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29 March 2010
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Editorial – Claire Brown

Family fortunes

Let's not play roulette

Despite family support being a central part of the current drug strategy, it has for years been poorly funded and sporadic. Whatever election promises are being made to make family life easier, they're unlikely to relate to substance misuse. It doesn't fit the billboards or the Saatchi campaigns and family services know they will continue to fight for attention – yet there will be no let-up in demand for them.

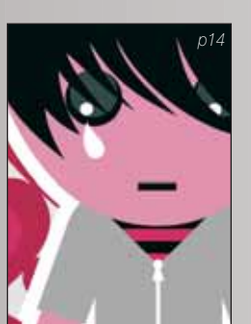
Adfam's manifesto (cover story, page 6) offers a survival kit for working smarter, to make sure the essentials of family support are not tossed overboard in a turbulent climate. Tightened budgets need not compromise clever commissioning and appropriate training to make sure workers can tune in properly to families' needs. Active data collection and monitoring must take place to make sure services provide the best value they can. And a concerted effort to influence and share knowledge with the services we connect with is an opportunity not to be ignored when everyone's looking for better ways to to run services on a shoestring.

The UKDPC estimates that there are at least 1.5m people in this country who are significantly affected by a relative's drug use – and these are the ones who live with the effects day by day. It doesn't even include the many other family members and friends that you feel powerless to get near. We all know that the scale of the problem is a howling mismatch with the level of service provision.

As Adfam's manifesto suggests and their conference reinforced, only tight working partnerships and continual knowledge about this complicated area of work will help families get the help they need, right from the crucial early stages. Carole Sharma's suggestion to skill up and specialise in every way you can is a good one – and a timely reminder that waiting for a new government to sharpen its axe will help no one at all.

See you again on 26 April after a break of one issue. Keep the letters coming and have a great Easter!

This issue



FEATURES

REGULARS

News in Brief

Social consultation

The Social Security Advisory Committee (SSAC) is consulting on the government's controversial welfare reform proposals. The two-year 'welfare reform drugs recovery pilot scheme' would require claimants to attend a two part substance related assessment (SRA) 'where there are reasonable grounds to suspect that they are dependent on, or have a propensity to misuse, a proscribed drug', with those who fail to attend two SRAs required to submit to a drug test. Claimants would have to comply with a mandatory rehabilitation plan and the regulations would also allow the sharing of data for the purposes of identifying problem drug users. The committee wants to hear the views of organisations and individuals before it makes its report to the secretary of state. More information at www.ssac.org.uk Responses should be sent to ssac@dwp.gsi.gov.uk before 12 April.

Cocaine cargoes

Cocaine traffickers shipping drugs to West Africa en route to other destinations are becoming more blatant according to the United Nations Office on Drugs and Crime (UNODC). Until recently most cocaine shipped to West Africa was transported by boat or light aircraft but traffickers are now using fleets of cargo planes and flying further inland. 'They are not flying under the radar – there is no radar,' said UNODC executive director Antonio Maria Costa.

NTA refocuses

The NTA has refocused its resources in light of the demands of the 2008 drug strategy, it has announced, allowing it to 'accelerate the development and delivery of the recovery and reintegration agenda in order to deliver the ambitions of service users and their families'. New structure available to download at www.nta.nhs.uk

Effective IBAs

Healthcare professionals are underestimating the potential of Identification and Brief Advice (IBA) in tackling alcohol harm, according to the Department of Health. Some GPs and nurses see it simply as a diagnostic tool, whereas it serves as an intervention in its own right, says DH. 'IBAs really work and are up there with some of the most effective interventions,' said Royal College of Physicians president Professor Ian Gilmore.

Call for mephedrone ban amid media frenzy

The government has indicated that it is likely to ban the 'legal high' mephedrone following advice from the Advisory Council on the Misuse of Drugs (ACMD), which it is expected to receive today (Monday). The drug – which at the moment can be legally bought online (*DDN*, 18 January, page 6) – has dominated newspaper headlines in recent weeks and has been 'linked to' a number of deaths.

ACMD interim chair Professor Les Iversen told the Home Affairs Select Committee that the drug was 'harmful' and indicated that the council would recommend it be classified as a class B substance. The UK Drug Policy Commission (UKDPC), however, has recommended that the drug be placed in a new category of drug control – 'category X' – pending a proper assessment of evidence of harm.

The new category would be used for emerging 'substances of concern' where decisions need to be taken 'on a properly analysed evidence base' and within a certain time limit. The process for banning drugs in the UK needs to be changed in order for the law not to be always 'behind the market', says the UKDPC. Both New Zealand and Germany have special categories of drug classification where drugs can be placed while their effects and harms are studied.

Transform said on its blog that the call for a ban was 'as ever... being driven by hysterical media hype' while Release said 'a full blown moral panic' had erupted over the drug. 'Popular media have reported developments in the most lurid and sensational terms, with hugely exaggerated claims made for the number of users and – especially – numbers of deaths, as deaths have been classified as resulting from the use of mephedrone before the evidence is in' it says. 'All sense of proportion' had been lost regarding the issue, states the charity, which wants to see a 'reasoned consideration of the research evidence'.

Meanwhile, stories carried by some newspapers about teachers having to hand mephedrone back to pupils have prompted schools minister Vernon Coaker to write to all schools in England making it clear that teachers have legal powers to confiscate the drug. 'You will be aware of recent media coverage of the 'legal high' mephedrone,' says the letter. 'Some questions have been raised as to whether teachers can confiscate such substances, given that they are not prohibited substances. As current guidance makes clear, schools do have the power to confiscate inappropriate items including a substance they believe to be mephedrone (or any other drug, whatever its legal status). They do not have to return such confiscated substances.'

The UKDPC has also announced that it is to carry out an evaluation of the entire mechanism of UK drug control over the next 18 months. 'We've thought for some time that the whole governance of drug policy is in need of a fresh look,' chief executive Roger Howard told *DDN*. 'One of the important parts of that is the drug control system, and it's quite clear that over the last few years the system has come under a lot of strain. Public, political and professional confidence in the system has suffered, and there is a lack of confidence about the role of evidence and research in the decision-making process. We have a Medicines Act, a Misuse of Drugs Act and other legislation and trading regulations which control substances, and we want to look at all the options available – are there other regulatory and control processes and mechanisms that could be used?'

The interim 'category x' would exist outside of the ABC classification, which was 'only ever meant to be a guide to sentences', he said. 'What we lack is a category where a substance of public concern can be recognised and public health information sent out. The situation is changing very rapidly. This isn't simply about mephedrone – it's quite clear that we are going to be faced over the coming years with an ever-increasing range of synthetically produced substances.'

Vernon Coaker: 'As current guidance makes clear, schools do have the power to confiscate inappropriate items including a substance they believe to be mephedrone (or any other drug, whatever its legal status). They do not have to return such confiscated substances.'

Government response on alcohol damage branded 'complacent'

The government's response to the Health Select Committee's report on alcohol misuse has been criticised as 'complacent' by alcohol charities. The select committee report had called for the regulation of alcohol promotion to be completely independent from the alcohol and advertising industries and for the introduction of a minimum price per unit of alcohol, among other measures (*DDN*, 18 January, page 5).

The damning report accused the government of giving the greatest emphasis to the 'least effective policies' of education and information campaigns and too little to pricing and marketing controls. Other recommendations included mandatory targets to reduce alcohol related hospital admissions and improving access to community-based alcohol treatment so that it is 'at least comparable to treatment for illegal drug addiction'.

Responding to the report's assertion that the current system of controls on advertising and marketing are failing, the government states that it 'continues to take the issue of excessive drinking very seriously' and would continue to 'ensure that emerging concerns about the possible impacts of advertising or weaknesses in regulation are fully examined'. On the issue of marketing regulation becoming independent of the alcohol and advertising industries, the government states that it is 'strongly supportive of the current regulatory system and notes that appropriate levels of independence are already built into the system'.

Alcohol Concern branded the response 'too complacent'. 'For the government to say its current plans are sufficient flies in the face of the evidence,' said chief executive Don Shenker. 'Whilst change cannot happen overnight, it certainly cannot happen if the government does nothing. The drinks industry will be delighted that government are not planning any further action to independently monitor or regulate their practice.'

Meanwhile, the government's mandatory code on alcohol sales – which controversially omits chief medical officer Sir Liam Donaldson's recommendation for a minimum price per unit of alcohol (*DDN*, 23 March 2009, page 5) – has been passed by the House of Lords and will come into effect this week. Sir Liam Donaldson, who is about to retire, told the *Daily Telegraph* that government rejection of his proposal had been his 'greatest disappointment' during his 12 years in the post.

Last week's budget, however, saw a rise of 10 per cent above inflation on duty rates for cider, designed to target higher strength brands. Alcohol Concern said the increase was 'long overdue' but would have 'no impact on the ability of major supermarkets to absorb increased duty rates and to continue to use alcohol as a loss leader', while Drinkaware chief executive Chris Sorek said 'Amending the under-taxing on cider is a responsible move by the government but increasing the duty on alcohol won't necessarily tackle alcohol misuse and change drinking behaviour.'

Health select committee first report of session 2009-10 – alcohol available at www.publications.parliament.uk/pa/cm/cmhealth.htm

The government response to the health select committee report on alcohol available at www.official-documents.gov.uk/document/cm78/7832/7832.asp

Fewer young women in heroin treatment

The number of women aged between 18 and 25 entering treatment for heroin addiction has fallen by 26 per cent since 2005, according to a new report from the NTA. There has also been a 19 per cent fall in the total number of women under 30 entering heroin programmes in England, according to *Women in drug treatment: what the latest figures reveal*.

The trend is offset by rising numbers of people entering treatment for cocaine and crack cocaine, the NTA acknowledges. The number of women entering treatment for crack is up by 14 per cent since 2005, while the number seeking treatment for cocaine for the first time has risen by a massive 55 per cent over the same period. However, the number of women under 30 entering drug treatment overall is still down by 9 per cent over four years.

Almost two thirds of the women entering treatment are mothers, says the report, nearly half of whom have a child living with them. The treatment data 'indicates that treatment outcomes for mothers are stronger than for those who were not parents,' says the NTA. Overall, women make up around 25 per cent of the total number of people in treatment, a figure that has remained stable for the last five years.

Women's drug problems can often be more complex than men's, states the report, with issues of childcare, abuse, prostitution and 'strong risk of stigmatisation'. The report acknowledges that many female drug users can be reluctant to enter treatment for fear their children will be taken away, giving rise to 'concerns that female drug users have specific experiences and complex needs that are not always recognised by treatment services'. The best place to resolve issues of access to – and appropriateness of – treatment services for women is through local needs assessments, it says.

The report also states that, while women tend to start using drugs later than men, they are 'more adept at seeking treatment for themselves' and tend to enter treatment earlier. The number of women leaving treatment free of drug dependency has almost doubled over the period 2005-09, and the number dropping out has fallen by more than a third. 'Treatment is the first step on the road to recovery, so it is encouraging that women tend to seek help of their own volition, enter treatment earlier before their drug misuse has become entrenched and frequently achieve better outcomes sooner,' said NTA director of delivery Rosanna O'Connor. 'Treatment provides the opportunity for individuals to get better, for families to stabilise, and for children to be looked after at home.'

Report available at www.nta.nhs.uk

News in Brief

Guess again

A drink that 'has consumers guessing whether it contains alcohol' is to be removed from sale for breaching the Portman Group's code. The group's independent complaints panel ruled that customers could be confused by the labelling of Yegaar. 'It is difficult for consumers to tell that Yegaar is an alcoholic drink, let alone how strong it is,' said Portman Group chief executive David Poley. 'We don't even know what kind of alcohol it contains. It is alarming that a drink is being marketed in this way.'

Hub of excellence

The 'HubCAPP project of the year 2009' award has gone to St Mary's Hospital, Paddington's alcohol health work, while the 'HubCAPP most useful project of the year' award has been won by Stoke-on-Trent Commissioning. The Hub of Commissioned Alcohol Projects and Policies (HubCAPP) is an online resource of alcohol initiatives. 'It's fantastic that so many have taken the time to vote,' said Alcohol Concern chief executive Don Shenker. 'It's good to see people in the field responding to this HubCAPP initiative and we are pleased that the work of St Mary's and Stoke has been recognised in this way.' Devon Alcohol Service was also highly recommended. www.hubcapp.org.uk

Policy posters

A new leaflet and poster has been produced by the London Drug Policy Forum (LDPF) providing information on the appearance, effects, legal position and potential risks of a range of drugs. 'Good quality information and advice helps limit the problems associated with drugs' says the LDPF. For free copies call 020 7332 3708.

Champion idea

There's still time to enter the 2010 Mentor UK CHAMP awards for a chance to win cash and support worth up to £20,000. 'Whether it's through sport, music, mentoring or classroom-based work, it's clear from the applications already coming in that the best of these projects really do provide children and young people with opportunities and offer real alternatives to abusing alcohol,' said Mentor UK CEO Paul Tuohy. To apply visit www.champawards.org.uk Deadline is 21 April.

Delegates at Adfam's conference last week explored how best to strengthen and build family support at a time of political and economic uncertainty. **David Gilliver** reports

HAPPY FAMILIES?

'For years, people in this field fighting for recognition for families affected by drugs and alcohol were knocking at closed doors,' Adfam chief executive Vivienne Evans told delegates, as she explained the decision to call the conference *Be careful what you wish for*. 'All of a sudden – particularly with the 2008 drugs strategy – doors opened. But there are still huge problems.'

One of the key issues facing the sector was the differing perceptions of what family work actually meant, she said, and the conference marked the launch of *Adfam's Manifesto for families – 5 key challenges for supporting families affected by drug and alcohol use*. Head of policy and regional development, Joss Smith, told delegates that the manifesto had come out of regional consultations with family support providers, drug and alcohol workers, children's services representatives and many others. 'We were keen to uncover whether the political debate had been translated into practice,' she said.

One of the main challenges identified was how to support families in their own right, as there were significant issues of accessibility and stigma. 'We need to build the capacity of services to make them quick and easy to access, and deliver local awareness-raising programmes, especially to under-represented populations,' she said. The second major challenge was around involving families in treatment. It was essential to provide practitioners with continuous training and encourage both a national understanding of confidentiality policies and a cultural shift to make service providers recognise that 'drug and alcohol use doesn't occur in a vacuum of the service user'.

The third challenge was monitoring the effectiveness of family support – improving data collection and ensuring a national framework for delivery. 'Services need to be accountable and able to work to a national standard,' she said. Making sure that all public services 'think family' was the fourth challenge, with public services having a duty to consider siblings, partners, parents and children, and a corresponding need for easy referral routes. The final challenge was effective commissioning, as historically family support had been poorly funded and sporadic. Commissioning processes needed to reflect the complex needs of families, she stressed, and ensure that family support was part of a long-term plan and embedded in local strategic working.

All of this came at a period of political and economic uncertainty, however.

'We're about to hit a time of change,' chief executive of the Federation of Drug and Alcohol Professionals (FDAP), Carole Sharma, told delegates. 'There's a greater debate about recovery, a big emphasis on psychological interventions, and an emphasis on improving communities instead of seeing treatment in isolation. But at the same time we face a time of austerity, and our bit of the forest may be one of the easiest to burn down.'

Recovery should be about being fulfilled, she told the conference – 'in the

client's terms, not the service provider's or the government's'. This meant being 'employed meaningfully, trained and educated, healthy and happy, able to look after your children and a valued member of a family.' In her field of workforce development what was needed was workers who could connect, make partnerships and genuinely get to know their clients, she said. 'A good worker can do a good job out of a carrier bag. And when I talk about the workforce I'm talking about paid and unpaid.' Broadening the skills base to include family and couples work was essential, she said.

Professionalisation meant workers being clear about the competencies they needed, which meant genuinely understanding partnership working and what partners could and couldn't do – 'go and spend time with housing, with social services, see how it really is'. 'There's going to be competition,' she warned. 'Commissioners are always looking for short cuts, so it's important that we can demonstrate our competency.' It was also important for professionals to seize opportunities, however. 'I think we're in a great moment. People are really interested in recovery and community recovery, and it would be a big mistake if we became a political football. People are talking about much more than just getting people off the streets and on methadone.'

GP and clinical director of SMMGP, Dr Chris Ford, put the general practice perspective, telling the conference that addiction was a family disease. 'If one person in a family is affected, then the whole family is.' Around 25 per cent of consultancies in general practice related directly to alcohol and another 25 per cent indirectly, she said.

'How families cope is remarkably similar,' she told the conference. 'But as a family disease, the family can become dysfunctional. Co-dependents may develop compulsions of their own, and patterns of denial can emerge – a refusal to accept that a drug and alcohol problem is developing, or to acknowledge the extent of the problem. By trying to "help", family and friends can make it easier for people to continue the disease and avoid the consequences of their actions.' Certain families were very damaged and some people 'had never had an image of family that wasn't about drugs and alcohol' she added.

The last few years had seen much more access to treatment, but overwhelmingly focused on the individual. 'We all know families are a valuable resource, but support services are still very few and unevenly balanced.' GPs had a key role to play as the first point of contact but were 'not always as involved as we should be,' she acknowledged. General practice was getting better at partnership and multi-disciplinary work, she said, 'but we're not there yet. There's a real need for training.'

Looking at the issue from the point of view of local implementation, independent drugs policy consultant Sara McGrail told delegates that the drugs strategy had brought new expectations on local partnerships. She'd been extensively involved in research around delivery of the strategy and found significant concerns about local capacity and central support, as well as variability in local structures, poor links with the community, limited relationships with central government and 'little if any local scrutiny'.

Central government had no mechanism to manage, monitor or deliver some of the most crucial aspects of the strategy, she said, including those around families. Many local partnerships were poorly supported and under resourced, local leadership could be weak, and areas of work not within the performance management framework were marginalised and often ignored. DAATs needed a greater understanding of all aspects of the strategy – 'not just drugs and crime' – and there needed to be dedicated resources for families and communities. The government also needed to ensure transitional arrangements were in place to enable people to make these shifts, rather than carry on working in the same way.

The next few years could see increased demand, diminishing resources and the possibility of different local structures, she said. 'How do people who are committed to supporting families survive in this brave new world? Understand local need and what you can deliver. There's no point setting up a service saying "we can solve this whole problem" when all you can do is chip away at it, but neither should you devalue that chipping away. Lobby your elected members – explain what you do and why you do it. Times of change are times of great opportunity. We've been through times of change in this field before and because of the commitment of workers we've managed to keep going.'

The NTA had always supported the role of carers in developing and – where appropriate – being involved in treatment, head of national delivery Lynn Bransby told the conference. 'Things are changing and there are levers and motivators that are much more likely to bring about results' – local protocols that meant every local area would be required to produce a joint framework between drug and alcohol services and children's services, she said.

'A good worker can do a good job out of a carrier bag... go and spend time with housing, with social services, see how it really is.'

There were 120,000 children in families where someone was in treatment, and the aspiration was to bring wider parenting services to drug treatment, she said. 'We want to see the resources focused on the most vulnerable families'. Pitfalls, however, included lack of cohesive action, passing the buck and the risk of people hiding their problems. 'The message needs to get out that these are supportive services, not surveillance services,' she said.

Head of families at risk at the Department for Children, Schools and Families, Nick Lawrence, told the conference that 'think family' was the overall banner for targeting families that needed support – ensuring that services working with vulnerable people identified families at risk, provided support at the earliest opportunity and met the full range of each family's needs. For families at risk of the poorest outcomes, the government had been funding Family Intervention Projects, he said, which were increasingly mapping their costs against savings for other agencies. The government was aiming for an integrated, appropriate response to all families at risk, from all local services, he said.

Independent research consultant Lorna Templeton had researched family members worldwide and found a unique set of stressful circumstances associated with living with substance use. Most reported that they had been living with the situation for an average of eight to ten years, feeling very isolated and with low levels of support, she said. Director of policy and research at the UK Drug Policy Commission (UKDPC) Nicola Singleton, meanwhile, said her organisation's research estimated the minimum number of people significantly affected by a relative's drug use at 1.5m, 250,000 of whom were affected by opiate or crack use. The number included 575,000 spouses, 610,000 parents and 250,000 other family members. 'But we know that there are a lot of other people,' she said. This was a 'robust, minimum' estimate that required people be living with the user and only counted one parent per user.

'It's the tip of the iceberg,' she said. 'But it's a starting point.' The UKDPC had tried to estimate the cost borne by family members of problem drug users in the UK and come up with £1.8bn per annum, based on loss of earnings, property stolen and excess healthcare costs among other things. 'We also looked at the value of support family members provided, based on what the cost would be if someone else had to provide it, and arrived at £750m a year, a considerable saving to services.' Adult family members needed to be recognised much more in data scores, she said, as they remained invisible. 'It's essential to demonstrate the value of what you're doing,' she urged delegates. 'In a time of financial constraint, things without an evidence base can fall by the wayside.'

Adfam's manifesto for families is available at www.adfam.org.uk

'I must acknowledge from the start that AA plays a major role in this country in supporting many in their own path towards recovery. I am only sharing my own experiences of AA and I came from its meetings knowing I needed further support to be able to stay alive... I have read all the books and tried so hard to follow the programme yet continually failed.'

Moving with the times

I felt the need to write a letter in utter gratitude for the two-part article on care and control within AA meetings (*DDN*, 16 November 2009, page 6, and 15 March 2010, page 14). I realise I am writing this from a male's point of view, yet I felt the second part of the article (the section 'a final word') gives me a voice to speak for myself.

I must acknowledge from the start that AA plays a major role in this country in supporting many in their own path towards recovery. I am only sharing my own experiences of AA and I came from its meetings knowing I needed further support to be able to stay alive.

Having drunk alcohol from the age of eight to the age of 41, when it had firmly taken over my whole life and left me on the streets, I resorted to any method I could possibly think of to obtain my next drink. Finally I was at death's door and literally obeyed anything that was said to me – one of which was 'go to AA'. This was reinforced by professionals from many quarters.

I firmly believed my life was going to be saved, yet once I'd walked into the room I sat very silently at the back, just listening to all that was being said. Anxious and fearful as I was, I persevered with what I had repeatedly been told.

I could relate to both parts of the article in every sense of the word. I had two sponsors yet could not connect my feelings in any way with what was being suggested to me. I found it very disturbing that the 12-step programme was trying to make me feel it was all my fault and nobody else's. My sponsors were not in any way allowing me to open up from within – a person who had been emotionally, physically and sexually abused from an early age.

I truly admire Grace for her courage to speak up and Dr Sarah Galvani for writing a very important and fundamental article for all members to try and understand the complexities of abuse, which come from so many areas of life. There are no 'expert' sponsors within the culture of AA and I have seen more damage and harm than good done to individuals, including myself, in the three years that I literally lived and breathed for the programme.

I have read all the books and tried so hard to follow the programme yet continually failed. I firmly believe AA helped my thought process and I'm sure I would not be here today to write this letter if I had not had the experience. Yet I am amazed that the 12 steps and traditions have not in any way changed since they were first introduced all those years ago. Maybe this is why there is such a high percentage of failures? Someone please educate a simple person and tell me what else hasn't changed with our times.

Compare it with the original highway code and how that has been continually improved to save lives of both drivers and pedestrians. It could work similarly for alcoholics and those who suffer the most, family members and loved ones.

In no way do I have the right to be judgemental towards AA and I still at times take individuals to meetings for support. Yet we women and men who have suffered abuse in our past, if pushed to find a sponsor or talk, will only defend ourselves by staying depressed, in denial, distracted, dissociated, and more often than not go back to our comfort zone of alcohol and drugs. Even the bible has been revamped to different versions – why can't AA do the same?

Sean Rendell, Hertfordshire

Cheap shots

Drs Alex Stevens and Polly Radcliffe would like to know whether I consider buying a 'sweetened cappuccino at the petrol station an utterly selfish act' (*DDN*, 15 March, page 11). Given the state of globalised capitalism I do what I can to not buy products that I know have been produced using 'violence and exploitation', to quote them, which would – fairly obviously, I would assume – rule out cocaine and heroin. My problem is with the people – and I've met *lots* of them – who'll sit pontificating with a rolled-up tenner in their hand about not buying a certain brand of coffee or trainers. Whether this is through staggering hypocrisy or staggering stupidity is anyone's guess.

As I said previously, the war on drugs is a catastrophic mess but the end result is that buying these drugs subsidises misery and horror. It's all very well, as Release do in their response to the Home Affairs Committee cocaine report, to say 'oh but the exploitation of drug mules and eradication of the rainforest is the fault of governments, not drugs'. True enough, but you may as well say 'I'm going to buy my clothes from the chain with the most reprehensible record on child sweat shop labour because it's international regulation that's at fault'.

To get back to the subject of stigma, 'nice people take drugs', to quote a particularly facile and pointless poster campaign. Of course, but so do lots of unpleasant people, and drugs can often exacerbate that unpleasantness, as anyone who has seen what crack can do will attest. Denying this does no one any good, least of all the client.

The good doctors then take me to task for 'unevidenced speculation' that drug gangsters would move into other areas of criminality – specifically people trafficking – rather than some legitimate field of endeavour. Firstly, it's not unevidenced, as a five-minute internet search on the disappeared of Cuidad Juarez will show. And just because a cohort of 200 shoplifters in Surrey, or whatever academic paper you want to dig up, showed they went straight when offending opportunities were reduced, doesn't mean that people who think nothing of emptying a bag of human heads onto a nightclub dance floor, or gunning down pregnant American consular staff – as they did just last week – will do the same. I don't know, maybe I'm stigmatising them. Perhaps Alex and Polly would like to apply for a research grant to go and find out? Thought not.

And while we're on the subject of not living in the real world, Chris Ford and co's attempt to seize the moral high ground and close down debate by asserting that Neil McKeganey's original article would be 'illegal under UK law' if it were about gay people is as inaccurate as it is cheap. Have these people ever looked at a British tabloid newspaper? Not only would it not be illegal, it would barely raise an eyebrow at the PCC. I don't agree with everything Neil McKeganey says, and I don't agree with everything Chris Ford says, but I wouldn't deny either of them the right to say

it. She should extend the same courtesy, or perhaps she'd prefer *DDN* to become some sort of *Pravda*, and read by nobody?

It's bad enough the orgy of self-congratulation that passes for 'debate' at either end of the spectrum – the recovery zealots or the likes of Transform greeting every announcement with the same howling hyperbole – and this sector is polarised enough without McCarthyite bullying witch-hunt tactics to silence people you don't happen to agree with. The field is about to face unprecedented financial and political pressures and it might be an idea to at least try and present some sort of a united front – God knows what it must look like to people on the outside. Most of us just want get on with our jobs to the best of our ability without having to unthinkingly submit to dogma of either stripe.
Molly Cochrane, by email

Distorted views

People who suffer with problematic drug use have been stigmatised for decades by the media, politicians, police, and too often even the health system. They need many things, but more stigma is not one of them.

Neil McKeganey may be an otherwise fine person, but his moralistic anti-drug ideology has completely distorted his understanding of drug use. Contrary to his opinion piece (*DDN*, 1 March, page 17), there is no evidence that stigmatising drug users helps them overcome their problems to the benefit of society. None, zero. Stigma only adds to their burdens and ours by deepening their deviant identity, retarding their recovery, and pushing them away from the treatment and other services they need. And as a matter of professional ethics, we doubt that problem drug users struggling to get healthy wish to be used as poster children for social marketing campaigns based on someone's theory of planned behaviour. If the expression of social disapproval is the goal, as with drink driving, this can take many useful forms that do not entail further stigmatising.

McKeganey's ideology trips him up repeatedly, as, for example, when he recently claimed in the *Big Issue* that methadone substitution treatment for opiate addiction is 'of uncertain benefit'. The scientific evidence shows unequivocally that methadone is the most effective treatment for getting addicts off the heroin rollercoaster, out of the criminal world, and into a more stable life. Yes, methadone is a drug, and McKeganey may prefer that opiate addicts just stop using all drugs. But this is his utopian fantasy, not a workable public policy.

We support Claire Brown's decision to publish McKeganey's piece and the responses to it. The best way to deal with dumb ideas is to put them next to smart ideas.
Prof Pat O'Hare, HIT, Liverpool and Prof Craig Reinarman, University of California

Stigmatiser or stigmatised?

Reading the recent spate of letters concerning stigma, complete with multiple academic signatories and copious footnotes, my heart rejoiced. I remembered a series of sketches on *The Mary Whitehouse Experience* where two ancient academics in a televised debate inevitably wound up swapping personal insults with ever-increasing vitriol.

A few years ago a friend of mine (an alcoholic and a heroin addict from out of town) was helping to decorate our house in a village here in Shetland. At lunchtime, midweek, he headed for the pub. When he came back he reported the conversation to me. The local alcoholics propping up the bar asked him what he was doing. He responded that he was helping to decorate a house for us at which point one of the guys said, 'I expect they're getting it ready for a load of dirty junkies.'

I laughed when my friend recounted this. We have known a few alcoholics and heroin addicts in the eight years we have run our project. Most of them have felt shame, some of them live there. I think most of us can think of things which we have said or done of which we have felt ashamed. How many of us would respond positively to being stigmatised?

Who is going to be the stigmatiser – pompous politicians or arrogant academics? What addicts need, what we all need is not stigma but grace! My favourite author on the subject of addiction Gerald May (*Addiction and Grace*, 1988) put it this way: 'Grace enables dignity within us by empowering our efforts to be honest and responsible. Grace enables humility within us by empowering our realisation that our efforts are insufficient by themselves. Grace enables receptivity and responsiveness within us by empowering our growing trust and our willingness to take the risks of faith.'
Andy Holt, Papa Stour Project

Evidence soup

With reference to the letter *Chemical soup* (*DDN*, March 15, page 11) I might be interested in reading the evidence Christine Hudson uses to support her argument that 'chemical additives, *whatever they are* (my italics), can and do have a regressive and degenerative effect on health' – except I can deduce from her line of work that she considers the use of actual evidence to be unnecessary. Maybe all of the 'long-term and degenerative disease and an increase in violence' in recent years are caused by the placebo effect?

Christine does however show a remarkable level of self-awareness. Who better understands that 'people are gullible enough to accept whatever they are sold, or told, is healthy and the correct way to live' than a homeopath? At least Christine is not likely to need a label to identify the chemical ingredients of her remedies – two parts hydrogen, one part oxygen.
Michael Nadasdy, DAT officer, East of England

We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3.

Media watch

DDN casts its eyes over news from elsewhere

Hillary Clinton made a state visit to Mexico to further talks on the continuing 'war on drugs'. Funding from the US has been pledged to aid Mexico in creating a 'stronger border' and finding ways to tackle the 'social problems linked to a rise in drug crime'. The country's strategy is to tackle cartels with a military presence, which President Calderon says needs strengthening in partnership with the US to be effective in cracking down on drugs-related violence.
The Times, 24 March

Councillor Gerry Breen, chair of the Dublin City Joint Policing Committee recently called for greater regulation on 'head shops', which sell legal highs such as Spice. He said that as some of the products are ingested, environmental health officers should be allowed to inspect establishments. He said that there is not 'a screed of quality control' about products sold and the government needed to 'get their finger out' on regulating the shops.
Irish Examiner, 19 March

The UK's largest drug-smuggling gang has been sentenced to a total of 70 years, for running an operation worth an estimated £63m. Identifying millions of pounds hidden abroad considered to be 'proceeds that came out of drug-trafficking activity', Judge Stone told the men 'I have to sentence you for the whole of the money laundering operation'. He has also prevented them from travelling abroad for two years after their release.
Surrey Comet, 25 March

Irish drinkers have been given special permission to raise a glass on Good Friday to celebrate the Munster v Leinster rugby match at Thomond Park. Normally, restrictions prevent bars opening on the holy day. While the stadium held a licence to serve alcohol during the fixture, local pubs did not and applied to the courts for the exemption as a 'last resort'. Limerick City Chairman, Jerry O'Dea, commented 'We see this decision as a victory for common sense and we feel that the majority of the public supported our members in their application'.
BBC News, 25 March

California could be the first US state to decriminalise cannabis if a November vote to allow possession of up to 28.5g of the drug for those of 21 and over is passed. Almost 700,000 signatures have so far been submitted on a petition backing the move.
Sky News, 25 March

Our environment has a crucial role to play in sustainable recovery. **James McCartney** looks at environmental conditioning, rehabilitation and the workplace

COGNITIVE NEUROSCIENCE PLAYS A SIGNIFICANT ROLE in the recovery process, and I'm intrigued by the evolution of organisational culture that can enhance consciousness, perception, memory and learning.

Neuroscientists have long understood that the brain can rewire itself in response to experience – a phenomenon known as neuroplasticity. This conjecture states that the structure of the brain's neural network changes during an individual lifetime in response to external stimuli, experience and activity. Therefore environmental conditions are critical to the whole process of reprogramming the mind and key to sustainable recovery and long term success with some of the most complex drug and alcohol misusers, many of whom have become programmed by a negative culture that has stifled their development.

One of the key components of a recovery programme is to develop the environmental conditions that can produce results with a client's rethinking process. The majority of people that access THOMAS (Those on the Margins of a Society) have protracted histories of criminality, institutional living, broken relationships and unemployability alongside prolific histories of drug and alcohol abuse. The starting place is to protect the environmental component that can change people's ways of functioning.

Hence we have to develop the culture that can make this possible. The intangible dynamic and creative elements of rehabilitation culture need to foster expression and engagement to create resonance with lived experience. In order to be developed, the client needs to engage with a change culture that can give him or her an accurate account of positive and negative functioning.

'Social intelligence can be profoundly developed when cultivated by the right people in the right culture.'

Early negative life events influence the cognitive pathway of perception, impacting on how people receive and process knowledge. The challenge for us in a residential setting is to produce a culture that can act as a mediator between past and present, creating new intelligence for reprogrammed functioning. With over 20 years experience of working with socially excluded people, I have long argued that we have insufficient developers of people within the recovery setting. People use terms like 'recovery coach' but it's far removed from my understanding of recovery coaching. These people operate more as project workers, counsellors or others so entrenched within the drug treatment world that they are cut off from the wider developmental intelligences needed for sustainability within the workplace. So when people enter the work environment they are ill prepared for the minefield of toxic emotion that can trigger people back to negative ways of functioning.

How do you begin to prepare someone for work when they have spent most of their late adolescence and early adult life institutionalised within the prison system, coupled with an operational functioning anaesthetised outside the prison walls with drugs and alcohol? The process of change can be a long drawn out event and it takes skilled workers to have a strategic understanding of organisational cultures and the impact they can have in making or breaking people on the road to sustainable recovery. However, social intelligence can be profoundly developed when cultivated by the right people in the right culture.

We need to invest more in therapeutic employment and extend development programmes beyond the six months duration period for recovery treatment. This will ultimately save the public purse and contribute to the reduction of public sector spending in the long term. Sustainability is needed for social mobility and it demands the most radical thinking and committed effort. Simply boosting funds for superficial programmes – which the evidence suggests is not working – is maybe the easiest strategy, but it is not the right one.

I have found that we have had the greatest successes with the people we have employed after two or more years of development in the post treatment phase. What's extraordinary is that most of these people have been prolific offenders who have gone on to climb a professional ladder embracing training, university and sustainable employment. Holistic development is not available for the long term, and yet it's pivotal for long-term success. Organisations embedded in the development of the people they serve gain the confidence and trust of each individual in a unique and personal way and continue to work with people in their rethinking process, converting reprogrammed functioning into long-term memory for sustainability.

Reprogramming the subconscious mind with the right environmental conditioning strengthens the retrieval process and makes change possible. Placing people in the wrong environmental conditions – and the workplace is full of them – can trigger unconscious sources of emotion and functioning, not yet reprogrammed, leading people back to a life of addiction and offending. Ecology of soul is needed, where we begin to understand the deep and holistic relationship between the worker and the work environment. It is about how this relationship is experienced, and the meaning we make of our lives as workers. Individual and collective energies in the workplace can be transformational but also destructive.

As we develop our service users our ultimate aim is that they can enjoy social mobility – greater opportunity for all, moving from disaffection to a meaningful and liberated life of empowerment and sustainable employment. For many, tackling their drug and alcohol addiction is just the beginning of a long process that involves a radical change of functioning. The government's employment programmes can have the most sophisticated training available, but if we fail to carry the multidimensional aspects of the human person with us, our service users become like wasps around a jam pot, ready for the trap that kills the change process.

James McCartney is chief executive of THOMAS (Those on the Margins of a Society)

A pilot project in Yorkshire is using outdoor activities like climbing, canoeing and kayaking to help rebuild service users' confidence – with impressive results. **DDN** reports

High hopes

FOR PEOPLE WITH LONG-TERM DRUG PROBLEMS, rebuilding self confidence can be one of the biggest obstacles they face. A project for service users in Selby, Yorkshire, however, is taking an energetic approach to addressing the problem.

Natural Highs is a pilot project that began last summer and involves canoeing, kayaking, climbing and archery, among other activities. The brainchild of drugs worker Anthony Nevens from York-based charity Compass, the project was set up with the help of service users themselves. 'Somebody who's been on drugs for such a long time – they're in services, they're getting treatment, they're getting pushed towards work but their confidence isn't up,' he says. 'These sort of activities help to build confidence.'

Twelve service users were involved in the first two-day pilot session, and there have been four more sessions since. 'We've more or less tailored it for substance misuse clients, to give them an end goal or a little bit of a trophy – a reason to move on from the past,' he says. 'We were really surprised at how well it went.'

At the moment Natural Highs is paid for entirely by fundraising through Compass, with the course taking place whenever the money is available. 'It was going to be a one-off because I had a little bit of money I'd applied for, but after that two-day event the guys wanted to carry it on,' he says. 'It was such a success that I got the go ahead to do that with the proviso that I would need to raise the money for each of the events – that's the problem at the moment. It's been recognised by the DAAT so we're hoping more funds will come our way – it's an extra little thing on top of what we provide, but hopefully we'll get some future funding.'

Feedback from service users has been exceptional, however, with several going on to join outdoors activities clubs. 'One of the guys, Simon, is training to be a climbing instructor,' says Nevens. 'He'd never climbed before in his life but he just had a natural ability and loved it. He was 12 years crack/heroin and he's completely drug free and out of treatment now. People don't realise that you can do these sporty, adrenaline things quite cheaply and close to where you live – we've got a climbing wall ten miles away, world class mountain biking routes, great kayaking clubs. Even if people do know about them, they're a bit intimidated about going down there on their own, but if we go as a group, or our service users go down in pairs, it gives them more confidence about doing it.'

'It is fair to say that we were all a little nervous on the first day,' says Andy, who's now a service user rep. As well as learning about teamwork and trusting others, it helped people discover their inner strengths, he says, as well as providing a sense of achievement through doing something that felt 'out of reach for people in our situation'.

People who have completed the course go on to facilitate the group the next time, and Compass is now looking at building the courses into its treatment structure. 'We've got plans to do another two-day event but staying over at a centre and incorporating cooking activities,' says Nevens. 'People getting together in an evening and cooking a meal together, team building – some people on the course hadn't even left Selby in ten years.'

Service users need to able to show that they are making some progress with their treatment in order to be eligible. 'There are conditions,' he says. 'You can't take drugs, obviously, and you can't drink either. Obviously there are health and safety regulations to adhere to, but we would tailor it to meet individual needs.'

One thing that does concern him is the lack of women who've signed up for Natural Highs, which has led to a broadening of the range of activities on offer. 'I started thinking about what we could do for people who weren't necessarily into the action man and adventure stuff but would give the same sort of results. We started thinking about acting, and we're now in the process of setting that up with St John's University in York. Again it's about building confidence, but people want to tell their story as well.'

Andy, meanwhile, has found the course has helped him put his 15 years of heroin use behind him. 'He was coming to the end of his treatment and it really inspired him to move on from it,' says Anthony Nevens. 'He now helps run the activities and he's training to be a kayak instructor himself so that he can pass on what he's learned to other people as a mentor.'

'It has helped us to readjust to life and to give something back by supporting each other,' says Andy. The project is the 'next step in moving out of services', he says, putting people in charge of their future. 'The group members' mutual support helps maintain our new substance-free lives and belief that anything is possible, no matter how crap your life was.'

Contact Anthony Nevens on 01757 212355 or Anthony.Nevens@COMPASS-UK.ORG

HARM REDUCTION COMES OF AGE

Next month IHRA's 21st international harm reduction conference returns to its first ever venue, Liverpool, a city with a proud heritage of both public health and harm reduction. **DDN** looks back at the early days

In the mid 1980s Liverpool was known as 'smack city'. An influx of cheap heroin had given the region problematic drug use way beyond the capacity of its treatment services – which, like the rest of the UK, were concentrated mainly on getting people off drugs. In 1985 the Mersey Regional Health Authority set up a drug information centre (Mersey Drug Training and Information Centre or MDTIC, which later became HIT) to provide a drop-in service for drug users, their parents, friends and members of the public. One of the first needle and syringe programmes started in a converted toilet in MDTIC. 'This was based on honest information, no scare stories, just factual information,' says Pat O'Hare, who moved over from Sefton Education Authority to become the MDTIC's director in 1987. 'The funny thing is we used to speak about harm reduction but never called it that at the time.'

This was the era when the threat of HIV and AIDS loomed large and public health information campaigns were governed by fear. It took a brave decision by some key figures working in public health and health promotion in Merseyside to try a different approach, focusing on practical advice and better services for drug users to prevent them from catching the virus from shared injecting equipment. Their pioneering efforts became known as the Mersey Harm Reduction Model, and drew inspiration from a multi-agency approach to AIDS prevention that seemed to be getting results in San Francisco.

With its primary aim to reduce risky sharing of injection equipment, the centre was easy to access, with long opening hours and non-judgemental staff. Reducing drug use and increasing abstinence were also objectives, but they came beneath reducing risk behaviour. Visitors could use the needle exchange, get a methadone prescription, access all kinds of information – and were encouraged to come back.

'Drug users came out of the woodwork who had never been to a drugs service – 25-year injectors with the most horrendous abscesses,' remembers O'Hare. 'At the time it was thought everyone in Liverpool smoked heroin and we used to say "there's not many injectors in Liverpool". But that was because we didn't know.'

Visitor numbers rocketed and the converted toilet was replaced by the Maryland Centre, to make room for healthcare and HIV prevention services. There was tangible reduction in needle and syringe-sharing behaviour – borne out by the fact an HIV epidemic did not materialise in Merseyside.

While HIV rates were still climbing in Manchester, just 30 miles away, the virus became 'statistically insignificant' in Liverpool, according to the regional epidemiologist. 'And while there are lots of reasons for that,' says O'Hare, 'the thing was in Liverpool we had all these services and in Manchester they didn't. It was years before they started doing this stuff.'

Active involvement of local police seemed to contribute strongly to the strategy's success.

'We worked closely with the police in that we told them what we were going to do, and eventually they felt ownership,' he says. 'The head of Merseyside's drug squad used to go to conferences and talk about "our harm reduction project" – there was this real sense of pride.'

While many aspects of harm reduction courted controversy, O'Hare remembers a 'real watershed' in public awareness relating to what he calls 'the Chill Out episode'. He casts his mind back to 1991 when he suddenly found himself on the front page of *The Liverpool Echo*, then *The Sun* and *The Daily Star*, whose headline screamed 'What a dope! Daft do-gooder tells kids it's OK to use killer drug'. The offending item was a leaflet he'd prepared, to inform young people about ecstasy.

'It started off by saying "it's not a good idea to use ecstasy – however if you do..." Well all hell broke loose,' he says. But the outcry presented an opportunity. O'Hare was soon defending the leaflet on national and local television, radio and in the newspapers – an unprecedented chance to hold a harm reduction debate with the public: 'I did Kilroy and all sorts of television shows and even *The Echo* gave me a double page to explain everything. It was quite a seminal moment in the UK. When we did that there were questions in Parliament – some people were saying we shouldn't have funding. But there was a massive shift in attitude.'

The other major shift was to take the progress in Merseyside and share it on a national and international stage. With visitors coming to Merseyside to 'learn and see what was happening', O'Hare was encouraged by Mersey's regional director of public health, John Ashton, to organise a conference. Despite 'not even knowing what an abstract was', he found himself with the job of organising the first international conference on his home turf.

'It was totally international from the start,' he says. 'I vividly remember being in our training room on Maryland Street the Saturday before the event. We were packing the conference bags, and saying "do you realise that people are flying here from all over the world?" It was amazing.'

Encouraged by the 420 delegates, he booked the next one in Barcelona, with each stage of the organising process a huge learning curve. In 1996 he suddenly found himself with the job of nurturing a fledgling International Harm Reduction Association that had been suggested by American addiction researcher Ernie Drucker, and threw himself into getting it off the ground.

'It took off to such an extent that our credibility far outstripped our ability to do it,' he remembers. 'Our capacity was so small yet everyone thought it was this big organisation. But we grew and became quite influential, getting in to see ministers on the back of the conference.'

By 2004, with his enthusiasm for travelling exhausted, O'Hare realised that he couldn't take the association to the next level. He became IHRA president and public health sociologist, Gerry Stimson, was brought in as executive director.

At this point IHRA relied mainly on personal contacts and networks, but had been very successful in promoting harm reduction to international agencies. 'What I wanted to do was capitalise on IHRA's position and give it the capacity to be a big player within harm reduction globally,' says Stimson.

He set 'strategic proactive advocacy' – not just responding to when things happen, but also looking forward – and 'quality policy analysis' as among key objectives. He also wanted to emphasise that harm reduction applies to all psychoactive drugs including alcohol and tobacco, an objective that hasn't yet been a successful as he would like. A grant from the UK Department for International Development in 2006 helped develop the strands of policy analysis, advocacy and working with partners.

Back in 2004 IHRA's entire annual budget was £120,000 which meant only part-time posts for Stimson and his colleague Jennifer Curcio. This year the budget is £1.2m, which doesn't include the separate conference budget and finance for joint projects, such as work in the Middle East with the World Health Organization.

But as the budget has increased, so has the task ahead. 'We're always looking for where we can have the biggest impact and make the biggest inroads,' says Stimson. 'The biggest insight for me has been the mileage we can get by focusing on human rights. As a public health sociologist and researcher I've pursued the public health argument for harm reduction. But the human rights argument has been particularly powerful in providing new leverage for harm reduction".

Among the current ten-strong staff team are Rick Lines and Damon Barratt, who opened his eyes to the range of mechanisms that could be used to call countries to account for their human rights records, in terms of the human rights conventions and treaties they had signed.

Through working with the UN special rapporteurs on areas such as the right to health, extrajudicial killings and torture, IHRA has helped 'people who hadn't had much to do with drugs before to suddenly realise that drugs and human rights are part of their mandate,' says Stimson.

Liaising with the UN High Commission on Human Rights has gone on to put pressure on other parts of the UN system. 'The United Nations Office on Drugs and Crime (UNODC) has always worked in a bit of a vacuum,' he says. 'But we're trying to break that cosy arena – what's been described as a parallel universe – and really put pressure on the UNODC by reminding it of its human rights obligations.

'And that opens up a whole new agenda about drug law reform – looking at some of the implications of the ways drug users are treated as a result of drug conventions and national laws. If you put a human rights angle in there you open up lots of new ways to argue for harm reduction and drug law reform.' Much of IHRA's method relies on working behind the scenes to encourage and cajole reform.

Equally prominent this year has been a project to map the state of global harm reduction led by Catherine Cook. It's not just about coverage of harm reduction, but also the amount of money going into it. 'None of us have been that astute at trying to influence the Global Fund to Fight AIDS, Tuberculosis and Malaria (the biggest funder of HIV/AIDS prevention and treatment) or getting other funders to put money into global harm reduction – so globally only about 5 per cent of drug injectors have any access to any kind of harm reduction services at all,' says Stimson.

IHRA's latest report shows that global funding of harm reduction amounts to around just three US cents a day, leading to the conclusion that spending needs to increase about 20-fold.

'It means we might need to think about harm reduction in totally different ways,' he reflects. 'This might mean you don't open up needle exchanges or methadone clinics, but try to integrate harm reduction into general medical care.'

And with this statement Stimson reflects that for him, harm reduction keeps on presenting new and bigger challenges. 'Every year, every month there are new ideas about how to push it forward, and that's how it's been for the last 20 years. Every year there are new things happening – it just doesn't stand still.'

Resourcing global harm reduction will be one of many topics explored at IHRA's 21st international harm reduction conference in Liverpool on 25-29 April. Details at www.ihra.net

'It took a brave decision by some key figures working in public health and health promotion in Merseyside to try a different approach, focusing on practical advice and better services for drug users.'

Consultations with young people have shown the need to refocus drug and alcohol services to make them directly relevant. **Marcus Roberts** explains

A year ago DrugScope published *Drug treatment at the crossroads*, a report that focused particularly on the debate about the respective merits of abstinence-based treatment versus harm reduction. At a time when the BBC among others was challenging the scale of use of substitute drugs like methadone, our first *Crossroads* report aimed to give a balanced viewpoint. It recognised that there had been huge strides forward, while arguing that there was still plenty to do.

This first report was largely silent on young people, but drug and alcohol treatment for the under-18s has been undergoing its own significant – if more modest – expansion. The numbers of under-18s in treatment went up from 17,001 in 2005-06 to 24,053 in 2008-09, with central government investment rising from £15.3m in 2003-04 to £24.7m in 2007-08. Only a minority of young people entering treatment are using heroin or crack cocaine (around 3 per cent in 2008-09, according to the NTA's annual report on substance misuse among young people). Most of them (nine out of ten) are seeking help with cannabis and/or alcohol.

The expansion of young people's drug and alcohol treatment has been partly driven by the wider Every Child Matters agenda, with the Department for Children, Schools and Families working jointly with the NTA nationally, and directors of children's services working with drug action teams locally – at least in theory. Of course this works better in some areas than others.

So last year we embarked on a second round of *Crossroads* consultations to get DrugScope members and other key stakeholders' views on young people's drug and alcohol treatment. We held consultation events in London, Birmingham, York and Gateshead, conducted a survey of more than 40 young people's substance misuse services, and talked with young people in East Ham and Brixton in London. We consulted members of the London Drug and Alcohol Network (LDAN), which merged with DrugScope last March. Finally, in February, we launched the second *Crossroads* report at a national conference on young people's treatment in central London, which we co-hosted with the National Children's Bureau. Here are some of the report's key messages:

The cannabis debate

There has been widespread concern about the impact of potent strains of cannabis on young people, particularly domestically-produced 'skunk'. In its 2008 report on cannabis classification, the ACMD was far from sanguine in its assessment of the potential harms of cannabis for a small minority of users. Some young people appeared to be spending large sums of money in pursuit of intense intoxication and psychological dependence was acknowledged as a real – if rare – phenomenon.

Of 43 young people's services responding to DrugScope's survey, two thirds believed that more potent strains of cannabis were resulting in greater harm to their clients. There is very little data to enable us to get a grip on the extent or consequences of heavy cannabis use. The British Crime Survey measure of 'frequent use' among 16 to 24-year-olds is 'use of any illicit drug at least once a month in the last year', which is of only limited help.

Polydrug use and legal highs

Last September DrugScope's *Druglink* magazine published its Annual Street Drugs Trend Survey. It found that 'young, recreational users are now swapping or combining cocaine, ketamine, GHB, ecstasy, cannabis and alcohol on a night out'. *Druglink* has produced regular reports on the emergence of 'legal highs', including GBL, BZP, Spice and mephedrone. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) declared in 2009 that 'polydrug patterns are the norm, and the combined use of different substances is responsible for, or complicates, most of the problems we face'.

Our report calls for more effective mechanisms for monitoring emerging trends, including the establishment of a national 'radar' service working with frontline services to share intelligence and to provide early warning of new trends. Such a service could be linked into, inform and support the needs assessment work of local commissioners.

A generational shift?

Only a small minority of under-18s in treatment are 'problem drug users' in the adult sense. Patterns of drug use are changing among 18 to 24-year-olds in treatment too. Last year an NTA press release heralded a 'generational shift in patterns of drug dependence in England' and the end of the 'Trainspotting generation'. One in five young adults entering treatment in 2008-09 sought help for powder cocaine problems. More recent NTA data, released in March, suggests that seven out of 10 people treated for powder cocaine have stopped using the drug after six months, or substantially reduced their use. This partly reflects the work to develop psychosocial interventions, which the NTA has prioritised since the publication of our first *Crossroads* report, which highlighted the need for a broader menu of treatment options to respond to emerging drug trends.

The emergence of new synthetic drugs and the growth in polydrug use is placing strains on our legal and policy frameworks too. How do you make rational decisions about the control of newly synthesised drugs before sufficient scientific

evidence is available? How does a legal and policy framework that has operated in substance-specific terms – for example, in the way harm is assessed by the drug classification system and problem drug use is defined – respond to harms that arise from interactions between drugs?

Against this background, our report calls for a review of the basis assumptions and frameworks of the drug treatment system, to take account of changing patterns of substance misuse – particularly among young people and young adults. It is questionable whether a purely substance-specific definition of 'problem drug use' is appropriate to the challenges ahead. In particular, the challenge of polydrug use requires a closer link with alcohol policy and alcohol services, and increased investment in the latter.

Contextualised view

Most people who are in specialist drug and alcohol treatment are otherwise at risk, or in trouble, or facing social exclusion. The young people who spoke to DrugScope about their own drug problems were clear about how everything connected in their lives. You can end up smoking skunk all day when it's readily available in your neighbourhood, your friends are using it, and you've got nowhere to go and nothing else to do. Getting 'out of it' is one way of coping with going back to a run-down flat in an unsafe neighbourhood.

We should not be surprised that most clients of young people's drug services have other problems too, and it makes sense that a lot of the support they receive from those services addresses the other issues in their lives. Young people we spoke to said that the main benefits of treatment services to them were things like positive and supportive relationships with keyworkers, help with housing, education and employment, the opportunity to mix with peers in a safe environment and access to music studios and IT equipment. A lot of these young people were not heavy drug or alcohol users and were not being treated in the narrow medical sense.

Is the focus on socially excluded and vulnerable young people something we should welcome or worry about? Surely it is appropriate given the links between drug and alcohol use and other problems, and it is a route through which young people can get holistic support. But the concern is that once a young person falls into the net of children's specialist treatment services everything about them may be labelled and pathologised, while more affluent young people are left to mature out of substance misuse.

Conversely, middle class young people with substance misuse problems may not find their way to treatment services, because they are unlikely to be directed through the main referral routes. DrugScope's report calls for the development of low threshold, high visibility drug and alcohol services in our towns and cities, so that young people who feel they may be developing problems know where to go for help, and can access brief interventions (and referral to other services where appropriate) in non-clinical settings.

'While those from the most marginalised communities are left to fend for themselves, young adults from supportive backgrounds receive a turbo charge from the state to propel them into adulthood'

A word about transition

Finally, what happens to people who hit their 18th birthday and still need specialist help for a drug or alcohol problem? The answer is that they may have no option but to drop out of the treatment system altogether, or to move over to adult services that can work very differently. We need a fundamental rethink of how we work with vulnerable young people in this transitional phase, recognising that processes of transition are multiple and complex.

The young people we talked to were not interested in moving to adult drug services, but they all talked about the other challenges of moving into adulthood – education, jobs, housing and relationships. A recent report from the Transition to Adulthood Alliance declares 'while there is recognition that under-18s deserve support and are worth investing in, there is a complete attitudinal change once they are over 18. While those from the most marginalised communities are left to fend for themselves, young adults from supportive backgrounds receive a turbo charge from the state to propel them into adulthood.'

DrugScope's report calls on the next government to develop a national policy framework for young adult services, which could take the form of a Green Paper. We will be looking to work with colleagues in other sectors – including mental health and criminal justice – to campaign for a more joined-up approach to transitional arrangements.

Dr Marcus Roberts is director of policy and membership at DrugScope

Young people's drug and alcohol treatment at the crossroads is available on the DrugScope website at www.drugscope.org.uk If you would be interested in joining DrugScope as a member and supporting this and other policy work, contact Carlita McKnight, membership development officer, by emailing carlitam@drugscope.org.uk

The Centre for Addiction Treatment Studies

in partnership with the University of Bath offer a suite of Continuing Professional Development units and two degree programmes with Summer Schools in Addictions Counselling.

For individuals interested in embarking on a career as an Addictions Counsellor there are Level 5 and 6, Fd Sc and BSc (Honours) programmes in Addictions Counselling available on a full-time basis and for practitioners already working in the field requiring enhanced and up-to-date skills we offer the same programmes with accelerated learning on a flexible part-time basis.

Alternatively we can offer a programme of Continuing Professional Development accredited by the University of Bath that include Management units designed for addictions professionals which are delivered over a 2 day residential period during the summer months.

For further information see our website at www.actiononaddiction.org.uk/trainingeducation/

or contact Carol Driver on 01985 843782
Email carol.driver@actiononaddiction.org.uk

Senior Therapist

Full-time, 37.5 hours
Roehampton
Salary £23,243 - £34,864
Grade 7

Priory Healthcare is the UK's leading provider of private mental health care. We have an outstanding reputation both for the service we deliver and for the investment we make in our people and in our environment. The Priory Hospital Roehampton is a teaching hospital renowned for its clinical excellence in the field of Addiction, Eating Disorders and Acute Mental Health.

We are looking to recruit a Senior Therapist. The successful candidate will need to be qualified as an Addiction Therapist or equivalent and experience in the facilitation of group, delivery of workshops and individual therapy within the addiction field, as well as care coordination and patient assessment skills. You will need to have FDAP membership and accreditation or evidence of working toward this is required. There will be potential weekend and evening work.

Candidate will need to have a minimum of 5 years experience or have worked previously in a senior post. Experience of working in a multi-disciplinary environment and ability to co-ordinate delivery of an Addiction Programme would be a distinct advantage.

For an application form, please contact Maria Tulloch-Edwards in Human Resources on 020 8392 4224 or email mariatulloch-edwards@priorygroup.com

Closing date for applications: 12th April 2010.

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Oxfordshire drug & alcohol action team

Oxfordshire NHS
Primary Care Trust

Provision of a Young People's Drug and Alcohol Service in Oxfordshire

TENDER ADVERT

The opportunity has arisen to tender for the provision of a Young People's Drug and Alcohol Service in Oxfordshire. The service will provide the following three key elements:

- *The provision of structured psychosocial interventions for young people aged 11 to under 19 whose drugs and/or alcohol is significantly impacting upon their social, physical and psychological functioning;*
- *The provision of structured psychosocial interventions for young people aged 11 to under 19 whose parental or family substance misuse is significantly impacting upon their lives;*
- *An early intervention rapid reaction team operating at tier 2; dedicated to the delivery of alcohol brief interventions for young people aged 11 to under 19.*

The contract will be for 3 years with the option to extend for a further 12 months. The contract value per annum will be a maximum of £318,000.

The closing date for the receipt of the completed tender documentation is 5pm on Monday 10th May 2010; any documentation received after this date may not be opened.

To express interest in this opportunity please e-mail Alan Kilham, Senior Procurement Manager at alan.kilham@oxfordshirepct.nhs.uk or telephone 07795 952888. Following receipt of Expression of Interests bidders will be advised as to how to access the tender documents.

All potential providers are asked to complete and return their tender (via the web site) by 5PM on the closing date. Tenders received/posted to the web site after this date may not be allowed or evaluated.

BLENHEIM CDP
THE LONDON DRUG AGENCY

Team Leader

£28,403 to £31,527 pa **35 hours per week**

Insight – Young People & Families Service – London W10

This is an open access service, providing support for young people and families up to age 25 affected by or living with drug related issues, in the Royal Borough of Kensington and Chelsea. We provide a range of services including drop-in, one-to-one support with onward referral, workshops, alternative therapies and information, advice and guidance on housing, education and employment.

As Team Leader, you will have the ability to effectively train, support and challenge a team of workers to improve practice and service delivery. You will carry a caseload of clients, and be a lead practitioner within the team, engaging and supporting young drug users, using a range of 1:1 and group interventions.

You will need to demonstrate supervisory skills, and substantial expertise of working with this client group. An understanding of the needs of younger drug users is essential, as is the commitment to maximise healthy opportunities and informed choices for your clients. The ability to build and maintain effective working relationships with partner agencies is also vital for this role.
REF: BCDP/16/DDN.

To request an application pack, please email info@peterlockyer.co.uk or telephone our response handling line on 01206 570706 quoting the reference number. Alternatively, you can download an application pack from our website www.blenheimcdp.org.uk

Closing date: 7 April 2010.

www.blenheimcdp.org.uk

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

Blenheim CDP: Registered Charity No. 293959.

DDN/FDAP WORKSHOPS

DDN Drink and Drugs News

fdap

NEW...NEW...NEW...NEW...NEW

Dual diagnosis training day

8 June

DDN are pleased to announce a brand new one-day workshop focusing on working with dual diagnosis clients. Using practical case studies and examples of good practice, the trainer – Brendan Georgeson from Walsingham House – will examine how to build and sustain a truly integrated service, how to overcome the fears of working with this client group and the transferable skills required. This practical workshop is mapped to MHNOS 23 (Mental Health Occupational Standards), DANOS AF3 (Drug and Alcohol National Occupational Standards) and the Knowledge and Skills Framework - KSF HWB. *Cost: £115 + vat*

15 June

Masterclass – registration with Care Quality Commission

All currently registered services will need to re-register with CQC between April and September 2010. Quasi-residential and community services will also need to register. David Finney, author of the national guidance for inspectors of residential services, will show you how to meet the new compliance criteria. *Cost: £135 + vat*

15 July

Legal highs and other new developments in drug use

This workshop will look at some of the latest developments in the use of pychoactive chemicals. It will cover information on mephedrone (4-mmc, miaow, m-cat), methylone, butylone, synthetic cannabinoids (Spice) and many others. Find out about tomorrow's drug use – today! The course is run by Ren Masetti, training co-ordinator for the Drug and Alcohol Action Team in Suffolk and freelance trainer. *Cost: £115 + vat*

15% discount to FDAP members.

All courses run from 10am – 4pm in central London, and include lunch and refreshments.

For more details about these workshops email ian@cjwellings.com or telephone 020 7463 2081. Or visit www.drinkanddrugsnews.com

Powys

Keep Powys Safe
Cadwch Bowys yn Ddiogel

Substance Misuse Service

EXPRESSIONS OF INTEREST

For PQQ for the provision of Drug and Alcohol Community Tier 2 and 3 Services for Children, Young People and Adults in Powys.

Powys County Council, on behalf of The Powys Community Safety Partnership, welcomes expressions of interest from suitably qualified and experienced organisations for the provision of the above services.

The successful provider will have a proven track record in delivering services that create a positive culture within the workforce and service users.

We would welcome partnership bids from public sector, private sector and voluntary sector with a clearly identified lead organisation.

The successful organisation will be expected to provide a range of treatment interventions for children, young people and adults that include:

Tier 2 – Advice, information and support

- Advice/information
- Offering user friendly, confidential substance misuse interventions to children/young people/adults
- Initial assessment and appropriate referral
- Full range of harm minimisation advice
- Prepare young people for transition
- Preparing service users for accessing structured care
- Needle exchange

Tier 3 – Drugs and alcohol interventions

- Joint assessments/care planning to children/young people/adults
- Needle exchange
- Key working including a range of psycho-social interventions
- Relapse prevention
- Preparation and referral for Tier 4 intervention
- After care and contingency management
- Carers/parents and concerned others support
- Integration with the Drugs Interventions Programme

The contract will be for 3 years with an anticipated start date of 1st April 2011, with the option to extend for a further 2 years at the Council's discretion.

To register an expression of interest and access the PQQ and supporting documentation please register with 'Sell 2 Wales':

www.sell2wales.co.uk

jobs.wycombe.gov.uk

Community Substance Misuse Worker

The post will focus on Asian and Travellers Communities Based in Aylesbury

Fixed-Term Contract ending 31st December 2011
£21,484 - £26,238 per annum with the potential to progress to £28,685 per annum

With experience of substance misuse issues and excellent community engagement skills, you will empower communities to engage in tackling substance misuse programmes. You will deliver a high quality, responsive substance misuse harm reduction programme, which will primarily target Black and Minorities Ethnic Communities across Buckinghamshire, you will be committed to a high quality service and encouraging involvement of members of the public.

For more information about the post and the project you can speak to either Lee Scrafton on 01296 387749 or Gillian Stimpson on 01494 421404.

Due to the nature of this post, it is exempt under the Rehabilitation of Offenders Act and full vetting will be carried out.

Closing date: 9th April 2010. Interviews: 23rd April 2010.
To apply visit http://jobs.wycombe.gov.uk, tel: (01494) 421141 quoting LLG04T.

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COMMUNITY DRUG SERVICE for SOUTH LONDON

DATA OFFICER

Part Time – 18 hours weekly,
Grade 27, NJC Scale
(6% Employer's Contributory Pension Scheme)

The successful candidate will work alongside our Information and Performance Manager assisting him in the processing of our clients' data. Working according to our existing system and policies, you will also be expected to follow national related guidelines and legislation.

DIRECTOR PA/ADMINISTRATION

Part Time – 18 hours weekly,
Grade 27, NJC Scale
(6% Employer's Contributory Pension Scheme)

The successful candidate will work alongside the CDSSL Managing Director assisting him in the daily running of operational management.

For an Application Pack for either of these positions, please call: 020 8773 9393

Closing date for completed applications for both positions : 5th of April 2010

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Are you looking for a rewarding new challenge?

Services Development Director

NJC 42-46 (currently £35,430 - £38,961 pa) • 37 hours per week

If you have substantial management experience in the substance misuse field and can support and help develop our services, then this is an ideal career opportunity to work at a senior level within a small, local, not-for-profit organisation.

Deputising for the Chief Executive to achieve the aims of our business strategy and develop services, you will co-ordinate all aspects of service delivery while developing and supporting team mangers. Furthermore, you will oversee quality and performance management - providing a strategic link to local frameworks and partnerships relevant to our work.

To be successful, you will possess extensive knowledge of substance misuse or related fields, be educated to degree level and hold a professional qualification. Experience in service management and history of successful bidding and developing new services are essential.

Interview date: w/c 3rd May 2010.

Project Worker: Day Services

NJC 26-32 (currently £22,221 - £27,052 pa) • 37 hours per week

This is a great opportunity to deliver structured day service programmes for substance misusers - carrying out a significant amount of group-based work and individual support.

You will need experience of providing advice, information and structured treatment to people with substance misuse problems. Knowledge of substance use/effects, harm reduction strategies and motivational issues in relation to substance users are essential and knowledge of different group work interventions would be desirable.

Interview date: w/c 3rd May 2010.

Temporary Outreach Worker

NJC 26-32 (currently £22,221 - £27,052 pro rata) • 22.5 hours per week
To cover maternity leave up to April 2011

This is an exciting opportunity for an experienced practitioner to provide advice/information to substance misusers through outreach and case management services.

Your substantial experience of providing advice, information and structured treatment to people with substance misuse problems will be matched by your knowledge of motivational issues. You will be able to work towards agreed objectives, priorities and deadlines, together with competent database skills.

Interview date: w/c 26th April 2010.

For an application pack, please visit www.lcp-trust.org.uk or contact us on 0116 252 1634.

Closing date for all posts: 12.00pm 14th April 2010.

LCPT is committed to being an equal opportunities employer and to promoting diversity. We are under-represented by ethnic minorities and men, and welcome applications from people from these groups.

RECRUIT WITH DDN JOBS!

and add to your bunch

We will be taking a break over the Easter period
but you can still recruit with *drinkanddrugsnews.com*
and the new weekly e-alert, DDN Bitesize.

Contact Faye Liddle on 020 7463 2205 or faye@cjwellings.com

HAPPY EASTER FROM THE DDN TEAM

We will be back on Monday 26th April

Bristol Drugs Project is an experienced, energetic and resourceful service delivering effective harm reduction and treatment services to over 3,200 individuals a year.

Drug-Using Parents Worker*

(Full-time 35 hours) – Job reference: DD1

Be part of our Family Support Service, this will involve delivering services to families/parents in the local community who are using drugs problematically. This role will offer keyworking and guidance around drug use, practical support, onward referral and transitional support for clients. The service also has a key role within the Bristol Maternity Drug Service.

This post operates within the community setting, in homes, partner agencies and is flexible to the needs of our service users.

You will need experience of working with drug users & we welcome past personal experience of problematic drug use.

** This post is female only; section 7(3) of the Sex Discrimination Act applies.*

For an informal discussion contact either Karen Black, Community Team Manager on (0117) 987 6021 or Jenny Cove, Family Support Senior Practitioner on 0117 987 6009.

Salary: **£17,195 progressing to £25,848, starting salary for suitably qualified candidates: £22,926.**
Closing date: **Monday 12th April at noon**
Interview date: **Wednesday 14th April**

Harm Reduction Worker

(Full-time, 35 hours) – ref: DD3

This is an exciting opportunity to be part of a 6 day harm reduction service for drug users where reducing risk is the goal. Why do injectors share? If you understand why and can work imaginatively to do something about it, we are keen to hear from you.

Some out of hours work will be involved. A full UK driving licence is essential.

For an informal discussion contact Steve Jackson,
High Support Manager on (0117) 987 6012.

Salary: **£17,195 progressing to £25,848, starting salary for suitably qualified candidates: £22,926.**
Closing date: **Monday 12th April at noon**

Senior Practitioner – Detached Work

(Full-time 35 hours) – Job reference: DD2

Alongside your main role of delivering detached services to targeted groups (women sex workers, those in homeless hostels and those requiring extra support to access treatment services), you will supervise a small team and play a key role in the ongoing development of this service.

You will need experience of working with drug users & we welcome past personal experience of problematic drug use.

For an informal discussion contact Steve Jackson,
High Support Manager on (0117) 987 6012.

Salary: **£23,713 progressing to £29,445**
Closing date: **Monday 12th April at noon**

Please contact Angelo Curtis, quoting the job reference, for an application pack: BDP, 11 Brunswick Square, Bristol BS2 8PE
Tel: (0117) 987 6004, E-mail: recruitment@bdp.org.uk

We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation.

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No CVs, agencies or publications.

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