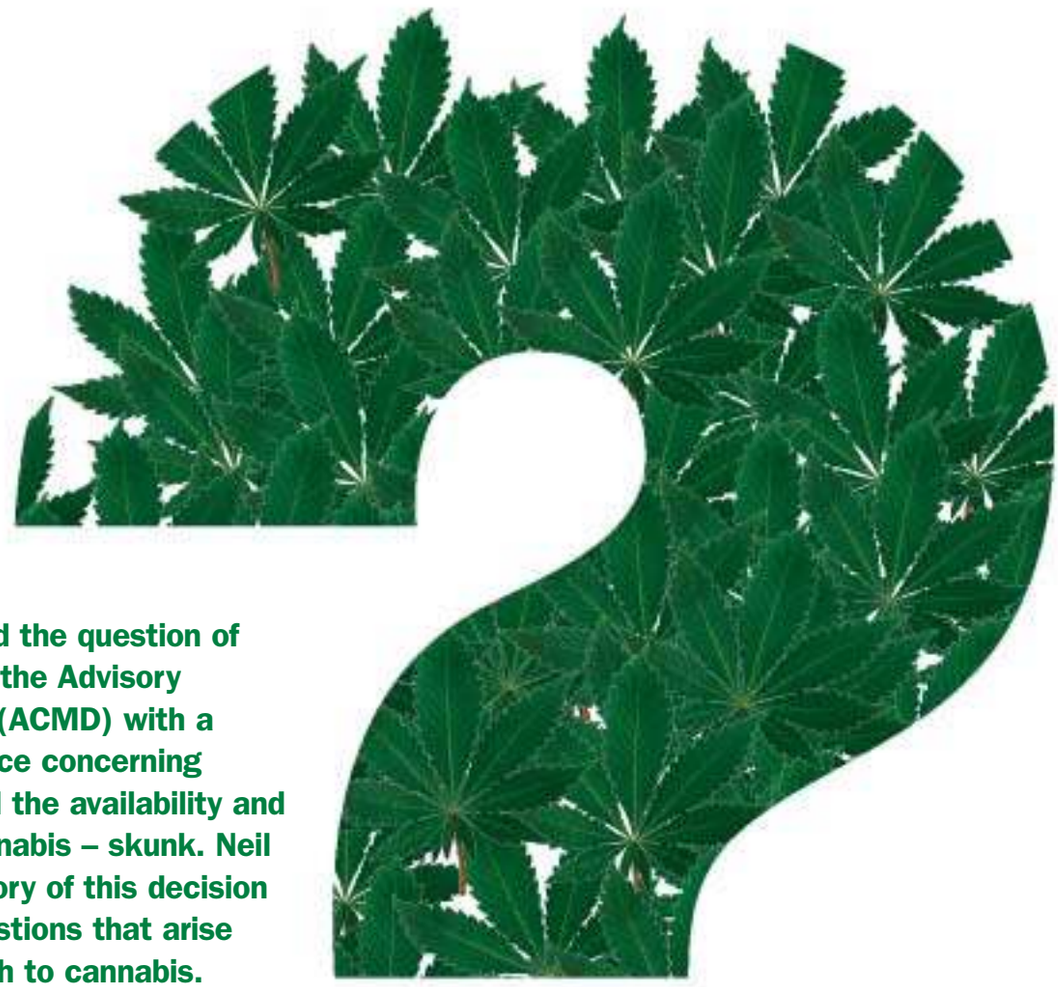
Dr Jonathan Sacks in his book *Politics of Hope* speaks about the limitations of the public sector. He develops the theory that the public sector has the innate disposition of the contractual relationship with the individual whereas the third sector is able to demonstrate the covenantal relationship. His conjecture is influential for third sector strategists. The covenantal concept takes the premise that to create change you need to build relationships of trust, faithfulness, loyalty and to enable people to believe in themselves so that they can value who they are. If we can foster such an environment there is the potential for people to become agents of change and builders of transformational communities.

I have worked with disadvantaged groups for almost 20 years and I have come to realise that if we are to make a difference to their lives, we need to foster an environment where they are invited to be part of the project that we and they want to develop – not recipients, but participants. In my management and leadership practice I use the metaphorical image of a laboratory and I invite my staff and our service users to come into the laboratory and experiment on how we can develop processes and systems to make our drug rehabilitation and resettlement programmes for ex-offenders more proficient in the delivery of sustainable development. If we are going to innovate radically we need to be flexible enough to incorporate ideas that can directly challenge our own hypothesis and take the risk of testing what might work. Here we begin the process of deduction and eventually arrive at self-motivated and energetic initiatives propelled by the very people who were once disenfranchised.

The major challenge for the third sector now is to seize the opportunity and realise that the public sector cannot function without it.

Rev Jim McCartney is chief executive of T.H.O.M.A.S. (Those on the Margins of a Society), St Anne's House, France Street, Blackburn BB2 1LX

Revisiting cannabis classification: some questions we should ask



The Home Secretary has referred the question of cannabis' classification back to the Advisory Council on the Misuse of Drugs (ACMD) with a request to look at recent evidence concerning cannabis and, mental health and the availability and effect of increased strength cannabis – skunk. Neil Hunt sets out a little of the history of this decision and some of the associated questions that arise from an evidence-based approach to cannabis.

Throughout the last part of the 20th century cannabis was classified as a class B drug under the Misuse of Drugs Act (1971), in the same category as amphetamine and most barbiturates. Within debates about drug control there has been widespread and longstanding criticism of its classification as a class B drug because of a view that, whilst potentially harmful, these risks were not commensurate with other class B drugs. Significantly, the Police Foundation's Independent Inquiry (1999) into the Misuse of Drugs Act (1971) reached the same conclusion and this, along with a report from the ACMD that drew similar conclusions (ACMD 2002) created a climate in which the Home Secretary could successfully seek the reclassification of cannabis, with an aim of decriminalising its use. Almost inevitably, given its significance for prohibitionists and drug law reformers alike, this decision was highly politicised: with both a small and a large 'P'.

In practice, the extent to which its decriminalisation was achieved was limited by the introduction of more stringent penalties for offences connected with class C drugs and many people have been confused about how the law has changed and how the police should now respond to cannabis use. Nevertheless, in some respects the changes can still be seen as a shift towards a more proportionate, evidence-based response.

Neither the evidence-base nor public opinion is static. Good public policy should be attentive to evolving evidence. Crucially, in the period following the decision to reclassify cannabis, new British and Dutch research has been published concerning the drug's potential role in causing or exacerbating major mental health problems (notably Arsenault *et al*. 2004; Henquet *et al*. 2004; Newcombe 2004). This has been accompanied by a series of media stories about the links between cannabis, psychosis and schizophrenia – especially among young people. Attention has also focused on changing cannabis potency and there is continuing interest in the way that cannabis is policed with respect to both resource utilisation and equity.

Prior to the 2005 general election, the Conservative party pledged to reclassify cannabis back to class B, putting pressure on Labour to keep step with efforts to appear equally tough on drugs – a posture that conventional wisdom, rightly or wrongly, says plays well with the electorate. The government's response was to refer cannabis back to the ACMD for their advice on the significance of the new evidence. To what extent this was driven by a passionate commitment to evidence-based policy or was just a politically expedient way of defusing the issue while an election loomed, is open to debate. However, the result is that the ACMD is once again reviewing aspects of the safety and control of cannabis.

No terms of reference have been provided to the ACMD in documentary form, although the ACMD's work has been directed towards concerns about the impact of cannabis on mental health and the availability and effect of increased strength cannabis. The ACMD's review process will be to take oral evidence in late summer 2005, which they will appraise with a view to reporting to ministers towards Christmas.

So, what questions are important to consider when appraising the latest evidence?

Most obviously and immediately, the ACMD will need to critically appraise the latest mental health research. In the field of epidemiology, does the work of researchers such as Arsenault *et al*, Newcombe and Henquet *et al*. suggest that the incidence of cannabis-associated psychosis is changing? Is the incidence of schizophrenia increasing and, if so, is there anything to suggest that this may be attributable to cannabis? At the neurological level, does new research suggest that we should re-evaluate our understanding of the way in which cannabis exposure contributes to later problems by causing transient or long-lasting changes to brain function – especially among young people and others who are exposed to sustained or high levels of cannabis?

In epidemiological terms, a different question concerns what is known about the impact of the declassification of cannabis on its use. Is there evidence that this has increased or even, paradoxically, decreased since the law has changed and how should any such change be interpreted. If cannabis consumption patterns have changed, is this associated with wider effects that are relevant to public health? For example, are changes associated with alterations to the use of other legal and illegal drugs? Are there corresponding decreases in the use of, say, alcohol or heroin that we should note? Or does increased use have a parallel rise in tobacco use?

The question of tobacco raises further questions about cannabis consumption patterns, some of which may be connected with the potency and form in which cannabis is available – recently reviewed for the EMCDDA by Les King (2004). Do we observe changes in these? Is there anything to suggest that this relates to changes in the way that cannabis is classified? Choices between consuming cannabis with tobacco, smoking it on its own (as resin or grass) or in a vaporiser that avoids the inhalation of smoke particles; each has a bearing on public health. Clearly, associated increases or decreases in tobacco use would affect respiratory and cardiac health. But is there evidence that cannabis potency is increasing, or of other shifts in cannabis consumption patterns that have implications for the way that we appraise risks to mental health?

By referring the classification of cannabis back to the ACMD, there is an implication that its classification can have a deterrent effect on its use and the accompanying harms. This poses questions for sociologists and criminologists. How have the changes to cannabis' classification been understood by the public? Do we detect changes in social attitudes towards cannabis use that suggest that its reclassification has led to increased social acceptability and a greater propensity to use cannabis? In particular, how have the attitudes of young people been affected? The UK stopped short of allowing a 'coffee shop' model, which might have allowed a degree of state control over who obtains cannabis and under what circumstances that is not so amenable to control within unregulated cannabis markets. But have the recent changes increased young people's access to cannabis and, if its classification was changed again, would this have any likely effect on consumption and harm? If the answer to this question is 'no' then it suggests that good social policy needs to be looking in other directions. What contribution can 'social marketing' approaches developed by organisations such as HIT make to cannabis use? Are there expanded responses that we should encourage from youth services? And are there enhanced ways in which young people's drug services can work with cannabis users? Framing our emerging understanding of cannabis-related harm purely within the debate about its classification does not mean that this is the most important direction in which to look, or the only policy option available to us.

Besides the questions about the immediate harms of cannabis and how our responses might reduce these, there are important questions to ask about the costs and other consequences of our societal response to cannabis. What is the impact on policing: community relations, the use of police time and the ability of the police to prioritise their activities? How have the recent changes been experienced and what are the possible effects of further changes? And if we adopt policies that increase the criminalisation of cannabis users, what are the direct costs of imprisoning more people? What are the associated costs within the criminal justice systems? And to what extent are there further costs, such as the impact on families when parents, carers or wage-earners are imprisoned, or the consequences for the offender of being marked with the stigma of a criminal record? Many such questions have recently been reviewed by Lenton (2005).

All of these questions seem germane to an understanding of the harms from cannabis and how we might best respond. It would not be enough to merely assess whether we think the harms associated with cannabis have changed. There is a clear requirement for the ACMD also to appraise whether changing its classification would be likely to have an impact on any new understanding of the risks and to weigh this against the possible costs of such an approach.

Crucially... new British and Dutch research has been published concerning the drug's potential role in causing or exacerbating major mental health problems. This has been accompanied by a series of media stories about the links between cannabis, psychosis and schizophrenia – especially among young people.

As a final thought, an evidence-based approach to drug policy suggests that we have a duty to promote the generation and proper use of good evidence. The declassification of cannabis represents something of a 'natural experiment'. For many questions about drug policy, a 'before and after' design of this sort is the most robust design that is practically or ethically feasible. The government's reclassification of cannabis has created the conditions for us to extend the evidence base on which policy decisions should be made. Commissioned research from research groups such as the Institute for Criminal Policy Research, Kings College London, along with the use of indicators that are structured into social research, such as the Exeter school surveys and the British Crime Survey will, in time, give valuable insights into the way that cannabis use alters in the wake of legal change.

Although it has been possible to outline a number of questions that arise from the reclassification of cannabis from class B to class C, it is in many ways premature to assess them. Consequently, one last question that the ACMD might consider, would be whether there are lost opportunities for evidence-based drug policy that could arise from policy reversals before the impact of one change has been properly evaluated?

References

ACMD (2002) *The classification of cannabis under the Misuse of Drugs Act 1971.* London: Home Office.

Arsenault L *et al.* (2004) *Causal association between cannabis and psychosis: examination of the evidence.* British Journal of Psychiatry. 184: 110-117.

EMCDDA (2004) *An overview of cannabis potency in Europe.* Lisbon: EMCDDA.

Henquet *et al.* (2004) *Prospective cohort study of cannabis use, predisposition for psychosis, and psychotic symptoms in young people.* BMJ. 330: 11-14.

Lenton, S. (2005). *Deterrence theory and the limitations of criminal penalties for cannabis use*. In Stockwell, T.R., Gruenewald, P., Toumbourou, J. and Loxley, W. *Preventing harmful substance use: The evidence base for policy and practice.* John Wiley & Sons Ltd, Chichester.

Newcombe R (2004) *does cannabis use cause psychosis? A study of trends in cannabis use and psychosis in England, 1995-2003*. Adiktologie. 4(4): 492-507

The Police Foundation (1999) *Report of the Independent Inquiry Into The Misuse of Drugs Act 1971* (AKA The Runciman Report)

Neil Hunt is Director of Research, KCA; Senior Research Associate, European Institute for Social Services, University of Kent; Honorary Research Fellow, Centre for Research on Drugs and Health Behaviour, Imperial College, London.

KCA are holding a conference in London on 16 September to assess and debate most recent evidence concerning cannabis use, harm and society's response.

For more details, call 01474 326168, email kcawps@globalnet.co.uk or visit www.cannabisconference.org.uk/

From dead drunk to streetwise

A little information can save a lot of lives, realised paramedic Steve Evans. The question was, how do you get through to know-it-all teenagers?

When paramedic Steve Evans rushed to the scene of the third drunk and unconscious teenager that evening, something snapped in his mind.

'I've been in the ambulance service a long time, but I was thinking hang on, what's going on here? These are three 11 to 13-year-olds, from three separate locations, in the one small town.'

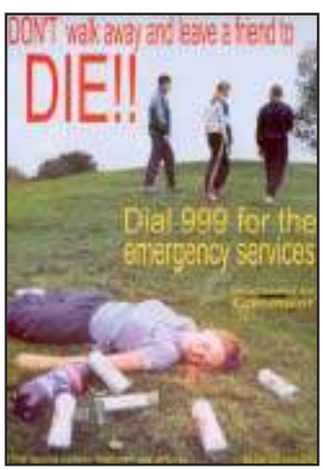
Not long after, he went out to a 12-year-old lad who had been abandoned by his friends, drunk, in a school playing field, in the middle of winter. The boy was lying on his back, liable to choke if he vomited, with an increased risk of hypothermia from the alcohol and cold weather. The playing field was dark and not visible from the road; all that saved him was a lone dog-walker who stumbled across him and phoned for an ambulance.

Evans dealt with the child, 'but the question in my head was – why would his friends walk away?,' he says. He decided to look into it, and came to the conclusion that it was down to sheer lack of knowledge: 'Because first aid is not taught in most schools, because it is not part of the national curriculum, they don't know what to do.' Add the fact that they don't know the recovery position to the fact that they're doing something they shouldn't be doing, and are frightened of getting in trouble with police and parents, and you have a pretty clear answer on why they walked away, according to Evans. He decided he couldn't sleep unless he did something about it.

Enter stage right: a photographer friend; enter stage left: young friends willing to be actors for the day. With props from the local off-licence, they produced a poster to launch the 'Don't Walk Away' campaign. Next came the challenge of distribution: 'I'm one person and I've got the whole of the country I want to say it to... so how do I get this out?' he wondered. Deciding he needed to deal with 'the top people', Evans sent a poster and covering letter to Tony Blair, saying 'Dear Prime Minister, you have a national problem on your hands' and a second one to Alan Milburn – 'Dear Secretary of State for Health...' He cornered Congleton MP Ann Winterton, while meeting her in a different work context, and persuaded her to lobby the opposition. She had initially expressed interest and invited him to email more details – 'but I said "better than that Ann, I have the posters and the covering letters with me"'. A week later he had a letter from Liam Fox (shadow Health Secretary at the time), saying 'you're absolutely right, I'll back you where I can'.

While events were gathering pace from Evans' first round of contacts, he certainly wasn't going to sit around and wait for things to happen. In the mean-time he had been nominated as a finalist for BBC television's 'NHS Heroes', for his work with schools and charities, so he asked if he could use the occasion to explain, on TV, how kids could put their friends in the recovery position. The BBC weren't keen – 'they said they didn't think it was a big problem'. But before he could scratch his head, Evans was contacted by the Department of Health's alcohol policy unit and invited to write detailed advice for their website.

'The first line goes "don't panic, the ambulance service is there to help you",' he says. And that's the tone: non patronising, practical advice on putting the friend in a recovery position, clearing their airway, staying with them, and sending someone to the edge of the school field, park or wherever, to wave the ambulance in.



'I tell them I went to school in Toxteth – which means I can't read or write, but I can fight anybody in this room! They all suddenly show respect.'

Evans wrote the advice with young people in mind, rather than lifting it out of first aid manuals. 'It's real life stuff,' he says, 'including clearing the area of broken glass, before you roll your friend into the recovery position.'

The posters 'took off' with a little help from GMTV, who sent a reporter to follow him around on a typical night's duty ('within five minutes we had stuff on the camera') and a lot of help from the High Sheriff of Cheshire and the Rotary Club's north west branches, who were generous in sponsoring posters – and then more posters, when they kept running out.

Evans has been fitting in talks to schools and clubs whenever he can – around his full-time job with the ambulance service. He's getting round the 'massive problem of being just one person' by letting schools copy his video, but dreams of a fairy godmother appearing, offering to reproduce it.

In nearly three years, the campaign has distributed at least 5,000 posters. Evans offers a neat solution to organisations who want a batch of posters: they can contact his printer direct and have them printed with their own logo on. They pay the printer for them, which leaves Evans out of the equation and with more time to keep distributing more first aid sheets and spreading the word to schools and universities.

He may seem like a brave soul, to turn up at Liverpool's toughest schools, armed with a video and posters – but elements of his routine are calculated to elicit co-operation. Not only does he have the video of himself on GMTV – 'It's him! It's him! He's on the telly!' – but he'll take no nonsense from the tough guys on the back row.

'I tell them I went to school in Toxteth – which means I can't read or write, but I can fight anybody in this room!,' he says. 'They all suddenly show respect.'

It's this determination to communicate at all levels that propels Evans from the classroom one minute, to hobnobbing with Tony Blair the next. Keep an eye out for the man with the rolled up posters; he'll stop at nothing to get his message heard – and perhaps save one more young life.

Steve Evans is a paramedic with the Merseyside Regional Ambulance Service. You can contact him about the campaign or posters at steve@samanco.freeserve.co.uk or through www.merseyambulance.nhs.uk. 'When things go wrong' first aid advice is on www.dh.gov.uk (type alcohol and young people into the search box).

He will be speaking at a conference on 'understanding underage and teenage drinking' in London on 28 September. DDN

I've completed rehab and I'm desperate to work in the field as I feel I can give a lot back. I am optimistic about my future, but I'm worried about how my history of drug dependency will look on paper to any prospective employer. Can anyone give me guidance on presenting myself honestly without destroying my chances of a full-time job?

Simon, Brighton

Hi Simon
Just briefly, PROMIS treatment centre in Kent have a very good set up for work experience and training. It's tough going, but great experience.
Yours Ben (by email)

Hi Simon
Unfortunately, as is often the case in the drug treatment field, the response you get to your honesty will depend largely on the area and/or service you choose to work with.

Many providers enforce their own 'two-year rule' when considering engaging with ex-users as employees, or even volunteers. The basic message of this policy is that you are not deemed worthy or capable to work in the drug treatment field if you have been in treatment yourself within the last two years.

However, in 2003 Drugscope and The National Treatment Agency published a document called *Enhancing Drug Services*, which contains the following statement:

'People with experience of drug use and drug treatment can be effective workers in drug services, particularly when they have support and backup from their management… Current and former drug users should not be considered or rejected for employment in a drug service solely on the basis of their drug use. It should not be assumed, however, that because an individual has experienced drug treatment they also have the competency to deliver it…

When considering current or ex-drug users for job vacancies, services should clearly state the expectations they have for their employees as well as the aims and objectives of the service. For example – a drug service seeking to engage with active drug users and provide them with harm reduction information and services, may encourage current users to be involved in their service as employees'
DrugScope / National Treatment Agency, Enhancing Drug Services, 2003. P. 22

As a result of this, some agencies and DATs have reviewed their employment policies and are beginning to encourage ex and stable users into the workforce, but it does still remain a postcode lottery.

The best advice I can give you is to get out there, be yourself and be truthful. If you see a job advertised that you like the look of, ask around and see what you can find out about that agency. Ring them yourself for an informal chat or possibly even a visit, and try and determine what their policy is on employing users.

And if you get knocked back, don't give up. There may be a local user group or project who could provide training opportunities or even volunteer placements; and although working for no pay is far from ideal, it can be an effective way to both reintegrate yourself into the workforce, and demonstrate to prospective employers that users can be good, productive workers. Either way, go for it and don't be dishonest.

I do believe we will begin to see a sea change against the discriminatory employment practices that the majority of users have had to face, and I sincerely hope you'll be one of the first to benefit from this.
Daren Garratt, Development Manager, The Alliance

Dear Simon
What strength you must have to go through rehab and beat drug addiction. I can not do it. You're a special person and when you write your C.V. you should write it with pride. The drug/ex drug user's biggest problem is low self-esteem.

Of all the people that go through rehab only a handful make it and stay drug free. So that makes you a part of a club, and anyone with any sense realises that membership of it takes an inner strength that the majority of the population has not got. If you are refused a job due to your past, then treat it as a Godsend – you would not want to work for that shallow minded fool. When a wise boss encounters you or your C.V., he will know you have achieved something very special and he will want you part of his team.

Hold your head up high Simon, be proud and walk tall.
With sincere respect,
David Wright, Inroads, South Wales

Dear Simon
I work for an organisation called Working Links on the Progress2Work contract and would welcome the chance to help you achieve your employment objectives. P2W is a voluntary project that works with individuals who have experienced a history of substance misuse, homelessness or are ex-offenders and operate a programme to help assist people in finding work and educational opportunities. We offer one-to-one support and can assist with CVs, application forms and interview techniques.

Many of our clients have significant gaps in their work history due to a range of reasons and we work to advise on and overcome these difficulties. If you would like to make an appointment then please feel free to contact me at anytime or maybe drop in to our offices for a chat. We are open from 9am till 5pm Monday to Friday.
Kieron Syms, P2W Consultant, Working Links, 27-29 North Street, Brighton BN1 1EB. Tel: (01273) 774010

Dear Simon
I read your question with interest. I am 20 years clean and sober and have been employed in drug and alcohol treatment since 1990. The first thing I would wonder is why someone who, I presume, had recently come out of rehab, would want to work in the field.

It is something I hear a lot from people in similar circumstances. We have maybe 30 employees a year from Transport for London going through residential rehab and least two or three of them each year talk about wanting to get into this field. Additionally, I get plenty of phone calls from people in similar situations who do not work for us.

My answer is always the same. First of all, I do not think a rational decision about embarking on such a career could be made within three years of treatment. Proper recovery, a healthy recovery requires a considerable commitment to personal change. That means someone's views, let alone their circumstances and lifestyle are likely to change enormously within that time.

I have known number of people go virtually straight from treatment into training and then onto clinical work. I have not known them in general to be rounded enough to be effective in this work. In some instances I think they are downright dangerous. It varies of course, somebody with a decent employment history will have probably a greater sense of reality about the working world than someone who has never worked.

My advice would be to do nothing in this field for at least a couple of years. Then maybe one could take a counselling certificate course, which really is an introduction to see if one is suitable. Following that, if the desire is still there, the diploma course is a two-year one. By that time someone would be four or five years out of rehab and, to be honest at that stage, most convictions, save those for very serious offences, would be irrelevant to an employer in a drug and alcohol milieu. Thus the dilemma does not really arise.
Nigel Radcliffe, London Underground

Reader's question

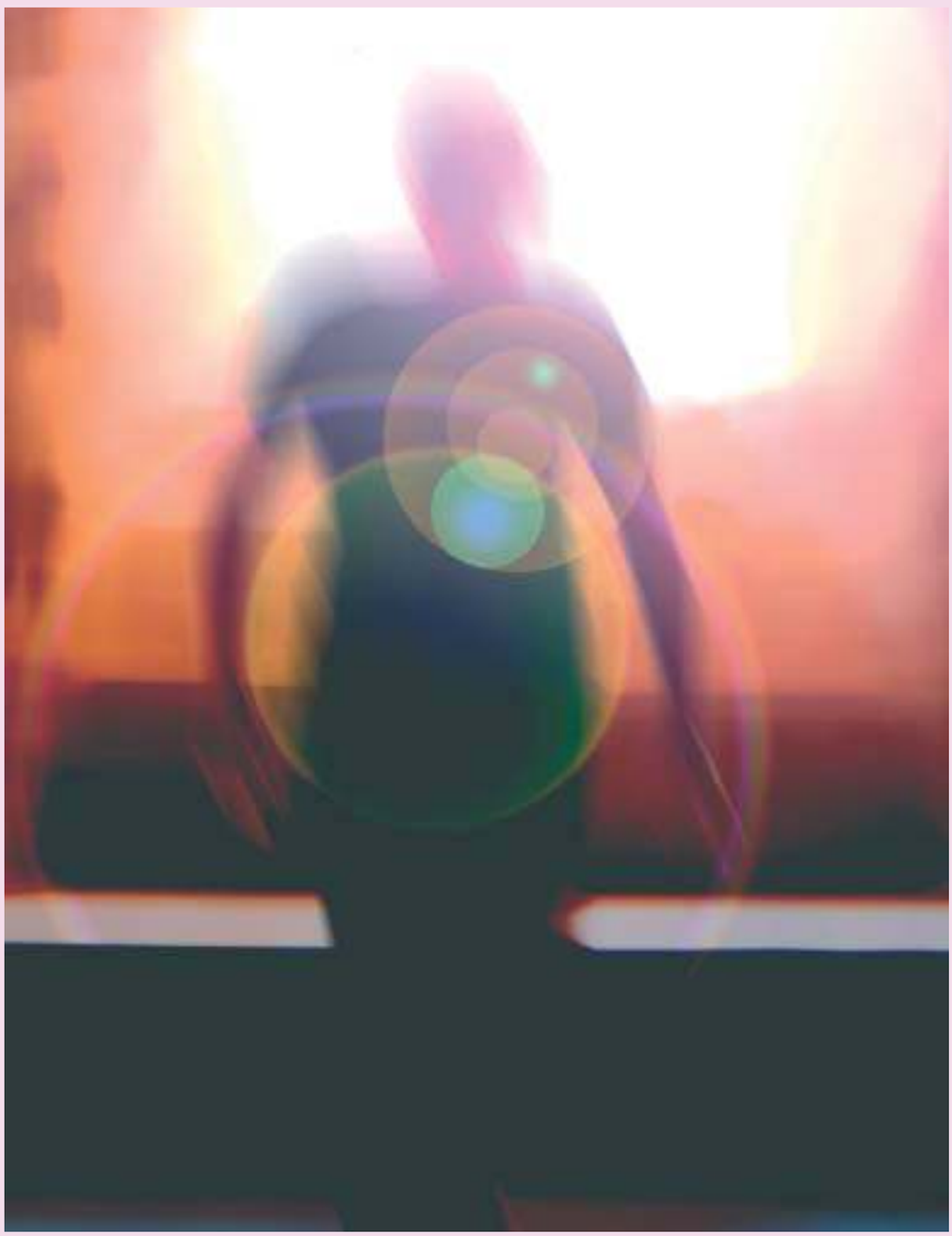
I am mother of a 22-year-old. I feel like I'm in an impossible situation. I discovered a while back that my son was a heroin addict. I joined a local support group and when he found out he went mad at me. He accused me of betraying him and telling the neighbours. I have been too scared to go back. Now I feel like a prisoner in my own home. Please help – I don't know how it has come to this.
Sandra, Yorkshire

Email your suggested answers to the editor by Tuesday 30 August, for inclusion in the 5 September issue of DDN.

New questions are welcome from readers.

Throwing light on the 12 steps

In the first part of Rosie B's brief introduction to the 12 steps as developed by AA, she looked at the concept of powerlessness, at the barriers to acceptance of the alcohol problem and the ability of alcohol to numb feelings which can block self-understanding and change. In this concluding part, she look a little deeper at steps two and three, and at the remaining 'growth steps.'



AA Members may be resistant at first to connect with the group. They may share how they are getting on or how they are feeling today and preface this with a statement – 'I am John and I am an alcoholic'. Most come to accept this not as stigmatic labelling but as a way of connecting in a group and it also helps them focus on why they are there – not because of their status, their job, their family life, but because of their addiction.

The second step – 'we came to believe that a power greater than ourselves could restore us to sanity', represents a conscious shift to acceptance that something outside of the self and the will can help relieve cravings to drink. This is probably the most controversial of all the steps of AA. It has been interpreted as the pre-eminent example of AA as a religion that promotes God as the supreme external force. It also pre-supposes that all AA members will come to accept that their drinking behaviour constitutes some form of insanity. It might indicate that for the atheist and the agnostic there is no hope. This is not the case. AA tradition insists that controversy and personal beliefs, both political and religious, are left outside the meeting room. Meeting rooms themselves are often held in church halls, but only because they are more cost effective and available. The only requirement for membership is a desire to stop drinking.

A whole chapter of AA's original *Big Book* of early founders' experiences is called 'We Agnostics'. In an increasingly secular age, belief in a God is a matter of choice and in AA the concept of a 'higher power' is the get-out-clause. For many, this simply means that the power that alcohol held over the individual can be replaced by the AA group itself and the supportive human relationships that are built there.

AA and the 12 steps teach tolerance as a way to inter-relate, both within the AA meeting rooms and in the wider world. Tolerance brings peace of mind in a life where intolerance is a noticeable characteristic of alcohol-fuelled behaviours.

The third step of AA is often a turning point – one to which many AA members will return to on a daily basis: 'We made a decision to turn our will and our lives over to the care of God as we understood him (or her).' It is a step for dealing with resentment and frustration in life that might trigger cravings. When the JCB of their own will meets the immovable object that life sometimes presents, this step says hand it over to a higher power – whoever or whatever you conceive that external force to be.

Practical application of the process of handing over is expressed in AA's 'Just for Today Card' which has imprinted on it the useful words to help members focus when things are going wrong in life: 'grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.'

AA has never claimed to be a substitute for other therapeutic interventions that an individual may need. Moreover, 12-step facilitation has been included within therapeutic programmes for substance misuse for decades.

AA members sometimes talk about how the penny takes a while to drop in understanding the meaning of all the 12 steps and the programme of AA. They find they return time and again to step one, two or three on a daily basis to keep balanced. Others talk about the process as peeling back layers of an onion to find who they are. It is about deeper self-awareness, but it is also a journey on the road to self-actualisation.

AA members call on a range of useful well-worn phrases, as tools to remind themselves to keep focused. One of these phrases is – 'there is no growth without pain'.

AA members never graduate as such. The 12 steps is not a PhD thesis either. It is a programme for living that is useful long after an individual has put down their drug of choice. The fact that people keep coming back to an AA meeting is often interpreted as a developing dependency on AA. The pros and cons of that are debatable. But what coming back does, is allow for reinforcement of the learning process which strengthens a personal commitment to change, that can be so easily challenged in daily life. It also encourages people to get involved, to maybe start up meetings where needed and carry the message of their own recovery to others.

Steps 4 to 12 have been called the real growth steps. They are designed to enable a person to re-evaluate their life, beginning with step 4 and an honest self-examination and in step 5 the sharing of events and themes in their life with another. Talking about losses, shame and guilt, related to their addiction, is tough. Such honest appraisal may need several re-visits and a shift to arriving at new perspectives of the past. Keeping a daily inventory keeps people mentally flexed to deal with life. Fear of growth and of life is replaced by a strength gained from fellow members, and for some it is true, from a faith. The emptiness inside, experienced by many in their drinking, disappears. People are encouraged to stop projecting into an unknown future which can fuel irrational fear, and after learning from their history, to move on from dwelling in a past that can't be changed.

Step 7 focuses on looking at the things about ourselves that cause us problems. Writing a balanced inventory of things we like about ourselves is of course as important as writing down the negatives, particularly for people who may have lost a sense of self-worth. People often find it extremely difficult to balance negative self-perception with positive assessment.

'In an increasingly secular age, belief in a God is a matter of choice and in AA the concept of a 'higher power' is the get-out-clause. For many, this simply means that the power that alcohol held over the individual can be replaced by the AA group itself and the supportive human relationships that are built there.'

Steps 8 and 9 and 10 help people to acknowledge past behaviours and to make amends to a list of people who were harmed in some way by drinking or drugging behaviours, and to continue to do so. This becomes part of an inner process of cleaning house. In step 8, AA advises that not everyone on the amendments list will appreciate being approached. Sometimes the willingness to make amends is all that is possible.

The 12 steps are not all about hard work. Step 11 is a re-vitalising step, and is there to encourage meditation and reflection. Ironically, many members, used to going to extreme lengths to plan a drinking strategy, find quiet meditation one of the hardest steps.

AA could not exist without step 12 being put into practice. The focus on helping others, but not 'fixing' others, requires an awareness of one's own limitations and motives. Learning the difference between humility and humiliation helps. Members of the AA 'fellowship' are often helped along the way by an AA sponsor, a person who will be about two years or more away from a drink or drug. All it takes is one sober person passing a message about how they stopped drinking to another human being who has asked for help. Sponsors act as guides and friends. The 12th step is the seed from which AA has grown to be worldwide organisation with meetings that take place most days of the week, at evenings and weekends in many towns and cities.

The AA 12-step book gives a fuller explanation of how it works. It involves lots of practical advice and common sense and it calls on deep personal knowledge and experiences of how people may relate better to themselves, to one another and a wider world without alcohol and go on to live useful productive lives. In that sense the steps are not owned by anyone but are open to everyone who wants to use them. That is also why they have been adapted for use with a range of other addictive problems.

AA members often remind each other that many more people go on to die from their addiction than will remain free of alcohol. That is undoubtedly true. This fact is possibly the best reason why the occasional article about the 12 steps and their benefits is important. Alcohol addiction and dependency is one of the greatest problems faced by many different societies across the world. Self-help grew from the users themselves, to address the problem. It's free, and it is available most evenings and weekends, it is accessible and its provision does not depend on government or any commissioner.

I have experienced the death of close friends and relatives from alcohol addiction and faced death myself. Any death is a tragedy. But death from alcohol misuse can be slow and tortuous for the individual and their family. It can be one of the loneliest, saddest, and deeply disturbing endings for any human being. It is not only the fact that alcohol misuse can affect almost every physical organ in the body including the brain, but alcohol addiction wastes so much human potential, often slowly but inexorably, without dignity but with anguish, without peace, but with turmoil. It leaves in its wake, ruined relationships, shattered families, broken homes and damaged children.

The gifts of AA are there for the taking, and in the very act of taking the 12 steps on board, an individual will find themselves in a giving relationship with other human beings. As AA members are fond of saying – you can't give away what you have not got.

In its 70th year, AA and its 12 steps have a lot to offer. But it is not the only way.

Drug and alcohol workers who are interested might benefit from visiting an open meeting of AA and NA as an observer. AA service offices can help you to find one near you. Call 0845 769 75555. The 12 traditions of AA may be found on the AA website: www.alcoholics-anonymous.org

Service users get on board for needs survey

User involvement is all about grabbing the moment and doing what needs doing – what better place to do a user needs survey than on a bus? Sharyn Charlton tells DDN what's been going on in South Tyneside.

When South Tyneside Advocacy Group was looking for a location for their drop-in centre, they came across the 'Health Express' bus. The vehicle was already used for other health-related campaigns, such as smoking and cancer awareness, so was a discrete and convenient place that service users felt comfortable using, according to Tyneside DAT's user involvement worker, Sharyn Charlton.

'At first we used it as a drop-in where people could come and have a chat, get a cuppa and a sandwich,' she says. But before long there were too many visitors for the space, and the group had to revert to office space for meetings. Not that this turned out badly. The Advocacy Group approached the DAT with its concerns, and has just been awarded £60,000 to open a user-led drop-in centre in the area.

The bus proved to be a perfect venue, with a large seating area, a private interviewing room, TV, video, heating, coffee-making facilities and a radio...

Latest use for the bus has been a piece of research commissioned by the DAT and carried out by the Advocacy Group, to find out more about geographical variations in drug users' needs in the region, which is split into the four areas of South Shields, Hebburn, Boldon and Jarrow.

The Advocacy Group received research training and interviewed 154 respondents in just two days. 'We had a fantastic response from local drug users and originally thought the research would take five to seven days... we had to cancel the bus for the rest of the week!' says Charlton.

Each interview took around 15 to 20 minutes and respondents were paid £10 for their time. The bus proved to be a perfect venue, with a large seating area, a private interviewing room, TV, video, heating, coffee-making facilities and a radio – 'which makes it quite comfortable'.

The group's research findings are now being analysed, and will be presented to drug users, the DAT and policy-makers in late August. The DAT is working towards building an 'evidence based learning portfolio' of the Advocacy Group's work, she says.

Certainly the group seems to have momentum. Next month they will be heading off to the lake district for five days with Sunderland and Gateshead user groups – a party of 28 – to do advocacy training, training in 'stronger voices' (consumer council training) as well as quad biking, raft building, kayaking and paintballing.

Back home, the group is working with local GPs to design a training package for other doctors in the area, an exercise that has involved 'being bogus patients at a local GP surgery' and filming consultations with doctors.

'So far this has gone really well,' says Charlton. Training works both ways, in informing doctors of drug users' needs 'and the effects they can have over that person's life and treatment', and in helping drug users to get the best out of their GP and surgery. The initiative will soon go a step further, in giving the group a taste of working with the practice's receptionists, 'so we can understand the pressures of their jobs'.

The bus seems to come in particularly well as a focal point for campaigns and research, she says. Next stop will be a harm minimisation campaign, which the group will launch in late September. **DDN**

Research and guidance

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

Retaining clients in drug treatment – Guide for providers and commissioners. NTA, June 2005.

The effectiveness of psychological therapies on drug misusing clients – A review of the effectiveness of psychological therapies. NTA, June 2005.

A national survey of retention in residential rehabilitation services – Research in to treatment retention in residential services. NTA, June 2005.

Opiate detox in an inpatient setting – A review of the use of inpatient services for opiate detoxification. NTA, June 2005.

Drug misuse treatment and reductions in crime – Review on impact of drug treatment on offending behaviour. NTA, June 2005.

Tier 4 services in England: Summary of needs assessment and inpatient review – Examining level of residential provision vs need. NTA, June 2005.

Women in drug treatment services – A research review re women in treatment. NTA, June 2005.

Young people's substance misuse treatment services – essential elements – Guide on commissioning and developing services. NTA, June 2005.

Outcome of waiting lists summary – Research summary on impact of waiting times. NTA, June 2005.

Developing peer led support for individuals leaving substance misuse treatment – Guidance on peer-led aftercare support. Home Office & NTA, May 2005.

User feedback and complaints – Good practice guidance on handling complaints. NTA, April 2005.

Working in partnership – Guidance on partnership working to improve care. NTA, April 2005.

Drug Intervention Programme for Children and Young People early evaluation findings – Evaluation of DIP for young children and young people. Home Office, April 2005.

National Offender Management Service (NOMS) Drug Strategy – Strategy for management of drug using offenders. Home Office (NOMS), January 2005.

Guidance for hepatitis A & B vaccination of drug users. – Guidance for primary care workers on hepatitis vaccination. RCGP, November 2004.

Guidance for working with cocaine & crack users in primary care – Guidance for primary care workers on crack and cocaine. RCGP, September 2004.

Guidance for use of buprenorphine for treatment of opioid dependence in primary care – Guidance for primary care workers on buprenorphone. RCGP, June 2004.

Should recreational drug use be criminalised? (part 2)

Professor David Clark continues to look at the arguments of the philosopher Douglas Husak about drug laws in the US, this time focusing on the negative effects of prohibition.

Douglas Husak argues that the injustice of criminalisation provides a strong reason to abandon punitive drug policies. He also argues that prohibition has caused a great deal of harm because it is counterproductive. He describes a number of bad consequences that are caused as a result of insisting that illicit drug users be punished.

Husak views racial bias as perhaps the most scandalous aspect of the punitive drug policy of the US. Even though white drug users outnumber blacks by a five to one margin, blacks comprise 62.7 per cent and whites 36.7 per cent of all drug offenders in state prisons. In Illinois, the state with the highest rate of black male drug offenders behind bars, a black man is 57 times more likely to be sent to prison on drug charges than a white man.

The disparity in punishment for possession of powder and crack cocaine is further evidence of racism in US drug policy. Whilst a first time offender convicted of possessing more than five grams of crack receives a mandatory sentence of five years imprisonment, 500 grams of powder cocaine are needed before offenders receive a comparable sentence. About 90 per cent of federal crack offenders are black, whilst almost 50 per cent of powder cocaine defendants are white.

Prohibitionists claim that prohibition is justified to protect health. The National Institute on Drug Abuse (NIDA) lists 25,000 fatalities per year from illicit drugs in the US. However, Husak argues that a majority of these deaths are more properly attributed to drug prohibition than to drug use.

Some 14,300 fatalities are due to hepatitis and AIDS, diseases caused (mostly) by shared dirty needles. Needle exchange schemes could have prevented many of these deaths – and have been very successful in other countries – but the possession, distribution, and sale of syringes remain criminal offences in much of the US. The federal government continues to prohibit the allocation of its funds for needle exchange programs.

There is vast historical evidence that demonstrates the pernicious role drugs have played in international affairs.

In 1999, Congress passed the Western Hemisphere Drug Elimination Act in 1999, which authorised over $246 million for crop eradication programs. Husak argues that 'these programs have exacerbated human rights violations, strengthened undemocratic governments, and have helped to forge alliances between guerrillas and peasant growers.' Eradication programs in Columbia have led to the clearing of over 1.75 million acres of Amazon rain forest and some environmentalists predict that within 50 years poor agricultural soils in Columbia may not be able to support the population. At the same time, aerial spraying of pesticides has destroyed legal subsistence crops and produced various health problems. Eradication programs have not reduced supplies to the US – crops are more likely to be moved elsewhere than eliminated.

In Illinois, the state with the highest rate of black male drug offenders behind bars, a black man is 57 times more likely to be sent to prison on drug charges than a white man.

It is argued by prohibitionists that drug users are more likely to commit crimes than those who do not use drugs. However, crime may actually be increased by prohibition. This is obvious in the case of systemic crime, with violence being more prevalent in illicit than in licit drug markets. Some people argue that more economic crimes are committed in a society with black market drugs than would be the case if drugs were decriminalised.

Although it is commonly assumed that communities become safer when criminals are sent to jail, this conventional wisdom has been challenged. Offenders become more deeply immersed in criminal subcultures and learn more sophisticated skills for committing crimes when in prison. And they eventually return to the neighbourhoods from which they came. Moreover, men who have been to prison are less likely to marry, get good jobs, or to develop productive relationships with family members once they are back on the streets – all of these increase their propensity to commit crime.

Husak believes that 'truth is among the casualties of our misguided drug policy'. Lies and hypocrisy prevail. 'The demonisation of illicit drugs is so pervasive that frank and honest discussion is almost impossible', and people are afraid of the repercussions if changes are made. Children are sceptical of what they are told about drugs, whilst educators may be sceptical about certain programs – and have proof backing this sceptism – but are scared to speak out because they may be called soft on drugs.

Prohibition has eroded civil liberties in which Americans take pride. Asset forfeiture has been a favourite strategy in the drug war. Assets may be seized if it is thought they were obtained by money obtained from drugs. This might preclude someone being able to pay for their defence.

Schoolchildren wishing to take part in after-school activities (*eg* playing clarinet) may be drug-tested. Women convicted of a drug offence may lose their social security benefits for life.

Husak points out that prohibition and the huge amounts of money in the illicit drug trade create irresistible temptations for law-enforcement agents to place themselves above the law. Some studies claim to conservatively estimate that 30 per cent of the nation's police officers have been unlawfully involved with illicit drugs. According to the Government Accounting Office, half of all the police officers in FBI-led corruption cases between 1993 and 1997 were convicted of drug-related offences.

The eighth and final counterproductive effect of prohibition put forward by Husak is that the US's 'punitive drug policies cost exorbitant amounts of money. The federal government now spends close to 20 billion dollars per year, and state and local governments at least that much again, on combating illegal drugs'.

A more detailed description of Husak's arguments can be found in his book – an excellent read – or in the About Drugs section of www.substancemisuse.net.

CRACK COCAINE NATIONAL CONFERENCE

18 October 2005

Jurys Inn, Broad Street, Birmingham

This one day conference will provide a unique opportunity for delegates to consolidate and improve their knowledge and skills within the area of crack cocaine. For the first time Birmingham Drug Action Team and Cranstoun Drug Services will be bringing together expert speakers to present the theoretical concepts when working in the area of crack and polydrug use. In addition a range of practitioners will facilitate workshops presenting practical measures with what works currently in the field. The day will cover important areas such as commissioning, treatment, young people, community engagement and criminal justice.

Altrix

TACKLING DRUGS CHANGING LIVES

Cranstoun drug services

Heart of Birmingham Teaching PCTs

For registration and enquiries please contact
Salma Master or Grantley Haynes on 0121 675 1804/1816
email Grantley.haynes@hobtpct.nhs.uk
Birmingham Drug Action Team
Part of Birmingham Community Safety Partnership
Ladbroke House, Bordesley Street, Digbeth, Birmingham, B5 5BL

National Criminal Justice Drug Workers Forum

First Annual National Conference

'DIP INTO PARTNERSHIPS'

19/20-21 SEPTEMBER 2005

MOAT HOUSE HOTEL, YORK

Aimed at those involved in drug services from all sectors of the criminal justice system, the theme of this two-day residential conference reflects the diversity of roles and partnerships operating in this field. Focused on worker development the event consists of a range of interactive and participative workshops as well as presentations on key themes, all designed to educate, inform, share and disseminate best practice and experiences between the sector partnerships.

For a full programme and registration details, contact:
The National Criminal Justice Drug Workers Forum
Tel: 01759 388855 Email: gill@altura-events.fsnet.co.uk
Or visit the website: www.drugreferral.org

Faculty of Health & Human Sciences

DipHE/BSc (Hons) Substance Use & Misuse Studies

Starting October 2005

Programme structure

The programme provides an essential overview on substance use and misuse issues from a number of perspectives, such as health and social care, criminal justice, child protection, young people and community care. It explores various types of substances commonly used and introduces a variety of evidence based interventions.

Modules can be taken in isolation or combined leading to a Diploma or Degree.

This multidisciplinary programme has been mapped against the Drug and Alcohol National Occupational Standards (www.danos.info).

Who can apply

The programme is suitable for a wide range of professionals working with alcohol and drug users including nurses, social workers, drug and alcohol treatment workers, those who work in homeless and youth services and in the criminal justice system, in both the statutory and voluntary sector.

020 8280 5705

health.tvu.ac.uk/sums health.ealing@tvu.ac.uk

Thames Valley University
London Reading Slough

TVU

NCA

Addictions FORUM

Pavilion

Exploring Research, Policy and Practice Issues

RESEARCH, POLICY PRACTICE

The NCA and the Addictions Forum are pleased to announce the 2005 International Addictions Conference. This high-profile joint venture aims to bring together all those who confront the challenge of addiction-related issues in research, policy and practice.

For further information please call Pavilion on 0870 890 1080, or visit www.pavpub.com

Date: Wednesday 7, Thursday 8 and Friday 9 September 2005
Venue: University of Ulster, Northern Ireland

Gwent Police is a progressive police force which aims to promote safety and reduce public disorder, crime and the fear of crime to the communities of South East Wales.

ARREST REFERRAL OFFICER

£22,476 - £26,085 per annum

37 hours per week

Gwent Police are seeking to employ an additional Arrest Referral Worker to join the existing team on a 12 month contract after which the post will be incorporated into the Drug Intervention Programme. Gwent Police is committed to ensure that all detainees passing through the cells of all police stations in Gwent are given the opportunity to speak to a Substance Misuse Worker.

The postholder will be responsible for delivering the existing system of arrest referral throughout the police stations/courts of Gwent.

There will be a requirement to liaise with partners from the local authority partnership substance misuse action teams, Gwent Specialist Substance Misuse Service, National Probation Service, the Gwent Alcohol Project and Kaleidoscope.

The successful candidates will have highly developed oral and written communication skills and must possess a Certificate in Counselling or other equivalent qualification with a minimum of 2 years experience in a counselling field.

Candidates should be IT literate and be proficient in the use of Microsoft Word and Excel packages.

A sound understanding of substance misuse and how it impacts on crime and disorder is essential.

Application forms and role descriptions are available from Personnel Department, Gwent Police Headquarters, Croesyceiliog, Cwmbran, NP44 2XJ. Tel: 01633 642133. Role descriptions are also available on our website.

Closing date: noon, 12th August 2005

CVs and/or late applications will not be accepted.

We welcome applications from all sections of our community. Gwent Police is committed to becoming and equal opportunities employer with selection based on merit. Applications for both full-time and job share are welcomed.

HEDDLU GWENT POLICE

www.gwent.police.uk

BRIGHTON OASIS PROJECT

Aiming to reduce drug-related harm to women and their families

Outreach Worker (Female*)

22.5 hours per week
£20,970 NJC scale point 27 pro-rata

This post is funded by Brighton and Hove City Council's Communities Against Drugs initiative. We are seeking to appoint an Outreach Worker to target high risk and priority women substance misusers and engage them with the City's treatment system. Candidates will have experience of helping women access substance misuse services, supporting women substance misusers in difficult situations, educating them about substance use, health and social well-being and assessing their needs for care.

Closing date for applications: **Tuesday 16th August 2005**
Interviews: **Wednesday 24th August 2005**

For a pack/further information,
please call Jess or Gary on 01273 694 222

BOP is committed to equal opportunities and welcomes applications from people with relevant life as well as professional experience, and those with disabilities who are currently under-represented in the organisation.

**This post is exempt under para 7 (2) of the Sex Discrimination Act*
Charity no: 0165503 Company no: 3447762

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.

Exeter, East & Mid-devon Adult service – Team Leader

EDP is well recognized as THE leading non-statutory service provider of drugs work within the Devon and DAAT areas. All Staff are fully committed to evidencing the highest standard of service provision and outcomes for service users.

Based: **Exeter – local travel required**
Ref: **09.05**
Salary: **£24,708 - £27,411 (NJC Scale 32-36)**
Hours: **35 (Full Time)**

We are looking for an experienced skilled individual with excellent leadership, communication and interpersonal skills. Professionally qualified, you will have an impressive record of experience within the substance misuse, criminal justice or related fields. You must be committed to achieving results, possess a proactive and outcome-focused approach to work, plus commitment to delivering the highest standard of professional practice.

The Exeter, East and Mid Devon adult services are commissioned to deliver direct access, needle exchange, structured case work, criminal justice services and structured day programmes. The successful applicant will assist the Head of Service ensuring service level agreements are achieved and that effective case supervision, support and management of staff takes place in accordance with evidence based practices. You will still have the opportunity to work directly with service users as you will be responsible for a small case load of clients with complex drug misuse problems.

You will be joining EDP at a time of review and development with a committed culture of improving our performance and outcomes for service users. You must be able to lead from the front and evidence commitment and skill in developing integrated partnership practices.

You will receive opportunities for professional development and learning as well as having the opportunity of working for an organisation that provides an excellent employee package.

Closing date: 12noon 8th August 2005

We would welcome applications from general or specialist drugs practitioners as vacancies arise from time to time.

Application forms for all posts available from:
Georgina Burford, Human Resources Officer,
EDP Drug & Alcohol Services, Dean Clarke House,
Southernhay East,
Exeter, EX1 1PQ,
Or E-mail recruitment@edp.org.uk
quoting the reference number.

For an informal discussion please contact either Caroline Moore, Head of Exeter, East & Mid Devon adults service on: 01392 666719, or JJ O'Reilly, Director of Client Services on: 01392 666721, following receipt of the application pack.

INVESTORS IN PEOPLE UK

LIFEBUOY

Lifebuoy is a new and dynamic provider of residential substance abuse rehabilitation. Working specifically in Herefordshire and its surrounding rural regions, our nine fully supported residential places, located in a rural setting, provide specialist rehabilitation techniques to counter the issues of rural isolation.

We are based in the Wye Valley, a designated Area of Outstanding Natural Beauty, and require a:

House Warden

(Salary £11,000pa 37hrs per week – flexible, to include full accommodation; this is a residential position)

The successful candidate will be responsible for out-of-hours security, administration, and supervision of up to nine service users. An empathy with persons undergoing abstinence-based rehabilitation would be advantageous. A person with a fully-resolved history of dependency and/or involvement with the criminal justice system would not automatically be precluded.

DANOS or QUADS qualifications are desirable but not essential.

It would be expected that the House Warden will work fully in conjunction with all staff.

This is an opportunity to engage at ground level with an ambitious and progressive organisation and, for the right person, not so much a job as a career.

For an informal chat call John Cooper on 01594 860185
Email info@lifebuoy.wyenet.co.uk
Application forms may also be obtained from:
Lifebuoy, PO Box 36, Ross-on-Wye HR9 6WA

We're Addaction, a leading UK charity working solely in the field of drug and alcohol treatment. With over 70 services, we work within communities and individually with clients from all backgrounds, helping to reduce substance misuse and to combat the harm it causes. Now we want you to help us evolve our services further and in the process find far-reaching solutions to one of the major social issues of our day.

Addaction is an equal opportunities employer.

Charity no. 1001957

www.addaction.org.uk

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

established 1967

addaction

LOOKING FOR A TRAINING FACILITATOR.

The SMART Scheme is a professional training programme run with our partners Rugby House. It provides the substance misuse field with experienced workers. We are looking for an individual who is committed to their professional development and has some experience of working with service users in the field.

NVQ TRAINER

Up to £27,700 depending on experience

Supporting trainees to gain their NVQ level 3 in Health & Social Care means much more than training delivery. You will work with our partner agency and your excellent team to develop and design new training packages. You will be constantly evaluating current training packages and looking for ways to improve them. You will also be involved in making decisions regarding trainee involvement from recruitment through to assessment and completion.

While a NVQ level 1 Assessor qualification is desirable, more important will be your experience, either in training or with group work. This base will give you the transferable skills to take on this role, and we can train you to get the official qualification. Additionally you will need to be confident, enthusiastic, self-motivated and able to reflect on your practice.

For an application pack, please call Judith Boateng on 020 7017 2723 or email j.boateng@addaction.org.uk quoting ref ADD-LR45

Closing date: 15 August 2005.

RAPt

REHABILITATION for ADDICTED PRISONERS TRUST
"STOPPING ADDICTION, STOPPING CRIME"

Following the recent Prison Service re-tendering exercise, RAPt has been awarded 14 new drug service units to provide CARAT Services and accredited 12-step based Substance Abuse Treatment Programme in HM Prisons across England. We are therefore undergoing a major expansion, offering many exciting opportunities to become part of one of the country's foremost providers of drug treatment services in prisons. We are currently looking for staff in the following positions and locations:

Senior CARAT Worker:

HMP Bullingdon, Oxon
Starting Salary £24,000

We are looking for a full time Senior CARAT Worker to join our team at HMP Bullingdon. For this position a good understanding of the drugs field and experience of working with this client group is essential, as is line management experience. Previous experience and a clear understanding of the CARAT system is highly desirable. You will also need to be efficient, enthusiastic and determined, with the ability to work in a challenging, sometimes pressurized environment.

CARAT Workers:

Various HM Prisons in London area
HMP Standford Hill, Sheppey, Kent; HMP Elmley, Sheppey, Kent; HMP Coldingley, Surrey.
Starting Salary £21,000 (plus £1,000 London Weighting for units located within M25)

We are looking for CARAT workers to join our teams at the above-mentioned establishments. For these positions, a good understanding of the drugs field and experience of working with this client group is essential. Previous experience and a clear understanding of the CARAT system are also desirable. You will need to be enthusiastic and very determined to be able to work within the challenging environment of a prison.

Counsellors:

HMP Swaleside, Sheppey, Kent;
HMP Bullingdon, Oxon
Starting Salary £21,000

We are looking for counsellors to join our teams at the above establishments. To be successful, you would need to have a thorough knowledge of, and commitment to 12-Step. Counselling qualifications and experience are essential, with experience of working with addicts desirable. Some level of training will be provided for staff with limited experience of working with this client group. You will also need to be efficient and determined, with the ability to work in a challenging environment.

Training Officer:

RAPt Head Office, Vauxhall, London
Part time: 20 hours per week; Starting Salary £24,000 (pro rata)

We are looking for a part time Training Officer to assist in the co-ordination and delivery of training programmes to RAPt CARAT and 12-step Treatment teams, as well as external training if required. To be successful, you would need experience of providing training to a diverse and varied group as well as a thorough understanding of accepted approaches to addiction treatment, especially 12-step. Strong written and verbal communication skills are also essential.

If you are interested in any of the advertised positions and would like to receive an application pack, please send an SAE for 45p to Amanda Coburn, RAPt, Riverside House, 27-29 Vauxhall Grove, London, SW8 1SY, clearly stating which position you are interested in.

Closing date for completed applications: Monday 15 August 2005

RAPt strongly encourages applications from Black and Minority Ethnic individuals and from those in recovery from addiction.

NO AGENCIES PLEASE

Registered Charity no. 1001701

www.rapt.org.uk

St.Helens Council

Join us. We're *Excellent!*

www.sthelens.gov.uk

St.Helens Council is one of an elite handful of councils to be classed as *Excellent* by the Audit Commission's Comprehensive Performance Assessment 2004

Chief Executive's Department

DAAT Business Manager

SCP 37 - 40, £28,179 - £30,747 • Ref. UHS5

DAAT Community Support & Information Officer

SCP 29 - 31, £22,512 - £24,000 • Ref. UHS6

37 hours per week

Are you looking for a new challenge?

Do you want to make a difference?

Do you want to work for an 'Excellent' Council?

Following a reorganisation of the management framework for the CDRP and the DAAT, the Council is looking to appoint to two key posts.

As well as being in a position to influence delivery, you will help develop and implement a performance management framework and ensure that service delivery targets are met. In particular, we are looking to develop community and service user involvement.

Whilst qualifications are important we are more interested in candidates who understand the issues around drug and alcohol misuse and the community benefits to be gained from having effective drug and alcohol interventions.

The posts will be located within St.Helens Council's Safer and Stronger Communities Team but you will be working with a range of partners. The posts are grant funded and initially the contracts will be up to the end of March 2006, although it is expected that funding will continue until March 2008.

Interviews for both posts will be held during week commencing 5th September 2005, although we recognise that this is in the holiday period and if you have commitments that make you unavailable during this period, please let us know on your application form.

For an application form, please contact Claire Barker on 01744 456072 or Human Resources, Town Hall, Victoria Square, St.Helens WA10 1HP. Alternatively email: ChiefExecutivesJobline@sthelens.gov.uk

Closing date: 16 August 2005.

St.Helens Council is committed to equal opportunities

When requesting an application form, please state your name, your address, the job you are interested in and the job reference number.

For a full list of all Council job vacancies, please visit the Council's website - www.sthelens.gov.uk

The Council is committed to providing a smoke free environment. Flexible working practices are in operation.

We're Addaction, a leading UK charity working solely in the field of drug and alcohol treatment. With over 70 services, we work within communities and individually with clients from all backgrounds, helping to reduce substance misuse and to combat the harm it causes. Now we want you to help us evolve our services further and in the process find far-reaching solutions to one of the major social issues of our day.

www.addaction.org.uk

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

established 1967

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'Breaking the Cycle' is groundbreaking

Addaction is looking for exceptional people for exceptional opportunities.

PROJECT CO-ORDINATORS (4 YEARS FIXED TERM)

Derby City — Ref: ADDDC48

West Cumbria — Ref: ADDWC49

£25,417 - £28,333 pa

London (Tower Hamlets) — Ref: ADDLR47

£31,780 - £35,140 pa

incl. London weighting and market adjustment

350,000 children are at risk in the UK from parental and carer drug misuse. Addaction has received £1 million from the Zurich Community Trust to set up pilot services in three different areas over four years. The pilot services will work with families at risk from what has been called the hidden harm of drugs misuse.

Project Co-ordinators will set up and co-ordinate the project working in their locality, and together across three pilot sites/regions. A major objective will be to develop an evidence-based treatment package designed to address the generational cycle of drugs misuse.

You will be working with families and carers in a variety of settings including the home. Part of the work will be to develop family-focused training packages for other relevant professionals in each area. Our aim is to build a body of knowledge backed by evidence. We will ally that with building experience of cross-sector working that could contribute to future family support and treatment delivery.

This transformational initiative has the potential to contribute to Government policy to address hidden harm. Addaction intends to develop this initiative as a way of bringing other charities and partner agencies together at a national level. The work you perform on the ground will inform a national steering group and also feed into seminars and publicity campaigns.

Your dynamism and commitment to change lives, your confidence and good organisation will help shape Breaking the Cycle. If you are currently working in family or child therapy and have a good knowledge of drug and alcohol issues then please apply to join us.

Full position details and application packs are available on our jobs section at www.addaction.org.uk or alternatively, email p.mcardle@addaction.org.uk or phone 020 7017 2723 quoting the appropriate reference number.

Closing date: 12 August 2005.

Solutions Action Management Recruitment & Consultancy

www.SamRecruitment.org.uk

Are You Looking For Staff?

We have a comprehensive database ofspecialist substance misuse personnel

DAT Co-ordinators ● RoB Co-ordinators ● Project Workers ● DIP Workers Counsellors
Commissioning Managers ● PPO workers ● TCAC workers ● Case Managers

Consultancy, Permanent, Temporary

"We have found Solutions Action Management to be a focussed professional and responsive provider of both Consultancy and interim management support as well as helping with our permanent DAT coordinator/ recruitment. They have been able to target our own specific needs and have provided high calibre candidates for us."
Chief Executive – Slough PCT

Contact the Director to discuss your recruitment needs: Samantha Morris Tel/Fax 020 8995 0919