DDN
Drink and Drugs News
30 July 2007
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Prisons and Beyond 2007

Ramada Jarvis Hotel, Leicester
11-12 October, 2007

Prisons and Beyond 2007 focuses on drug treatment services in custody and timely effective continuity of care after release, and is targeted at front line staff and managers in prisons, probation, criminal justice integrated teams and the wider criminal justice field.

This is the second year the conference has been run and builds on the success of 'Prisons and Beyond, 2006'.

The aims of the event are:

To update front line workers and managers on the latest developments in the substance misuse field and within the criminal justice system.

To give feedback from last year's conference taking into account how policy had moved on, what has been achieved and what still needs doing better.

To provide practical training and learning opportunities on issues of relevance to good practice in the treatment and management of substance misusing offenders.

To provide an opportunity for practitioners and managers to contribute to the development of substance misuse-related policy and practice in prisons and beyond.

To provide a networking opportunity for front line workers and managers from prisons and the wider criminal justice field.

The conference will incorporate plenary presentations, practical workshops and seminars, and interactive debates.

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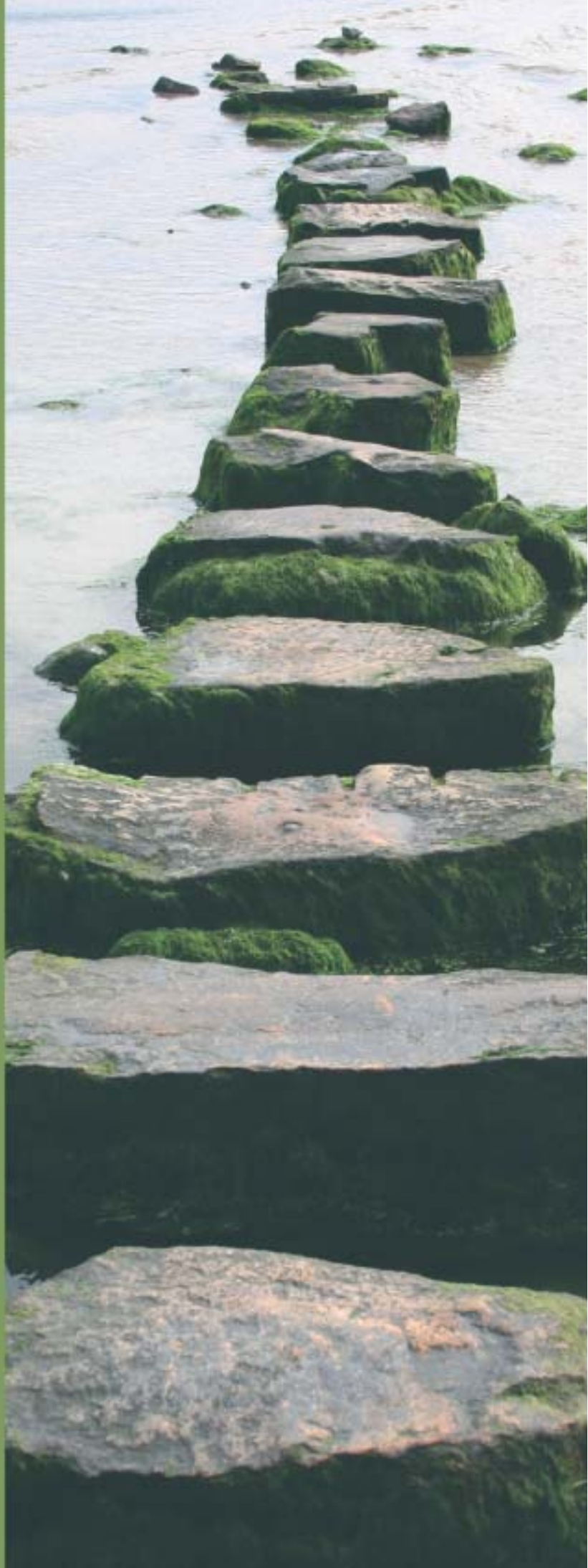
NOMS fdap Adfam EATA feel good

Organised by NOMS Prison Drug Strategy Team, in association with the Home Office, Federation of Drug & Alcohol Professionals (FDAP), ADFAM (Families, Drugs and Alcohol) and the European Association for the Treatment of Addiction (EATA).



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Drink and Drugs News

30 July 2007

Editor's letter

'We have moved on from a polarised debate and single approaches to a balanced strategy focused on outcomes, based on evidence and delivered through partnership', says home Secretary Jacqui Smith, in her foreword to the new drugs consultation paper, launched this week.

Have we? That's surely where we need to be, but there are many signs we're not there yet. The need for evidence is constantly emphasised, underlined by the work of the UKDPC and others. Polarisation is rife, sometimes surfacing in robust debate, but all too often lurking in local treatment services with the risk of excluding those who don't conform to an expected mould. Partnerships, when they work well can work very well (as in the screening initiative on page 14), but there are too many examples of agencies in the same area whose idea of joined-up working means cutting out the client. Things don't often move as straightforwardly as they should within one drug service, let alone between different agencies, as Dr Chris Ford's post-it demonstrates (page 13).

The home secretary also calls for 'greater integration across employment, housing and resettlement', a need emphasised by our cover story. We know only too well what happens when people come out of treatment and back into a hostel of drug users. The numbers of drug users in treatment might well have doubled, but we have to make sure service users are having the best chance of permanent integration.

Drugs minister Vernon Coaker urges DDN readers to participate fully in the consultation (page 8) and I hope you will seize this opportunity with both hands. We're taking a break from publication in August, so I would like to thank you wholeheartedly for all your support, contributions, and advertising – which enables us to keep DDN independent and free of charge to everyone in the field. We'll be back on 10 September, raring to go with your thoughts on new drug strategy. Keep writing in over the summer!

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In this issue

Launch of drugs strategy consultation: views from the field

'The fact that there is still so little money going into prevention means that many of the grass-roots projects that Mentor works with, and which do such important work within their local communities, will struggle to survive financially. The best prevention initiatives out there are those that influence children's attitudes, their skills and their behaviour so that when they are older they can avoid the damage that the misuse of drugs can cause.'
Mentor UK

'We caution that whilst there are many questions to ask, there are relatively few answers backed up by sufficient evidence. Despite coming to the end of a ten-year drug strategy, we don't know enough about what works or why, which leaves policy makers having to operate partially blind. We need to invest now in a better, independent evaluation of policy and practice so that we can look forward to more effective policies based on solid evidence.'
UK Drug Policy Commission

'We hope the government's strategy will ensure that children receive fact-based education from professionally trained teachers. But drug education should not be about trying to scare pupils, as those tactics simply serve to reduce the credibility of the message.'
Drug Education Forum

'The government appears committed to a drug policy that criminalises the poorest and most disadvantaged in our community, grants a multi-billion pound monopoly to organised crime and dramatically increases the harms suffered by our communities.'
Transform

What do you think should be in the strategy? DDN will be including comments and inviting debate during the consultation period. Send your comments to the editor, claire@cjwellings.com

Home Office minister Vernon Coaker introduces the consultation and invites your input: see page 8

Drugs strategy: government pledges focus on education

The government's next drug strategy will focus on educating the young and protecting the vulnerable, home secretary Jacqui Smith said as she announced what's billed as the largest ever public consultation on the subject. Responses to *Drugs: our community, your say* will feed into the new strategy, to begin next April. The Advisory Council on the Misuse of Drugs (ACMD) would also begin a six-month review of cannabis classification in the light of concern over the availability of stronger strains of the drug, she said.

Ministers will focus on education and treatment as well as enforcement against drug dealers in drawing up the strategy, she said. Key areas will include ensuring better continuity of care after treatment, strengthening support for families of drug misusers and more consultation with local communities on addressing drug-related crime. More than £5m would be made available for the 'Frank' drug awareness campaign, she said.

'I want to sharpen our focus, target the most vulnerable and educate the young,' said the home secretary. 'We need to ensure that treatment is effective and followed through and I know that many users need extra help to get their lives together and establish themselves within society.'

While drugs agencies welcomed the extra cash for drugs awareness, they stressed the need for a focus on prevention rather than cure, rather than relying on criminal justice interventions and treatment (see column, left). A spokesperson for Transform, meanwhile, said that the announcement of a review of cannabis classification was 'all about political posturing and has nothing to do with science. In reality the potency issue and mental health issues associated with cannabis are well understood and have not change significantly since they were last reviewed by the ACMD in 2005'.

DrugScope said it was 'surprised' by the announcement. 'We believe the decision to keep the drug at Class C, as recommended by the ACMD, was right then and it is difficult to see why it need be changed now,' said chief executive Martin Barnes. 'The government promised a review of the system of drugs classification in January 2006 and then changed its mind. That review now needs to happen.'

To take part in the consultation visit www.drugs.gov.co.uk. Deadline for responses is 19 October 2007.

A&E departments ignore screening opportunities

Only two per cent of accident and emergency departments are formally assessing hazardous drinking by patients, according to a survey by Action on Addiction.

The charity found that just four out of 191 hospitals questioned were screening as a part of routine. Just 24 of the A&E departments were asking patients general questions about their alcohol consumption.

Action on Addiction compared their results to previous research that found that up to 40 per cent of people attending A&E would benefit from help with their hazardous drinking. Only one in ten departments in the northern region were questioning patients about their alcohol consumption, despite the 2004 ANARP survey identifying the region as having the largest proportion of harmful drinkers.

Health psychologist Bob Patton of the National Addiction Centre, who conducted the survey, said A&E departments' commitment to dealing with alcohol problems was encouraging, but suggested going further with a proactive approach: 'We know that just asking patients a few simple questions about their drinking can help more people be made aware of their alcohol consumption and hopefully reduce this,' he said.

Action on Addiction recommended A&E departments consider easy-to-implement methods such as a single alcohol screening question or the Paddington Alcohol Test, which make patients consider how much they drink.

'NHS staff in A&E departments are under immense pressure due to lack of time and resources,' said joint chief executive Lesley King-Lewis. 'However by taking the time to formally test patients in this way we may actually prevent re-attendance.'

See feature on page 14

Findings launches 'what works' web resource

Research on what works in substance misuse treatment is now freely accessible as a website resource.

Internationally respected *Drug and Alcohol Findings* magazine has transferred its content, previously only available as a subscription publication, to the site, http://findings.org.uk

Back issues are being added to the downloadable archive, as well as the popular 'nuggets' series, which shows research findings in context and with implications for practice.

Content of the magazine is used regularly by many practitioners in the UK and abroad to evaluate what works. Plymouth DAAT manager Gary Wallace says they have found it 'an essential tool [that] helped us sift relevant research and identify evidence from around the world that has significantly informed our change processes'. The *Findings* partners – editor Mike Ashton, Alcohol Concern, DrugScope and the National Addiction Centre – hope the transition to website format will give easy access to information on proven methods.

Visitors can sign up for email updates, and there are plans for an 'effectiveness bank' to be set up, offering research papers and abstracts. The project has had initial funding from the J. Paul Getty Jr. Charitable Trust.

Motivate substance misusers says NICE

Combining social and psychological techniques to motivate substance misusers to adopt a drug-free lifestyle with advice on detoxification will substantially improve recovery rates, according to new guidelines issued by the National Institute for Health and Clinical Excellence (NICE) and the National Collaborating Centre for Mental Health.

The guidelines focus on positive encouragement for change and combine advice to families and carers on supporting someone trying to become free of drugs with opportunities for substance misusers to make their own choices in adopting a drug-free lifestyle.

Among the recommendations are that two motivational sessions of up to 45 minutes should be offered to provide non-judgemental feedback whenever concerns about drug misuse are identified, and that healthcare staff should routinely provide information about self-help groups for those who misuse drugs.

Detoxification should be an available option for those who are opioid dependant and have made a choice to stop taking drugs, say the guidelines, but they should always be given detailed information about the risks and benefits of the treatment first.

They also recommend the introduction of contingency management programmes by drug services, with incentives like shopping vouchers 'contingent on each drug-negative test', or being able to take methadone doses at home rather than under supervision. These have predictably been seized on by sections of the press.

'Some of the treatment options we are recommending in this guideline, such as offering incentives to drug users to encourage them to stop using drugs will be seen as controversial,' said consulting clinical psychologist and joint director of the National Collaborating Centre for Mental Health, Steve Pilling. 'However, we've studied the results from trials involving over 5,000 participants from all over the world which show clearly that substance misusers are much more likely to succeed in treatment if they are given encouragement for the effort they are making in coming off their drug habit.'

The guidelines are available at www.nice.org.uk/CG51 and www.nice.org/CG52

MPs launch inquiry into 'hidden' misuse

An inquiry into the scale of the misuse of 'over the counter' drugs, along with the social and psychological harm caused, has been launched by the All Party Parliamentary Group on Drug Misuse (APPGDM).

The cross-party group particularly wants to hear from members of the public who have been affected by misuse of prescription-only drugs, as well as those in the treatment and healthcare sectors, to build an in-depth study into this often unrecognised area of drug misuse. The inquiry, facilitated by DrugScope, will look particularly at the role of the internet in supplying over the counter and prescription-only drugs, who should take responsibility for tackling their misuse, and whether enough help is available for those experiencing problems with misuse of these drugs.

The inquiry will build a picture of the exact scale of the problem, patterns and trends, and the physical, economic, social and psychological harm caused, said group chair Dr Brian Iddon MP. 'We are increasingly concerned about the number of users buying medicines online, where they face the very real risk of buying counterfeit products that may be dangerous,' he said.

The deadline for submission of written evidence is 12 October, and the findings will be published in a report next year. For more information visit www.drugscope.org.uk

Brown hints at 24-hour licensing rethink

A review of 24-hour alcohol licensing has been ordered by Gordon Brown following a study at London's St Thomas's Hospital that found an increase in the number of overnight A&E visits since the laws were relaxed. The Home Office will consult police and local authorities in problem areas, but the prime minister stressed there was no need to 'rush to judgement'.

Meanwhile a call for age-based drinking guidelines to go alongside those based on gender has been made by professor of Gerontology at Brunel University, Mary Gilhooly. While older people are less able to metabolise alcohol, the generation now hitting their sixties have traditionally been bigger drinkers than previous generations and are likely to remain so, she says.

'If you take a cohort that has always drunk a lot, like the baby boomers, they will probably drink a lot over the sensible limit when they are older,' she said, adding that many elderly people should be advised not to drink at all.

Scots recommend methadone audit

A national system to monitor the prescription of methadone across Scotland has been recommended by the Scottish Executive. It calls for a national methadone audit system, incorporating local data collection, as a priority.

The review was ordered by the Scottish Executive following the death of a two-year-old child in East Lothian after drinking methadone prescribed to his parents. Around 21,000 people in Scotland are now receiving methadone to treat their heroin addiction.

Methadone helped stabilise often chaotic lives, said community safety minister Fergus Ewing, but there were 'areas of concern' about its use, that required 'improving service delivery, improving consistency of provision and, above all, improving integration of methadone treatment with the extra support needed to achieve the ultimate goal of recovery from addiction'.

Reducing harm and promoting recovery: a report on methadone treatment for substance misuse in Scotland: www.scotland. gov.uk/Publications

News in brief

Childhood challenges

Prescriptions of anti-depressants to under-16s have risen by more than a third in the last decade, according to figures from the Department for Children, Schools and Families. Last year 109,535 prescriptions were made, compared to 78,353 ten years ago. Children's charities have warned of a generation becoming addicted to prescription drugs, prescribed to tackle anxiety and depression brought on by family breakdown and exam stress. Meanwhile, a survey by the Schools Health Education Unit reports that up to 10 per cent of primary school children and 19 per cent of 12 and 13-year-olds had had an alcoholic drink in the previous week, rising to 40 per cent of 14 and 15-year-olds. Underage girls were more likely to be drinkers than boys.

Ratify your results

Drug action teams and equivalent partnerships, along with primary care trusts and strategic health authorities, have until midnight on 6 August to ratify their provisional and anonymised results for the 2006/07 substance misuse review. They should also submit details of any extenuating circumstances which may have affected either their performance or their ability to submit data. More information at www.healthcarecommision.org.uk Protocols and proformas for ratifying data and extenuating circumstances available on www.nta.nhs.uk

Infectious behaviour

Alcohol is being blamed for an increase in the number of sexually transmitted infections among young people. The Health Protection Agency's fourth annual report shows that new diagnoses of genital herpes increased by 9 per cent between 2005 and 06, with diagnoses of chlamydia up 4 per cent and genital warts by 3 per cent. The HPA said that the increase was also partly a result of more people coming forward for testing, as awareness of these infections increased. Meanwhile, a study by the British Beer & Pub Association (BBPA) claims that more than one million people a month are being turned away from pubs for being under 18 or failing to have the right proof of age. Police forces and trading standards officers are currently mounting more than 3,000 underage 'test purchase' operations in pubs and off-licences, says the association.

Home and **Dry**

While common sense would dictate that there's little point in spending money on treatment programmes only to then house people in hostels rife with drug use, that's exactly what often happens. **David Gilliver** looks at the need for better co-operation between the housing and treatment sectors.

Homelessness and drug use are inextricably linked. The agencies that deal with them, however, are not. Three quarters of homeless people have a history of problematic substance misuse, rising to more than four fifths of rough sleepers, and drug users are seven times more likely to be homeless than the general population. But, historically, the drugs and housing sectors have tended to work in isolation.

A new report and toolkit from Homeless Link looks at how housing and treatment services can work together to make sure treatment is as effective as possible and reduce the risk of homelessness among drug users engaging in that treatment.

Tackling one without the other risks failure, wasted resources and wasted effort, says *Clean Break*. Putting someone through an expensive treatment regime only for them to end up in a hostel next to people actively using is clearly not a recipe for success. Nor is someone completing treatment only to find themselves without access to decent housing, training, job opportunities or hope.

'We tend to talk about people as drug users engaging in treatment or we talk about them as homeless, when often we'll be talking about the same individual,' says head of policy analysis at Homeless Link, Alice Evans. 'What the housing and treatment sectors need to do is make sure the services we're providing work together, so it's that oft-used word, partnership. But it takes a lot of time and resources to get those partnerships set up and properly supported.'

People with serious drug misuse problems tend to lead chaotic lives, and homeless people entering treatment when no suitable accommodation is available clearly have a far lower chance of successfully completing treatment. 'Decent housing is critical throughout all stages of treatment, not just the latter stages,' says Evans. 'It's critical that people have somewhere stable when they engage in their treatment.'

The study found that when treatment and housing services do work together effectively, the benefits include lower rates of both repeat homelessness and anti-social behaviour, and that people are far more likely to stay in treatment programmes. It also revealed an urgent need for a range of housing options to be available for those at different stages – whether that means short stay accommodation to bridge gaps in service availability or help assessment, 24-hour supported accommodation for chaotic drug users, or general needs housing with floating support for those who have stabilised or stopped their use.

The report wants to see jointly commissioned research from relevant government departments on the impact of different housing models on treatment, and for the needs of homeless drug users to be assessed in regional housing and homelessness strategies.

'We need a national evaluation of the impact of these different forms of housing on treatment outcomes,' says Alice Evans. 'Is it a settled home that someone needs, is it RSL [registered social landlord] or local authority

'When treatment and housing services do work together effectively, the benefits include lower rates of both repeat homelessness and anti-social behaviour, and that people are far more likely to stay in treatment programmes.'

accommodation, or would they do just as well in the private rented sector if they had the right support? Understanding all of that, and what would work best, is very important for how you plan the services you're providing. At the moment most of it's just based on what you can access – what's available locally and what you're going to be able to get people into.'

This lack of appropriate housing is leading to people becoming lost in the system and far higher rates of relapse than are necessary, says the study, along with inappropriate referrals to existing supported housing. Most worrying of all, however, is that it often means those desperately trying to come off drugs living in very close proximity to people actively using, or chaotic drug users ending up sleeping rough.

'Because so many homeless people are drug users they'll either stay away from hostels with a zero tolerance drugs policy, or else lie,' says Grant Everitt, who runs Shelter's street homeless project. 'Drug use is rife in a lot of homeless hostels, despite the fact that many will have a 'no drugs' policy. They either kind of ignore the drug use or people tell lies to get in, so it's going on illicitly. Obviously, one of the main ways you remain clear of drugs is to stay away from them.'

Shelter produced its own report, Safe as houses, just over a year ago, which found that demand for housing far exceeded supply among single homeless people with support needs. Even where services were provided, however, many projects excluded drug users altogether and some would only consider those already in structured treatment. Almost all had admission criteria banning drugs or drug use on the premises, punishable by eviction. While on the face of it this might seem like a common sense approach – housing providers aiming to provide a safe and supportive environment and keep within the law – Shelter found in reality it simply meant the drug users not openly discussing their problems with the service providers. They further found, unsurprisingly, that while drug use can be a trigger factor for homelessness, homelessness was a far bigger trigger factor for increased drug use, with people either starting to use or increasing their use to cope with the situation. So those trapped in this 'revolving door' situation then find their drug use becoming more and more of an obstacle to accessing services.

One of the most sensible ways of tackling this, says Safe as Houses is through an increase in the number of projects for ongoing drug users who perhaps aren't ready to stop using yet, as well as drug-free housing (*DDN*, 8 May 2006, page 10). 'The reality is that if you have a homeless hostel you are by default working with drug users, whether you say you are or not,' says Grant Everitt. 'So we need to get through to organisations that if they find they have a drug user they don't have to evict them. Give them a warning – if they're just back on the streets, that's bad all round. The biggest gap in provision tends to be at the more chaotic end, people who haven't controlled their drug use.'

Shelter looked at projects like New Steine Mews in Brighton, a hostel for ex-rough sleepers split into separate areas for those in structured treatment, for those beginning to address their drug use, and for those not ready to do so yet. 'Projects like this have a very good record in attracting people who would otherwise be homeless, and of getting people into treatment because they conclude themselves that it's a good idea,' says Grant Everitt. 'If you want to provide a comprehensive solution, and projects that are genuinely drug free, then you need somewhere for the drug users to go.'

A significant barrier to this approach however, remains the hangover from the Wintercomfort case, in which charity director Ruth Wyner and centre manager John Brock were given lengthy prison sentences for supposedly allowing heroin use on the premises in a Cambridgeshire day centre. 'That put a lot of homeless organisations off working with drug users, and it still influences today's policy,' says Grant Everitt. 'It's why a lot say they have a zero tolerance approach, because they think otherwise the police will come and shut them down, which is not actually the case.

'The police have in fact been very welcoming of the approach we recommend,' he continues, 'because if you're a drug user in accommodation, not only have you got a better chance of reducing your drug use but you're less of a threat to other people – you're not likely to leave your needles in someone's garden and so forth. Housing drug users – even ones who aren't ready to give up – is safer for everyone. It's safer for the residents and safer for staff, because acknowledging it means you can have policies and training in place to protect your workers. And it's safer for the wider community, because the drug use is controlled in a property rather than taking place on the streets.'

So is a lack of joined-up working leading to precious resources being wasted? 'Of the areas we looked at, in some places the two sectors were working very well together and in some they weren't,' says Alice Evans. 'They may have been working well at a strategic level but it hadn't filtered down to the practical level. There's definitely a lot more integrated work that could be happening, and a better understanding of the pressures on each of the sectors – understanding where the other person's coming from. I do think it's improving though, particularly on a national level, but there's more for people to understand.'

'The area that's gravely lacking joined up working is that those on the drug treatment side tend to see outcomes just in terms of treatment,' says Grant Everitt. 'You're going to have more chance of success if the person is stably housed, so it needs far more close and co-ordinated working with the housing sector. We haven't really got there with that yet.'

Homeless Link's Clean Break toolkit is online at *www.toolkits.homeless.org.uk/cleanbreak*

Safe as Houses* can be obtained through Shelter's website. For more information visit *http://england.shelter.org.uk/policy/policy-825.cfm/plitem/225/

Home Office minister **Vernon Coaker** introduces the Drug Strategy Consultation, launched this week, and calls on DDN readers to play a key part in honest and open debate.

'Early intervention is the key to tackling drug use'

The wellbeing of our young people is of fundamental importance to the government. We all want to ensure every child, regardless of background, can make the most of the opportunities that they are presented with. A key part of that approach is ensuring that young people avoid the harm caused by illegal drugs.

We have made tackling drugs a major priority. Since 2001 we have invested £9bn in cutting the harm caused by drugs through a strategy of enforcement, education, early intervention and treatment.

I am proud of what we have achieved in recent years. And by we, I mean the multitude of professionals and volunteers across England and Wales who are involved in drug programmes and diversionary projects, as well as the government and police.

An excellent example of this round approach is Positive Futures, which has the backing of £6m from the Home Office, and supports 121 projects around England and Wales that provide sports activities and vocational training. This helps to boost the self-esteem of young people, making them less likely to indulge in illegal drugs.

Many of us can point to the fall in the harm caused by drugs, as measured by the Drug Harm Index. Drug use across all ages has fallen by 17 per cent since 1998 while young people's drug use has fallen by nearly a quarter over the same period.

Enforcement – by which I mean putting dealers behind bars and disrupting drug supplies – is a vital part of our strategy. We want to harness the full force of all our law enforcement agencies, from neighbourhood police to the Serious Organised Crime Agency, to crack down on drug dealers so that they stop bringing illegal drugs into communities. We have been successfully thwarting drug dealers: last year, for example, we seized almost 75 tonnes of Class A drugs, worth £3bn.

Nonetheless I have never been complacent about the formidable challenge posed by illegal drugs. We are dealing with one of the most complex social problems faced by western societies.

It is for that reason that we want to have a wide open debate about how best to tackle drug use. I want to hear from professionals at the frontline about how we can further reduce the harm caused by drugs and help users re-establish themselves in the community.

This focus is behind our decision to consider cannabis classification, as announced by the prime minister recently. The independent Advisory Council on the Misuse of Drugs will look at the scientific evidence for reclassification of the Class C drug to see whether we need to take into account the fact that there are stronger strains of the drug, often called skunk, on the market.

I await the Advisory Council's recommendation with interest. Any decision we take will be consistent with our stated aim of reducing the harm caused by illegal drugs.

Drug education has developed a great deal in recent years. Our approach has been to empower young people with the knowledge of the devastating effects of illegal drugs. Rather than simply order young people that they should not use illegal substances, this means telling young people about the increased risk of heart attacks associated with cocaine and the mental health effects of cannabis.

This has been the approach of the 'Frank' campaign, which has benefited from over £23m of government funds in the last four years alone, to complement drug education in secondary schools.

The 'Frank' campaign plays a significant part of our support for young people. Drug use is falling among young people. The most recent schools survey, published by the Information Centre in March this year, showed that compared to the previous year fewer pupils aged between 11 and 15 had taken drugs in the month before the survey, fewer pupils had taken drugs in the previous year overall and that the number of pupils who said they had taken drugs once a month had fallen as well.

In addition, more than half of young people now agree with the statement that cannabis is 'very likely' to damage health – an increase of over 10 per cent on the previous year.

As drugs minister I find this heartening, but I know there is much more to do. Fewer than five per cent of pupils took Class A drugs according to the schools survey, and this is a figure that has remained stable in the last seven years. But I want to drive it down even further.

We are keen to have a wide-ranging, honest and open debate about how best to tackle drugs. I hope readers of *Drink and Drugs News* magazine will play a constructive role in that process.

To view and respond to the drug strategy consultation document, 'Drugs: Our Community, Your Say', go to http://drugs.homeoffice.gov.uk/

'In the last issue of DDN, workforce development seemed rather gloomy. I personally don't share this view... at Blenheim CDP we take workforce development seriously. A commitment to staff development is written into the organisation's core principles and the NTA workforce targets form part of the organisation's strategic business plan.'

Developing workforce

In the last issue of *DDN*, workforce development seemed a rather gloomy issue (*DDN*, 16 July, page 8). I personally don't share this view, so would like to share some examples of how Blenheim CDP is taking this agenda forward.

At Blenheim CDP we take workforce development seriously. A commitment to staff development is written into the organisation's core principles and the NTA workforce targets form part of the organisation's strategic business plan.

On a practical level, Blenheim CDP and Quay Assessment have come together to design and deliver 'SMASH' which stands for Substance Misuse Award in Social Health. The qualification gained is the NVQ Level 3 course in Health and Social Care; however the course is tailor-made for workers in the substance misuse field and directly supports Blenheim CDP and other organisations to meet the NTA workforce targets.

During 2007-8 more than 100 staff from London based substance misuse organisations will complete the qualification. The course offers a unique mix of training in the core DANOS (Drug & Alcohol National Occupational Standards) units as well as assessment of learning and practice that will ultimately lead to the award of the NVQ Level 3.

Additionally, all Blenheim CDP staff will by the end of 2007 be members of the FDAP professional certification scheme, which is recognised as meeting the NTA target of working towards an NVQ Level 3 or equivalent. All Blenheim CDP workers will be expected to meet the standard for registration and to work towards the required accreditation. Managers within the organisation are supported to begin a Level 4 or higher management qualification.

Blenheim CDP is renowned for the extent and quality of its work to involve volunteers in all aspects of service provision. Annually we recruit, train and support more than 40 volunteers. Volunteers are provided with a detailed programme of induction training, supervision and support in their work, and the opportunity of gaining accreditation of their knowledge and skill through our unique LOCN accredited course, A Pathway to Drugs Work. By combining structured learning with a 'hands-on' experience, volunteers develop all the relevant skills, knowledge and experience necessary to pursue a career in the drugs field.

All staff at Blenheim CDP are trained in the use of ITEP (International Treatment Effectiveness Project). The training relates to node-link mapping (referred to as mapping), and a brief intervention aimed at changing thinking patterns. Mapping provides a visual communication tool for clarifying information shared between client and key-worker. Its regular use during key-working sessions provides a model for systematic and 'cause-effect' thinking and problem-solving, which clients begin to adopt. Other initiatives include a core training programme and a range of external training for other organisations.

Future planned initiatives include the development of a range of accredited continual professional development (CPD) awards with people completing clusters of units relevant to their role to ensure continuous professional development and assessment of competence.

This work is supported by a dedicated learning and development team who increasingly work to support managers to identify ongoing training needs of individuals and teams.

John Jolly, CEO, Blenheim CDP

Distorting the truth

Suggestions that the proposals in the *Breakthrough Britain* report are intended to close down needle exchanges and end methadone describing, are exaggerated if not deliberately distorted (*DDN*, 16 July, page 4). What is clear is that all services will be subject to independent clinical evaluation and those found to be substandard will be closed.

It is not difficult to understand how a disturbed mind, or the mind of someone who lacks comprehension abilities, could distort, or misinterpret proposals to bring about desperately needed improvements to the current poorly managed methods of methadone dispensing. But it is baffling how balanced, well-read people could have come to such a conclusion.

The *Breakthrough Britain* report is a skilfully balanced mix of empirical evidence from around the world, together with an objective review of the outcome of differing treatment modalities provided by NTORS – and last but by no means least, the anecdotal evidence of DAT teams and users with their vital, but frequently disregarded, first-hand knowledge and experience of the shortcomings of the present strategy.

It is this carefully researched and unprecedented collection of all of the foregoing evidence in one document, which clearly shows that an eclectic and balanced mix of valid harm reduction methods and abstinence focused treatment are capable of providing effective and satisfactory outcomes. Far from making a clean break from harm reduction programmes, the reference to Kaleidoscope in the report makes it clear that Iain Duncan Smith is ready to embrace valid programmes which do not keep users locked into addiction – unlike the proposed extended prescribing of heroin, which has as much to do with harm reduction as encouraging someone suffering from emphysema, to continue smoking.

It is also puzzling and indeed seemingly self contradictory, to note that the report has been met with undisguised hostility and concerted attempts to discredit it by various members of The Alliance, who among other professed objectives, are intent on improving the welfare of users. Less than two months ago, one member publicly called on the current administration to get addicts off of drugs – but presented with proposals that aspire to do just that, he accuses the Conservatives of 'failing to grasp the nettle'. How strange!

Peter O'Loughlin, Eden Lodge Practice.

Abstinence as starting point

I am finding myself reading *DDN* in a complete outrage today – it just strikes me that we have got things drastically wrong. I volunteer with a number of drugs projects, but I feel Release and the editor have missed the point.

During my reading around the subject of addiction I came across some writing by Leah Betts' parents, which I happen to empathise with. I struggle with harm reduction; I want to see people recover to live healthy and productive lives, not be encouraged to stay on gear safely (if staying on heroin can ever be made to be safe).

I do not want users to get injuries through injecting with dirty needles (does anyone?), but is a needle exchange really a long-term solution to the client's problem? Are users going to delay their shot for ten minutes while they get to a safe location? My experience tells me they are focused on scoring; everything else is unimportant.

The crux of my argument is this: the best form of harm reduction is abstinence. If someone is abstinent then we have to reduce the harm on their body to zero. Perhaps using this as a starting point would enable projects to work with other client issues, *eg* prostitution, family care and parental skills, with an increasing sense of perspective and focus. Harm reduction merely plasters over the scars of a user, whereas long-term abstinence forms the basis of a holistic solution.

What prevents the abstinence taking off? I go back to the point made by Leah Betts' parents. The abstinence model requires abstinent practitioners (let's face it, practitioners would be a bunch of hypocrites if they weren't). Imagine the scene, providing alcohol advice to a client all day towards the goal of abstinence, then the practitioner goes to the pub for a few scoops after work and on the way to the kebab house bumps into a client struggling to stay sober. I don't think the client would be stopping to think about the situation being normalised. The abstinence model requires sacrifice – are you reader, practitioner, prepared to make that sacrifice to help your clients?

We had fantastic news recently that Gordon Brown has pulled the plug on this super casino in my home city of Manchester. He seems to think that not having the super casino is the best way to prevent the social problem of problematic gambling. I was delighted to hear this – it made my day. Perhaps the new government line is going to be truly revolutionary!

Tim Wightman, Huddersfield

Widening the safety net

Substance misuse manager **Caroline Cockwell** explains how her team at Bristol Prison is using naltrexone at a far earlier stage in treatment to give prisoners a better chance of avoiding relapse.

It has been estimated that there are around 40,000 people who misuse substances in prison in England and Wales at any one time – almost half of the total prison population. A UK survey also revealed that 21 per cent had used illicit substances during their sentence. Needless to say this presents major challenges for staff working in this environment – none more so than for our substance misuse team at Bristol Prison.

HMP Bristol is a busy category B prison, which takes prisoners from all local courts and holds in the region of 600 male prisoners. These range from remand to sentenced prisoners, as well as a small number of young offenders. Our team will offer a range of treatments for anyone declaring a drug or alcohol problem as they arrive at HMP Bristol, which usually means around 35 new problematic opiate users per week. These treatment options range from support and advice via the Counselling, Assessment, Referral, Advice and Throughcare services (CARATs) to a variety of pharmacological interventions for detoxification, maintenance and relapse treatment and prevention.

A recent innovation in the prison is the formation of the relapse prevention and treatment clinic, which not only provides the option of treatment with the opiate blocker naltrexone, but also encourages prisoners to link in with the CARATs team who will provide appropriate psychosocial support. Together with Carole Preston, another member of the nursing team, I have successfully completed the nurse prescriber course, which has enabled the whole of the relapse, treatment and prevention service to be nurse-led. We are able to prescribe naltrexone as well as other symptomatic and non-opiate detoxification treatments such as lofexidine.

Naltrexone is increasingly being offered throughout the prison system to prisoners who are about to be released back into the community, as a way of helping to reduce relapse and the risk of drug overdose at this extremely vulnerable time. We decided to offer clients in Bristol Prison the opportunity of beginning naltrexone treatment at a far earlier stage of their sentence providing they meet the following criteria:

- They are serving a sentence of between one and 12 months.
- They can demonstrate motivation, by engaging with CARATs for example.
- They are in good health and opiate free.
- They have a prescriber on release.

The rationale for this innovative approach is that the Integrated Drug Treatment System (IDTS) recommends that a variety of treatment options – not solely methadone maintenance – should be made available. On a practical level, prison presents a window of opportunity for many prisoners to make significant changes in their drug-taking careers. Many are able to cease or reduce their consumption of drugs while they are inside but the gap between detoxification and release leaves them vulnerable to relapse.

In a community setting, naltrexone would be offered immediately following the withdrawal period, and so it is logical to offer a similar service in prisons.

Naltrexone provides prisoners with a 'safety net', which helps them to resist pressures and temptations as well as providing an opportunity to demonstrate to family and the criminal justice system their commitment to remaining opiate-free.

We find that starting the client on naltrexone early gives them the opportunity to discuss any issues or concerns about their medication, which will enable them to feel confident about their treatment and so improve their compliance.

Also, because Bristol is a local prison, clients are often transferred to other establishments soon after sentence – an unsettling and stressful event that can trigger a relapse. In this situation, naltrexone can provide the prisoner with some protection before they enter another establishment.

In setting up this enhanced and innovative treatment service, our substance misuse team has been grateful for the support and encouragement we have received from colleagues within the prison, the PCT and Bristol Specialist Drug Service and we are now optimistic that this type of provision will expand across the region.

Caroline Cockwell is the substance misuse manager at Bristol Prison.

Team support: Caroline Cockwell (right) joined forces with nursing colleague Carole Preston to offer more active relapse prevention.

Why do prisoners relapse?

Prisoners can relapse if they have had some bad news, are experiencing pressure from other prisoners, or they have succumbed to temptation on their wing. Or it might happen if they are celebrating some good news, they might be joining in with other prisoners, or they may be responding to boredom.

What does naltrexone do?

Naltrexone is an opioid antagonist (usually known as Opizone or Nalorex), which is licensed for use as an additional therapy within a comprehensive treatment programme for detoxified patients who have been opioid-dependent. It binds competitively to the opiate receptors in the brain and blocks the euphoric effects of opiates, which means that they have no effect. Blocking the effects of opiates can help to eliminate their 'rewarding' effects, which play a significant part in craving and subsequent relapse. However, it is important to be aware that any treatment that results in a loss of tolerance to opiates, should be supported by training and advice on preventing overdose should the client return to opiate use.

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

Supervision sessions

Dear Lizzie
Might I suggest a few things. You have already started the process of keeping a valuable member of your staff who I am sure has contributed to alleviating suffering for addicts in her care.

I am sure you have made her aware of this – it sounds like a case of burnout to me. I am sure you have done a thorough exploration to cater for your worker's needs.

I would suggest that you need to be aware of the need for all employees to have regular supervision sessions, especially when the workload is getting people down and there is a noticeable change in the working climate.

Those of us who have had a negative experience of addiction and turned it around to help others are invaluable to the workplace, as we have such an in-depth understanding of our clients. Unfortunately, maintenance of our successful recovery to keep us working on par loses its priority.

You and your team have a very realistic insight. I wish you all well.
Chris Donnelly, Newcastle

Good connections

Dear Lizzie
I can only speak from my own personal experience and the experiences of some of my friends and colleagues within the field. I had been four years clean and was working for a private treatment provider when I relapsed (through personal reasons, not work related issues) and as I now know, was very, very lucky. My employer treated me with the same care and respect with which they treat all their clients. They accepted my condition as an illness as they would with a client who came to them with similar problems, and arranged residential treatment away from my home and workplace.

Through links they had with a different provider, they were able to arrange immediate treatment for me that would have been way beyond my means and meant I avoided the (at the time) long waiting list for statutory referral. I returned to work two months later and have been (I believe) a valued employee for the last three years, repaying the faith of my employer. Friends and colleagues that I know have not been so lucky.

Their employers have either not been so sympathetic or simply have not been as well connected as mine and as able to arrange treatment so easily. Often these people have ended up resigning from their jobs and disappearing from the system with the result that they have not received proper treatment till a lot later than they should have – and in one case too late. The only practical advice I can offer from my experience is to try everything you can, get in touch with all your contacts and try and arrange confidential treatment for your colleague as soon as possible. You owe it to her as an employee and more importantly, as a human being.
Ali, by email

Root of the problem

Dear Lizzie
Ok, good points first. Your colleague has come to you for help rather than trying to hide things and the fact that she got clean to begin with suggests that there is hope she might be able to do it again.

However, I don't see how she can do her job effectively whilst she is using. She needs time off and some sort of plan in place to get her clean. In your line of work, you should have some good clinical contacts and might be able to find a suitable place for her to go on some sort of detox programme.

Try also to identify what has made her relapse – has she started seeing old friends who are known users? She needs to rethink her life so that she doesn't relapse again after she hopefully gets clean.
Ian, Harrogate.

Policy, policy, policy

Dear Lizzie
Although I'm unable to provide suggestions for individual support, your question raises the wider issue of alcohol and drug misuse in the workplace and how organisations are equipped to deal with this.

I believe the following process, within an effective HR policy and procedure framework, shows how organisations can address employee drug and alcohol misuse supportively, fairly and minimise the impact on service delivery:

- Wherever possible an employee's drug and alcohol misuse should be treated as a health problem.
- A drugs and alcohol in the workplace policy and procedure can provide a framework for the employer and employee to identify the most appropriate areas for support.
- Such a policy and procedure can provide an outline of the level and type of support an organisation is able to offer its employees, eg referral to another agency, counselling, GP.
- Time off while rehabilitating and the individual's return to work can be covered by an organisation's sickness absence procedure.
- A drugs and alcohol in the workplace policy and procedure can assure the employee that related information will remain confidential and only shared within the organisation on a need-to-know basis.
- In instances of relapse during treatment each case can be considered on its merits to determine whether a further opportunity should be offered and whether performance management/disciplinary procedures should be invoked.

While the above is based on good practice guidelines, for a variety of reasons, some organisations may agree that an employee's drug and alcohol misuse is a matter for dismissal. Consequently, organisational requirements should be clearly stated within the rules of the organisation and disciplinary/performance management procedures followed when necessary. The issue of drug and alcohol workers relapsing can be complex and sensitive; the above is a way to ensure employers treat employees fairly and supportively while meeting the needs of their organisation.
Coreen Nugent, Organisations Policies Training (OPT), Coreen.Nugent@optforlearning.co.uk

Play the game

Dear Lizzie
It is stating the obvious that solid recovery is based on honesty, but like pregnancy it does not come in half measures. How disappointing it is to have a management system, which in spite of its fine words in terms of supporting staff, rarely delivers.

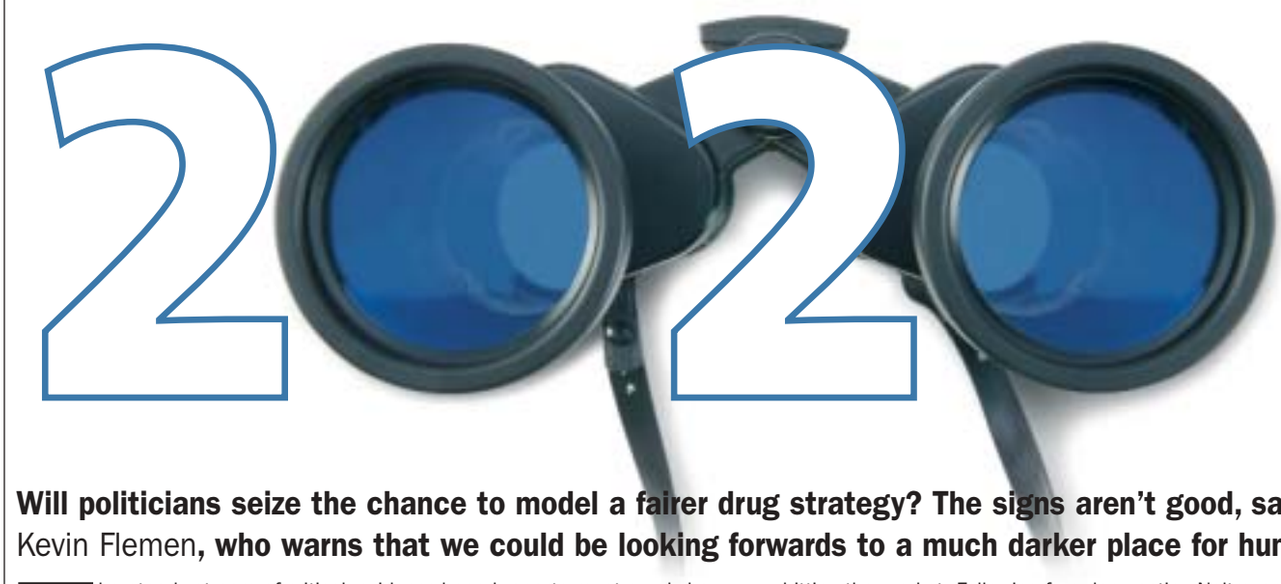
I have experience of a service where a senior manager was allowed to go without sanction when s/he was convicted of drink driving, yet a more junior staff member was dismissed for a conviction for cannabis possession. Worse still, service users are aware of this and that most hard earned commodity, credibility, has been lost.

To the question in hand I suggest she is economical with the facts – every other so and so is – and play the stress card while she sorts herself out.
Best of luck,
Joe, by email

Reader's question

I enjoy my role as a drugs worker and feel that I am working well with my clients, but recently I have been feeling very over-supervised. My manager has started to sit in on my client meetings and interrupts to the point where I'm feeling thoroughly undermined. I feel I'm being picked on. How can I tackle this calmly and constructively?
Rob, by email

Email your suggested answers to the editor by Tuesday 4 September for inclusion in the 10 September issue.



Will politicians seize the chance to model a fairer drug strategy? The signs aren't good, says Kevin Flemen**, who warns that we could be looking forwards to a much darker place for human rights.**

The steady stream of critical, evidence-based reports must surely be chipping away at the edifice of drug prohibition policy. Mustn't it? Each new report is heralded by a chorus signalling that it represents another nail in the coffin of a discredited strategy. But there's precious little evidence that the reports are going to result in a sea-change in drugs strategy.

Much energy has been expended on lobbying and consulting in the run-up to the launch of the new ten-year drug strategy. But early signs and comments do not suggest that there will be a radical change in direction.

Some commentators, DrugScope included, had held out hope that the Conservatives, under David Cameron, would have the courage to break with past dogma and pursue a balanced, evidence-based drug strategy. The Conservative strategy document *Breakthrough Britain* should thoroughly disabuse anyone of this notion.

In fact, despite the wishful optimism of many key commentators, the future may instead be a far darker place.

Testing times

Drug testing technology, already becoming more widespread in pub and club settings, seems likely to spread further. It's already been piloted in some schools, apparently with the blessing of the Association of Chief Police Officers (ACPO). Some police forces have used it at roadside traps, stopping cars and swabbing drivers. And at least two police forces have tried to persuade hostels to allow the police to test residents for contact with drugs.

As technology such as the Itemiser Ion Track equipment becomes more portable and affordable, the testing check points in other public arenas – railway stations and job centres for example – are likely to become more widespread. Ultimately, we can expect to see the technology integrated with other systems – a rapid thumb detection system as you gain entry to your workplace for example, or the transport system.

At present anyone is at liberty to refuse to be scanned, but such a refusal could be grounds for a search. As the Police and Criminal Evidence Act (PACE) hasn't been revised to cover 'new' approaches, such as Itemisers use or sniffer dogs in public settings, there is no clarity as to the legal status of such search techniques.

The techno-cure

We've already seen advances in the development of drug treatment: media including *The New Scientist* have reported the development of promising cocaine 'vaccines', potential cannabis antagonists, and the introduction of combined naltrexone and buprenorphine treatments like Suboxone are touted as the next steps in the pharmacopoeia of drug treatment.

Further down the line, we can expect to see more combined treatments hitting the market. Following from long acting Naltrexone implants, how about a combination blocker that includes not just an opiate antagonist, but a cannabis, alcohol and cocaine antagonist? As a deep implant lasting up to 12 months it would form the lynchpin of mandatory drug treatment. And by building a RFID (Radio Frequency Identification) chip into each implant they should be easy to monitor for tampering.

More laws, stronger laws

Of course, having new treatments is no use unless backed up by a robust legislative framework. Having moved further and further in the past decade towards coerced treatment models, a logical endpoint is the introduction of legal powers to enforce treatment – such as implants – on users.

There is huge scope for other legislative developments: the government wants to extend closure powers to all premises, not just those involving class A drugs.

There have been proposals that would require statutory or voluntary sector workers to inform police of all people they thought could have the potential to be violent – including those with alcohol or drug problems. And as testing technology becomes more widespread and reliable, it seems more likely than not that new offences – such as past drug use, as evidenced by a drug test – will be created.

ID cards and the cashless society

The biggest 'power' to control drugs and drug use probably won't come from drugs legislation at all, but from the introduction of identity cards and the end of cash.

Unless there are some substantial changes, it will be mandatory to possess an ID card in the not-too-distant future. While the requirement to carry the card at all times may be far off, an increase in police powers to stop people and seek to ascertain their identity and movements, as discussed at the ACPO conference, is already being considered.

Within a short time, ID would be required in a wide-range of situations – swipeable ID cards which could provide access to buildings, to transport networks, before collecting methadone, and when receiving benefits.

ID cards will mesh neatly with another foreseeable development: the last days of cash and the rise of debit and cash-free payments.

The use of debit or credit cards for a growing number of purchases is already widely established. New trials in London are looking at the use of Oyster cards – already used as a pre-payment system on public transport, as a way of making small payments without cash. Items under ten pounds could be paid by Oyster; more than that, on a debit card – all backed up by the verification of an ID card as required.

Street level drug use is heavily predicated around cash – the sale of goods or services for cash, which can, in turn, be used to buy drugs, But how does one beg, sell sex, or fence stolen goods in a cashless society?

ision

Information is king

Thanks to the rapidly burgeoning database industry, the ability to closely monitor drug users should increase dramatically in the coming decade. Using the national ID card database, and by cross-referencing that with the NOMS database, relevant NHS databases and the police national computer, it should be very feasible to identify, trace and monitor the majority of people who use drugs problematically in the UK.

But of great importance will be the proposals to identify and flag young people who use drugs early on, and ensure that they too are added to a database of young people 'at risk'. The foundation for this will be ContactPoint, the DfES-managed database that will go live from 2008. This will include basic information on all children in England under 18 years of age. There is scope for this to record that a child is accessing drug-related services, and this information to be shared with other professionals without the child's consent.

By ensuring close dovetailing between these, NHS, ID and offender databases, it should be relatively easy to achieve early identification and close monitoring of drug users from early years to adulthood and beyond.

The absence of checks and balances

Many of the ideas or concepts described above are at various stages of development or implementation. And in this brave new phase of the 'war on drugs', few are asking 'should we be doing it?' Defending the idea that human rights should be extended to drug users is becoming less and less fashionable.

Ten years ago, the idea that a person, convicted of no offence, could be locked out of the home that they legally owned, without there being any proof of any wrong-doing would have been inconceivable. Back then, the principle of defending the right to housing, and security of tenure would have been a cause celebre. But because the houses involved were labelled 'crack dens' and the people involved were the nation's new folk devils, such legislation was passed unchallenged.

So given this lack of effective and coordinated challenges to the erosions of civil liberties that is becoming commonplace in the 'war on drugs', we can expect to see more such encroachments.

If, just if, the new developments described above were effective in identifying and controlling drug use, would the loss of privacy and liberty involved be a price worth paying?

This article was originally delivered as a presentation for the Genesis Hope Project conference in Stoke on Trent in 2007.

Kevin Flemen runs the drugs consultancy KFx. Details at www.ixion.demon.co.uk

Post-its from Practice

Lost in paperwork

Getting into treatment can be a long and tortuous business in some cases, says Dr Chris Ford.

Stuart is the partner of one of my patients and came to see me the other day with a story that was difficult to believe. However the service in question has confirmed the facts of the matter.

Stuart took a day off work to attend our local drug service for an initial assessment. At his next appointment the drug worker made a partial assessment and so asked him to return for another one hour appointment. At this next appointment he learnt that his written assessment had been lost (the service does not yet use computers) and that all 15 pages of the local assessment form had to be completed again before he was put on the two-week waiting list to see the doctor for assessment.

Surprisingly, he still attended, was assessed by the doctor, and chose methadone substitution. He was told at this point that prescribing would be dependent on attending three consecutive days of titration and also dependent on his withdrawal symptoms, which would be measured objectively. However when he attended, he was deemed not to be in 'enough' withdrawal, although he felt and looked awful. Stuart heroically returned the next day and although his heroin use was more than 1 g a day, was given only 20mls substitution of methadone mixture by supervised consumption.

This was the final straw. Stuart had told them that he needed to leave for work at 7am the next day, and so supervised consumption would be difficult as there wasn't a late opening chemist close to where he lived or worked.

Stuart presented to us in withdrawal. He had an excellent assessment in 20 minutes by our specialist drugs counsellor, who gained the necessary vital information and undertook a urine drug test, which confirmed the use of heroin. This was followed by a ten-minute review of the assessment and a physical examination from me, which confirmed Stuart had normal blood pressure, a clear chest, old and fresh track-marks up both arms and enormous pupils. He left the surgery that day with a prescription for 40mg of methadone mixture and another dated the next day for 40mg, with an appointment to return the following afternoon.

Four weeks into treatment Stuart is doing very well, having settled on 90mls of methadone mixture. He still has his job and is now using his wages to pay back borrowed money to his partner; they are even planning a holiday.

Stuart's story raises several concerns: why was he not told properly about the assessment process so that he could give fully informed consent to the treatment? Why is the service so unconcerned with their blunders, their lack of encouragement and timely care? If Stuart had been a young mother with children or had been more problematic, I don't think such a person would have managed to make the third, let alone the fifth appointment when the first methadone was dispensed. Finally, if staff apply guidelines as tramlines or are completely risk averse, whether due to inexperience or to lack of clinical expertise or resources, then the final service will likely be a poor production line process.

Stuart won't be complaining about his experience at the local service, so they continue to be unaware that they are failing to provide a patient centred service – but I'll use his promised postcard as a positive marker of ours.

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

Catching them **young**

A simple screening process can catch young people at the early stages of drink and drug misuse and point them away from lasting harm. St Helens Council Young People's Drug/Alcohol Team and Knowsley Substance Misuse Nursing Service (Health and Social Care) share promising results of a pilot scheme demonstrating positive partnership working alongside Whiston Hospital Trust and St Helens PCT.

A BBC documentary at the end of last year claimed that there has been a 20 per cent increase in the number of 14 to 15-year-olds presenting at accident and emergency wards for drink-related incidents. These statistics may be the harsh reality of today's youth culture; but to professionals working within the substance misuse field, they provide more evidence of the need for agencies to work together in addressing both the social and individual aspects of alcohol and drug related harm.

The Health Advisory Service (HAS) *The Substance of Young Needs Review 2001*, recommends introducing drug and alcohol screening for young people in health services.

In the spirit of partnership working, two substance misuse teams from neighbouring boroughs within Merseyside have introduced clear care pathways from a local general hospital into young people's substance misuse community services. The aim is to provide direct follow-up for young people who arrive intoxicated at A&E, but we hope it could also have an impact on revolving door syndrome, as well as enhancing current good practice and consistency of care.

The pilot screening tool encourages hospital staff to screen – with consent – any young person aged 11 or over for drugs and alcohol, regardless of their reason for attending the hospital.

Following the screening, if necessary, they are then given information about substances and relevant local support services, or (with consent) they are referred to an appropriate substance misuse service in their area for a comprehensive assessment.

The focus of the screening tool is to identify substance related issues and facilitate referrals to community services – principally young people's drug and alcohol teams and specialist nursing services. Its aims were identified by looking at national and local strategy, and by consultation with service providers in the two boroughs. In developing the screening tool, young people were asked if they felt that questions about drug and alcohol use were relevant and appropriate to ask within the hospital environment. They all felt that they were, and that having it taking place in a hospital would lead to appropriate treatment.

The HAS review calls for healthcare professionals to research the effectiveness of screening, assessment and brief interventions, and suggests these initiatives could make a significant impact on public health.

We decided that given the busy nature of hospitals, particularly A&E, screening had to be as short, straightforward and quick to administer as possible. Our screening tool is currently a one sided, predominantly 'tick box' carbonated document, separated as follows: Part a – copy for hospital records; part b – copy for the school nurse; part c –copy for the relevant young persons substance misuse team.

Introducing screening is not intended to replace any existing protocols, but it allows the young person to make informed choices in relation to further support for their drug and/or alcohol use. It also lets us consider the wider agenda, such as whether child protection procedures might be needed.

The screening tool emphasised our need to formalise links between school nurses and the young people's substance misuse services through a structured care pathway. Ongoing use of screening has not only had a positive impact on appropriate referral; it has also improved lines of communication, enabled information-sharing, and made multi-disciplinary working more effective. School nurses are able to follow up and monitor those young people who refused an initial referral to the Tier 3 service, and help to raise awareness of those young people whose substance use may currently be within the experimentation stages, so that information can be targeted appropriately.

Through the 'paediatric liaison' route, young people up to the age of 16 years would normally be identified as needing advice and support around drugs or alcohol. Before the screening tool was introduced there were concerns that those aged 16-18 would not being identified as at risk or needing help, as they were recognised as adults within the hospital admissions process. The screening process would prevent these young people from being excluded from support.

The main strength of such a screening tool is not only its simplicity in being a one-sided questionnaire, but the fact that the hospital staff are able to offer this input across boroughs and have built up working relationships and contacts with the young people's substance misuse teams within each of its main servicing areas – in our case, St Helens and Knowsley.

Through screening we can establish recent consumption and identify immediate health risks in relation to recent heavy drug or alcohol use. These can be considered in relation to potential hospital treatment or medication, so that modifications can take place. For example, the impact of recent amphetamine use needs to be considered if a general anaesthetic is prescribed.

A recent evaluation of the screening tool revealed that health professionals had, at times, been reluctant to deal with drug or alcohol issues among young people. In some cases this was seen as relating to a lack of understanding and knowledge about the needs of young people in relation to drugs and alcohol and how to deal with such issues. The screening process, combined with supported training around drug and alcohol awareness, provides hospital staff with a quick and straightforward means of broaching the subject with young people, understanding related needs and providing an opportunity for appropriate referral.

While the rationale and aims of the screening tool are clear, we now need further investment in its delivery and use on a number of levels. During its pilot phase the screening work relied on good will and the excellent working relationships between frontline workers. For the tool to be used consistently and effectively, it needed to be recognised at a strategic level and embedded within other 'day-to-day' hospital procedures. This has now been achieved, and the young persons substance use screening tool is to become part of standard practice.

Madeline Jones (St Helens Young Peoples Drug and Alcohol Team) & Debbie Olyott (Knowsley Substance Misuse Service) are available on email for further information regarding the screening process: madeline jones@sthelens.gov.uk/debra.olyott@knowsley.nhs.uk

Heroin overdose (part 3)

Professor David Clark continues to look at various ways that can be used to reduce the number of heroin overdoses and overdose deaths, and at the responsibility that we all share in trying to do this.

In my last Briefing, I emphasised that a wide range of people are potentially able to help reduce the number of heroin overdoses. These include heroin users themselves, specialist and generalist workers in the field, family members and friends, commissioners and policy makers, and even members of the general public. In this Briefing, I continue to look at ways in which these various groups of people can contribute.

Heroin users most commonly overdose when in company, and death from overdose is rarely instantaneous, creating opportunities for those present – most commonly other heroin users – to reduce potential morbidity and mortality by intervening in some way.

However, research has consistently shown that only a small proportion of overdose witnesses use first aid measures, such as cardiopulmonary resuscitation (CPR) and placing the overdose victim in the coma position. Moreover, studies reveal that an ambulance is called in only about 50 per cent of cases.

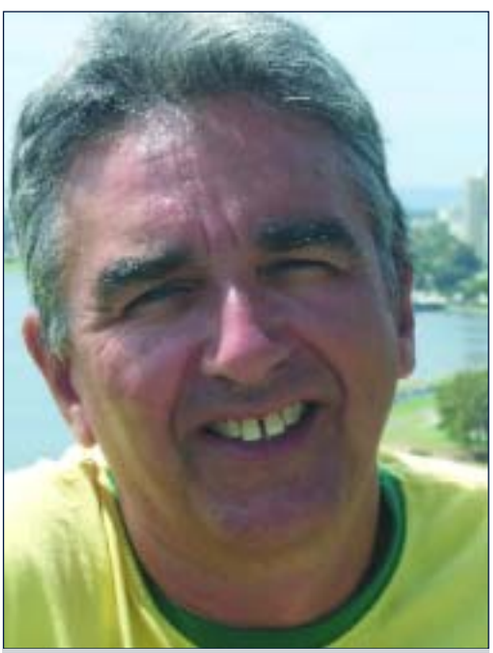
Many heroin users who do not call emergency services fail to do because they are concerned about being arrested by the police, for possible manslaughter or for possession of drugs. Despite the fact that there is no reason for the police to turn up at an overdose incident unless a fatality has occurred, they generally do so in the UK. This is not the case in Australia.

There are a variety of ways in which we can reduce overdose deaths by a greater 'engagement' of overdose witnesses.

Treatment agencies should offer regular education courses on drug overdose, with topics ranging from prevention measures through to first aid classes. These courses should involve discussion between service users and staff as to how to increase the flow of credible messages about overdose among a networks of users.

Police should not attend a non-fatal overdose unless essential. Ambulance crew should acknowledge the help of witnesses when merited. If a heroin user has done something right they should be told, since they will be more likely to do it again.

Research has found that rather than being thanked for their positive and sometimes life-saving actions – which can enhance their self-esteem – heroin users are often looked down upon by members of emergency services and, in particular, by the police:



'Police should not attend a non-fatal overdose unless essential'

'...They just treated me like a dirty junkie which I suppose I was... but if it wasn't for me he would be dead, you know.' (Unpublished WIRED research in Swansea.)

Heroin users must accept that they have to provide information for the coroner's court if they are witness to an overdose death. Treatment agencies should provide them with information about, and support concerning, the giving of information and attending a coroner's court.

Naloxone, an opiate receptor antagonist, is used to reverse the life-threatening suppression of respiration caused by heroin. Whilst naloxone is often used by ambulance services to 'revive' people who have overdosed on heroin, the drug is not freely available for use by heroin users.

Policymakers and commissioners need to take up the suggestions of John Strang and colleagues (*British Medical Journal*, 21 June 2007) to increase the availability of naloxone and provide relevant training to non-healthcare staff, and to users, their families and carers.

Three groups are considered to have a relatively higher incidence of heroin overdose: former users who are just leaving prison, former users who have been on an abstinence-based treatment programme, and clients in the early stages of a methadone substitution programme.

The dangers of overdose to people in these situations needs to appreciated, not just by the individuals themselves, but also by their families and carers, as well as by practitioners and commissioners. The reality is that most members of the latter groups are not well-trained or well-informed about heroin overdose.

One of the fears expressed by parents is the 'knock on the door' – by a policeman ready to inform them that their son or daughter had been found dead, of a suspected heroin overdose. Given their concerns, and lack of knowledge about overdose, it is important that family members and carers receive credible, objective and understanding communications from those people they turn to for advice and support, such as their GP.

One mother who participated in a WIRED research project was told by her GP: 'I think you've got to face the fact that... your son is gonna die... it's either gonna be accidental or deliberate... he's not getting better. He's as bad as he can be, he's taking anything and everything; he's so desperate.'

She received no support or advice. Although this is an isolated example, it emphasises the need for better training and education, and understanding about heroin overdose among generalist workers.

As a final comment, it must be recognised that we live in a society that is highly prejudiced against heroin users. As a result, some heroin users are less likely to access treatment services, and some ex-users are less likely to be accepted by, and be integrated back into, 'normal' society (a critical element of recovery). They are therefore likely to continue using, or start using again, thereby being at risk of overdose.

Reducing prejudice, stigmatisation and stereotyping of heroin users will reduce heroin overdoses and deaths.

Go public with your ambition

Adult Services

Joint Commissioning Manager

■ Winchester ■ Up to £38,585 ■ Ref: 13243

The Hampshire Drug & Alcohol Action Team (DAAT) is a multi-agency partnership, responsible for the local implementation of the Government's ten-year drug strategy 'Tackling Drugs'.

This is a key role leading on the ongoing development and implementation of a local strategy to ensure the delivery of effective drug treatment services throughout Hampshire to meet local needs. This will include extensive partnership working with other agencies to identify and develop opportunities for both specialist service delivery and integration within mainstream services to provide maximum benefits to service users during their treatment and recovery.

It is essential that you'll demonstrate competencies in a commissioning role at a senior managerial level, together with experience of working in a multi-agency environment. You'll possess excellent interpersonal skills, strong analytical skills and the ability to communicate and work constructively with a broad range of people and organisations.

For an informal discussion please contact Sue Wilks, DAAT Manager, on 01962 826025.

Closing date: 13 August 2007. Interview date: 6 September 2007.

Visit www.jobs.hants.gov.uk to find out more and apply online. Alternatively contact the Resourcing Centre on 0845 850 0184 or e-mail us at resourcing@hants.gov.uk for further information. Textphone users only can call free on 0808 100 2484.

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

Hampshire County Council

Service Managers

£30,594 - £33,945 pa

Portobello Road Project - London W10

This is an open access service providing information, advice and support to reduce drug-related harm to both individuals and the wider community in Kensington and Chelsea. The service provides a range of services including: drop-in, needle exchange and one-to-one keyworking with onward referral. **REF: BCDP/14/DDN.**

Quantum Project - London SE23

This is an open access service offering a range of support for drug users in Lewisham, specifically targeting primary heroin and crack users. The service provides a drop-in, keyworking and needle exchange, and also works with local GPs to advise on substitute prescribing. **REF: BCDP/15/DDN.**

For both of the above positions, you will have a proven track record of developing projects and an extensive background of working with service users in substance misuse. You should also have a background in staff management and supervision, as well as excellent skills in care provision development, implementation and monitoring.

Southwark Contact Team - London SE5
Package includes £1,000 pa retention bonus
Up to one year contract - maternity cover

This service is part of the Drug Interventions Programme (DIP) in Southwark that aims to increase access to treatment for those coming into the Criminal Justice system. We work in police custody areas and magistrates courts, targeting those offenders arrested for trigger offences and who have tested positive for Class A drugs.

You will have overall responsibility for the clinical management and day-to-day running of this service, and directly manage 12 permanent staff that are split into two teams covering custody and the court, each headed by a Team Leader. You should have an excellent understanding of DIP and substance misuse services, as well as effective people management skills to manage a large staff team. **REF: BCDP/11/DDN.**

We offer a range of benefits including: contributory pension scheme, generous holiday entitlement, flexible working and a comprehensive training programme.

To request an application pack, please telephone our response handling line on 01206 570706 or email: info@peterlockyer.co.uk quoting the appropriate reference number. Closing date for completed applications: 17th August 2007.

www.blenheimcdp.org.uk Blenheim CDP Registered Charity No. 293959.

Providing quality services in response to the changing needs of diverse communities.

Blenheim CDP has recently been created from the merger of two leading London-based drug services - The Blenheim and Community Drug Project (CDP) - both with a long history of providing quality services in this sector. Together we have been providing services to reduce the harm caused by drug misuse both to individuals and communities for over 40 years.

We value diversity in our workforce and welcome applications from all sections of the community.

Blenheim cdp

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combating homelessness, creating opportunities, promoting change

ROUTE 1 PROJECT

BHT's Route 1 Project provides practical housing support to 53 residents with mental health support needs. Working alongside Sussex Partnership NHS Trust the service supports people to sustain tenancies in a range of self contained accommodation, shared flats and shared houses across six supported housing schemes, including one high support house.

MANAGER (DETOX SUPPORT AND MOVE ON PROJECT)

Salary £25,437–£27,492 per annum (includes on call)*
NJC Scale Point 32, rising by annual increments to scale point 35
6% (reviewed annually) pension contribution
35 hours per week
Annual leave entitlement starts at 25 working days

We are seeking to appoint a Manager to lead our Detox Support staff team in delivering support and encouraging our clients to see that long-term recovery from addiction is possible, within the 12 step model of recovery. The Manager will undertake all aspects of support and housing management responsibilities, including delivering therapeutic interventions with clients on both an individual and group basis. You will be responsible for day to day service delivery, team supervision, contract compliance and service development.

The successful applicant will have a relevant professional qualification, experience in counselling and group work and experience of working with people recovering from addiction. They will also possess excellent interpersonal skills and be keen to join a committed and talented team. At least one years experience of managing/co-ordinating a support service and significant experience of working in a therapeutic or related field of work is essential.

Closing Date: 12 Noon Friday 17th August 2007
Interview Date: Friday 24th August 2007

***(cost of living increase pending)**

INTERESTED? To download the job documents and application form please visit the jobs section of our website (www.bht.org.uk) or alternatively write to the HR Officer, BHT, 144 London Road, Brighton, BN1 4PH specifying the post you are interested in and enclosing an A4 self addressed stamped envelope (.44p). Please note CV's will not be accepted.

BHT operates an Equal Opportunities policy. Please note that a CRB Enhanced Disclosure will be required as a condition of employment

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THE Space KC

The Space KC provides a range of holistic support services for young people in London including a harm reduction service, drugs and sexual health advice, training, counselling, a drug free programme, complementary therapies, specialist clinics and an LGB group.

The project uses the Criminal Records Bureau disclosure service. An enhanced disclosure is required for this post. Registered Charity Number: 1003657

Full Time Practitioner (Drug Free Programme)

Salary range: NJC Points 26-31 (£23,994 - £27,807)

Required to deliver the drug-free programme: a structured substance misuse programme for young people from our two sites – Earl's Court and Golborne Road.

Must have:

- At least 1 year's experience of working in the substance misuse field
- At least 1 year's experience of working with young people
- Ability to develop relevant programme activity

The Space KC encourages applications from men as they are under-represented in the organisation.

For an application pack call Elizabeth Oakley on 020 7373 2335 or email info@thespacekc.org

Closing Date: 16 August 2007

'From dependence to independence.'

WELLINGTON LODGE

Addiction counsellors and bank staff required

Candidates must be qualified counsellors and have experience in group and individual therapy within the drug and alcohol field. FDAP accreditation or proof of working towards this is essential. The candidate must be flexible to meet the needs of the client group. Salary depends upon experience.

All posts subject to Enhanced CRB and POVA checks.

Applicants that require an application form or further information please contact info@wellingtonlodge.org or telephone 020 8421 2266

Kaleidoscope Project is an innovative treatment provider seeking to provide good accessible treatment services to those experiencing illicit drug misuse problems. Hospitality is key to all our services.

Kaleidoscope

Project Workers (F/T) £17,000-£21,000 pa

You will be part of a multi-disciplinary team providing care planning and support of illicit substance users. The role includes supporting the methadone administration programme, liaison with partner agencies and some administrative work. A proven record in the social care field would be an advantage.

Closing date: 31 August 2007

For an informal discussion please contact
Sian Chicken, Drugs Services Manager on 0208 549 2681.
For an application form and job description please call
Veronica Snowball on 01633 245012

INVESTOR IN PEOPLE

Kaleidoscope is committed to equal opportunities and welcomes applicants from diverse communities.

Northamptonshire NHS
Teaching Primary Care Trust

Provision of Integrated Drug Treatment System, (IDTS)

TACKLING DRUGS CHANGING LIVES

HMP Onley and HMP Rye Hill

Advert for the Provision of Integrated Drug Treatment Systems at HMP Onley and HMP Rye hill. The Contracting authority is Northamptonshire Teaching Primary Care Trust, Bevan House, Kettering Parkway, Venture Park, Kettering NN15 6XR. Telephone 01536 480300.

The Integrated Drug Treatment System has been devised to ensure that better drug treatment is available for prisoners consistent with the NTA Models of Care and Treatment Effectiveness strategy.

The key objectives:

- To provide the full range of drug treatments within prison, including prescribing, which within the constraints of the prison setting is equal to those provided in the community.
- Improve care coordination of prisoners within the prison by integrating treatment with CARAT, Health Care and Mental Health Services.
- To ensure greater continuity of care for drug users when entering, moving between and exiting prisons, and in so doing reduce offending and drug related deaths.
- To improve links with community based services including primary care services, criminal justice teams (CJIT), and other drug treatment providers.

The service will be located in buildings within the prison boundary in accommodation provided by HMP Services. Note that Rye Hill and Onley are adjacent to one another, the contractor will be expected to provide services in both prisons plus an option to provide same to other Public Sector Prisons within Northamptonshire.

Start date for the contract is to be agreed with the successful bidder, the contract period is to be for two years with an option of an additional further one or two years.

Conditions of Participation –

Organisations wishing to register an interest in tendering should submit an expression of interest in writing by email or fax to cathy.headland@nhft.northants.nhs.uk, fax 01604 595186, contact Cathy Headland on 01604 595373. Your email response must give your organisation's name and should be titled 'Provision of Integrated Drug Treatment System, (IDTS) at HMP Onley and HMP Rye Hill'. The deadline for receiving Expressions of Interest is the 6th August 2007. Following this interested parties will be sent the full tender pack including a Pre-Qualification Questionnaire (PQQ). Further details on the evaluation process will be contained within this document.

It is the bidder's responsibility to ensure that all the completed documentation has been received by Cathy Headland by the specified closing date below. Any Bidder may be disqualified if they fail to provide the information requested (where relevant to them) by the closing date shown below.

Deadline for receiving tenders: 14th September 2007 at noon.

For an informal discussion please contact Pat Reihill on 01788 523400 ext 3562 or by email: preihill@blueyonder.co.uk

We are a flexible employer committed to Improving Working Lives.

DDN – FDAP workshops

fdap

DDN Drink and Drug News

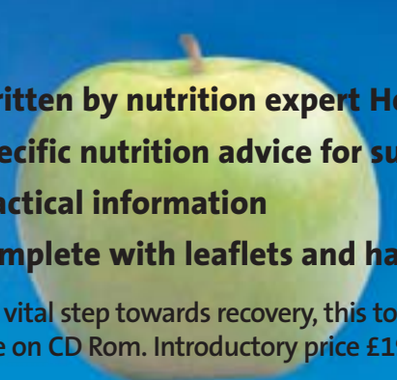
The essential drug and alcohol worker	Supervision, appraisal and DANOS	Performance management
17-21 September, London	8 October, London	15 October, London
This five-day course provides a full introduction to the elements of effective drugs and alcohol work. This workshop is delivered in association with DDN and DrugScope.	This one day workshop for line managers and HR directors covers supervision, appraisal and development of front line staff against DANOS and other national occupational standards.	This one day workshop for line managers and HR directors builds on the 'Supervision, appraisal and DANOS' workshop, and focuses on managing and developing practitioners' performances.

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

Contact Tracy Aphra e: tracy@cjwellings.com t: 020 7463 2085

The DDN nutrition toolkit

an essential aid for everyone working with substance misuse



- **Written by nutrition expert Helen Sandwell**
- **Specific nutrition advice for substance users**
- **Practical information**
- **Complete with leaflets and handouts**

Healthy eating is a vital step towards recovery, this toolkit shows you how. Available on CD Rom. Introductory price £19.95 + P&P

To order your copy contact Tracy Aphra:
e: tracy@cjwellings.com t: 020 7463 2085

DDN is now taking a Summer break, we will be back to our fortnightly frequency from Monday 10 September. Advert deadline 6 September.

Bolton NHS
Primary Care Trust

Adult Services

Joint Commissioning Support Officer (Alcohol)

Ref: 681/7108V

• £22,886 - £31,004 pa • 37.5 hours per week

Closing Date: 20 August 2007.

Apply online: **www.bolton.nhs.uk**

Smoke free Workplace, Striving for Equality
Providing support for staff with caring responsibilities.

Bridgegate Drug Services is an independent company with charity status and funding that provides services for people with substance misuse problems, their families and concerned others, across Peterborough and Cambridgeshire.

Engagement Lead (Adult Services)

Salary £23,952-£26,928p.a. (NJC pay scale 30-34)

37 hours per week, located in Peterborough

We are seeking a dynamic self-starter who is able to lead our Engagement and Harm Reduction services. The successful applicant will be responsible for the co-ordination of the Peterborough office's Open Access services. This includes Needle Exchange services, telephone helpline and assistance to face to face enquiries. You will be working to defined targets and will be expected to demonstrate your ability to translate our strategic goals into clear performance outcomes. This role offers an opportunity to develop innovative outreach and community initiatives. You will need a relevant qualification and a proven track record.

For an application pack please call Marion Denny on 01733 314551, or email admin@bridgegate.org.uk
Applications close 13 August 07. Interviews to start 28 Aug.

We are an equal opportunities employer and committed to supporting the development of our staff. All posts are subject to a Criminal Records Bureau check.

The Open University

FDAP/Alcohol Concern Assessors and Verifiers

The Open University VQ Assessment Centre is looking for qualified assessors and verifiers to help them, on a consultancy basis, to deliver a suite of vocational awards based on the DANOS units. These awards, ranging from three to ten units, have been developed in conjunction with the Federation of Drug and Alcohol Professionals and Alcohol Concern. The awards are designed to recognise and demonstrate the competences of managers and practitioners in the drugs and alcohol field - in line with the DANOS-based competence framework.

All assessment relating to these awards is desk based so there will be little requirement for you to travel. As a consultant assessor, you will be required to assess a case-load of candidates, enabling them to achieve their qualification.

It is essential that you already have the D32/D33 or A1 assessor, or the D34 or V1 internal verification qualification. You must also have at least two years of occupational experience within this sector and have evidence of assessment activity within the last 12 months.

The amount of work you will be offered will be dependant on the number of candidate registrations that the centre receives at each of its quarterly registration periods.

If you are interested in working with us, please email nvq-enquiries@open.ac.uk attaching your most recent CV, an outline of your sector and assessment experience and an indication of the number of candidates you feel you will be able to support.

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winthrop hall

SUCCESS IN RECOVERY

SUBSTANCE MISUSE NURSES (Night or Day)

Salary to £35,000

Superb Working Environment

Excellent Package

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

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

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

Either RMN or RGN, you will be experienced in the addictions field or supportive areas. In particular, you will be expected to:

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

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

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

Closing date for applications 13 August 2007

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