7 June 2010
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Drink and Drugs News

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Cloaking device

Why prejudice is obscuring basic support

There have been 14 murders of sex workers since the Ipswich cases four years ago. The cost of initiatives to improve sex workers' safety is a drop in the ocean compared to the millions of pounds spent on a murder investigation, so why have the dreadful events in Bradford been allowed to happen?

The interview with Shelly Stoops (page 6) is illuminating. Not only does it remind us of the appalling stigma that gets in the way of communicating with women involved with this profession, it also provides highly sustainable arguments for the economics of prevention. Sadly, many outside this field won't look as far as the economics, because the label 'prostitute' will categorise the subject before they've read as far as the bit about the grieving family. But if they do, they will start to understand that quite apart from the much needed compassion there is a strong financial case for reviewing the laws around sex work – laws that force women to put themselves at risk by working alone in dangerous surroundings. The Home Office has been funding Shelly's post as independent sexual violence advisor – a post renewable year on year – because it fitted the 'ensuring justice' strand of the government's 2006 prostitution strategy. Let's hope that the new government is steadfast in building on this modest start.

The theme of support networks comes up again in our second women-themed feature (page 10), which touches on the isolation many women feel when substance misuse gets in the way of running family life effectively. Once again, it was roundly agreed that services need to be accessible and non-judgemental before they have a hope of making contact that might lead to successful interventions. Accessibility of services failed spectacularly for Scott, as his mother describes in the wake of her heartbreaking loss (page 12). There are so many 'whys' for Maureen – let's hope the questions reach out-of-hours services.

This issue

FEATURES

REGULARS

News in Brief

Anthrax update

There have now been 43 confirmed cases of anthrax among drug users in Scotland, according to the latest figures from Health Protection Scotland, including 13 deaths. There has also been a reported case of botulism in a heroin user in north west London – last year the Health Protection Agency (HPA) reported 'an unusual recent increase' in reported cases of wound botulism among injecting drug users in the south east of England.

Info balls

A new alcohol awareness campaign for the World Cup has been launched by Drinkaware. Aimed at men aged 30-44, *Hoof It!* includes a website, local events and the distribution of 10,000 footballs carrying alcohol information. The charity has also teamed up with the Foreign and Commonwealth Office and the Football Supporters Federation to provide alcohol advice to fans travelling to South Africa. 'We want to encourage men to think about how much alcohol they drink and to consider ways of limiting their consumption,' said Drinkaware chief executive Chris Sorek. *www.drinkaware.co.uk/campaigns/hoof-it*

Young voices

A series of narratives from children on substance misuse issues has been issued by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Around 60,000 children in Europe are estimated to be living with people receiving treatment for substance problems, says EMCDDA. *Children's voices: experiences and perceptions of European children on drug and alcohol issues available at www.emcdda.europa.eu/*

Funding the future

A fundraising event is being held in Bristol on 1 July to raise money for the Southmead Project, which works to tackle domestic violence, abuse and substance misuse (*DDN*, 26 January 2009, page 14). 'Southmead Project has a proud record of achievement earned over the last 16 years and remains at the forefront of community work,' said CEO Mike Peirce. 'Domestic abuse and violence-related incidences contribute to over 80 per cent of our workload with adults.' For more information, or to make a donation, visit *www.southmeadproject.org.uk/how_to_help/get_involved.php*

Pressure grows to introduce minimum alcohol unit price

The National Institute for Health and Clinical Excellence (NICE) has added its voice to calls for the introduction of a minimum price per unit of alcohol in its new guide *Alcohol use disorders: preventing the development of hazardous and harmful drinking*. The organisation, which produces guidance on public health and clinical practice, states that alcohol 'needs to be less affordable and less easy to buy'.

The guidance wants to see the introduction of a minimum price which is then regularly reviewed 'so that alcohol does not become more affordable over time'. It also wants to see 'protection of the public's health' added to licensing objectives – as is the case in Scotland – and applications for new licences considered on the number of outlets in a given area, proposed opening hours and likely impacts on crime and disorder. Local authorities should consider restricting new licenses in areas already 'saturated', it says.

The document, which is the result of a wide consultation (*DDN*, 19 October 2009, page 5), also proposes reductions in individual import allowances and 'the days and hours that (alcohol) can be purchased'. It also calls for advertising regulations to be strengthened to shield children and young people from exposure to alcohol products, adding that 'a complete ban on alcohol advertising should be considered to protect these high risk groups even more', as is the case with tobacco.

The previous government's mandatory code for alcohol retailers did not include a minimum price per unit, despite calls from health organisations and professionals including the chief medical officer (*DDN*, 18 May 2009, page 4). The Scottish Parliament's Health and Sport Committee, however, has allowed that country's alcohol bill – which does include provisions for a minimum price – to proceed to the next parliamentary stage, although there is ongoing controversy in the Scottish press about lack of information on the intended price.

'Alcohol misuse is a major public health concern which kills thousands of people every year and causes a multitude of physical, behavioural and mental health problems,' said NICE's public health director, Professor Mike Kelly. 'What's more, it costs the NHS over £2bn annually to treat the chronic and acute effects of alcohol – this is money that could be spent elsewhere to treat conditions that are not so easily preventable. Based on the international evidence, it is clear that policy change is the best way to go about transforming the country's unhealthy relationship with alcohol and prevent people from getting to the stage where they are drinking worryingly large amounts.'

'With practically every health body in the country now backing the move on alcohol minimum pricing, the new government needs to accept the evidence and introduce a minimum price urgently before thousands more lives are affected,' said Alcohol Concern chief executive Don Shenker. 'Government should also act immediately to ensure children's exposure to alcohol advertising is as low as possible, by overhauling advertising regulations which purport to protect children, but actually leave children saturated with alcohol advertising on a daily basis.'

Tesco has become the first UK retailer to back the coalition government's proposal to ban the sale of below-cost alcohol (*DDN*, 24 May, page 4), adding that it would 'stand ready' to support ministers if they decided to opt for a minimum price. 'Pricing controls can only be effective if they apply to all alcohol retailers and the only way that can happen is through government taking the lead,' said the company's executive director for corporate and legal affairs, Lucy Neville-Rolfe.

NICE guidance available to download at www.nice.org.uk

EU launches mephedrone investigation

The Council of the EU has formally requested a 'scientific investigation into the health and social risks' of mephedrone from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The investigation will be carried out by the EMCDDA's scientific committee alongside representatives from the European Commission, law enforcement agency Europol, EU member states and the European Medicines Agency, with a report expected at the end of next month.

Meanwhile, news that toxicology tests have revealed that two deaths in Scunthorpe described by sections of the media as being the result of mephedrone use were not in fact linked to the drug has led the UK Drug Policy Commission (UKDPC) to call for a full overview of the way drugs are regulated in the UK. There was widespread criticism from many in the drugs field that the government's decision to ban the substance and make it a class B drug had been driven in part by the media (*DDN*, 26 April, page 4).

'The only good that might emerge from this fiasco is a long-overdue review of drug control policy,' said UKDPC member Professor Colin Blakemore. 'We believe the new government has an opportunity to both better protect the public and save money by reshaping the architecture for decision making,' added chief executive Roger Howard. 'Getting the governance right will lead to better outcomes for every community in Britain, and rebuild trust between experts and politicians.'

Scots harden their attitudes towards harm reduction

Support among Scots for legalising cannabis has dropped from 32 per cent to 24 per cent since 2001, according to the *2009 Scottish Social Attitudes Survey*, while support for harm reduction has also fallen.

Among those who had tried cannabis, the drop in support for legalisation was even more pronounced – down to 47 per cent from 70 per cent in 2001, while just 24 per cent of 18 to 24-year-olds thought the drug should be legalised, compared to 62 per cent in 2001. Forty-seven per cent of those questioned in the government-funded survey knew someone who had taken illegal drugs, up six per cent from 2001. However, only 34 per cent thought people should not be prosecuted for possession of a small amount of cannabis for personal use, compared to 51 per cent in 2001.

Twenty-five per cent of those questioned in 2009 agreed with the statement 'we need to accept that illegal drug use is a normal part of some people's lives', down from 40 per cent. Eighty per cent agreed with the statement 'the only real way of helping drug addicts is to get them to stop using drugs altogether', while support for harm reduction measures had dropped from 62 per cent to 50 per cent.

In terms of the main priorities for tackling heroin use, 'tougher penalties for those who use drugs' and 'more education about drugs' were both agreed with by 32 per cent. Meanwhile, 44 per cent disagreed, and 40 per cent agreed, with giving young people information on how to use drugs more safely. 'Findings on the relationship between supporting education on drugs in general, and support for educating young people on how to use drugs more safely suggest that there may be continued resistance in some quarters to educational messages that seek to promote harm reduction messages,' the report states.

Available at www.scotland.gov.uk/Publications

Organisations join forces on drug treatment policy

A drug treatment 'consensus statement' has been issued by four major drugs organisations in order to safeguard funding for treatment and 'ensure that public debate about drug treatment recognises the progress that has been made in improving the lives of individuals, families and their communities'.

Signed by the chief executives of Adfam, DrugScope, The Alliance and EATA, the statement says 'we believe that investment in drug treatment is vital and should continue to be a priority for public health'. The document calls on government and other policy makers to commit to an evidence-based, non-partisan approach to policy that 'respects the advice of independent experts' and where the same principles apply as to the treatment of conditions like cancer, heart disease or schizophrenia.

The document wants to see better links between agencies to support recovery and reintegration, as well as personalised, needs-driven treatment that addresses all kinds of drug use and poly drug use, not just heroin and crack cocaine. 'Alcohol treatment should be available to all who need it,' it states.

'Decision-makers and opinion formers have a responsibility to make sure that taxpayers' money is spent wisely, on services that deliver on public priorities and with public benefits,' it says. 'We recognise that tough decisions need to be made between competing priorities, particularly at a time of spending restraint. But we also know that any disinvestment in drug treatment services will leave some of the most excluded and marginalised in our society with no second chances and no route back. It will also result in greater costs in the long run, as we pay the price of not intervening in support of people who are prepared to face up to their drug problems and try to get their lives on track.'

Full document available on our website, www.drinkanddrugsnews.com

ALWAYS REMEMBERED: More than 400 people gathered on 21 May for the 3rd Merseyside Annual Candlelight Vigil to remember those who had died as the result of alcoholism and addiction. They listened to speakers who shared their personal testimony and people who performed poetry in honour of their loved ones. Jacquie Johnston-Lynch, head of service at SHARP Liverpool, commented: 'It was an incredibly moving event. We will continue to remember the lives of our loved ones every year, celebrating them instead of shoving their memories away as societal stigma would have us do.'

News in Brief

Enforcement drive

The police are stepping up their annual summer drink and drug driving campaign, the Association of Chief Police Officers (ACPO) has announced. 'We are doing more roadside stop and check operations than ever before, at all times of the day and night and on all types of road,' said ACPO lead on drink and drug driving, deputy chief constable Adam Briggs. The campaign began last week – more than 121,000 people were stopped and tested during last year's 30-day crackdown.

Drug deaths down

A total of 316 people died as a result of dependence on drugs in 2009, according to inquest verdicts – 260 males and 56 females. A further 250 – 216 of them male – died from 'non-dependent abuse of drugs', according to the Ministry of Justice document *Statistics on deaths reported to coroners, England and Wales 2009*. The figures are lower than for the previous year, which stood at 343 and 274 respectively. *www.justice.gov.uk/coronersannual.htm*

Family functions

Consultations for service managers and practitioners to examine the roles of family support workers are being held by the Drug Sector Partnership as part of a workforce development project to build a fully trained family support workforce. The partnership – Adfam, The Alliance, DrugScope and EATA – is holding afternoon consultations on 6 July (London) and 13 July (Leeds). *Contact Oliver Standing at Adfam: o.standing@adfam.org.uk*

Staggering statistics

More than 520,000 people in the UK go to work hungover each day, with the average person suffering a hangover three times a month, according to research by Drinkaware. Seven per cent of the 1,000 people questioned admitted to having to leave work early, while 17 per cent said they had made mistakes at work while hungover. 'Having a hangover at work doesn't just affect the person who has drunk to excess,' said Drinkaware chief executive Chris Sorek. 'With hundreds of thousands of people going to work every day after a heavy night, it impacts work productivity and even results in employees going home sick.'

'Sex workers are a drug dealer's dream. They've got access to cash, and quickly... One woman described it to me as being like a hamster on a wheel – work, score, work, score, work, score, collapse.'

With headlines dominated by the appalling events in Bradford, **David Gilliver** talks to the only independent sexual violence advisor in post at a UK sex worker project

SAFETY FIRST

'They're shite, killed by shite. Who gives a shite?' This apparently was the view of one police officer after the murder of a female sex worker in the 1990s. 'Drug-using sex workers are the forgotten victims of sexual violence,' says Shelly Stoops, independent sexual violence advisor (ISVA) for the Armistead Street Project in Liverpool. Inevitably, with the headlines dominated by the cases of Susan Rushworth, Suzanne Blamires and Shelley Armitage in Bradford, she's had a hectic week. 'I've had the media all over me,' she says. 'It's really sad that this is the only opportunity you get to talk about rational stuff.'

The Armistead Street project began in 2005 and is run by the Armistead Centre, a free and confidential sexual health promotion service for the gay community and female and male sex workers, delivered by Liverpool's PCT, NHS Liverpool Community Health. 'There was a project before us, but it closed because of lack of funding,' she says. 'Armistead babysat and did the outreach for a year, and formally got the contract in 2005. We got funding from the Home Office in 2006 for the ISVA role, and it's still the only sex work project in the UK to have that.' While the results have been 'amazing' – the conviction rate for rapes against sex workers in Liverpool now stands at 67 per cent, compared to six per cent for rapes nationally – every year the service has to put in a fresh bid for the money to sustain the ISVA post.

Ninety-eight per cent of her clients are dependent on class A drugs and/or alcohol, she says, a figure that 'would be echoed for street sex workers all around the UK'. Furthermore, the women are specifically targeted by local dealers. 'Sex workers are a drug dealer's dream. They've got access to cash, and quickly. They can go out and do a punter or two, go and score, then back again. One woman described it to me as being like a hamster on a wheel – work, score, work, score, work, score, collapse. She didn't have time for eating or bathing.'

The line quickly becomes blurred between developing a habit and going into sex work to pay for it, and using drugs to get through the work itself, she says. 'Women are using drugs to numb themselves because of what they're doing, and also working because they need drugs. My clients already had addictions when they came into it, but street sex work and drug use obviously correlate with all kinds of other problems – abuse, experience of being a looked-after child in the care system, poverty, lack of opportunity. That's not a gender thing either – we also have a project for male sex workers, which is quite a distinct market, with people doing business not necessarily for money but for a bed, drugs, a meal.'

The project works closely with local drug services as well as the police, sexual health and contraception clinics and local hostels to arrange emergency accommodation. The response from the women has been overwhelmingly positive, she says, with little or no suspicion even at the outset. 'We're seen as being here just for them, which to them shows that people do care. They really appreciate it, especially if there's been a murder – the fact that we'll be out there on the streets with them, reassuring them and making sure they're looked after.'

The majority of her clients are aged between 30 and 34, with the rest largely in the 25-29 range – 'that doesn't fit with the stereotype of the "teenage prostitute",' she says. One of the things that would most benefit them would be an expansion of treatment options, she stresses – she's been told of cases elsewhere in the country of police coercing women into entering treatment on threat of arrest. 'What kind of choice is that? We need more choices in treatment as it is – it's not just about methadone. People should have choices around prescribing, and treatment needs to be accessible at the point of contact – when people ask for it, it needs to be there.'

There was also a noticeable culture change when crack entered Liverpool's sex work scene, she says. 'The women weren't watching each other's backs any more. It damaged that sense of solidarity and sisterhood, which led to an increase in risk and danger.' A growing number of sex work projects now offer in-house prescribing, however, and 'there's evidence that that really makes a difference'.

There's no such thing as a typical day at the project, she says. 'It can involve being in the office, with clients, or training and then it can all go out of the window because we get a phone call that someone's been raped. That could come in the day, but most of the time it comes in the middle of the night and I'd then go out to the client.' Is she ever able to switch off from the work? 'You have to, but sometimes it's very hard to do that. You wouldn't be any good if you didn't have a very strong personal connection.'

The assumption that the police had learned their lesson on attitudes to sex work with the Yorkshire Ripper case and the Ipswich murders of 2006 turned out to be overly optimistic. Does she detect any signs that attitudes are changing, albeit slowly? 'There are very definitely pockets of good practice, and there are a couple of cities that adopt a really pragmatic approach, although I can't really name them because *Daily Mail* readers would be up in arms. But overall it is hard.'

In 12 per cent of the 86 cases of rape recorded in the Liverpool north area last year, the victims were sex workers, while in 2007/08 the figure had been 22 per cent. A 2002 survey that questioned Liverpool sex workers about why they would not report attacks to the police elicited responses ranging from 'I don't want to be identified as a sex worker' to 'they might judge me' to 'they never do anything anyway'. Merseyside Police, however, have since taken the step of classing violence against sex workers as a hate crime, the only police force to do so. Is she hopeful that other forces might take the same approach? 'I am, and we've had several forces visit Merseyside and ask for guidance about how they can adopt a similar model. It's seen as a beacon, but so far no one has done it.'

Overall, legislation has worked to make women less safe, she stresses – sex workers in Bradford had previously been working in a residential area but the police moved them to an industrial zone where they were far more vulnerable. 'Somewhere where they're open to all kinds of abuse,' she says. 'No one's there to hear you scream. And if women work in a flat with someone else, they're open to brothel-keeping laws – women have been murdered working alone in flats.' Is it possible that the Bradford case might lead to an overhaul of the law? 'Yes, but what they're saying is they want tougher laws, which is not going to work – it's a knee-jerk reaction and it's misinformed.'

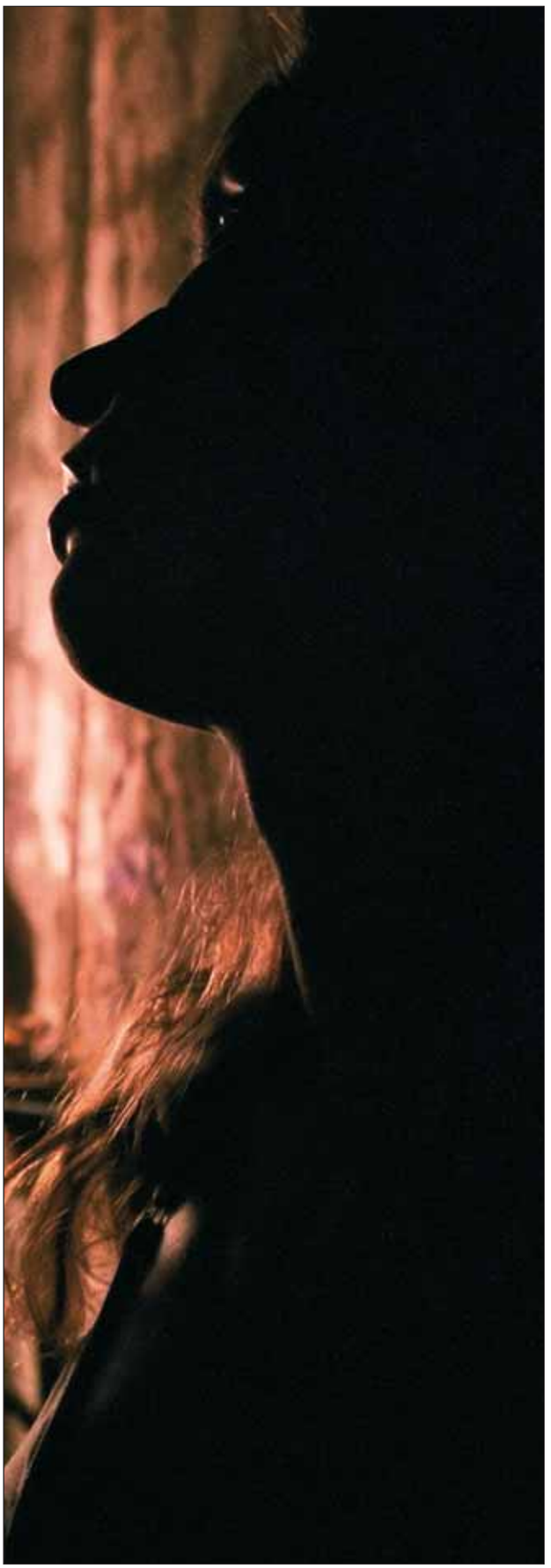
The government's prostitution strategy of 2006 had five strands – prevention, tackling demand, developing routes out, ensuring justice and tackling off-street prostitution. The original funding for the ISVA post came from the 'ensuring justice' strand, which focused on making sure that sex workers who are victims are treated with respect. The same year, however, saw the Ipswich murders. 'They spent about £20,000 on sex worker safety and about £20m on the Ipswich murder investigation. I know where the money would be better spent – on prevention.'

Best practice in police work prioritises safety over enforcement, she stresses, and the use of dedicated police liaison officers. 'There are lots of liaison officers in the country but what I find problematic is that often those officers will still be involved in enforcement – you have to have separation, you have to be pragmatic. If someone has a warrant for shoplifting or non-appearance or whatever and they get raped, then they're scared to come forward, so that has to be put aside. Those are the pragmatic decisions that have to be taken – prioritising the needs of that woman. I'm not saying you don't deal with that other stuff, but you can deal with it later.'

In Merseyside, it's now standard for police officers who deal with sexual offences to be trained in issues of sex work, and the key issue, she says, is that when women do report incidents they are believed. 'If you're a taxi driver and someone rips you off for a tenner you're not going to spend hours in a police station reporting it when you could be out earning hundreds instead. Women would not report these things if they weren't extremely serious.

'When [the Bradford story broke] you just think "are we learning nothing?" Why, why, why is this happening again?' The case means there have now been 14 murders of sex workers since Ipswich. However, there is some sense that things are moving in a positive direction – funding was agreed in April for five more ISVAs in sex work projects, although they're not yet in post. From a legislative perspective what would she most like to see? 'Decriminalisation – let's take it out of the back streets, let's have a reasoned, adult debate about this. It totally mirrors the drugs debate – let's take it out of the criminal fraternity.

'I'm very much a believer that people have the right to choose whether they want to sex work and, while some people will believe it isn't a choice, all the choices we have are in some way circumscribed,' she says. 'We have to think about allowing those choices to be made and having a debate around that. We can never guard against everything but what we can say is overwhelmingly it's safer for women to work together, indoors. And the media needs to stop saying "three prostitutes have been murdered" and start saying "three women have been murdered". These women were all somebody's daughter, friend, sister, mum, wife, partner, and they were all loved.'



DAILY DELIVERY

On *DS Daily*'s first anniversary, editor **Jim Young** takes us behind the scenes of the online news service

A YEAR AGO DrugScope launched a drug and alcohol news service called *DS Daily*, with myself as editor. We hit the ground running with 16 articles on the first day, and by the end of our first full month we had 51 entries in the reports section. In September 2009 we combined forces with *Drink and Drugs News' DDN Daily* service to give the best possible daily update to both sets of subscribers, which is why *DDN* is now associated with *DS Daily*.

Each day I get up at 6am to trawl the worldwide media, and I spend my evenings going through more professional resources. The plethora of excellent information on international websites is simply too much for the busy professional to visit and assess. Digital news feeds are uniquely inane in returning reports about cracks in a bridge when searching for crack cocaine – or they return innumerable results that are too tenuously related to the criteria to be of any value. It is only by winnowing the considerable chaff from this harvest that the grains of truth can be presented.

Of course one person's truth is another person's bias, and that's why we aim to carry all shades of opinion without finding fault or favour. It's not always easy to assess the balance, but we must be doing something right judging by the increase in the number of subscribers day on day. My editorial work is made easier by the fact that, although I have a science and nursing background, I have never actually worked in the drug and alcohol field so I carry no excess baggage.

While *DS Daily* is hosted on the DrugScope server and I rely on the IT skills of their webmaster, it is an important feature of the service that my independence as editor is never compromised. I have managed to develop a feel for current topics of interest and debate, and I also receive many emails suggesting topics that might be suitable for inclusion.

I try to keep the format of *DS Daily* as fixed as possible, with UK news first, followed by Europe, Canada, USA, Australia and New Zealand, then the rest of the world. I usually run drug news followed by alcohol, but the order changes to reflect the importance of the story. Peripheral material is never overlooked as every speciality has interests that diffuse across the more obvious boundaries. The format of the headline listing and short blurb lends itself to quick perusal, so every reader can take or leave each article according to their personal preferences.

Because the *DS Daily* newsletter is sent out each morning there are times when breaking news has to wait almost 24 hours before dissemination, so we have begun to share news items on Twitter in as near to real-time as is possible.

On a personal note, I find it very rewarding to be working at the centre of a communications hub for drug and alcohol information from across the world. Because of my neutrality as editor I find that most conversations about submissions are friendly and personal. However serious the issues are for the drug and alcohol field, and however polarised the debates become, we must never lose sight of our shared humanity. In this vein I welcome all views at *DS Daily*.

Jim Young invites readers' suggestions for inclusion on DS Daily. Email jimy@drugscope.org.uk

LETTERS

Academic integrity

I was rather surprised to see Alan Joyce's apparent reference to Scottish Addiction Studies (SAS) in his article *Talking heads* (*DDN*, 24 May, page 10). Mr Joyce implies that the SAS network is in some way colluding with the Centre for Social Justice to drive forward a politically motivated, abstentionist agenda.

SAS is a network of over 20 academics in various departments across the University of Stirling – one of the largest addiction-related academic partnerships in the UK. Within this network, partners have interests in a wide range of addiction-related issues including the marketing and promotion of tobacco products, the management of people with alcohol-related brain damage, women substance misusers in the criminal justice system, drug and alcohol misuse in pregnancy, self-help and recovery, assessment and management of chronic leg ulceration and the experiences of non-treatment seeking recreational users. Our work over this wide range of interests is commonly characterised by a strong belief in bridging the gaps between the research and the practitioner communities and producing research findings that can be readily used in treatment and prevention.

In all this work, our academic integrity is of critical importance. We do not pursue any political agenda and our primary interest is in the exploration and development of the evidence base and the translation of research findings into effective practice. We have never, to our knowledge, worked alongside or with the Centre for Social Justice and it would seem unlikely that we will do so in the future.

In one other important respect, Mr Joyce's article appeared to be somewhat ill informed. His rather cavalier dismissal of 'talking therapies' – by which he appears to refer to almost every treatment intervention other than substitute prescribing – displayed little understanding of the vast array of research undertaken in the addiction field over the past 50-100 years. Surely Mr Joyce is not suggesting that huge, scientifically robust studies such as DARP, TOPS, DATOS, Project MATCH and NTORS – all of which reported significant value to psychosocial interventions and peer support – are without validity. If so, he really has to provide a more scientific proof that he was able to do in his article.

There is a common view (with which Mr Joyce appears to be at odds) within contemporary addiction studies, that addiction is a hugely complex disorder which is impacted upon by environment, culture and individual mental health; a reversion to a Jellinek-style belief in a simple disease model where pharmacotherapeutic intervention is the only valid response seems entirely at odds with such thinking.

As academics and committed addiction researchers we welcome discussion and debate around these issues but we do not believe that gratuitous asides about 'agendas', 'malice' and 'conspiracy' advance our knowledge of the issues, or are conducive to the development of best practice.

P R Yates, senior research fellow, Scottish Addiction Studies, University of Stirling

Dizzee thinking

After reading Alan Joyce's article I can understand his anxieties regarding the role of talking therapies in any government direction on drug treatment.

Harm reduction can be a good treatment option for those who have not 'crossed the line' with their drug or alcohol use, and prescribing can be a form of harm reduction if it means a user will no longer inject. But I have heard from many service users I have worked with that they would rather stay on the heroin than be subjected to methadone for years on end. I have been told by users that methadone takes away motivation, and the withdrawals from the juice can be worse than heroin itself.

My view is that a low dosage script to start with and then a Suboxone

'We do not pursue any political agenda... We have never, to our knowledge, worked alongside or with the Centre for Social Justice...'

detox would lessen the masses of funding for prescriptions, which is where a lot of government cash is being spent. I say government cash, but it is actually the good old taxpayer's proceeds that go on medication being dished out.

One of Alan's arguments was the lack of long term follow-up studies that track service users who have used talk therapies. My argument is that while a lot of these patients will have moved on, some may have come back through the system to start over again. I also feel that prolonged maintenance prescribing does not deal with the problem – which is the cognition of the sufferer who turns to drugs to shut up the addictive voice. So by continuing to use another substance, *ie* any form of prescribing, the addiction is never dealt with.

The rapper Dizzee Rascal has openly said that talking about his turmoil has helped him move on from his old lifestyle. Dizzee also does not agree that hours of therapy are the answer, but simply by pouring out his heart he has freed himself up. An empathic listener who can also help someone change their habitual mindset really has to be a better option than staying on an opiate substitute.

David Casellas, by email

Two steps back

The National Addiction Centre has announced that 'injectable medical grade heroin should be offered under supervision to the most hardened addicts', which of course was first proposed by the psycho-pharmaceutical industry when the government asked for advice in the 1950s.

But with dosages necessary every eight hours it proved unworkable, and to say that an addict could consider returning to work whilst injecting heroin is totally unrealistic. It was because of such unworkability that the industry proposed methadone, at one dose a day.

Few employers would want a taxpayer-supplied addict to drive his delivery van, or to work a factory machine, or be a school caretaker, any more than he would want a street-supplied addict to do these jobs. And how does one supervise injections in working hours and around midnight?

Professor McKeganey's Glasgow University drug usage research team revealed that only 3 per cent of methadone users quit using methadone, and the NTA confirmed this. So, how can Professor Strang's team possibly claim there are only 'around 5 to 10 per cent of heroin addicts who fail to quit despite use of conventional treatments, such as methadone'? It is closer to 97 per cent who fail to quit as a result of conventional treatments.

You don't treat a person who has been burned by continuing to burn him, and you don't rescue an addict from addiction by giving him free doses of the substance to which he is addicted. This is an admission that the National Addiction Institute doesn't have a clue about the real nature of addiction and recovery therefrom, which they insist on considering a 'medical' matter.

Dr Roy Robertson said that free medical grade heroin 'is the intensive care for those heroin users who have failed after all sorts of other available treatments and continue to inject'.

He could be right – but only if the National Addiction Centre had ever bothered to try the most successful of the world's available addiction recovery systems, which has nothing to do with medical treatment and everything to do with training and restoration of personal responsibility.

Kenneth Eckersley, CEO, Addiction Recovery Training Services

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity. Visit our forum at www.drinkanddrugsnews.com

SUPERMARKET SWEEP

The coalition government has announced plans to stop supermarkets using alcohol as a loss leader. **Alan Alker** considers the potential impacts

IN RECENT YEARS supermarkets have made increasing use of alcohol promotions to boost their customer footfall and profits. These promotions are usually widely advertised and involve two or three large packs of beer or cider for £15-£20. The supermarkets hope that these will lure price-conscious shoppers who will then go on to complete their weekly 'big shop', with promotions common during bank holiday weekends and major football tournaments.

As England's final World Cup warm-up game coincided with the Whitsun weekend, I thought this would be a good time to investigate. I decided to visit four of the main national supermarkets and three of the main discount stores near where I live. All the stores were busy despite the wet weather, and all four of the major supermarkets had alcohol promotions. Their foyers were festooned with St. George's flags and 'Come on England!' posters while mountains of Stella Artois cans jostled for space with (rather optimistic) displays of barbecues and parasols. Sainsbury's offered three packs for £20, Asda two for £15 and Morrison's three for £18. Tesco say that a ban on cut-price alcohol should be introduced, though their store still seemed to have some of the cheapest alcohol available (two packs for £16, three for £20). While none of the discount stores I visited had similar promotions, the cheapest alcohol was their white cider, with just one of the ten cheapest drinks being sold as part of the promotions – Strongbow cider from Tesco.

It's widely accepted that a significant increase in the price of alcohol may be an effective means of reducing consumption, and therefore alcohol-related health and social problems. One suggested option is the setting of a minimum price for a unit of alcohol, but the oft-cited counter argument is that this would penalise the majority of the population who drink responsibly. A less-frequently voiced objection, though, concerns the impact on dependent drinkers who may be consuming 30-40 units daily. It could exacerbate the drinker's already serious financial problems, leading to increased debts, unpaid bills and rent arrears. A limited income may be directed towards the purchase of alcohol and away from food – with the risk of malnutrition and related problems. It could also lead to an increase in crime, such as shoplifting alcohol, the use of illicitly-produced alcohol and even a return to surrogate alcohol like surgical spirits and cleaning fluids. The risk of acute withdrawal would be heightened, possibly resulting in increased hospital admissions following withdrawal seizures or DTs.

An alternative, or complementary, approach would be to restrict availability. Just as alcohol has become more affordable, it has also become much more available with pubs that used to shut down every afternoon and close promptly at 11pm now able to open from 7am until the early hours. Supermarkets offering vast displays of alcohol and open 24 hours have replaced off-licences limited by restrictive opening time legislation. The number of licensed premises has increased significantly over the past 30 years and now few corner shops are without a comprehensive selection of alcoholic drinks.

A straightforward, though controversial, means to reduce availability would be to raise the age of alcohol purchase, for example from 18 to 21. This was achieved in the USA via the National Minimum Drinking Age Act of 1984 and many other countries have a purchase age above 18 years, including India, Iceland, Japan and Canada. This would almost certainly have a profound impact on consumption but it's unlikely that any of our political parties would risk such a policy for fear of alienating a large swathe of new voters who could swing the result of a forthcoming election. Regardless of the evidence, the likelihood of this happening is less than that of England winning the World Cup.

Alan Alker is clinical nurse specialist/team manager at Tameside and Glossop Drugs and Alcohol Service, Pennine Care Foundation Trust

Supporting women substance misusers and their families was the theme of a recent conference organised by the Brighton Oasis Project. **David Gilliver** reports

FEMALE FRIENDLY

'It will be interesting to see what the new government does about family support,' Adfam's head of policy and regional development, Joss Smith, told delegates at the Oasis Project's *Women and children first?* conference in Brighton. 'What this brave new world of politics will mean for the future of drug and alcohol services, and for families with multiple needs.'

Sixty-one per cent of people who came into treatment were parents, and half had their children living with them, said the NTA's head of delivery for the south, Lynn Bransby. 'It's not a minor part of the treatment system.' Better links with family services to assess women's parenting skills at the outset were essential, she stressed, in order to make sure support was available where it was needed. 'We want to see drug treatment agencies gathering the right information about parenting at the beginning, and offering harm reduction advice.'

Drug treatment workers were not expert in assessing parenting capacity, she acknowledged, but they could act as a vehicle to move people on to appropriate agencies, potentially through joint commissioning. 'That's a debate that every treatment agency needs to be having,' she said, adding that the coalition government's emphasis on localism would also lead to more decisions being made at local level. 'We live in interesting times,' she told the conference.

Adfam had carried out consultations last year as part of its *Manifesto for families*, Smith told delegates, and among the key themes to emerge had been the need for a national understanding of confidentiality. 'It was thought that perhaps the true meaning of confidentiality had been lost along the way and that we need to have a common sense understanding,' she said. It was also essential that public services 'think family' and that services genuinely worked together. 'Partnership is a wonderful word but it's harder making it work in practice than just writing it down,' she said. Commissioning effectively was also vital, as families had needs that 'work across so many different agendas'.

Describing his work in legal cases involving the children of substance-using mothers, barrister David Spicer said 'it's stressful work, because the nature of the decisions have an impact, and the potential for falling out with other professionals and agencies is huge. There's no room for lack of clarity or certainty about roles and responsibilities.'

There was often a dislocation between policy and delivery, he told delegates, and the starting point for reaching sound judgements always needed to be

'Sixty-one per cent of people who came into treatment were parents, and half had their children living with them.'

reasonableness and drawing appropriate inferences. The complexities demanded a rigorous approach, yet social workers received little or no training in drug misuse issues before qualifying. Terminology was also vital, he stressed. 'If we're going to talk to each other more we need to understand what the other is saying. What does "chronic" mean? Health professionals would say "long lasting" but others would say "serious". And is "morbidity" concerned with death or with sickness and disease?'

While drug use for men was often seen as 'a risky stage they go through', women drug users were 'really demonised and looked down on,' director of the Brighton Oasis Project, Jo-Anne Welsh, told the conference. 'We see the impact of substance misuse on children and we don't minimise that in any way. There's also the question "where are the fathers in all this?", as they're often completely absent or, at best, not a protective factor in their children's lives.'

Oasis delivered tier 2 and tier 3 services alongside services for sex workers, assertive outreach, a crèche and therapeutic services for younger people, as well as working with women offenders, she said. 'Women are outnumbered three to one in treatment, and there are lots of reasons for that.' These included childcare, fear of asking for help and the implications that might have for children.

'We're seeing increasing numbers of women sent to prison each year, and 66 per cent report drug or alcohol misuse,' she continued. Women tended to be more hidden in their drug use, however, and therefore perhaps perceived as needing treatment less than men. 'They're perhaps less problematic until they come to the attention of family services.'

Once in treatment, women benefited from one-to-one work as well the peer support that came with group work, Oasis Project volunteer Cheryl Hilton – who had come through the programme herself – told delegates. They valued support, trust, reliability, friendly faces and honesty, as well as a daily structure. Services needed to be accessible and non-judgemental, and safety was paramount, she said. Rewarding clients with things like certificates and flowers also worked well – 'that's important for people who might think they've never achieved anything before.'

In terms of substance use and mental health dual diagnosis, this was 'usual rather than exceptional', dual diagnosis nurse consultant at Sussex Partnership NHS Foundation Trust, Dr Anita Green, told the conference. Parenting issues made the situation even more complicated for women – mental health issues adding to the harsh stereotyping and stigmatisation women suffered in comparison to men meant even more of a disincentive to seek treatment, as worries about children became more acute. Separate funding streams also meant that people had fallen through the cracks. 'It's so important that we work together, particularly including women's sector organisations,' she said. 'Partnerships are essential to providing a cohesive service.

'Some of the women I see have had long periods of hospitalisation and medication,' she continued. 'With women, the dash for abstinence isn't always a realistic option and we have to be careful with that – it's important to think about harm reduction and how that fits with treatment.' Drugs were memory suppressors for women with histories of physical and sexual abuse, so it was important to approach detoxification 'very carefully', she said, and dual diagnosis could often be missed in women accessing treatment – 'we need to think about whether dual diagnosis is under-identified because of the way women present, with all the issues of non-disclosure. Maybe we need more women-only outreach workers to work with women who don't feel they fit into the specific care models provided.'

Of all the ways substance misuse could have an impact on women's lives, pregnancy was the most extreme example, consultant at the Trevor Mann Baby Unit at Brighton's Royal Sussex County Hospital, Dr Neil Aiton, told delegates. Drugs and alcohol could have an impact on general health, nutrition, antenatal attendance, blood-borne virus infection, psychiatric illness and domestic violence. 'If there are two things that dramatically increase the risks to a baby's future they are being born early and being born growth retarded,' he said. 'We had a woman who was fearful of accessing services and had gone into labour with twins at 27 weeks. That's not a good outcome.'

There were also serious issues around organ formation and early foetal loss, he continued. 'A lot of drug users are not experiencing regular periods and they don't think they're going to get pregnant, but then bam! It arrives. My duty of care during pregnancy is to the mother but after the baby is born, as a paediatrician my duty is to the baby. That has interesting ramifications in terms of working with other professionals in health and social care.'

Maternal substance misuse could affect the mother's health, the pregnancy, the foetus and the baby after its birth, he stressed. 'These mums need many extra appointments and the involvement of many professionals – obstetric, neonatal, social work, housing and scans. Any engagement is better than no engagement but it's really encouraging to see how many mums who are in a bad place will move in the direction of seeing there's something more important than themselves, even if that means recognising that the baby would be better off with someone other than them.'

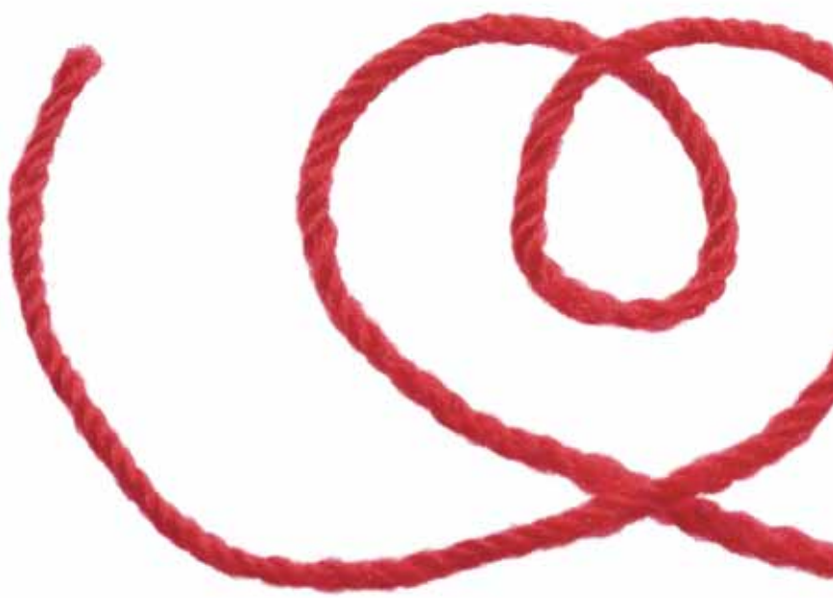
However it was important to point out that with regular methadone use – and the cessation of illegal opiate use – 'you can still get normal birth weight and normal pregnancy,' he said. 'There is, of course, the risk of neonatal withdrawal, but the best start that baby can have is to get to the end of pregnancy and be a normal birth weight. Neonatal withdrawal can be managed properly.'

Around 30 per cent of domestic violence cases began during pregnancy, however, manager of community outreach and therapeutic services at Rise in Brighton, Jessica Taylor, told delegates. One of the challenges of identifying domestic violence when substance misuse was the presenting issue was that 'the primary presenting issue masks other needs' – partly a result of the secrecy and shame surrounding both issues.

'Domestic violence is not an anger management problem,' said her colleague Rose Hawkins. 'It's a calculating, coercive pattern of undermining behaviour in which someone seeks control.' Substance-using victims of domestic violence often perceived violence as normal, she added – 'they don't really question it. Part of our work is about challenging that denial.' Women who misuse substances were also often excluded from services, said Taylor. 'It doesn't mean she's permanently excluded but it can be problematic.' The threat of children being taken away could also be a way of keeping victims compliant and afraid of involving the authorities, she stressed.

'So why don't women just leave?' said Taylor. Fear of the abuser, fear of being alone, denial, rationalisation and normalisation all played a role, and women who stayed often became extremely isolated, losing the networks around them. Practical issues included money, accommodation, employment and, of course, the children, as well as concerns about whether they'd be believed if they did disclose. Once again, interagency working was crucial, delegates heard. 'If there's two issues going on, it's not helpful to say "we'll deal with one first"' said Hawkins. 'Very often people can't address one without the other.'

Scott's drug service was fantastic and his caseworker brilliant, but that didn't stop him becoming a drug death statistic when he tried to ask for help out of normal hours. Why is prejudice getting in the way of essential healthcare, asks his heartbroken mother, **Maureen Roberts**



TOO LITTLE TOO LATE

ON THE MAY BANK HOLIDAY, Scott was late going to the chemist for his methadone and the chemist was shut. He always picked up his prescription up on a Monday, but because of the bank holiday it was pick-up on a Saturday – but they shut at 1pm. Scott went just after 1pm and they'd gone. Nobody was there.

So he contacted the emergency doctor service and told them what had happened, and they said 'tough', basically. Nobody would dispense any to him, and he was told he'd have to wait till the Tuesday.

If you speak to people who've got drug problems they'll tell you they dread Christmas, they dread bank holidays, they don't like Saturdays or Sundays. Scott's service is fantastic and his caseworker is brilliant, but it was unfortunate it was a bank holiday and nobody was there to be contacted.

He rung around trying to get methadone and got some on the black market that had been watered. So he suffered from the Saturday onwards. He was in withdrawal. He went back to the service on the Tuesday and they sorted him out.

But because he hadn't picked up for the four days there was a problem. After they'd realised what had gone on they gave him a prescription, so Scott took his methadone on the Tuesday and the Wednesday and he started to be sick on the Thursday. He bought some more methadone on the black market to make himself feel well again.

'He's where he is now because services still treat drug addicts like people who are trying to have them over. You can't go and say you're having a genuine emergency.'

He was OK Friday and Saturday, but on Sunday morning he was vomiting again and had some more methadone – not a lot, because he hadn't got a lot. I suspect that Scott died of methadone poisoning because his tolerance would have gone down after four days without it.

Scott should not be where he is now. He's where he is now because services still treat drug addicts like people who are trying to have them over. You can't go and say you're having a genuine emergency – Scott had even gone and said 'you can supervise me so I can get back on my prescription. I can come everyday and you can give me methadone'. But the answer was no.

I didn't know he'd been sick on the Sunday. I'd seen him on the Sunday night and he wasn't intoxicated, nothing. I didn't know about the sickness. But I do know that if I'd taken him to the A&E department, nobody would have looked for methadone poisoning. Because we don't talk about it.

He died on 10 May. The doctor came round last Sunday and gave me an injection and some tablets. But no tablets are going to help me. I loved that boy and there was nothing in his life that was taboo, nothing that we couldn't talk about.

We don't talk about methadone poisoning and Scott is sadly going to be a drug stat, when that wasn't his life. We have to talk about this problem that some people have, what the signs are and how we inform the medical profession. Scott could have easily been sorted out with some naltrexone.

When services are not available, people are still using the old prejudices that they're just trying to get some extra drugs. That's what happens at the stand-in service, the medical relief service that works at weekends when the doctor's not available.

I know that if I go to hospital they can access my medical notes very quickly, through a computer. When they also know who my doctor is, they can find out other things about me. If Scott had been asthmatic or insulin dependent, he would have had the prescription written for him on the Saturday. But because he was addicted to methadone, nobody was going to help him.

The relief service didn't suggest anything for someone who was methadone dependent. He was willing to go to the outpatients or the pharmacy, but he didn't

get anything till the Tuesday. Tolerance to methadone drops really quickly.

Scott couldn't mess about because he had a full-time job. He'd been so ill for days because of this non-service and all he wanted to do was make himself feel better. Scott was on 85ml a day. The thing that went wrong was his tolerance dropped so quickly.

My son died of methadone poisoning – I don't need the coroner to tell me. I know he was completely heroin free – he worked 70 hours a week. This was a man who was getting on with his life.

The Cord

By Maureen Roberts

We are still connected
My son and I
An invisible cord
Not seen to the eye
It's not like the cord
That connects till birth
This cord can't be seen
By any on earth

This cord does its work
Right from the start
It binds us together
It's attached to my heart
I know it's there
Though no one can see
The invisible cord
From my Scott to me

The strength of the cord
Is hard to describe
It can't be destroyed
Nor be denied
It's stronger than any cord
Man could create
It stands the test
And takes any weight

Although you are gone
And not here with me
The cord is still there
But no one can see
It pulls at my heart
Till I'm bruised and I am sore
But this cord is my lifeline
As never before

I am thankful that God
Connects us this way
A mother and son
Death can't take away

Comment

A call to arms

A little support can go a long way to bolster service user groups amid the cutbacks, argues Tim Sampey

A NEW GOVERNMENT, a raft of funding cuts and the London Service User Forum (LSUF) is gone. Which leaves a simple question – does it really matter?

I think it does. The LSUF has had a long and colourful history. Often argumentative, especially in the early years, full of passion and fury, sometimes disorganised and occasionally very funny to watch, it nevertheless provided a learning opportunity for many of us who were to become embroiled in service user involvement.

It was a forum where we could put names to faces, discuss our ideas, swap models of practice and pass back and forth our individual experiences with treatment providers and DAATs. It allowed us to support each other personally and professionally. Perhaps most importantly of all, it was the only place that people new to service user involvement could meet their peers en masse and be guided through this strange world by others walking the same road.

For many of us the forum was the place we sought the strength and encouragement to continue with our work. Inspired by each other, we returned to our boroughs invigorated and recharged. I met most of the people I know who have made a real difference to service user involvement in London at the forum.

Let us not forget that in the last five to seven years, service users in London have taken some enormous steps. We have seen the growth of the Alliance, the creation of peer-run, socially-based tier 2 weekend services, sports clubs, women's groups and support groups. Significantly, many DAATs encouraged a real involvement at policy level that was once considered unthinkable. The list of service user achievements is long and growing on an almost weekly basis. The LSUF was central to this process, and needs to remain so. In the long term, it might well prove vital to service user involvement that we keep it alive.

We owe the NTA our thanks for creating and hosting the LSUF for so long. But where next? I would suggest we see this not as a time for mourning but as the moment when we come of age and take the LSUF fully into our own hands. I would like the NTA to consider hosting a final forum in which London's service users can meet to discuss the creation of a new forum and look at the practical issues necessary to taking this forward.

We are more than capable of creating and managing our own steering group. Asking all of the London DAATs to take turns in providing a venue and refreshments for a LSUF that would take place on a quarterly basis seems reasonable. In return we would commit to organising the event, and ensuring that their local service user group would be supported to showcase their own work. If this event were to be staged four times a year, and bearing in mind there are 33 London DAATs, it would be a minimal commitment of perhaps once every five or six years for each DAAT – hardly expensive or time consuming.

So, is the NTA prepared to host one last forum? Are the London DAATs prepared to make a fairly minimal commitment to supporting a wider vision of service user involvement in the capital than might currently be in their local remits? Are London's service user coordinators, service user leads and service users willing to join forces and commit to the work necessary to keep the forum alive?

Answers on a postcard to kandcsudrg@yahoo.com or hicksonrobert@ymail.com

Tim Sampey is service user coordinator at Kensington and Chelsea

MYSTERY SOLVED

How are service users really treated when they visit a needle exchange? Wandsworth PCT decided to find out, says **Raychel Peters**

Wandsworth's pharmacy-based needle exchange service has been operational for several years now and a fixed needle exchange site based at Wandsworth Drug Project has been up and running since April 2008. While there is regular monthly support and training provided to pharmacists and the fixed site, no specific audit of the service had been conducted which prompted us to conduct a 'mystery shopper' exercise.

This was carried out at both services for the first time in September 2008 to make sure that clients' requests and concerns were responded to appropriately. Through analysing the data collected we were able to identify areas of concern and work closely with the needle exchanges, and it also provided a good opportunity to acknowledge the exchanges that provided the best service. We therefore decided the exercise should be rolled out annually.

The aim is to monitor the overall needle exchange scheme and to test specific knowledge and skills. Seven clients were recruited, four of whom are using the needle exchange on a regular basis and are not engaged with any services, along with three recommended by the Wandsworth Service User Forum. The criteria were that they must either be currently injecting and using the exchanges, or had in the past, and the exercise is completely confidential. Clients were given false names and profiles to use in the pharmacies, and were not able to carry out the exercise in their own pharmacy.

There were sets of questions for each service as well as scenarios that the service users were briefed on in advance. Clients provided verbal feedback with the opportunity to provide any additional comments and concerns.

The main areas that the mystery shoppers looked at were whether staff were complying with the aims and objectives as set out in the service level agreement as well as standards for infection control and health and safety in relation to sharps, and whether they were providing a dedicated response and high quality service to meet individual needs. There was also ongoing training needs analysis – identifying weaknesses in the service to assess the effectiveness of training and if there were any immediate training needs – and monitoring the service as a whole.

The service users worked very closely with the needle exchange facilitator and service user coordinator and after each pharmacy questionnaire were paid £10. Service users could only carry out the exercises at a maximum two pharmacies a week – a disclaimer form was signed after each payment.

Each mystery shopper was asked the same questions about all of the pharmacies and the fixed site – how they were greeted, who served (counter staff or pharmacist), how long it took, were they treated in a non judgemental way, were they provided with information leaflets and were they asked to complete a client form.

The vast majority were greeted immediately, especially in the 2009 exercise and

'The help of the service users has enabled the DAAT to develop the service for the future and it is a model the DAAT will adapt to other areas of the treatment system, to ensure services are meeting the needs of drug users...'

on the question of whether the greeting was friendly, the vast majority said it was.

To the question 'were you given the opportunity to request pick and mix?' – to determine service users' ability to request different size needles and syringes – most answered 'no' in both 2008 and 2009, and information on pick and mix will be included in the ongoing training provided throughout the year. On the question 'were you asked if you had used the exchange before?' the vast majority answered yes with, again, improved results in 2009 – all staff will be advised to ask clients if they have used the needle exchange before and provide a starter pack.

The overwhelming majority were treated in non-judgemental manner. However most reported that staff had not asked them to complete the client form that monitors the number of injecting clients in the borough and the drugs they are injecting, so all staff will now be advised of the importance of completing a new client form. To the question 'were you provided with an information leaflet?' the vast majority said yes, an improvement on 2008. However to the question 'were you informed of the times that you can access the services?' most answered no in both 2008 and 2009. All pharmacy-based needle exchanges will be asked to advise all services users of the opening times of pharmacies, especially over public holidays.

Scenarios enacted included the mystery shopper collecting for a friend, asking for advice on harm reduction for groin or neck injecting and routes out of injecting, asking about getting into treatment and getting a script, and whether the service can be used by those living out of the borough.

Mystery shoppers asked specific overdose-related questions, such as telling the pharmacist they drank alcohol and were receiving a prescription for methadone but were using on top. They were also asked to advise the pharmacist that they had shared paraphernalia and had not been tested for any BBVs and that they had an injecting site that had become infected in the past – did staff provide advice around BBVs and suggest vaccination options?

In 2009 all pharmacies were given different scenarios to those they had been given the year before, with underperforming pharmacies undergoing training in their particular areas of need. After analysing the data, the findings were very positive – all ten pharmacies within the borough provided an excellent service and complied with all the aims and objectives set out in the service level agreement, signposting the most vulnerable clients to other services and to A&E, whether with injecting infections or just because of poor health.

Pharmacists were polite and non-judgemental, treating service users no differently to other customers. The counter staff and pharmacist were respectful when issuing equipment and aware of the service users' needs, and all pharmacies were very knowledgeable regarding supplying clean injecting equipment and advising clients about overdose issues. There did seem to be some uncertainty, however, regarding information about available treatments, including complementary therapies, as well as whether people were able to use the services if they lived out of borough. No one was turned away who stated that they lived out of borough, but the staff seemed to be unsure of the protocol, and this has now been addressed through providing each pharmacy with a signposting folder with information about all local services. All staff were professional, discreet and provided services users with as much information as possible, with some even accessing the internet for the client.

At Wandsworth Drug Project's fixed needle exchange clients are able to collect clean injecting equipment and receive professional advice and help. A bloodborne virus nurse is on hand two days a week and key workers provide one-to-one counselling and advice on detox, rehab and further education. When the mystery shopper was rolled out initially, however, the project did not perform as well as expected, so last year the exercise was carried out on three different occasions and various times of the day.

This time the fixed site provided an outstanding service on all occasions – all members of staff were friendly, courteous and greeted the services users within minutes of them attending. All service users were asked to complete a new client form and to provide information on injecting sites. This was done with clients' consent by asking them to make a cross or crosses on a body map, so staff could provide harm reduction advice on safer injecting practices, bloodborne virus testing, cleaning sites and routing veins.

Clients attending the fixed site are often near to the end of their injecting career, with many injecting in dangerous sites such as the groin or neck. While the pharmacies provide an excellent service they are unable to deal with the more chaotic and vulnerable service users, and one service user stated he would not have informed the pharmacist of the sore in his groin, but he felt that he was able to do so at the fixed site.

In the 2008 programme the main areas of concern were around interaction with service users, discreetly identifying clients who need to use the needle exchange, asking if clients had anything to return and what they had done with the used paraphernalia, and ensuring accurate harm reduction information and advice was provided. There were also issues around advising clients of opening times and other exchanges nearby and ensuring new clients registered and completed new client forms. Training and support in all of these areas was then provided throughout the year to all pharmacies.

Rolling out the mystery shopper for the second year has proven to be very encouraging – it's shown that training for pharmacists and counter staff has meant the services have been greatly enhanced. The help of the service users has enabled the DAAT to develop the service for the future and it is a model the DAAT will adapt to other areas of the treatment system, to ensure services are meeting the needs of drug users in Wandsworth.

All counter staff and pharmacists will have in-house training that will be rolled out quarterly. Any new staff that will be in contact with the needle exchange will be trained immediately, and all pharmacies will be provided with a signposting folder with information on all services in Wandsworth. And, of course, we will continue roll out the mystery shopper exercise.

Raychel Peters is needle exchange facilitator at Wandsworth PCT

DRUGS, ALCOHOL AND CRIMINAL JUSTICE
ETHICS, EFFECTIVENESS AND ECONOMICS OF INTERVENTIONS

CENTRAL LONDON
23-25 JUNE 2010

Speakers include:

Diane Abbott MP for Hackney North and Stoke Newington and Labour leadership candidate, and **Inspector Leroy Logan** from the Metropolitan Police.

What are the links between drugs and violent crime in the UK?

Damon Barrett IHRA, **Niamh Eastwood**, Release and **Niki Adreescu** APADOR-CH, Romania

Patient or prisoner? Human rights and informed consent in the criminal justice system – an examination of the delivery of health care in custodial settings.

Paul Hayes NTA, **Eric Schneider** ACCES France, and **Diane Hilton** Phoenix Futures.

Interventions and the continuum of care – what do we mean by harm reduction and recovery, what is integrated treatment and how is it best delivered?

This conference takes place at a time of unprecedented competition for scarce resources. To be able to demonstrate value for money is critical, nowhere more so than in drug and alcohol treatment. The conference will look at a range of interventions and treatments, from harm reduction to drug-free recovery. While no single treatment modality can deal effectively with the complex range of presented needs, delegates will debate how to most effectively combine the different components to provide the best possible service for clients.

Other presentations from:

Stephen Rolles, Transform; **Mark Dixneuf**, SIDACTION, France; **Alex Stevens**, University of Kent; **Linda Davies**, University of Manchester; **Ambros Uchtenhagen**, Institute of Public Health, Switzerland.

Full details and booking at:

www.connectionsproject.eu

THE NEWHAM SUBSTANCE MISUSE PARTNERSHIP INVITES EXPRESSIONS OF INTEREST TO TENDER FOR THE MOVING ON SERVICE

The Newham Substance Misuse Partnership is proud to offer a real opportunity for a suitably qualified and experienced organisation to deliver the Tier 2·3 Moving On Service.

The Newham Substance Misuse Partnership on behalf of NHS Newham and the London Borough of Newham are redesigning their drug and alcohol treatment system in line with the personalisation agenda, with a focus on treatment effectiveness and recovery. Newham is also currently developing high quality and productive services comprising a selection of innovative and exciting 'Hub & Spokes' which aims to improve health and well-being to the people of Newham.

The successful organisation will offer a service which will act as a gateway to permanent accommodation, support people to lead healthier drug and alcohol free lives and facilitate independent living. The service will provide individual living skills such as life skills, advice, relapse prevention, financial management; and access to education, employment and housing. The service will work in collaboration with the Drug and Alcohol Care Management Team and other relevant partners to deliver sustainable and holistic aftercare packages addressing service users housing, education, training and employment needs.

It is anticipated that the contract will be let for 3 years commencing 01 April 2011.

For further information, and/or to express an interest, please contact: Steve Frost, Senior Procurement Manager, NHS Newham, Warehouse K, Unit 8, 2 Western Gateway, Royal Victoria Dock, London E16 1DQ or email: steve.frost@newhampct.nhs.uk

The closing date for expressions of interest is 12 noon on Wednesday 07 July 2010. Late expressions of interest will not be accepted. The Newham Substance Misuse Partnership reserves the right not to make an award.

Newham London

NHS Newham

THE NEWHAM SUBSTANCE MISUSE PARTNERSHIP INVITES EXPRESSIONS OF INTEREST TO TENDER FOR THE DRUG AND ALCOHOL ASSESSMENT AND CARE MANAGEMENT TEAM SERVICE

The Newham Substance Misuse Partnership is proud to offer a real opportunity for a suitably qualified and experienced organisation to deliver the Tier 3 Drug and Alcohol Assessment and Care Management Team Service.

The Newham Substance Misuse Partnership on behalf of NHS Newham and the London Borough of Newham are redesigning their drug and alcohol treatment system in line with the personalisation agenda, with a focus on treatment effectiveness and recovery. Newham is also currently developing high quality and productive services comprising a selection of innovative and exciting 'Hub & Spokes' which aims to improve health and well-being to the people of Newham.

The successful organisation will offer an open access service which will deliver social and crisis support, care co-ordination and management for service users with drug, alcohol, drug/alcohol and mental health issues. The service will also act as a gateway to other relevant services as well as providing on-going care planning for those service users engaged within the community prescribing service.

It is anticipated that the contract will be let for 3 years commencing 01 April 2011.

For further information, and/or to express an interest, please contact: Steve Frost, Senior Procurement Manager, NHS Newham, Warehouse K, Unit 8, 2 Western Gateway, Royal Victoria Dock, London E16 1DQ or email: steve.frost@newhampct.nhs.uk

The closing date for expressions of interest is 12 noon on Wednesday 07 July 2010. Late expressions of interest will not be accepted. The Newham Substance Misuse Partnership reserves the right not to make an award.

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Closing Date: 12 noon on 16 June.

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dan.essery@synergygroup.co.uk

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harbour drug & alcohol services

Harbour Drug & Alcohol Service provides a range of interventions for people with problematic substance use in the Plymouth area.

Harbour combines the skills and experience of a diverse workforce and welcome applications from candidates who can demonstrate a genuine commitment to achieving positive outcomes for highly marginalised client groups.

Practice Supervisor — Community Access Team

Starting salary £25,904 pa
37 hours per week

The role of the Practice Supervisor is to ensure that all clients receive an equitable, quality service. You will support the Service Manager in ensuring that services are provided in line with Models of Care for drug and alcohol misuse and other dependence guidelines, including operational policies.

You will also provide practitioners with one-to-one supervision and offer a consultancy service in their area of specialism. Qualified to deliver substance misuse specialist interventions, your qualification or relevant experience will enable you to work in a regulated profession. Experience in providing supervision is preferential. **Ref: AIRSSP1**

Our benefits include:

- 28 days annual leave per annum (including incremental increases) plus recognised Bank Holidays.
- Company pension and life assurance schemes.
- Free occupational health services.
- Implementation of policies to positively promote a work/life balance.
- Commitment to continued professional development.

Closing date: Friday, 18th June 2010.

Further information and an application form can only be downloaded from www.harbour.org.uk

For an informal discussion, please contact Julie-Anne Sunderland on 01752 434283.

Harbour is an equal opportunity employer and invite applications from all sectors of the community. All post holders will be subject to an enhanced CRB check and satisfactory references.

Can you help overcome the harms caused by alcohol, drugs and gambling?

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Last year over 10,000 people contacted our services for help. We are passionate about what we do and are looking for positive, skilled and enthusiastic people to join us.

- **Service Manager** – Birmingham Tier 3 Services Ref: B/10/21
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- **Participation Workers** Ref: B/10/23
  £19,621 – £22,958 per annum, pro rata
  1 x 37 hours per week, based in Birmingham and Solihull
  1 x 37 hours per week, based in the Black Country
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- **Practitioner** – Birmingham Tier 2 Hospital Service Ref: B/10/24
  £19,621 – £22,958 per annum • 37 hours per week

For further information, the opportunity to download an application pack and full details of our current vacancies, please visit www.aquarius.org.uk

Alternatively, email: recruitment@aquarius.org.uk or write to Human Resources, 2nd Floor, 16 Kent Street, Birmingham B5 6RD quoting the relevant reference number.

Closing date: noon on Friday, 25th June 2010.

Successful candidates will be subject to an enhanced CRB check.

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INVESTORS IN PEOPLE

Action on Addiction

Therapeutic Practitioner / Tutor

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Salary circa £25k per annum & benefits

We are seeking to recruit a Therapeutic Practitioner to join the Families Plus Team to provide therapeutic services to family members affected by substance misuse. This role involves the development and delivery of training to professionals and the education of the public and relevant professionals.

The ideal candidate will have a minimum of two years experience in a clinical role; possess excellent interpersonal and communication skills and be educated to degree level.

For more information and to apply for this post, please visit our website.

Closing Date: 18 June 2010
Interview Date: 23 June 2010

www.actiononaddiction.org.uk

INVESTOR IN PEOPLE

The Chemical Dependency Centre, Clouds and Action on Addiction have merged. The new organisation is called Action on Addiction. Charity No. 1117988

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First-rate clinical skills and an in-depth knowledge of current substance misuse practice are both essential. Just as important though, you must be a confident and assertive individual who can handle complex situations within this challenging environment.

In return, we'll give you full support to develop your career with one of the UK's leading private providers of NHS care.

For more information, please call Syreeta Harewood on 0118 952 1810.

To apply, please visit www.careuk.com/jobs

Closing date: 20 June 2010.

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