DDN
Drink and Drugs News

2 June 2008
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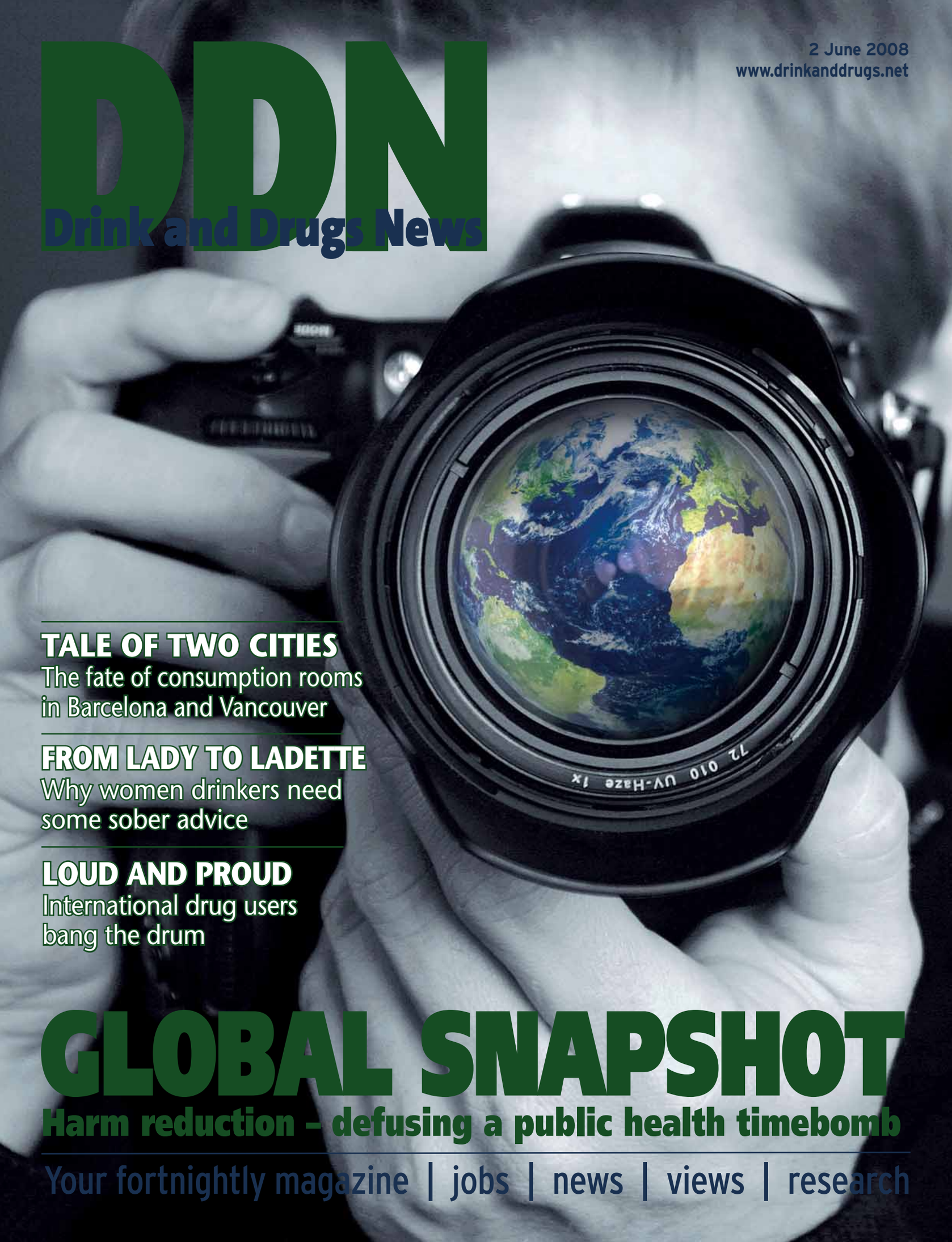

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DDN
Drink and Drug News

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Editorial – Claire Brown

Taking a global snapshot

Why harm reduction must focus on the public health challenge

BECOMING IMMERSED in an international harm reduction conference is quite an intense experience, but that's what we did last month at IHRA's event in Barcelona. It was the first time DDN had been to this annual event, and the first time we had been invited to produce daily magazines covering it. We decided to make the most of the opportunity by sharing some of the insights to harm reduction revealed by delegates from different countries, in this issue of the magazine.

Harm reduction so often becomes one half of an over-familiar polarised debate in the UK, but looking at the reasoning behind basic measures to reduce the spread of HIV and hepatitis C is a stark reminder of the public health challenge at the heart of organisations such as IHRA. It was also an eye-opener to the different barriers to accessing treatment services posed by different cultures. Harm reduction would be a different (and very remote) concept to the drug using women in Ukraine (page 15), compared to the new International Sex Worker Harm Reduction Caucus that brought their stand and their banners to the conference to demonstrate that being loud and proud is essential to fighting the disease and discrimination that can so dangerously accompany stigma.

We've a lively letters page this fortnight (page 6), thanks to last issue's cover story 'Different roads'. It's divided our readers and provoked some strong comments on treatment philosophy which I hope will continue. The varied backgrounds and experiences of our correspondents are enriching the debate.

There's also another fan for Bri, whom I'd like to thank for sharing his story (page 19). We got to know Bri at our service user involvement conference in January; he decided he would write his story in the hope of inspiring at least somebody else to keep going when the going gets tough. It's not easy to share your lowest moments, but judging by some of the feedback he's had, it's been worth the painful memories.

This issue

News in Brief

FRANK is five

The government's FRANK campaign was five years old last month, during which time it has seen 22 million visits to its website, received more than 2.5 million calls and made more than 57,000 referrals for support. 'Alongside education and enforcement, FRANK continues to play a vital role in allowing young people to make the choice not to take drugs,' said Home Office minister Vernon Coaker. 'It has a proven track record in reaching young people, with 81 per cent saying they would recommend FRANK to a friend.'

On message

Scotland's first text message-based campaign targeting young people with messages about cocaine use has been carried out by Alcohol and Drugs in Edinburgh and Crew 2000. *Chemical Romance* used Bluetooth transmitters in nightclubs to send harm reduction messages and information on sources of help to nearly 1,400 mobile phones over a ten-day period. 'The aim of *Chemical Romance* was to test the effectiveness of information technology in delivering a harm reduction message to people's mobile phones,' said Crew 2000 team leader Matt Straw. 'One of the advantages of using this method is it allowed us to target very precisely those who are at risk of encountering or developing problems with cocaine.'

Carlin for Council

Mentor UK and Drug Education Forum chair Eric Carlin has been officially appointed to the Advisory Council for the Misuse of Drugs (ACMD). 'I'm very pleased to be another voice for prevention and drug education on the ACMD,' he said. 'I hope that my appointment will strengthen that perspective in the deliberations of the council and ensure that our work is founded on an understanding of the needs of children and young people living in a drug using world.' Professor David Nutt has been appointed the new chair of the ACMD, the home secretary has announced, taking over from Professor Sir Michael Rawlins who steps down in October.

Scots drugs strategy 'a new era'

Scotland's drugs strategy represents 'a new era' in the country's approach to tackling drugs, according to community safety minister Fergus Ewing. Launched last week, key points of the strategy – the first since devolution – include a renewed focus on recovery, a wide ranging information campaign and a recognition that action will need to be backed up with policies focusing on the underlying causes of drug misuse, such as poverty.

A central part of the strategy will be to develop more effective responses to children at risk from their parents' substance misuse, says the government.

The education campaign will see 'provision of factual information on drugs to every household with parents or grandparents in Scotland', and the strategy will also include measures to strengthen powers to seize assets from drug dealers, a commitment to better quality drug treatment in prisons and tracking of investment in drug services and their outcomes. The extension of drug treatment and testing orders is also being piloted.

Scotland has an estimated 52,000 problem drug users, at a cost to society of £2.6bn. 'For two decades Scotland has been in the grip of drugs – reacting and responding to the impact they have had on our people, our public services and our economic potential,' said Fergus Ewing. 'Many people with problem drug use are motivated and determined to recover – we want them to have the best chance to do so.'

The government would not 'second guess clinicians,' he said, and helping people move on after treatment would be a priority. The way services were planned, commissioned and delivered would all be reviewed. A drug recovery network has been set up to promote and support the concept of recovery, and the government has promised that treatment will be better integrated with wider social care, housing, mental health and education services among others. There would also be ongoing multi-agency training to help identify children at risk at an early stage, and better sharing of good practice.

'Recovery by individuals from the effects of drug use lies at the heart of this strategy and clinical, social and other services, working together, will offer each client the maximum opportunity to address the complex issues they face in dealing with their drug use,' said chief medical officer Harry Burns.

The Scottish Drugs Forum fully supported the new strategy, 'because it acknowledges that medical help or prison sentences on their own are not nearly adequate to help people overcome their drugs problems,' said forum director David Liddell.

'It makes clear, and rightly so, that providing services such as family support, housing and opportunities for education, training and employment have an enormous part to play in preventing people from developing drugs problems and helping them move away from them. This is a highly ambitious plan of action, which will demand a variety of agencies to change the way they work. It is vital that they also have the energy, commitment and appropriate resources to see it through.'

Full strategy available at www.scotland.gov.uk/Publications/2008/05/22161610/12

Alcohol-related hospital admissions double

The number of alcohol-related hospital admissions has more than doubled in England since 1995, according to new figures from the NHS Information Centre. In 2006/07 there were 57,100 admissions with a primary diagnosis specifically related to alcohol, such as alcoholic liver disease.

Nearly ten per cent of those involved patients aged under 18, according to *Statistics on alcohol: England 2008*. There were also 6,500 alcohol-related deaths in 2006, a 19 per cent increase since 2001 – two thirds of the deaths were men. The report also reveals that the number of prescription items dispensed in primary care to treat alcohol dependency had increased by 20 per cent in the last four years.

'This report shows alcohol is placing an increasing burden right across the NHS – from the GP surgery to the hospital bed,' said chief executive of the NHS Information Centre, Tim Straughan. 'These rises paint a worrying picture about the relationship between the population and the bottle.'

Meanwhile, a large-scale campaign to educate the public about alcohol units has been launched by the Department of Health. Part of the *Know your limits* campaign, £6m will be spent on press, billboard, TV and radio adverts in 2008/09 as well as a £4m binge drinking awareness campaign to be launched by the Home Office this month.

A recent YouGov poll revealed that 77 per cent of English drinkers did not know how many units were in a large glass of wine, while nearly 58 per cent did not know that a large gin and tonic contained two units and 35 per cent did not know that a pint of normal strength beer contained the same. The survey also showed that drinkers aged over 55 had less awareness of alcohol units than those in the 18-24 age range.

'Glass sizes have grown larger and the strength of many wines and beers has increased, so it's no wonder some of us have lost track of our alcohol consumption,' said public health minister Dawn Primarolo. 'This campaign is all about helping people understand how many units are in their favourite drinks, and helping them to keep an eye on their intake for the good of their long term health.'

'Sadly the first time many people get to discover the effects of underestimating alcohol limits is when they end up in A&E and other hospital departments,' said Turning Point's substance misuse spokesperson Harry Walker. 'Although the government's campaign is vital, we know from the experience of our alcohol treatment services that information isn't enough. What is needed is access to treatment, particularly for people from the poorest communities. We are uncovering a worrying number of NHS 'frequent flyers' who experience undiagnosed problematic alcohol use.'

A new online unit calculator has also been launched at www.nhs.uk/units.

Report available at www.ic.nhs.uk/pubs/alcohol08

Government targets cocaine in new campaign

The government has launched a major new campaign on the health and social effects of cocaine use, specifically targeting young people. A £1m FRANK campaign to 'deglamourise' the drug – aimed at 15-18 year olds – will coincide with a commitment to the Colombian government's 'shared responsibility' campaign, which highlights the consequences of the cocaine trade.

The government will also issue a new leaflet on the dangers of cocaine and host a summit looking at how to reduce use of the drug. Cocaine is the only drug that has risen in use in the last decade, although this has stabilised since 2000.

'Cocaine use has been stable in recent years but it is a very dangerous drug for users and has a devastating impact on the people that live in producing countries,' said Home Office minister Vernon Coaker. 'Cocaine users need to realise that their drug use destroys more than their health – it destroys the lives of innocent people caught up in kidnapping, exploitation and armed violence. We will continue to tackle cocaine and other illegal drugs through tough enforcement, innovative prevention campaigns, effective education and, where necessary, tailored treatment.'

The government also announced new crackhouse closure orders as part of National Tackling Drugs Week last month, as well as awareness sessions for parents and a 'shop a dealer' campaign.

'We particularly welcome the government's emphasis on the social harms of using cocaine, and would encourage a similar focus on tackling heroin and crack use,' said Turning Point's senior substance misuse advisor Harry Walker. 'However, working with someone to tackle their substance misuse is only part of the answer. The crucial factor is to focus on people's whole picture of needs such as lack of employment and housing. The government must tackle these wider issues, not as an add-on, but as a vital integrated tool to really turn lives around.'

Shared responsibility: Drugs Minister Vernon Coaker (right) launches the new cocaine campaign in London's Trafalgar Square, with Colombian Vice President Francisco Santos Caldéron and former Blur bassist Alex James (left).

Put public health at the centre of drug control, says UN

It is time to put public health at the centre of drug control, executive director of the United Nations Office on Drugs and Crime (UNODC) Antonio Maria Costa told delegates at the 19th International Harm Reduction Association conference in Barcelona. The UN's approach was now one of 'the three HRs' – harm reduction, health rights and human rights, he promised.

In the last few decades the prevailing focus of drug policy had been law enforcement and this had had unintended consequences, he acknowledged, with public health pushed into the background. Nonetheless, drug control worked, he told delegates. 'Five million people a year die from tobacco related problems, and 2.5 million die from alcohol related problems. With drugs, it is less than 250,000.'

It was still essential to reduce the supply of drugs, to stop people taking drugs and stop drug traffickers exploiting the misery of 'addicts and their families', he said. It was also vital to mitigate the risk of drug use relating to the HIV pandemic. 'My proposition is to recast your mission in a revolutionary way,' he told delegates.

Harm reduction had done great things, in terms of distributing needles and condoms to drug dependent people. 'But I submit to you that this is not sufficient unless it is done in such a way that it puts an end to the suffering of drug addicts.' Too often harm reduction had accepted, or even condoned, drug use, he said.

'What is needed is a package of measures that is innovative and richer in terms of possible consequences,' he told the conference. Firstly, it was essential to devote more attention to prevention. It was also vital to reach out to those who needed treatment but couldn't afford it, and more support was needed for making drug treatment a mainstream part of public health. The UN was stepping up its efforts to achieve these things, he said. HIV/Aids was the fastest growing area of UNODC activities, and the UN approach was that drug dependency should be treated as an illness as well as a social issue.

Human rights were at the centre of the UN's mandate and had to be central to drug control, seeing people as individuals rather than drug addicts. 'Although drugs kill, we should not kill because of drugs,' he said. 'If we are to move beyond merely containing the world's drug problem, we need a more balanced and radical approach to drug control.'

News in Brief

C Plan

Phase 2 of Scotland's hepatitis C action plan has been launched to raise awareness through education and prevention, backed up with more than £43m to improve testing, treatment, diagnosis and support. The number of hepatitis C-related liver deaths in the country doubled between 1999 and 2005. 'Hepatitis C is a significant public health challenge for Scotland as we have almost 50,000 people living with the infection and 38,000 of them are chronic carriers,' said public health minister Shona Robison. 'There is still a lot of ignorance… part of our plan will be to work to raise awareness among professionals, the public and those at risk of infection.'

Hackney enforcers

'Strong and sustained enforcement' will be at the heart of Hackney's approach to drugs, said mayor Jules Pipe at the launch of Hackney DAAT's five-year strategy *Achievement and challenge – tackling drug and alcohol misuse*. The strategy also places a focus on working with the London borough's diverse communities to help encourage people to admit to having a problem and access services, including the establishment of a new black and ethnic minority volunteering programme.

Fit for purpose

Outdoor exercise classes run by British Military Fitness are being used to boost the confidence of ex rough sleepers, as part of joint project between Westminster council's DAAT and Turning Point's Hungerford Project. Five former homeless men are taking part in classes in London's Hyde Park as part of the scheme, the first of its kind in the country. The sessions are designed to improve fitness and sleep, and raise self-esteem. 'We wanted to get involved with this project because so many people that end up on the streets in London, or who have addiction problems or both, are ex armed forces people,' said Barney Larkin of British Military Fitness. 'Our sessions are a success because they involve team work and give people a sense of real achievement.'

'To arrest active addiction – the inevitable result of sustained indulgence in more or less all mood-altering chemicals – there is ultimately no other way than eventual achievement of total abstinence from all toxic substances... Substituting one addictive substance for another, even more addictive substance, is both baffling to comprehend and ridiculous to contemplate.'

Maintenance worries

The article 'Different Roads' (*DDN*, 19 May, page 6) is one of the most important and poignant that *DDN* has published so far, not least for the erudite weight given to the subject by the status of the authors, who are perhaps the foremost authorities on research evidence for treatment outcomes in this country.

I feel very emotional after reading the piece because, as with many others, abstinence-based recovery not only saved my life but has been ongoing in helping me to achieve my potential as a human being. It allows me to draw on my true inner resources for spiritual development through, in my particular case, meditation practice and fulfilment through work, which, as it happens, is in the field of addiction treatment.

It is not a coincidence, I believe, that all spiritual disciplines (apart from the perverted ones) or paths of personal progress and self-realisation recommend total abstinence from intoxicants of all kinds. This is because, in my view, intoxicating substances at best mask or act as a barrier to the realisation of inner potential, whether spiritual, mental or physical. Most, if not all, 'maintenance' substances cloak potential for personal inner growth in a suffocating chemical blanket.

This is not to say that reduction regimes are not useful and even imperative in detoxification protocols; this is where there is a clear valuable and relevant use for chemical support.

Since the dawn of time, the spiritually-realised and more highly advanced members of all human communities have pointed to abstinence from all mood-altering substances and behaviours in order to achieve stability and progressive-development on a personal level for all individuals who want to travel a path to the achievement of full individual human potential.

To arrest active addiction – the inevitable result of sustained indulgence in more or less all mood-altering chemicals – there is ultimately no other way than eventual achievement of total abstinence from all toxic substances. It is as simple as that, basically. Substituting one addictive substance for another, even more addictive substance, is both baffling to comprehend and ridiculous to contemplate.

There is a place for harm minimisation, of course there is, and it is so important that non-abstinence-based services nowadays exist to serve the needs of those who cannot achieve abstinence, especially in the initial stages.

It is the 'maintenance' culture that troubles me. If doctors sanction maintenance prescriptions because of the 'above all, do no harm' ethic, well... they might need to re-evaluate their understanding of ethics. They may be getting it the wrong way round.

John Graham,
self-employed addiction treatment practitioner

A singular lack of evidence

David Best, Jessica Loaring, Safeena Ghufran and Ed Day really do need to get out of the lab a bit. Their conclusion at the end of their article 'Different Roads' bordered on the absurd.

'We should not give people the impression that they can have maintenance and abstinence' they proclaimed. Well, we aren't, so don't worry about it. They state that the idea of 'reduction towards abstinence' is a 'moot point'. Well, until they can find a better, more cost-effective way of moving toward abstinence this is the only relevant debate.

Most, if not all, drug workers and NHS prescribers with whom I have worked will indeed encourage abstinence to all but the most chaotic. Now, granted, this abstinence may take some time, with scripts being reduced over a period of years and lapses occurring frequently, but the intent is still there. Surely improving the likelihood that such people will achieve this abstinence should not be sidelined? Yet this was the conclusion of the article.

But to their original point: medicated recovery is a fallacy, the only way forward is abstinence. The article failed to offer anything by way of proof that this was true. It just took it as fact and moved on. It implied that 'housing, employment and effective social reintegration' was somehow a poor way of judging treatment outcomes, then went on to imply that such wishy-washy (not to mention almost incalculable) terms such as 'hope' 'engagement' and 'commitment' were the proper ways to define 'true recovery'.

They state that engagement with services two or more times was a predictor of poor abstinence outcomes. However, they fail to prove a direct correlation with these two pieces of information. A simple explanation might be that the more chaotic users are more likely to attempt (and fail) treatment and that the less chaotic are more likely to get treatment right first time or even attempt abstinence without need of formal intervention.

This lack of evidence for their supposed proposition ('medicated recovery doesn't exist') leads directly to the question: 'Why knock the achievements of those that have actually achieved medicated recovery?' We should have no doubt that they do exist – I imagine there will be a flurry of letters from just such people, outraged at the suggestion of this article's authors that their recovery is worthless.

And what have the authors achieved by attempting to undermine these people? Well, little to nothing from what I can tell. Spawned an unoriginal and ultimately pointless article that fails to add to an already tired debate, maybe generate a bit of publicity for their forthcoming research. Well done guys, I can see why you get your research grants…

Stephen, by email

Mutual necessities

While agreeing as I usually do with much of what my friends David Best and Ed Day have to say in 'Different Roads', I found their conclusions puzzling.

As some know, I have been banging on for years[1] that harm reduction and abstinence treatment modalities (or philosophies) are not mutually exclusive, they are in fact mutually dependent – and I have never found that 'juggling both is unlikely to succeed'.

An individual patient will demand and respond to differing approaches during his addicted career, and a decent service should be able to meet those changes and support what the patient is motivated for at that time. I absolutely agree that few, if anyone, approaching a service for the first time would say that they wanted a lifetime of servitude to a drug service, a doctor, a pharmacist and a rather boring drug – but evidence supports the practice of prescribing, at least at the outset.

True, prescribing may demotivate some who are so powerfully motivated that abstinence may have a decent chance at achieving durable abstinence, and in so doing may doom them to more time in treatment than might have been achievable. But there are many more patients

who are grateful for this period of stabilisation and see it as a necessary step before the final push for abstinence, which as we see all around us, is indeed achieved by many, and from within the same service.

Prescribing without the hope of eventual independence is philosophically bankrupt, and abstinence without the safety net of harm reduction when relapse occurs is dangerous – they need each other, so treatment services need to provide both, effectively and wholeheartedly.

Dr Gordon Morse, Clinical Lead, Turning Point Somerset

[1] Network, 22 April 2008, 'Why Are We Fighting', Gordon Morse. Online at www.smmgp.org.uk

Abstinence defined

The Birmingham University team is right to sharply differentiate between maintenance prescribing and abstinence in 'Different Roads'. The former is like taking an alcoholic off whisky and then buying him vodka for life at taxpayers' expense!

By recognising 'managed addiction' as 'non-abstinence', we are able to take a better look at what true abstinence is, and the dictionary tells us that it is 'the act of refraining (usually voluntarily) from the ingestion of some substance' – which allows various ways for an individual to achieve this state.

The first is the 'naturally abstinent state' into which 99 per cent of the population are born, and to which natural recovery, 'maturing out' and effective rehabilitation returns former addicts.

Then there are those, who with the support of fraternal organisations such as AA, NA and CA eventually make it through to self-sustained abstinence.

Next there is the group indicated by Professor David Clark, when he observed that 'Most people who recover from drugs problems do so on their own, without formal treatment', and he suggested that, to be effective, interventions should facilitate natural change processes.

Finally, there are those programmes which validate Clark, but which also recognise that there is a much larger group who are also capable of attaining relaxed unsupported abstinence for life – if they are trained in a workable method of recovery which they may then, of their own volition, apply to themselves and their condition.

But this is achieved only if drug usage is recognised and handled as a matter of personal choice and self-determined discipline rather than as a medical condition.

Success with hundreds of thousands of addicts over 42 years and across 43 countries demonstrates that the addict himself is the only person regularly capable of withdrawing and recovering himself from drug usage on a relaxed lifelong abstinence basis.

And the beauty of training an addict to get himself off drugs is that he carries that knowledge with him for the rest of his life and, even if he again relapses, he still has an effective recovery tool immediately to hand.

E. Kenneth Eckersley, CEO Addiction Recovery Training Services, former magistrate and retired justice of the peace.

A question of logic

The article 'Different Roads' made a number of interesting points but I have to question the logic of the statement that 'two prior episodes of formal treatment is actually associated with reduced likelihood of sustained abstinence' – surely this has to do with sampling bias. Is it not also the case that those who need repeated cancer treatment have more chance of dying of cancer; that is not to say that cancer treatment does not work.

Niall Scott, dual diagnosis development worker, North Shrewsbury CMHT

Of particular interest

The 19 May issue of *DDN* was particularly interesting, with several items which I would like to comment on.

Firstly, regarding the 'Different Roads' article: I would say that in practice, the roads are not so clear cut and may change as the person travels through treatment. So often, the priority is to help someone to stabilise their life first, so they can then make informed decisions about the long term. Initially, many people just want some decent help and cannot look further than that. Therefore the road may well be the same for many people whether they can detox – quickly, slowly, or never. I don't think it is helpful to polarise the debate into rigid extremes and paths set in stone.

Secondly, regarding the letter 'Choosing residential treatment' (page 8): I would like to point out that residential treatment centres have no control over the quality of treatment when people have left them, and so to devise a rating system based on long-term outcome is meaningless in this context. There are other measures, such as completion rates, waiting lists, patient satisfaction, and so on, which are better markers of quality.

Thirdly, I would like to congratulate and encourage Bri on his series of articles – I especially look forward to reading them. Frank personal experience, written in an easily readable form, is very helpful in understanding the people we see every day – and ourselves, and can definitely influence practice for the better.

Fourthly, and perhaps most contentiously, can we please have some scientific basis for treatments promoted in the magazine. I refer to 'A Polish Experience' (page 12) about auricular acupuncture which seemed to be promoting treatment involving 'detox points' and 'hepatitis C'. Now, I am aware that there is evidence for auricular acupuncture in stimulant withdrawal, but this seems to make more widespread claims – and it would be very interesting to hear what evidence there is for them. I was especially intrigued by the plastic ear and the supposed areas relating to other parts of the body. What is the evidence for that?

It is good to have a magazine that can produce debate – and that is often how we learn – so, anyone for more debate?

Joss Bray, by email

Rehab Outcomes Project

The letter from Kenneth Eckersley (*DDN*, 19 May, page 8) about residential rehabilitation correctly highlights the importance of outcome data.

Although the publication of star ratings by CSCI (for England) is an important step forwards, CSCI and the other UK regulators are limited in their scope of interest to compliance with National Care Standards.

Care managers continue have very limited information about how rehabs compare and what they actually achieve for clients; this gravely undermines the effectiveness of this corner of the substance misuse field.

The Rehab Outcomes Project is under development to address this need. We aim to improve the effectiveness of residential rehabilitation in the UK by collating and sharing information about the outcome, effectiveness and quality of these important services.

The project is based on a pilot outcome-monitoring scheme run by the author in London several years ago. More information is available from the project website www.rehaboutcomesproject.info/ where you can register interest in the consultation or pilot later in the summer.

Richard Phillips, Rehab Outcomes Project

And finally…

I note with a mixture of incredulity and amusement Professor McKeganey's latest volley (*DDN*, 19 May, page 9) in what began as a debate over standards in the drug treatment workplace and how best to assure them. His intervention once again misses entirely the point I sought to make; however, I am content to yield to him the last public word he so clearly needs, while thanking him for the apology issued privately.

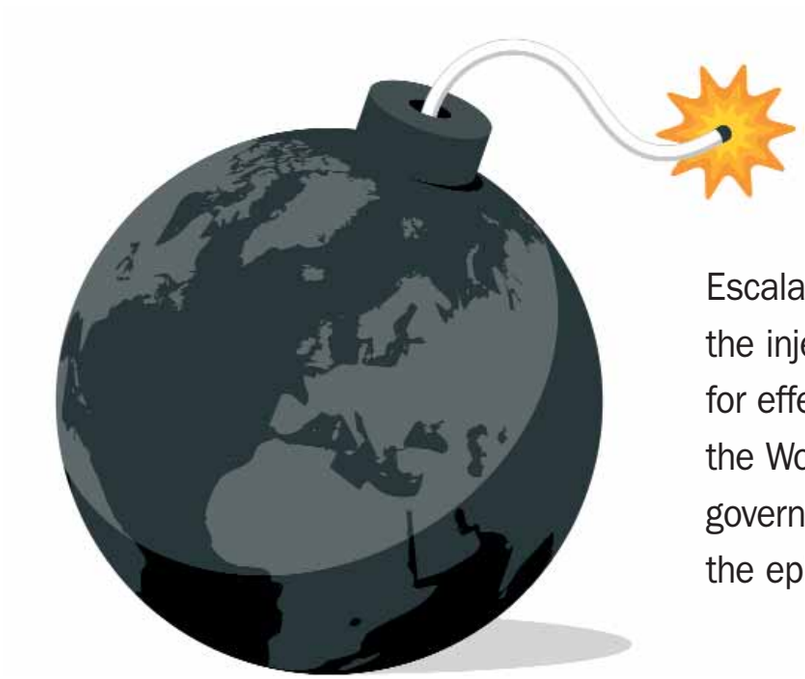
Sebastian Saville, executive director, Release

We welcome your letters

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

Harm reduction: **A global snapshot**

Defusing the hidden timebomb



Escalating rates of HIV and hepatitis C infection in the injecting community highlight the urgent need for effective harm reduction. Dr Jeffrey Lazarus of the World Health Organisation told DDN how some governments are in danger of turning a blind eye to the epidemics in their midst.

There are now an estimated 2.4 million people in the WHO European Region living with HIV, which is a substantial public health challenge by anyone's standards. However, poor surveillance, gaps in knowledge and misunderstandings around transmission routes are compounding the problem.

In Eastern Europe, the epidemic is spreading most rapidly among the male injecting drug population and their sexual partners. What's more, in some areas with high infection rates, these surveillance and epidemiological 'blind spots' mean that effective prevention measures can be minimal.

So is transmission in these areas primarily through injecting drug use? 'We've found that many of the women who report heterosexual transmission of HIV have a history of injecting,' says Dr Jeffrey Lazarus of the World Health Organization (WHO). 'It means we'll never know how they got infected, but knowing how difficult it is to acquire HIV sexually and how easy it is from a contaminated needle, you don't need a PhD [to make the connection].'

Co-infection with hepatitis C is also a serious and growing concern – a hidden epidemic in the 'invisible' population, and a 'serious one by anyone's standards', according to Dr Lazarus. 'It's always difficult with populations on the margins such as IDUs,' he explains. 'We know they're there, and the governments know they're there too, but they're stigmatised and hidden to the general population.'

If the governments know this is happening, is it fair to say that there is a lack of commitment in some countries to properly address the issue? 'There is definitely a lack of commitment, particularly in terms of evidence-based treatment for drug dependency,' he says. 'Some countries are treating them, but they might be locked into "treatment" centres, as in the case of the Russian women who burned to death in a centre where even the windows were barred. If you talk to a Russian narcologist they might say "we have tens of thousands of drug users being treated", but they're being treated with detox and abstinence and so on.

'What's needed is evidence-based treatment, which is primarily three things: opioid substitution therapy, needle exchange, and – if they have HIV and need the treatment – antiretroviral therapy.'

It can also be important to make sure people are fully aware of what is meant by harm reduction, he maintains. 'We need to remind people that there are

'THE SCIENTIFIC DEBATE HAS BEEN WON – HARM REDUCTION WORKS,' said Professor Gerry Stimson, opening IHRA's 19th international conference 'Harm Reduction 2008' in Barcelona. Since the 1980s, harm reduction had matured from a few needle exchange and outreach projects to large-scale initiatives to suit different countries' particular cultural, religious and political contexts.

Against a backdrop of recent approval from the United Nations and other major international groups, he acknowledged that there was still a tremendous amount to do and 'many obstacles in our way'.

UN special rapporteur, Professor Paul Hunt, said the fundamental human right to health meant countries had a legal obligation to put comprehensive harm reduction services in place for people who use drugs. 'Everyone has the right to the highest attainable standard of health,' he told delegates in the opening session.

Our reports on the following pages give a snapshot of the conference, where *DDN* produced three *Daily Update* newspapers. Speakers from around the world highlighted areas of most need and pockets of progress.

We begin with a look at harm reduction in relation to blood borne viruses – a stark reminder of why harm reduction should never be a remote concept, but is everything to do with public health.

IHRA's Global State of Harm Reduction report is at www.ihra.net

those three components – five years ago anti-retroviral therapy wasn't considered harm reduction because almost no one was receiving it, whether they were a drug user or not. That's been scaled up and now we're saying that it's an integral part of harm reduction.'

Given that there is clearly an urgent need for policymakers to tackle this problem, how does the harm reduction sector go about overcoming opposition and reluctance? 'There are various ways to approach it, depending on who you're talking to,' says Dr Lazarus. 'Even if they treat drug users as a marginalised group you can make the public health argument that says "they will get HIV and they will spread tuberculosis, so it will come back at you". You can't just say that because we don't inject ourselves, we're not going to be affected by the several million injectors who are getting infectious diseases.'

Some commentators point to a lack of joint working as another stumbling block, with the specialist knowledge held by two distinct groups – the drug treatment sector on the one hand and AIDS specialists on the other – who seldom work together. 'It's a structural health systems issue, where collaboration and integration is needed,' he says. 'We're not talking about everyone sharing an office, but simple things like offering a battery of tests (*eg* TB and HIV and even hepatitis) at two different centres.'

The fact that hepatitis C can be a latent illness – with many people having no symptoms for years – can also be a contributory factor to the lack of data on hepatitis C prevalence in some countries. 'There's an incredible gap in surveillance,' he stresses. 'A key finding from our research has been how little we know about such a major epidemic, but when we do find out what the regional situation is, it's unbelievable.'

So what's the answer? 'Promoting testing is essential,' he says. 'The offer of a test and linking the hepatitis tests to everything from care in TB clinics to care in AIDS centres is a natural offer. But testing is only the first step. Affordable, effective treatment for all in need is the goal.'

One in 12 people worldwide are living with either chronic hepatitis B or chronic hepatitis C. For information and campaigns of the World Hepatitis Alliance, visit www.aminumber12.org

Crystal meth users on dangerous track to HIV

The relationship between methamphetamine and HIV is more complex than is the case with other drugs like opioids, says Bradley Mathers of the National Drug and Alcohol Research Centre at the University of New South Wales.

Poor data gave inconclusive evidence on the relative contribution of injecting behaviour and sexual behaviour to HIV transmission. 'Are methamphetamine users at greater risk than other drug users? Do they share equipment more?' The evidence was inconclusive, because of population factors, he said.

Most studies had focused on gay male populations in higher income countries, so how applicable they were to other countries was unclear. However, methamphetamine increased sexual drive, euphoria and lowered inhibitions and was therefore likely to lead to higher risk behaviour such as unprotected sex, multiple partners and 'esoteric sex.' Another factor was that users may also be part of a 'risk attracted' population, people already more likely to engage in other risky behaviours, he said.

In terms of harm reduction, methamphetamine users and injectors were generally less likely to be engaging with services than heroin users, and more likely to get equipment from other sources. Therefore harm reduction services needed to think about the safe injecting and drug use harm messages they were using. 'The way in which both equipment and messages are delivered needs to be looked at,' he said, and in the light of the sexual risk behaviours that went along with methamphetamine use, condom distribution and safe sex messages, along with peer education, were vital.

'We also need accurate community education to counteract media hysteria and public health scare tactics,' he said. The harm reduction field had been very good at responding to opioid users, but they needed to be quicker in responding to methamphetamine users. 'It is likely that the burden of HIV associated with methamphetamine has the potential to be greater than that associated with opioid injection,' he warned.

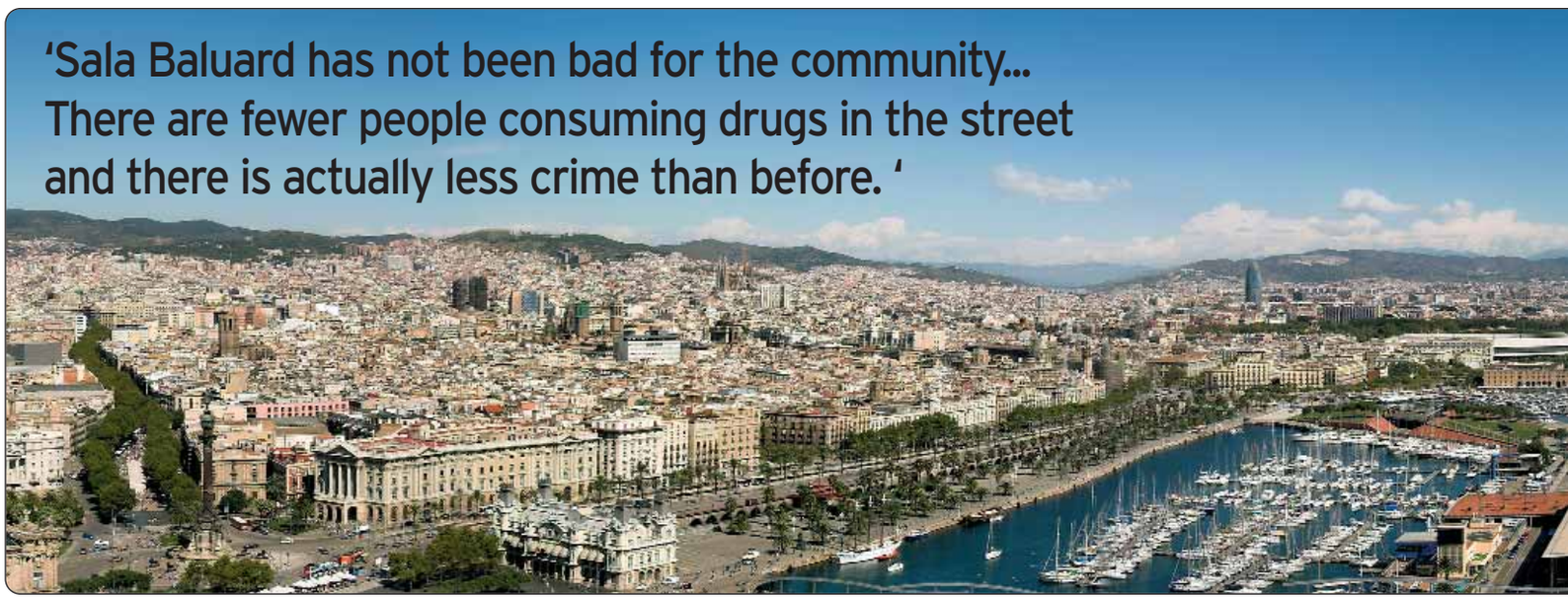
How effective are interventions in cutting HIV and hep C?

'We need to do more than give out syringes and verbal messages,' says Allan Clear, executive director of the US Harm Reduction Coalition, who explained how implementing a large scale needle exchange programme in New York had reduced HIV and hepatitis C infection.

His evidence came from a study of 600 subjects per year between 1990, when the exchange had begun, and 2007. 'We ran underground exchange programmes before being legalised by the state department of health in 1992,' he said. 'It was scaled up in 1995.' While hep C prevalence among HIV positive subjects in the early 1990s was 100 per cent, this had reduced to 82 per cent by the start of the 21st century – 'still way too high,' he said. Among the HIV negative population, however, it fell from 91 per cent to 62 per cent in the same period and among new injectors – those injecting for six years or less – there was a dramatic fall from 80 per cent to 38 per cent.

'Trends of hep C went down when we started to scale up the needle exchange and there was more liberal access to syringes,' he said. 'The best measure of how to go forward is to look at new injectors since the scale-up and keep monitoring them, as they will have spent their entire injection careers in an environment with relatively good access to legal syringes.'

Social marketing with hep C rather than HIV at its core was essential, he stressed. 'If you can prevent the spread of hep C, you can prevent the spread of HIV.'



Getting to the point of harm reduction

Barcelona has embraced harm reduction by providing safe, supervised 'consumption rooms' for service users. DDN talked to a physician working in the largest, the Sala Baluard.

Like many port cities, Barcelona has a long history of drug culture and drug use, particularly around the once notorious El Raval or 'barrio chino' area. A few years ago, however, concerned by the social and public health implications of widespread intravenous drug use, the city authorities took the decision to open the first of Barcelona's injection facilities, or 'consumption rooms'. Here service users could not only go to inject safely, away from the dangers of the street, but gain access to vital health and social care services as well.

Opening in November 2003, Sala Baluard was the first, and is still the largest, of the city's five consumption rooms. Unlike the others, which open for between eight and ten hours at a time, it is open 24 hours a day, seven days a week. A nurse and an auxiliary are available at all times, and doctors work at the facility in shifts that add up to around 20 hours cover each week.

Manel Anoro is a general physician in Barcelona's primary healthcare services with a long-standing interest in drug treatment, and he works at Sala Baluard one morning a week. So what is a consumption room actually like? 'It's not a large room,' he says. 'There are six injection points, which are basically chairs with a small table, and people are allowed to stay for 30 minutes after they have injected. There is also a needle exchange facility in the reception area.'

Barcelona's consumption rooms grew from relatively primitive beginnings. Previously the city's injecting drug scene had become concentrated in the Can Tunis area near the harbour. Dr Anoro was part of a team that had been visiting the district since the late 1990s, offering a needle exchange service and providing food. 'It was the same sort of area that you can find in other cities in Europe – a place where you could buy and consume, with no police around,' he says. The team began providing a special injection room in a large tent, and then in a van – 'a very simple place,' as he describes it.

Things changed when the city authorities decided to turn the area into a major parking facility for the harbour, which had the not altogether surprising consequence of displacing all of those selling and using drugs back to the city centre. 'After they all went to the city, the council debated what to do,' he says. 'Whether there should be a new special quarter, or whether an injection room like they had in Germany or Switzerland should be opened instead. They decided to provide facilities inside the city.'

Consumption rooms in Spain operate on two different models. Of the three cities to have them – Madrid, Barcelona and Bilbao – the latter two are the only ones that have agreed to have the main facilities inside the city itself. 'They said "OK, we have this problem in our city so we'll start to resolve it in the city – it will be a city solution"', he says. 'In Madrid, it's a different kind of solution – it's a large injection room, but it's outside the city. It's horrible, like a drug Disneyworld, and some people never leave. They live and die there. Maybe that's an easier solution, but I don't think it's a good solution.'

Perhaps surprisingly, Sala Baluard is in Barcelona's old city, by the Monument a Colom and just minutes from the prime tourist area of Las Ramblas. How did the city react to the consumption room being sited there – was it a controversial move? 'Barcelona has a long tradition of people who consume drugs, so it didn't really seem strange,' he says. 'But some people said they didn't want the facility near their homes. You have to explain to the community what you are doing, and if people start complaining to the papers and the TV then it can lead to a bad situation. But after a while it becomes clear that these facilities are not problematic.'

Five years since the facility opened, have the objections died down? 'They see that Sala Baluard has not been bad for the community,' he says. 'There are fewer people consuming drugs in the street and there is actually less crime than before. There might be small amounts of consumption and selling immediately around the facility, but that's all. There is no violence and no major problems. There is always a police car near Sala Baluard – maybe that's not really necessary, but the community say they want it.'

Is it possible to quantify the effect the facility has had on public health in the city? 'It's very difficult to know the exact impact,' he says. 'There are around 180-200 injections taking place each day in the facility. That's a lot of people and a lot of injections – one person might do two or three injections. If we didn't have Sala Baluard, then most of those injections would take place in the street. We have around 100 overdoses a year in the facility – if they were happening outside of Sala Baluard then it's possible that a large percentage would die. So it's a big impact, but it's difficult to measure exactly.'

Overseeing the injections, however, is only part of the job. Staff at the facility provide the service users with vital medical cards and other documents, and offer a pathway to a range of treatments and care. It's extremely difficult to access health services in Spain without the right documents, and many of those using Sala Baluard have chaotic lifestyles – in addition to substance misuse, many are rough sleepers and may not be Spanish nationals.

'Many are from outside Spain and the EU,' he says. 'They might be sleeping in the street so they lose papers or the papers are stolen – we don't have a lot of people coming to us with all their papers in order. We can provide them with health cards and other documents and help them replace lost passports. We give out health cards because if you don't have a health card, you can't do anything.'

The facility provides a first point of contact where the health of the service users can be assessed and from where they can be referred to other services, medical or social. 'We say "come here – you can do an injection" and then we can start to work with them. Otherwise it would be impossible to work with some people because they don't go to the doctor, they don't go anywhere. We are the first door they come through – we tell them they don't need a number, they don't need documents, they don't need anything to come to us. It becomes a first step for their treatment – it's very important to have easy access with no problems and no barriers.'

If the nurse notices someone with a problem they will refer them to one of the doctors, who offers antibiotic treatments and basic primary healthcare as well as methadone programmes. If the service users are found to have serious medical conditions, however, they are referred to the relevant facilities. 'We don't have specialists here,' he says. 'If they have problems such as hepatitis C, we will send them on to the normal health services. What we do is not really clinical work, it's more like social work. The most important work is done by the nurse team.'

Are there plans to open more consumption rooms in the city? 'The local community has recognised that it's important to have the facilities, because these people have an illness,' he says. 'But they don't want to be the only quarter to have them – they say new facilities should be in other quarters. I'd like to see more opened, but that depends on the council and if the local communities can be persuaded. Hopefully they will.'

'Paralysis by analysis' derailed Vancouver's injection facility

'From the outset we were operating in a highly politicised environment,' said assistant professor in the University of British Columbia's department of medicine, Thomas Kerr, as he began to explain the problems that Vancouver's safer injection facility had run into.

OPENED IN 2003, Insite was North America's first supervised injection facility. Launched as a pilot, it was allowed to operate as long as it was robustly evaluated and, given the controversy surrounding the venture, every possible step was taken to ensure scientific rigour and maximum transparency. 'There was a requirement that all data be peer reviewed,' he said. 'But before the evaluation produced any results the political fireworks started.' There were even accusations of 'state sponsored suicide'.

Research, however, showed that the facility did 'everything people expected it to', with reductions in HIV risk behaviour and public disorder, increased uptake of detox programmes and no increase in drug-related crime. Furthermore there was successful management of more than 1,000 overdoses with no deaths.

'We held a press conference in 2006 and said that based on the evidence the facility should remain open,' he said. 'This is when things really got ugly.' An application was made for funding for a further three and a half years, but by now Drug Free America, the International Narcotics Control Board, the Canadian Police Association and the Royal Canadian Mounted Police and others had become involved, the latter going so far as to fund its own reports which were then leaked to the media. The Canadian Police Association issued a press release calling for the facility to be closed, while The International Narcotics Control Board declared that supervised injection facilities were in violation of international drug laws.

Despite the fact that polls showed that more than 70 per cent of the local population supported it, the health minister elected not to renew funding. There was an outcry from the scientific community, with the decision branded a 'policy horror story' and claims that funding had been discontinued for political purposes.

'We have documented examples of interference in the independent peer review process,' he said. 'There was a halting of research, the placement of gag orders on new research and the government worked to manufacture uncertainty and create "paralysis by analysis".' People had questioned whether it was right for him to comment on the political wranglings, he said. 'But scientists have a right and an obligation to enter the political debate.'

The fate of Vancouver's supervised injecting site hangs in the balance, with a decision expected imminently. To support the campaign to keep it open, visit www.lettertostephenharper.com where you can join scientists, academics and medical professionals in adding your signature to a letter to the Canadian Prime Minister.

Why have women become an 'at risk' group for alcohol harm? It's a complex issue, says Betsy Thom, professor of health policy at Middlesex University.

From lady to ladette?

Throughout history, and across cultures, men are more likely to consume alcohol than women; they drink more and they engage in riskier drinking and riskier alcohol-related behaviours. Why, then are women often listed as a group that is 'at risk'?

Women's alcohol consumption has risen considerably in some countries and in recent decades young women are particularly likely to drink more and in more harmful ways. Research studies have increased our knowledge of women's greater physiological vulnerability to the effects of alcohol and have drawn attention to the potential dangers of drinking during pregnancy.

But these facts alone do not account for the 'at risk' label nor for the recent alarm which has focused media attention on women's consumption and, especially, their 'binge' drinking. Explanations for the 'moral panic' which has attended changes in women's drinking at various times and places, have highlighted women's social roles and the social expectations and pressures which, traditionally, have placed women in the position of 'moral guardians' of society – and of their menfolk.

Changes in female drinking and drunkenness represent a threat to the social order, particularly when linked with other changes in women's lifestyles and status, for instance, their visibility in public life, employment, and in 'male' leisure spheres such as public houses.

By focusing on women as a risk group and generating stereotypical images such as the 'ladette', we may do more harm than good if attention is diverted away from the diversity of consumption patterns among women and the need for appropriate forms of prevention, harm reduction and intervention for those women who do drink problematically or put themselves at risk of alcohol-related harm. Even within a country, issues of age, employment, ethnicity, social class, marital status, health and religious beliefs, and the differing social contexts of women's lives result in many different, changing patterns of consumption and associated harms. Globally, the picture becomes more complex still.

Existing research on gender sensitive harm reduction approaches is sparse. Clearly, women would benefit from wider adoption of community prevention and harm reduction programmes which target local communities and attempt to put in place policies, professional partnerships and community involvement designed to change aspects of local systems which create or sustain problem drinking. This might entail environmental design, such as better lit streets around drinking venues, the provision of adequate, safe transport, attempts to change tolerance of intoxication and challenging intentions of 'drinking to get drunk'.

At the individual level, brief interventions have proved effective although the findings from research are less clear for women than for men. Self-help approaches and help-lines are also popular with women and may provide a good method of first contact.

However, in trying to identify women who are 'at risk' or drinking harmfully, we need to keep in mind the continuing barriers faced by many women seeking help and remaining in treatment – stigma and judgemental attitudes from professionals as well as others, fear of 'the authorities' and repercussions for children, carer responsibilities which limit freedom to access services, living with a heavy drinking spouse – among other difficulties.

Harm reduction for women requires tackling the attitudes and behaviours of professionals and the general public as well as delivering appropriate assistance to those women who are 'at risk'.

Novel interventions needed for alcohol harm reduction

Alcohol harm reduction is about balancing protection of individuals and communities with demands of commerce and business, says Ann Roche from Flinders University, Australia.

'FOR MANY PEOPLE, applying harm reduction concepts and principles to alcohol will be new and may seem alien,' said Anne Roche. 'The invitation is to apply your existing knowledge and understanding of harm reduction as it applies to drugs, to alcohol.'

The concept of alcohol harm reduction is not a new one, she explained. 'The actual origin of harm reduction pre-dates 20th century concerns with illicit drugs or HIV and Aids. It has subsequently been appropriated by the drugs field.'

However, there was 'a huge level of confusion, ambiguity and conflict about every issue related to alcohol', she said, including little international agreement about safe drinking levels, when drinking becomes problematic, and what should be done to contain harms.

Many countries were already practising some alcohol harm reduction measures, such as producing low alcohol drinks and carrying out random breath testing. There was increasing focus on encouraging a safer drinking environment, by improving staff training to deal with intoxicated patrons and prevent them from drinking more. More radical harm reduction strategies included proposals to provide 'wet rooms' to allow controlled drinking environments for 'at risk' groups such as homeless people.

Harm reduction in any context was often dogged by stigma and fear, said Ms Roche. Success depended on 'novel methods and interventions which may push the limits of accepted moral standards'.

HOUSING 'A RIGHT NOT A REWARD'

Seattle's 'wet housing' puts a roof over alcoholics' heads without insisting that they first give up the bottle – a vital first step to harm reduction, says Alan Marlatt.

'THE BELIEF is that housing is a basic human right, not a reward for clinical success,' said Alan Marlatt, professor of psychology at the University of Washington. He was explaining *Housing First*, a project that provides housing for homeless alcoholics in Seattle. 'It's estimated that there are about 1,000 chronic public inebriates living on the streets there,' he said. 'Average life expectancy is 47.'

Housing First is wet housing – the residents are allowed to drink in their units – and it is staffed 24 hours a day. Co-ordinated by the Downtown Emergency Services Center, the scheme was designated as 'pre-recovery' housing for those unwilling or unable to abstain, he said, and clients were able to move in directly from the streets. 'It's a harm reduction approach – abstinence is not mandatory. It offers a home to live in and in which to get better.

'It was very controversial, of course,' he continued. 'The press in Seattle were dead set against it to begin with. There was a small amount of positive coverage, but mostly it was negative.' Most editorials were strongly opposed and headlines included 'liberal lunacy' and 'too bad stupidity is legal'.

The project co-ordinators were given a list of alcoholics living on the streets by the medical services, and those with the highest medical costs were prioritised. Most residents have been men, and primarily Caucasian and native American. 'There were 79 offers of housing made to fill 75 places – only four people turned down a place, and 71 per cent stayed for at least a year.'

All residents completed extensive interviews, and the results have been extremely encouraging, he said. There have been significant drops in shelter and medical centre visits, emergency medical service calls, use of 'sobering centres' and jail time, along with the attendant costs of each, while detox admissions remained roughly the same. Overall cost savings have added up to $2m.

'There have been reductions in drinking even though treatment is not required. This was because they had housing and didn't feel the need to drink so much,' he explained. 'Some residents even handed their alcohol over to staff and asked them to give it to them a little bit at a time.' The future focus would be on a more assertive programme to reduce alcohol consumption, he said.

'Things are looking promising,' he concluded. 'People have started to think "well, if it's saving taxpayers' money maybe it's a good thing". Even the press have started to become more favourable.'

Can police help to arrest drunken culture?

Police in Queensland are engaging in a 'softly softly' approach to alcohol-related crime, by building partnerships with colleagues in health and local government.

'TO PUT IT PLAINLY, too many Australians now partake in "drunken" cultures rather than drinking cultures.' Katherine Mann, senior police officer in the Drug and Alcohol Coordination Unit of Queensland Police Service, highlighted this quote from the Australian National Alcohol Strategy. Police spent a third of their time responding to alcohol-related incidents, and alcohol was involved in a quarter of incidents attended by police, she said.

'To put it plainly, too many Australians now partake in "drunken" cultures rather than drinking cultures.'

Ms Mann's home state provided plentiful data on high-risk drinking, containing some of the riskiest drinkers in Australia. Eighty per cent of Queenslanders drank alcohol and many young people were contributing to the 40 per cent of drinkers who consumed alcohol at risky levels.

The police's priorities were dealing with immediate consequences – the violence surrounding intoxication, particularly where underage drinkers were involved. Much of their core business stemmed from alcohol – whether a personal attack, an act of vandalism, or an accident.

The Queensland Police Service had become actively engaged in harm reduction, through developing a proactive approach to dealing with alcohol abuse, said Ms Mann. This approach involved co-ordinating all areas of their work – legislation, policy and enforcement, as well as building partnerships between the health and law enforcement sectors, and liquor licensing and local government, licensees and the security industry.

'A successful partnership depends on early identification of who needs to be involved,' she pointed out. Agreement of goals, strategies and outcomes had been key to making sure all parties participated in the national alcohol and drug policy's three strands of supply reduction, demand reduction and harm reduction.

In practice, it had paved the way for initiatives such as 'accords' – agreed written codes of conduct – between licensees and other key stakeholders in defined areas. It had also assisted police in implementing the 'state-wide safety action plan' to boost safety in and around pubs and clubs by limiting drink promotions and competitions, enhancing security with closed-circuit televisions and crowd controllers, and making sure all serving staff were given training on responsible serving.

There now needed to be some tough talking on the inevitable conflicts of interest among stakeholders. Evidence pointed to the harm reduction that limiting alcohol availability would have – but a government that enjoyed the alcohol industry's significant contribution to the economy was willing to ignore that.

'It's a conundrum for governments who have to balance the positive financial gains with the economic costs to the community in lost productivity, road accidents, crime and the severe strain on already-stretched public health resources,' said Ms Mann. 'Clearly more work needs to be done to achieve a more significant and more sustained impact across the board,' she acknowledged.

'Access means different things. It means something very different if you're a Muslim woman in Afghanistan than if you're an aboriginal woman in northern Canada.'

Access all areas

What can be done to ensure gender equality in the field of harm reduction? Sue Currie shared her thoughts with DDN ahead of chairing a conference plenary session on gender equality.

HISTORICALLY, HARM REDUCTION programmes have tended to operate on a 'one size fits all' basis, says Sue Currie. 'They focus on the individual regardless of gender, and they don't integrate – or take into account the circumstances of – women and families and children.'

The marginalisation of women is clearly an extremely complex issue, that varies between countries and communities. 'It's a cultural issue and a religious issue,' she says. 'There could be environmental circumstances, and for indigenous cultures there are other issues at stake as well – it's important to try and identify all the potential barriers to accessing services.

'Access means different things. It means something very different if you're a Muslim woman in Afghanistan than if you're an aboriginal woman in northern Canada. Even if you're in North America, accessing a programme might mean coming up against barriers for you and your family, like potential child protection issues.'

She is optimistic that things are starting to change, however. The conference gave a chance to evaluate examples of best practice from around the world, and show what works.

'We're highlighting positive inclusive programmes and strategies,' she says. 'We want to make clear that being inclusive of women and acknowledging gender doesn't mean you're exclusive of men, because quite often it can be perceived as an either/or situation. We have to be inclusive of everyone and create services that work for everyone.'

Safety in numbers

Sex workers from different countries used the conference as an opportunity to share discussion of harm reduction at an international level

AN INTERNATIONAL Sex Worker Harm Reduction Caucus has just been formed by sex workers and their organisations from all over the world. A first statement from the group asserts that sex work is not itself inherently harmful, and should be recognised as 'work' to give sex workers safe working conditions.

'We are resolute that any harm associated with sex work results from repressive environments in which sex work is not recognised as work, and because sex workers lack basic human rights and access to appropriate health services,' says the group.

In the spirit of the service users' slogan 'nothing about us, without us', the Caucus is also keen to encourage empowerment, which they say is essential to fight HIV and discriminations without stigma: 'Sex workers are their own best resource – they should be at the forefront of developing and implementing the programmes and policies that impact on their lives.'

Kitten Infinite from the Sex Worker Outreach Project (SWOP) in Chicago explained to *DDN* how sex workers can 'work smarter not harder' by managing their own risk.

'An example is encouraging sex workers to share clients,' she said. 'Sharing information with another sex worker negotiates control over situations… it fosters community. Many sex workers experience isolation within their work and seeking out other sex workers to share the dividends creates relationships that keep sex workers safe.'

Research from St James Infirmary in the US showed sex workers within a community experienced lower instances of violence, sexually transmitted infections and HIV. It also sent important messages to the client, Kitten Infinite pointed out: 'Clients who acknowledge a sex worker has the support of community are less likely to exploit or harm them as well.'

More information about the Sex Worker Harm Reduction Caucus is at www.bestpracticespolicy.org/caucus.html.

SEX WORKERS DENIED DRUG TREATMENT

Sweden has changed its law to make sex work illegal – with the knock-on effect of excluding many women from drug and alcohol treatment.

'IF THERE ARE TWO TYPES of people who shouldn't exist in Sweden, it's drug users and sex workers,' said activist and international spokesperson for Swedish sex workers, Pye Jakobsson. The country's administration was becoming increasingly punitive and discriminatory towards both groups, she said.

A law had been introduced to make the purchasing of sexual services illegal, with a prison sentence of up to six months. 'Because this was so controversial, they put it in a package around violence against women so no one could be against it,' she said. 'But this forcing of victim status on us extremely stigmatising, and sex workers themselves were excluded from the debate.'

The end result had been to deny women access to vital services, she explained. There were very few clinics that dealt with sex workers and most existed to try and get the women out of sex work. All were hard to access, with strictly defined geographical boundaries for eligibility and little effective outreach work.

'Sex workers are routinely denied drug and alcohol treatment,' said Ms Jakobsson. 'They say "we will only help you if you stop selling sex" because the assumption is that we only take drugs because we can't stand selling sex. Often methadone will only be prescribed if the woman stops selling sex.'

The law also meant that free condoms were no longer allowed to be distributed to sex workers as this was seen as facilitating illegal activity. 'If anybody knows about HIV prevention, it's us,' she said. 'You can't get an apartment if people know what you do, because the assumption is you're going to start a brothel, and it's difficult to get insurance.' Child custody issues could also be a major problem, even long after someone had stopped working in the sex industry. Women – especially mothers – were extremely reluctant to report violence, as the police were obliged to inform social services that they were sex workers, she said.

'The social stigma is very isolating. and being isolated from society is extremely frightening,' said Ms Jakobsson. 'This is not just about sex workers' rights. This is about human rights, and how they are being violated in the EU in 2008.'

Hidden targets

Research from Eastern Europe demonstrates the layers of stigma obscuring drug using women from basic healthcare.

Reaching Russia's drug-using women

'Women injecting drug users are one of the most stigmatised groups in Russia,' said Peter Meylakhs of the Center for Independent Social Research in St Petersburg. 'Services specifically designed for them are scarce and not easy to access.'

He had carried out research to identify barriers that hinder women taking advantage of the services. 'The main barriers are any kind of costs – whether financial, time or emotional,' he said. 'Everybody understands financial costs. But what if a woman is sick, needs treatment but doesn't want to go to the doctor and be stigmatised?'

Barriers for women injecting drug users accessing treatment included a hostile social environment, active drug use, emotional dependence on partners, childcare, the fear of looking like a bad mother, and the fear of their HIV positive status being revealed.

Women could often see their drug use as their main and only problem and other health problems could be ignored, said Mr Meylakhs. There were also the analgesic properties of the drugs to be considered: 'Because they're on opiates, nothing hurts. So they only go to the doctor when things are really bad. They think "drug use is my main problem – I'll get off drugs first and then I'll go to the doctor".' Another problem was the 'hierarchisation' of patients, he said, with rehab patients often treated better than detox patients.

Lowering institutional barriers would require changes in legislation and structural reform, he said. 'There's no point blaming individual doctors – they're often overwhelmed, overworked and burnt out.'

Ukraine and Georgia ignore epidemic

'The experience of getting healthcare for women who use drugs is not a very comfortable one,' said Sophie Pinkham, project officer at the Open Society Institute's public health programme, reporting on research carried out in Ukraine and Georgia.

The research was based on focus groups with users and providers, 'to listen to what drug users thought about their lives and the services available, as well as what providers thought.'

Ukraine was now facing a 'feminisation' of its HIV epidemic, with women accounting for 40 per cent of cases. 'It's not clear how much of this is down to drug use because data collection is very flawed,' said Ms Pinkham. 'But STI rates are through the roof and unsafe abortions – involving significant risk of death and infertility – are commonplace.'

Ukraine's National Reproductive Health Programme was often inaccessible and unfriendly towards drug users, she said. 'They don't consider drug users and sex workers to be target groups and the stigma towards them is intense. Women also reported extremely low levels of condom use, for the same reasons as all over the world – expressions of trust and the risk of violence from partners and clients.'

There were several layers of stigma that kept women from accessing services – stigma from health workers, self-stigma in terms of the way they expect to be treated and tangible barriers, such as the fact that STI diagnosis and treatment was not free. 'Community health centres do not do STI diagnosis,' she said. 'It has to be sent away to a lab, and there is a fee attached. You have to pay for everything – even confidentiality costs extra.' Most people found out they were HIV positive when in hospital for something else and were often treated in an uncompassionate way.

Women often had very little control over how they took drugs, she said. 'The men usually obtain and inject the drugs – after they have injected themselves – and there is lots of transitional sex.' The fact that women usually stayed at home and were dependent on men made them an especially hard to reach group, and there were significant issues of low self esteem and low educational levels along with physical and sexual abuse. 'Because of the intense stigma of women IDUs, they often have a very limited social circle and lose social contexts much quicker than men,' she said. 'There's no one for them to depend on except men.'

Barriers to access included the attitudes of male partners, children, geography, time and the fear of public exposure. In Georgia, meanwhile, only preliminary results were available because women were so stigmatised that they refused to participate in focus groups, even with trained female outreach workers.

Integrated and gender-sensitive services were needed, alongside improved provider training, according to Ms Pinkham. 'Providers are a huge part of the problem and they could be a big part of the solution,' she said.

'As drug users we demand to have our voices heard'

Getting the message across: This banner protest calling for better standards of human rights in Spanish prisons was among the campaigns at the international conference. Drug user groups articulated their concerns through different media during the week, giving an insight to international service user involvement.

What motivates drug user activists to stand up in public and declare their drug use, attracting all kinds of moralistic judgments and hatred?

The answer, said Milena Naydenova of the International Network of People Who Use Drugs (INPUD), was that drug users' rights continued to be violated, despite initially good intentions of the three UN Drugs Conventions, so there was more need than ever to shout for radical change. At its most obvious, violation of international human rights law was demonstrated by the death penalty for drugs-related offences still existing in more than 30 countries, she said.

But drug policy failure had escalated health problems worldwide, spreading HIV and hepatitis C among intravenous street users, said Ms Naydenova. Despite this, drug users were forced to accept that the treatments they needed were unaccessible to them, because of insufficient or prohibitively expensive treatment programmes.

'Half a century of permanent failures should be enough to convince everybody that a radical change is needed,' she said. While drug user activists understood the risks illegal drugs posed to their health, she explained, they believed in providing people with the opportunity to make well-informed decisions on their lives, and arming them with all possible options to reduce the risks and harms of using psychoactive substances.

'In this sense, drug user activism is harm reduction,' she said. 'Because even under the current circumstances, we give the right information to our peers and make everything possible to reduce the risks of health damage through peer support, advocacy and debates.'

While the first drug user organisations were set up to deal with immediate health issues and save lives through peer support and needle exchanges, the movement had matured to campaign for political changes – the only way to 'bring a real change for all of us'.

A recent survey of drug user organisations conducted by INPUD showed the scale of work needed to reach those in most need of support. More than half of organisations that responded were from Europe, a quarter were from Asia, but there was just one responding organisation from Africa, one from Australia, and no contact at all from drug user organisations in South America.

INPUD hoped to increase international networking and since officially registering the organisation last July, with support and funding from IHRA, had participated in several high-level consultation meetings.

'We demand to be accepted as equal stakeholders in drug policy debates and to have our voices heard,' said Ms Naydenova.

PROHIBITION – 'WHEN PUBLIC HEALTH BECOMES AN ALIBI'

THE 'WAR ON DRUGS' was justified more and more as a public health issue, said Eric Schneider of French user activist organisation ASUD. 'But more and more often it is a war on drug users. Prohibition is defined by the law – but what leads to the law?'

Prohibition was based on society's moral values and religious behaviour rules, he said, and depending on the laws of individual countries, application and repression would vary, as would the consequences. These could include jail or even the death penalty, along with things like unjustified body and home searches. Prohibition also reinforced criminality, he said. 'Slowly but surely, you will enter crime, like the 17- or 18-year-old who goes to prison for a bit of cannabis, as is the case in France.'

Other social and health consequences included the removal of citizens' rights and citizen status, and serious consequences for personal, professional and social life. 'As a field worker, I've seen Muslim clients commit suicide because of rejection by the family,' he said. 'As a drug user you are also immediately classed as a bad parent – you have to prove that you are not.'

The clandestine use that comes with prohibition also led to increases in risky behaviour and exposure to major health issues, he stressed, stating that many drug-related accidental deaths were not recorded as such, meaning that accurate data was hard to come by. Prohibition could also be used as an excuse to express racism, he said. 'In France, how many times have we heard 'it's the Arabs, it's the Chinese, it's the Blacks'?

'We have to go back to the debate and we have to fight prohibition,' he stated. 'We always hear "it's not the time – governments are not ready and people are not ready". But it's never the time – we need to fight now, because it's not just a matter for drug users alone, but for those who care for them and those who work with them.'

A voice in the wilderness

'Magazines can come from nowhere. They can come from an idea, a passion, a view,' said *Black Poppy* editor Erin O'Mara. She was speaking at an interactive conference session on drug user magazines, with the theme 'a voice, a view, a vehicle for change', which heard from magazine representatives from around the world.

One of the main benefits of user magazines was the ability to give drug users a voice and an identity, said *Black Poppy* editor, Erin O'Mara. 'When *Black Poppy* was started in the UK in 1998 drug users had no say in their treatment,' said Ms O'Mara. 'It was a very punitive system and the only information available was about the diseases we could give to other people.'

The impetus to launch the magazine came from 'seeing friends very ill with no information and no one to talk to,' she said. Initial funding came from a local needle exchange, and everything was written and laid out exclusively by drug users. 'We've grown haphazardly,' she said. 'We're still a small team but we've been able to establish a good reputation and loyal readership because we've written about how we felt and haven't allowed ourselves to be censored.'

Censorship was often a serious issue when trying to publish user magazines, participants agreed. Those whose publications received government funding spoke of the straitjacket that could be imposed, including having to seek official approval for every issue before publication. 'We are allowed to talk about discrimination, but not about the pleasure of taking drugs,' said Fabrice Olivet of French magazine *ASUD*.

ASUD launched in 1992 when 40 per cent of French injecting drug users were infected with HIV. 'There was little treatment available and harsh drug laws,' he said. 'Part of the reason the magazine was launched was to see if harm reduction could be a success.' It is now published three times a year with a print run of 20,000 and national circulation across France. Funding is half public and half private, but French law means there is little possibility of developing the magazine outside of the medical and harm reduction arena.

However, the magazine's real success has been to create a genuine network and spread activism, he stressed, something echoed by several delegates. 'The first success of *ASUD* was to exist,' he said. 'To give drug users a voice was astonishing.'

'User magazines are a vehicle for motivation for drug user groups,' said Dirk Schäffer of German magazine *Drogenkurier*. Launched at a time when needle exchange was illegal in Germany and policy was abstinence based, most of the early readers were doctors and people from treatment organisations. 'Then we sold adverts, went to colour and widened the content to include drug culture and treatment reports. But the one thing we've never changed in 20 years is that all the articles were written by drug users.'

But this doesn't guarantee a good response, reported Annie Madden of Australia's *Junk Mail*. The magazine aimed to raise consciousness with longer articles on policy, but that didn't suit all the readership. 'Drug users can often be the most critical voices,' she said. 'Some don't want to read long articles, but many do.'

Twice yearly *Junk Mail* now has a print run of 10,000 and an estimated readership of up to 40,000. Funding initially came form hepatitis C prevention money, which meant that was all they could discuss and each issue was subject to approval. 'It was killing the magazine,' she said.

'We told the government we didn't want their money and it's now funded privately. Australia is very much portrayed as a liberal paradise for drug users, but I would say 'don't believe the hype'.

Some delegates felt that despite the empowering aspects of the magazines, there could sometimes be a wider agenda at work. 'Being a voice and having a view is not enough to change things,' said Fabrice Olivet. 'We are useful for governments and professionals, but we need to be become a vehicle for change.' However, that very empowerment and voice represented a dramatic change in itself, said Erin O'Mara. 'While it might not be an obvious vehicle for change in terms of politics, it is in people's lives.'

The power of networking is now being harnessed through a new website, *The Drum Alliance*, which Ms O'Mara launched at the conference. Set up to provide an international portal for drug-related media, the site will bring together information from drug user magazines as well as 'straight' drug media aimed at drug treatment professionals.

Using forums and a free subscription 'e-newsletter', it will give the opportunity of sharing information across different magazine genres and bring together the publications and their potential contributors. It is hoped that the site will improve the quality, diversity and accessibility of drugs information, as well as providing a reliable resource for mainstream media writing about drugs issues.

The new site is at www.thedrumalliance.net

Illegal in much of the west, ibogaine is a controversial drug which evidence – albeit much of it anecdotal – suggests has an extraordinary capacity to interrupt the craving for opiates and other substances. DDN speaks to a man who has spent decades trying to convince the world of its treatment potential.

The end of addiction?

Ibogaine is steeped in controversy. Derived from the root bark of the west African iboga plant, it is used in shamanic religious rituals in countries like Gabon and Cameroon, and a quick trawl of the internet will find many westerners, drawn by the substance's hallucinogenic and mystical properties, sharing their experiences of travelling there to take part. What it will also reveal, however, are several – very convincing – first person accounts of its properties as almost a 'one shot' cure for addictive cravings, whether for heroin, cocaine or alcohol.

New York-based Howard Lotsof is president of the Dora Weiner Foundation, which is dedicated to the promotion of ibogaine as a means of bringing a non-stigmatising 'humane therapy' to the treatment of addiction – their website even features a patients' bill of rights. He first took ibogaine in the 1960s, without knowing what to expect, and was astounded by the effect.

'There was a lot of drug experimentation going on back then,' he says. 'A few of us had formed what was almost a focus group to look into a wide variety of drug experiences, because we anticipated that – through drugs like LSD and mescaline – a beneficial societal effect would take place. So we were investigating every possible drug you could look at and ibogaine came into that. But the effects were completely unexpected and dramatic.'

He has taken ibogaine eight times over a 40-year period and has described its effects as like 'a laser guided smart missile for trauma'. Those using it for treatment purposes report not only a remarkable cessation of addictive cravings, but also an extra-ordinary clarity of vision, insight and understanding of the underlying reason for their addiction.

So is its treatment value primarily psychological or physiological, or is it hard to separate the two? 'It's impossible to separate,' he says. 'What's interesting is that the science has been directed towards the physiological mechanisms, and ibogaine has become a tool for studying the science of addiction. But psychologically it seems to have the ability to self-direct the subject to areas that need attention and questions that need answers. The thing is, we all know our questions and we all know our answers. Ibogaine somehow allows that activity to take place.'

Ibogaine's legal status in the UK and elsewhere is as an unlicensed, experimental medication, and while possession may not be illegal, distributing it could lead to prosecution. Possession, however, is illegal in the US and parts of Europe including Belgium, Switzerland and Denmark. But how much could its lack of uptake as a treatment tool be put down to reluctance on the part of drug companies – who make substantial profits from opioid replacement and other drugs – to invest in research into something that, if the anecdotal evidence is to be believed, would have a dramatic effect on the treatment sector? 'It's not necessarily a matter of resistance,' he says. 'It's just not the format of a drug they'd want to develop. The principal concept behind the pharmaceutical industry is to turn a profit for their shareholders and ibogaine just doesn't fit that definition.

'You're looking at something that's principally a single administration drug and a molecule that's found in nature, that cannot be owned. The pharmaceutical companies will generally develop drugs in areas they're familiar with – this would be an orphan drug.'

Critics of ibogaine's treatment potential, however, point to the lack of hard evidence and even reported deaths from its use, although proponents of the drug say either continued opioid use or a pre-existing medical condition – rather than ibogaine itself – was the cause in each case.

Howard Lotsof was actively involved in lobbying the US government for a change in legalisation until around 1995, but says the work of the foundation now is primarily to make information available and consult with those in the US and elsewhere interested in developing ibogaine.

Given that the drug is clearly extremely powerful, how safe is its use in this unregulated underground treatment system? 'People are taking it under either medical or user self-help group supervision,' he says. 'Ibogaine is packaged as a therapy – it has little or no abuse potential. There's heroin everywhere, but try to find ibogaine.'

EVIDENCE FOR IBOGAINE 'UNCONVINCING'

The evidence to support the use of ibogaine in treating heroin dependence is unconvincing, says Australian Alcohol and Drug Service director Dr Alex Wodak.

DESPITE MANY ADVOCATES for its use and a growing underground treatment network, ibogaine remains an unregulated drug. 'There was an era when medications were not regulated and that was not a happy era,' said Dr Wodak, citing the Thalidomide tragedy of the 1960s which had led to a dramatic shake up of the system. 'Regulation is particularly important for vulnerable populations, and injecting drug users definitely fall into that category,' he told delegates at the IHRA conference debate about ibogaine. 'All new drugs are considered to be ineffective and unsafe until proven otherwise, and drugs for drug dependency should be no exception.'

There was undoubtedly a genuine need for new treatments for heroin dependency however, he said. 'Opioid substitution is effective, but we need new options. The problem with ibogaine is lack of evidence.' A range of studies was needed from use in different countries, with rigorous designs including randomised controlled trials and published in reputable, peer-refereed journals, he said. 'Evidence that ibogaine is effective as a treatment is minimal – there are few studies, they involve small numbers of subjects, are mainly self reported, with short follow up and lots of "mights", "maybes" and "could haves".'

Could ibogaine could be used in detoxification to aid short term, safe, comfortable withdrawal? 'There are more studies on ibogaine for detoxification than for heroin dependency treatment, but these are still only preliminary and the evidence is still unconvincing,' he said. 'Supporters of ibogaine make a number of claims – that it reduces drug cravings, opioid withdrawal symptoms and the sustained complete withdrawal of opioid withdrawal symptoms,' he acknowledged. 'In terms of safety we'd like to see lots of laboratory studies in animals and human studies, both short and long term.' Deaths and severe illnesses had also been reported, he said, and the data for safety was still at a minimal stage. 'We should not make the mistake of thinking its safe because it's organic,' he stressed.

There were insufficient resources to research every drug and funding decisions were often made using hard-nosed criteria, he said. 'So, should people just go ahead and use ibogaine anyway? There have been too many tragedies from cutting corners in drug regulation. We have to accept the assumption that ibogaine is ineffective and unsafe until evidence to the contrary emerges. In 2008 we really do not have evidence that it is an effective and safe treatment for heroin dependence and for use in heroin detoxification.'

Bri Edwards

My great escape

Bri brings us up to date in the fifth part of his story. Will he find the strength to reject drugs once and for all?

After that fall and the doctor coming round, I was in the position to choose either to go back to the world of addiction or continue on my walk with God and my wife and family. My wife Lyn also said 'choose me or the drugs'.

So I went upstairs and found what remaining diamorphine tablets I had. At the time we burned logs on an open fire. I took the contents of the bottle and threw them into the flames.

The thoughts that went through my head revolved around what I had, and what I wanted to achieve. But the temptation pulled on me so hard that I just wanted to disappear and not have to face that struggle. I had struggled so much, and I was darned sick of struggling. Should I get rid of these tablets that made me feel pain free for a start, but also helped me to cope with the complications of life?

Other people seemed so sorted out, and they said they cared about me and my feelings. But did they just see me as an addict? As the minutes, hours and days went by, I played a chess game in my mind. I was being pulled into a world that made my addiction seem all rosey and no hassle. I looked at how after all these years I had a house, and a child, and my Lyn. Suddenly that was on the line; Lyn's words 'either me or the drugs' kept ringing in my ears. 'Me or the drugs.' How dare she do that to me after all I had done in the past? She wanted more – how dare she? I swore out loud and felt the pain.

I remember sitting down on my own in the garden and looking round at what I had planted. I thought how lovely that garden was, and how God had given me the talent to grow trees and fruit. And now it was crunch time, sitting there. I prayed and asked God if he was really there – and if I was what they call a new creation, why did I feel like this? And the answer was: 'Stop fighting what I have in store for you. This life of drugs will only bring untold despair.'

I remembered the rent boys in London's Piccadilly and the prostitutes I used to share a joint with, and how I used to shoot up in the toilets all around the universities in London. I knew them all – and I was dicing with going back to that! Man, I must need my head looking at. No, the decision was made: go on and change, and let the change be real. Do not muck around in the mire, walk in the light. I was that new creation.

I had to go on, and go on I did – as I go on to this day. The struggle is not as intense by any means as it was, but I am always aware of what I am, and the changes and decisions I have made. I feel they were the right ones. I wrote these articles as a reminder to me of what I was and who I am now, and with the thought that I might be able to inspire or give faith to help somebody going through what I went through.

God was, and is, inspiring my life. Without the love of Christ and my family, I would surely have been in a pine box years ago. People who knew me before, could not believe that I could believe in something so strongly that I would stand up and talk about my faith in Jesus. I am talking about faith in a living saviour – not in churches or people – but a personal walk with my Lord. I tried so many times before, but fell flat on my face. Thank you Lord for giving me this chance.

Bri Edwards now lives with his wife in Seascale, Cumbria.

Events

06 June – London
London Drug Policy Forum
Organised by LDPF. This one-day conference aims to look at the implications of *Drugs: Protecting Families and Communities* for local partnerships and explore issues faced in creating the systems and services for the future. *www.cityoflondon.gov.uk/NR/rdonlyres/C05EC1CD-FE2E-42D9-832B-85109A60AFC1/0/SS_LDPF_Joiningitup Flyer2008.pdf*

10 June – Glasgow
Drugs and Alcohol Today – Scotland
Organised by Pavilion and others. This is the Scottish equivalent of the London *Drugs and Alcohol Today* event and is now in its third year. More information and a booking form from Pavilion. *www.pavpub.com*

11 June – London
Treatment and reintegration: Delivering the drug strategy
Organised by NTA. This one-day conference aims to debate on the meaning of the new drug strategy. More information and a booking form from Pavilion – *www.pavpub.com*

30 June-1 July – Birmingham
UK national smoking cessation conference
Organised by Exchange Supplies. This 4th annual conference aims to provide a unique forum for professional development and knowledge sharing in the smoking cessation field. More details – *01305 262244, www.uknscc.org*

3 July – London
Dual diagnosis – substance misuse: the challenges for mental health professionals
Organised by Pavilion. This conference addresses substance misuse from a mental health perspective and ask how we turn good practice into reality. More information and a booking form from Pavilion – *www.pavpub.com*

8-10 September – Stockholm
The International Conference, World Forum Against Drugs.
Organised by World Forum. This conference aims to exchange ideas and share experiences on how to develop methods and move forward to the visionary goal of a world free from drug abuse. Details at www.wfad08.org

27-28 October – London
National Conference on Injecting Drug Use
Organised by Exchange Supplies. The NCIDU conference aims to develop the field, share information and learn by bringing together clinicians, researchers and users. More details – *01305 262244, www.exchangesupplies.org*

13-14 November – London
Society for the Study of Addiction's 2008 Symposium
Organised by SSA. This year's event focuses on 'Addiction across the lifespan: tracking processes of recovery'. More details from graham.hunt@leedspct.nhs.uk or tel: 0113 295 2787.

STOP PRESS: SAVE THE DATE!
Thursday 29 January 2009 – Birmingham
DDN/Alliance 2nd Service User Involvement Conference
Details coming soon – register your interest by emailing ian@cjwelllings.com and we'll keep you posted.

Post-its from Practice

Changing places

Changing GPs is not always a simple affair, says Dr Chris Ford

Jack had been a patient of ours for just over two years. He had come to register with us when he had moved in with his brother and sister-in-law six months after his wife had died. He was struggling with her death, had stopped his HIV medications and gone back on heroin and crack. His health had deteriorated and his brother being concerned about him asked if he could register with us. We agreed, as the only condition for registration is living in our practice area.

Over the following months Jack's health rapidly improved. He engaged well with our local HIV doctor and restarted his HIV medications. This doctor is a gem and treats all people with the same respect however they got their HIV infection. He started bereavement counselling and although he still feels an acute loss of his life partner, he is dealing with his feelings better. His physical health is markedly improved and he is settled on 120mg methadone mixture and 30mg diazepam. His urine screens show no other drugs and he doesn't drink.

In the last few months he has been spending more time in his own flat in another part of London and he now felt ready to move back completely. He came to ask me if he could continue to be registered with us. When I explained that that was not possible, Jack became very anxious. He had not previously had good experiences with GPs and was not registered for several years before he came to Lonsdale. I quickly reassured him that I would not leave him without a GP who was able to care for him.

Little did I know how difficult that would be and what a learning curve it would be for me. Many times I have been able to use the 'network' of friendly GPs, but he lived in an area where I wasn't aware of any such GPs. Hence, I used yell.com to search for all the practices in his area.

For a moment, I thought how shall I decide? Unsure, I simply started from the top of the list. Wanting to find someone who would be able to care for Jack, I decided after checking with the receptionist that he was in their area, that I would discuss his health issues personally with the doctor.

My first call ended very quickly, as the doctor said very rudely 'we don't do those here'! I wanted to argue with him – but was it worth it? The second was similar, although the receptionist was much more obstructive and rude before I even got to the doctor.

The third in some ways disturbed me even more. He said he was happy and confident to manage Jack's HIV infection, but he would not manage his drug problem. I (foolishly?) asked why. He implied people who used drugs were bad and it was a criminal offence. I for a change (!) got on my high horse and informed him that it was one of the most useful things I did in general practice. You saw people change, they were always interesting people and the rewards to you and them were great – not to mention it being a sanctioned and ethical responsibility of GPs to meet the health needs of their local community, irrespective of personally held judgements regarding the lifestyles of the people we are employed to serve. He totally disagreed and after a further attempt I gave up and felt very sad that there were those in my profession who were so prejudiced. I know how he made me feel, so I was reminded a little of what it must feel like to attend there as a drug user.

But happily my fourth call reminded me of the opposite. As soon as I spoke to the receptionist I knew I was onto a winning wicket! She was cheery and helpful and completely like what I am used to at Lonsdale. She apologised that she couldn't put me through to the doctor right away because she was out on a visit but took my number and said she would get her to call. The doctor did within the next hour, was delightful and agreed to take over the care of Jack as soon as he had registered.

More than 30 per cent of practices now involved with primary care drug treatment, and all the GPs I know, see this as a vital part of general practice. Because of this, I think I had forgotten how much prejudice there still is in my area of medicine and perhaps Jack's story was a necessary reminder of this. I struggle with reconciling such prejudice with the values and purpose of general practice. So the question that remained for me is: would I want a patient of mine to see the third doctor for anything? The answer for me is 'no'.

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

A letter to a friend

Professor David Clark describes his thoughts about his change of career to an old neuroscience friend in America

Hi Buddy,
I remember our times together in the neuroscience field very fondly. It was great!

However, as you know, the time came when I felt I was not doing what I wanted to do – help people. Despite what I had achieved, and the great talk I could give on addiction and the brain, I felt that my work – and that of most other neuroscientists – was not actually helping people overcome substance use problems.

I certainly made the right decision to leave neuroscience! I'm now in a fascinating field and I know that I am doing something that will contribute to helping people, albeit indirectly.

Given that the field crosses the boundaries of so many disciplines and sectors in society, I am meeting a diverse range of people and I am involved in a wide range of issues. I am also learning so much.

I love meeting people who have recovered or are recovering from addiction. How some of them have overcome the difficulties they have faced is beyond me. There have shown so much bravery and I am sometimes left in awe.

The field can also be very frustrating, because of the politics and other rubbish that goes on. One thing that annoys me is the stigmatisation and stereotyping of people with substance use problems and their families. This exists at all levels of society, including among practitioners and commissioners who are supposed to be helping people get better.

One annoying thing was going to a service user conference and hearing the Head of the National Treatment Agency say, 'Because you are seen as a threat, the government is prepared to spend money on drug treatment'.

It seems that the poor health and social welfare of people with substance use problems are not a sufficient priority – it is the crime committed by a small proportion that matters. This attitude is confirmed by the fact that the treatment system is embedded in the criminal justice sector, not in the health or social welfare sectors.

Great message for some of society's most damaged individuals and families: a big door with a sign saying, 'Enter here. Get treatment, so society can be protected.'

Research shows that a key element of recovery is being accepted as 'normal' by a so-called 'normal' society. Society with its prejudice is shooting itself in the foot in relation to helping people overcome substance use problems.

'Ultimately, our organisation Wired In aims to provide an environment of opportunity, choice and hope, enabling individuals and families to find recovery.'

So what do I do with my time? Well, it's different to our days together, in that I don't devote as much time to conducting original research.

The best way that I can describe what I do, is that I try to get the most relevant and important information to the right people. Most of this information is already out there in one form or other, or could be accessed if we did things differently.

The information helps practitioners and commissioners do their job better, and people with substance use problems better understand how they can overcome their problems. One important strand of our work is to develop multimedia training, education and self-help guides.

So where do I get this knowledge and information from? Some comes from scientific research – a lot of the top science generally gets as far as specialist journals, but no further.

One vast, but relatively untapped source of information, is the people who are recovering/recovered from serious substance use problems. Their views and experiences are invaluable.

However, this field has historically spent most of its time and money focusing on the problem (addiction) rather than the solution (recovery). It has spent little time trying to understand how millions of people have found recovery.

My team are trying to change that, and also help recovered/recovering people join together to form recovery communities and help others overcome serious substance use problems.

Your country is leading the way in this regard – we are way behind. It's strange that after so many years of original thinking and experimental work in my own laboratory, that I am now using the expertise and advances of others to bring about much-needed change.

Our government-led treatment system is rather naïve in various other ways – it focuses on the 'drug' problem, rather than 'the drug, person and social context'. It thinks that teaching people about drugs will stop them using, when in fact we need to be teaching people about how to change behaviour.

You're probably saying that I must be in my element, teaching people about things that help people get better. Well, yes and no. I will be in my element when I can get my material to the right people.

But it is a challenge getting there. One of the frustrations is that the field spends very little money training practitioners and commissioners. Another is that there is a resistance to change amongst many people in this field, and a desire to control the agenda from the top. We are trying to bring about significant change, and give more control to the people and to communities.

Ultimately, our organisation Wired In aims to provide an environment of opportunity, choice and hope for people, enabling individuals and families to find recovery.

Take care,
David *(www.davidclarkwired.blogspot.com)*

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

Training for Drug & Alcohol Practitioners

Programmes from 2008/09

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

Certificate in Substance Misuse Management (Stage 1)

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

18 month programme from September 2008 or by negotiation

Certificate in the Management of Substance Misusing Offenders (Stage 1)

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

18 month programme from September 2008 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

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

2 year programme from October 2008

BSc in Substance Misuse Management (Stage 3)

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

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

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

Design & Print Centre 105884 02/08

While Barcelona prepared itself for the International Harm Reduction Associations' (IHRA) 19th Conference 'Towards a Global Approach', nine delegates from the UK set off to take part in an experimental International Harm Reduction Academy.

HIT launch first harm reduction academy at the 2008 Barcelona Harm Reduction Conference

Barcelona 2008 provided the setting for the first International Harm Reduction Academy, a pilot project delivered by HIT the UK based training and communications agency and supported by IHRA, The Conference Consortium and The National Treatment Agency. The process was observed and evaluated by academic staff from Liverpool's John Moores University.

Delegates at the Harm Reduction Academy

The idea of an academy was first proposed following the 2007 conference in Warsaw as a way of both enhancing the learning experience for conference delegates and eventually offering internationally recognised academic credits that could be used to build formal qualifications.

As part of this pilot project, nine candidates were recruited by the NTA and sponsored to attend Barcelona 2008 and the Harm Reduction Academy. Academy delegates were required to follow a learning pathway through the main conference programme, selecting a minimum of six sessions plus three tutorials and a closing feedback session (16hrs learning). In addition, candidates were required to compile and submit evidence of learning contained within a personal learning journal.

The Academy opened on Saturday 10th May with an introduction to harm reduction theory and practice including presentations from Alan McGee (HIT), Ralf Jürgens and Diane Riley (International Harm Reduction Alliance), Jamie Bridge (IHRA) and Martin Chandler (LJMU). Sally Woods and Jim McVeigh (LJMU) provided an overview of the process of observation and academic assessment.

In-spite of some initial reservations around 'prescriptive' learning, delegate feedback was extremely encouraging. Most found that the planned pathway through the conference increased focus and provided continuity throughout the programme while tutorials allowed for critical comment, clarification and considerations for policy implementation.

"the need to engage with the prescribed sessions gave in part, a direction of travel and rooted what could easily have become a completely overwhelming event"

Throughout the conference candidates gathered new and comparative research evidence which they were able to discuss and assimilate during tutorial sessions. Records and reflections from discussion groups enabled candidates to compile individual learning journals which were submitted up on completion.

Academic staff from Liverpool John Moores University will be carrying out formal assessments before certificates of achievement will be issued in June. However initial impressions from observations carried out by the academic assessment team throughout the academy process are extremely encouraging.

"The level of understanding, debate and analysis demonstrated during feedback sessions was equal to that of any academic tutorial"

HIT, Liverpool John Moores University, The Conference Consortium and IHRA look forward to the development of a more comprehensive academy programme for 2009 and aim to roll out a fully academic accredited academy programme ready for the International Harm Reduction Conference returning to Liverpool in 2010.

HIT provides a comprehensive range of training courses, publications and health information campaigns.
For further information please contact alan.mcgee@hit.org.uk or visit our website www.hit.org.uk

INTERNATIONAL HARM REDUCTION ASSOCIATION

The leading international organisation promoting the reduction of harms related to illicit drugs, tobacco and alcohol on a global basis. IHRA works with international bodies, regional and national networks, policymakers, people who use drugs and affected communities to advocate for practical and evidence-based policies and responses.

www.ihra.net

IHRA and the Conference Consortium would like to thank everyone who took part in and contributed to Harm Reduction 2008. The conference attracted 1,300 delegates from all over the world, and was a great success. We are especially grateful to everyone who sponsored or exhibited at the event; without their support this conference would not be possible.

Many thanks to: Blackwell Publishing, CompWare Medical, Exchange Supplies, Frontier Medical, HIT, STRADA, The International Caucus of Sex Workers, The Perry Clayman Project, The NTA.

See you all in 2009!

The success story for PCP goes on

PCP drug and alcohol rehabilitation centre launched in the United Kingdom four years ago, and in Spain three years ago. The commitment of our staff and the strength of our philosophy – that treatment should be available to all, not just the privileged – has seen our business grow to such an extent that we have now:

- opened a new Secondary Care Unit in Luton for 15 clients
- opened a larger fully residential clinic in Spain for 24 clients

To ensure we meet the needs of all addicts seeking recovery we have also launched a 24 hour free phone service 08000 380480 so that, whatever the time of day or night, we are there to help when an addict finally decides to seek recovery.

Contact:
Darren Rolfe
Treatment Director
darren@pcpluton.com
01582 730 113
info@pcpluton.com

Or Samantha Meadows
Admissions Consultant
www.pcpluton.com
08000 380 480
info@pcpluton.com

www.pcpspain.com

PCP Luton

- *£450 per week Primary treatment*
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- *Quasi residential with Sober Living Houses within one mile radius of centre*
- *24 hour care*
- *12 week Primary treatment, with option of Secondary*
- *Detox facilitated*
- *12 Step and holistic therapy*
- *Statistical information on clients available on a weekly basis*

PCP Spain

- *£995 per week*
- *Six week treatment*
- *Fully Residential*
- *12 step & holistic therapy*
- *Detox Facilitated*
- *Collection and take back to Granada airport*
- *Discreet, Rural location*
- *Fast track four week program – £1,295 per week*
- *Two week therapeutic detox – £2,495*

Institute of Lifelong Learning

Foundation Degree in Drug and Alcohol Counselling

Delivered by Distance Learning and on-campus in Northampton

These two courses are four-year part-time degrees which prepare students to work professionally as drug and alcohol counsellors.

The Distance Learning course is available to applicants already working with drug or alcohol-using clients. It runs via the Internet, supported by intensive yearly workshops.

The Northampton course is available to applicants without current clients, and runs on Monday evenings.

Contact: Course Administrator, University of Leicester Northampton Centre, Northampton College Building, Lower Mounts, Northampton, NN1 3DE
Call: 01604 736215
Email: couns.northampton@le.ac.uk
Visit: www.le.ac.uk/lifelonglearning/counselling

www.le.ac.uk

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Speedball/Snowball Injecting:
Responding to the combined injecting of heroin and crack.
A one-day course providing a comprehensive examination of the risks, harms and practice issues relating to this emerging form of drug use.

Drug Use and Mental Health:
Understanding mental health, mental health services and the management of dual diagnosis.
A three-day introduction to the various forms of mental disorder, the roles and responsibilities of services and practical skills for assessing suicide and depression.

General Healthcare Assessments for Drug Users:
Enhanced interventions for non-medical drug workers.
One-day skills-based training in which participants learn to screen drug users' body mass index, blood pressure, pulse and respiratory function to support the delivery of comprehensive healthcare assessments.

These tried and tested courses, all mapped to DANOS, are designed to enhance good practice by improving worker competency in a range of key areas. The training offers good value for money as it is delivered locally at venues chosen by your service/DAT and can therefore be adapted to meet your particular needs.

To book or for more information contact either:
Danny Morris danny@dannymorris.org 01432 870972 or 079 7040 6853
Neil Hunt neil@neilhunt.org 01622 717652 or 077 8066 5830

DDN in association with FDAP

"The trainer worked at our pace, which helped us to learn in a relaxed environment"

"Well presented and interactive"

Essential workshops

National Occupational Standards – Supervision and appraisal

14 July 2008 – central London

This one-day practical workshop for line managers and HR directors focuses on managing and developing practitioners' performance against DANOS and other national occupational standards. Using real examples, participants will work through different assessment scenarios and look at ways of managing and developing frontline workers. Run by Iain Armstrong – a leading expert in DANOS and workforce development.

Cost: £110 + VAT per head (15% reduction for FDAP members/affiliates).
Rates for groups on application. Contact Tracy Aphra.
e: tracy@cjwellings.com, t: 020 7463 2085.

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HALTON BOROUGH COUNCIL

Safer Halton PARTNERSHIP
a member of the Halton Strategic Partnership

INVITATION TO TENDER

HALTON Substance Misuse Service (HDAS – HSMS)

Halton Drug & Alcohol Team, on behalf of the Safer Halton Partnership and Halton & St Helens PCT, is seeking expressions of interest from suitably qualified and experienced organisations to provide a fully integrated substance misuse service.

The successful organisation will have a strong, proven track record in achieving a change in the culture of the workforce with the outcomes of delivering a high quality service that is organised around meeting the needs of individual service users, actively supporting social inclusion and sustained recovery, and effectively contributing to protecting families and communities. Applicants will also need to evidence their ability to work creatively and effectively with a range of partner organisations that can also have a positive impact on service user's lives.

The contract will initially be for 3 years, with an option to extend for 1 further year, dependant on performance, revenue and national/local policy.

For organisations committed to supporting service users achieve choice and independence in their lives, this is an exciting opportunity to offer more than a prescription.

Stage 1 Expressions of interest must be submitted via e-mail by 4pm, 14th July 2008 to Jane Ascott, Office Manager, e-mail jane.ascott@halton.gov.uk.

All interested parties will be invited to attend a Consultation meeting / question and answer session from 12.30pm, Monday 4th August 2008, Civic Suite, Runcorn Town Hall, Heath Road, Runcorn, WA7 5TD.

Stage 2 All interested parties will be required to complete a Pre-Qualification Questionnaire, the responses to which will be assessed to compile a short-list of parties to whom the final tender documentation will be issued.

The deadline for receipt of the PQQ is 4pm, 18th August 2008

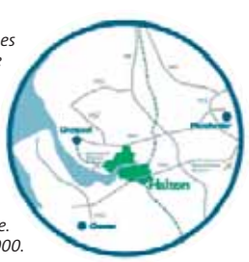
Stage 3 Tender documentation will be sent to the selected applicants week commencing 25th August 2008. The deadline for return of tender applications is 29th September 2008.

Under no circumstances will late applications be considered

Stage 4 Applicants are asked to note that interviews will take place week commencing 20th October 2008.

Please note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) will apply to this service. The aim is for the new service to be operational by 1st April 2009. The duration of the contract will be a minimum of 3 years and no longer than four years and subject to future funding allocations.

HALTON:
The borough of Halton in Cheshire is made up of two towns - Runcorn and Widnes – situated between Manchester and Liverpool and linked by the River Mersey. The two towns are joined by the well-known Silver Jubilee Bridge – the only river crossing between the Mersey tunnels in Liverpool and Warrington. However, the Council is the lead agency in the Mersey Crossing Group, which is currently lobbying for a new Mersey Crossing. Halton Borough Council has been awarded Beacon status for Improving Urban Green Spaces, Better Local Public Transport and Planning for Business. The Council has been awarded an 'excellent' rating in a recent CPA inspection and won a Local Government Chronicle Award for its innovative Benefits Express – a mobile benefits service. There are 51,350 households in the borough and a population of just over 118,000.



Camden

There's nowhere quite like Camden. Creative, vibrant, challenging and diverse, we're committed to excellence in everything we do. We're seeking talented people who will *focus on our customers, take responsibility, work together and find better and cheaper ways of doing things*. So, if you share these values, think about joining us.

Family Support Worker - Substance Misuse

£24, 588 - £26, 025 p.a. inc.
Two year fixed term contract

Joining our multi-disciplinary team, you'll provide support to families in the area who have been affected by substance misuse. As well as offering assistance and guidance to children, you'll offer parenting support and work with treatment providers to help them develop one-to-one provision.

Along with significant experience in this arena, you should be confident caring for children. In addition, you'll need a practical knowledge of child protection and family support.

This is a re-advertisement, previous applicants need not apply.

For an informal discussion please contact, Alison Johnson, Senior Practitioner Substance Misuse - MALT, on 020 7974 3378.

This position is subject to an enhanced CRB check.

Camden Council values the diversity of its community and aims to have a workforce that reflects this. We therefore encourage applications from all sections of the community.

Camden is committed to the protection and safety of children and vulnerable adults and expects all staff to share this commitment.

For further information and to apply online 24 hours a day, please visit www.camden.gov.uk/jobs
Please quote job ref: IRC2620
Closing date: 23 June 2008.
Interview date: 7 July 2008.

INVESTOR IN PEOPLE

looking for new opportunities?

bdp

Bristol Drugs Project is an experienced, energetic and resourceful service delivering effective harm reduction and treatment services to over 3,000 individuals a year.

ALCOHOL SERVICES WORKER – full-time – ref: DD01
Delivering a counselling and support service for people wanting to control or end their drinking, you will need experience of working with people with alcohol problems and a counselling qualification. For an informal discussion contact Justin Hoggans, Structured Support Services Manager, on (0117) 987 6007

CRIMINAL JUSTICE WORKER – 30 hours a week – ref: DD02
The Criminal Justice Service at BDP seeks to deliver effective interventions to drug-using offenders, in partnership with the Probation Service, Criminal Justice Intervention Teams, and the Prison Service. We are looking for experience of working with drug-users, excellent engagement skills and an understanding of the Criminal Justice System. For an informal discussion contact Steve Jackson, High Support Services Manager, on (0117) 987 6012.

Salary scale for both posts: £16,617 - £24,980 (pro rata based on 35 hours a week), starting salary for suitably qualified candidates: £22,156. A pay award is pending. For both jobs you will need experience of working with drug users and we welcome past personal experience of problematic drug use.

Funded by Safer Bristol - Bristol Community Safety & Drugs Partnership

Closing date: Tuesday 24th June at noon

Please fax, e-mail or write to Alice Walker, quoting the job reference, for an application pack: BDP, 11 Brunswick Square, Bristol BS2 8PE Fax: (0117) 987 1900, 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. No CV's agencies or publications.

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The DDN nutrition toolkit

"an essential aid for everyone working with substance misuse"

- Written by nutrition expert Helen Sandwell
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Healthy eating is a vital step towards recovery, this toolkit shows you how. Available on CD Rom. Introductory price £19.95 + P&P

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

Tender for the Provision of Psycho-Social Intervention Service

ROCHDALE METROPOLITAN BOROUGH COUNCIL

Rochdale Safer Communities Partnership is seeking an organisation to provide psycho social interventions within the community setting to drug misusers in the Rochdale borough. The appointed service will deliver a range of evidence-based interventions to drug misusers at various stages of their treatment. The programme will include therapeutic work coupled with education and skills training to promote community reintegration.

Potential bidders will be asked to outline their delivery model through the submission of a service specification.

To request information pack and tender documentation please contact:

Corporate Procurement Unit, Floor 7, Municipal Offices, Smith Street, Rochdale, OL16 1LQ. Telephone: 01706 925481. Fax: 01706 925476
Email: corporate.procurement@rochdale.gov.uk

Rochdale Safer Communities Partnership

The final date and time for the submission of tender documents is 22 July 2008 at 2pm.

COUNSELLOR

CLOUDS HOUSE, EAST KNOYLE

Salary from £21,319 per annum,
25 days holiday per year plus additional benefits

We are seeking to recruit an Addictions Counsellor to work as part of the Treatment Team providing a full range of Counselling Services to beneficiaries in our residential treatment centre.

For more information and an application pack, please contact the HR Office on 01747 830733. Alternatively email your interest (providing your postal address) to mardeen.willows@actiononaddiction.org.uk

Closing Date: 20 June 2008

www.actiononaddiction.org.uk

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

Action on Addiction

INVESTOR IN PEOPLE

Community worker/ Outreach worker

Salary – £19,575 plus benefits

Welcome
Rebuilding Lives

Welcome is an independent charity offering both Tier 2 and Tier 3 interventions for individuals affected by substance misuse.

We are currently recruiting a Community worker/ Outreach worker at our centre in Chelmsley Wood.

The post will involve working within a drop in centre providing interventions and support for substance misusers within the Borough of Solihull. The post will also involve an outreach element, providing outreach interventions for individuals who are affected by substance misuse.

For more information please call Lauren Page on 0121 6784743.

Closing Date: 13th June 2008

ADULT SERVICES

City of Westminster

In the heart of London, you'll find famous shops and legendary landmarks alongside Britain's flagship council - setting the standards others follow and delivering world class city management in a low-tax environment. Westminster - you can build your future here.

Business Re-Let Manager

£37,743 - £41,583 pa
Short term contract 31 March 2010 Ref: 3229

An energetic, enthusiastic, and committed professional, you will project manage the overall re-let strategy for treatment services while supporting the decision making and service redesign process. As an experienced Prince 2 practitioner you will have a proven track record in managing multi disciplinary projects, business management, policy development and organisational change.

Training & Development Manager

£30,717 - £33,777 pa Ref: 3234

As training lead within the DAAT you will lead on the overall workforce development strategy for Westminster DAAT and develop close working links with a broad range of statutory and voluntary services as well as users of those services to implement a first class training programme for Westminster. Your proven track record in the substance misuse field will be complemented by an understanding of the issues relating to training.

Commissioning Officer

£30,018 - £32,094 pa Ref: 3231

You will monitor local treatment services on an ongoing basis, build links with internal and external partners, and identify trends to help inform future commissioning decisions. Educated to degree level, with the ability to communicate with professionals at all levels, you will bring a sound understanding of relevant legislation.

The above roles are subject to a CRB check

Young People's Officer

£21,843 - £23,916 pa Ref: 3233

In this key role, you will support the Young People's Commissioner by leading service developments for the local Young People's Treatment System and coordinating a series of conferences, seminars, and training events. An excellent communicator, you will have experience of conducting projects using various qualitative and quantitative research methods.

This role is subject to an enhanced CRB check

For an informal discussion about any of the above roles, please contact Davina Leeds, Service Development Manager on 020 7641 3466.

The above roles are politically restricted

Involvement Manager

£29,202 - £32,094 pa Ref: 3232

A graduate-calibre professional, you will co-ordinate the Council's response to communities affected by substance misuse, and take the lead for service user and carer involvement in the Drug and Alcohol Action team. Considerable experience of community development work and sound relationship building skills will be vital.

This role is subject to an enhanced CRB check

This role is politically restricted

For an informal discussion, please contact David Eastwood, Drugs & Crime Manager on 020 7641 2886.

Project Support Officer

£21,843 - £23,916 pa Ref: 3239

You will support the Drug and Alcohol Action Team in delivering the National Drugs Strategy at a local level by providing project and administrative support. This will include assisting with quality improvement initiatives. Skilled in audio and copy typing and minute taking, you will have experience in a busy office.

For an informal discussion, please contact Selina Douglas, Head of Joint Commissioning for Substance Misuse and homelessness health on 020 7641 3467.

Our selection process reflects our commitment to safeguarding children and vulnerable adults.

Benefits: | Generous annual leave | Interest free season ticket loan | Excellent pension scheme | Staff discount card.

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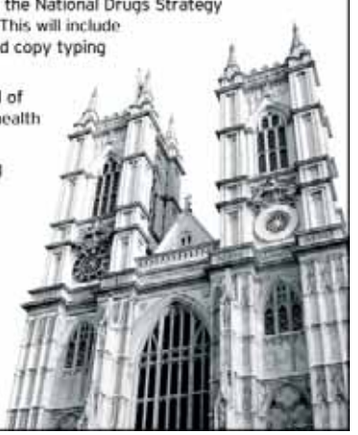
Alternatively, email: applications.hrdirect@westminster.gov.uk or telephone 0870 606 0505, quoting the relevant reference.

THE TIMES BEST COUNCILS TO WORK FOR 2007

Closing date: 18 June 2008.



Mentor

PREVENTION OPPORTUNITY PROTECTION

Mentor UK wishes to appoint a

DEVELOPMENT DIRECTOR

With the support of Futurebuilders England, Mentor UK, the UK's leading drug and alcohol misuse prevention charity, wishes to recruit a **Development Director** to lead on the development and marketing of a new Mentor UK national "Quality Counts" Standard for drug misuse prevention which it will aim to position as the "industry" norm.

The Development Director will also recruit and train a small "Quality Counts" staff team which will provide packages including expert web-based, telephone and face to face advice to assist practitioners in preparing to meet the "Quality Counts" Standard. This will include guidance on using a Prevention Toolkit to evaluate and review services in line with current best practice. It will also include an assessment service for agencies to achieve the "Quality Counts" Prevention Mark.

Starting Salary: £45,000 p.a. plus 6% pension contribution

After year one, sales-related incentives will be available dependent on performance.

Candidates must have:

- **a track record of achievement in marketing and sales**
- **the ability to innovate and develop ideas**
- **an understanding of and commitment to quality public services**
- **the ability to develop, manage and support a dynamic team**
- **excellent presentation skills**

To read more about Mentor UK's work visit www.mentorfoundation.org/uk

Download the Job Description (including Person Specification) and a "Quality Counts" Project Briefing at www.mentorfoundation.org/uk/jobs

Applications by CV and covering letter explaining how your skills and experience meet the Person Specification for this post should be sent to admin@mentoruk.org

Closing Date for Applications: 23rd June 2008

Mentor Foundation UK

4th Floor, 74 Great Eastern Street

London EC2A 3JG

tel: 020 7739 8494

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want to join a

successful, dynamic, expanding team?

Due to our continued growth TTP Counselling is looking to recruit the following members to its team:

MANAGER, COUNSELLING SERVICES (Warrington)

Salary £30k to £35k

Experienced Service Manager required for our new 80 bed centre in the North West.
Must have direct personal experience of the 12 step programme of recovery and managing a team of counsellors.
You must be trained to a minimum of diploma level and have 3 year managerial experience.

COUNSELLORS (Warrington)

Salary £14k to £24k

If you are qualified, in training or wish to train, to a minimum of diploma level and **have personal/professional experience of the 12 step recovery programme**, we want to hear from you.

Please email your CV, with covering letter, to dave.cooper@ttpcc.org.uk

ttp counselling

alcohol and drug rehab

www.ttpcc.org