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DDN
Drink and Drugs News

5 September 2005
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HEPATITIS C
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QUESTIONS AND ANSWERS
Addict's mother told: be cruel to be kind

THE CRACKS BEGIN TO SHOW

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MKD.061/Ed:001/03/05

Published by

CJ Wellings

On behalf of

fdap

Federation of Drug and Alcohol Professionals

WIRED

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Drink and Drugs News in partnership with:

Adfam

The Alliance

EATA

European Association for the Treatment of Addiction

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Drink and Drugs News

5 September 2005

Editor's letter

It's good to be back after the summer break, and first things first: thank you to all of you who have already sent in completed readers' questionnaires online. The feedback is invaluable to us, and I am finding your suggestions for features and areas that we might cover extremely helpful in planning future issues of DDN. It's useful to know the subjects you want to read about.

We're including the questionnaire in this issue on page 16, in case you don't have easy email or internet access, so please spare a few minutes to let us know what you think.

With crack use on the increase and concerns about the gap in tailored services it's good to hear of the joint-working between GPs and crack users to create a dialogue and work towards harm reduction – a valuable demonstration of surpassing good intentions on user involvement. These are the initiatives that get results and transmit a very positive message to hard to reach groups – that there is help and advice available without hysteria.

We have plenty of reader comment and opinion in this issue: on methadone maintenance, Hepatitis C, NTA strategy, binge drinking, the diamorphine crisis, government drug policy – and how best to guide a distraught mother through her son's heroin addiction, in Q&A on page 12. The contributions highlight the varied experiences of our readership and give valuable expertise from different parts of the field.

Loughborough's SUGA kick off our service user group factfile this issue, on page 14. Service users: let us know what's happening in your group!

Please complete our reader's questionnaire: online at www.fdap.org.uk or on Wired's 'Daily Dose' at www.dailydose.net – or fill out the survey on page 16 if you prefer to send it by post.

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Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ

Printed on environmentally friendly paper by the Manson Group Ltd

Cover:
Science Photo Library

In this issue

Blueprint moves to next stage of drugs education

The biggest drug education research programme ever run in this country has completed its delivery stage, according to the Home Office.

'Blueprint', initiated as a partnership between the Home Office, Department for Education and Skills and the Department of Health, aimed to provide evidence of what works to educate 11 to 13-year-olds about risks of drug use – with a longer term aim of reducing the number of young people who become involved in taking drugs.

Secondary schools in Cheshire, Derby City, Derbyshire and Lancashire have been taking part in the programme, which piloted Blueprint educational materials and trialled ten drug education lessons on 11-year-old pupils, with a further eight lessons the following year.

The lessons focused on developing decision-making and problem-solving skills relating to situations where they might encounter drugs, as well as factual information.

Rejecting 'just say no' models of the past, the programme has linked to schools, parents, health policy, media, and the community, though partnering with drug action teams, regional government offices, health school programme co-ordinators, school drug advisors and primary care trusts.

Feedback collated from pupils reflected interest in the interactive materials used in the programmes, particularly games and role-play. Some found the lessons too crammed with complex material and 'a lot to take in', but there was good feedback on the interactive classes (prompted by Blueprint materials, issued to teachers) and the clear information about drug properties and how to recognise them.

Research on Blueprint will continue until 2007, when the final evaluation report will be published.

For more information on the Blueprint Drug Education Research Programme, email Ruth Joyce, Blueprint manager, at ruth.joyce@homeoffice.gsi.gov.uk

Middlesbrough Crack Team, Lucy Nugent, Peter Kelsey and team leader Karl Sheldon (right), with Addaction manager Ian Morris (second left).

Addiction gets alternative treatment

Brazil nuts, pumpkin and sunflower seeds, essential oils and liquorice root are being offered to crack users in Middlesbrough. The area's Crack Project Team is trialling 'natural remedies' as a way of fighting the physical and psychological problems of addiction.

The trial is still at an early stage, but the crack team reports positive results in reducing craving and helping people develop relaxation techniques. They report additional benefits in 'helping the user understand their own bodies and how they can regain control of their lives'.

Working with users to test the effectiveness of nuts, oils, teas and roots has enabled them to consider sleep patterns, general relaxation, detoxification, and the way the drug works – which helps work towards developing stronger individual treatment plans, according to the team.

Success of an initial two-year pilot programme led to the team being awarded funding for Middlesbrough DAT to run a three-year outreach service, provided by Addaction. The service supports crack users and their families.

Managers get investment in skills training

Drug and alcohol treatment charity Addaction has announced investment in its staff through arranging an Open University leadership development programme for managers.

Through a combination of supported distance learning and face-to-face workshops, participants will develop skills in team leadership, performance management and coping with change.

Addaction's director of human resources, Guy Pink, said joining with the OU to roll out the 'leading for results' programme emphasised 'our commitment to staff and to improvement in skills that ultimately will be of benefit to our clients'.

The first group begins the three-month course in September, but all managers will have completed the training by the end of 2006.

Employer's attitude still barrier to job for many

Most employers still refuse to employ people with a history of drug or alcohol problems or a criminal record, according to the Chartered Institute of Personnel and Development.

The CIPD's quarterly Labour Market Outlook found that employers were far more likely to consider migrant workers, the over 50s and lone parents, rather than the 'core jobless' – the government's term for those with a drug or criminal history, or who have had long-term sickness or incapacity.

A third of employees thought the core jobless did not make reliable employees and a quarter lacked trust in their employability. A fifth said they had had 'bad experience' of people hired from one of these core groups, and more than half said nothing would persuade them to recruit staff from them.

CIPD chief economist John Philpott said government needed to address such negative employer attitudes and improve the employability of core jobless groups to reinvigorate its welfare to work agenda.

Quarterly labour market outlook surveys are archived on the CIPD's website, www.cipd.co.uk

Ketamine gains ground on the party scene

Ketamine has joined the list of popular party drugs like ecstasy, according to *DrugLink* magazine's latest Street Prices Survey.

The anaesthetic, which has strong hallucinogenic properties and is most commonly used by vets, was on sale in eight of the 15 areas featured in the survey. The drug was previously associated with the gay clubbing scene, but is now likely to be used by people aged 18-25 'for a more trippy night out', according to a drugs worker in Birmingham.

DrugLink's editor, Harry Shapiro, commented: 'the emergence of ketamine as a key substance of choice is an entirely new phenomenon since we carried out the survey in 2004, when it didn't figure at all.'

An article on the drugs survey appears in the September/October edition of DrugLink, published by the charity DrugScope. For more information on effects and risks of ketamine, visit www.drugscope.org.uk

New Hope drop-in centre opens its doors to drug users in Bracknell – the first in the borough to offer advice and support to beat addiction. Turning Point chief executive Lord Victor Adebowale, cutting the ribbon at the opening ceremony, said the centre would offer progress-to-work, giving service users access to vocational training and the chance to get back to work after a period of social care. Daphne Obang, director of social services and housing, said the centre would offer preventative measures as well as advice for drug users.

NTA treatment strategy

Partnership to review drug treatment services

The National Treatment Agency has launched a three-year programme of reviews relating to drug treatment, in partnership with the Healthcare Commission.

The reviews begin in November and aim to help DATs improve their service delivery to clients. They will focus on care planning and co-ordination and community specialist prescribing, and follow a successful pilot programme covering 14 areas in England during 2004/5.

All organisations will have their performance assessed from data already collected nationally, with supplementary data included on each review topic. For the second part of the review process, the ten per cent of organisations or treatment systems with the weakest assessments will receive help in developing an action plan to improve performance. The review will contribute to delivery of the NTA's treatment effectiveness strategy launched in June, which aims to improve the client's journey through treatment.

Anna Walker, chief executive of the Healthcare Commission, said they had teamed up with the NTA because improving drug treatment services was an important priority for the commission: 'By working together, we will be able to give local drug action teams useful information which will enable them to bring better, more appropriate, services to clients.'

Reported rise for numbers in drug treatment

The number of people in contact with specialist drug treatment services in England has risen by 27 per cent between 2003/04 and 2004/05, according provisional figures from the NTA.

Chief executive Paul Hayes welcomed the news, as 'it clearly shows that additional funding and improved performance management is having an impact'. He said the NTA was ahead of the target to double the number of people in services between 1998 and 2008 and said that the NTA's treatment effectiveness strategy would help to sustain this increase in capacity.

DrugScope's chief executive Martin Barnes called the increase in numbers 'significant and encouraging', but said much more needed to be done to improve housing and employment support for drug users in treatment.

'Unless the social factors which can lead to problem drug use or cause people to fall back on a drug habit are tackled, the full benefit of spending on treatment will not be realised,' he commented.

The Prime Minister launched the NTA's treatment effectiveness strategy in the North, through an appearance in Darlington. He called on stakeholders to get behind the strategy on drugs – but declined to promise similar funding increases for alcohol treatment, saying that the key issue in relation to alcohol was to educate increasingly affluent young people with disposable incomes about the risk of misuse.

Notes from the Alliance

Methadone and beyond

With the flag for user involvement flying high, why do we still tolerate cripplingly discriminatory legislation, asks Daren Garratt, development manager at the Alliance.

It's encouraging to note that the Drug Interventions Programme, Drug Strategy Directorate and National Treatment Agency are currently working with the University of Central Lancashire's Centre for Ethnicity and Health to develop best practice guidance on peer led support for ex users. For the Drug Strategy Directorate, one of the main aims of this work is to advocate at a strategic level on behalf of drug users, particularly those who have left treatment in the community and/or in prison. Most importantly, it aims to better develop peer-led support, which has previously received little but lip service. The importance of integrating user involvement and peer-led support with drug treatment within the criminal justice system can't be underestimated, but there remains a very real fear that, unless we can lobby for effective policy change at a strategic level, we may be dooming many ex-cons to fail; particularly those who view user involvement as a way to mobilise themselves, secure employment and give something back to their community.

Why? Because under present legislature you cannot get public liability insurance if you've got a conviction, regardless of the nature of the crime or when you served your sentence.

It's a shameful situation that makes a mockery of the Rehabilitation of Offenders Act, and could seriously jeopardise both the NTA's Treatment Effectiveness Strategy and the Home Office's new peer support project.

Think about it. You've just completed a prison sentence and, thanks to the highly effective, individually tailored drug treatment regime you received you're ready to contact your DAT, get involved in user involvement and, ideally, set-up your own group and provide some peer-led interventions. The DAT is great, the local agency is encouraging and gets you in touch with some local users and neighbouring groups who willingly share their best practice and help you draw up a terms of reference and constitution. You're all set. This is the last step in your recovery. You've found your vocation, you're respected, you've got a purpose, self-worth and the ability to finally stop being defined by the mistakes of your past and build a brighter future. To celebrate, you decide to launch your new group with a big DAT-supported open-air event… but you can't because you can't get public liability insurance, which also means you can't legitimately establish your group and support your peers in your own premises. You're back to square one. What was the point?

This was a painful lesson recently learned by the ever impressive Morph in Southampton who, after arranging and promoting a massive local authority approved community day in a local park, discovered they'd have to cancel the whole thing at the 11th hour because they were denied public liability insurance due to the fact that the organisers had long-spent drug convictions.

We mention tokenism a lot when we talk of user involvement. The new desire of the Home Office to develop this strand of support within the criminal justice system is extremely welcome, but runs the risk of falling at the first hurdle unless we can begin to address this unnecessary barrier.

Cracking the habit

Crack use is on the increase – and the government is powering major initiatives to rid the streets of Class A drugs. The results of Operation Crackdown, a three-month campaign by the Association of Chief Police Officers and the Home Office, were announced last month: among the statistics, 170 crack houses were closed and 3.4kg of crack cocaine were taken off the streets.

While acknowledging the 'fantastic effort by the 33 police forces involved', DrugScope warned of the need to back up campaigns such as Operation Crackdown with wider initiatives to tackle underlying causes of drug-related disorder. Chief executive Martin Barnes warned against 'simply displacing the problem', and called for 'a mix of interventions… including appropriate prevention, education, social services, treatment and housing provision'.

With crack use rising from an estimated 63,000 to 79,000 people in the last year, compared to 64,000 people using heroin, the government and treatment agencies are not responding quickly enough to deal with this growing social problem, according to Turning Point, which published these figures in its *Crack Report*, launched in July.

The social care organisation, which has contact with around 120,000 people a year with drug and alcohol, mental health or learning disability problems, blames a national shortfall in crack treatment on the focus on heroin. Primary heroin users account for 78 per cent of those in community treatment, with just 7 per cent admitted for crack use and 15 per cent for combined crack and heroin use.

The figures change for numbers in treatment admitted through the criminal justice system: heroin users make up 29 per cent of those in treatment, but the proportion of crack users climbs to 14 per cent, and combined heroin and crack users make up the highest proportion at 57 per cent.

All this points to 'massive unmet need' – a lack of treatment provision for crack users, before they find themselves stuck in the criminal justice system, according to Turning Point.

Their recommendations are three-fold: they want more investment in specialist crack treatment services, with more places in community based and residential services; they are calling for the NTA and DATs to collect better information on patterns and prevalence of crack use, to inform agencies; and they want education and prevention programmes to reach out to at-risk groups, particularly young people who are in danger of being 'outside the system'.

The problem, they say, is that drug services tend to be focused on opiates and are applied to crack without adaptation. This can severely limit opportunities for crack users to engage in support, which Turning Point say risks further alienating black and minority ethnic users who often feel excluded from existing services.

The recommendations in Turning Point's *Crack Report* stress the vital part that wider social services must play in helping former crack users rebuild their lives and reintegrate with the community. It is generally acknowledged that emerging from treatment without a home, a job, adequate training to get a job, and unmanageable debts is likely to send ex-users spiralling back to relapse.

Furthermore, 'crack misuse is implicated in a range of social problems – it is interwoven with prostitution and dramatically undermines regeneration and neighbourhood renewal initiatives,' warns Turning Point's chief executive, Lord Victor Adebowale, appealing to government to consider the fabric of society. 'Without urgent action, we face an escalation of the crack problem and a continued growth in the number of crack users in future generations.'

'Drug services tend to be focused on opiates and are applied to crack without adaptation. This can severely limit opportunities for crack users to engage in support, which… risks further alienating black and minority ethnic users who often feel excluded from existing services.'

The other important strand in planning services involves recognising the strong link between crack use and mental health problems, and Turning Point recommends closer planning and agreed protocols between substance misuse, dual diagnosis and mental health services. This joint working has never been needed more urgently: at the same time that the mental health link is being recognised, people

Crack use is on the increase and services are under pressure to tailor support before clients reach the criminal justice system. Initiatives in primary care are already demonstrating that crack users are within reach of help and harm reduction.

using crack and heroin are firmly in the frame for being 'responsible for a disproportionate level of drug related crime'.

The Royal College of General Practitioners has responded to the steady rise of cocaine use over the past two decades by setting up training for GPs to 'power up practice' in working with crack users. The training programme has now been running for two years and was developed in response to GPs' calls for help: there was little guidance available on how to treat people who used crack as a primary or secondary drug.

'Lots of people say you can't do harm reduction with crack,' says Dr Chris Ford, who teamed up with trainer Matthew Southwell to prove exactly the opposite. Training for primary care staff was carried out involving crack cocaine users, who were invited to bring their equipment to the sessions to demonstrate first hand how they used crack.

'Matt came up with the idea of having four users showing what they did – their methods of piping, injecting, smoking, chasing,' explains Dr Ford. It was an unusual approach to training – 'we were a little worried about being on the front page of *The Daily Mail* at one stage: "GP tells you how to smoke crack!", she says, but weighing up the risk of being misunderstood, against the chance to convey powerful harm reduction messages to the heart of drug using communities, was an easy decision.

The two-way nature of the training came as a surprise to crack users who had become used to a judgmental treatment setting. Saying 'well look, this is a better way of doing it, it will do you less harm' had the effect of making crack users nearly fall off their chairs, according to Dr Ford, 'because there was no hint of "you're a horrible person and you must go away because you're a crack smoker". They were being told "the way that you're doing this is damaging yourself, and I can actually explain to you how you can use it more safely'.

The training sessions have produced a 'helpful circle': crack users have said they found the information valuable, and have passed it onto their peers. Getting them to come to the surgery and say 'I'm using crack and I'm getting a problem with it' opens up opportunities to help, and developing a dialogue with GPs is a vital part of this.

'There is no sense of "us and them" at the training, no sense of people being shocked or horrified,' says Dr Ford. The second day of the training involves GPs explaining what damage you can do to your heart, and discussing how harm reduction can apply to specific areas of health.

With figures from the British Crime Survey publicising links between crack use and crime, Dr Ford is keen to emphasise that the two are not linked in the majority of cases. She is protective of 'my little crack users who come and talk to me about smoking' because they are willing to take practical steps to improve their health. Furthermore, she is extremely optimistic about the participation of crack users and GPs that have made the training 'just extraordinary – the best training I've ever been part of, because it is very practical'. **DDN**

'Guidance for working with cocaine and crack users in primary care' is available at www.smmgp.co.uk

The next national training days for primary care staff to work with people who use crack cocaine, will be held in London on Tuesday 18 October 2005 (Part 1, led by Matthew Southwell from Traffasi Training, and involving crack users) and Tuesday 22 October (Part 2, led by GP peer tutors). The cost is £95 per person or £80 (subsidised place) for past or current RCGP certificate applicants.

For more information and an application form, email moniquetomlinson@wdi.co.uk or call Monique on 020 7269 0662.

Key messages for harm reduction

- **There is no completely safe way to take cocaine or crack, but advice can be given on how to use them more safely.**
- **Explain about health risks: local burns, damage to the lungs, heart and liver.**
- **Frequent injecting increases risk of damage to the tissues, local and systemic infections and DVT.**
- **Always advise about sharing any injecting, piping or snorting equipment.**
- **Advise pipers to switch from using plastic bottles or cans to quality glass pipes, and to avoid inhaling ash, paint, dust, water and other particles to the lungs.**
- **Encourage the move towards non-injecting routes, such as chasing or piping.**
- **Get the user to set themselves rules and stick to them, *eg* putting off the first pipe of the day for as long as possible.**
- **Understand signs of overdose and how to manage it. Call an ambulance early.**
- **Encourage individuals to bring in their paraphernalia to show you what they do, so you can work together to minimise the harm caused by using crack.**

NTA strategy: raising expectations, but heading for a funding crisis

One crucial fact has not come across sufficiently clearly in the coverage of the NTA's Effectiveness Strategy launch (DDN, 11 July, page 6). Underlying it (as Paul Hayes hinted at the launch event) is an anticipated reduction in the money available to treat each patient. Over the same period (2002/03 to 2005/06) the NTA foresees a 28 per cent rise in patient numbers while according to the Prime Minister's Strategy Unit, treatment spending will rise by about 18 per cent. The latter figure takes into account inflation and the fact that much treatment spending is outside the central pooled budget, the increases in which look far more impressive. It is difficult to reconcile this figure with NTA figures, but it is the only official figure of its kind that I know of.

One way to square this circle is to get people out of treatment quicker so that existing treatment slots can be used to absorb more new patients, and this is exactly what the Effectiveness Strategy envisages. It plans to get there by emphasising the provision of 'housing, education, employment and other crucial auxiliary services' needed to get people to the point where they have 'a genuine prospect of maintaining an independent, economically active life' without needing illegal drugs or continued treatment.

This is indeed a worthy ambition and one to be applauded if this is what patients want, and many do. The problem is that it may take more money – much more – to provide people with this degree of support than it does to quietly maintain them on methadone. Rather than meaning less need be spent per patient, it could mean that more will need to be spent.

The people involved often have severe mental and life problems and have to reverse the deficits accrued during a decade or more devoted to dependent drug use rather than getting qualifications, work experience, capital for housing, and building relationships supportive of a non-dependent lifestyle. To truly turn things around we may need to enter the territory of low caseload intensive case management, supported housing and supported employment, 24-hour intensive and assertive outreach teams, reconstruction of family relationships, and so on. To assume that all this will be provided through partnerships with other agencies, yet still be accessed by drug users and effectively delivered, is at best a long-term ambition, at worst, unrealistic.

Even if resources are increased, the risk is that this difficult and expensive work will not be done or will be short-changed. To meet the new expectations about 'successful' treatment completion, people may be led to exit treatment only to come back sooner rather than later because their lives have not fundamentally altered for the better. It is crucial to have ways of picking this up, otherwise their leaving could be counted as a successful treatment completion and their return as a successful new client engagement, even though for them the whole process was a revolving door flop.

It seems that this can be done using the National Drug Treatment Monitoring System and in Merseyside, it has been. The report illustrates the risk: 56 per cent of the clients recorded as 'discharged drug free' returned to treatment the following year, just 6 per cent fewer than among treatment drop-outs. In this case, an apparently successful treatment completion seemed to mean little in terms of improving the chances that patients had been helped to construct lives satisfying and stable enough to avoid a return to dependent drug use.

Mike Ashton

Binge drinking and public health

Recently the Parliamentary Office of Science and Technology has released a 'postnote' reviewing 'binge drinking and the public health'. The review uses the definition of eight units for men and six units for women, namely twice the daily-recommended limits for sensible drinking, established by the Department of Health. The report states that binge drinking 'is predominantly seen in those ages 16-24, but may also extend to those in their 30s'. However research published by ourselves indicates that whilst binge drinking is more common in the 20s a substantial number of people report binge drinking, as defined above, in their 30s, 40s and 50s. Thus binge drinking is not the sole preserve of the young adult.

The report also states that heavy alcohol misuse is 'responsible' for 15-25 per cent of suicides and 65 per cent of suicide attempts. However it is not possible to attribute such cause and effect. Indeed Alcohol Concern, the reported source of these data, actually report that '65 per cent of suicide attempts are related to alcohol (Department of Health 1993)' and '15-25 per cent of actual suicides are associated with alcoholism (Gunnell and Frankell 1994)'.

In spite of these concerns, this review is very welcome and should be widely consulted.

David Ball, Senior Lecturer and Honorary Consultant Psychiatrist; and Media Review Editor for *Addiction Biology*

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Let's challenge addiction, not collude with it

I am writing in response to the vitriolic reply (DDN, 11 July, page 9) to my letter in your 27 June issue. I wrote my original letter in frustration after spending half a day with a client who had been placed on a D.T.T.O. and was receiving lots of testing and no treatment – unless you consider methadone helpful, which Michael Linnell obviously does. In fact people like Michael are in highly paid jobs on the back of supporting a model that helps virtually no-one. I don't understand why he feels he needs to try and paint me as some kind of weak-minded moron who does not understand what the problem is or how to tackle it.

The first mistake people like Michael make is to think about addiction in practical terms. There is no rhyme or reason to addiction. Educating addicts about safe injecting, H.I.V, Hep C *etc* is great; however, at 10pm when the needle exchange and chemist are shut and the only syringe available has been used by one or two others, common sense goes out of the window as the compulsion to use drugs overrides it. Michael also suggests that I get out and meet people who have been helped by methadone: believe me I've tried. I am out every day meeting clients and their friends on the front line. Is there any safe way of using drugs?

The best form of harm minimisation is to not use drugs. Methadone is useful in the short term under medical supervision when detoxing. However, many countries do not use it at all because it often causes more problems than the original addiction.

Quoting from theoretical models does not make you an expert. Drug addicts don't pass through stages; they switch addictions, go to prison, and die. Overdoses are in the nature of addiction. I am 47 years old and have spent 25 years in active addiction. All my childhood friends are dead; my experience is of a practical kind that you could not learn in any classroom. I speak from experience when I say that education is not the answer. I have many friends who are in a 'maintenance phase' from addiction and we all agree that we knew the dangers of sharing needles and unsafe injecting, but in active addiction were compelled to do

'Drug addicts don't pass through stages; they switch addictions, go to prison, and die. Overdoses are in the nature of addiction. I am 47 years old and have spent 25 years in active addiction. All my childhood friends are dead; my experience is of a practical kind that you could not learn in any classroom. I speak from experience when I say that education is not the answer.'

things that put us at risk.

I am not advocating any one kind of treatment, just saying let's stop wasting money on a model that's about as much use as an ashtray on a motorbike. Let's challenge addiction, not collude with it. As I said in the start of my letter, my client who is on a D.T.T.O is about to be breached. Why? Because he is refusing a methadone programme and being honest, by saying 'I've had them in the past, I cannot stick to them, and I end up with two habits instead of one. They don't help, I need a detox and rehab.' Ask the politicians why he cannot have one.

Roy Fisher, Bristol

Support for clinical supervision

Sue Fletcher's call for more attention to be paid to clinical supervision (DDN 25 July 2005) is welcome, especially in the light of new findings on training motivational therapists which showed that only when this was followed up by something very like clinical supervision did client responses improve. It may help readers to know that the first (as far as I know) guide to clinical supervision of people working with drug and alcohol users has been published by the Australian National Centre for Education and Training on Addiction and made available on their web site at www.nceta.flinders.edu.au/pdf/clinical-supervision/TheGuide.pdf.

Mike Ashton,
Editor, Drug and Alcohol Findings,
www.drugandalcoholfindings.org.uk

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Sloppy stats could explain low-key drug report

Re 'What No. 10 didn't want you to know about UK drug policy' (DDN, 25 July, page 10): I had a few concerns about the rigour with which this report was put together. The aspect that most concerned me was about the mental health problems caused by drugs. Heroin came out miles top, with cannabis a long way second. Amphetamine did not register at all. Now heroin is not known for causing mental health problems whilst amphetamine certainly is. This is explained when you look at the figures used, admissions to psychiatric hospital. Most inpatient detoxes for heroin are done in psychiatric hospital and therefore will have been counted, even though this was not a psychiatric admission. Amphetamine caused problems will probably have another title for the cause of admission (psychosis, drug induced psychosis *etc*) and will not have been counted. With such sloppy use of statistics it makes me wonder about the overall quality of the report and whether No 10 suppressed it because it wasn't very good, as opposed to more machiavellian reasons.

Jim Barnard,
Primary Care Adviser, SMMGP

Diamorphine crisis is fuelled by greed

I have just read the latest DDN editorial (DDN, 25 July, page 3). Although I have not got a clear-cut answer as to why there is still a shortage of diamorphine, I may be able to shed some light onto the matter.

I was speaking to someone from the UNODC recently about the various opium eradication programmes they are involved in. I asked the person why, in the light of the diamorphine shortage, there is no investment in Afghanistan (as there is in India) for producing pharmaceutical diamorphine from the poppy cultivation.

The answer was rather surprising but then again it had to be about money, control (and greed). First of all, pharmaceutical diamorphine is controlled by a tight-knit 'cartel' and they would not want their controlled market to be flooded with Afghan opium, as this would obviously bring the prices crashing down. The knock-on effect, he explained, would be that farmers in India would then also suffer.

It is clear that the farmers would certainly benefit as would the NHS, patients, *etc*, if the decision was made.

However, there are further issues with the DEA having their agenda and the Americans generally distrustful of the situation in Afghanistan; it would take a brave UN to make that decision.

Laurent Galichet, Managing Editor,
***Clarke's Analysis of Drugs and Poisons*,**
The Royal Pharmaceutical Society of Great Britain

Comment

Methadone Maintenance – For Better Or Worse?

I listen with interest to the growing debate about the value of methadone maintenance and the passionate arguments for and against. Today I'm a man with a satisfying rewarding career, a lovely wife, children and a fulfilling life in every sense and I'm grateful on a daily basis that during my own heroin years of '81 to '87 you had a better chance of winning the pools than landing a maintenance script.

Many people today might think those were the bad old days, when you were lucky to get a six week reducing script and if you didn't come off drugs with that, you were branded a failure and unlikely to get further help. My idea of a needle exchange was buying a used syringe from some stranger on the front line, getting the barrel moving with a bit of margarine and sharpening the needle on a mirror. The only time you didn't use someone else's syringe was if they were bright yellow, unless of course you had some water to rinse it with.

It's true, life as an addict in those days was very hard; if you didn't get your money you were sick. There was no script to fall back on, there were often heroin droughts – even if you had money at times like that you'd probably be sold snide (fake heroin). The crazy thing was, you'd hand your money over knowing it was snide, just in case there was a tiny bit of real heroin there. It was a miserable life: no caring drug workers, no empathic doctors – just a society that branded you undesirable, dealers to rip you off and police to lock you up.

The madness came to an end for me in July 1987 when I entered a residential treatment centre in Surrey, paid for by my long suffering parents. When I came off drugs I was left with the emotional baggage that most users take drugs for in the first place. For months, years even, I suffered from depression, overwhelming feelings of shame and low self esteem, rage, fear and anxiety. A thousand painful feelings and a thousand reasons to use again. Why didn't I use? Why did I hang on in there until life started to get better? Just one reason: because I knew that however hard life was without drugs, it was harder with them.

So why do I thank my lucky stars there were no services for drug users? Because today it's just too easy to be an addict. Where's the incentive to stay off drugs, when there's free methadone for as long as you want it? No addict needs to feel the terror of knowing that you've got no more heroin and you're going to get sicker and sicker over the next few days – not with a nice fat bottle of methadone under the bed. That terror is what gets you off drugs eventually and the memory of it keeps you off.

I know this letter will upset a lot of people, but there's also a lot who know exactly where I'm coming from because they've been there, done that. I work in the substance misuse field today and for all the thousands of people on methadone, I don't see many getting off the stuff. Yes, there are a few very capable individuals who are on methadone for years and have successful lives, but let's not hide from the fact there are a lot more who use on top of their scripts, or sit at home leading unfulfilling lives, which constantly revolve around their next dose of medication.

Having said all this though, I can't honestly state that methadone maintenance doesn't have a place. I'm a humane person and the way I was treated as an addict was inhumane. What I do believe, is that there is far too much emphasis on methadone and not enough effort made to encourage people to consider abstinence, particularly younger people.

My challenge to the NTA and drugs policy makers is this: if your son or daughter came to you and admitted they had a heroin addiction, would you be satisfied if they went to a drug team and ended up on methadone maintenance, or would you want them to go away to a first rate rehab, get the help, motivation and encouragement to come off drugs and stay that way? I think we all know the answer to that one.

John

Competent counsellors:
why high standards should not be optional

Counselling is a highly skilled job – yet currently anyone can set themselves up in practice. This has to change through accredited training that will guarantee minimum standards, says Simon Shepherd.

Would you get on a 'plane with an untrained pilot? Would you go under the knife of a surgeon who had all the dexterity of Frank Bruno, with his gloves on? No, I thought not – yet while many drug and alcohol workers are highly competent professionals, we all know that that is not always the case.

The DANOS national occupational standards, and the qualifications and certification schemes linked to them (including FDAP's Drug and Alcohol Professional Certification and the Health and Social Care NVQ framework) should help to drive up further the already high standards in our field, but DANOS doesn't cover everything.

While we would want to all doctors in the substance misuse field to be competent in the DANOS units relevant to their role, I for one would not be very happy going to see a doctor whose only qualification was an NVQ in Health and Social Care. Likewise, nurses working in our field need to be 'DANOS-competent' but being DANOS competent alone does not give someone all the skills and knowledge they need to work as a nurse.

Yet although counselling is also a complex profession, which requires a high level of skills and knowledge, currently anyone can set themselves up in practice and counsel often highly vulnerable clients, without so much as a correspondence course to their name.

Sooner or later this is going to change. The government is busy regulating a whole range of ancillary health care professions such as chiropracty, psychology and art therapy – and counselling is next on the list. But regulation is still a few years away – first we need to get all the different counselling organisations to agree on the right way forward. Because many of our members are counsellors, we have a seat on the working party – it's a bit like pulling teeth and trying to herd cats at the same time. And regulation will be based on certain minimum standards and will, we fear, fall a long way short of guaranteeing the kind of highly professional counsellor workforce we need – which is where the various 'gold standard' counsellor accreditation schemes come in.

We believe that anyone working as a counsellor should either be, or at least be working towards being, accredited by one of the recognised counsellor organisations.

For counsellors working in the substance misuse field, there are a range of available options – from generic schemes like that of the British Association of Counsellors and Psychotherapists (BACP), to the substance-use-specific National Counsellor Accreditation Certificate (NCAC) offered by FDAP.

As with nurses and doctors, counsellors working in our field need not only to be competent as counsellors, but also to have the skills and knowledge required to work in drug and alcohol settings. The advantage of substance-use-specific counsellor accreditations, is that as well as demonstrating a person's competence as a counsellor they also provide evidence of competence in a number of relevant units from the DANOS standards.

And the advantage of our NCAC counsellor accreditation over other counsellor accreditation schemes in our field, is that it is the only one to confer eligibility for the UK Register of Counsellors (UKRC).

FDAP was admitted to the United Kingdom Register of Counsellors (UKRC) as an accrediting body in 2004. This entitles all our NCAC accredited counsellors to apply for UKRC registration on the same terms as the accredited practitioners of the British Association for Counselling and Psychotherapy (BACP) and Confederation of Scottish Counselling Agencies (COSCA). Registrants of the UKRC are able to include their details on the online UKRC register and can advertise in the UKRC corporate box in Yellow Pages.

Admission to the UKRC will also make our NCAC accredited counsellors well placed when it comes to the regulation of counselling. While we can not be sure exactly what the regulation requirements will be, it is clear that anyone who is eligible for the UKRC will certainly be eligible to call themselves a counsellor under whatever regulatory framework is eventually put in place.

Simon Shepherd is chief executive of the Federation of Drug and Alcohol Professionals. For more information about FDAP's NCAC accreditation – or DANOS-based Drug and Alcohol Professional Certification – see under 'Professional Certification' at www.fdap.org.uk.

Under the standard route to NCAC accreditation, applicants must demonstrate:

- **Competence in the full range of 'core functions' of drug and alcohol counselling.**
- **A clear personal philosophy and approach to counselling.**
- **An ongoing commitment to professional development.**

In addition, they must have:

- **Four years of work experience as a counsellor – at least 2.5 years in substance use field.**
- **600 hours of supervised face-to-face individual, couples or group counselling – at least 400 hours in substance use field.**
- **A further 300 hours of supervised experience related to other 'core functions' – at least 200 hours in substance use field.**
- **450 hours of training relevant to the counsellor's role in the drug and alcohol field.**

Subject to satisfactory references from a supervisor and professional referee, experienced counsellors will be eligible for NCAC accreditation if they have four years' supervised experience as a drug/alcohol counsellor and are already accredited as a counsellor by one of the following organisations: BACP, UKCP, COSCA, NAADAC(US), IC&RC, BPS (as a counselling psychologist), or any organisation recognised as an accrediting body by the United Kingdom Register of Counsellors (UKRC).

Hepatitis C: abstinence-based treatments deserve a bigger role

The value of abstinence is often discounted when giving treatment options to those with Hepatitis C. Commissioning services should reconsider the value of these services, say Tim Leighton and Nick Barton from Clouds.

The Department of Health calls it 'the silent epidemic'. It is estimated that there are up to 500,000 people infected with Hepatitis C in the UK, with between 200,000-300,000 in England alone. About a fifth of these will probably develop cirrhosis of the liver after 20 or more years of infection. It is likely that a considerable number of these will require liver transplants to survive. Of the 50,000 or so that have been diagnosed, most are current or former drug users. People who used drugs in the 70s and 80s are considered to be at higher risk. Samples of current intravenous users show various rates of HCV infection; up to 52 per cent for London and 54 per cent for the North West. Rates in some areas such as Glasgow were much higher than this in the early 90s but appear to have reduced to around 60 per cent.

Early diagnosis and treatment are now considered essential in order to increase the chance of clearance and to reduce the progression to liver damage. The costs of combination therapy (Interferon alfa-2a pr2b with Ribavirin), is £6,000 for 24 weeks, doubling to £12,000 for 48 weeks. These costs can be put into perspective by the costs of a liver transplant, which are quoted as between £70,000 to £100,000. However, the total costs of the procedure, the anti-rejection drugs and long-term aftercare have been estimated as high as £250,000. Dr Torbjorn Sundkvist, consultant in communicable disease control at the Suffolk Health Protection Unit argues that the department of Health should make extra money available for the treatment of Hepatitis C, which is a chronic, or ongoing, illness.

There is a consensus that heavy alcohol use of more than 7-8 units a day will be likely to accelerate the development of fibrosis and cirrhosis. There is mixed and inadequate evidence about the effects of lower level of consumption. There is probably a genetic vulnerability to alcohol-related liver disease progression, which means some people may be able to get away with considerable alcohol consumption without increasing the progression. Women with Hepatitis C may be at more risk of alcohol related liver damage.

The *National Treatment Outcome research Study* (NTORS) found that 33 per cent of drug misusers were drinking above safe weekly limits at the point of intake. The average daily consumption was 18 units in drug misusers entering residential treatment and 11 units in those entering community methadone programmes. NTORS also found that at one-year follow-up, a substantial proportion continued to drink above safe levels. An evaluation of the treatment outcomes of Clouds House tallied with the NTORS findings. It showed that people referred primarily for a drug problem reported an average daily consumption of 20 units of alcohol per day. This compared to 30 units a day for those referred primarily for alcohol dependence.

Much has been made since NTORS of the failure of drug treatment agencies to address alcohol consumption among drug misusers. This makes sense for general health reasons, but there is another angle to consider: the need to slow or halt the rates of progressive liver damage caused by Hepatitis C, which can eventually require very expensive and radical interventions. Such progressive damage can be arrested by abstinence from alcohol followed by interferon treatment and possibly reversed, as there is evidence that fibrosis repairs itself after successful treatment. This would seem on the face of it to be a powerful motivation for former drug misusers to adopt an alcohol-free lifestyle also. Certainly those undergoing treatment for Hepatitis C should know that alcohol use is considered seriously to interfere with that treatment. It appears to reduce adherence to the treatment and, although more evidence is required, may actually make the drugs less effective.

'Despite the recommendations and the evident risks involved in ignoring them, the value of treatment options that include abstinence from alcohol for drug misusers have not been given sufficient recognition. It is time to bridge this gap.'

In July 2004, the Department of Health published *Hepatitis C: Action Plan for England*. Although it indicates clearly that alcohol consumption is a factor associated with rapid progression of the disease, there is no mention in its 'ongoing' or 'future' actions of interventions to reduce or eliminate alcohol consumption among vulnerable drug users. The *Alcohol Harm Reduction Strategy for England* is similarly deficient. The NTA's *Models of Care for Treatment of Adult Drug Misusers,* on the other hand, does make a recommendation of 'complete abstinence from alcohol… to prevent progression of liver disease'. It adds that, 'even small amounts of alcohol can for some be harmful'.

Despite the recommendations and the evident risks involved in ignoring them, the value of treatment options that include abstinence from alcohol for drug misusers have not been given sufficient recognition. It is time to bridge this gap. Public Health Authorities, PCTs, Drug Action Teams and anyone else commissioning or purchasing services for drug misuse and dependence need to take note.

Existing harm reduction strategies generally aim to minimise new infections and quite rightly so, but this doesn't help those who are already infected and in whom liver disease is progressing relentlessly, in many cases undiagnosed. For this we need a 'transitional' intervention that can help move people towards significant and comprehensive change. Under these circumstances, an effective treatment model that involves engagement with self-help programmes in a supportive fellowship of peers, such as those that draw on the 12-Step approach, offers two distinct advantages. It aims at helping people become abstinent and it routinely addresses the alcohol consumption of people who are considered primarily as drug users. In other words, this type of intervention has a significant role to play in extending the lives of individuals and reducing the nation's health costs where liver disease is concerned.

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

Sandra, Yorkshire

Dear Sandra,
I really understand how difficult this must be for you and see why it must feel like an impossible situation. It is very common for people, particularly parents, to feel like this. Without knowing more about you and your family's situation, it is difficult to give you clear advice but here are a few ideas.

Your son seems to have a lot of control over you, which he manages by intimidating and manipulating you. This means he gets what he wants and you don't get what you need, rather than seeing everyone's needs as equal and different. One reason he may be angry with you is that you took some control back by going to the group and in his powerlessness he has tried to regain control over you. If you seek help with how to cope with his intimidation and manipulation (such as exploring how conflict is created and identifying strategies to cope with it) you can experiment with ways that enable you to begin meeting your needs.

What about communication? Has there been a breakdown in the way you and your son communicate? Have you explained to him exactly why you are going to a support group and what happens there and that it is confidential? Maybe he is imagining all sorts of things are happening that aren't. He may need reassurance that you are getting this help for you and that by helping yourself you may be able to understand him better and help him. Maybe he is fearful of you changing.

At Adfam, we often find that if one family member changes the way they do things this has an effect on all the other family members. Maybe, by receiving support, you are learning to transfer back to your son some of the responsibility you might have been taking for him. Naturally your son could feel some anger – even betrayal – around this if that is what he has grown accustomed to. Responsibility is often related to issues of dependency.

Parents often feel the need to provide all the care they can for their children and protect them from the consequences of their actions. While they are children this is wholly appropriate, however when children become adults it is sometimes difficult to relinquish that protection and allow them to take more responsibility for themselves and learn that their actions have consequences.

Instead of the child learning to satisfy their own needs, they continue to seek satisfaction from their parents. This co-dependency between parent and adult 'child' is very common and can be worked through where there is the realisation that that is what is going on. Maybe there is some co-dependency with you and your son?

'Maybe he is imagining all sorts of things are happening that aren't. He may need reassurance that you are getting this help for you and that by helping yourself you may be able to understand him better and help him. Maybe he is fearful of you changing.'

It might be that you need to think about how you are parenting your son. Is your relationship one of parent-child, or is it one of adult-adult? Are you protecting him from the consequences of his actions? Is he expecting you to continue satisfying needs that he could satisfy himself? There are still many ways for you to help and support your son that will also encourage him to mature as a person and take more responsibility for himself. I suggest you get support with what to do and how to do it.

You might also want to think about the boundaries around the behaviour you are prepared to accept from him.

Boundaries are like rules; they can define what behaviour we find acceptable from those around us. Often, in families where there is drug use, the family accepts behaviour from the drug user that they wouldn't from anybody else. In your situation, is it acceptable to you to feel a prisoner in your own home? Is it acceptable for you to not attend a support group? Is it acceptable to live in fear of your son? Would you find his behaviour acceptable from your other children?

When setting boundaries consider: What do you hope to achieve by setting the boundary? Is it realistic? Can you follow through if the boundary is broken? Where, when and how should you set the boundary? What support might you need to set, keep and follow through on the consequences of a boundary being broken? I suggest you seek help, guidance and support with this.

Ultimately you cannot stop someone using drugs if that is what they want to do. What you can do is change the way you respond to them and their drug use. You can do this by looking at how you are managing it now and how you might do it differently in a way that is supportive of you and your son. This is neither pain free nor quick – but it is possible.

I suggest you get as well informed about heroin use, its associated behaviour, the risks from its use for you and your son, how to reduce those risks and how drug users change. This will help you to understand what is happening and to reduce the harm caused through drug use.

Much of this will probably take time and you need to cope with this situation now. I encourage you to continue seeking the help and support you believe you need. I suggest you explore other avenues to get the help, guidance and support that anyone would need facing your situation. For example, a counsellor, helplines, the internet, and booklets such as those written by Adfam.

Russell Cowan, Co-ordinating Support Worker, Adfam

Hi Sandra
I am an ex-addict. You must not keep this problem to yourself, as life will get very, very horrible in every way shape and form for all your family members involved. You will have to lock every thing valuable away, or it will end up in the local pawnbrokers. Secondly don't trust a word your son says, until his addiction is under control.

I'm sorry to be so blunt, but you have a rocky road ahead of you unless you get the right help. GPs are working well with local drug/alcohol teams, to combat addiction. Your son needs telling by you, how much you love and care for him. But he also needs telling the hard facts about heroin addiction.

Please be strong and remember one thing. Never ever help to feed his addiction. Also be prepared to find him alternative accommodation in the short term, as the pain and strain can break a family.

My heart is with you, be strong.

Andrew Kevan

Dear Sandra,
I too am the mother of a son who is a heroin addict. In fact you may have read my story in *DDN* 30 May. I understand your fear because I have first hand experience of it. I also know that what is happening to you is

wrong. No-one has to accept the unacceptable. Families Anonymous has a group in Bradford and another in Pocklington. There is a website www.famanon.org.uk. The helpline number is 0845 1200 660. Phone for free literature and the members' password for the website.

I started going to meetings four years ago. My son had to be sectioned because he became so violent and out of control. The Court granted me an Injunction with Power of Arrest to stop him coming to my house. He is now living in a hostel and is in recovery.

Anyone who is subjected to violence is entitled to police protection. Ask yourself this: if MY son behaved like your son in YOUR home, what would you do? The fact that we happened to give birth to someone does not entitle them to abuse us.

When someone is in the grip of drugs the only thing that matters to them is how to get their next fix. Everything else is secondary. The 'real' person is hidden behind the compulsive need for the next fix.

I am not a bit surprised that your son said you had betrayed him. He is probably frightened that you will become stronger and that you will stop being his doormat. He knows what he is doing. He is working to his own agenda. But he is manipulating you so that he can continue his drug abuse.

Please telephone the Families Anonymous helpline. The office is staffed from 1pm to 4pm every day. Every evening there is a volunteer that you can call who knows exactly how you feel. This is from 6pm to 10pm on weeknights and from 2pm to 10pm on weekends and Bank Holidays.

My thoughts are with you.

Anne, Surrey

Dear Sandra

You have a 22-year-old, full adult male living in your house as an addict. This is not a child. To begin with, his anger at you involves the fact that you have been helping him shelter and hide his addiction. Now that you have sought assistance for yourself, he feels exposed. Answer: so what? At some point, he will have to come out of denial and get help for himself, or suffer the other three consequences: jail, institutions or death. Do you want him to overdose and die in your home?

An intervention would help with other family members, preferably an uncle, brother, sister and/or any number of family members who can support you in attempting to get him in treatment. Support in numbers helps. Additionally, maybe you seeking help for yourself with a support group of your own will encourage him to seek assistance.

A. R. Hassan PhD, RAS, CCS

Dear Sandra,

Please go back to your support group. It is nothing to do with your son. If your neighbours know – so what? (Chances are that they are perfectly aware of his heroin addiction without you having to tell them). If your son is threatening you – call the police and have him removed from your home.

Why should you have to be scared because of his illness and his unwillingness to do anything about it? In the long run you are not helping him by keeping his addiction a secret, in fact quite the opposite. The sooner he faces the consequences of his addiction, the sooner he can get help. If he is not yet ready to address his problem, why should you have to put up with it? Living with an addict is soul destroying – you need support and have every right to get it and if he doesn't like it, tough. Remember, you are not helping him by enabling him to carry on – there is plenty of help available for drug addicts out there.

Fiona Dunwoodie, One North East (London) – 1 NE

Sandra.

There's a lot of stuff going on here. To start with your last comment '....how it's come to this'. You seem to wonder how come your son's on heroin in the first place – 'why me/us/him?'

Well, it's not as unusual as you might think and it's, generally, NOT the parents' fault. So don't beat yourself up about it. You appear to have gone to a support group for yourself – not your son – and good on you for doing that. As a recovering addict myself (and now an addictions counsellor) I know that no amount of cajoling, persuading, threatening – call it what you want – from my family made me give it up, and you have to face it, your son is no different; he'll only deal with it when HE is ready.

In the meantime you need to look after YOU; only by doing that can you be there for your son when he IS ready to seek help. He's the prisoner – of the gear – not you, so don't be pushed into that corner by him; it sounds tough, and it is, but you need to be.

You can do it, if you want it enough; just as he will, hopefully, find recovery.

Best wishes.

Geoff Walker

'You need to look after YOU; only by doing that can you be there for your son when he IS ready to seek help. He's the prisoner – of the gear – not you, so don't be pushed into that corner by him; it sounds tough, and it is, but you need to be.'

Dear Sandra

Joining a support group is vital to your survival under your present circumstances. You will learn coping mechanisms, the effects of drugs on your son, how the family is affected by substance misuse and attending the group will also take you out of isolation. Often the mum's needs are never met because all the attention is given to the child who is using the drugs.

Your son needs to be made aware that you have needs as well as him. You can offer your son support by accompanying him to a drug agency were he will receive treatment for his substance misuse. If he decides he does not want help, you will need to be firm with him because his drug use will become more problematic. If you decide to let him stay at home, you will need to make some ground rules that need to be adhered too. If the situation becomes unbearable, which at some point it will, you may have to ask him to leave home.

Hope this information is of some help to you.

Maddy Vaz, Sanctuary Family Support, Liverpool

Reader's question

My client has made great progress in fighting his alcoholism, but recently his father died from liver disease and it has set him back significantly. Alcoholism runs in his family and he has become convinced that it's in his blood to follow the same fate. How can I convince him that he can take his future into his own hands?

Graham, drug and alcohol worker, Glasgow

Email your suggested answers to the editor by Tuesday 13 September for inclusion in the 19 September issue of DDN.

New questions are welcome from readers.

Fact file

Service User Groups

This issue: Robin Earle from **Service User Group for Action (SUGA)** in Loughborough

When and why did you start your group?
Founded June 2005, I started the group because I found it so hard to get information and help with my own alcoholism. We as a group want to make the pathway to finding information and support much easier.

How many members do you have?
We have a core group committee of five people and hold regular meetings which attract around 20-30.

How did you obtain funding?
We have a small amount of ongoing funding from the Drugs and Alcohol Action Team (DAAT) for Leicestershire and Rutland, which covers meeting rooms *etc*. Our time is given on a voluntary basis and we are also obtaining help from Charnwood CVS with free training courses. Also, we are in the process of applying for funding from Lottery Grants for Local Groups.

Where, and how regularly, do you hold meetings?
We hold bi-weekly core group meetings at Turning Point in Loughborough and monthly public meetings at The Spectrum Centre, St Peter's Community Centre, Storer Road, Loughborough.

What do you hope members get from attending?
The Group's Vision is 'Help people come "Out of the Darkness" of their Addiction'.

How do you keep it going?
A great team which is eager to help people; and support from the DAAT, Turning Point Loughborough, the Voluntary Sector Partnership for Mental Health and Charnwood CVS.

What have been your highlights so far?
The group was very proud to receive the backing of Andy Reed MP in a recent press release from his office. We as a group believe it is very important to be recognised by important local figures such as Mr Reed, and hope we can develop these contacts to benefit the group's goals.

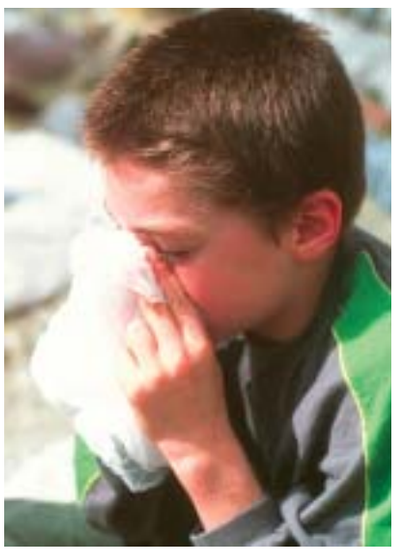
How do you communicate with your members?
At present we have a mailing list of both snail and e-mail and meeting posters are placed around the town *eg* Police Station, Library, Court, Loughborough College. Also, we are putting together both a newsletter and a website.

Have you any tips for others starting a service user group?
Go out and ask for help. There may not be lots of money around but there are lots of people willing to help. We also are very willing to help other groups.

Book review

Dangerous Highs: Children and young people calling ChildLine about volatile substance abuse

Reviewed by Richard Ives, educari (www.educari.com)



Price £11.95 (£9.95 to NCB members).
ISBN: 1 904787 51 7.
Order from www.ncb-books.org.uk
or call the order line on 020 7843 6029.

This 38 page book from the National Children's Bureau (NCB) and ChildLine presents information based on 356 calls made to ChildLine from 1999 to 2003 that (wholly or partly) concerned volatile substance abuse (VSA).

NCB has been concerned with VSA for many years, commencing in the early 1980s when I was employed there on a DH-funded project on VSA. A continuing task has been to keep VSA on professionals' agendas – although VSA is associated with more teenage deaths than illegal drugs, it tends to be neglected.

Therefore anything that draws professional's attention to this problem is welcome; the annual reports on VSA-related deaths produced by St George's Hospital Medical School (see www.vsareports.org) have helped to keep the issue on the agenda as well as demonstrating the worrying extent of the problem and providing useful details (such as the range of products associated with deaths) and careful scientific analysis.

The extent of VSA use has been researched as part of the European-wide ESPAD study on alcohol and drugs, and data on use within the UK are also available from the DH/NFER Surveys of 11- to 15-year-olds and from the British Crime Survey (for over-16s). (*Dangerous Highs* refers to these studies, although it is a pity data from the 1999 ESPAD survey are referred to, which are quite different from the figures in the current [2003] survey.)

This NCB Report helps to personalise this survey data through case study detail of some of the 356 calls to ChildLine. They make harrowing reading.

The analysis is less useful because it is careless in, for example, using the term 'solvents' instead of volatile substances (not all volatile substances are 'solvents'), and lacking clarity about the difference between those 'sniffers' who call ChildLine and those (the majority) who don't. This results in misleading statements, such as: '…solvents are mostly not used for fun or "the buzz"' (page 2) – while this is true of most of callers to ChildLine, it is probably not true of the majority of sniffers. By definition, these people haven't got problems with VSA so they won't be calling ChildLine; an uninformed reader of this report might therefore be led only to look for VSA among children with other problems. But a key message from the research on VSA-related deaths is that a proportion of the deaths occur to experimental users, and survey evidence shows experimentation is not confined to marginalised young people, so that parents and professionals need to be aware of the possibility of VSA by any young person.

Another drawback of this report is its tendency to take what young people say at face value rather than subjecting it to scrutiny. For example, the report highlights the fact that female callers say that they are getting high with (or even 'addicted to') nail varnish or nail varnish remover. While it is true that young people attempt to misuse these products, chemical evidence and evidence from field work with sniffers indicate that no 'high' is produced from sniffing them.

By not distinguishing sufficiently between experimental VSA and the kind of VSA reported by ChildLine callers, the book's call for VSA-related education focuses on that suited to those with chronic problems. But it is more important to get right the primary prevention and education aimed at all children and young people – we can't predict who will experiment with VSA so every child needs basic VSA-related education. But while this 'must take account of the uniqueness of VSA' (page 29), it must also be in the context of the misuse of other substances. This is fundamental – and is emphasised in the 2004 DfES guidelines on drug education, but is nowhere mentioned in this book. The unfortunate effect of prioritising VSA but not contextualising it correctly is that its neglect is more likely to continue.

The harms and risks of substance use

Professor David Clark reflects on the ways that drugs, alcohol and solvents can cause harm, and describes various risk factors. He emphasises the importance of providing realistic and objective information about the risks of substance use.

There is much discussion about the harms and risks of drug use, particularly in the popular press. The relative harms of different drugs are compared, and the law tries to operate a control system with drugs purportedly graded by their dangers, albeit with alcohol and tobacco forgotten.

Heroin and cocaine are considered to be particularly dangerous. And yet, there are people that have taken cocaine or clean, prescribed heroin for many years and have suffered no physical harm. There is no given in the world of drugs – except that all substances (even water) can kill if given in sufficient quantity.

In his excellent book *Matters of Substance: Drugs – and why everyone's a user*, Griffith Edwards points out:

'With drugs nothing is always. Their use does not carry a guarantee of danger, but neither is their safety guaranteed. What one needs to ask about any substance is not whether in absolute terms it is safe, but rather the degree of risk which may attach to its use.'

The harm caused by substance use needs to be considered in a variety of ways. Use of drugs, alcohol and solvents can carry risk to different aspects of life. They may threaten physical or mental health, social circumstances, educational and employment status, and may put a person at risk with the criminal justice system.

Substance use may also affect the safety and welfare of others. Other people may be affected negatively by the transmission of blood borne viruses through sexual contact with an infected drug user, through violence committed by a person who is drunk, or by someone who is driving while under the influence of a sedative prescription drug. The harmony and happiness of families can be disrupted, and in the extreme whole communities can be affected.

Harm done by substance use can be major or minor. It can also be a one-off or chronic. Harm may be caused directly by the drug itself, and/or by the lifestyle associated with use of the drug, for example, with street heroin.

For some harm, an increasing risk is associated with longer-term and heavier substance use. However, for other types of problems, the risk can be much more random: the twentieth experience with ecstasy or a solvent may trigger some reaction leading to death; the first injection of heroin may lead to infection with Hepatitis C which kills the person years later; the heavy drinking session may lead to the person tripping on the pavement into the path of an approaching vehicle.

'With drugs nothing is always. Their use does not carry a guarantee of danger, but neither is their safety guaranteed. What one needs to ask about any substance is not whether in absolute terms it is safe, but rather the degree of risk which may attach to its use.' Griffith Edwards

With illicit drugs, there is the possibility of contaminants in the drug which can cause illness and even death. In one example, heroin users in California injected unknowingly a synthetic drug known as MPTP, which produced symptoms of Parkinson's disease.

This movement disorder, caused by a massive depletion of dopamine neurons in the brain, mostly occurs in people over 60 years old. In this case, young heroin users developed the symptoms within 24 hours of taking the drug. The condition was irreversible and could only be alleviated by l-dopa.

The particular harm caused by substances is also dependent on the route by which they are administered. Injecting drugs can lead to the transmission of blood borne viruses, smoking to lung damage, drinking of alcohol to cancer of the gullet. Accidental overdose is more likely to occur following injection than ingestion of tablets. Users of illicit heroin are also unaware of the purity of the substance they purchase – an unusually pure, or contaminated, batch of heroin can cause overdose.

One of the dangers of drugs and alcohol is their propensity to cause addiction or dependence. In simple terms, dependence can be seen as an impairment in a person's ability or power to choose. The drug becomes more important to the person than other aspects of their life, which the majority of people would consider as essential. Dependence drives forward heavy and persistent drug use, ultimately increasing the likelihood of self-harm.

The particular effects of a drug, and the development of dependence, are influenced not only by the intrinsic properties of the drug and its route of administration, but also by the previous drug experience of the user, their physical and psychological characteristics, and the setting in which the drug is taken. Therefore, these factors can influence the harm caused by drugs.

Overdoses are more likely when a heroin user leaves prison, since he is likely to forget or not understand that his body has lost its tolerance to the drug. Amphetamine psychosis will be more likely to occur in an individual with a propensity to schizophrenic symptoms. Alcohol-induced violence is more likely to occur in certain environments than in others.

Finally, and not least, is that the dangers of many substances can be exacerbated by taking another at the same time. For example, the likelihood of overdose after heroin is increased if the person is also drinking alcohol.

Psychoactive substances have been used in society for thousands of years. They will remain with us for as long as mankind wishes to change his state of consciousness, for whatever reason. These substances – be they legal or illegal – will always have harm and risks associated with them.

What is important in today's society is to keep people well-informed about the potential harms of drugs, alcohol and solvents and the circumstances in which they can be dangerous. We do not need media hype or campaigns that over-exaggerate the risks. We need to be objective and realistic.

DDN Readers' Survey

We are very keen to hear what you think about the magazine, so please take a few minutes to fill in the DDN readers' survey. The easiest way to do this is to fill in our online survey at **www.drinkanddrugs.net/survey.html** or if you do not have internet access, please photocopy or cut out this form and return it to us at:

Readers' Survey, Drink and Drugs News,
CJ Wellings Ltd, Southbank House, Black Prince Road, London, SE1 7SJ

All completed forms received by 1 October 2005 will be entered into a draw to win an ipod shuffle.

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fdap
The Federation of Drug and Alcohol Professionals
Conference 2005

7 November
London (RIBA)

Organised by FDAP in association with Skills for Health and Home Office, Drug Strategy Directorate. This year's conference will include workshops, seminars and debates on a range of issues of relevance to the field. The focus will be on helping to inform the practice of front line workers, their managers and commissioners, and on giving workers the opportunity to have their say on important issues of the day. Topics to be covered include: NTA treatment effectiveness strategy; models of care for alcohol; residential services review; HIV & Hepatitis; nutrition and addiction; dealing with sexual abuse; prescribing interventions; engaging service users; staff training & development; DANOS; drug consumption rooms; and DIP.

For more information and a booking form see 'events' at www.fdap.org.uk, or contact Alan Whittemore, Conference administrator on 0870 763 6139 or email office@fdap.org.uk

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

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Attendance fee £130

For **booking information**, see
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Thursday October 13th, 2005
09.30 to 16.30
The Legends Lounge Suite
Pride Park Stadium
Derby DE24 8XL

The Training Exchange

The Training Exchange Drug & Alcohol Training Programme Autumn/Winter 2005/6

the TRAINING exchange

One day courses (£95 + VAT)

Introduction to Drugs Work	13th October
Alcohol & Poly Drug Use	3rd November
Difficult & Aggressive Behaviour	21st November
Working with Diversity	30th November
Drugs & Housing	1st December
Personality Disorders	13th December
Crack Awareness & Users' Needs	14th December
Service User Involvement	17th January 2006
Women & Drugs	25th January 2006
Steroids & Steroid Users	31st January 2006

Two day courses (£180 + VAT)

Motivational Interviewing	19th & 20th October
Brief Solution Focussed Therapy	10th & 11th November
Relapse Prevention	6th & 7th December
Dual Diagnosis	19th & 20th January 2006
Young People - Mental Health& Emotional Support Needs	1 & 2 February 2006

All the courses in this programme are mapped to DANOS.

All courses take place in Bristol.

For further details and full course outlines contact
The Training Exchange,
Easton Business Centre,
Bristol BS5 0HE
Tel/Fax: 0117 941 5859
email: admin@trainingexchange.org.uk
www. trainingexchange.org.uk

The Training Exchange is an independent training and consultancy service. We focus on issues that affect health, young people and communities.

Sex In The City: How Do Drug Services Respond?

Wednesday, 28th September 2005

Scottish drugs Forum

28 September, Edinburgh

Around 5000 women in Scotland may be working in the sex industry. Strathclyde Police estimates that 1400 women are involved in street prostitution within Glasgow city – nearly 95 percent of whom use drugs, mainly 'street' heroin. Little information is available on the extent of male prostitution, linked to drug problems, within Scotland.

This conference – chaired by Margo MacDonald, a member of the Scottish Executive's Expert Group on Prostitution and MSP for Lothians – will focus on how Scotland's drug services are responding to the needs of sex workers with drug problems.

Topics for debate will include:

- What are the concerns of sex workers with drug problems?
- How can we best respond to the needs of sex workers with drug problems?
- What are the barriers and opportunities within drug services in meeting their needs?
- Is there a strong link between recreational drug use and blood borne viruses among male sex workers?
- Government consultations on tackling the difficult social and welfare issues associated with prostitution – what emerges from them to impact on the individual and local communities?
- What can we learn from policy and practice at a local, UK and international level?
- How can all stakeholders, such as planners, specialist agencies and drug services, protect the wellbeing of those involved in prostitution and maintain community safety?

SDF Members £100 Non-members £130

For more information contact 0141 221 1175
e-mail: enquiries@sdf.org.uk
www.sdf.org.uk

Association of Nurses in Substance Abuse

21st national conference

Health Improvement: Our Agenda for Change

Speakers include:
Shan Barcroft – Nurse advisor clinical team, National Treatment Agency
Professor Carolyn Steele – Director NIMHE East Midlands Development Centre
Pamela Spalding – Drug Strategy Directorate, Home Office

Aims:

- To bring together nurses from all fields and professionals who have an interest in substance misuse
- To highlight the area of substance misuse in nursing
- To provide a setting for communication of the latest research and skills in the field
- To discuss the impact of recent legislative changes affecting nurses, allied professionals and substance misusers

21-23 September 2005
Chester College University

ANSA
Association of Nurses in Substance Abuse

For more information please contact Professional Briefings on 01920 487 673

CRACK COCAINE NATIONAL CONFERENCE

18 October 2005
Jurys Inn, Broad Street, Birmingham

Altrix

TACKLING DRUGS CHANGING LIVES

Cranstoun drug services

Heart of Birmingham Teaching NHS

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

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

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nafas

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Full –time 35 hrs per week

Nafas is a specialist BME drug agency based in East London providing a range of quality treatment, education and outreach services. We are now seeking to recruit an Addictions Counsellor to our structured day programme which is primarily targeted at the Bangladeshi community in the London Borough of Tower Hamlets.

Service delivery will be characterised by a flexible, proactive approach to the engagement of clients. We are therefore looking to recruit a motivated, experienced counsellor to take on this exciting challenge.

The role will encompass initial client assessment, individual care planning, a personal caseload and some group therapy work. The post-holder will be familiar with a range of CBT, motivational interventions and relapse prevention strategies and will be qualified according to BACP standards. The post holder will also be familiar with the cultural needs of drug users from the Bangladeshi community.

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adminnafas@btconnect.com

or download from www.nafas.org

Closing Date 30th September 2005

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salfordsmart young people's service

Lifeline Project

SALFORD

We are recruiting a

Young Person's Substance Misuse Accommodation Worker

REF (YPAW -2) Salary SCP 22-28 (£17,922 - £21,654)

Fixed Term contract to March 2007

A new specialist substance misuse post has been developed to help address the needs of young people who are experiencing difficulties in accessing and maintaining housing as a result of their drug use. The post will be based within SMART (Salford under 19's Substance Misuse Service) but will maintain strong links with housing services.

The Accommodation Worker will work across the City of Salford area. The worker will provide a wide range of services to young people to help reduce the problems caused by, or associated with drug and/or alcohol use.

Dip SW or Nursing qualification or equivalent professional qualification desirable, but not essential.

The successful candidate will be subject to clearance from the Criminal Records Bureau as these posts are exempt from the Rehabilitation of Offenders Act (1974)

For an informal discussion about the post **contact Mathew Benham on 0161 788 9108**

For an application pack please call 0161 788 9108

Completed applications to be returned by **Wednesday 14th September 2005**

Lifeline welcomes applications regardless of race, colour, nationality, ethnicity, religion, gender, sexual orientation, marital status, disability or age. Applicants are considered on the basis of their merits and abilities for the job.

A Registered Charity No: 515691 & A company Registered by Guarantee No: 1842240

RCGP Substance Misuse Unit

Suite 914, Fraser House, 32/38 Leman Street, London, E1 8EW
TEL 0207 173 6090 FAX 0207 173 6089
EMAIL drugmisuse-enquiries@rcgp.org.uk

Sex, Drugs and HIV Task Group

UPDATE ON METHADONE PRESCRIBING

Including the launch of:
'GUIDANCE FOR THE USE OF METHADONE FOR THE TREATMENT OF OPIOID DEPENDANCE IN PRIMARY CARE'

Friday 4th November 2005
THE THISTLE TOWER HOTEL
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If you are concerned about any of the issues, then this day is for you.

Speakers include:
Dr Jenny Keen – Clinical Director, Sheffield Primary Care Clinic
Dr Chris Ford - GP and SMMGP Adviser
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Cost for the day:
Past and current certificate applicants/graduates: £80
All other delegates: £95

For further information and to reserve yourself a place at the event please contact:
Tel: 020 7173 6091
email: drugmisuse-enquiries@rcgp.org.uk

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We are looking for qualified (accredited) and experienced individuals who can deliver therapy within our model and contribute to other care work as part of an integrated therapeutic model (this could include some evening and weekend duty). Willowdene Farm is an equal opportunities employer and therefore invites applications from anyone who may be interested and qualified.

Closing date for applications: 30th September 2005
Send a personal letter of application with a detailed CV to:
Willowdene Farm Ltd, Chorley Nr Bridgnorth, Shropshire, WV16 6PP
Or contact Jenny for an information pack on: 01746 718658

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Drug and Alcohol Team Manager
Swindon Community Safety Partnership

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