DDN
Drink and Drugs News
2 July 2007
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THE WRONG GAME
Sex workers persecuted and criminalised in Ipswich

MOVING BACKWARDS
Release warn that drug policy isn't working

BECOMING STRONG
Families living through drug and alcohol addiction

CRIME AND PUNISHMENT
Use and abuse of the criminal justice system

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Drink and Drugs News

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Editor's letter

Release's 40th anniversary conference last week gave a fascinating – and deeply disturbing – look back to the beginning of the 'war on drugs'.

The artist Caroline Coon told how she had set up and run Release with fellow art students, because she couldn't believe the government's 'stop and search' regime that suddenly pervaded sixties' hippie culture – ordinary kids doing their thing, harming nobody else.

At the time she threw herself into the cause of bring cases to the authorities' attention – cases like 19-year-old Barry, who ended up in Wormwood Scrubs for being at a party where a small amount of cannabis was found. She thought there must be some some mistake: that our government and justice system didn't realise what was happening to ordinary young people. She thought that if Release shouted loud enough, the prohibition 'drug law scandal' would stop. Of course it didn't.

Forty years on, Caroline Coon says she is 'sorry that all of us who have campaigned to end prohibition have not yet succeeded' – a sentiment that was backed by others who spoke out (and wrote out), then and now.

Has the climate changed at all? Or have we moved further into victimising those in society who can least handle it? John Furniss thinks so, as he question's Ipswich's strategy on sex workers (page 6). The pervasive influence of the media in influencing drug policy comes in for a battering in this article, as well as at the Release conference – even Sunday Times and Guardian journalist Simon Jenkins blamed politicians for 'cowering behind the press'.

This week we've had a change of Prime Minister; will the new cabinet make a difference? Gordon Brown has promised 'a radical review of the anti-drugs strategy' that includes helping those with substance problems into treatment earlier. Whether this will be proactive as opposed to reactive remains to be seen.

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In this issue

Global drug abuse epidemic 'stabilising'

A global epidemic of drug abuse appears to have been averted – with growing evidence the problem is being steadily brought under control, Antonio Maria Costa, executive director of the United Nations Office of Drugs and Crime, announced last week. Launching the UNODC World Drug Report 2007, Mr Costa said recent data showed that global markets for illicit drugs had remained stable.

'For almost all drugs – cocaine, heroin, amphetamines – there are signs of overall stability, whether we speak of production, trafficking or consumption,' he said.

Importantly, for the first time in years, there was no upward swing in the global consumption of cannabis, and encouragement could also be taken from the fact that consumption of amphetamine-type stimulants, such as ecstasy, had also stabilised. There was also a clear downward trend in consumption of these drugs in North America, and to a lesser degree, Europe.

However, Mr Costa was keen to stress the good news did not mean the drug problem was solved, and said authorities could not afford complacency.

Progress in some areas had been offset by negative trends elsewhere – for example while cocaine use in the United States had declined, it had increased at an alarming rate in Western and Central Europe. Statistics on cocaine consumption in Western and Central Europe estimated that 2.4 per cent of the UK's adult population used the drug. The UK was second only to Spain in this category, and among the top ten for all other drug consumption.

If the world's drug problem was ever to be reduced, Mr Costa said governments would have to move beyond enforcement and toward preventive measures. Levels of drug consumption must be brought down and this would require better education and – in particular – better treatment of drug addiction.

'Drug addition is an illness that must be prevented and treated. Early detection tests, better therapies and the integration of drug treatment into public health and social services programmes can free people from their dependence on drugs,' he said. 'Treating those who suffer from drugs is an investment in the health of our nations, as much as treating HIV or tuberculosis.'

The 2007 World Drug Report is online at www.unodc.org/unodc/world_drug_report.html

Transform accuses UN of dressing up drug policy failure as success

Lobby group Transform Drug Policy Foundation has condemned the UNODC for attempting to 'dress up' drug policy failures as success. In a critical attack on the organisation's World Drug Report 2007, TDPF information officer Steve Rolles said that ten years ago the UNODC had pledged to create a drug-free world.

'However, the UNODC's own reports have chronicled the continued rise in the production and use of drugs over the last decade, particularly of the most dangerous drugs – heroin and cocaine,' he said. 'By any measure the UNODC's policy has been an abject failure with Afghanistan opium production breaking new records and cocaine use in Europe rising dramatically.'

The organisation had to start considering alternative strategies to control drug markets, and in particular move away from 'futile' eradication programmes, he said.

The World Drug Report was also criticised by international policy research institute, the Transnational Institute. The report, according to spokesperson Tom Blickman, was based on incomplete data, and in some cases 'inconvenient information is deliberately swept under the carpet'.

'The discrepancy between the UNODC assessment and other reports shows that the office cannot be relied upon to take on a transparent, objective and balanced evaluation process of the global drugs situation that is needed unless it is combined with scrutiny of independent experts,' said Mr Blickman.

Young people from Kensington and Chelsea took part in Cannabis Action Group's Media Challenge to produce a health warning on the dangers of cannabis. With a budget of £500 each, the groups of 11- to 18-year-old students were given free reign to create posters, t-shirts and films to deliver messages to other young people in the borough. The winning team, five 12- and 13-year-old pupils from Holland Park School produced circus clown posters with the word 'stupid' replacing 'smart'. Runner-up was Andreas Rodriguez, an 18-year-old receiving support from the resettlement and aftercare team, who impressed judges with his rap song called Mary Jane – slang for cannabis.

Europe calls for local authorities to fine-tune policies to regional need

European Union member state governments should look to local authorities to help them address drug-related problems, according to Wolfgang Götz, director of the European Monitoring Centre for Drugs and Drug Addiction.

In a speech to mark the International Day Against Drug Abuse and Illicit Trafficking on 27 June, Mr Götz described local authorities as the 'logical partners' in dealing with the social repercussions of drug use. 'They are best placed to fine-tune and adapt drug policies to the needs and resources of their community,' he said.

Most drug treatment services were currently managed and financed by local authorities, and many did so successfully. However, there were challenges ahead for which governments would need to offer their full support. In particular, treatment centres would have to evolve, as most were still very much geared toward helping those with heroin-related problems.

'But as more and more individuals seek treatment for problems linked to synthetic drugs, cannabis, cocaine or polydrug use, services will need to adapt to more, and very varied problems,' Mr Götz said. 'Extra demands will also be placed on them as a result of a trend to divert drug users away from the criminal justice system towards treatment and social reintegration.'

Local authorities also had a key role in identifying emerging drug trends, and alerting others to them. 'It is likely that new forms of drug use will be adopted by a few individuals, among small groups or in particular regions, localities, cities or social settings,' he added.

Lack of targets lets down strategy, says AC

The government's latest alcohol harm reduction strategy is an important step forward in addressing the nation's drinking problems, but it still contains fundamental flaws, Alcohol Concern has stated.

In its response to *Safe, Sensible, Social: The next steps in the national alcohol strategy*, the charity welcomed the focus on reducing harm among risk groups – specifically young and underage drinkers, and adults unaware of the seriousness of their drinking habits. The strategy objectives – namely reducing the number of adults who regularly twice the recommended limit and reducing the number of underage drinkers and the amount they consumed – were also applauded.

However, the charity expressed concern that the strategy did not quantify by how much these reductions should be, nor did it set any timescales. Such oversights, the charity argued, could lead the strategy as being judged as yet another missed opportunity.

There was also a complete lack of commitment to helping more problem drinkers entered treatment, or to narrow the gap between treatment demand and provision. Structured treatment for problem drinkers appeared to have been 'sidelined' in favour of promoting measures such as helplines, internet resources and self-help groups.

'These tools should not be seen as a catch-all for dependent drinkers who do require professional support,' the charity said. 'Treatment services appear to have become more and more sidelined with each strategy the government produces and this is particularly concerning when considering the cost savings that could be made from investment.'

These omissions, along with a lack of any ring-fenced funding to tackle alcohol-related problems, meant the rate of improvement in this area would continue to be slow, the charity stated.

BMA calls for collaboration to end Scotland's drink problem

A five-point plan to tackle Scotland's escalating drink problem has been unveiled by the British Medical Association Scotland. The plan has been developed in response to new statistics, which indicate alcohol claims the lives of six Scots each day.

The BMA called on the Scottish Executive to use its legislative powers in a number of areas – rather than rely on voluntary agreements.

At the top of its list was a call for the executive to use its powers under the 2005 Licensing (Scotland) Act to end the cheap drinks promotion of alcohol in off-licences, supermarkets and other outlets. Such promotions encouraged people to buy more alcohol than they needed, BMA Scotland argued. Some supermarkets, it noted, were using cheap alcoholic drinks as a method of luring people into their stores and in some cases, alcoholic drinks were now cheaper than bottled water. Alcoholic drinks manufacturers should be barred from sponsoring sporting and entertainment events with a young target audience, and they should also be legally forced to clearly label their drinks with the number of alcoholic units in each, said the BMA.

Scottish police should be given the power to conduct random breath tests, as these, the authority argued would be a 'vital element in deterring people from drinking and driving'. Again, this measure could be implemented by the Scottish Executive. A new UK-wide blood alcohol limit of 80mg should also be introduced, according to the BMA.

'The death toll from alcohol misuse is completely unacceptable and the government must take action,' said Dr Peter Terry, chair of BMA Scotland. 'Worryingly, more and more teenagers are drinking at an earlier age and we must do more to combat this trend. Increasing price is one part of a strategy that can deter children from purchasing alcohol.' The BMA would also like to see more done in primary schools to educate children about the dangers of drink before they were drawn in by industry advertising.

'After smoking, alcohol is the next big public health priority and I want Scottish minister to work with doctors to end Scotland's drink problem,' said Dr Terry.

Similar calls were made by BMA Cymru Wales when it published its own four-point plan to tackle Welsh drinking problems. The Welsh division also called for legislation to ban the deep discounting of alcohol by supermarkets and other retailers, and to force drinks manufacturers to label products appropriately. In addition, BMA Cymru Wales called for more research into how pricing mechanisms could be used to discourage heavy consumption of alcohol. Evidence suggested this could be particularly effective in reducing alcohol consumption among adolescents.

A national reduction in the legal alcohol blood limit for driving was also supported.

Reports are under regional sections of the website, www.bma.org.uk

Drug users expect overdoses

Drug-related overdoses and deaths are firmly embedded in the daily lives of Welsh drug users, results from a new survey have revealed. The survey of 150 drug users, undertaken by the Swansea Drugs Project, found that 61 per cent of those surveyed had overdosed at one point, and 53 per cent had done so on more than one occasion.

Three-quarters knew a family member or friend who had overdosed, and 57 per cent knew a family member or friend who had died from an overdose. Such statistics, said Ifor Glyn, manager of the Swansea Drugs Project, were extremely worrying. 'Drug related deaths and overdose are being seen as an acceptable risk for those taking drugs,' Mr Glyn said.

Comprehensive education and prevention strategies were needed to inform drug users of the risks, and teach them how to respond to an emergency. Such strategies were needed urgently, given the alarming rise in drug-related overdoses and deaths throughout Swansea over the past ten months.

'Drug overdoses do not need to be fatal, and can be prevented,' Mr Glyn said. 'Agencies like the Swansea Drug Project, and others such as health, police, homelessness and all social care agencies must work together to inform and prevent unnecessary tragedies.'

The survey also asked drug users what information and services were currently missing. Drug users identified a need for more prescribing places, shorter waiting times for treatment and better information on the purity of street drugs.

Alcohol hospital admissions double

Adult hospital admissions related to alcohol have more than doubled in the last decade, according to the latest figures from the NHS Information Centre. The figures, released last week, show that in 1995/96 there were 89,280 admissions related to alcohol, while in 2005/06 there were 187,640 admissions. The number of children under the age of 16 admitted to hospital with alcohol-related diagnoses had also increased by one third.

The statistics showed that in cases where alcohol was related to the primary diagnosis, the most common causes of hospital admission were mental and behavioural disorder related to alcohol, followed by alcoholic liver disease. Where alcohol was related to a secondary diagnosis, reasons for admissions ranged from accidents, injuries and falls, to some types of cancers. In 2005, 6,570 people died from causes directly linked to alcohol consumption, of these, just under two-thirds died from alcoholic liver disease.

'These figures show some worrying trends about the effects on society of consuming excessive amounts of alcohol,' said Prof Denise Lievesley, chief executive of the Information Centre. 'We hope the government and other policy makers will use these figures to inform the development and implementation of policies to help reduce the harm that excessive alcohol consumption can cause.'

The full report is at www.ic.nhs.uk/pubs/alcoholeng07

'Quite revealingly... communities where prostitute women are working can ring up "Cleaner Ipswich", on 0800 and grass up a punter, persistent sex worker, abused child or trafficked woman – as if grassing up a woman trying to make a living from her own body and skills was the same as grassing up a child abuser.'

From before the time of Jack the Ripper in central London there has been a bloody path of chopped up, abused and terrified women that has recently manifested again in Ipswich. The horror of the acts and the sympathy that the public have had for the women and their families, have unfortunately not been echoed by the official responses. It appears that on the ground, the conditions that enabled these murders to occur have become even more embedded.

The recent response by Ipswich to the tragic killings of five young women has highlighted key issues for drug services that define the field at this time in our evolving history. Reading the *Ipswich street prostitution strategy 2007-2012* poses difficult questions in how we as a society respond to addiction, prostitution and serial killers.

Crime reduction partnerships have moved into a central position in both holding purse strings and in dictating policy for drug agencies. Many community drug services now are directed to do criminal justice work with the list of Restrictions On Bail (ROB), Drug Rehabilitation Requirements (DRR) and Drug Intervention Projects (DIP) forever expanding. Drugs and crime are viewed as inseparable – a 'one size fits all' policy response to a complex set of realities.

As services, we work ever more as an add-on to court orders, as one element in a list of conditions and punitive actions that are aimed at curbing and changing behaviour. Our knowledge about poverty, bad housing, low prospects and neighbourhoods riddled with drugs, counts for little in this new 'treatment' regimen. It's the addict's fault, pure and simple.

This situation as highlighted in Ipswich, has baked a strange cake indeed. From the start of the Ipswich Crime and Disorder Partnership response, it is clear that they consider their media image to be a central tenet of the operation. It's point number one on the policy. Image is all. It follows on to highlight police operations, having a female bobby, cctv and targeting 'persistent prostitutes' (*ie* ones who have been stopped once) as the way forward. Once 'caught', both punters and sex workers are to be funnelled through to Acceptable Behaviour Contracts (ABCs), ASBOs and coercive treatment plans. If they don't play the game, it's then public humiliation, forfeit of driving licence and the end result, prison. For an essentially consensual transaction between two adults – however one may morally view that.

Quite revealingly, the partnership notes that the communities where prostitute women are working can ring up 'Cleaner Ipswich', on 0800 and grass up a punter, persistent sex worker, abused child or trafficked woman – as if grassing up a woman trying to make a living from her own body and skills was the same as grassing up a child abuser. The witch-hunting this invites speaks volumes. The opposite of clean is dirty.

With regards to the gauntlet of fear, actual murders and day-to-day 'incidents' that happen with street prostitution, the nearest the Ipswich Crime and Disorder Partnership gets to any mention of violence is the fear that their 'assertive

Playing the **wrong** game

In the aftermath of the five recent murders, Ipswich is using its crime reduction partnership to chase persistent sex workers into the criminal justice system with the help of willing local media. But the strategy is wrong, and money being spent on persecution should be used to help them off drugs and out of prostitution, argues **John Furniss.**

outreach' police and civilian teams may get attacked. So much for the victims and potential victims. So much for the majority of people who, at the time of the dreadful killings, felt for and empathised with the women on our TV screens and their families...

The murders arose from intense police operations, where women addicted to drugs were forced to earn their bags of heroin and rocks of crack by going into ever more unlit, vacant and dangerous places. Ipswich's Partnership Policy acknowledges that by increasing targeting there will be a 'displacement,' *ie* that the 'wretched' and 'unclean' will be forced into the murky periphery.

Many of us are familiar with this mix of hard Home Office direction, narrow terms of policy and aggressive policing where, when things go wrong, the victims and potential victims are blamed.

Whatever your thoughts, women who work the beat generally support themselves in their addictions and are to a degree independent in being able to earn. It ain't perfect, but it's survival and it pays for the bags.

Women at the 'lower end' of the sex trade are no different from anyone else. They are not worse addicts, they love their children and grieve when they are separated from them just as any mother would. But criminalisation makes them more vulnerable: to arrest, exploitation, discrimination, to being misjudged, ignored and dismissed.

Policy directs a clean sweep off the street away from the public gaze. Behind closed doors, on a credit card, with 'clean' sheets, 'clean' snow and a number of MPs or judges in attendance there is nothing but silence and tacit acceptance so long as the *News of the World* doesn't find out. Whereas the establishment increasingly turns a blind on corruption, sex with a prostitute can still lead to resignation.

Here comes the double whammy. The 'abused exploited individual sex worker' is in the same sentence the 'persistent anti-social prostitute addict' who needs compulsory interventions sanctioned by the courts. Drug services are very aware that poverty, being in care, prison and a crap education contribute to addiction, prostitution and shoplifting. However, in the current matrix, projects are funnelled into being soft and not-so-soft police and agents of the courts. With an ever-growing set of recidivist drug offenders, this policy frustrates and disturbs many of us.

Criminal justice drug intervention generally means methadone and a set amount of weeks heroin or crack free, to trumpet 'successful intervention'. It's an Alice in Wonderland world where sub-standard care and a focus on the individual as the key to change, make for great but misleading statistics. This narrow band of measures purposefully ignores the complexity of people's lives.

A few savvy companies have become very rich from this. It's an expanding market. But the 'abused exploited individual', whether s/he is a prostitute or not, is no better off.

It's no surprise that from the 1980s those areas that suffered industrial decimation became the powerhouses of drug gangs and addiction. It's a way to make money where jobs are scarce and low paid. The free market in action.

A few in the drugs field are now raising their heads above the parapet, challenging the repressive criminal justice responses that have been forced on from high. A different approach, one that's centred on the needs and experiences of people addicted to drugs has to come into play. The money that is being spent on persecuting sex workers could actually improve their lives rather than providing work for the law enforcement specialists, consultants, court officers, researchers and drug services.

The sun is rising a little in Glasgow and New Zealand, where the policymakers have been big enough and brave enough to realise that health and safety are central, whatever their own moral position. Both the safety zone in Clydeside and the decriminalisation in NZ have cut violence, increased reporting and enabled a genuine movement into treatment for those who want it.

The Safety First Coalition, co-ordinated by the English Collective of Prostitutes, is campaigning to safeguard women's lives. The authorities must provide useful and compassionate responses to the repeated incidents where women are killed, hurt and saddled with the burden of addiction. The Ipswich response is dangerous. We believe that decriminalisation is a necessary step for women to be able to work openly and get the respect and protection every worker is entitled to as well the support they may need to get off drugs and out of prostitution if they want to. Help not persecution. Keeping the living living is our primary aim.

John Furniss is a member of the Safety First Coalition, which will be launching in the House of Commons on 9 July in committee room 11. For more details email ecp@allwomencount.net

New justice reforms propose rehab for sex workers

The Criminal Justice and Immigration Bill, published this week, proposes compulsory drug and alcohol rehabilitation courses for sex workers, as an alternative to prison. David Hanson, the justice ministers introduced the initiative in a package of measures that would 'give the courts the tools to issue tough community sentences to rehabilitate offenders and reduce re-offending and in doing so make best use of prison and resources'.

A review of sex offence laws also proposed that the term 'common prostitute' – which dates back to the 1824 Vagrancy Act – be dropped from legislation, to be replaced by the word 'person'.

The government predicts that measures introduced by the Bill could save the over-burdened prison system around 1,400 places.

Media Watch

Head of the Scottish Crime and Drug Enforcement Agency (SCDEA), Graeme Pearson, warned of the possibility of increasing methamphetamine use in Scotland. 'I've certainly never been in the business of wanting to scare people. But I do think methamphetamine is a present threat, which might arrive in Scotland,' said Mr Pearson in the SCDEA annual report. His view was supported by Tom Wood, chair of the Scottish Association of Alcohol and Drugs Action Teams, who said it was a case of when, not if. A spokesman for the Scottish Drugs Forum agreed the threat had to be monitored, but added that dealing with Scotland's 50,000 heroin users was a bigger issue.
The Scotsman, 29 June

Prescription heroin for problematic users has been backed by members of the Scottish Parliament. Following recommendations from Tayside Police chief constable John Vine, MSP Bill Wilson lodged a motion calling for the initiative to be investigated, and suggested purchasing Afghanistan's opium crop to control supply to Scotland. But the Scottish Executive said there were no plans to consider prescribing heroin; instead, more resources would be targeted towards getting people off drugs.
The Scotsman, 27 June

New prime minister, Gordon Brown has promised 'a radical review of our anti-drugs strategy'. Speaking while still chancellor at last week's Association of Chief Police Officers (ACPO) annual conference, Mr Brown said that drug education should be extended to children aged ten and under, as well as ensuring those with substance misuse problems had access to treatment earlier. He pledged to work with police to build confidence of communities to 'name, shame and push out the dealers and the gangs'.
The Telegraph, 21 June

A new survey by trading standards officers in the North West of England revealed a drop in the number of children buying and consuming alcohol. The poll of nearly 12,000 schoolchildren aged 14 to 16 in North West England showed that the proportion of children who admit buying their own alcohol in off-licences, supermarkets and pubs had dropped from 40 per cent to 28 per cent in the last two years. Tony Allen, chair of the Trading Standards North West Under Age Sales Strategy Group, which organised the survey, said: 'Children are telling us that it is much harder to buy alcohol now than it used to be.'
The Publican, 29 June

The legal drug benzylpiperazine (BZP), known as XTC, Jax, Pep Twisted or Pep Love, could be banned across Europe on recommendation from Europol and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The report's authors list a range of adverse side effects, from confusion to vomiting, which could last 24 hours after use. The drug is available on many websites, marketed as a 'safe' alternative to ecstasy.
The Guardian, 18 June

'What we are doing does not work and research reflects this, yet we persist in harm reduction models that enable addiction as well as "walking with" and "holding the hands" of our clients. This merely removes individual responsibility and essentially institutionalises them into addiction services for many, many years.'

Enough is enough

I'm getting out of addictions, after ten years in the field and with a wealth of knowledge and experience. The reason? What we are doing does not work and research reflects this, yet we persist in harm reduction models that enable addiction as well as 'walking with' and 'holding the hands' of our clients. This merely removes individual responsibility and essentially institutionalises them into addiction services for many, many years.

In Glasgow where I work, generations of families are on our caseloads. Are we providing a better service? Are the treatment models appropriate? Are less people being referred? Are we moving people out of services? By the looks of it, no.

Further frustration for staff, is the overzealous and obsessive focus on the children of our clients. Now I'm all for protecting the children when it is required, but the tail is now wagging the dog. Being on a few days' training with children and family teams does not make me an expert, nor do I want to be. I came into addictions to work with adults with addiction problems, not to make sure 'wee Kylie' is developing properly and going to school. However, me attending these courses does tick a few boxes in the legal department!

I have found myself recently trying hard to defend my social work and child and family colleagues, but it is proving more difficult. To highlight this, this case study was used at a child protection course last year. A couple have a child, the father's drug use is chaotic and deals in heroin at a low level and the mother, though on a methadone prescription has a diazepam problem and left the ward 48 hours after giving birth for 22 hours, to buy and use illicit diazepam. However, the child and family team make every effort to keep the family together.

I asked what would happen if a childless couple with the same profile made contact with the child and family team and wanted to adopt or foster. Of course that would not be allowed to happen I was told. I cannot defend or work with such hypocrisy any more. More concerning is that we now know that those with addiction problems are avoiding services as word soon gets round that overzealous social workers are ready to become involved, whether the client wants them or not.

I'm waiting on my start date from the police force. I wish my clients well after I leave.
Brian, via e-mail

Mouth swab warning

I am a nurse/team leader at the Lifeline project in Manchester. The service provides needle exchange, advice and information and nursing services. Hep B/C and HIV testing is available for clients to access following pre-test discussion.

This letter is to act as a warning for other workers with regard to the use of mouth swab kits for blood-borne virus testing. I would also like to hear from other professionals who may have had similar experiences. The following is a descriptive account and is not research based.

I have had two results which appear to conflict with venous samples in relation to hep C antibody. The venous sample has demonstrated a positive antibody and the mouth swab a negative antibody.

Although the research suggests this may very

occasionally occur, I am concerned that it has happened twice in 12 months at a service that does only a small volume of testing. It would appear from the research that such cases do go on to demonstrate a negative PCR, however this is as a result of studying individual cases where problems have been identified as opposed to randomised quantitative research.

My other, probably more pertinent concern regards client perception and client information. For instance I am not aware that the swab companies currently recommend any particular advice with regard to information given with a negative antibody result.

A client may draw potentially dangerous conclusions from a negative antibody result if they have a prolonged and significant exposure history and yet are given a negative swab result. There may also be potential implications for assessing the exposure risk in relation to the testing of partners.

Matt Brierley, Lifeline Manchester.
Email Matt@lifeline.org.uk

Not yet sober?

I'd like to thank Daren Garratt (*DDN*, 18 June, page 9) for his interesting response to my letter in the previous issue, especially his comments regarding people being uncomfortable with the non-harmful use of Addictive Psycho Active Drugs (APAD).

In a bid to support his hypothesis, Daren quotes from my website, www.edenlodgepractice.com. In doing so he chooses to quote out of context, which hopefully is deliberate, rather than anything to do with his self-acknowledged 'drug-addled brain'. What my website actually says is:

'Whatever your drug(s) of choice are, my wish for you is that they are not costing you more than money. I hope that your drug(s) of choice just provides enjoyment, without harming anyone else. If you think that booze and/or drugs might be costing you more than money, the table below listing the four most popular drugs, will give you some ideas as to why.'

If that indicates in any way that I am uncomfortable, or 'puritanical', with the idea of people using drugs in a non-harmful way, I have no doubt there will be numerous people willing to point it out. What I am uncomfortable with is the irresponsible claim, by the RSA, and eagerly repeated by others, that 'the majority of people can use APAD, without harming themselves or others'. It is gratifying that Daren has now amended that nonsense from claim to 'assertion' and, to read 'many', instead of 'majority'. He is of course entitled to his opinion, providing it is clear that it is just an opinion, rather than fact.

Sadly, like so many who are in treatment, Daren in referring to his own brain bravely and honestly, acknowledges he is not one of them. However I am delighted to learn that he is now what he refers to as 'clean', but which I prefer to call abstinent, if not yet sober. I congratulate him and hope that his journey of drug-free recovery is both fulfilling and rewarding.

Peter O'Loughlin, The Eden Lodge Practice

Post-its from Practice

One step forward... but one stride needed

Has NICE guidance improved hepatitis C treatment in your area? If not, why not? asks **Dr Chris Ford**

Fran was excited about her follow-up hepatitis appointment as she was hoping this time to be accepted for treatment. She was now beginning to experience symptoms such as lethargy and poor concentration from her disease. I had re-referred her earlier than planned for a review with the hepatologists as her last visit had been before the latest NICE guidance which now recommends treatment for mild to moderate disease and for active injectors[1].

Fran was very stable on oral methadone, no longer injected, did not drink and had normal liver function tests. She had been told at her previous visit that she did not 'need' treatment and she couldn't have it!

When the updated NICE guidance came out we informed all patients to highlight the changes. We wanted to see if anyone who hadn't previously accepted referral or who was currently being followed up would now 'qualify' for treatment, explained that liver biopsy was no longer mandatory, and that early treatment gave the best results. For me Fran now fell into this latter group, and as she was genotype 3a she wanted to get started as soon as possible.

Hence I was shocked when I saw her a few days after her liver appointment looking really fed-up. She explained that she had again been told that she didn't need treatment. I have tried to speak to the consultant without success and have waited several weeks for a reply to my enquiring letter.

Although the NICE guidance was a step forward for hepatitis C it seems many things still need to change before the situation improves: 1) hospital units need to implement the guidance, 2) some consultants need to stop practising opinion-based rather than evidence-based medicine, 3) PCTs need to promote local awareness, clinical networks and provide funding for treatment, and 4) awareness, testing and referral for treatment in primary care needs to increase.

To help with the fourth point we have produced new guidance to improve the management of hepatitis C in primary care. It is estimated that between 0.4 and 1 per cent of the UK population are infected with HCV, equating to 250,000–600,000 sufferers. Early treatment of chronic hepatitis C (CHC) is more effective at clearing the virus in 50 to 80 per cent of people, depending on their genotype, but Britain currently has a poor record in treating patients with CHC.

Out of the total UK infected population, fewer than 17 per cent have been diagnosed and it is estimated that only about one in 20 of those diagnosed are being treated each year. Every GP is likely to have between eight to 18 infected individuals on their patient list, so it is essential that we work in general practice to strengthen our knowledge about this disease, increase our testing and encourage those who test positive to attend for early treatment[2]. We hope that the guidance will be useful in bringing about this change. We have also developed a hepatitis C e-module[3].

To treat more people makes complete sense in human terms but it also makes economic sense, as many of the Frans will develop end-stage liver disease and cost the state much more ultimately. Let's get out there – test and refer for treatment all those people with CHC that consent (NTA asking for 100 per cent screening is worthless and potentially damaging to people without the added target of people getting treatment) and let's not forget to challenge consultants and specialist nurses who refuse to treat people who currently inject drugs or have previously done so – you have the evidence base and NICE on your side!

Dr Chris Ford is a GP Lonsdale and clinical lead for SMMGP

1. National Institute for Health and Clinical Excellence (NICE). *Peginterferon alfa and ribavirin for the treatment of mild chronic hepatitis C*. NICE technology appraisal guidance 106, August 2006, www.nice.org.uk
2. *Guidance for the prevention, testing, treatment and management of hepatitis C in primary care* is available to download from www.rcgp.org.uk and www.smmgp.org.uk.
3. The Hepatitis C e-module can be accessed via www.doctors.net.uk

Is drug policy moving backwards?

Speakers at last week's Release conference agreed that drug policy isn't working, and warned that our failure to look beyond crime and punishment would continue to stall progress. **DDN** reports.

'The past 40 years have proved that the hard authoritarian punishment model of demonising drug dealers and users is a failure. Prohibition causes harms far greater than those it is intended to address. It is an expensive malevolent social policy that, far from protecting society from any harms drugs can do, is a barrier impeding our ability to help vulnerable people, especially those under the age of 18.'

These were the words of Caroline Coon, founder of drug users' support charity Release, who spoke at their 40th anniversary conference last week. Now 62, she looked back to 1967 and remembered her 'youthful outrage at the way powerful adults treat young people'. She recalled the Release casebook of those early days, when suspicious looking young people were stopped and searched and 'disappeared into the prison system'. She evoked an era when the authorities suddenly turned on hippie culture and dragged many young people through the courts for possessing the smallest amounts of cannabis. Fast forwarding to earlier this year, Coon said she had to pinch herself while watching the Home Secretary on TV in May, announcing new stop and search powers. She felt that there had been an astonishing refusal to learn from unworkable drugs policy, which continued to drive a wedge between politicians and democracy.

Back in the '60s many people came to Release because 'the only problem they had with drugs was that they were being criminalised and threatened with prison'. Others who were experiencing problems with their drug use needed help, not punishment; their behaviour was 'a sure indicator of distress' and a sign that they needed social support intervention from careful adults outside the family, said Coon.

'Whatever the law, humans will use pleasure-giving drugs. Whatever the law, we will always need to care for those who use drugs self-destructively to mask emotional distress... We should not vote for politicians who insist on dragging vulnerable "problematic" people through the courts,' she said.

Opening Release's conference, Simon Hughes MP warned that we were continuing to build up the number of suspects in our society, 'people it's likely

police will go after first, who include many drug users – a higher number here than in any other country in Europe.

'Once branded a drug user, it can become a difficulty for life,' he said.

Hughes was worried about the 'creeping pace' of legislation that made drug users likely targets. Anti-social behaviour orders were building a reservoir of people who could find themselves in the criminal justice system, if they triggered a breach. Police had a right to enter members of the public on the DNA database 'even if you are stopped and have done nothing', and four million people had been entered already. Biometric tests and fingerprinting were coming soon he said, and ID cards would be introduced in two years' time.

Law changes worried Hughes on several levels. He felt legislation was becoming 'less comprehensible' to normal people, while money on legal and aid and advice had increased in 'minuscule proportion' to the amount spent on other public services. 'So liberties are being reduced while the chances of getting appropriate help are diminished.' Around 80,000 people were incarcerated in UK prisons, he pointed out – more than ever, and more than in other European countries. Many of these prisoners had a history of drug use.

'I am absolutely clear that people with a history of drug or alcohol use are not best served in prison,' he said.

Lord David Ramsbotham, former chief inspector of prisons, agreed with this sentiment. His experience had led him to the conclusion that 'our prisons are not fit for purpose'. Furthermore, the National Offender Management Service (NOMS), created in 2005 to modernise the approach, had become 'the nightmare on Marsham Street, a monster bureaucracy'. 'No-one knows what it's doing and it deflects people from what they could be doing', he commented.

Mandatory drug testing was a farce, as it used figures taken from just 5 per cent of prisoners to represent drug-taking in prisons, he said. The CARAT scheme was also farcical he believed, as nothing happened to support people once they were released from prison.

The prison system had lost sight of helping people to make the transition back to law-abiding lives, said Ramsbotham, who highlighted the need to look at what was stopping them from rejoining society – lack of education, blood-borne viruses, substance misuse. Transformation of empty, listless days, to a full and active routine could give people a different experience of prison, he believed: 'This lack of activity is behind suicides, drug-taking and assaults.'

He also believed imprisoning people close to their home area would give them a much better chance of reintegrating to their family and community, and give local organisations an opportunity to support them through their rehabilitation.

When British Leyland had a skills shortage they went to Preston Prison and trained up prisoners for jobs, giving them a route to employment and a chance to re-establish themselves in the community.

'We should use the opportunity of a prison sentence to identify, challenge and treat problems people might have,' he said. 'The amount of money that's been wasted in the prison system makes me weep,' he added. 'As it's currently structured, prison is no place for treatment.'

Joe Boyd, American record producer and author, was in and around Release in the early days, and saw at first hand Caroline Coon's 'will and determination' in representing 'ordinary kids [who] were seen to be indulging in deviant behaviour'.

'June 1967 was the beginning of the war on drugs,' he recalled. 'Psychedelic culture and flamboyance gave society the trigger for a more aggressive stance. Did it work? Of course not.'

Busted twice for drugs, once in the US and once here, Boyd experienced a white middle class version of drug law: in each case he got off because he had been to Harvard, spoke nicely, dressed up for his trial. 'It was not in the interests of the system that I should be thrown onto the other side,' he said.

He realised that others from a less fortunate background were having an entirely different experience.

'The vast war on drugs in this country has been excuse to have a war on the underclass... it is used to attack people on the other side of the divide,' he said. 'In the name of the war on drugs, terrible crimes have been committed.' Allen St Pierre added his comments from his perspective as executive director of the US-based lobbying organisation, NORML, which campaigns to legalise cannabis. Of 2.3m people in jail in the US, between 60,000 and 80,000 had been imprisoned for cannabis alone – 'someone is arrested for cannabis every 40 seconds'.

He warned against the 'new reefer madness being practised here in the UK' and said it was important risks were not exaggerated, particularly by the media.

'Hold your media and don't allow them to be baseless in fact,' he said. 'Reefer madness is highly contagious.'

Simon Jenkins, a *Guardian* and *Sunday Times* columnist, had covered the London drugs scene as a young reporter and long since formed the view that 'the only way we can tackle problems of drugs is by legalising the bloody things'.

He had harsh criticism of existing drug policy, particularly the West's attempts to control cannabis; cocaine (by 'wiping Columbia off the map'); and opium ('sending Clare Short out to suppress the Afghan opium crop had the startling result of increasing production by 1000 per cent – surely the most successful economic policy ever!').

'The Afghan economy is the opium crop. Why are we spraying, oppressing, killing people who produce it? It's a more stupid policy than the middle ages could have produced,' he commented. 'The entire developed world pretends this is not a problem... [but] it needs the G8 countries to acknowledge that it's us doing the wrecking.'

There were many examples from other European countries that could help us break our record as the worst in Europe for drug addiction, he added.

Jenkins believed the 1971 Misuse of Drugs Act 'was a poisonous act in every sense' and said politicians were terrified to repeal it. Furthermore, politicians cowered behind the press, he commented, adding that 'the press doesn't rule this country'.

'We thought the media and politicians would be smarter now, because they're of our generation – but they're not!'

'Get together politicians and senior editors and ask them what their big problem is with the facts,' he suggested. 'This stuff has to be brought under control... I believe we have a public ready to press the press.'

We were talking about these issues 40 years ago, reflected Ethan Nadelmann, executive director of the Drug Policy Alliance, a US-based national organisation that campaigns to 'end the war on drugs'.

'We thought the media and politicians would be smarter now, because they're of our generation – but they're not!,' he said. Instead there was a 'slow creep' towards more drug testing and a 'maximum surveillance society', with a camera on every corner. Society had become reliant on a media that dragged out the worst examples of people who have used drugs. 'Reporters are going to go to treatment centres and prisons, where people have screwed up. Imagine doing the same with alcohol,' he commented.

Living in a 'highly stimulating and demanding society', gave rise to many contradictions. Who was to judge that amphetamines were only harmful, he asked, using the example of improved performance in US military who had been given speed to improve concentration and stamina. Many of us relied on coffee each day; some other cultures chewed coca leaf as a normal part of routine – a 'slow drip' way of taking cocaine.

'Who's going to say who's going to use what?' he asked, commenting that doctors were 'often caught up in the latest fads and fashions' on drug sales.

Qualifying his opinions by acknowledging that 'we should never take abstinence out of the equation, as for some people this works best', Nadelmann questioned the basis for drug prohibition: the assumption that 'drug-free' is our natural state.

'There's a puritanical religious belief in a drug-free society, and a notion of polluting this God-given vessel, particularly in the US,' he said.

'There's a perception that we're all born chemical free – but we're all wired differently.' **DDN**

Release relies on donations to continue providing free advice on drugs, the law and human rights to those who need it, including the legal helpline. Visit www.release.org.uk

Living with someone with drug or alcohol problems can pull families into a world they are ill equipped to deal with. With the right support they can come out stronger, say Moira **and** Christine**, who share difficult experiences.**

Coming through stronger

'We carry on as normal, when our lives are so far from normality...'

Moira Rothery has worked in the substance misuse industry for 23 years as a nurse/counsellor, and is co-founder of Detox At Home (www.detox-at-home.com).

Where did I put them? Everyone misplaces things from time to time, but for the wife, husband, parent or partner of an alcoholic or drug addict 'misplacing' possessions is a daily occurrence when the addict is using. We hide the keys to the car to prevent them from driving while intoxicated, crashing the car, getting arrested, harming themselves or God forbid, harming others. We hide the credit cards to prevent them from running up huge debts on impulsive purchases, buying more of their substance or gambling. We hide the pills that the doctor prescribed for our own stress and inability to sleep, to prevent them from easy access to a means of killing themselves because they feel so wretched and guilty for their using. 'Where did I put them?'

We the partners, try to carry on with our lives as though things are normal, when the life we are leading is so far from normality. We live in fear, fear of their relapse. We watch their behaviour for telltale signs; we look at their eyes; we search all the hiding spots; we get anxious when they go out and are delayed for any reason. And then it happens.

The relapse and the chaos that ensue turn our world upside-down, and permeate every aspect of our lives. We try to continue to keep everything going as the world expects to see it, but the world sees us as we are. We appear forgetful, scattered and inept to everyone around us. Who wouldn't be, when you live with and love someone who is actively destroying the life that you had both planned and worked so hard for?

The world sees us as distracted, anxious and even sometimes incompetent. We may even be accused of using ourselves, because our behaviour in trying to handle the addict mimics that of a using addict. We become isolated from our friends and family because we fear their condemnation of the person we love and of ourselves. They ask why we stay. The answer to that is simple. Addiction is a disease. We wouldn't leave if they were suffering from another mental illness like schizophrenia. We would pray that they take their tablets each day. With addiction, we pray that they don't take their substance any day.

We, the family, need the help and support of others who can remind us that we are not crazy, that our life is crazy and difficult right now, but that we have options. We need people to talk with about our fears and our strengths. We need to be reminded that we have those strengths and that we have the option to use them.

'We admitted that we were powerless over alcohol – that our lives had become unmanageable...'

When Christine's husband was admitted to a residential rehabilitation unit for alcohol dependence, she joined a family support group that helped her work with the 12-step philosophy to come to terms with her own emotional recovery.

I wish I could remember the day that I realised that my life had become unmanageable. Was it the day when it took another person to make me realise that in trying to suffocate me, my husband had not only committed what would be considered in law a serious assault, but that my life could actually be in danger?

Perhaps it was when I checked the mileage on my car and discovered that in seven months I had travelled over 15,000 miles, visiting hospitals, taking him to appointments, attending therapy sessions or just moving all his belongings back home. That I only felt safe and secure in my car with my music blaring. That when driving home I wanted the road to go on forever.

Maybe it was when I admitted that all I could manage in a day was to get up and hope to get to the end of it without another drama, crisis or trauma occurring.

It certainly wasn't the time when I had to inform the police that my husband, who having taken his own discharge from hospital in a very distressed and sedated condition, was now hiding behind a block of flats, indulging in self harm by taking a razor blade to his arms, slicing them like pieces of raw meat.

Nor was it the evening when he relapsed and drank two bottles of cheap whisky in a field, cutting his arms and being picked up by the police. Seeing him in A&E, this horrible goblin-like creature uttering hurtful and obscene comments at me and then falling asleep on the floor covered in mud, blood and vomit. And me thinking 'it was only two', but it wasn't only two drinks or even two doubles, but two bottles.

It wasn't when I had to take yet more sick leave from work, or when I looked at my payslips and saw ever-decreasing amounts of take home pay, or our dwindling savings that had been for our future.

It certainly wasn't the evening that he stood at the bottom of the stairs, holding a knife across his wrist and daring me to tell him to cut.

It wasn't even a single moment or a combination of events over the Christmas and New Year period when I told him that if he messed me about one more time that that would be the end of our marriage and yet within two hours he had smashed up a room, slashed his arms and had made another verbal and physical assault against me.

No, it was the morning in early January when I woke up and told him I wanted a divorce. From the moment I said those few words I felt a great weight lift off my shoulders and a deep blackness leave me.

Within two days he had moved out. I can't say that I don't miss him, but I don't know which 'him' I miss. It certainly isn't the person who had returned from hospital a few weeks before, who had hardly spoken, had not washed or changed his clothes so that I wouldn't want to go near him. The person I miss is the man who came out of rehab in May. A gentle, loving man, with any number of emotional and psychological problems, but one that I fell in love with all over again.

From the moment I admitted I was powerless over his addiction, that I hadn't caused it and couldn't control or cure it, my instinct for self-preservation and survival took over. Each day I grew stronger with an inner happiness and contentment that depended on no others' emotions or moods but my own. I got 'my self' back.

I wish these changes could have come about without the horrors that happened to me and my husband and the loss of our marriage. But they didn't. While I don't think I enabled him to carry on drinking to the point of alcoholism, purely because I was ignorant of the fact, I do accept that I enabled much negative behaviour throughout our relationship to the detriment of us both. Alcoholism didn't make me the person I was. My characteristics were formed many, many years before my husband picked up his first drink. The coping strategies, the staying silent when I should have spoken up, the desire to please, the wishing for a better tomorrow, were already laid down long before we met.

I like the person I have become. The old persona still pops up from time to time, but I know how to handle her and send her packing. I still obsess about certain things – still want to change things/people/events/outcomes that I have no control over. And I do think I had more fun on occasions in, if not my 'child ego', at least my obnoxious, bolshy, adolescent one!

I am more open, comfortable with my feelings and emotions, and able to say what I really want to.

Never again will I accept the role of 'co-dependent'. I no longer believe I am better than anyone else and have learnt compassion and humility.

It has taken very many years to reach here and my bottom line is that I am glad it all happened.

Events

FDAP Events

6 July – London
FDAP/CoG workforce development seminar – Organised in association with the Competence Group (CoG), this one-day seminar aims to update participants and exchange good practice on workforce development in line with DANOS and other National Occupational Standards. The seminar is open to FDAP affiliates and DAT workforce leads only. www.fdap.org.uk.

11-12 October – Leicester
Prisons and beyond... 2007 – Organised by the National Offender Management Service (NOMS), in association with FDAP, ADFAM and EATA. Targeted at frontline staff, managers and commissioners involved in the treatment of drug using offenders in custody and after release, this two-day event incorporates plenary presentations, practical workshops and seminars, and interactive debates and conference dinner with speaker. Details available shortly on www.fdap.org.

13 November – London
5th Annual Drug and Alcohol Professionals Conference – Organised by FDAP. Details available shortly on www.fdap.org

Other events

11-12 July – Birmingham
Journey's end: An end to rough sleeping – Organised by Homeless Link. This two-day event focuses on building on progress to date in helping rough sleepers to 'come in from the cold' – examining what has worked and what hasn't, and considering implications for the future. www.homeless.org.uk

12-13 July – Cambridge
DrugScope Conference – Organised by DrugScope. This two day event, 'Policy, practice and passion: driving drugs work forward' will feature guest speakers, interactive sessions and advice surgeries, all geared to driving the work of the drugs field forward in changing times. www.drugscope.org.uk

4 September – Stirling
Tackling volatile substance abuse – Organised by Re-Solv and the Forth Valley Substance Abuse Team, to launch a new training resource and hear speakers with a broad spectrum of views on tackling VSA. www.re-solv.org

4 October – London
Fetal Alcohol Spectrum Disorders (FASD) – The Untold Story – Organised by NOFAS-UK. Their 3rd conference aims to educate those who work with children affected by prenatal alcohol exposure about the needs of people with FASD. www.nofas-uk.org

5 October – Liverpool
Performance and image enhancing drugs conference – Organised by Centre for Public Health and Research Institute for Sport and Exercise Sciences at Liverpool John Moores University. This one day event will focus on the latest information and evidence relating to the use of performance and image enhancing drugs and facilitate the exchange of knowledge, views and experiences. http://pied-conference.net.

15-16 October – Glasgow
National conference on injecting drug use – Organised by Exchange Supplies. This year's event will cover a range of issues such as: how to reduce sharing; needle exchange for young people; pharmacy needle exchange; and provision of naloxone to reduce drug related deaths. www.exchangesupplies.org

My son is a university graduate, who's doing well at work. He drinks now and again, and is a non smoker who exercises regularly. He has admitted to me that sometimes on a night out he takes cocaine and other drugs. He doesn't see this as a problem and tells me that it is just part and parcel of modern Britain. Should I be concerned?
Marian, Merseyside

All adults here

Dear Marian
Ninety five percent of drug use is 'recreational' – only five percent of people who use drugs do so in a problematic way. Drug use (especially the so-called party drugs like cocaine and ecstasy) has become totally normalised among young people and it is easy to understand why. Years of drug information and education that just demonised drug use and drug users has been discredited by young people's actual experiences.

People have for a long time questioned why alcohol should be the only legal intoxicant and helped by the increased availability of other drugs, many want to get their highs in other ways. Very few of these young people go on to become problematic drug users, in the same way that few drinkers become alcoholics.

Of course there are some health risks associated with this behaviour, such as strain on the heart and increased blood pressure but as a young healthy man, who you say only uses occasionally, he is a relatively low risk – would you be concerned if he had other statistically far more dangerous hobbies such as rock climbing or playing rugby?

One of the main risks of drug use for most young people is the illegality of their actions and the possibility of being arrested, which can affect careers, travel plans, finances and even in extreme cases personal freedom. There are ethical problems with using some drugs, especially cocaine, which helps to fund serious criminal organisations both in this country and overseas – but this moral issue is a personal one for your son to decide.

I of course understand your concern for your son, especially when he is engaged in an activity that you yourself have no experience of, but there is a lot of good impartial information available on this subject. Reading this will help you make your own informed judgement on the risks being taken.

Your son sounds like an intelligent individual and your relationship with him appears open and trusting, allowing him to come to you if he ever has a problem. Responding to him as a responsible adult is the best support that you can give him.
Benny, Norfolk

Calm approach

Dear Marian
It sounds like you're going to speak with your son again about this matter. I feel it's very important to think carefully first, and your approach should be considered properly.

He's told you he sometimes takes cocaine and mixes other drugs on a night out and because of this you are concerned – and as a mother, rightly so. What do you do, you're asking, what shall I say? Will I lose his trust? How can I measure his drug-taking?

How about thinking of harm reduction strategies in preparation of your next talk, get him involved in why such a special individual like himself needs to be pigeonholed with others. He's not part and parcel of others' behaviour, he's an individual in his own right. He sounds like a well-balanced young man with a bright future.

It's picking the right time to talk, as with anyone that we feel may be at risk – when they are receptive to the information on offer, not when they are intoxicated or not listening.

I feel this is a golden opportunity to challenge his behaviour through equal sharing – you'll both learn a lot. You'll be surprised how, by bringing him to awareness at this early stage, your concerns will hopefully trigger a process of change in his drug-taking before an addiction can manifest itself.

Remember, take a calm approach. See him when he's home again and have a talk. You'll find the words.
Chris, Newcastle

Testing the limits

Dear Marian
Your son is right, drug-taking is part and parcel of modern Britain – but so is the damage that drugs do.

There's a limit to what you can do here. If your son is still away from home – he's already broken his bonds with parental authority and is testing his freedom. He may well be testing your reaction, or he may well be keeping you in touch with his lifestyle – it's hard to gauge your relationship with your son from your letter.

I would suggest responding as calmly as you can. Don't be shocked or judgmental, but don't condone his drug-taking either. You will find an opportunity to tell him to go easy on harmful substances. Most students leave their experimentation behind when the novelty wears off.
Jenny, Oxford

Reader's question

A drug and alcohol worker in my team has come to me wanting support because she has just relapsed after several years. She is a valued member of staff and we want to help her over this episode and keep her in her post. Can anyone suggest practical support we can give her?
Lizzie, by email

Email your suggested answers to the editor by Tuesday 10 July for inclusion in the 16 July issue.

Heroin overdose

Professor David Clark briefly summarises some of the main research findings focusing on the incidence and possible causes of heroin overdose.

At a recent conference on overdose in Swansea, I was reminded of a number of myths related to heroin overdose that still circulate among users, family members, practitioners and policy makers. These myths hamper the development and implementation of strategies to reduce deaths caused by overdose of heroin and other drugs.

Accidental overdose is the most common cause of death among heroin users. Research studies have revealed that 50-70 per cent of injecting drug users (IDUs) have experienced a non-fatal overdose at some time in their lives, with 20-30 per cent overdosing in the preceding 12 months.

Death from heroin overdose is due to respiratory arrest. Many people who die from heroin overdose do so two to three hours after taking the drug, which means that there is often a long time period during which the person can be helped.

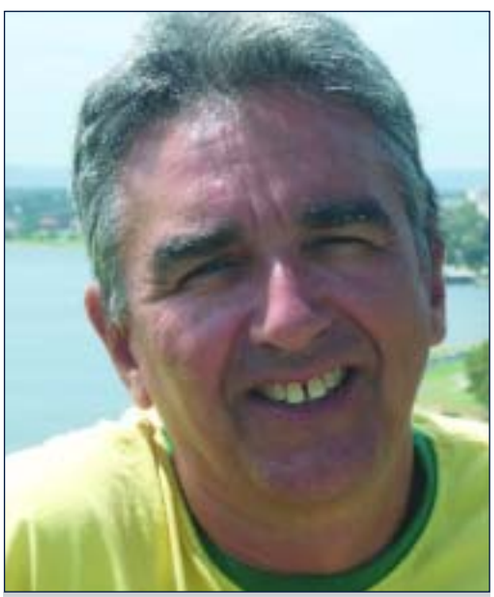
Extensive research has shown the following risk factors for overdose: using the drug intravenously; having a history of heroin dependence; using the drug after a period of non-use or reduced use; not being in treatment for heroin dependence; and concomitant use of depressants, such as alcohol and benzodiazepines, *eg* valium.

It is commonly believed that many overdose deaths occur among young, relatively inexperienced heroin users. However, research has consistently found that most victims of fatal overdose are aged in their late 20s and early 30s. They generally have a long history of heroin dependence. The greater incidence of drug overdose among older users is somewhat counter-intuitive, since one would expect younger users to have less tolerance, and a relatively poor ability to determine the dose of heroin.

Another counter-intuitive finding revealed by research is that at autopsy a large proportion of overdose fatalities have relatively low blood morphine concentrations (heroin is rapidly metabolised to morphine in the body). This finding conflicts with the widely held view that overdose is the result of using a quantity or quality (purity) of the drug in excess of the person's normal tolerance.

Moreover, research has shown only a moderate correlation between the purity of street heroin seizures and the numbers of deaths from overdose. Research has also dispelled the notion that overdose fatalities are related to contaminants in heroin.

What factors underlie the strong age patterns and apparently low blood morphine concentrations found in overdose fatalities?



"Another counter-intuitive finding is that at autopsy a large proportion of overdose fatalities have relatively low blood morphine concentrations..."

A significant number of overdose fatalities occur after periods of reduced use, such as immediately after release from prison. The increased risk for overdose following release is likely to be related to the person taking heroin at a time of low tolerance to the drug, following a period of non-use or reduced use in prison. Hair analysis studies, showing that overdose fatalities were using less heroin than active street users in the months preceding death, confirm this idea.

The loss of tolerance may also be at least partially responsible for the age-related trends in overdose deaths. It has been suggested that, after a decade of use, some users cut down their consumption of heroin as a result of tiring of the rigours of the heroin-using lifestyle.

Entry into abstinence-based treatment also represents a potentially risky period for heroin overdose if the person relapses, since tolerance is lost to the drug or to methadone.

The loss of tolerance that occurs following termination of heroin use may vary for different effects of the drug. Thus, users who reduce their consumption may be at greater risk of overdose as their tolerance to the respiratory depressant effects may have diminished more rapidly than their tolerance to the desired psychological effects of the drug.

Concomitant use of other central nervous system depressant drugs, in particular alcohol and benzodiazepines, is known to increase the risk of heroin overdose, both fatal and non-fatal. Heroin is more likely to cause overdose in people who have been drinking alcohol or taking benzodiazepines because these latter substances can potentiate the respiratory depressant effects of the opiate.

Researchers do not believe that poly-drug use and loss of tolerance can fully explain both the age-dependency of overdose victims and the low morphine concentrations associated with these deaths. They have suggested that mortality from heroin overdose might (also) be associated with systemic disease, some of which may have occurred as a result of previous non-fatal overdose(s). Two examples are provided here.

An involvement of liver disease or dysfunction in heroin overdose is possible, since opiates are metabolised in the liver and drug clearance is reduced in people with liver cirrhosis. IDUs are at significantly increased risk for liver disease, in large part due to their increased likelihood of contracting hepatitis C. Moderate levels of alcohol have been found to exacerbate liver damage arising from hepatitis.

Reduced metabolism of heroin in users with liver damage could prolong the period of heavy intoxication in which they are at risk for overdosing by respiratory depression.

Opiate overdose deaths may also be linked to pulmonary dysfunction, which can result in an increased vulnerability to fatal respiratory depression. Heroin users are likely to exhibit impaired pulmonary dysfunction due to smoking (cigarettes, heroin, crack cocaine), complications of overdose, and their increased susceptibility to infection, the latter arising in part from their poor health and lifestyle.

Recommended reading:
M. Warner-Smith et al (2001), 'Heroin overdose: causes and consequences', Addiction 96: 1113.

First Notice

Substance Misusing Parents and their Children

Towards Effective Services

Tuesday, 20th November 2007
Regent's College, Regent's Park, London, NW1 4NS

The conference aims to:

Highlight the impact of substance misusing parents on children.

Provide a cross-disciplinary forum in which a range of people with an interest in the well-being of substance misusing parents and their children can exchange ideas.

Update participants on relevant research and good practice.

Support an evidence-based approach to a challenging social problem.

The event will bring together national strategic leads, clinicians, commissioners for health and social care to debate, explore and develop responses to this controversial issue.

K·C·A Training & Workforce Development

To register for details contact:
KCA Training and Workforce Development
43A Windmill Street, Gravesend, Kent, DA12 1BA
Tel: 01474 326168 Email: tcw@kca.org.uk

Keith Chadwick Associates/ Manchester Centre for CBT

COGNITIVE BEHAVIOUR THERAPY SKILLS WORKSHOPS

Training Courses for Drug & Alcohol Workers
(DANOS mapped)

NOW BOOKING FOR AUTUMN 2007

Introduction to CBT (2 days) Manchester 13 & 14 September
Introduction to CBT (2 days) Birmingham 2 & 3 October
Critical Incident Stress Debriefing (2 days) Manchester 7 & 8 November
Critical Incident Stress Debriefing (2 days) Birmingham 15 & 16 November
Working with Trauma & PTSD (2 days) Manchester 22 & 23 November

We also provide in-house training courses for organisations.
For further information on the range of courses **MCCBT** provides please visit our website at **www.cbt-centre.co.uk** or email **info@cbt-centre.co.uk** Tel: **0845 052 3949**.

TVU Thames Valley University
London Reading Slough

TEL: 0800 036 8888
healthenqs@tvu.ac.uk
www.tvu.ac.uk/ddn

my choice my future

DIPHE/BSC (HONS) SUBSTANCE USE AND MISSUE STUDIES
Starting October 2007 and February 2008

CPPD THE USE AND PROBLEM USE OF DRUGS AND ALCOHOL
Starting February 2008

At our Brentford Campus, West London

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

Modules

- Substance Use and Misuse in Context
- Substance Use and Misuse Treatment Interventions
- Enhancing Practice in Substance Misuse
- Cultural Competence in Dealing with People with Drug and Alcohol Problems
- Dual Diagnosis: Exploring Interventions for People with Mental Health and Substance Misuse Problems
- Substance Misuse Prevention Interventions for Young People
- The Criminal Justice System and Substance Misuse
- Communicable Diseases (HIV, HCV, TB): Substance Misuse and Health Behaviour

Modules can be taken alone or combined leading to a Diploma or Degree.
This programme has been mapped against DANOS (www.danos.info).

Kent Drug & Alcohol Action Teams

Eastern and Coastal Kent NHS
Primary Care Trust

Kent County Council

EXPRESSIONS OF INTEREST

Tier 2 - Alcohol Brief Intervention Workers

Kent Drugs and Alcohol Action Team (KDAAT), Eastern and Coastal Kent PCT, Community Safety Partners and their providers, are inviting companies to express interest in providing Tier 2 - Alcohol Brief Intervention Workers.
This service will support delivery of National Alcohol and Choosing Health Strategies as well as local and national targets to:

1. Improve:

- Treatment and support to people with alcohol related problems
- The wider population's physical and mental health
- Knowledge and use of "safe" drinking limits
- Community and personal safety

2. Reduce:

- Harmful and problematic alcohol consumption
- Anti-social behaviour
- Acquisitive and violent crime
- Domestic violence
- Costs to Health, Social Services and the Criminal Justice system

The provider would be required to fulfil 7 posts (6 intervention workers and 1 administration post) to cover the following districts:

Ashford	Shepway	Canterbury
Swale	Dover	Thanet

Organisations wishing to express an interest in providing this service, should apply in the first instance to CJEU@kent.gov.uk **no later than 1700hrs 13 July 2007.**

Late applications cannot be accepted

This opportunity may be advertised in other publications

Bedfordshire county council

Community Services

BDAT Team

BDAT Information and Contracts Performance Manager

£32,487 - £36,636 pa
Quote ref: BCC203

This is your chance to join a dynamic and enthusiastic team working strategically and flexibly to respond to national targets and local needs.

In this key role, you will lead on the contracting and business elements of Bedfordshire Drug Action Team commissioning. Focused on ensuring best value and facilitating high quality services, you will lead on contract compliance, financial monitoring, data collection, and information analysis.

Educated to degree level or equivalent, you will have experience of data systems, collection, and analysis together with the ability to set up, monitor, and performance manage contracts. Skilled in the use of spreadsheets and databases, you will also have a flair for communication and presentation.

Closing date: 16 July 2007.

Interview date: Week commencing 30 July 2007.

To apply online visit www.bedfordshire.gov.uk

Email: jobs@bedsccrecruitment.com or phone 0870 043 4897 between 9am - 6pm Monday to Friday. Text phone service available (for the deaf or hard of hearing) 18001 0870 043 4897.

www.bedfordshire.gov.uk
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Chartered Psychologist

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P.L. (Health Visitor)

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- Video demonstrations of techniques
- Comprehensive further reading and resources list
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- Post-seminar case support and consultancy available

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www.skilldevelopment.co.uk

Why you cannot afford to miss this course?

- ✓ Learn how complex multiple problems don't need lengthy complex solutions
- ✓ Effect change in behaviour, thoughts and feelings in 1-4 contacts....even with very "stuck" clients
- ✓ Evidence based
- ✓ Video demonstrations of techniques
- ✓ Strategies to prevent client dependency
- ✓ Identify your most challenging clients' undiscovered personal strengths and resources
- ✓ Discover how to be optimistic and motivated with your most difficult cases
- ✓ Learn how to be brief when you were trained to be deep and spot complex causes and needs
- ✓ Invaluable in a range of health and social care environments across the age span

FREE CD-ROM included containing presentation, guided reading list, evidence-based reference list, further resources and COPIABLE WORKSHEETS for use with clients.

Dates and Venues:

10 December 2007	London
11 December 2007	Birmingham
12 December 2007	Manchester
13 December 2007	Harrogate
14 December 2007	Nottingham
17 December 2007	Glasgow
18 December 2007	Bristol
19 December 2007	London

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- 24 Hours, 7 Days a week care
- 36 beds quasi residential Primary - £350 per week
- 24 beds quasi residential Secondary - £300 per week
- 12 week programme
- We give you statistical information on line every week regarding your client without fail
- Detox facilitated
- 12 step and holistic therapy

For further information please contact Darren Rolfe

CALL FREE 08000 380 480

Email: Darren@pcpluton.com
Web: www.pcpluton.com

addaction

Criminal Justice Worker

£17,833 - £20,801 pro rata
Fleetwood
To apply, visit our website.
Closing date: 9 July 2007.

where everyone's unique

Charity no. 1001957

www.addaction.org.uk

Barton Hill Settlement is a community-managed, multi-purpose centre providing a range of services within inner city East Bristol.

We require a

Project Manager

To take responsibility for the strategic development of the Community Action Around Alcohol and Drugs project – ensuring it serves local people effectively and is linked to the regional and national D&A strategy.

For an informal chat phone Joanna Holmes, Senior Manager on 0117 9556971 ext 222

Starting Salary: £29,860
Hours: 35 per week

Closing date for all applications: Monday 16th July 2007 at 10am
Interview Date: Tuesday 31st July 2007.

For a job pack giving more detailed information please contact Central Services Office, Barton Hill Settlement, 43 Ducie Road, Barton Hill. BRISTOL BS5 0AX
Tel: 0117 9556971 Email: gemmac@bartonhillsettlement.org.uk
For more information look on our website:

www.bartonhillsettlement.org.uk

Barton Hill Settlement welcomes applications from all sections of the community
Limited Company Number 5031499 Registered Charity Number 1103139

EXPRESSIONS OF INTEREST TO PARTICIPATE IN THE TENDERING PROCESS TO SECURE THE INTEGRATED DRUG TREATMENT SERVICE CLINICAL MANAGEMENT MODEL AT HMP STAFFORD AND FEATHERSTONE.

The Staffordshire County Drug and Alcohol Action Team are seeking expressions of interest from suitably qualified organisations wishing to participate in the tendering process for the provision of the integrated drug treatment service clinical management model at HMP Stafford and Featherstone.

The tender process will be undertaken in two stages. Firstly the submission of a pre-qualification questionnaire, secondly, suitably qualified organisations will be invited to submit full tender documents. Interested parties are asked to note the following timetable:

- Week commencing **3rd September 2007** - Send out full tender documents, to be returned by **5th October 2007.**
- Week commencing **19th November 2007** - Selected providers will be invited to present their model.

The total yearly value of the contract to be awarded is expected to be in the region of **£175,300 (approx)** to commence for a 12 month period from April 2008.

For further information please contact Laura Keiher, Community and Criminal Justice Commissioning Officer on (01785) 223176 or laura.keiher@scdaat.co.uk

Expressions of interest should be made verbally or by email to Julie Gardiner on 01785 223176 or julie.gardiner@scdaat.co.uk by no later than **6th July 2007.** The date for return of the pre-qualification questionnaire will be **3pm 20th July 2007.**

Staffordshire County
Drug and Alcohol Action Team

DDN/FDAP workshops

fdap DDN

Brief Interventions on Alcohol
23 July, London

This one-day interactive workshop will examine screening tools and short motivational interventions. This workshop is mapped to DANOS and provides vital information for all drug and alcohol workers.

The essential drug and alcohol worker
17-21 September, London

This five-day course provides a full introduction to the elements of effective drugs and alcohol work. This workshop is delivered in association with DDN and DrugScope.

All one day workshops cost: £110 + VAT per head
Five day workshop cost: £635 + VAT per head
(15% reduction for FDAP members/affiliates – rates for groups on application)

Contact Ruth Raymond
e: ruth@cjwellings.com
t: 020 7463 2085

We take action to disarm addiction. We do this through research, treatment, family support, education and training.

Our Day Treatment Centres are currently looking to recruit the following people:

- Counsellor (1 full-time and 1 part-time position) London
- Counsellor (part-time) Liverpool
- Admissions and Referrals Coordinator London
- Receptionist & Admin Assistant London
- PA to CEO and Principal Consultant London

Counsellor to provide a counselling service to clients both individually and collectively and responsible for managing a caseload. Experience in the addictions field preferable but not essential. Admissions and Referral Co-ordinator to manage and coordinate the admission process of all clients into treatment. Receptionist & Admin Assistant to run an efficient and effective reception and provide comprehensive administrative support. PA to provide confidential support to the CEO and Principal Consultant.

For more information and to receive an application pack for any of the above roles, please contact Mardeen Willows on 01747 830 733 alternatively email Mardeen.willows@actiononaddiction.org.uk Closing date: 13th July 2007

Action on Addiction

The Chemical Dependency Centre has merged with Action on Addiction and Cloads. The new organisation is called Action on Addiction.
www.actiononaddiction.org.uk Charity No: 1117988

Part-time office assistant

Central London

A happy communicative person is wanted to assist with general office duties at **CJ Wellings**, the small publishing company that produces **DDN**. The job involves maintaining the accounts system, dealing with customer enquiries, managing workshop and event bookings and assisting the editor with transcribing interviews.

The right candidate must be literate and numerate with good computer skills and a friendly professional telephone manner, but above all must be willing to pitch in and work within a small team.

£8.50 p/h, 20 hours a week
(hours flexible although mornings are preferred)

Please email CV with covering letter to ian@cjwellings.com

CJ Wellings

ARA addiction recovery agency

The Addiction Recovery Agency, provides abstinence-based and harm reduction services to people with drug and alcohol misuse problems.

As part of an exciting expansion of the North Somerset Service we are looking to recruit:

Project Worker – Day Care

Salary: £21,000 – £23,500 Job Ref: GE006

As a key member of our Day Care Team you will be a diploma qualified counsellor, with experience of substance misuse services, assessments and partnership working.

Drugs Worker – Brief Interventions Service

Salary: £21,000 - £23,500 Job Ref: GE007

You will be an experienced drugs and alcohol worker providing brief interventions therapy, assessments and partnership working.

Closing date: 9.00am Monday 23 July 2007

To apply visit www.addictionrecovery.org.uk or call 0117 934 0844.
Benefits include: 25 days leave, 35 hour week, pension, training.

ARA is working towards equal opportunities and welcomes applications from all sections of the community. Registered Charity No 1002224

PRIORY

Addictions Counsellors

Farm Place - £18,422-£30,705
30 hrs & 37.5 hrs (2 posts)

The Priory Hospital Woking - £18,422-£30,705
37.5 hrs (1 post)

We are currently looking for creative and experienced 12 step Therapists to join our team providing a 7-day treatment programme to our patients. The candidate will be a qualified counsellor and have experience in facilitation of group and individual therapy within the addiction field. FDAP accreditation or evidence of working towards this is required. The successful applicant must enjoy working as part of a multidisciplinary team and be willing to be flexible to the needs of a busy unit. In return for your commitment and hard work you will work in a well-resourced, first class environment.

For more information and/or an informal visit please contact:

Martin Smith, Programme Director, Farm Place on 01306 627742.

For an application form and job description contact Lindsay Womersley, HR Administrator at: Farm Place, Stane Street, Ockley, Nr Dorking, Surrey RH5 5NG. Email: lindsaywomersley@prioryhealthcare.com

Rebecca Wood, Addiction Treatment Co-ordinator, The Priory Hospital Woking on 01483 489211.

For an application form and job description contact Joan Bendy, HR Administrator at: The Priory Hospital Woking, Chobham Road, Knaphill, Woking, Surrey GU21 2QF. Email: joanbendy@prioryhealthcare.com

Closing date: 13th July 2007.

The successful candidate will be required to apply for a Disclosure at the Enhanced level from the Criminal Records Bureau. Further information can be obtained from www.disclosure.gov.uk

We are an equal opportunities employer.

www.priorygroup.com

winthrop hall

SUCCESS IN RECOVERY

SUBSTANCE MISUSE NURSES (Night or Day)

Salary to £35,000

Superb Working Environment

Excellent Package

Winthrop Hall, part of Success in Recovery, is a new company formed for the purpose of delivering groundbreaking treatment of drug and alcohol addiction in the UK, for individuals who can fund their own treatment. Our first residential treatment centre, providing discreet, private residential and follow-up treatment of addictions, is a unique, high quality, purpose-built facility, located south of Maidstone in Kent and will open in September 2007.

Our goal is to establish a centre of excellence in this field and our fundamental guiding principle will be research based and outcome driven client centred care pathways, delivered in a supportive and interactive environment. The therapeutic programme will combine traditional 12-Step treatment married with a broad psychological input, based on cognitive and behavioural treatment principles, the latest in medical science whilst incorporating alternative therapies.

We are seeking to recruit outstanding Substance Misuse Nurses, with the motivation and skills to deliver our programme and achieve successful outcomes for our clients. Candidates must be dynamic, talented, articulate and enthusiastic, who will not only be passionate about delivering first class client care, but will also believe they can truly match our mission statement of Undeniable Excellence.

Either RMN or RGN, you will be experienced in the addictions field and have undertaken further training in addiction or supportive areas. In particular, you will be expected to:

- Play a key role in the client's medical detoxification;
- Be involved in assessment, planning, implementation and evaluation of client care;
- Utilise other supporting skills or training within this field as you will be expected to play an important role in other therapeutic activities within the centre; and
- Be a valued member of the multi-disciplinary team.

We offer an extremely attractive salary and benefit package as well as our commitment to your ongoing professional development.

If you are interested in this opportunity please e-mail a brief CV or résumé of your background and experience and a covering letter to the Human Resources Department at **recruitment@successinrecovery.co.uk**

Closing date for applications is 16th July 2007.

This post requires an Enhanced Disclosure under the Care Standards Act 2000

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HMP & YOI ASHFIELD

At HMP & YOI Ashfield, situated in Pucklechurch village, a rural setting outside Bristol, we are committed to the rehabilitation of young offenders between the ages of 15 and 18 years.

Having acquired further funding from the Youth Justice Board, the award winning Young Person's Substance Misuse Team at HMP & YOI Ashfield have a number of additional vacancies.

If you are genuinely interested in empowering young people to look at change and are a creative, innovative person who encompasses the Every Child Matters Agenda, we would welcome your application. The following positions are available and will be responsible for:

SUBSTANCE MISUSE MANAGER
£30,929 - £32,535 per annum

- Strategic implementation encompassing, DATs, NOMS, ROMS
- National Specification implementation, integration and management for juveniles in custody
- Multi-disciplinary performance management and monitoring whilst promoting effective and best practice, and the every child matters agenda

SUBSTANCE MISUSE TEAM LEADER
£28,595 - £29,666 per annum

- Case Management, care planning and resettlement
- Supervision, monitoring and evaluating service provision
- Day to day allocation and interventions and in the absence of the manager oversee day to day provision

SUBSTANCE MISUSE WORKERS X 4
£17,018 - £19,693 per annum

- Assessments, education and prevention within a national standard requirement
- Young peoples intervention support and programmes whilst facilitating learning
- Care planning, monitoring, resettlement and throughcare

The successful applicants will be expected to complete a 11-week Prison Custody officer's course within twelve months of starting.

Closing date for completed applications: Wednesday 18th July 2007

Along with a competitive salary, other benefits include a Stakeholder Pension (company contribution up to 6%), life assurance, free parking, subsidised canteen and a healthcare plan.

HMP & YOI Ashfield is a non-smoking establishment.

If you feel you can make the difference in a challenging environment then contact the HR Team:

ashfieldrecruitment@premier-serco.com

or call for an application form:

0117 303 8058

The Human Resources & Development Dept,
HMP & YOI Ashfield,
Shortwood Road, Pucklechurch,
Bristol BS16 9QJ
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want to join a young, dynamic, expanding team?

Due to our unprecedented growth TTP Counselling is looking to recruit the following members to its team:

2 BUSINESS DEVELOPMENT MANAGERS
Luton and North West
Salary £24k basic OTE £36k
Developing business relationships with both statutory and GP referrers. 2 years+ working within the substance misuse field and familiar with DAT/DIP referral pathways and purchasing of Tier 4 services. Knowledge of the 12 Step programme of recovery is preferred but not essential.

MANAGER, DETOX FACILITY
Surrey
Salary £30k to £35k
Responsible for running the TTP detox facility in Surrey. You will lead the nursing team and ensure that residents receive a high quality service in a safe environment. The following competencies are required:

- Leadership and management
- Financial management
- Appropriate level nursing qualifications
- Professional nursing expertise working with substance misuse clients
- Able to communicate to various audiences, written and oral
- Facilities management

MANAGER, COUNSELLING SERVICES
North West
Salary £30k to £35k
Experienced Service Manager required for our new 80 bed centre in the North West (opens January 2008). Direct personal experience of the 12 step programme of recovery and managing a team of counsellors. You must be trained to a minimum of diploma level and have 3 years managerial experience.

10 COUNSELLORS
Luton and North West
Salary £14 to 24k
If you are qualified, in training or wish to train, to a minimum of diploma level and have personal/professional experience of the 12 Step recovery programme, we want to hear from you.

email your CV to recruit@ttpcc.org
or call Gavin Cooper on 0845 241 3401

ttp counselling

alcohol and drug rehab

www.ttpcc.org