DDN
Drink and Drugs News

28 January 2008
www.drinkanddrugs.net

**GROUP ACTION**
'Fact file' special – service user groups around the country

**UNCHARTED WATERS**
Unregulated alternative therapies – how bad is it?

**CHANGING RULES**
Could increasing tax on alcohol really work?

# AN ACTIVE LOCAL FORCE

## Wolverhampton service user team gets creative

Your fortnightly magazine | jobs | news | views | research

A one day Conference and launch of the new Taylor & Francis Journal

# Mental Health and Substance Use
## *(dual diagnosis)*

## Meeting the Challenge; Current thinking and developments

**Tuesday 11 March 2008**

**Trinity Park Conference Centre, IPSWICH**

Further details and online booking at:
www.smhp.nhs.uk/conference

This one day conference explores some of the issues facing clients, professionals and services. It provides an insight into current thinking and latest developments in the field from a variety of perspectives: policy, practice and training. The conference draws together some of the UK's leading clinicians, researchers and educators to consider how we meet the challenge, now and in the future, providing a thought provoking day.

In addition, the conference has the pleasure of hosting the UK launch of the new, international Taylor and Francis journal *Mental Health and Substance Use: dual diagnosis* and an opportunity to meet the Editor and members of the Advisory Board. All delegates will receive a year's subscription to the journal and a copy of the first issue in their welcome pack.

Routledge
Taylor & Francis Group

Suffolk NHS
Mental Health Partnership NHS Trust

Published by

CJ Wellings

In partnership with

FDAP
Federation of Drug and Alcohol Professionals

WIRED
Empowering People

Drink and Drugs News partners:

Adfam
Alcohol Concern
The Alliance
ANSA
drugsandalcohol today
EATA
European Association for the Treatment of Addiction
The Federation
LDAN
Mentor
RELEASE
SMMGP



# Drink and Drugs News

28 January 2008

## Editor's letter

Wolverhampton's Service User Involvement Team are doing so much, it was difficult to cram it all into one article (cover story). Behind the tangible successes of the group are a raft of partnerships and a lot of goodwill and co-operation from neighbouring services, including treatment providers, police, probation, and businesses like the local art gallery, who are being generous with facilities and offering new opportunities to develop talent.

The group is powered by the enthusiasm and commitment of its project manager and team, including a growing band of volunteers, and is given vital support by the local commissioner, the regional alliance advocate (who was determined to see the service user group regenerated to useful purpose) and others.

It's not all been plain sailing. But the team's journey is an inspiring example of what determination, creativity and enthusiasm can achieve when carefully blended with a vital base mixture of structured planning. Trickier issues will test the group's patience, but they have passed a vital milestone in getting local services to engage in a dialogue of improvement and to publicly display their responses to criticism in their waiting rooms, in a show of commitment to do better. In a short space of time, the group has become an impossible-to-ignore element of local treatment planning. The comments from SUIT's members show the difference the initiative has had on their lives and outlook – and that's got to be encouragement to those who are wondering whether the workload is worth it.

We wanted to know how other service user groups around the country were getting on, so have extended our regular 'fact file' for this issue, to create space for a round-up of eight groups. We'll keep the fact files coming in future issues, but hopefully it will give encouragement that, in the words of Wakefield's correspondent, 'one step at a time will amount to a giant leap'!

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

**Reporter:**
David Gilliver
e: david@cjwellings.com

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

**Designer:**
Jez Tucker
e: jez@cjwellings.com

**Subscriptions:**
e: subs@cjwellings.com

**Events:**
e: office@fdap.org.uk

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

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ
Printed on environmentally friendly paper by the Manson Group Ltd

**Cover:** Dan Tero

## In this issue

## News in Brief

**Toolkit launched**

A new toolkit to help local teams develop strategies to support the government's *Safe, Sensible, Social* strategy has been launched by the Home Office. The *Alcohol strategy local implementation toolkit* is aimed at those leading and developing strategies to tackle alcohol-related ill health and crime in PCTs, local authorites, DAATs, children's services and local partnerships. The toolkit provides a step-by-step guide on how to develop a strategy, along with a range of suggested activities to help with the key areas of children and young people, health and community safety.

*Available at www.crimereduction.homeoffice.gov.uk/drugsalcohol/drugsalcohol097.htm*

**Agreements explained**

A new briefing paper from Alcohol Concern aims to demonstrate how Local Area Agreements (LAAs) can be used to galvanise action on alcohol at local level. It sets out how LAAs represent the most important local delivery mechanism for 2008's Public Service Agreements from last year's Comprehensive Spending Review and are the best way to achieve a joined-up approach to reducing alcohol-related harm. The briefing paper includes an explanation of how LAAs work and fit in local delivery structures, as well as sections on targets and funding.

*Local area agreements – factsheet available on www.alcoholconcern.org.uk/files/20080115_151308_Local%20Area%20Agreements%202.pdf*

**A family affair**

Families and carers of people with drug and alcohol misuse problems were brought together for a conference in Bristol earlier this month, jointly organised by the Drugs and Homeless Initiative (DHI) and Southmead Project. It is estimated that around 10,000 people in Bristol and South Gloucestershire are dependent on alcohol or drugs or both. 'Whilst working with substance misusers for 11 years it was impossible for me not to see the damage drug and alcohol misuse has on carers, but at that time there were limited opportunities to provide services geared to their needs,' said senior practitioner (families) for DHI Esther Harris. 'This conference aims to give carers a voice and tell them that, with support, they can improve their lives in their own right.'

# Men drinking more than twice as much as women

**Men are drinking twice as much alcohol as women, according to new figures from the Office for National Statistics (ONS).** Men drink 18.7 units of alcohol per week, compared with 9 units for women, according to *Smoking and drinking among adults 2006 and Drinking: adults' behaviour and knowledge in 2007.*

Men also drank on more days of the week than women, with 21 per cent having drunk on at least five of the previous seven days, compared with 11 per cent of women, and were also more likely to have drunk on at least one day in the previous week. Men and women in 'managerial and professional' households were found to drink more (15.1 units per week) than those in households classified by the statistics as 'routine and manual' (11.6 units per week). Alcohol consumption was also higher in England and Wales than Scotland, at an average of 13.7 and 13.5 units per week respectively compared with 11.6 units.

The statistics take account for the first time of the trend towards stronger drinks and larger measures, with the calculation methods updated accordingly. 'For this reason it is not possible to compare like-with-like figures from previous years,' say ONS. 'However, estimates from the last ten years using the old methodology suggest that the trend in alcohol consumption may be downward.' The proportion of men drinking more than 21 units a week on average fell from 29 per cent in 2000 to 23 per cent in 2006, while the proportion of women drinking more than 14 units a week fell from 17 per cent to 12 per cent in the same period.

'What these figures show yet again more than anything else is the need to treat self-reported data with caution,' said Alcohol Concern spokesperson Frank Soodeen. 'People are clearly confused about how much they are drinking, given changes within the drinks market in terms of strength and size of measures. While we certainly welcome any suggestion that overall consumption is falling it is nevertheless still the case that substantial numbers of men and women are drinking above the safe limit and we need to continue to spread the message that harmful drinking carries serious potential risks to one's health and wellbeing.'

*Available at www.statistics.gov.uk/pdfdir/ghs0108.pdf*

# Mentor on the lookout for CHAMPs

**Three £20,000 prizes are on offer in Mentor UK's 2008 Alcohol Misuse Prevention Awards.** Known as the CHAMP (Promoting Children's Health through Alcohol Misuse Prevention) awards, they are open to schemes that help stop children up to the age of 14 misusing alcohol, and prizes consist of £10,000 cash plus £10,000 worth of consultancy help to expand the projects.

Anyone can nominate a scheme, and the awards are split into categories for work in schools, the community and for projects led by young people. After a shortlist is drawn up by a panel of experts, the final winners will be chosen by panels of young people under 14 and announced at a ceremony in November.

'At Mentor UK we believe that by promoting healthy attitudes and behaviours with young people as early as possible, within their local communities, we can prevent many lives being wrecked,' said chief executive Eric Carlin. 'The Mentor UK CHAMP awards aim to showcase the very best prevention schemes, and to share what works with others so that effective alcohol misuse prevention programmes can develop right across the country. We are especially interested in hearing about schemes that help youngsters avoid the risks of trying alcohol by tackling boredom or the lack of aspiration, for example, or schemes that encourage achievement and motivation.'

*Application forms and guidance notes available at www.mentorfoundation.org/uk/awards Closing date for entries is 20 April.*

# Autumn offensive on underage drinking

**More than 3,700 litres of beer, cider, alcopops, wine and spirits were seized from young people under 18 during a police crackdown on underage drinking last autumn, according to the Home Office.**

Police and community support officers visited known underage drinking areas during the campaign, which ran from early October to early November, with a focus on weekends and half term holidays as well as Halloween and Bonfire Night.

It followed a summer initiative that saw more than 3,000 off-licences and pubs subject to underage test purchasing operations by police and trading standards officers, with premises that persistently sold alcohol to minors having their licences revoked (*DDN*, 22 October 2007, page 4).

'Confiscation compliments our efforts to tackle the supply of alcohol to children,' said Home Office minister Vernon Coaker. 'The enforcement of underage sales law has hardened dramatically in recent years and I know that many alcohol retailers have raised their game and now routinely apply "Challenge 21" criteria to anyone who looks underage.'

The police also used new powers under the 2006 Violent Crime Reduction Act to disperse groups suspected of alcohol-related crime or disorder. 'The government remains committed to working with the police and local authorities to use every measure at our disposal – both coercive and cooperative – to make sure everyone over the age of 18 can enjoy alcohol safely and responsibly,' he said.

**ABOVE THE CLOUDS:** Rachael Walters receives her First Class BSc (Honours) Degree in Addictions Counselling with fellow Honours graduates Andrew Bivar Telles Mendes and Adrian Edwards. The degrees, offered by the Clouds training course in partnership with the University of Bath, are the first of their kind in the UK. Clouds, which is now part of Action of Addiction, also offers foundation courses in response to the shortage of well-trained professionals in the field (*DDN*, 12 March 2007, page 12). 'It was the most challenging study programme I have undertaken,' said Rachael Walters. 'I am now well equipped to further develop my career in the addictions field and would recommend and encourage anyone considering this worthwhile course to go for it – it is truly amazing what you can achieve.'

# Survey reveals ignorance and prejudice on HIV

**Almost a third (31 per cent) of people questioned in a MORI poll commissioned by the National Aids Trust (NAT) could not identify sharing needles when injecting drugs as a method of transmission for HIV.** Just 6 per cent of almost 2,000 respondents to the Public attitudes towards HIV survey successfully identified all routes of infection with no false responses.

Fewer people identified the correct routes than when the survey was taken in 2000, with more than a fifth (21 per cent) failing to recognise unprotected sex between heterosexual couples as a way of contracting HIV. According to the Health Protection Agency (HPA), there were 73,000 people living with HIV in the UK in 2006, with nearly 8,000 new infections. The HPA estimates that one in three infections are undiagnosed.

'In recent years we have witnessed knowledge and understanding about HIV decline at the same time that HIV diagnoses have reached an all time high,' said NAT chief executive Deborah Jack. 'By 2010 there will be over 100,000 people living with HIV in the UK if current trends continue.'

Two thirds (66 per cent) of respondents, furthermore, either 'strongly' agreed or 'tended to' agree that people who had become infected with HIV through taking drugs 'had only themselves to blame'. More than two thirds, however, said that if a family member or neighbour was HIV positive it would not affect their relationship with them.

'The British public reveal a mix of attitudes to HIV in this survey,' said Deborah Jack. 'Whilst the majority of people say they would be supportive of someone they know who became infected with HIV, there remains a culture of blame that would never be associated with any other illness. We need a zero tolerance policy towards HIV stigma at every level. Knowledge is our best weapon against stigma and discrimination.'

*Report available at www.nat.org.uk/document/405*

# Commitment to competence

**New guidance on workforce qualifications after April have been issued by the NTA to coincide with the discontinuation of the three targets used by the NTA and the Home Office as a way of 'focusing the workforce agenda'.** Although the NTA will not be setting new workforce targets after this date, 'it is important that commissioners and services continue to work towards a workforce which is fully competent and able to demonstrate its competence in line with the joint NTA/Home Office Workforce Development Plan,' it says.

The guidance concludes that 'it remains our clear ambition... that all drug treatment sector staff and managers have a recognised competency assessed or professional qualification appropriate to their role and are pursuing relevant continuous development.'

'We welcome this clear and unequivocal statement – after a period of some uncertainty – underlining the NTA's ongoing commitment to a competent and qualified workforce,' said FDAP chief executive Simon Shepherd.

*Available at www.nta.nhs.uk/areas/workforce/default.aspx*

## News in Brief

### Peer places

A new peer advocacy service is to be launched next month by the Westminster Drug Project (WDP), with the aim of partnering clients with peers who can offer emotional and practical support and act as a role model. The six month pilot will be funded by the London Borough of Westminster. The service is for Westminster clients but the peer advocates themselves can be from anywhere, provided they are referred by their drug worker, have successfully undergone treatment and are either abstinent or stable. WDP will then match them with clients whose needs fit with their skills and experience. 'This is a quality training course that will produce competent and confident peer advocates,' said workforce development coordinator (voluntary services) Joe Vincent. 'I think the participants will progress significantly in their own learning and development, as well as being a great help and support to the future service users of Westminster.'

Places are still available for the 15 February training course. For more information send an email to joe@wdp-drugs.org.uk

### Reiver reward

The Reiver Project, which provides a community-based service for young people under 16 with drug and alcohol problems in the Borders district of Scotland has been awarded more than £500,000 in Big Lottery funding. The project also supports the families of young people referred to them and offers help in raising awareness of problem behaviours and ways of dealing with them.

### Leap of faith

Four more patients have successfully completed the LEAP (Lothians and Edinburgh Abstinence Programme), which offers a three-month intensive community-based programme including education and vocational training (*DDN*, 14 January, page 6). 'It is promising to see patients achieve the level of progress that our new graduates have reached during their time with us,' said clinical lead of LEAP, NHS Lothian Dr David McCartney. 'The project is both intensive and demanding so our patients need to be motivated to get clean and stay clean.'

# Making the **suit** fit

Making service user involvement into an active local force in Wolverhampton meant introducing structure, accountability – and a lot of creativity, as **DDN** found out.

A text message beeps on my mobile phone. It's warning me that dodgy benzodiazepines are being circulated in Bilston – benzos with a blue tinge to them, nicknamed blue bombs. 'One case we have heard of, person ended up in A&E from poss OD. Be careful,' says the text.

This is Wolverhampton's Service User Involvement Team (SUIT)'s interactive text network in action. A few weeks after DDN was invited to sign up and try the service, I have been invited to an allotment event, an open forum, and a debate on the 2008 treatment plan; asked if I'd like to try designing the drug service's new logo; and asked for my feedback on a couple of treatment providers.

Talking to Andy Corfield, project manager for SUIT, it's clear that there is indeed plenty going on. Besides the allotment project, there's a women's group, a hep C group, an alcohol awareness group and an art project – with others, like a fishing project – in the pipeline.

The art project will be 'the big thing for us this year', according to Corfield. Service users will work with Wolverhampton art gallery to develop their own artistic skills. The partnership will give service users access to premises, a tutor and materials that they wouldn't normally have access to; the idea is to produce an exhibition of their art to display at the gallery.

The other very tangible creation from the group is its magazine, *Substance* – a well-produced publication with engaging articles and artwork. Produced by an enthusiastic committee of volunteers, the mag is not afraid to say what needs to be said: in last autumn's issue between the news and project updates is an eye-wateringly practical guide to injecting safely where the sun doesn't shine – or the jauntily referenced 'squirting up your bum (UYB)'. Another article tackles how to alleviate constipation and there are questions and answers, personal stories and tips on safe disposal of syringes.

The content is bold, acknowledges Andy Corfield, but there's an authoritative framework to the harm reduction advice. Local GP Dr George Ryan checked the health-related content to make sure the advice was sound. There's a rule for the editorial team, says Corfield: 'You can be brave, but you've got to be brave professionally. You've got to have substance, which is where the name of the magazine came from.'

SUIT is buzzing with activities at the moment, but it's taken effort and imagination to get things to this stage. 'The biggest problem we've had – similar to a lot of user teams – is getting service users in a room to have a meeting,' says Corfield. 'Whether you call it a user group meeting or an open forum, it's getting them into that room – which is where the text network idea comes in.' That, combined with the creative input from members, has taken the group from a dwindling annex of a local treatment provider to a full-bodied participant in local treatment planning. The rebirth was instigated by Tony Birt, the Alliance's West Midlands' advocate.


While commissioned to go to Wolverhampton a day a week, he saw the dwindling state of affairs and decided to bite the bullet and get the new project manager on board. The vision was to empower service users to have a say in their own treatment, alongside the Alliance's advocacy service which tackles individual problems.

Andy Corfield's appointment last February has galvanised the process. As a full-time member of staff, supported by his part-time administrator Mel, he has been able to sustain momentum. He is obviously a 'doer', which he himself sees as impatience – 'I like things done yesterday!' From student days, when he was president of the student union, he has been co-ordinating activities. Throw in a year's experience as a journalist on a local paper, a spell working at the job centre doing incapacity benefit work that brought him in touch with a residential rehab, and essential experience as a drug worker, and it's easy to see why he finds his role as SUIT project manager his 'dream job that [I] fell into'.

While personal chemistry obviously plays its part, Corfield attributes much of the team's progress to the way Wolverhampton's service user involvement is structured. The local DAT made the practical decision of commissioning the Voluntary Sector Council to employ the service user involvement officer – Corfield's post. Creating and building up the team around the VSC gave a useful independence, he believes, particularly as they offer professional help – such as accountants to give a hand with managing budgets.

Asked to suggest what's particularly helped the group's progress, Corfield is quick to identify (with the rueful addition that 'I'll seem quite sad!') performance management and outcome monitoring as essential everyday tools. Talking to commissioners in a language they understand has cut corners in getting what they need, he points out. Negotiations are a known quantity; the group can specify exactly what they can offer for a specific budget, based on a real track record. The outcomes they promise are reliable, not built on ideas without substance.

It helps that 'our commissioner's superb' he says – demonstrating that the commissioner-provider relationship is, for once, working as it should. 'A lot of people think that doing stats and that kind of stuff is boring – but it's so vital really,' says Corfield. 'We can easily justify what we've done, why we've done it, and what effect it's had.'

Whatever the paperwork reveals, SUIT is certainly getting noticed locally. West Midlands Police are keen to network to share information on contaminated drugs. The probation service actively encourages feedback, inviting the group to meet on its premises. Local services are having to sit up and take notice: SUIT are developing a mystery shopper programme, based on members' evidence. 'Services say that key workers spend an hour with each client – 20 minutes doing harm reduction, 20 minutes doing social development, this sort of stuff,' says Corfield. 'But we keep hearing that clients are kept waiting for 55 minutes, seen for five minutes, given their script and told "thank you very much, goodbye".'

The group is making real inroads to improvement by communicating proactively with treatment providers. Comment boxes are being placed in the services to bring complaints to light; then managers' responses are displayed next to the comment, on a poster in their waiting room.

With momentum riding high, Andy Corfield is optimistic about what Wolverhampton's service users can achieve. But he emphases that it doesn't happen overnight, and others in a similar situation must be prepared for a certain amount of trial and error to cater for different personalities. He has had to establish certain ground rules – the most straightforward being that when you're representing the team, you cannot be under the influence, and must keep drugs well away from the premises. A volunteer that violated this rule had to be suspended for four weeks from their duties; they could still attend projects such as the allotment scheme, but could not work in the office. It's a kind of tough love he admits, but his experience as a drugs worker has taught him the value of boundaries – and sure enough the person re-engaged with the project. In such instances it's important to keep the case confidential, Corfield emphasises, and to help the person catch up with work so there are no barriers to rejoining the team.

The result is a professional team, built on trust, that does not patronise its members. Problems and conflicts come up from time to time, but the agenda of respect will encourage working through to a solution. As SUIT members themselves testify, a well-run service user group can be a rewarding journey towards building confidence and rediscovering opportunity. **DDN**

## SUITS YOU...

Leanne started using heroin at the age of 15. As she reveals, six years later she is drug free, has a healthy one-year-old boy and is studying for a BA (Hons) in Criminal Justice and Social Welfare Law.

It's not been an easy journey or a straightforward one, she explains. 'I have been through virtually every treatment avenue from Shared Care to Youth Offending Team and had at least five different workers from specialist midwives to young people's workers.

'It was about eight months ago when I was stable on a methadone script and had little else to do with my time that I thought why not use my experiences of drug treatment to help others,' she says. This was when Leanne made contact with Wolverhampton Service User Involvement Team.

At that time SUIT had only been going a couple of months and had just two volunteers. 'I felt that as both the other volunteers were male, the team needed an injection of female logic. I also feel very passionate about how women are treated by drug services, so decided to create SUIT Women's Group,' she says.

'Volunteering with SUIT has given me the confidence and support not only go through a home detox from my methadone but to start at the local University to obtain my degree,' she adds. 'It's all about working as a team, meeting new people and making new friends.'

Alongside running the women's user group, Leanne has completed an NCFE Certificate in Drug Awareness, given talks to probation officers about her experiences, assisted drug services in interviewing new staff and become a qualified auricular acupuncturist.

'I'm not stopping at that either,' she adds. 'I am combining my studies with my volunteer work as I feel it's important for me to give something back to both drug Services and SUIT, especially after everything they have given me.

'I would like to encourage everyone else out there to get involved in your local user group. Not only will you get new opportunities like me, but one person really can make a difference.'

Wolverhampton's Service User Involvement Team prides itself on including non-opiate users, as one volunteer explains.

'As a stimulant only user, I felt local treatment services were not fully meeting my needs. I attended YMCA Bridge Project's structured day programme and had auricular acupuncture along with other Complementary therapies, but always felt I needed to do more, and that's why I started to get involved with SUIT,' he says.

'In my first week as a volunteer we visited another local project where I got the idea of running our own Allotment Project. I took this to the team and ended up running the thing!'

Allotment projects are not just a great way to get out in the open but they have added benefits, he explains.

'Having set up the allotment and worked on it for a few months, I noticed that I was starting to get involved with other stuff such as writing articles for *Substance* (Wolverhampton's Service User Magazine). This also helped develop my confidence and enabled me to start having a voice about how local services treat stimulant only users.'

Wolverhampton is now looking to commission a specific stimulant service and SUIT has played an integral part in the tendering panel for it.

'It all shows that we are making a difference, which is really important to me,' explains the volunteer. 'However it is not always easy. There seem to be a lot of politics around in the service user world and some of us feel this gets in the way of making a real difference to our mates and others in treatment.

'Thankfully we at SUIT make an effort to strike the balance between playing politics and making a difference.'

## Media Watch

Police in Scotland are trialling a scheme to allow police to track where alcohol has been illegally bought by, or for, under-18s. Off-licences will be able to use ultraviolet pens to mark bottles and cans. Chief Inspector Paul Eddington, the operational commander for Ross, Cromarty and Skye, who is behind the scheme, is frustrated that some parents view their children drinking as less dangerous than smoking cannabis. Parents need to know what their children are up to and speak to them about their responsibilities, he said.
***The Sunday Herald, 21 January***

Two 16-year-old British girls have been sentenced to a year in jail in Ghana. Yasemin Vatansever and Yatunde Diya from North London were arrested trying to board a plane in the capital Accra last July. They both denied trying to smuggle cocaine in two laptop bags but the prosecution claimed they had been involved from the start.
***The London Metro, 23 January***

One of Northern Ireland's longest established drug support services faces closure because of lack of funding. Centre manager, Anne Henry, appealed for crucial aid for The Hope Centre in Ballymena, Co Antrim: 'We are in desperate need of additional funding in order to sustain the vital services currently being offered,' she said.
***Belfast Telegraph, 23 January***

The Scottish government has commissioned a large scale study into heroin and cocaine use in Scotland. The study, which will cost £175,000, and is being led by Doctor Gordon Hay from the Centre of Drug Misuse at Glasgow University, is the first of its kind since 2003. Drug-related deaths have been rising in Scotland and 2006 saw the highest number, 421, since records began. The 2003 research concluded that there were 50,000 serious drug users in Scotland – about one per cent of the population. Nobody knows what the current scale of class A drug use is. Experts say this is hampering action to tackle a drugs problem that is among the highest in Western Europe.
***The Scotsman, 14 January***

**"The BMA recognised that the effective blockade methadone dose is between 80-120ml to stop heroin attaching itself to the opiate receptors in the brain. Our average dosage is around 50ml."**

### Filling a need

I feel the need to respond to Kenneth Eckersley of Addiction Recovery Training Services, who attacked harm reduction and methadone maintenance (*DDN*, 14 January, page 8).

First of all Kenneth derides the fact that methadone maintenance is effective in reducing drug use and crime and then goes on to ask if the social worker whose letter he is attacking knows that methadone is highly addictive.

Well I never Kenneth, methadone highly addictive – thanks for letting us all know that.

'Eighty per cent of those on methadone use another drug once a week,' he says and '44 per cent use heroin once a day'. (These facts from an article in a regional *Big Issue* are hardly representative of the UK.)

Let us state the obvious for Kenneth and any right-wing think tanks.

Eighty per cent are on methadone and other drugs – like maybe cannabis. So what – at least they are not injecting street heroin into their arms or groins, which is why people with compassion understand it is this that needs stopping. We have a hepatitis C epidemic, HIV rising, rising endocarditis (7 in 1,000 injecting drug users), and increasing attacks on working girls. I feel that this is of more importance than people on methadone having a toke.

Forty-four per cent are still using heroin – well if you knew anything about methadone, you would realise that people who use heroin on top are not on a sufficient dose, because if they were it would block the effects of heroin. The BMA recognised that the effective blockade methadone dose is between 80-120ml to stop heroin attaching itself to the opiate receptors in the brain. Our average dosage is around 50ml.

People on methadone are better at planning crime, you say that the police are saying. Crime is crime for God's sake, whether planned or not, and you seem to forget the fact that for every £1 spent on a methadone script £10 is saved on criminal related issues.

What you Kenneth, and your Tory, Sweden-supporting friends seem to forget is that not everyone wants abstinence!

So how do you force it – cut benefits? That equals more crime. Prison? There's just as much heroin inside as on the outside.

Abstinence works, but people have to be ready for it. At the end of the day, people have and always will use mood-altering chemicals – you don't like it, so everyone must beat to your drum? Not while there is still breath in my body.

**David Wright, drug advocate and SMUG (Substance Misuse User Group Wales) proud member.**

### Logical four-minute warning!

The article written by John Jolly (*DDN*, 14 January, page 14) makes easy and logical reading even for the layman who is unaware of addiction and all the issues surrounding recovery.

It brought back memories for me of when I first sought help and support in both the private and public sector. I was, in a nutshell, totally petrified, untrusting and anxious, knowing I was going to be judged as I walked through any of the doors. It takes a huge amount of courage and strength for any addict to go through this stage – I am sure other addicts will agree on this and will have been through similar situations.

There were places I just did not return to because of the 'welcome' I'd received. The majority of professionals in both sectors are not addicts so would not know or understand where I, or others, come from. So maybe this clearly written article could easily be discussed at any staff meeting in all sectors, to review the ways that individual staff first approach and invite addicts into their organisation. It wouldn't cost a penny for any sector, and could be a useful tool for personal development for all individuals in whatever role they play towards supporting addicts as they begin to seek recovery.

**S Rendell, by e-mail**

### Changing lives

**Apologies to the Home Office and award winners: in our last issue we named the annual awards as 'Tackling Drugs, Saving Lives' instead of 'Tackling Drugs, Changing Lives' – 'although hopefully we are doing that too,' a Home Office spokesperson added, in pointing out our mistake.**

## We welcome your letters

**Please email letters to the editor, claire@cjwellings.com or post them to the DDN address on page 3. Letters may be edited for reasons of space or clarity – please limit length to 350 words.**

# Changing the rules on alcohol

Is an across-the-board increase in tax really the answer? asks **Kevin Wilson**.


**Practically every day alcohol misuse hits the headlines. The issue of underage drinking and the associated crime, disorder and the increase in alcohol-related diseases is a problem affecting most towns and cities.**

Many suggestions have been made through the media to address this situation during the past few months, the most notable being to raise the drinking age to 21 years old and to increase the tax on alcoholic drinks. But in my view, these suggestions are neither reasonable, practical, nor popular.

For instance the suggestion to raise the drinking age to 21 years would mean that a person can, at 18 years old, be married, have children, work, have a mortgage, vote, fight (and die) for their country but not be allowed to have a pint of beer in their local pub.

An across-the-board rise in tax on alcohol may not lower the amount of alcohol sold, but may encourage people to change their drinking habits from pub to home. Some pubs have had a drop in trade since the smoking ban came into force; a further drop could result in many pubs and small breweries closing and have a drastic effect on the night-time economy and an increase in unemployment. Pubs in city centres are likely to survive, but the traditional country pubs or community 'locals' may struggle. For many villages and communities the local pub plays an important social role, especially for elderly residents. Do we want to risk them closing?

Tax increases on smoking encourage the sale of black market cigarettes, many of which contain more harmful chemicals than the genuine product. A similar rise in black market alcohol would be much harder to police, bringing more young people into contact with continental beers and spirits with a much higher ABV. Do we really want to see more illegal alcohol sold on our streets?

A tax increase could encourage some people to turn to cheaper recreational drugs such as cannabis, amphetamines and cocaine, fuelling an increase in addiction and a rise in associated crime.

It seems morally wrong to punish sensible drinkers in order to tackle people who abuse alcohol. The message we want to put across is to drink sensibly, moderately and responsibly.

As chief executive of a registered charity which has been providing services for people affected by alcohol misuse for the past 27 years, I have considered various practical solutions to tackle our binge drinking culture and promote more sensible drinking habits.

The first suggestion is to legislate to increase the age that you can purchase 'off sales' of alcohol to 21 years old. I believe it is less likely that a 21-year-old would purchase alcohol to give it to a young teenager, as they tend to be in different peer groups.

I would also urge the government to consider raising the tax on these sales. Alcohol from a supermarket, corner shop or off-licence is cheaper now than it ever has been. The traditional pub is finding it very hard to compete, limiting the opportunities for people to drink in pubs in a social setting where behaviour can be more easily policed.

This generation has a culture of going out with the sole intention of drinking to get drunk. Most beers and wines are much stronger than ever before, which is unintentionally fuelling this culture.

I suggest that the government introduces a graduated tax on alcoholic beverages; a tax rise for drinks with a higher than average alcohol by volume measurement (ABV) and a lower tax for drinks with a low ABV. Most standard beers and lagers have an ABV of around 4.0 to 4.4 per cent, which could be the normal tax band.

Strong wines could be taxed on a similar basis, with 10 per cent ABV as the normal tax band. This would not only discourage people from buying strong beers; it would also encourage the breweries to make more alcoholic drinks with a lower ABV and less 'super' strength drinks.

These measures could be much more popular with the general public, brewers and publicans, as they do not penalise the majority of the population who are social, sensible and responsible drinkers. They would go a long way towards changing the present culture of alcohol abuse and promoting sensible, moderate and responsible drinking habits.

The extension of licensing law is more complicated to review. Limited evidence suggests that it has helped reduce the number of violent incidents from groups of people leaving the pubs at closing time and curbed the habit buying swift rounds of spirit 'chasers' when last orders are called; so has made an impact on our binge drinking habits. However, anecdotal evidence suggests that it may be encouraging people, in the long term, to drink more alcohol. We need the government to carry out further research before considering any change in the law, and to continue to allow local licensing authorities to decide on drinking hours based on their particular local circumstances and any police concerns.

My final suggestion is that any money gained from raising taxes on strong alcoholic drinks should be used for the treatment of people with alcohol dependency.

**Kevin Wilson is chief executive of The Albert Centre, a drug and alcohol charity based in Middlesbrough.**

# Uncharted waters

No one wants to stifle innovation, but many in the field are concerned at the lack of regulation for alternative therapies on offer for drug and alcohol problems. **David Gilliver** looks at how the door is open for the public to be fleeced – and worse.

It's very hard to gauge the scale of unregulated therapies being offered for addiction issues, but a quick trawl of the internet will throw up endless options. Those in the field may know almost at a glance which are reliable, respectable and effective but members of the public may well not. They may also be in a desperate situation and willing to try anything for themselves or their loved ones.

'There needs to be some kind of mechanism for a member of the general public to look at a website and know whether something has safeguards and guarantees,' says Kevin Flemen of KFx. 'The wider public don't know the differences between all the different organisations and treatments. Compare a new age clinic and a hypnotherapist both doing smoking cessation, for example. It may be a very good and responsible hypnotherapist, and regulated by various industry bodies, but how does a member of the public differentiate between those two practitioners, neither of whom are doing nicotine replacement therapy or NHS work? They're both private. If I'm not offering a regulated therapy then there is simply no governance.'

At the moment, private clinics are regulated by the Healthcare Commission under the Care Standards Act 2000, but only when they are GP-led and issuing prescriptions. A nurse-led clinic is not subject to regulation. 'Anybody who wants to set up a service that's not GP-led can do so,' says chief executive of FDAP, Simon Shepherd. 'Private healthcare services are regulated by the Healthcare Commission, but what constitutes a healthcare service is quite interesting – you would assume it was anything that offers healthcare, including clinics, but it's not. You can run a nurse-led clinic for drugs and alcohol in the private sector and there's no way of quality-assuring it. There's no way of knowing the scale of the problem, but it's big enough that something needs to be done. The alternative to regulation is whistle blowing – as a field, we draw attention to things we're concerned with – but the problem with that is it doesn't get out to the wider public.'

Residential services are regulated, as, clearly, are NHS services, while day care and non-residential services run by the voluntary sector are effectively quality assured by the commissioning teams. 'If they don't think the services are good enough they can put them out to tender again, so mainstream drug and alcohol treatment provision is broadly overseen to make sure that the system on offer is appropriate and offered at a reasonable level of quality,' says Shepherd. 'Some of these systems are by no means perfect but at least if you know there's something absolutely outrageous going on there's a way of pulling the plug on it. If a street agency is offering a below par service, ultimately the commissioners of the service will pick that up. The bit that falls through the gap is any service that doesn't seek government funding.'

One lever is that trading standards departments and the Advertising Standards Authority (AAA) can investigate to make sure spurious claims are not being made about the services on offer. 'This only provides limited protection for the public,' says Shepherd. 'Trading standards are local authority departments, so if you're offering a national service who's responsible for that? And you have to convince advertising standards that it's worth investigating because they get thousands of complaints. At the end of the day, they're not experts in this field and not really in a position to make effective judgements.'

Counselling, meanwhile, is unregulated but counsellors should be accredited, and the AAA does not allow addiction counsellors to advertise their services in directories such as the Yellow Pages and yell.com, on the basis that there is no recognised body quality-assuring their work. 'There are really tight restrictions on what counsellors can claim to offer, particularly around drugs and alcohol,' says Shepherd. 'Yet if you set up a nurse-led private clinic and say you're offering quasi-medical care then that appears to be OK. We would want to see only counsellors who have had proper training around substance misuse being able to provide private counselling services around these issues, but there are counsellors who are not accredited by a recognised body providing services.'

But isn't there an argument that there may be lots of new, innovative and exciting treatments out there and they should be given an opportunity? 'We cannot allow people providing services that fly in the face of available evidence to continue to operate unchallenged,' he says. 'We can allow free innovation and services that don't have an evidence base to underpin them, provided there's a strong theoretical base or rationale and that they are then subject to thorough examination. They should only be offered for a trial period while they're being investigated, and offered as unproven services, not treatments. You can allow for innovation through that process – you can trial stuff but the public needs to be aware it's a trial.'

The danger, of course, is not just that people are fleeced by perhaps unscrupulous and unqualified practitioners; it is also the very real health risks associated with such a vulnerable clientele. If people withdraw from opiates or alcohol without the prescription of any substitutes in order to rely on an 'alternative' therapy, then they could be at great risk. 'The cost of getting it wrong for this client group is immense,' says Simon Shepherd, 'for the client, their family and for wider society. And there are very real dangers with this client group of getting it catastrophically wrong – if you try and encourage someone with a long history of alcohol dependency to stop drinking overnight, they will die, simple as that. Nobody should be working with alcoholics unless they're fully aware of the medical realities, so it's critical that we have some form of control.'

'The biggest thing in all of this is that if there's an evidence base then you can prove it, and if you can prove it then that's fine,' says Sharon Carson, chief executive of EATA. 'But if there's no evidence base then it's a big problem. The question is around what we are doing in the sector to regulate what is happening and make sure that people accessing the treatment are getting treatment of the best quality. We have an accreditation programme which we encourage our members to apply for because we can guarantee a level of quality in service delivery that way, but we're not a regulatory body. At the moment there are a few things in place but there's no regulated collective checklist and nothing that all types of treatment organisations have to demonstrate that they've complied with. It definitely needs to be raised on the agenda.

'What we do as an organisation is to try work with central bodies to say we need to improve the quality of treatment,' she continues. 'There are things that can be done as a sector to ensure we have the appropriate treatment and we need to start working on those – it's been on the agenda but it's not been particularly high on the agenda and that's got to change. In any treatment sector, you have huge amounts of regulation and standards, and drugs and alcohol is falling behind.'

'Encouraging membership of voluntary schemes is not a solution,' says Kevin Flemen. 'As long as other practitioners can practise regardless of these schemes, then the voluntary system is meaningless. Rather than just having a competency framework, there should be some benchmarking for the general public which allows them to establish if the service meets basic minimum standards. This would allow any member of the public to visit a website and see, via some simple authentication system, that it is a legitimate service with, say, a bronze, silver or gold status or something like that. We need a threshold to say that basic minimum standards are being met by this organisation, which doesn't necessarily vouch for the effectiveness of the therapy but works on the basis that it's a therapy that is at least recognised by the drugs field rather than being some Mickey Mouse quackery, and that criminal record checks and things like that have been carried out.

'If I want to be FDAP approved there's a regulatory framework in place, but if I don't want to be approved then there's no strategy for stopping me practising and I find that astonishing,' he continues. 'It's a bigger issue than just drugs, it's the huge unregulated alternative practices market, everything from allergies to cancer treatment. But I think ultimately the Department of Health should regulate the field – I don't think it should be up to the field itself to regulate, and I don't think it's about DANOS competencies. I do think there needs to be a clear licensing system, but it's a huge thing to take on, and the Department of Health doesn't see it as their role – I find it amazing that no one sees it as their role. We can spend five years lobbying for strategic change, but during that time thousands of people are going to be ripped off by rogue traders.'

# Group action

In a 'fact file' special, we've rounded up progress reports from some of the many active service user groups around the country.

## Russell Headley reports from Service User Skills Training (SUST) in Bristol

**When and why did you start your group?**
We started up in February 2005. The aim was to bridge the gap between early recovery or stabilisation and engaging in meaningful voluntary work. SUST facilitates two out-of-hours open access sessions on a Thursday evening and Saturday afternoon, and does ear acupuncture during the week.

**How many members do you have?**
Currently about 18. It was never intended for people to stay on long term.

**How did you obtain funding?**
Some funding comes from the drug strategy team and some from training fees.

**Where and how regularly do you hold meetings?**
The group has clinical supervision once a month and members can meet with staff on a regular basis.

**What do you hope members get from attending?**
A sense of responsibility, ongoing support, advice and information around training needs, and support around funding for courses.

**How do you keep it going?**
We offer support and try to be accommodating to the wishes of the group.

**What have been your highlights so far?**
We've always been able to open the out-of-hours drop-in.

**How do you communicate with your members?**
We use email, text, telephone, messages in pigeonholes and good old-fashioned one-to-one.

**Have you any tips for others starting a group?**
Allow the group as much freedom as your agency or service can bear. Be accessible at short notice; be involved but do not meddle. Have faith in your group and be aware of any problems that may arise.

## Sharron Terzza reports from Sandwell Addicts Views Expressed (SAVE)

**When and why did you start your group?**
SAVE lifted off in October 2005. In the past a service user group was tried and failed to take off. The drug and alcohol action team then approached local service users to create a newsletter. Since then we have grown from regular newsletters and SAVE meetings to attending conferences, training, speaking on behalf of service users in the Sandwell area and giving input on service delivery.

**How many members do you have?**
We currently have 11 members, with many others that have come and gone for various reasons.

**How did you obtain funding?**
From the DAAT.

**Where and how regularly do you hold meetings?**
At SAVE, c/o 3rd Floor, West House, Lombard Street West, West Bromwich. It's central, to give members easy access and we reimburse their travel expenses. We meet once a month for our newsletter; twice a month for a SAVE meeting; once every three months for our overdose meeting; and once every six months for our overdose workshop.

**What do you hope members get from attending?**
They gain confidence and meet new people. It's a safe place where they can understand how the system and services work better, gain training, look at job opportunities, enhance their CV, and meet like-minded people at all stages of recovery.

**How do you keep it going?**
Commitment is the key, and we are lucky to have that in our group. The cash incentive to be paid for meetings other than SAVE's own is another bonus.

**What have been your highlights so far?**
Being involved in decision-making and policies, such as needle exchange and the changes surrounding it. Being involved in the pack contents, along with the overdose workshops that we have delivered, gives the group members a real sense of achievement. Overall it feels good to make a difference.

**How do you communicate with your members?**
Group members communicate via telephone, email letters and meetings, while newsletters and overdose workshops communicate to the service users as a whole.

**Have you any tips for others starting a group?**
Always be honest and open with each other, and avoid being judgmental of others. Set out a constitution and basic ground rules from the start. We try to keep our group laid back and relaxed. It is a really effective learning curve, so try and use it as such. Respect and accept others' opinions and be able to agree to disagree. Work at a pace that suits everyone. Above all, keep it confidential and safe!

## Angela Brinkworth reports from Recovering Addicts Peer Support (RAPS) in Newport, Gwent

**When and why did you start your group?**
Founding RAPS represented the culmination of a six-year plan formulated in forum theatre workshops with ex-offenders on Drug Treatment and Testing Orders in Newport. The action plan was supported by the then DTTO manager Gareth Hopkins and Make A Change was founded in 2002 to raise funds to put the plan into action. RAPS are still being supported by Make A Change.

**How many members do you have?**
The original membership was 20 volunteers. The first project was a Forum theatre workshop presentation devised by six volunteers based on the combined experience of their journey to heroin addiction. It was called *Jamie's Story* – a short play that was presented in schools, community venues, and to young offenders and other DTTO Units in Wales.

**How did you obtain funding?**
This project was funded by a £5,000 Awards for All Wales grant. Make A Change volunteers were the first group of ex-offenders to go back inside a Welsh prison where they performed and facilitated a forum with inmates and staff on 'drugs In prison'. A £10,000 grant from the European Social Risk funded *The Journey Home* – devised, written and filmed by volunteers, to highlight the need for better aftercare provision for offenders with addiction issues post release and to support pre-release training. Subsequent funding supported by research in three Welsh prisons led to a 40-hour peer support training programme for volunteers over 26 weeks, supported by the Welsh Charitable Stadium Trust.

**Where and how regularly do you hold meetings?**
Five RAPS peer supporters meet once weekly. Participants to their group self-refer and are referred by Gwent probation and Bridgend Park Prison. Peer supporters receive ongoing supervision and training from Make A Change.

**What do you hope members get from attending?**
Members get the opportunity to actively participate in discussion and dialogue between themselves and


the communities they come from, demonstrating that with support they can engage in finding and implementing solutions to the problems they face in their everyday lives.

**How do you keep it going?**
A grant from the Communities Trust Fund and the South Wales Workers Education Association has resulted In *OFFIT* – a newsletter for addicts by addicts – and money to employ a project manager to lead the group toward independence from Make A Change and to fundraise for the groups long-term sustainability.

**What have been your highlights so far?**
The positive reaction of young people to *Jamie's Story*. The realisation that members have something of great value to offer service providers. Meeting the police and drug prevention professionals on an equal footing. OFFIT being recommended to the Welsh Assembly as an example of good practice.

**Have you any tips for others starting a group?**
We were very lucky to have a DTTO manager with the imagination to try something different. It has not been easy being a small voluntary organisation offering an alterative 'TO' ( Theatre of The Oppressed) approach to engage with people recovering from drug addiction, but it works. Imagination is our greatest resource... and finding a place 'to be' which is safe and respectful, accepting people for who they are, and what they can be.

## Herman Prestcote reports from Southend User Forum (SUF)

**When and why did you start your group?**
We started up in March 2006.

**How many members do you have?**
We currently have 14 SUF members.

**How did you obtain funding?**
We are supported by the Southend DAAT.

**Where and how regularly do you hold meetings?**
Meetings are once or twice a month, at a local night shelter – in the daytime.

**What do you hope members get from attending?**
They experience engagement – and hopefully a sense of purpose, friendship, and personal development.

**How do you keep it going?**
By involving members, keeping in regular contact with them, listening to feedback – and through a democratic approach (hard work!).

**What have been your highlights so far?**
Being invited onto the strategic partnership group.

**How do you communicate with your members?**
We keep in touch by phone and in person.

**Have you any tips for others starting a group?**
Only start if you are well enough, and can offer commitments of time and energy.

## Russell Headley reports from Service User Group Action Reaction (SUGAR) in Bristol

**When and why did you start your group?**
SUGAR was started in May 2006. As providers we placed a poster in our open access space asking for service users to attend and form a service user group. We felt it was time for services users to have more of a voice in how we deliver our services.

**How many members do you have?**
It varies from week to week. There are about six core members and others who attend or participate in events as and when they can.

**How did you obtain funding?**
SUGAR is not funded by the Community Action Around Alcohol and Drugs project (CAAAD). But we provide tea, coffee and meeting space and have offered to pay travel expenses and childcare costs.

**Where and how regularly do you hold meetings?**
We originally planned the meetings to be once a month. After the first meeting, members decided to meet on a weekly basis. They use the open access lounge on a Wednesday morning.

**What do you hope members get from attending?**
They can affect how services are delivered within the project, and gain a sense of ownership and the opportunity to engage in some meaningful activities.

**How do you keep it going?**
We offer support, encouragement and try to be accommodating to the wishes of the group. The group seems to be self-maintaining as they have autonomy around what they do.

**Continued**

**What have been your highlights so far?**
The newsletters they produce, the fortnightly Saturday night social events and the money they have raised themselves. The energy that is produced brings a tear to my eye sometimes.

**How do you communicate with your members?**
As peer support and progression routes co-ordinator, I attend the weekly meetings and am accessible during the week, some evenings and Saturday afternoon. We use email, text, telephone, messages in pigeonholes and good old fashioned one-to-one.

**Have you any tips for others starting a group?**
Have faith in your group and be mindful of the members' limitations.

## Christina MacDonald reports from the service user group of West Glamorgan Council on Alcohol and Drug Abuse (WGCADA)

**When and why did you start your group?**
The group first met on 19 October 2007 to foster a better relationship between service users and staff.

**How many members do you have?**
We have eight regular members, but our group is open to all WGCADA service users.

**How did you obtain funding?**
WGCADA provides us with the resources we need.

**Where and how regularly do you hold meetings?**
Monthly, at WGCADA.

**What do you hope members get from attending?**
We hope members get a feeling of involvement, and a voice.

**How do you keep it going?**
In a word, enthusiasm.

**What have been your highlights so far?**
A staff photo-board, service users' noticeboard, and non-facilitated meetings.

**How do you communicate with your members?**
Through the service users' noticeboard, published minutes, and word of mouth.

**Have you any tips for others starting a group?**
Get a commitment of support from the management. Keep it practical. Don't take on too much at once. Be prepared to do some work.

## Caroline Marshall reports from SU4em in Wakefield

**When and why did you start your group?**
The Forum was formed in March 2007. Several service users were becoming actively involved within their local services and were interested in developing a group to maintain this involvement the Substance Misuse Commissioning Group (SMCG) allocated a worker from the commissioning team to support and facilitate the Forum.

**How many members do you have?**
The Forum currently has a core of five service user representatives. It operates on a strategic level. The reps are currently developing peer led service user groups within services with the aim of developing one unified Service User Group for all service users to be involved.

**How did you obtain funding?**
The SMCG have allocated a service user budget which is managed in partnership with the Forum.

**Where and how regularly do you hold meetings?**
The Forum is held at Wakefield Treatment Service on a fortnightly basis.

**What do you hope members get from attending?**
Members on a professional level have developed a wide range of transferable skills and attended various specialised and generic training courses. They are able to represent and provide the service users with requested information and be the voice and link in the commissioning processes. On a personal level they support one another, have developed friendships and most of all enjoy their involvement!

**How do you keep it going?**
Forum members are supported and listened to – their involvement is important and decisions are made with their input. Involvement is not seen as tokenistic but a two-way benefit.

**What have been your highlights so far?**
The progression of the Forum in a short space of time. Service user led research, which has been displayed at the Society of Study for Addiction Conference. One of our members was nominated to be an NTA regional representative in the TOP consultation. Design and roll out of SU Magazine for all service users in the Wakefield Integrated Substance Misuse Services (WISMS). Development of peer-led groups in services. Positive participation in commissioning and provider processes. And finally… the friendships gained!

**How do you communicate with your members?**
Email and phone – all reps have access to a mobile phone at each Service.

**Have you any tips for others starting a group?**
Start by contacting local treatment services or your DAT for advice, support and a financial contribution. Try to be patient with any red tape and persevere with your aim and goals. Each person has their own strengths; use these skills to develop the group and always keep smiling… one step at a time will amount to a giant leap!

## Mahmood Waraich reports from User Forum Oldham (UFO)

**When and why did you start your group?**
We started six years ago for the purpose of consultation.

**How many members do you have?**
There are between 15 and 20 people attending the group.

**How did you obtain funding?**
Funding was from the DAAT.

**Where and how regularly do you hold meetings?**
Meetings are held every week. They're on Tuesday for the sub-group and Wednesday for the actual group.

**What do you hope members get from attending?**
More knowledge, confidence, friendship, education, health information, strength, and structuring time.

**How do you keep it going?**
By having a sub-group to organise meetings; by reimbursing bus fares; and by holding sports events.

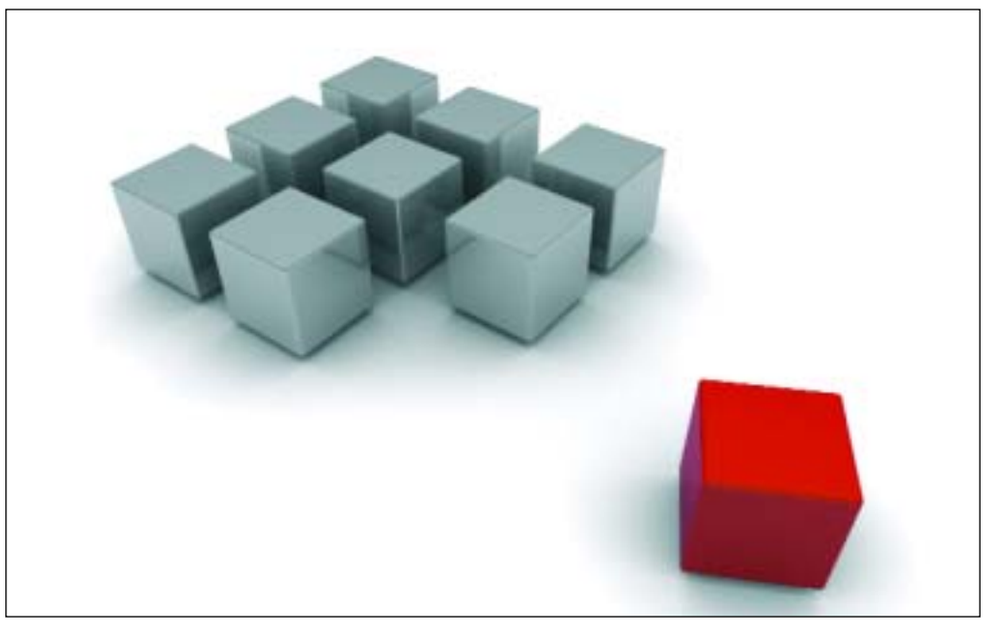
**What have been your highlights so far?**
Different day-trips; consultation days; an accredited confrontation conference in Manchester; winning a regional football competition; doing the 'Race for Life'.

**How do you communicate with your members?**
Through our own magazine, and the users' and carers' shop.

**Have you any tips for others starting a group?**
Organise sub-group, recommend ground rules and keep motivated. Have a structure, keep working together, be organised and plan ahead.

# Rules of engagement

Many people feel that services need to become more culturally sensitive and aware in order to engage people from BME communities in treatment. **David Gilliver** hears some of the arguments.



**It's often stated – but perhaps always worth repeating – that while people from BME communities are over-represented in the drug-related crime statistics they remain under-represented in treatment.** Although there's no one reason for this – and no one solution – it does seem that services should be doing more to both engage and retain people from these communities in treatment.

'A lot of the people that we're treating at the moment have gone into the mainstream community drug teams and basically dropped out because they'd found them to be culturally incompetent or insensitive,' says director of Right Start Foundation International, Shaukat Warraich. 'Often service providers seemed to have little understanding of the social issues around drugs, and were not asking the right questions in the counselling or motivational interviews. The treatment providers are not tackling the fundamental issues that made people start taking drugs in the first place.'

Even before that stage however, there is the issue of accessing services in the first place, or even being aware that they exist. 'It's partly about knowing what services are there, and that's not necessarily just relevant to BME groups,' says professor of addiction research at the University of Birmingham's School of Psychology, Alex Copello. 'It's often difficult to know what's available, but when you add in things like language issues it can be even more difficult.'

In some communities particularly, fears of shame and stigmatisation can play a powerful role. People may be frightened to be seen entering a treatment centre because of repercussions in their community or extended family. 'Stigma is an issue in some groups,' says Copello. 'In some of the Pakistani groups we've been working with, people can be very worried about the impact the knowledge of a drug problem can have on their family or their perception in the community. There are also issues of mistrust – whether things are going to be confidential and so on.'

So what should service providers be doing? 'There are examples of services that are effective at targeting particular communities, so it's a case of trying to learn from the experiences that show it can be done,' says Copello. 'It might involve some kind of outreach, or using community resources where people can go and find out information – for example working with Asian women in a way that might alert them to the fact that there's help available if they're facing a drug problem in the family.

'In the context of the Pakistani and Kashmiri community in Birmingham, for example, what we've found is that the communities are very responsive to working in that way,' he continues. 'You can engage with women who are mothers or partners of young people with drug problems and use brief strategies to support them and make them feel more able to cope. You might start with a family member who's affected, but that might lead the person using the drug to start thinking about treatment. Working in that way might also help to engage people in services so it's not just targeting the users – you can have a much broader approach.'

Another priority is perhaps to get more people from the communities themselves into the sector as drug workers and counsellors. 'A lot of the services don't reflect the communities they're serving, but trying to recruit people from ethnic minority communities is a challenge.' says Shaukat Warraich. 'When we started our ethnic minority women's project, for example, we made sure we were meeting them on their territory and speaking their language – they're helped by women similar to them. As a result, we had around 40 women come into treatment within the first three months. Hundreds of people are telling us they know other people affected by drugs or taking drugs and not accessing treatment.'

'As with every service you can get good and bad experiences and good and bad workers,' says Alex Copello, 'but there is a sense that in order to engage people and keep them engaged in areas with high BME populations you need to reflect that in the staff. Ultimately it's about finding the right person for the job, whether people have got the opportunities for training and how to attract the right people. There needs to be work to ensure that those things are balanced.'

So is there any sense that things are improving? 'It's a complex picture and no one strategy is going to lead to an improvement. But to be fair there has been quite a bit of work done over the last four or five years,' says Copello. 'Things are improving, but there's still a gulf and if you look at treatment services they're still mostly engaging particular groups of people that are using particular drugs. People from BME communities tend not to access treatment services in the kind of numbers you would expect, given the amount of drug problems that we know are in those communities.'

**Drugs conference 2008 – engaging ethnic minorities on the drugs issue takes place in Birmingham on 20 February. For more information visit www.rightstart.org.uk**

University of Kent | Kent Institute of Medicine and Health Sciences (KIMHS)

# Training for Drug & Alcohol Practitioners

## Programmes from 2008/09

Our university accredited, modular programmes incorporate the "Models of Care" framework, DANOS competencies and QuADS benchmarks. Being taught in five-day blocks, they are accessible to students living in or outside Kent, are ideal for those new to or returning to study. All programmes aim at a wide range of professionals in healthcare, counselling, criminal justice, the community and social care etc. who access clients with substance use related problems.

### Certificate in Substance Misuse Management

This access level Certificate provides a broad introduction for practitioners who work with problem substance users, or expect to in the near future. The programme is delivered in Canterbury and across the UK where there are cohorts of 10 or more students. It is a recognised benchmark for those seeking an accredited qualification. The programme also offers beneficial training for all social, health and education professionals whose work includes contact with problem substance users.

**18 month programme from September 2008 or by negotiation** **(Stage 1)**

### Certificate in the Management of Substance Misusing Offenders

This Certificate is an access programme for prison and probation officers, drug and alcohol workers, health and social care professionals working with problem substance users in the criminal justice system. It includes NTA and Home Office strategies, eg. DRRs, CJIP, CARAT and DIP issues, ethics, cultural factors, managing challenging behaviour and working in multi agency, criminal justice settings. Available across the UK for cohorts of 10 or more students.

**18 month programme from September 2008 or by negotiation** **(Stage 1)**

### Diploma in Substance Misuse Management

The Diploma provides a framework for understanding the biological, psychological and social perspectives of substance misuse, within the context of service provision. The programme aims to develop therapeutic understanding and client specific interventions, against the backdrop of current research and thinking in the field.

**2 year programme from October 2008** **(Stage 2)**

### BSc in Substance Misuse Management

The BSc programme provides in-depth study of the psychological, environmental and biological aspects of addictive behaviours, this includes training in ethics, research methods and the implementation of a small research project. You will be encouraged to develop a detailed understanding of client assessment and outcome monitoring, skills required by project workers, managers and commissioners. POST-GRADUATE RESEARCH OPPORTUNITIES are also available in this area of study.

**2 year (top-up of Diploma) or 4 year programme from November 2008** **(Stage 3)**

**For further information and an application form, please contact:**
**Teresa Shiel, Programme Co-ordinator**
**KIMHS, Research and Development Centre, University of Kent, Canterbury, Kent CT2 7PD**
**Telephone: 01227 824330 Email: T.Shiel@kent.ac.uk**
**KIMHS webpage: www.kent.ac.uk/kimhs/courses**

University of Kent

## Dialectical Behaviour Therapy (DBT) for Substance Misusers

**25-26 February 2008**

**Hilton Hotel, 1 William St, GLASGOW G3 8HT**

This two day workshop presents an overview of DBT for substance misusers. Participants will learn how cognitive-behavioural strategies are blended with acceptance and mindfulness approaches to help clients who have serious, chronic mental health problems in addition to substance misuse.

Research summaries published by the National Treatment Agency (NTA, August 2004) indicate that almost 30% of service users in drug treatment, and over 50% of those in alcohol treatment, experience psychiatric co-morbidity, for which DBT is designed.

**More about the evidence base for DBT adapted for substance misusers with BPD …**
Controlled pilot studies in the USA have demonstrated 63% retention in treatment & significantly better maintenance of treatment gains compared to a control condition (over 12+ months)

**For further information please contact Beverley Taylor**
**Tel 01978 350073 Fax 01978 358974**
**Email beverley.taylor@extra-ibs.com**
**Register online at www.dbt.uk.net**

**Co-sponsored by Behavioural Tech LLC, Seattle, WA**

*British Isles DBT Training, Croesnewydd Hall,*
*Wrexham Technology Park, WREXHAM, LL13 7YP*

Tameside & Glossop NHS
Primary Care Trust

## Expressions of Interest – Independence Initiative

Tameside & Glossop PCT, on behalf of the Crime and Disorder Reduction Partnership (CDRP), is seeking Expressions of Interest for suitably experienced providers as part of a tendering process, to provide a recovering substance misusers Independence Initiative to the residents of the Tameside Metropolitan Borough and Glossop.

The planned service will work with individuals, local agencies and the wider community to facilitate the long-term rehabilitation of patients with a history of substance misuse. It will provide a personal programme addressing individual needs, overcoming barriers to progression and assisting reintegration into the community.

The service is anticipated to commence on 1st April 2008 for a 3 year period, with an option to extend for up to 2 additional years.

**Expressions of Interest in tendering must be received by Monday 11th February 2008, and should be sent to tam-pct.Procurement@nhs.net**

**Should you have any queries please contact Nathan Liptrot (Contracting & Performance Directorate) via e-mail: nathan.liptrot@nhs.net**

## Drugs and Homeless Initiative

"Meeting the Needs of the Individual. Making a Difference in the Community"

The Drugs & Homeless Initiative is an award winning charity that seeks to assist people to address problematic drug and alcohol use, with particular regard for those who are socially excluded as a result of poor housing, lack of employable skills or other means.

DHI

### Director of Operations (based in Bath or Swindon negotiable)

Salary scale: NJC pt 50-55 (£40,965-£45,407)

This is a new and exciting opportunity for a dynamic individual to lead and develop upon DHI's operational management structure.

The ideal candidate will possess excellent leadership, negotiation and interpersonal skills. They will have experience of senior management including, overseeing operational development, performance management, monitoring and auditing and quality assurance systems. Ideally you will have an understanding of current practice and trends in substance misuse and housing; to ensure DHI's commitment to operational excellence and development of best practice. A professional qualification in management, health or social care is desirable.

Interviews for this post will be on 6th and 7th March, candidates will need to be available for both days.

### Senior Support Worker (Wiltshire based)

Salary scale: NJC pt 26-29 (£21,412-£23,749)

We are looking to recruit a Senior Support Worker based in Corsham. Community4 is a consortium of four organisations, including DHI, working together to provide housing related support to people living in Wiltshire.

You will have a comprehensive understanding of assessment and support planning systems and the ability to provide case management to workers. The successful candidate will ideally have sound experience of providing effective support to people with differing needs. You will be responsible for the electronic referral and allocation system and will therefore need excellent IT skills.

### Housing Support Workers (Positions in Bath, Swindon and South Gloucester)

Salary scale: NJC pt 22-26 (£18,895-£21,412)

DHI is looking to recruit several positions across its housing services. Applicants should have experience of support working, preferably in the housing field and have an understanding of issues facing vulnerable people and those with substance misuse problems.

**Benefits include 25 days annual leave, a commitment to training, and an optional contributory pension scheme.**
**Application packs and further information can be downloaded from DHI's website at: www.drugsandhomeless.org.uk or by calling 01225 329411.**
**Closing date for all posts: 20th February 2008 at 5pm.**

*DHI is striving to be an equal opportunities employer* *Registered charity no. 1078154*

**Addiction Dependency Solutions** remain on the cutting edge of innovation and good practice in working together to prevent and reduce the harm caused by alcohol and drugs to individuals, their families and the community.

We are pleased to announce we have been awarded by Stafford SCDAAT the Structured Day Programme and Drug Intervention Programme contract across Staffordshire to provide services for substance misusers from April 2008.

As a result, we are looking to recruit enthusiastic and motivated individuals to fill the following posts:

### Service Manager
**Salary: £29,326 pa** **Hours: 35 pw** **Ref: 08/08**

### Team Leader (Structured Day Programme)
**Salary: £23,232 pa** **Hours: 35 pw** **Ref: 08/09**

### Structured Day Programme Workers
**Salary: £20,516 pa** **Hours: 35 pw** **Ref: 08/10**

*Application forms and further details are available from:*
*H R Administrator, 87 Oldham Street, Manchester, M4 1LW*
*Tel: 0161 834 9777*

*Or can be downloaded directly from our website:*
*www.alcoholanddrugservices.org.uk*

**Closing Date for Applications:** **8 February 2008**
**Proposed Interview Dates:** **25-27 February 2008**

Staffordshire County Drug and Alcohol Action Team

ADS Addiction Dependency Solutions

Go public with your ambition

## Children's Services

# Drug & Alcohol Strategy Manager

■ Winchester ■ £39,087 - £46,674 ■ Ref: 14321

Hampshire Children's Services are committed to taking a strategic lead to drive forward an agenda that recognises the needs of young people in relation to substance misuse. Joining us, you'll work as part of a newly created Health, Personal Development & Well-Being Team where you'll focus on the local delivery of the young peoples' element of the new National Drug Strategy to be launched in 2008.

In this key role you'll ensure the development of universal and targeted prevention strategies are developed in line with National Indicators, Public Service and Local Area Agreements. You'll have a particular focus on integration within mainstream provision and some commissioning of new services linking the work of the many departments and agencies, statutory and non statutory, involved in supporting young people who misuse drugs.

With DipSW or equivalent qualification you'll have had substantial experience of working at a strategic level in a multi-agency environment with a focus on young people. You must be able to demonstrate an understanding of drug related issues and legislation. IT literate, you'll be competent across a range of applications and have experience of project management.

For an informal discussion please contact Glynis Wright, County Inspector/Advisor (PDL) on 023 8081 6133.

**Closing date: 8 February 2008.**

**Interview date: 4th March 2008.**

**To apply online or view further details of this or any of our current vacancies please visit www.jobs.hants.gov.uk Alternatively you can contact the Resourcing Centre on 0845 850 0184, or e-mail us at resourcing@hants.gov.uk for further information. Please quote the appropriate reference. Textphone users only can call free on 0808 100 2484.**

**Apply online at www.jobs.hants.gov.uk**

IN PROMOTING EQUAL OPPORTUNITIES, WE WELCOME APPLICATIONS FROM ALL SECTIONS OF THE COMMUNITY.

Hampshire County Council

---

Dorset HealthCare NHS
NHS Foundation Trust

## Addiction Services

### Integrated Manager (RMN or DIPSW), Bournemouth Community Addiction Team (BCAT), Band 8A (🚗)(*)

**£36,112 - £43,335 p.a., depending upon experience**

Dorset HealthCare NHS Foundation Trust and Bournemouth Borough Council Community Care Services have a long-standing commitment to collaborative working and joint service provision in delivering high quality and innovative services to Service Users and Carers in the Bournemouth area. We work closely in partnership with Service User Forums, the Voluntary Sector and Primary Care.

We are seeking to recruit a Manager to lead our well established comprehensive Bournemouth Community Addiction Team (BCAT). This post will be based at Park Lodge, Kings Park Community Hospital in **Boscombe**, and is an exciting opportunity to work with our dynamic multidisciplinary team, which is achieving the targets set by the National Treatment Agency, and to move forward the shared care agenda with primary care. You should be able to demonstrate experience in a leadership and service development role, as well as having a clear understanding of the requirements of the Models of Care document, and a track record of meeting objectives and targets. In addition, you will be able to provide effective line management and case-load supervision to clinical staff.

This jointly funded post will be employed by Dorset HealthCare NHS Foundation Trust and will report to the Addictions Service Manager on a day to day basis.

It is essential that you have **a relevant Professional qualification, RMN or DIPSW**, staff supervision and management experience, together with experience of working across a range of agencies and a clear understanding of the key issues of the National Treatment Agency agenda.

By joining our dynamic and forward thinking team, we can offer a real opportunity to help develop services in Bournemouth. We are also committed to continuous professional development.

☎ **Informal enquiries are welcomed, please contact Tony Deavin, Addictions and Employment Opportunities Manager on (01202) 479856 or David Palmer, Mental Health & Addiction Services Manager on (01202) 705576.**

**Ref: 152-W108**

**Closing date:** 21 February 2008

**Apply online at:** www.jobs.nhs.uk or
☎ (01202) 392750 (24-hour Jobline) for an application pack.

**Website:** www.dorsethealthcare.nhs.uk

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

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

**COMMITTED TO EQUALITY AND DIVERSITY**
**We are a No Smoking organisation.**

MINDFUL EMPLOYER work life

---

# www.drinkanddrugs.net

---

**STILL NO.1 FOR RECRUITMENT AND CONSULTANCY**

**020 8987 6061**

**SUBSTANCE MISUSE PERSONNEL**

**PERMANENT - TEMPORARY - CONSULTANCY**

Supplying experienced, trained staff:

Commissioning ❖ Service Reviews ❖ DIP Management ❖ DAT Co-ordination ❖ Needs Assessments ❖ Project Management ❖ Group & 1-1 drug workers ❖ Prison & Community drug workers ❖ Nurses (detox, therapeutic, managers) ❖ *plus many more roles..... call today*

**NOW REGISTERING AND SUPPLYING NURSES**

Register online www.SamRecruitment.org.uk

---

**BBT are specialists in Social Care recruitment**

With 25 offices across the UK, we are always ideally located to find the right role for you.

We currently have fantastic opportunities Nationwide for:

- **Drug & Alcohol Workers**
- **Substance Misuse Nurses**

**Excellent rates of pay • Free CRB check**

To apply, call **Kate Heeligan** on **0161 831 5225** or email **kheeligan@bbt.co.uk**

bbt beresford blake thomas