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DDN
Drink and Drugs News

30 May 2005
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Drink and Drugs News

30 May 2005

Editor's letter

When you've got an out of control drug or alcohol user in the family, the last thing you want to do is talk about it. You watch that person transform and lose control, and you wonder why they don't notice what they're losing – but you don't want to tell friends, neighbours, the rest of the family. Gradually they slip out of view at family gatherings, and you are left wondering if you will ever get them back before it's too late.

If you're lucky, someone will point you in the direction of one of the excellent family support groups around the country. The work of these services cannot be underestimated – if you are in any doubt, read a mother's story on page 8.

It may seem surprising that learning to laugh about a situation so dire could even come into the equation, but our look at the good practice guide for family services (page 6) describes essential building blocks for keeping family life intact.

Advice from consultation with service users all over the country has been used to draw up quality standards that should help family services with their bids for funding. Many find it hard to keep a high profile for much-needed money, when they are used to dealing in anonymity.

For an inside view from a service provider, we asked the service manager from Hetty's about what happens on a 'typical' day. The Nottinghamshire service has found imaginative ways to reach out to families who have become prisoners in their own homes.

David Wright comes to the end of his six-part story on page 14 – and concludes by thanking his mother. After all he put them through, he still wonders at his parents' willingness to support him. But as so many of the services say, what better resource to harness than a drug or alcohol user's own family?

Editor:
Claire Brown
t: 020 7463 2164
e: claire@cjwellings.com

Advertising Manager:
Ian Ralph
t: 020 7463 2081
e: ian@cjwellings.com

Designer:
Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

Website:
www.drinkanddrugs.net
Website maintained by wiredupwales.com

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In this issue

Media watch

Children who play truant from school are more likely to use drugs than people from other vulnerable groups, according to Home Office research. Larger numbers of truants or adults who skipped school in their youth had used drugs than serious offenders, persistent criminals, the homeless or people who had spent time in care.
Manchester Evening News 26 May

A jury at Exeter Crown Court has been listening to 'coded' telephone conversations between prisoners in Channings Wood jail and people on the outside allegedly putting the finishing touches to a conspiracy to smuggle drugs into the compound. A police expert told the jury how slang terms for drugs were used as part of a plot to get in supplies of heroin and cannabis for inmates: 'nine of magic dragon' was used to refer to a nine bar of cannabis and magic dragon was slang for cannabis as in Puff the Magic Dragon, Other terms used included 'fleetwood' which was interpreted by the officer to be rhyming slang, as in Fleetwood Mac referring to smack or heroin.
South Devon Herald Express, 26 May

A scheme designed to make Glasgow city centre a safer place for revellers kicks off next month. The Best Bar None scheme will require pub and club owners who sign up to detail their policies on drugs, health and safety, public nuisance prevention, dispersal and security training. They will receive accreditation if inspectors are satisfied after an audit.
Evening Times, 26 May

A gardener accused of helping to run a cannabis factory told a jury he thought the drug plants were legal 'herbal remedies'. Speaking through an interpreter, the 31-year-old man, said 'I didn't think there was anything suspicious about it. I was told they were herbal plants, remedies, that would be used in Chinese medicine.' The case continues.
Greenwich Mercury, 27 May

Lager and wine will be on tap round the clock in the new *Big Brother* house: 'The move is likely to cause explosive viewing with contestants able to get plastered whenever they feel like it – as long as *Big Brother* keeps the taps flowing.'
The People, 22 May

Drug use falls among youngsters – as city executives take up cocaine

The number of young people using Class A drugs has remained stable in the last five years, according to a report published by the Home Office this week. Use of any drug among 16 to 24-year-olds had decreased significantly, says the report, which focused on drug use in England and Wales in 2003-2004.

Statistics for the 16 to 59-year-old told a different story. While use of any drug was stable, use of Class A drugs had increased significantly, mainly due to a rise in cocaine and ecstasy use. The lifestyle factors most associated with taking Class A drugs included being young, male, unmarried or divorced, and visiting pubs or wine bars three times a week.

Highest levels of drug use were found in 'rising areas' of prosperous professionals and better-off executives in inner-city areas, rather than 'thriving areas' of wealthy achievers and affluent greys. Londoners were most likely to take drugs, while the West Midlands reported lowest levels.

The use of hallucinogens, particularly LSD, had decreased significantly in the higher age groups and there was a gradual decrease in the use of amphetamines, steroids and glues among all ages. Cannabis increased from 1996 and 1998, but had stabilised since then.

The Home Office commented that the government's drug strategy was delivering tangible results through seizing record numbers of drugs and getting 54 per cent more drug users in treatment than in 1998 and announced 'we are well on track to reach our target of directing 1,000 drug-misusing offenders a week into treatment by 2008'.

Marcus Roberts, head of policy at DrugScope, said the findings contradicted recent media reports that drug use was going through the roof.

'Of course the increase in Class A drug use is worrying and we can't afford to be complacent about the continued popularity of cocaine, but it's time to focus on what is really happening with drugs in this country.'

Home Office commitment to race equality scheme

The Home Office has updated its race equality scheme, declaring strengthened commitment to promoting race equality and eliminating discrimination.

The framework updates the 2002 scheme and includes associate schemes for the prison service and national probation directorate.

Home Office minister Paul Goggins, said the scheme would ensure that race equality ran through all Home Office work, benefiting members of the public who used services, as well as staff.

'As the lead government department on race equality it is essential that we set an example to the public sector and work towards achieving a society where there is respect for all, regardless of race,' he said.

Education forum calls for legal clarity on cannabis

A call for clarity on the legal status of cannabis has been made by the Drug Education Forum.

The national umbrella body, which promotes effective drug education in England, is appealing to the Advisory Council on the Misuse of Drugs to provide a definitive view on whether the decision to reclassify cannabis was correct.

Home Secretary Charles Clarke asked the ACMD to look at the government's decision to downgrade cannabis from a Class B drug to Class C in March, in response to recent concerns about cannabis use and mental health problems. Recent research has suggested that there may be a link between cannabis use and the risk of psychotic symptoms, provoking Mr Clark's request.

Dr Jenny McWhirter, chair of the Drug Education Forum, said that a clear view from the government on the dangers of cannabis was essential, if coherent messages were to be passed to schoolchildren:

'Teachers need to be sure what the law says about cannabis so that they are not giving contradictory messages to young people.'

GPs show they are keen to treat drug users

A drug misuse certificate has been awarded to 400 GPs since the course was launched a year ago, according to latest figures from the Royal College of General Practitioners.

The Management of Drug Misuse Part One teaches practical skills to GPs wanting to provide treatment to drug users as part of a locally or nationally enhanced service.

The award includes face-to-face training, as well as a modular programme. At least 3,000 GPs have now completed the electronic module part of the course, through an e-learning programme.

More than 1,000 GPs have already completed the RCGP part two course in drug misuse, developed four years ago, which equips GPs to develop a special interest in the field.

Dr Jenny Keen, clinical lead for the RCGP, said the uptake of the new certificate showed that GPs across the country were keen to get involved with treating drug users.

'Patients will benefit and lives will be saved as a result of GPs being trained and able to offer treatment to drug users in the surgery,' she commented. It was an area where doctors had traditionally had very little training, and the new RCGP course would help to fill the gap, according to Dr Keen.

WAM winners: The 'What About Me?' team at Newark and Sherwood PCT have won first prize in the communications category of Trent Regional Health Authority's 'building on success' awards for their video for siblings, children and friends of substance users – part of their service for families. See feature on page 7.

WHO resolves action on alcohol

The World Health Assembly has adopted a resolution to look at public health problems from alcohol.

As decision-making body of the World Health Organisation, the Assembly involves representatives from WHO's 192 member states to agree priorities on global public health.

Rising rates of alcohol consumption, particularly among the young, had identified alcohol as one of the leading risks to health. It was a causal factor in more than 60 diseases, including cardiovascular disease, mental disorders, road traffic injuries and death, and high-risk behaviours.

WHO would consult with a range of stakeholders to develop effective policies to address alcohol-related issues. In previous statements, the organisation has called alcohol and tobacco a far greater threat to public health than illegal drugs.

Have your say on MoCAM

Alcohol Concern is considering running an additional event in its series of consultation workshops on Models of Care for Alcohol Misusers (MoCAM). Regional events, running until the end of June, have been fully booked and an extra event is being considered. It will probably be held in London. If you are interested in attending, visit mocam@alcoholconcern.org.uk.

Workshops do not replace direct responses to the NTA. Visit www.nta.nhs.uk to respond by the deadline of 1 July.

Guide arms drinkers with safety tips

A booklet advising how to drink and stay safe, has been produced by Alcohol Concern and the Suzy Lamplugh Trust.

Funded by the Home Office, the guide is not about telling people not to drink, but warns that alcohol can affect a person's judgement on whether a situation is safe.

'You don't need to be staggering drunk for this to happen,' Alcohol Concern's chief executive, Srabani Sen commented. 'Even a few drinks can make us decide to take risks such as getting into the back of unlicensed cabs which we wouldn't dream of doing normally.'

Julie Bentley, chief executive of the Suzy Lamplugh Trust said that alongside the recent spotlight on drunken violence, it was 'equally important to remember just how vulnerable drink can make people'.

Home Office Minister Paul Goggins said drinkers needed to realise that they were more vulnerable to certain types of crime, including sexual attacks.

For copies of the leaflet, send SAE to You + Alcohol + Safety, at Alcohol Concern, Waterbridge House, 32-36 Loman Street, London SE1 0EE, tel: 020 7928 7377 or The Suzy Lamplugh Trust, PO Box 17818, London SW14 8WW, tel: 020 8876 0305.

METHADONE & BEYOND

NOTES FROM THE ALLIANCE

In this first of a regularly monthly column exploring the experiences and work of The Alliance, Daren Garratt explains why everyone from street users to the Chief Executive of the NTA needs effective, sustainable advocacy to work.

In *Drug Misuse and Dependence – Guidelines on Clinical Management*, (Department of Health, 1999) it is clearly documented that if users seeking substitute prescribing want to achieve a stabilised, well-functioning quality of life, the optimum maintenance dose of methadone should be 'up to a total of between 60 and 120mg' (p.47).

Unfortunately, the reality of UK drug treatment still paints a very different picture.

In the third National Treatment Agency *Research into practice* publication (May 2004) it was found that:

- In British methadone treatment, doses are on average less than 50mg daily and only just over a quarter of service users receive over 60mg.
- Higher doses have been consistently shown to encourage treatment retention and reductions in illicit drug use in methadone maintenance regimes.
- Lower dose levels may be undermining the provision of optimal services and compromising the therapeutic relationship between service user and key worker.
- Recent research shows that responsive and flexible individualised dosing can help foster the therapeutic relationship and may lead to improved outcomes and reductions in illicit drug use.

Furthermore, as we move swiftly into a new era of 'Treatment Effectiveness', it is important to note that this new NTA initiative is largely underpinned by a Public Service Agreement (PSA) target to:

'increase year on year the proportion of users successfully sustaining or completing treatment programmes'.

(Treatment Effectiveness: Demonstration analysis of treatment surveillance data about treatment completion and retention [National Drug Evidence Centre [NDEC], University of Manchester], National Treatment Agency, December 2004)

It appears, therefore, that if the Treatment Effectiveness programme is to work, then advocacy needs to be a central component, because

- 'success' equates with higher retention (NTA, December 2004), and
- 'higher retention' is better achieved when users receive higher doses (NTA, May 2004).

Unfortunately, as there are great swathes of the country where sub-optimal dosing is still the norm, we need to ensure that there are enough trained and mentored user-advocates to support their peers and lobby for appropriate and effective, evidence-based prescribing practices.

Indeed, the need for robust commissioning guidance on the development of advocacy services and the establishment of a National Model of Advocacy have been acknowledged by the NTA as key requirements for supporting the next round of treatment planning in October. Sadly, the financial constraints placed upon the NTA this year mean that the only money they can identify to develop and deliver these essential elements of a flagship national project won't even cover the costs of a part-time worker.

It's depressing but that's the way it is. The real worry, though, is that until we get peer-advocacy properly developed, networked, coordinated and resourced, the chances are that the reality of 'treatment effectiveness' will continue to rely on your postcode or the politics and attitude of your treatment provider or prescribing GP.

Sweet dreams

Ask the family

The anonymity essential to many family support services often leaves them at the back of the queue for support, advice – and funding. A trio of charities has developed a good practice guide and quality standards based on asking service users what really works, to inspire those working in this difficult and demanding environment.

There is still some way to go until dedicated support for all families is seen as an essential element of service provision in every area of England, according to *We Count Too*, a new report from Adfam, Famfed and Pada.

The three family support charities have taken steps towards addressing this. With Home Office funding, they carried out national consultation on best practice and quality standards in the family support field, and are now distributing the results to Drug Action Teams, family support groups, throughcare and aftercare teams to give them fresh ideas and feedback on what constitutes an effective service.

Bringing service users into the exercise has been the key to bringing in thoughtful and deliverable ideas, according to Adfam's chief executive, Vivienne Evans. Through user forums and stakeholder groups held across the country, service users shared their experiences: what was good, what helped – and what didn't.

The picture built up from talking to families was of the devastating effect that a person with a drug or alcohol problem could have on the rest of the family. Stress soon builds up from the fears about their family member's health, their changed behaviour and the possibility that they may be involved in criminal activity. Parents worry about the effect on their other children – at the same time as worrying that all their attention is being focused on the drug user – and are frequently in a fretful cycle of covering up the problem from friends, neighbours, and the 'authorities'. By the time they contact a family support service, they are often exhausted and in despair.

So what helps families out of this initial low point, when they feel that nothing they can do will have any effect?

Assuring confidentiality is an important first step. Then comes the clear information – to help people understand what is happening, what effects different drugs have, what is likely to happen during the cycle of addiction.

Empathy as well as sympathy plays a strong role, demonstrated by many local support groups who involve volunteers that have been in the same situation. People need to know that they are talking to someone who understands and knows what they are going through.

Practical help is equally important, sorting out day-to-day issues that may have been neglected in the crisis, and dealing with stress that may be getting in the way of work and normal routine.

The benefits of halving problems through sharing them, is central to much of the feedback offered by service users. Many reported that they were initially confused by the anger and betrayal they felt towards their family member, but found strength through communicating their feelings, so they could 'act, rather than react', be positive – and even learn to laugh about the situation occasionally, instead of crying.

Guilt and shame were found to be common negative feelings, which could again be diffused through talking, learning from other people's experiences – and realising that there were others in a worse situation. Addressing the signs of social isolation was equally important for others in the family, to prevent siblings from becoming depressed, withdrawn, and bullied by other children. Participants in the consultation reported that getting involved in activities for themselves and their children had built their confidence and self-esteem. Learning to think positively again was a vital part of getting back on track, and support, praise and encouragement could not be under-estimated in helping people get on with their lives.

We Count Too moves on from looking at what works and how to address diverse needs, to suggesting a good practice menu of services. A set of checklists covers one-to-one support services; how to provide clear information; presenting different options for personal learning; how to make a good telephone helpline; practical suggestions for an effective support group; ideas for helping families work together; and how to tailor services for people in different circumstances – grandparents, partners, siblings, families involved with the criminal justice system, or those who have been bereaved by drug use. Lists of support groups for each category complete the resource.

In return for listening to what works, the charities have come up with a set of basic quality standards that should underpin every service, covering the style and approach of services and the boundaries they should observe. These should not only help with quality, but will provide a good practice evidence base for funding, according to Adfam's Vivienne Evans.

'I hope the guide gives local groups some benchmarks, so they'll be able to judge themselves and be able to apply for funding based on evidence,' she says. 'It'll give them credibility – and hopefully mean more services are commissioned. Ultimately that will support the family members themselves.'

We Count Too: Good practice and quality standards for work with family members affected by someone else's drug use is online at www.drugs.gov.uk (type 'We Count Too' in the search field).

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Offering a lifeline

Hetty's in Nottinghamshire has been offering advice for families of drug users for the last five years. Their most recent service, What About Me (WAM) has become a popular service for children aged 5 to 19 who are affected by someone else's substance use: it offers help lines, text services, videos as well as providing school visits and one-to-ones. DDN asked Nina Dauban, the service manager, what happens at the other end of the helpline.

'People often come into contact with Hetty's by calling the telephone helpline. The line is open from 9-7pm, 365 days a year, and on an average day we will receive five or six incoming calls,' says Dauban. 'They call for a variety of reasons; there's no such thing as typical caller. Usually a couple of the calls will be for specific information – "I found this white powder in my son's bedroom". Obviously we can't make drugs analyses over the phone, but we can send them literature to begin educating them on different types of drugs. Other callers will have ongoing problems and we deal with each one individually. We provide bespoke information for each client, not just sending out standard literature, and we will try to research practical help such as the availability of local services. This will often involve arranging follow-up phone calls or one-to-ones with the client.

Hetty's staff have all had personal experience of dealing with the problems caused by having someone close them involved in substance misuse, and while they rarely disclose this to clients, their ability to draw on it helps them gain their trust. This personal experience is complemented by the strong emphasis placed on professional standards. All of the team are DANOS trained and many have their OCN level 3. 'We offer an ideal place for people wishing to start a career in substance misuse,' says Dauban. 'I am able to offer flexible hours to suit the individual and centre things around the needs of the worker, not the institution.'

While all of Hetty's staff are involved with manning the phone line, much of their time is spent meeting clients and raising awareness in the community. Most of the team will spend one day a week networking, which involves 'working to combat discrimination and changing peoples attitudes'.

'Our team are constantly on the route march of attitude adjustment,' says Dauban. 'We sometimes go back to places and find our posters have been taken down and our literature put away. Some people aren't comfortable with dealing with drug issues and don't want it in their health centre or library. We try and talk to them and show them our video. Often after seeing that their reaction changes and they feel a bit more "there but for the grace of God".'

Client one-to-ones are an essential part of Hetty's work. All visits are completely confidential and the utmost care is taken to ensure the user won't be present or turn up. 'We are not there to act as arbitrators between the user and the family', Dauban explains, and this can mean meeting in neutral venues such as cafes or libraries, or the client coming to the centre. It can very hard to get some people out: 'they have become prisoners in their own homes'.

So much of the emphasis is on the user, but Hetty's tries to offer something for their family to give them a break – most recently Reiki sessions and meditation – which is often the only thing that the person will have done purely for themselves for a long time.

At the same time, staff try and educate the family that sometimes their attempts to help the user, like giving them money for drugs, can make problems worse. It may stop them committing crime in the short term, but contributes to keeping the problem hidden for longer. Giving them support and access to information can make them invaluable: 'the family really is a free 24-7 support service that needs to be utilised'.

Always trying to be innovative with the services they offer, Hetty's and WAM run joint prison visits to six prisons to talk to prisoners about how their families will be feeling. They explain that they need to accept it can take a long time to re-establish a situation of trust again. 'We can sometimes write on behalf of the prisoner to their family to let them know that they are trying to change,' says Dauban. 'Often the family will follow this up and contact us, and we are able to offer ongoing support.' They also get a lot of prisoners' children contacting them after their parent referred them to WAM. One of the most successful projects for educating young people has been the WAM video, which 'can be very hard to watch' but has been called highly effective, with interest from as far afield as Finland.

Like all managers, a lot of Dauban's time is spent managing budgets and writing funding bids. 'Chasing funding is my forte,' according to Dauban, 'but there's no way we would ever have been able to have got half of our projects off the ground without the commitment and support of our local DAT co-ordinator'.

'With all of our projects Hetty's and WAM try to stick to one guiding philosophy,' says Dauban, '– and that's to never doubt that a small step with the help of someone who cares can change your world.'

'...there's no such thing as typical caller. Usually a couple of the calls will be for specific information – "I found this white powder in my son's bedroom"... We deal with each one individually. We provide bespoke information for each client, not just sending out standard literature.'

Visit Hetty's at www.hettys.co.uk and WAM at www.what-about-me-co.uk

A Mother's story

I am 58 and divorced. I have two children, a son of 22 and a daughter of 20. I have been living with my partner since 1994, plus his four children. By the year 2000 my household was in a mess. Dysfunctional would have been a doddle. I was very depressed and was trying to keep everyone happy.

My son, who had had problems of living in reality for years, had become gradually worse and worse. He suffered from depression and when extremely upset would cut himself mostly on his arms. When he went to sixth form college he began smoking cigarettes – then pot. He told me about this and I thought that it was very occasional and 'not a big problem'. In fact it seemed to calm him down and reduce the number of times that he cut himself. A year later a 'friend' introduced him to heroin. He smoked it and he loved it. I did what many have done before me and will do after me. I held him during his come down. I lectured, pleaded, cried, yelled and paid. I drove him to pick up. I hid. I denied. I tried to 'love him out of it'. I encouraged the friends that I thought were 'OK'. But he became increasingly abusive and violent. In hindsight I realise that he was also using cocaine and that the 'pot' he was using daily was actually skunk. I struggled and sank.

One of my son's psychiatrists suggested that I needed help and to contact Families Anonymous. I confess that I thought it strange. After all it was my son who needed help not me. When he was having a truly terrible 'come down' I had phoned every drug related agency available. The most helpful were the NHS helpline and Narcotics Anonymous, who both suggested Families Anonymous.

So for a while I ignored this advice but then I reached my 'rock bottom'. I had gone from a size 10/12 weighing 9 stone to a something weighing 7 stone. I couldn't eat, sleep or deal with my life or my family. My life had become truly unmanageable. As many people do, I wanted answers and a solution to my son's problem. I wanted someone, anybody, to tell me what to do to stop my son abusing drugs.

So Families Anonymous it obviously had to be. I went, I cried, I told my story. I listened. I heard. My goodness, what I heard. Two members had sons over 30 years old who still had an ongoing problem. This had two effects on me: one was despair; the second was a conviction that this would not be me in ten years time.

The most important message I brought home was 'I do not have to accept the unacceptable'. I had never thought of that. Coincidentally, the next day my son said he would have to go back to dealing to make enough money to continue with his habit. I said 'no, this is unacceptable' – and to my amazement, he didn't do it. I felt the first whisper of power. But I also knew that the last thing I could do was to throw him out. After all he really couldn't live without me… how would he cope?

With each FA meeting I went to I became stronger, little by little. I read the FA booklet *Tough Love* ten times a day. To stop the rising panic, I would say to myself 'one minute at a time', 'I am in no danger right this second', 'nothing bad is happening right now', over and over again. I put my faith in a higher power and prayed for my own recovery. I read as much literature as I could get my hands on. I found a second FA meeting nearby and so I went to two meetings a week (and have continued to do so). As I became stronger, my son became more violent and abusive.

'At that time he was on five different prescription drugs for his depression and mood swings, plus methadone that was supposed to be instead of heroin, but he was also using skunk, cocaine, crack, LSD, ketamine, GHB and heroin regularly…'

At that time he was on five different prescription drugs for his depression and mood swings, plus methadone that was supposed to be instead of heroin, but he was also using skunk, cocaine, crack, LSD, ketamine, GHB and heroin regularly – and anything else he could afford. He had tried every single drug available.

The psychiatrist decided he must have a review. He went along but he became abusive and violent to the Mental Health Team and he was Sectioned under the Mental Health Act 1984. A Section 2. This meant he was locked up for 28 days for assessment. You may be shocked or even horrified to know that I have never felt so free. It was wonderful. He had a social worker and various psychiatrists working with him. I felt that for the first time he was safe and getting the help he so desperately needed. Because I was so frightened of him I obtained an injunction with power of arrest because he had become so violent. I wrote to my son and told him that I would not be seeing him until he was truly clean.

After 28 days in a secure unit they moved him to a rehab centre where he had his own room and access to good facilities. He was clean. He is a very bright person and he became bored. Against medical advice he discharged himself and went to stay with a friend. It didn't last. The friends had to ask him to leave as he wouldn't stick to their very reasonable house rules. He moved area and this meant that he had to see a new doctor. He was phoning home in a panic 20 times a day leaving desperate messages. It was unbearable. I changed my number to ex-directory and changed my mobile number.

He came round to the house. He ran around screaming that he wanted a hug and tried to get in through an upstairs window. He was literally climbing the walls. I hid in my bedroom, locked the door and called the police. He was frantic and the police took him away at my instigation. In court he was reprimanded and then let off. Ten days later he came round again. He spoke to me through the door and then went berserk. He smashed a window with his hands.

For the criminal damage and causing an accident he received a conditional discharge for six months. At the later committal hearing where I represented myself, the judge asked me what I thought should be his sentence and I said that since the system had let him down, jail would be the only place where he could get the treatment he needed. I couldn't believe that I could be so strong when he was sitting right behind me – but that is the power of FA. The judge let him off with no penalty, but warned him that a third breach would mean prison.

Two years later I had not seen my son, except on two occasions in Court. I had phoned him on his birthday the year before, and had a good conversation. Since then he relapsed and ended up homeless on the streets. He found a place in a night shelter and from there was taken in by a housing association that specialises in homeless people with various problems, including those recovering from addiction. After six months, because his letters became increasingly encouraging and coherent, my partner suggested we all had lunch. That went well. He was still taking a low dose of methadone and still prescribed valium but was trying to cut these down. He was talking about his future and said he understood what I did and why I did it. Unfortunately he relapsed before Christmas last year, so everything went back a step, but he is still working on becoming healthy.

My message to anyone finding themselves in a situation like mine is take the advice of those people who can see the pain you are going through. Attend a Families Anonymous meeting if you are lucky enough to have one in your area. Take everything you can from the programme and use it. Addiction is a family illness. You must survive. You must have a life. The rest of the family must have a life.

Families Anonymous national helpline is 0845 1200 660.

Harm reduction: science and social movement

I have no disagreement with Neil McKeganey's views (letters, *DDN*, 18 April) that harm reduction should address the needs of families and communities as well as of drug users, and that it needs to be self-critical. But his piece – with its selective focus and reporting – does an injustice to the conference and its participants.

The 16th International Conference on the Reduction of Drug Related Harm in Belfast attracted over 1,000 people from nearly 60 countries. There were large groups from Indonesia, Thailand, Iran and Malaysia. Talks were presented across 70 sessions. Over 150 posters were on display. The conference theme was 'Widening the agenda', and the range and diversity of the conference programme indicated that this agenda was considerably met. Presentations covered science and research, policy and practice, and critical commentaries on harm reduction issues. The programme had ten major pathways: HIV/AIDS and other blood borne infections, law enforcement and harm reduction, prisons, social context and policy responses, young people and education, harm reduction philosophy and practice, services and treatment, drugs and injecting and harm reduction practice. The Film Fest showed over 40 short films to a large and highly appreciative audience. McKeganey comments that a session on the impact of parental drug use on children attracted less than 10 per cent of the 1,000 delegates – given the range of session choices, that was an excellent audience!

Harm reduction is certainly – for some people – a social movement; but it is also evidence based, good public health, pragmatic social policy, and a practical response to pressing issues. The conference succeeds because it brings together an extremely wide range of people. It attracts UN officials from WHO, World Bank, UNICEF, UNAIDS, and UNODC; policy makers, politicians, and government officials; scientists and researchers; harm reduction advocates; people working in health, criminal justice, social welfare, and education; people in national and international NGOs (*eg* the International Federation of the Red Cross and Red Crescent Societies, Family Health International, and the HIV/AIDS Alliance); and people affected by HIV/AIDS and drug use.

This is hardly a group of people who – in McKeganey's words – are there for a 'celebration of the drug using lifestyle'. People at the conference hold many different views on drug use – there are prohibitionists, people in NA, pragmatic public heath workers, and some seeking drug policy reform. Most people at the conference are clearly against unfettered drug use. Nor is it true to say that the main tenor of the conference is about the right of the individual to use his or her drugs of choice with the least harm. This is to confuse the human rights of drug users (a key principle of harm reduction) with the human rights to use drugs (an issue for other organisations and fora).

There are indeed some vociferous drug users in attendance. We go to great lengths to ensure their participation. We include drug users in the opening and closing ceremonies, have a plenary drug user speaker, and ensure – in whatever the country the conference is held – that the medical needs of drug users are met. I think we may be the only international conference which assists in the provision of methadone and other substitution treatment for those who need it.

McKeganey argues that harm reduction is in danger of being just a social movement, and hence is in danger of being uncritical and strong on rhetoric. This sets up a false opposition between science and social movements. There are plenty of social movements which clearly base their activity on the evidence – as harm reduction does. There is no difficulty in being both a science and a social movement. The harm reduction field is typified by extensive efforts to provide an evidence base – and as a result there is more evidence for the effectiveness of harm reduction interventions than for many other drug interventions.

To criticise the conference for being in danger of being long on rhetoric sits oddly with the rhetorical devices used in his letter: for example, the use of terms such as 'loved ones', when referring to those who may be harmed by drug users, and the aforementioned reference to 'celebration' of a drug using lifestyle. A paragraph is devoted to a researcher from a harm reduction service in Australia who is reported saying that he would underplay information critical of the service he was evaluating. I can't but agree that this researcher is wrong. But so too are writers who selectively use evidence that fits their argument.

The majority of drug users and drug problems are in developing and transitional countries. In many of these countries harm reduction and drug treatment services are very thin on the ground. What most drug users get instead is penal excesses, neglect of their rights to health care, no or ineffective treatment, community and judicial harassment, and marginalisation of themselves and their families. There is a huge need to argue for an evidence-based and human rights based approach to reducing drug related harms. I make no excuse that harm reduction brings together science, good policy, and practice, and that for some it is a social movement – that is part of how we change the world for the better.

Prof Gerry Stimson, executive director, International Harm Reduction Association www.ihra.net

STOP don't RUN

Many strange things have happened to me
But this I won't forget for eternity
I am currently laid up with two guards at my side
Because I thought I was clever and that I could hide
But I went on the run – turned up in Bracknell Town
Fell 32 feet straight onto the ground
I've broken my arm and smashed up my feet
Had a seven hour operation I've got a big frame in my heel
It wouldn't have happened if I hadn't went to do a deal
But it's woken me up proper opened my eyes
I am really lucky – I should have died
But I know I'm a fighter and soon I'll be well
So I'll look at this paper and a story will tell
Look what can happen when you don't stop and think
Hang around with people who live for drugs and drink
But I'm out real soon – hopefully I'll walk again
Stuck with the thought never run again!!

Nathan Brooks

Abstinence offers a clear advantage

On the issue of harm reduction (*DDN*, 18 April): The aim of harm reduction is to limit use to an amount which significantly reduces or removes the harmful effects. However this often causes a problem: what is the required reduction and how is this measured? For every individual there will be a number of factors influencing what may be a varying limit – a limit which can be hard to identify, let alone meet. Therefore in the harm reduction versus abstinence debate, I would propagate that in many cases, abstinence has one particular advantage (aside from the physiological benefits): abstinence establishes a clear set line with no option for manipulating.

Of course abstinence may not be suitable for many, but for those who see it as an option, the clarity of where those goal posts lie often eliminates the easiest pitfall of harm reduction – overstepping the sometimes blurred line back into harmful levels of use. Of course, successful harm reduction is more suited for many, but for those achieve the feat of sustained abstinence, rewards are reaped with the greatest chance of avoiding relapse back into harmful use.

James Morris, alcohol strategy development officer, London Borough of Hammersmith And Fulham

Learning from experience

Above is a poem written by a drug user from Bracknell Forest.

He had been in custody, doing well and had been clean for approx nine months, and was then moved to an open prison.

Unfortunately the move did not go well and he absconded from the prison and was at large for around four weeks.

Unable to access the support he needed to maintain his recovery, he drifted back into drug usage and eventually the police caught up with him. In a state of panic he climbed out of a window in a block of flats to attempt to get away – this resulted in him falling 32 feet and nearly losing his left foot.

The poem was written whilst he was recovering from the injuries in the John Radcliffe Hospital – he has since gone back to Bulingdon to complete his sentence.

The reason I am in possession of this poem is that the young man is my son and he asked me to see if this could be published and hopefully get a message across to others.

Name and address withheld.

Drugs don't fit 'disease model'

It concerns me to hear an addiction psychiatrist, Dr Finch, applying the disease card to people who use drugs (GP debate, *DDN*, 16 May). To compare this 'chronic disease' with diabetes or asthma is wholly inappropriate. Unlike the latter conditions which we know are lifelong, the drug 'disease' can be eliminated by a voluntary choice the like of which those with diabetes and asthma don't get. It probably makes her job much easier, diagnosing her patients with the 'disease' especially when prescribing medication results, but isn't this rather patronising to those who have a drug habit? Therapists should look at the whole picture and remember that patient belief in the 'disease model' tends to predict greater relapse.

Russell Jones, by email

St. Custard's, Kent

School Report

Pupil Name: Random Drug Testing

Term: Spring 2005

Form Tutor's Report:

Looking at Random Drug Testing's (RDT's) school report is not a happy experience. In all areas of school life, RDT has failed to meet expectations. RDT came to us highly recommended and we have made strenuous efforts to help RDT fit in.

However, RDT has represented a big drain on school resources, impacted on school morale and upset a number of pupils and parents with no measurable gain.

	Grade
Science: RDT in school has used a process of oral fluid collection called Intercept ® Oral Mucosal Transudate (OMT) – a small mouth swab. This is sent off for analysis and shows up some – but not all drugs. It does not, for example, show up solvents like glue or gas, alcohol or magic mushrooms. So some young people may switch substances away from detectable ones like cannabis, onto undetectable and more hazardous ones, like butane gas. OMT can't detect drugs that were used a while ago. It is most useful for showing up recent drug use - this is why it is most useful when used in 'safety critical' settings like for railway workers. OMT shows what was used in the last one to three days – depending on which drug was used. So it is a poor method for random sampling: if a young person smoked cannabis on Friday night, they would not test positive if they were tested on the following Tuesday. So the odds of cannabis – or other drugs – showing up in a school drug test are low, especially with infrequent use.	D
Business Studies: Companies can make a lot of money out of RDT – if they can persuade schools to take it on. Altrix, who supply Abbey School in Kent with Intercept kits saw its earnings go up by a staggering 403 per cent in 2004. So the companies are keen to see drug testing in schools be extended. More schools doing more testing means colossal profits. Each test and analysis costs around £35. So a school testing 20 pupils a week would need to spend £700 per week, or around £28,000 per year. This works out, across a region with ten secondary schools, at £280,000 per year. This would be enough to employ ten full time drug educators or counsellors, to educate and support young people! No wonder the testing companies are keen to see more schools take up drug testing: nationally there are massive profits to be made!	A+ (for the testing company) D- (for the school)
Law: Drug Testing companies are aware that RDT may be hard to defend against a legal challenge – especially when they are used in school settings. It may be that RDT can be challenged under Article 8 of the Human Rights Act – which says, 'everyone has the right to respect for his private and family life…' So far, it has been argued that where someone is involved in a safety critical task – such as driving a train – the need to protect public safety means that someone may need to interfere with the right to privacy. But, in a setting such as schools or college, it is less likely that RDT could be justified in the interests of public safety.	C
Young people also have the right to decline to be tested: consent from parents cannot overwhelm the right of a young person to refuse if the young person can be considered 'competent'. But schools are not always making it clear that young people can refuse to be tested. At present, state schools have not chosen to make testing mandatory, and pupils cannot be excluded solely for refusing a test. It is likely that, if a state school made testing mandatory and made exclusion an outcome for refusing a test, such a measure would be challenged under Human Rights legislation.	Grade
Maths: The odds of detecting drug use within a small-scale random testing regime are not good. In a large school, randomly testing people is hit and miss. It relies on picking someone who not only uses drugs, but has done so in the last 1-3 days. So statistically the odds are against low levels of drug use being detected through such an approach. It is more likely to miss drug use than to detect it.	D
Personal Social and Health Education (PSHE): RDT is not a good substitute for effective drugs education. This should be undertaken by trained teachers in a supportive environment. RDT can get in the way of such a process – it can make people feel too threatened to talk to their teachers about substance use, and make it more difficult to seek support. Teachers are forced into more of a policing role, and so may be less able to deliver support when it is most needed.	F

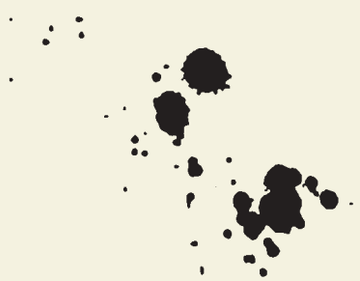
	Grade
Media Studies: The media have been very interested in RDT and it has meant a great deal of attention for a school that has put such a programme in place. It makes it hard to make informed and balanced decisions when the media are paying such close attention. Especially if a tabloid like the 'News of the World' has sponsored the trials to make news. But more importantly, it makes it very difficult to agree that this is all in the pupil's best interest. When a school starts inviting the media in to witness pupils being tested for drugs, it suggests that head teachers are more interested in publicity than best practice in drugs education and prevention.	F
International Studies: RDT has been trialled in a number of countries and has been used in some American states. It has been subject to a number of legal trials and has also been reviewed as part of a large-scale national study. Some schools made testing a mandatory part of extracurricular activities. But, rather than reducing drug use, they found that people chose to drop out of these activities. This was unfortunate – engagement in such activities is a key way of reducing drug problems. In a study of 76,000 students by the University of Michigan, levels of drug use were actually higher in schools with drug testing than those without. Contrary to what advocates for testing say, there was no evidence that testing regimes discouraged drug use.	E

Headteacher's Comments:

Random Drug Testing (RDT) arrived in the school early this year and, despite initial hopes, has proved to be a disruptive influence.

We had hoped that RDT would have a benign effect on pupils, and discourage use of drugs. But instead we have been concerned that RDT may encourage other pupils to hide their drug use better, switch to drugs which are harder to detect, or truant from school when tests were expected.

We are also concerned that RDT's arrival has meant that we have been distracted away from effective models of drug education and prevention. As the comments from other teachers' highlight, many aspects of RDT's performance have been distinctly lack-lustre and so, it is with some regret, that we feel that RDT is not suited to our learning environment and so will be asked to leave at the end of this term.



General Attendance and Behaviour: Even when you've done nothing wrong, processes like RDT are stressful. Rather than concentrating on lessons, there's every risk that pupils will worry about tests. Tests can and do throw up 'false positives', where household medicines or other items suggest an illegal drug has been used. So imagine sitting around, waiting to find out if you've been selected for a test, and then waiting to find out what the results are. More stress, more anxiety, increased chance of truanting from school: all the factors that actually contribute to substance use amongst young people.

Even when substance use has been identified as an issue, exclusion from school will rarely be the appropriate response: education, support and, where appropriate drug treatment will be the right response in most circumstances. Such interventions will work best where the young person feels safe enough to discuss their drug use with someone that they trust – not because they have failed a drugs test.

It is hard to keep the outcomes of RDT confidential in school settings: any pupil who is the subject of additional school attention following a RDT will inevitably be suspected, rightly or wrongly, of drug use.

Further Reading and Where to Get Help

For help or advice on schools and drug policy contact:

Children's Legal Centre: www.childrenslegalcentre.com: clc@essex.ac.uk

For drugs information and advice

Frank: www.talktofrank.com 0800 77 66 00

Further reading

Making Sense of Student Drug Testing: Why educators are saying no: ACLU/Drug Policy Alliance: Jan 2004

Random Drug Testing of Schoolchildren – A Shot in the Arm or a shot in the foot for drug prevention: Neil McKeganey: Joseph Rowntree Foundation: 2005

Drugs – Guidance for Schools: DfES: 2004

Inside the orange room - how pupils are tested for drugs: Guardian: 11.1.05

Four week wait for results at drug test school: Guardian: 7.1.05

Questions raised as school starts random drug tests : Guardian: 6.1.05

School launches drug-testing programme: Guardian: 5.1.05

Pupils to face random drug tests: Guardian: 29.12.04

Report compiled by Kevin Flemen, KFx

Visit www.ixion.demon.co.uk for news briefings and resources, including *Drugs Dogs and Schools*, a booklet for pupils and parents.

Too much too young:
a snapshot of prisoners' drug use

HMP Gloucester carried out a survey of prisoners' history of drug and alcohol use, with the aim of reviewing current and future service provision. The results provided an enlightening snapshot of the problems and multiple social needs faced by prisoners: for many, problematic drug use appears to be an inevitable pathway, as Lynne Rhodes describes.

The Home Office's report *Reducing Re-offending by Ex-prisoners* highlights the deep problems faced by many of the UK's 75,000 prisoners and shows how the risk of re-offending is intrinsically linked with social exclusion. Many have very poor skills, are unemployed on entering prison, and have a history of homelessness, drug addiction and mental health problems. Nine key factors were identified by the Social Exclusion Unit as influencing reoffending: education, employment, drug and alcohol misuse, mental and physical health, attitudes and self-control, institutionalisation and life skills, housing, financial support and debt, and family networks.

Prisoners were found to be over 20 times more likely than the general population to have been excluded from school. The exclusion continued: despite high levels of need, many had been excluded from access to services and an estimated half of prisoners had no GP before they came into custody. One prison drugs project found that although 70 per cent of those entering the prison had a drug misuse problem, 80 per cent of these had never had any contact with drug treatment services.

Home Office research in 2000 found that 66 per cent of prisoners said they had taken heroin every day in the 30 days before going to prison; in a typical week an average £550 was spent supporting their drug habit. A 1997 study of remand prisoners at Durham reported that 57 per cent of men were using illicit drugs and 32 per cent met DSM-IV criteria for misuse or dependence on alcohol. 71 per cent of the sample was judged to require help directed at their drug or alcohol use and 36 per cent required detoxification.

HMP Gloucester, a prison with up to 329 inmates, conducted a survey to determine whether drug use reflected national statistics in scale, severity and type of drug. Most interviewees gave a history of multiple (poly) drug use and experimentation on their journey to becoming a problematic heroin or crack user (or both). Many continued to use other drugs in addition to their main drug of choice, particularly diazepam as part of the stimulant/depressant cyclic nature of their daily lifestyle.

Of the individuals who admitted problematic drug use prior to custody, 91 per cent had used a drug immediately before being taken into custody, 3 per cent had remained free from drugs for a month before custody, 1 per cent had remained drug free for three to six months before, and another 1 per cent had managed to stay drug free for six to 12 months.

The remaining 4 per cent had stayed drug free for 12 months to three years. However on interview it became evident that all of those who had remained drug free for this length of time had an excessive alcohol intake, and were in need of medical treatment for withdrawal symptoms and interventions to address their alcohol use, to preserve their long-term health prospects. Alcohol intake was assessed using the Drinkwise London Units Ready Reckoner and took into account the type of alcohol and amount the individual described drinking per day.

- 22.9 per cent described having an alcohol problem.
- 9 per cent described weekend or binge drinking.
- 43.8 per cent needed detoxification treatment on reception to the prison.
- 40 per cent described having received help in the past (GP/NHS/AA/Probation)
- 93 per cent stated that they would like help to address their alcohol use.

The drinkers needed special interventions, considering the high incidence of hepatitis C among IV drug users. Excessive alcohol use in those infected with hepatitis C is strongly associated with a greater likelihood of progression to serious liver complications.

With increases in the number of short-term prisoners and large numbers of transfers during prison sentences, many offenders are not in the same place for long enough to access effective interventions. However, often it is these short-term prisoners that would benefit the most: Home Office research has indicated that drug misuse is most prevalent among offenders sentenced to less than a year in prison.

The research at Gloucester highlighted the relationship between drug use and time in custody. 30.5 per cent admitted using drugs immediately after release from last period in custody; 43.7 per cent had been out of prison for less than six months before entering custody again. Of those who admitted drug use, 91 per cent had used a drug immediately before entering custody; the remainder had been clean from drugs for one to six months before. This is a good indicator of the 'revolving door' of short term remand and sentencing in problematic drug users, especially when viewed with the offence-related statistics showing the high levels of theft and burglary committed to support a drug habit. It is also relevant to the risk of overdose and drug-related death; it has been widely recognised that detoxification in prison and subsequent release is a very high-risk time for problematic drug users, with a 34 times higher risk of death within two weeks, according to the Home Office.

About the subjects...

Information was gathered by semi-structured interview, after informed verbal consent was given. Data was anonymous and entered on to a secure database. To keep the study manageable, the decision was taken that it would be limited to the first 300 receptions into the prison from the start of the survey and repeated at a later date to attempt to replicate the findings or consider changes in trends at that time.

Of 300 receptions, 249 were interviewed (83 per cent); of the remainder four refused (1.3 per cent), 47 (15.7 per cent) were not interviewed due to lack of time available for interview – some were transferred, others were released before being seen.

- 60 per cent were on remand; 40 per cent had a determinate sentence.
- 90.3 per cent were white, 8.4 per cent were black; 1.3 per cent were Asian.
- 72 per cent were under 32 years old; 8 per cent were aged 22 years and under.
- 9 per cent were first time prisoners, 76 per cent had served a prison sentence before, others had been in prison on remand but not sentenced.
- Almost 39 per cent had previous convictions of a violent nature, 2 per cent were in prison for sexual offences. Of the whole interview sample, 73 per cent stated that their offence was drug or alcohol related in some way.
- 50.6 per cent had committed acquisitive offences (theft, burglary, handling stolen goods); 14.4 per cent had committed violent offences, 12.4 per cent had driving offences, 7.2 per cent were in custody for supplying drugs, (84.6 per cent of total sample). There were no offences of possession of drugs resulting in a prison sentence. The remainder of offences ranged from non-payment of fines to murder.
- 145 of the 249 (58.2 per cent) interviewed admitted problematic drug use before they were taken into custody. Of these, 49.7 per cent had used drugs immediately before being arrested and required medical treatment for withdrawal symptoms or detoxification prescribing. When questioned about the history of their drug use, over 70 per cent admitted that they had used drugs at some time in the past.

The study also provided an opportunity to investigate drug use initiation history. The Updated Drug Strategy stated that drug use by young people increased throughout the 1980s and early 1990s. Since 1998, the proportion of 16 to 24-year-olds using Class A drugs in the previous year has remained stable at about 8 per cent, and the number of 16 to 19-year-olds using drugs fell from 34 per cent in 1994 to 28 per cent in 2001/02. The results obtained at HMP Gloucester gave a snapshot of age of first drug use, type of drug and age at first conviction.

Addressing drug and alcohol problems is a concern for the majority of individuals entering custody. Problematic drug use – particularly of heroin and crack – is the single biggest issue for almost 60 per cent of inmates entering HMP Gloucester. Detoxification was required for 91 per cent of the inmates surveyed, who entered the prison with a drug problem. 23 per cent of them had acute and ongoing problems with excessive alcohol use, of which 44 per cent required prescribed detoxification.

For those not ready to access treatment and stop taking drugs, health education on safer injecting and overdose prevention is crucial. 51 per cent of the sample had been in contact with a community drug team for needle exchange and other drop-in services, but only about a quarter had ever accessed any kind of treatment. However many of those who had accessed treatment had been in contact with multiple agencies; this indicates that once the decision to address drug problems is taken, the motivation to engage with services is high.

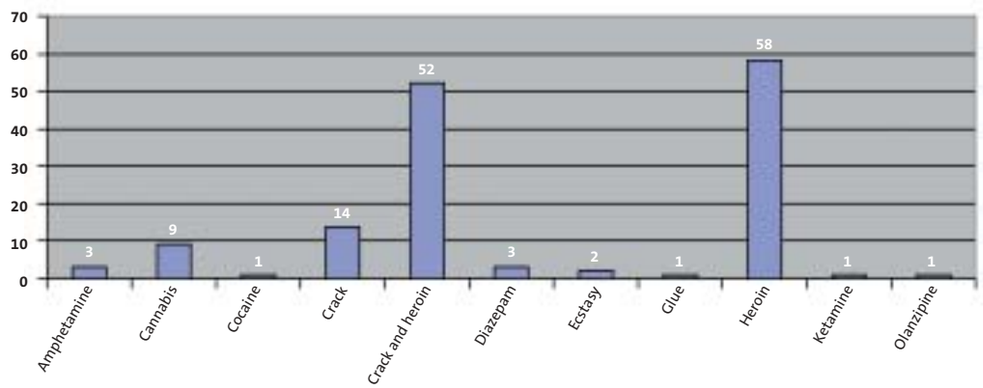
Almost 20 per cent of the sample were not interviewed due to lack of time, demonstrating the extremely transient nature of the population and the difficulties this group have of being able to access effective, long-term support. Over 27 per cent of inmates in the sample originated from courts that were outside HMP Gloucester's normal catchment area or were transfers from other prisons; again this is indicative of the transience of the population and is relevant to referrals to community agencies for support upon release from prison.

Effective communication and prompt access and engagement with services both inside and outside prison are essential to give those who are ready to address their drug misuse the opportunity to do so. The Drug Interventions Programme (formerly CJIP) is intended to address this problem, but it will take time for it to become effective in the long term. Referrals to Drug Intervention Programmes that are not in the local area can be difficult; we have found that it is enormously helpful for inmates to meet their community drug worker before their release from prison and for them to be directly involved in their own Release Plan.

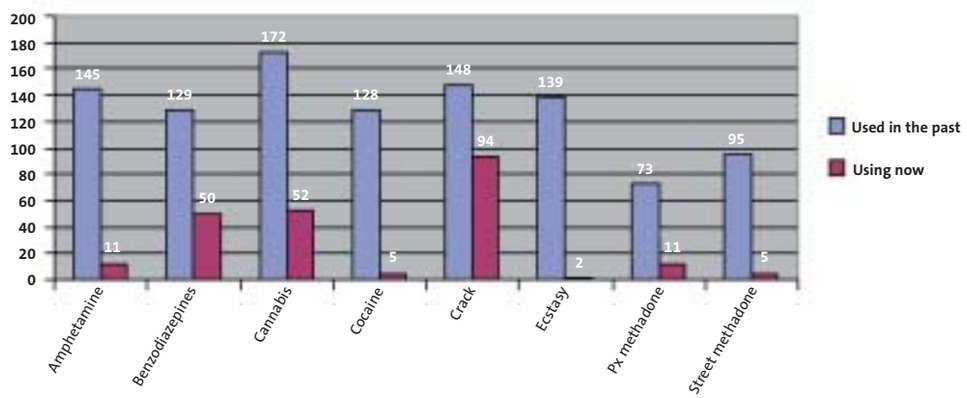
Many prisoners have multiple problems that are chronically inter-related with their drug use – physical and mental health issues, social problems, education and employment. These need to be addressed through a holistic programme of help, appropriately case managed, to minimise any likelihood of relapse, related re-offending or reconviction and support their transition back into the community.

Lynne Rhodes is drug strategy and CJIP/DIP lead nurse at HMP Gloucester.

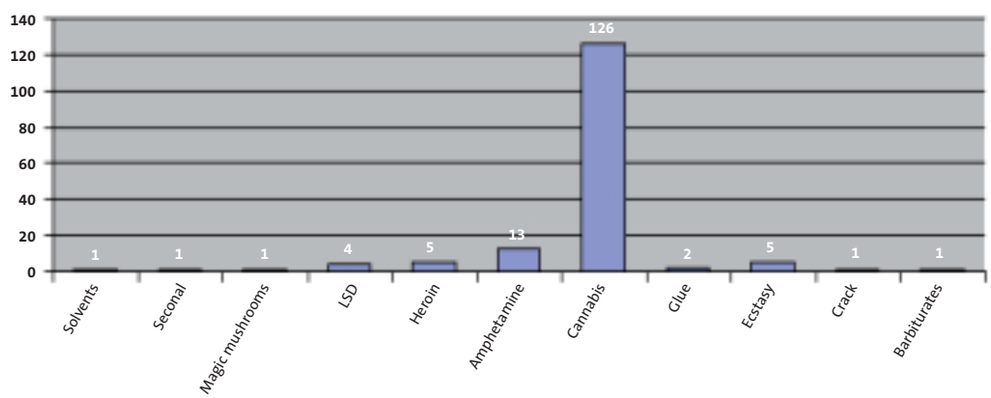
Main drug of choice before custody



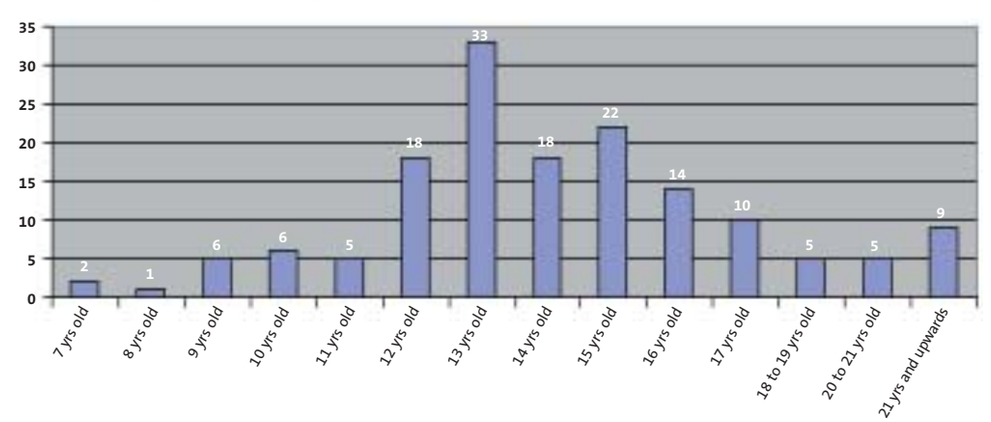
All drugs used immediately prior to custody – in addition to heroin, which for 40 per cent, was the main drug of choice



First drug ever used



Age at first drug use



Diary of a heroin addict

In the sixth and final part of his story, David Wright faces tough decisions, the pain of grief, the ultimate test of selfishness – and the realisation that he must make his journey count for something positive.

So there I was, back to the only life I had known of heroin and alcohol, but this time it felt different. I had experienced six months of sobriety in the rehab and I liked that feeling better than this drug haze. So I decided I would go to my mom and dad, tell them everything and see if I could move back to South Wales. You see my parents were of the 1940s generation and did not know the difference between cannabis and heroin. So even though I had been in the rehab they thought it was for smoking joints!

After I told them everything, including my plans, they said they would support me. All the times I kicked sand in their face; the love of a parent runs so deep, as deep as deep can go. As I would find out.

So I arranged to stay in a hostel that the rehab owned in Cardiff. Scott my soulmate drove me there. I knew he did not want to because we would miss each other, but Scott had done a lot of things for me and we were as close as close can be.

At the hostel my first objective was to get a methadone script, which I did in the first week. Scott had given me a little to keep me well. Thanks again mate.

So here I was in my new life, and has luck would have it I met Murray (ex-rehab) who turned me on to selling *The Big Issue*. As I knew Newport from the rehab days, I was sent to sell there. Times were at their best, I had money in my pocket, I weaned myself off my methadone, met a girl. Things could not have been going better until a Newport council official came up to me and told me to ring the hostel in Cardiff. Chris had died.

I have had two soul mates in my life, Scott being one and Chris the other. If you have been following this story you will remember Chris was the guy who drank a bottle of vodka a day, smoked loads of dope and took Df118s by the bucketful. I spent many of the happiest days of my life sat with Chris in his front room, sound system on full blast, buzzing off the dope and the DFs. I miss him so much. As I was carrying his coffin, back at the hostel in Cardiff my flat was done over and all my music gear was nicked.

So I said goodbye to Gwyn who had moved into the hostel a few months before (I knew him from the rehab) and got a bedsit in Newport. I did an Access course at university and my relationship with this girl was going well. I finished the Access course and on the enrolment day for my degree, my brother phoned me. Dad had died of a massive heart attack – that floored me. His funeral was a daze of opiates and brandy; the degree went down the tubes. Then to top it all, my partner became pregnant and on 10 November 1998 my son was born. On 5 February 2000 my daughter was born – but I'm afraid by then I had lost the ability to cope.

Opiates and alcohol came before my children. You may think what a selfish bastard – and you would be right. When you need a chemical to function, everything becomes second to that. Everything.

Even then the drugs stop working, so you end up in the cul-de-sac of despair. It was at this point someone gave me the helpline number of the Methadone Alliance.

It was a day when I was suffering from lack of heroin. The phone was answered by the wonderful Bill Nelles, founder of the Alliance. He told me I was sick and needed to see a doctor. So I did, and to my good fortune I came across a doctor who prescribed methadone. To cut a long story short, I ended up with a GP who raised my script through the roof – up to 150ml. I was bombed out by the high dose and at the time could not understand what the doctor was up to. Then I had a hit of heroin and did not feel it. The amount of methadone had blocked all my opiate receptors so there was no room for the heroin. Clever doctor.

I kept in contact with Bill Nelles and he invited me to train as a drug advocate, representing the rights of drug users. I jumped at the chance and lived the hotel life in London on two separate occasions. I attended a few conferences... free champagne, fresh salmon... I was in dreamland.

But back in Wales, I had a lot – and still have a lot – of work to do, to give users a voice. I do this with a newsletter for drug users called *The Heroin Herald*, which is online. It was through the Heroin Herald that Maggs Lyons from Inroads Cardiff contacted me. I went for a talk with the boss Steve Lyons, to see how we could help each other. He did all the helping, giving me a workplace and a computer to work from. Inroads is an open access drop in/needle exchange. Go to www.inroadswales.org and check them out – that's where I am based now. If you do not live in Wales but feel you are being treated unfairly by the medical services go to www.m-alliance.org.uk or phone the helpline Monday to Friday, between 12.00pm and 5.00pm on 020 7837 4379. Do it – you have rights.

I would like to pay respect to the people who I know that have died through drugs: Chris, Vanessa, Mickey, John, Phil, Banny, Gwyn, Ann, Keith. The list goes on.

Finally I pay tribute to the people who have supported me: Scott and Ann, Bill Nelles, Steve and Maggs Lyons, Dave Hiscox who helps me with my bills.

Taking drugs starts off a bit of fun and some people stop and 'settle down'. Others become dependant, and over half of those die young.

The rest of us have to have support, whether physical or psychological, or both. Because drugs don't just fuck your body up, they mess your head up. All in all they ruin your life. But with support you can make the best of a bad situation. And if you have a mother like mine, you're halfway there.

'After I told them everything, including my plans, they said they would support me. All the times I kicked sand in their face; the love of a parent runs so deep, as deep as deep can go. As I would find out.'

Historical Perspectives: Cocaine

Professor David Clark traces the history of cocaine, linking the Incas, Freud, Thomas Edison, Sherlock Holmes and Coca Cola.

Cocaine is extracted from the leaf of a small tree known as the coca (Erythroxylum coca), which is native to South America.

Coca leaves have been found in burial chambers in Peru dating back to 2500 B.C. The Incas started to use coca around the tenth century. It was a sacred drug, used primarily by priests and nobility for special ceremonies. 'Mama coca' was thought to have grown from the remains of a beautiful woman.

When Spaniards first conquered the Incas they banned coca use for religious reasons. However, the Spanish soon found advantages of the drug, although they did not use it themselves. Incas would work harder and longer, as well as eat less, if allowed to chew coca. The Roman Catholic church dropped objections to coca, since it became rich by charging a tithe – one tenth of the value of any crop.

The coca plant was virtually unknown in Europe until the nineteenth century. European naturalists exploring Peru started to experiment with the drug. Although coca was transported to Europe it was not used, probably because of deterioration of samples, as well as an aversion to chewing the leaves.

The active ingredient was identified and isolated by Albert Niemann in Germany in 1860. He called it cocaine. In 1883, Aschenbradt wrote an article describing the usefulness of cocaine for exhaustion, alleviating pain, and enabling sick soldiers to continue to function.

Freud saw this article and tried cocaine. He extolled the virtues of the drug in an article entitled 'Uber Coca'. He claimed that cocaine could be used to increase a person's physical capacity during stressful times, to restore mental capacity decreased by fatigue, to alleviate depression, to treat gastric disorders, asthma, and morphine and alcohol problems.

Freud treated his friend Ernst von Fleischl-Marxzow for nervous exhaustion resulting from morphine withdrawal. In Uber Coca (1884), Freud stated: 'The treatment of morphine addiction with coca does not, therefore, result merely in the exchange of one kind of addiction for another – it does not turn the morphine addict into a conqueror; the use of coca is only temporary.'

Fleischl was eventually consuming a gram a day and became the first European cocaine addict. He suffered paranoid delusions and the formication syndrome (feeling of bugs crawling under the skin).

There was a cocaine epidemic in the 1880s and the drug was injected by the upper middle class. Robert Louis Stevenson used cocaine while writing 'The Strange Case of Dr Jekyll and Mr Hyde'. Conan Doyles's Sherlock Holmes injected cocaine. In 1910, *Current Literature* stated that cocaine was responsible for the smooth and flowing sentences characteristic of the period.

In 1887, US Surgeon General, Dr William Hammond, recommended that cocaine be used for the treatment of depression. He asserted that there was no such thing as a 'cocaine habit'. Freud claimed that only those who had previously used morphine became dependent on cocaine.

As a result of the interest of Freud and others, the production of cocaine by the German drug company Merck increased by 0.4 kilo in 1883 to 83,343 kilograms in 1885. Prices rose dramatically. Drug manufacturers strove to improve their supply of coca leaves.

Freud has been strongly criticised for his falsified data, lying about treatment, resolute management of his own reputation, and persuasive blame of others for his own shortcomings.

Coca-Cola originally contained cocaine and was advertised as 'the brain tonic and intellectual soda-fountain beverage'.

In 1863, Angelo Mariani, a Corsican chemist, patented Vin Mariani which contained coca. Advertisements included testimonials from Thomas Edison, Robert Louis Stevenson, Jules Verne, President Ulysses S. Grant and Pope Leo XIII.

Coca-Cola originally contained cocaine and was advertised as 'the brain tonic and intellectual soda-fountain beverage'.

Cocaine became available in Europe and America in a variety of other preparations marketed by reputable companies. Medical opinion stated that only those who lacked willpower became a regular user of the drug.

An advertisement for Metcalf's Wine of Coca stated: 'Public speakers, singers and actors have found wine of coca to be a valuable tonic to the vocal cords. Athletes, pedestrians, and baseball players have found by practical experience that a steady course of coca taken both before and after any trial of strength or endurance will impart energy to every movement, and prevent fatigue. Elderly people have found it a reliable aphrodisiac superior to any other drug.'

Casualties began to emerge – overdose, cocaine psychosis, severe dependence – and opinion started to change. Writing describing the case of Annie Meyers was influential: 'I deliberately took a pair of shears and prised loose a tooth that was filled with gold. I then extracted the tooth, smashed it up, and the gold went to the nearest pawnshop (the blood streaming down my face and drenching my clothes) where I sold it for 80 cents.'

The moralistic propaganda of the temperance movement began to include anti-drug statements. In the early decades of the twentieth century, cocaine (and cannabis) were stigmatised in America for their association with poor labourers drawn from ethnic minorities. They sniffed cocaine because they could not afford needles, distinguishing them from doctors, lawyers and middle classes who injected the drug.

In 1903, the American Pharmacological Association reported that 'almost every coloured prostitute and a few white women are addicted to cocaine'.

In 1914, the Harrison Narcotic Act in the US effectively banned the use of opium, morphine and cocaine.

SMMGP

Planning and Developing Shared Care – A Training Day for London based services

29th June 2005

9.30 – 4.00pm

Hampstead Britannia Hotel, Primrose Hill Road, NW3

A day for those involved in developing shared care, including:
Shared care workers and Co-ordinators, GPs,
Commissioners and people who use services

The day will give you the opportunity to:

- Understand the development of shared care
- Look at and share good practice
- Find out about future developments in shared care
- Map and plan shared care development in your area

Please be aware that places may be limited to ensure that we get representatives of all areas and that it is only open to London based services. A final agenda and details of the venue will be sent out closer to the time.

To apply to attend this event, please contact Mark Birtwistle c/o SMMGP, Bolton, Salford & Trafford Mental Health Trust, Bury New Road, Prestwich M25 3BL
E-mail: mark@smmgp2.demon.co.uk Fax: 0161 772 3546

RSDC

Responding to the Drugs & Alcohol Agendas

Evaluations
- Small and Large Projects, Services and Networks
- Harm Reduction / Health Promotion
- Mental Health / Dual Diagnosis / Personality Disorder

Strategy
- Multiple Service Reviews / Community Need Assessment
- Stakeholder Consultations
- Shared Care / Strategic Approaches to Commissioning
- Supra-district / Regional Commissioning

Service Development
- Development Proposals
- Steering Group / Project / Change Management
- Keeping Things on Track ...

Availability
- Supply Side Studies / Mapping of Drugs Markets
- Impact of Policing

Special Groups
- Young People / Dual Diagnosis / Offenders
- Family Issues (Parent, Grandparent, Carer & Child)

Training
- Events linked to DANOS / UK Workforce Development
- http://www.rsdc.org/html/training/programmes.htm
- On-site Training!

Telephone: (+44) 0113 244 8277
www.rsdc.org / info@rsdc.org

APPOINTMENT OF CONTRACTORS FOR THE SOUTH WALES DRUG INTERVENTION PROGRAMME/ CRIMINAL JUSTICE INTEGRATION TEAM

The Council of the City and County of Cardiff, on behalf of the South Wales Drug Intervention Programme seeks to appoint four contracts with service providers whom it may call upon to contribute to the service delivery in the following packages, under the auspices of the Drugs Implementation Programme:

Package 1 Reduce drug related offending
Package 2 Reduce the number of drug related deaths
Package 3 Provide front line client contact through Criminal Justice Intervention Teams
Package 4 Increase the number of clients accessing level 2 substance misuse treatment with rapid access to short term prescribing whilst awaiting level 3 treatment
Package 5 Co-ordinate 'wraparound services' for drug misusers within the Criminal Justice System
Package 6 Secure general health gains (for example, blood born viruses, hepatitis etc.)
Package 7 Support families and children affected by drug use
Package 8 Encourage the active involvement of ex-users and volunteers

It is anticipated that the total value of each of the 4 contracts will be approximately 800,625 GBP for Cardiff and Vale of Glamorgan, 571,875 GBP for Swansea, 457,500 GBP for Merthyr Tydfil and Rhondda Cynon Taff and 457,500GBP for Neath Port Talbot and Bridgend over the 18 monthly period, commencing in October 2005 and completion by March 2007, with an option to extend the contract by 12 months, subject to continuation of funding through Central Government and via the Drugs Implementation Programme.

The Contractor(s) will be able to demonstrate:

(1) Ability to develop and deliver a level 2 substance misuse service, to people with substance misuse problems, with rapid access to short termprescribing whilst awaiting level 3 treatment.
(2) An External Service Audit demonstrating a proven ability to provide advice and support to individuals facing drug and alcohol issues over the last 3 years.
(3) Published reports that through intervention of your services there has been a reduction of drug related offending, reduction in the number of drug related deaths and improvement in the well being of the service user.

Applicants will be required to complete a Pre Qualification Questionnaire including financial status, organisational structure, Health & Safety Record and a commitment to delivering of services in accordance with good practice in issues of diversity.
Applicants will be asked to provide details of similar schemes undertaken together with their proposed method statement.
References may be sought from bankers and relevant clients at this stage.

The Closing Date for application will be 24th June 2005.

Return of questionnaire/s by 30th June 2005 latest.

Applicants should apply at this stage to:
Alan Jones, Senior Procurement Officer, Procurement & Supplies, Cardiff County Council, Bessemer Close, Leckwith Industrial Estate, Cardiff, CF11 8XH
Tel: (029) 2087 3742 Fax: (029) 2037 7605 E-Mail: ajones@cardiff.gov.uk

CARDIFF
CAERDYDD

CRI

Crime Reduction Initiatives contributes to public safety by preventing crime and alleviating its worst effects. Specialising in services to substance misusers, women, young people at risk and ex-offenders, our dedicated team delivers high quality interventions, support and residential services.

North Lincolnshire Drug Intervention Programme – based in Scunthorpe

TEAM LEADER *(Ref IM018)*

Salary £23,743 – £25,166 • Full Time

In partnership with the Drug Action Team and Safer Neighbourhoods, CRI are looking to recruit an experienced Team Leader for the Drug Interventions Programme. The DIP team in North Lincolnshire is now well established and highly regarded. Suitable candidates will have an excellent understanding of substance misuse and related offending, sound knowledge of the criminal justice system and the ability to lead a team effectively within a performance management framework. The current success of DIP in North Lincolnshire is directly attributable to excellent partnership working and as such we are looking for an individual able to build upon this. The current funding for DIP is in place until March 2007.

London Services – based at Kings Cross

ADMINISTRATOR *(Ref DB092)*

Salary £20,715 – £21,831 • Full time (inc. LW)

CRI provides services to some of the most challenging service user groups in the country, including those aimed at substance misusers, ex-offenders, homeless and others in the street population and young people. We are now looking to appoint a dynamic and energetic person as Administrator supporting the Director of London Services and other senior managers of this division of CRI. Enthusiastic, highly motivated and able to work on your own initiative, you will have a minimum of 2 years experience in an administrative role and have advanced IT skills including Microsoft Office, Access and Excel. You will also have excellent communication and organisational skills and experience of data input and reporting. You will also ensure that the office is well run and that callers, either in person or by phone, receive a first class service.

Closing date for both posts: 8th June 2005.
To obtain an application pack and further information about CRI please visit our website www.cri.org.uk. Alternatively call our recruitment line on 01273 523611 (24 hour answer phone) quoting the relevant job reference number.

The successful candidate will be subject to a Criminal Records Bureau check at enhanced level. In return for your commitment and enthusiasm CRI offers competitive salaries, excellent terms and conditions of employment and comprehensive training and development opportunities.

Committed to anti-discriminatory practice. CRI aims to be an equal opportunities employer.
Registered Charity No: 1079027

Better communities through purposeful lives

Equinox

Equinox is a respected and innovative charity providing a range of high quality residential and community based services for people with alcohol, drug and mental health problems; women and those involved in the criminal justice system.

THE NORTH LEWISHAM TIER 2 DRUGS SERVICE contract has been awarded to Equinox from June 2005. We will be providing a range of interventions including advice/information, assessment, support and key-working, GP Shared Care, needle exchange, relapse prevention and onward referral. The service will provide broad open-access to clients through both centre-based and outreach activities, with an emphasis on partnership working with other agencies in Lewisham.

Drugs Workers

£22,638 - £24,792 per annum inc.

Ref: DW/NL

If you are an experienced substance misuse worker with the enthusiasm and creativity to contribute to the development of this exciting new service, we would like to hear from you. We are specifically looking for people who:

- Have a minimum of two years' experience working with substance misusers.
- Have experience of providing community based services, outreach, harm minimisation, healthcare, direct access, key working **or** aftercare to this client group.
- Are able to deliver flexible, responsive and needs led services.
- Work effectively in a team, in partnership and on their own initiative.

In order to meet the needs of service users from the Vietnamese community in North Lewisham, we are seeking to appoint someone who has a comprehensive knowledge and understanding of Vietnamese language and culture to one of these posts.

If you would like to find out more about the new service or the above post, please ring Sharon Bye, Operations Director, on 020 7939 9816.

We offer a pension scheme (after six months' service), flexible employment policies, a commitment to staff development and a supportive working environment.

Information and application forms are available from the recruitment line on 020 7939 9813. Alternatively, you can email recruitment@equinoxcare.org.uk or visit our website www.equinoxcare.org.uk CVs will not be accepted. Please quote the reference stated above. Closing date: 8 June 2005.
Interview date: w/c 13 June 2005.

Equinox is working towards Equal Opportunities.

www.drinkanddrugs.net

Support Worker

HHP

An opportunity has arisen for the appointment of a Support Worker with experience of supporting substance misuse clients, to work as part of a small team in a hostel for single homeless adults.

In addition to general support, the successful candidate will help to develop provision of longer term accommodation and support for clients with drug or alcohol dependency. Outreach and Drop-in support will also be involved.

This is a full time post involving flexible working over 7 days with occasional sleep-in duties. This is a one year contract in the first instance. Salary scale £19,000 to £23,000 depending on qualifications / experience.

Closing date for applications: Friday 10th June 2005

For an application pack and/or further information please phone either Liz MacKenzie or Helen Jacques on 01423 566900 or email, authorisedpeople@aol.com

Angel

Drug Services

WORK WITH ANGEL'S MOBILE NEEDLE EXCHANGE IN KING'S X

Sessional Mobile Needle Exchange Workers

Salary NJC scale 21-29

£11.30 to £14.07 per hr, depending on experience

Your role involves the provision of needle exchange and harm reduction services to street drug users. Significant experience of work in Tier 2 advice, information and needle exchange services is required.

Shift hours are 5.30 to 9.30 pm, Sunday to Friday. A minimum of two fixed shifts per week is required, and a clean driving license is preferred.

• Angel Drug Services is an equal opportunities employer

For an application pack, ring June on: 020 7812 5469,

or e-mail: juneb@angeldrug.org.uk

Closing date for applications is Friday 10th June, 2005

ripple

Ripple Drugs Services Ltd is now seeking to increase its team of specialist workers for a range of services targeting drug dependents in the Bradford District.

Clinical Drugs Worker

- Based at Ripple Drugs Services, Buttershaw, Bradford (37 hrs 5days/week) Ref: DW/1

To work alongside GPs and other Clinical Drugs Workers in a busy substance misuse clinic within the Bradford South & West Primary Care Trust.

To deliver key-worker services to clients, providing appropriate support and intervention in line with National Treatment Agency Models of Care.

Applicants will preferably be educated to degree level although consideration will be given to applicants with 'A' levels or equivalent.
Have experience of working in a health, drug dependency, or service for the socially excluded environment.
Have knowledge of substance misuse and treatment.
Be willing to undertake further training and education as required.
Good ICT skills are essential.

Salary Range: £19,200 - £21,600 dependent upon experience and subject to review September 2005

For further information and application pack contact Stuart Dale on 01274 696712 or e-mail stuart@ripple.org.uk

Closing date for applications is Friday 10 June 2005, with interviews w/c 13 June 2005

KCA (UK) is an expanding and vibrant organisation providing a wide range of high quality and innovative specialist services. Founded in 1975 and currently employing over 200 paid and unpaid staff, it has an annual income of £5 million and is becoming established as one of the leading service providers in the South East Region. Our aim is to deliver individually tailored care packages which are effective in reducing drug and alcohol related harm and are based on cost-efficient structures, processes and delivery mechanisms

Due to the expansion of the Tier 3 Community Prescribing Service opportunities have arisen to be part of KCA's Substitute Prescribing Service in East Kent.

REF: 289 – Community Drugs Workers x 2

Salary £19,656 - £25,437 (SCP 25-33) - 37 hours per week

Essential Car User Allowance

Working closely with medical staff, you will provide assessment and keyworker support to service users accessing the substitute prescribing service. The aim of the role is to assist chaotic injecting drug users to stabilise their drug use and lifestyle.

Significant experience of working with people with drug related problems, a genuine commitment to this client group and a background and qualification in nursing or other relevant profession are essential.

There is scope to be involved in developing associated specialisms within the team.

For application forms contact: KCA (UK), Dan House, 44 East Street, Faversham, Kent ME13 8AT. Telephone 01795 590635, Fax 01795 539351, Email marina@kca.org.uk, website kca.org.uk.

Closing date: 10th June 2005
Interview date: To be confirmed

KCA (UK) is committed to the principles of equality of opportunity for all
Charity No: 292824

For better mental health

Substance Misuse Service User Involvement Worker for Mind in Brighton & Hove

Service User involvement is a high priority for service planning. We have a new post to support this and seeking an enthusiastic and motivated individual to develop and strengthen our existing service user groups to improve involvement within our drug and alcohol treatment systems

We want to recruit a worker who will ensure that service user involvement becomes a reality. You should have experience of substance misuse services, preferably as a service user and be able to motivate people to get involved. You should also have the skills to deliver training and an ability to develop constructive working relationships with people from diverse backgrounds. Knowledge of all issues relating to drug and alcohol use and misuse is essential.

Initially funded for one year.

This is a part time position 20hrs week. Salary based on NJC SO1 £22512 pro rota equivalent to £12864 per annum

For an information pack please send a 46p stamped A4 envelope to Mind in Brighton and Hove, 60 Sackville Gardens, Hove BN34GH

dasl

drug and alcohol service for london

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

Women, Domestic Violence and Substance Misuse Worker

Section 7(2)(e) Sex Discrimination Act Applies
£25,535 p.a. for 35 hrs/wk - ref: 05/1
Funded to 31.03.07 by
the Association of London Government (ALG).

Association of London Government

You will provide one to one brief intervention support and advice, and run a regular structured support group to women with substance misuse problems due to a previous/current violent relationship and to women experiencing substance misuse related domestic violence in Newham, Tower Hamlets and Redbridge. There will be some training required for local professionals, raising awareness of substance misuse and domestic violence. A background in drugs and alcohol or domestic violence work is required. An ability to set and work within very clear boundaries is essential.

Domestic Violence & Substance Misuse Male Worker

Section 7(2)(e) Sex Discrimination Act Applies
£12,767 p.a. for 17.5 hrs/wk - ref: 05/2
Funded for two years.

This is a new post to expand the work already undertaken within the women's domestic violence service. You will be responsible for co-facilitating the perpetrators' group for heterosexual men who have identified problems with domestic violence and substance misuse, including undertaking assessments, outreach and development. A background in drugs and alcohol is required along with an understanding of the effects of domestic violence and substance misuse on women partners, and children growing up within a violent/abusive environment.

Family Therapist

£13,866 p.a. for 17.5 hrs/wk - ref: 05/3
Funded to 31.03.06 by Newham Children's Fund (may be extended depending on funding)

This post aims to prevent the damage in terms of aspects of social exclusion, experienced by children and young people living with parents or carers who may be drinking or using drugs problematically. You will offer therapeutic sessions to parents and young people aged between 5 & 13. A family therapy qualification is required, preferably a qualifying level of training in systemic family therapy with a recognised training institution, along with experience of working with families and young people and substance use.

Complex Needs Worker

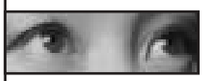
£25,535 p.a. for 35 hrs/wk - ref: 05/4

This post seeks to address the difficulties faced by clients with mental health as well as alcohol and/or drug use issues. You will develop and maintain links with mental health, drug, alcohol and domestic violence services, be involved in assessment and referral of clients already engaged with these organisations, and act as a resource on dual diagnosis, undertaking outreach and health promotion work. RMN or Dip SW, or other extensive experience of working within mental health services as well as experience of working with clients who have alcohol/drug use problems is required, along with an understanding of the social learning model of substance use.

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

For an application pack (paper/electronic packs available) contact
DASL, Capital House, 134-138 Romford Road, Stratford, London E15 4LD.
Tel: 020 8257 3068, email: jobvacancies@dasl.org.uk quoting job title/reference number.
Closing date: 9 am 17.6.05. Interviews (posts 1-3): Friday, 24.6.05.

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



Harnessing potential

At Phoenix House, we give substance misusers the opportunity to rebuild their lives in a way that ends their dependence on drugs and alcohol.

Family Service Manager
Starting Salary in the range of £30,003 - £30,904

Have you got what it takes to join us at our Sheffield Family Service?
You will shape the success of a unique and highly regarded 24-bed service that allows adults to address their dependency problems whilst their children attend an on-site day care facility. As the Registered Care Home Manager, you will direct and develop the service and oversee all aspects of care planning, staff deployment and financial management. This will include using your strong management skills to lead and develop your team and maintain occupancy at budgeted levels.

Along with a diploma in Social Work, CQSW or equivalent professional qualification, you will need at least five years' experience – two or more of them in a supervisory or managerial role. You will certainly need a good knowledge of relevant legislation and the issues relating to substance misuse. And in addition to effective communication and organisational skills, you must have an innovative approach to service delivery and a real commitment to meeting the needs of drug users.

Closing date for applications: 13 June 2005 (Ref SFS/M)

PHOENIX HOUSE SHEFFIELD COMMUNITY SERVICES
Substance Misuse Worker
Starting salary: £19,618

Join our skilled community team and you will deliver a tier 3 drug worker service working closely with our partner Housing Associations (Target Housing and Action Housing) to offer structured support, harm reduction work and relapse prevention advice to their tenants experiencing difficulties due to substance misuse. You will offer a comprehensive assessment of individual's needs and develop care plans to achieve their goals, motivating your clients to make changes and learn effective strategies to rebuild their lives. You will be flexible and experienced, with a relevant qualification or a background in drugs work and a positive attitude towards our service users. A current driving licence is desirable and car user allowance is available.

Closing date for applications: 14 June 2005 (Ref SCS/M)

Innovation isn't confined to the way we deliver our services: it extends to the way we develop and reward our people. So along with an attractive salary (inclusive of essential car users allowance) you can expect first-class training opportunities, ongoing professional development, ample scope for promotion and a range of benefits that includes a final salary pension scheme.

For further information, or to download an application pack and job description please visit www.phoenixhouse.org.uk, email recruit@phoenixhouse.org.uk, or phone our recruitment line on 0114 267 8094. Please quote appropriate ref.

phoenixhouse
www.phoenixhouse.org.uk Rebuilding Lives

Committed to a policy that promotes equality and diversity
Charity registration number: 284880

INVESTOR IN PEOPLE

East Kent NHS
NHS and Social Care Partnership Trust

EAST KENT COMMUNITY ALCOHOL SERVICE
ST. MARTINS HOSPITAL, CANTERBURY

ALCOHOL WORKER (*)(🚗)

(REF: R615)
Salary: £20,872 - £28,975 p.a.
or Salary A&C: £21,549 - £25,212 p.a.
Pay scale dependent on qualification and experience
Full-time: 37.5 hours per week

We are looking for someone to join our team, which delivers alcohol services across East Kent. You will need experience in the addictions field and be able to show evidence of a commitment to working with this client group.

You must have the ability to conduct treatment in individual, group and family settings, coupled with the ability to work collaboratively with partners in other agencies.

You will be based at the Headquarters of Mount Zeehan in Canterbury, but will be required to travel to our satellite clinics across East Kent.

This service offers a wide range of treatments and interventions, and there is particular emphasis on psychological models of intervention.

For further information, please contact Bill Reading, Service Manager on 01227 761310 or email: bill.reading@ekentmhr.nhs.uk

TO APPLY: We encourage applicants to apply on-line go to www.jobs.nhs.uk and click on employer list. Or contact our 24-hour Recruitment Line on 01227 812244 quoting the above reference number, or write to the Recruitment Team, Personnel Consortium, Trust Headquarters, Littlebourne Road, Canterbury CT1 1AZ.

Closing date for completed applications: 17 June 2005.

For other job opportunities go to our website www.ekpt.nhs.uk

We are in the process of implementing Agenda for Change.

(*) Employment in this post is subject to a satisfactory Enhanced Disclosure from the Criminal Records Bureau.

(🚗) Car owner/driver essential, subject to the provisions of the Disability Discrimination Act (1995).

We operate a non-smoking policy
Working Towards Equal Opportunities

Are You Looking For Staff?

We have a comprehensive database of specialist substance misuse personnel

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

Consultancy, Permanent, Temporary

www.SamRecruitment.org.uk

"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