DDN
Drink and Drugs News
3 December 2007
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REVIEW OF THE YEAR
DDN looks back at our headlines of 2007

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Drink and Drugs News

3 December 2007

Editor's letter

Doing a review of the year makes the months flash past very quickly. But it also reminds you of how much headbanging goes on. (Not the heavy metal variety.)

Back in July, the Sainsbury Centre for Mental Health published a report that highlighted severe failure to treat dual diagnosis prisoners – the many inmates with both mental health and substance misuse problems – and pointed to under-resourcing of inreach teams. And what's this in the news this issue..? Another report from the same source highlighting the same problems and pointing out that they are being ignored. Do we really wonder why prison overcrowding has been getting worse all year?

We always want treatment to be evidence based. But there's an awful lot of evidence we choose to ignore. This year saw in-depth reports released from newly set-up groups as well as familiar organisations and treatment bodies who care deeply about influencing a new drug strategy. A wider public health approach has been underlined many times and must surely be taken on board – and that needn't conflict with existing strategy. As our letters page underlines, there are many conflicting views on preferred modes of treatment – but the common theme that unites is the need to give each individual the best chance of recovery, *ie* a healthy life integrated with society.

Nick Barton takes the lid off quality in our lead feature, as well as giving us an excuse for a Christmassy cover. (And a further excuse to eat a box of chocolates while taking the photo.) Is your service providing the standard of treatment you would give your own relative? A self-audit can be tough, but Nick's five assessment parameters can help.

It's time for our Christmas break! We publish DDN again on 14 January, but in the meantime we're here for all your letters, articles, adverts (which can still go online) publishing jobs and service user conference enquiries, so stay in touch!

Season's greetings to all our loyal readers and advertisers – see you in 2008.

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News in Brief

Guiding hand

New national guidance on the best ways of encouraging children not to drink, reducing harm among those who do, and delaying the age at which they start, has been launched by the National Institute for Health and Clinical Excellence (NICE). Among its recommendations are that brief one-to-one advice should be offered to young people thought to be drinking at harmful levels, and parents or carers should be offered information on developing their parenting skills where appropriate. 'Many different factors have an influence on alcohol consumption among children and young people, including peer pressure, the media and the availability and cost of alcohol,' said NICE chief executive Andrew Dillon. 'It is important that we now have national guidance for tackling this issue so that we can do everything possible to delay the onset of drinking and reduce the harmful effects of alcohol use.'

Available at www.nice.org.uk/PH1007

Service uncertainty

Professionals working with children whose parents have drink and drug misuse problems are worried that their services will be at risk after March next year when two important funding streams end, delegates at the *Substance misusing parents and their children: towards effective services* conference, organised by charity KCA heard. The Children's Fund and ring-fenced 'partnership grants' both end in April 2008.

Kids talk tough

Young people want tougher penalties for drug dealers and drunk drivers as well as more early intervention services for people with substance misuse problems, according to research by Mentor UK which has been working with the Department of Children, Schools and Families to make sure young people's views are fed into the government's new drug strategy. They also want drug education to consist of honest messages delivered by adults they can trust. 'Young people are those most affected by drug misuse,' said development officer at Mentor UK, Susi Farnsworth. 'It is vital that we listen to young people to find out what they say will reduce the risks.'

Report available at www.mentorfoundation.org/uploads/UK_YIP_Drug_Strategy_Feedback.pdf

Teachers need more drug education

Secondary school teachers still have 'limited expertise in the methodology of teaching PHSE' and more high quality and intensive training is essential, according to a new Home Office report on the Blueprint education research programme, designed to pilot the effectiveness of an evidence-based drug education programme in schools.

The report also found that recruiting parents into drug prevention activities could turn out to be a much more long-term process than was originally expected, as parents – particularly in deprived areas – were often hard to engage and reluctant to engage in groups and activities. Longer planning times would allow for more engagement with agencies at a local level, it said.

Chair of the Drug Education Forum Eric Carlin urged the government to make drug education part of teachers' initial training, as the report found that high quality training made them feel much more confident in teaching the subject. 'It's time that drug education became a subject that teachers feel comfortable tackling,' he said. 'We urge the government to ensure that community-based approaches to drug education are complementary to those happening in schools, especially considering those who may not be in schools due to absence or exclusion.' More work also needed to be done on providing parents with what they need to support their children, he said.

Full reports available at http://drugs.homeoffice.gov.uk/publication-search/blueprint/dpreports/

Prisoners' drug and alcohol problems 'being ignored'

The mental health needs of prisoners – including those with drug and alcohol problems – are being ignored because of lack of capacity in prison primary care, according to a new policy paper by the Sainsbury Centre for Mental Health. *Getting the basics right* wants to see every prison in England have its own dedicated general practice within its budget – to guard against NHS budget cuts – as well as the establishment of a new professional body to set standards for prison primary care.

Most prison GPs have no mental health training, and some clinics are staffed by locum doctors with very little time available for each patient, while the average size of a prison inreach mental health team is only a third of the necessary level, it says. Delegates at the NOMS Prisons and beyond conference in October heard how a growing prison population was proving a challenge to helping those prisoners with drug and alcohol misuse problems and that BME prisoners in particular were being failed by the system (*DDN*, 5 November, pages 9-16).

Up to 52 per cent of prisoners have a drug dependency and up to 30 per cent an alcohol dependency, compared to just over 4 per cent and 8 per cent respectively of the general population, says the paper. Levels of substance misuse among younger prisoners are even higher, and drug-related mortality is seven times higher in the two weeks immediately after release than at any other time.

'Research across the country has shown that the majority of prisoners experience depression and anxiety,' said Sainsbury Centre's prisons and criminal justice programme director Sean Duggan. 'Many also have drug and alcohol problems, learning disabilities and a history of being abused. It is tragic that these problems are being ignored when they go to prison. We need to look urgently at how we can identify prisoners in distress and offer them care and support that might make a difference to them and, ultimately, to their families and communities.'

Getting the basics right available at www.scmh.org.uk/80256FBD004F6342/vWeb/pcKHAL796MYK

Drug use 'stabilising'

Overall levels of drug use in Europe appear to be stabilising after a decade of increasing use, according to the European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) latest report.

Heroin use and drug injecting have become less common, cannabis use is stabilising but there are rising levels of cocaine use. Around 4.5 million people in Europe used cocaine in the last year, and there was no downward trend in drug-related deaths, according to the 2007 *Annual report on the state of the drugs problem in Europe*.

Around 2 million people had taken cocaine in the last month – more than double the estimated figure for ecstasy – making it the second most widely used drug after cannabis. Spain and the UK had the highest prevalence, and almost a quarter of demands for treatment in Europe were related to cocaine.

The highest rates of cannabis use among 15-34 year olds were found in Spain and the Czech Republic, where 20 per cent and 19.3 per cent had used the drug in the last year. The UK came fifth at 16.3 per cent, behind France and Italy. Out of all of those countries, rates of use were only increasing in Italy, however. Injecting drug use had become a less common route for HIV transmission, but still accounted for 3,500 newly diagnosed cases.

The high number of drug-related deaths, despite decreasing heroin use, was thought to be related to increased polydrug use and the wider availability of heroin, and the report questioned the sustainability of this levelling off of use in the face of increased opium production in Afghanistan.

EMCDDA director Wolfgang Gotz said the report 'reveals that drug use has stabilised in a number of important areas, albeit at historically high levels. In some cases, there are even signs that merit cautious optimism – such as relatively stable levels of heroin and cannabis consumption and mostly low rates of HIV transmission among drug injectors'.

'Within the EU there are still extensive differences between countries in the nature and scale of their drug problems and how they approach them,' he continued. 'However, we agree more and more on fundamental issues, such as the need for drug policies to be balanced, comprehensive and evidence-based and the importance of prevention, treatment and social rehabilitation.'

Dexy's Sussex winners: Kevin Rowland of 80s chart-toppers Dexy's Midnight Runners presents prizes to winners in the young people's category of West Sussex DAAT's photo competition. Entrants were asked to illustrate how they would feel if they were living with someone with a drug or alcohol addiction, and Mr Rowland chose 12-year-old Benjamin Allen (top right) as category winner, for his chilly autumn scene captioned 'when will the sunshine return to our lives'. All entries are on the DAAT's website at www.westsussexdaat.co.uk.

Welfare lacking in police activity

'Welfare-orientated activities', such as referrals to drug treatment services, are not a core part of routine encounters between the police and problem drug misusers, according to a new report by the Joseph Rowntree Foundation.

Street policing of problem drug users studied the activities of police over an 18-month period in three areas of England and Wales, and found that the aim was to 'manage' problem drug users rather respond to specific crimes. This usually involved name checks and moving people on, rather than use of formal police powers.

The outcome of arrests for possession of Class A drugs varied from 'no further action' to caution or charge between the three areas, while police said discretion would be used if evidence of Class A use – like needles – was found during a search. The police said the value of these methods was to communicate to problem drug users that their movements were being monitored. They in turn experienced resentment and hostility, with some choosing to move to other police areas, which severed contact with treatment agencies and other support bodies.

Opportunities to provide support were under-utilised says the report, which recommends the police provide telephone numbers or referrals to support and advice agencies not just for drugs but for employment, housing and benefits. 'Moving problem drug users elsewhere in a piecemeal manner is unlikely to address their problems,' it says. 'It is also likely to have repercussions for residents and policing and support agencies in the area drug users are moved into.'

Available at www.jrf.org.uk/knowledge/findings/ socialpolicy/2161.asp

Dealers undeterred by prison

Prison is not considered a serious deterrent to involvement in the illegal drugs trade for large numbers of high-level dealers, according to a new Home Office report.

The research, based on face-to-face interviews with more than 220 people in prison for serious drugs offences, found that confiscation of assets was seen as a far greater problem and that prison was viewed as 'either an occupational hazard or an unlikely risk'.

Having served time in prison was in fact seen as a way of proving trustworthiness, with most dealers having entered drug dealing through family or friends – the implication being that 'drug dealing spreads contagiously from dealer to new dealer'. 'This combined with the barriers to entry being minimal for individuals who know someone in the trade, has disappointing implications for policy and law enforcement,' it concludes. Most dealers were also extremely adept at finding new markets and exploiting new opportunities.

The illicit drug trade in the United Kingdom available at www.homeoffice.gov.uk/rds/pdfs07/rdsolr2007.pdf

NTA wants competence proof

According to targets set by NTA, 60 per cent of 'professionally qualified' adult drug treatment workers should be able to demonstrate their competence against relevant DANOS standards by April 2008, and 75 per cent of the rest of the workforce should be able to do likewise by the same date.

While the NTA have announced that they will not be setting any new qualification targets after 2008, these targets remain in force. The agency has just issued new guidance stressing that, post 2008: 'It is important that commissioners and services continue to work towards a workforce which is fully competent and able to demonstrate its competence in line with the joint NTA/Home Office Workforce Development Plan.'

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

Commenting on the new guidance, FDAP's Chief Executive, Simon Shepherd, told DDN: 'There has been a lot of concern about what would happen to the NTA targets after 2008, it is good to see that the NTA remains committed to the ongoing development of the workforce – both frontline staff and managers – after this time.'

News in Brief

Called to the bar

The UK's first Family Drug and Alcohol Court – based on a US model – has been set up by three London local authorities to offer more structured support to families affected by drug and alcohol misuse issues and to try and reduce the number of children taken into care. Islington, Camden and Westminster councils have set up the court, which will be based at the Inner London Family Proceedings Court, to provide assessment and support to those families affected by drug and alcohol misuse issues. Two thirds of all care proceedings involving the three councils are initiated by parental substance misuse.

Southwark safety

A list of hints for pub, bar and club operators during the Christmas party season has been sent out in the Safer Southwark Partnership's latest licensee newsletter. These include not allowing the premises to become overcrowded; having enough well trained and responsible staff on hand; and making sure a good range of food and reasonably priced soft drinks are provided. Staff are advised to be vigilant on drunkenness and under-age drinking, and are also asked to avoid irresponsible drinks promotions. The partnership will be running a campaign targeting irresponsible sales in the run-up to Christmas.

Rory's ruin

A new book tackling the issue of harm caused to children by parental alcohol problems has been launched by Alcohol Focus Scotland. Rory, the story of a dog who can't understand why his owner is acting in a strange way until he learns that it's because he has a problem with alcohol, is aimed at primary school children and designed to be used by teachers, social workers and counsellors. More than 100,000 children in Scotland are thought to be affected by a parent with a drink problem. 'We need to protect the children of problem drinkers so they don't feel alone or confused about their parents' behaviour,' said Alcohol Focus Scotland's chief executive Jack Law.

Quality straight

The obsession with quantity over quality is failing our clients. Shaking up our priorities could offer a more inspiring box of tricks, says **Nick Barton**.

Since the start of Drug Strategy we have heard a fair bit about 'quality' in relation to treatment and rehabilitation. Even the NTA, always keen to broadcast the numbers of people 'in treatment', has declared that 'quantity without quality is a waste of resources'. Will quality remain an agenda item to be perpetually carried forward with pious intent, or dare we hope that commissioners and providers – and it is everyone's responsibility – will infuse their policies and practices with a new drive for real quality? The clients, their families, their communities, the taxpayer and other funders must hope so.

It is the provider's obligation to deliver a quality service, and it is the commissioner's responsibility to help make it possible. But where in the current system are the incentives to ensure a wholehearted commitment to quality? Even should such incentives exist, too many people involved in the arrangement and delivery of treatment have a wholly inadequate conception of what is required to achieve real quality, including the cost implications.

Would-be service users and their carers are left in the dark. There is precious little in the way of useful information about what they should reasonably expect of treatment services, where good quality treatment and care may be had, or what should guide their choices – assuming they have any choice when push comes to shove.

So what do we, or should we, mean by the term 'quality' in relation to the delivery of a treatment service? Let me suggest five key parameters for assessing the quality of a service:

1. The service responds appropriately and conscientiously to the clients/patients and their current condition.

This requires an ever-growing fund of knowledge and understanding, as well as a range of skills (clinical, supervisory and managerial), adequate resources and the intelligence, creativity and discipline to apply them effectively to a diverse population. The service demonstrates its ability to respond to the needs of each individual, neither under nor over treating, and will continuously monitor, audit and thereby improve its own competence. No stone is left unturned in efforts to find the best ways of helping individuals; there is continuous evaluation and no complacent ticking of so-called competency boxes. The service provider is prepared to recognise that its own belief systems, assumptions, practices, policies, culture and traditions may sometimes prevent clear sight of the client.

2. The service provides a well thought out intervention that draws on available evidence and is consistently delivered as described.

Addiction, the diverse people who suffer from it and therefore the delivery of an addiction treatment service, tend

to be far more complicated than imagined. The approach therefore needs to be soundly constructed, grounded in available evidence, supplemented by thorough good sense, expertly practised and well maintained.

A wide-ranging review undertaken by researchers in the US discovered that that there was little discernible competence in (psychosocial) treatment practice across that country (Miller and Carroll, and Rounsaville, *Addiction* 102,863-869). It's a disturbing thought. In many cases, what was happening in practice bore little resemblance to what the provider claimed to be delivering and I would not be surprised to discover that this was also often the case throughout the UK.

So a quality service is one that is able to demonstrate continuous self-auditing, skillful change management and investment in meaningful training and development of all staff, that is exclusively keyed to achieving specified treatment objectives.

3. The service ensures a comprehensive, consistently positive and memorable experience.

A powerfully positive experience is vital to act as an effective antidote to those soul-sapping negative messages which form the staple psychological diet of our clients. A comprehensive approach helps to achieve this by paying diligent attention to all aspects of the client's experience of care and takes full account of the whole person in doing so. As my colleague Tim Leighton, director of the Centre for Addiction Treatment Studies, explains, for an experience to be transforming, it must be memorable. It must get under the skin, stay with the person and have an extended afterlife. Consistency is achieved by a genuine, unswerving commitment to continuous improvement. Sweat the small stuff, as the saying goes.

4. The service optimises the chances of achieving the best outcome.

We should of course be able to tell something about the quality of the service by the outcomes it achieves, or contributes to. In this respect we tend to zero in on 'clinical' interventions. However, the Organisational Readiness for Change measure, or ORC for short (Lehman *et al*, 2002), is one instrument adding weight to the growing body of evidence to indicate that client outcomes may relate to a number of factors about the treatment service and the way it operates as a whole. Other evidence shows that better organisational functioning correlates with better engagement by the patient and better retention. It would seem logical that the more ambitious the targeted outcome and the more complex the client's situation, the greater the need for high quality inputs.

However limited, we must pay attention to existing evidence, while not being constrained by it. Finding out more about what helps secure the required outcomes must be a priority – and it will not be the same for everyone. We should undertake a great deal more qualitative as well as quantitative research to uncover what service users find most helpful in achieving their treatment goals.

Nonetheless we have to be careful to avoid over-simplistic judgements and conclusions about outcomes. It is recognised that someone could get better in spite of the treatment experience, rather than because of it. Outcomes are not the only signal of quality, nor should they be.

5. The service conscientiously reduces to a minimum the risk of any incidental or consequential harm.

There is no justification for a poor quality service. We are caring for vulnerable people and, at the very least, we have an obligation to do everything possible not to compound the harm already suffered and to minimise the risk of any further harm – particularly at our hands. A service must be ethical to its core, vigilant and proactive in identifying and reducing risks.

The achievement of real quality through the application of this five-part template requires a dynamic combination of culture and formal controls. In many ways, the cultural aspects are of greater importance because the culture – hopefully one of passionately conscientious care – is the most affecting part of the client's experience. Compliance with formal processes without the culture results in organisations going through the motions. A quality-driven culture will have no problem embracing formalised measures, even those it finds rather tediously bureaucratic. Obviously, if such controls carry the pressure of external scrutiny, there is more chance of the desired effect. But it is important to be motivated by a desire to achieve benefit rather than by fear of censure.

'Would-be service users and their carers are left in the dark. There is precious little in the way of useful information about what they should reasonably expect of treatment services, where good quality treatment and care may be had, or what should guide their choices – assuming they have any choice.'

I have identified at least a dozen formal schemes that are intended to have some impact on the quality of treatment delivery. Ranging from guidance to legally enforceable regulation, they carry varying degrees of weight where requirements for compliance are concerned. The overall effect, however, is of a motley group of uncoordinated initiatives that reveal both gaps and overlaps and leaves doubts about what to rely on.

The danger is that these schemes may be latched on to in a somewhat haphazard unsystematic way, possibly to impress market players rather than to manage their incorporation into a genuinely quality-focused approach. On the plus side, this patchwork provides some sort of palette from which to work.

Can we trust providers to be sufficiently diligent in their attention to quality when providing care without some sort of objective systematic check? Sadly in many cases I rather doubt it, especially in a market where price alone governs so many decisions. One of the 14 essential tenets of quality as proposed by W. Edwards Deming, an early guru of the quality management field was: 'End the practice of awarding business on the basis of price.' As Health Economist, Christine Godfrey has more recently explained, 'Low financial costs per person do not imply that services are cost effective.'

Regulation may help in buying a basic degree of protection for clients. But there are major obstacles that are holding us back from delivering treatment services of genuine quality. Alongside the lack of any convincing lead from government on translating lofty aspiration to action on the ground, there is an uncoordinated array of initiatives aimed at quality control. The obsession with raw targets, encouraging quantity over quality, give little incentive to achieve quality – and closure of low quality providers is rare. Price comes above value for many commissioners and purchasers, perpetuating low standards, and the scant evidence we have about what clients find helpful is often ignored. Inadequacy of staff training and a lack of in-depth professional education reinforces a culture where the complexity of clients' condition and the resources needed to treat them are under recognised.

Thankfully examples of real commitment to quality can be found. The indifference to quality exhibited by some commissioners and purchasers (and even more shamefully, providers) may well come down to the fact that they and their loved ones are not the people who will have to make use of the service they are arranging, buying or providing. If it were their own money and their own treatment they might take the matter of quality rather more seriously.

Nick Barton is joint chief executive of Action on Addiction

'There is a choice to be made in drug policy spending, but not between crime and health harm reduction. A pound spent on prison cannot be spent on treatment, residential or otherwise. This conflict in spending priorities is much more important than the rather tired argument between abstinence and harm reduction...'

Distorted evidence

Many drug service users, workers, managers, commissioners and researchers would support a call for residential rehabilitation to be more widely available. However, such a call should not be based on a distortion of the available evidence. Kathy Gyngell and Andy Horwood write that 'drug-free recovery achieved through residential treatment is the only intervention with a real weight of evidence to support the work being done' (*DDN*, 19 November, page 8). This is not true.

Repeated studies of various forms of treatment – many using methods far more rigorous than the NTORS and DORIS studies referred to – have shown that both methadone maintenance and residential treatment are effective in reducing drug use and crime (see, for example, the meta-analysis published in 2002 in Drug and Alcohol Dependence by Prendergast *et al*, or the Cochrane review of methadone maintenance of the same year, or even this year's NICE guidance on drug misuse). If there is evidence that residential treatment is more cost-effective than other modalities, let's see it, rather than relying on a guess from a drug service manager, as Gyngell and Horwood seem to.

They also suggest that the report published by the UK Drug Policy Commission sets up a false choice between reducing health and criminal harms. As one of the authors (with Peter Reuter) of this report, I can say that this, again, is not true. In a field where definitive proof of positive impacts is hard to find, there is evidence to suggest that harm reduction and treatment are effective in both saving lives and cutting crime. There is far less evidence that increasing the imprisonment of drug offenders (as has been done in the UK in the last decade) has a good effect on either crime or health.

So there is a choice to be made in drug policy spending, but not between crime and health harm reduction. A pound spent on prison cannot be spent on treatment, residential or otherwise. This conflict in spending priorities is much more important than the rather tired argument between abstinence and harm reduction which Gyngell and Horwood seek to revive.

Alex Stevens, Senior Researcher, European Institute of Social Services, University of Kent

A life of choice

I read your recent article 'Abstinence – a better way to a brighter future?' with increasing irritation (*DDN*, 19 November, page 8). I have been maintained on methadone by my GP for some years; before this I was an IV user of heroin and cocaine with rapidly collapsing veins and deteriorating health. Methadone has given me the opportunity to live an ordinary life with choices.

I'm lucky enough to be able to pick up my medication weekly so it causes very little disruption to my life and is also cheaper to society at large as it reduces dispensing costs. Yes, sometimes I still smoke heroin but it no longer dominates my life and as a result I have the time to do a lot of work around service user involvement and sit on multi-disciplinary panels here in Bristol involved in monitoring and improving treatment for me and fellow drug users.

Some time ago I tried for drug abstinence but simply ended up relapsing – the whole process caused much unnecessary pain and disruption. I've always been aware of the option of residential rehab, but it's not something I want. Many service users I work with are drug/alcohol abstinent and I believe that shaping policy on the basis of comments from people who have already achieved this is fatally flawed.

The Conservatives should pay more attention to those of us still choosing to use drugs. Residential rehab is an immensely expensive option and should only be promoted for those that want it – otherwise it's a huge waste of resources! It's well worth remembering that drug users who are not in any kind of treatment *ie* substitute prescribing, are ten times more likely to die.

Richie Moore, Bristol

Need a reality check

I read Kathy Gyngell and Andy Horwood's article (*DDN*, 19 November, page 8) with a certain level of positive anticipation. There is no doubt that residential rehab and abstinence programs have fallen by the wayside as the government focuses heavily on Tier 2 and 3 interventions. However, apart from a brief nod at the end to 'redressing the balance', the two authors present their argument very much as an 'either/or' debate (an accusation they themselves level at the RSA reports conclusions on crime and health).

The reality of the situation is that Tier 2 and 3 treatment sectors should feed directly into Tier 4. There is no reason why an abstinence emphasis should be mutually exclusive from a harm reduction emphasis – I would go so far as to say, funding issues aside, many areas are already using this double-pronged approach.

Comparisons were made between treatment programs in Holland and Sweden – somewhat fatuous due to the admitted low drug use in those countries. I ask the authors to look at another country with a more comparable drug problem to the UK – the USA. For many years, fuelled by 'the War on Drugs' and an almost fanatical inability to accept the failure of this policy, abstinence programs have dominated. In full, over 90 per cent of American residential rehabs (a much more common treatment option than in the UK) are currently 12-step based. Has it solved the country's problem? Has it come close? I think we all know the answers...

I share some concerns with the authors about workers becoming 'harm reduction Nazis' – if a client tells me that he wants to aim for rehab, I want to help him achieve this. Forcing people to move forward slower than they want to, will do more harm than good – I have seen this and

always despair. However, I have the same concern about the 'abstinence Nazis' – forcing people to go forward more quickly than they are prepared to is simply setting them up to fail.

The '58 per cent of addicts want to become drug free' statistic (bandied about so gratuitously by prominent Tory politicians recently – we should not forget that the authors of this report are politically motivated) reflects my own personal experience of client work. But it doesn't mean that they all want to have immediate detox and rehab as their only option. Most would prefer to have community-based substitute prescribing treatments, and aim toward becoming drug free at their own pace. And where does this 'abstinence only' programme leave the other 42 per cent? Do we just ignore their needs?

In conclusion, the reality of the situation is that there is a rehab funding crisis occurring in the UK at the moment, one that has been well reported in *DDN*. Improving the situation should not be at the expense of Tier 2 and 3 services.

Stephen, by email

Surely some mistake?

I was delighted to see the 'First National Service User Involvement Conference' on the 31 January, in Birmingham (my old stomping ground) advertised on the *DDN* website. And there in bold letters, 'Nothing about without us'. Well, I am afraid it will be 'without us' – well those who can't afford to pay £88 as service users.

I am not stupid enough not to realise this conference is very costly to put on – hiring the venue, food and drink (smoked salmon and champagne seems to be a favourite as I remember). This conference 90 per cent of British service users will know nothing about. The majority of the ones who will find out about it will not be able to afford to attend.

There are multi-national pharmaceutical companies making billions from service users. There will be organisations who are funded by these companies who will have their stalls out, selling their products. Same old story.

David Wright
Volunteer Welsh Drug advocate

We sincerely hope it won't be the same old story. We're doing everything we can (as a free magazine) to keep costs of our conference down and are pleased to say that most DATs are meeting us half way and covering the costs for service users – we have places booked from all over the country, from Cornwall to Newcastle. For those who can't get their DAT to pay for a place, please contact us and we will do all we can to help you attend.
Editor

Problematic assumption

Neil McKeganey's letter (*DDN*, 19 November, page 15) contains a significant error. He states that if only 8 per cent of addicts left treatment drug free, then this is equal to 92 per cent of clients leaving with 'an ongoing drug problem'.

Unless we consider all ongoing drug use to be necessarily problematic, which I suspect Professor McKeganey does, then this is an erroneous assumption.

Paul Jacob, substance misuse worker, Brighton and Hove.

No dignity in drugs

In the report of his call for changes, (*DDN*, 19 November, page 6) there is no indication that Martin Barnes mentioned recovery as a viable option. His justified call for users to have 'choice' and 'dignity', does not appear to acknowledge that those still dependent on drugs have relinquished such human rights, with the drug induced erosion of their free will to exercise either – a decay that is irreversible with ongoing use. Their ability to address their mental physical and spiritual problems, together with their fundamental material needs is unable to develop and mature with continued drug use.

Paul Hayes calls for helping people out of 'treatment', while avoiding the reality that those still using are unable to start on the journey of recovery, which includes exercising the choice of using or not. Failure to recognise or acknowledge that simple fact eliminates the desirable goal of helping users to acknowledge and accept that if they choose to use, they surrender their choice to recover, together with their dignity.

Professor David Clark got it right as usual, with his call to focus on the individual and their recovery. In doing so he pointed out that current protocols were preventing people leaving treatment drug free; that both commissioners and practitioners have yet to develop a clear understanding of how to help service users start on the road to recovery.

It is clear that the current practices, which are, in part, due to the NTA's insistence on politically motivated and convenient targets, combined with their seeming lack of insight into the complex nature of addiction, is denying users the 'choice' and 'dignity', which Martin Barnes rightly called for, inasmuch as any aspiration or hope that users have of becoming drug free is passively, if not actively, discouraged.

The latter view gains substance with the welcome appearance of Kathy Gyngell and Andy Horwood's excellent article in the same issue (page 8). Here they present the untainted facts and truth, together with the no-nonsense opinion of Paul Gilman. In doing so they highlight the superficiality of unsustainable and, in some cases, ludicrous claims of success, in respect of drug-related harms, based on the hopelessly inadequate and shallow 'Drugs Harm Index'.

Peter O'Loughlin,
The Eden Lodge Practice

Speak up about abstinence

I was taken by the different view of recovery of those presenting at the FDAP conference in early November (*DDN*, 19 November, page 6). I think David Clark summed it up when he said the word 'recovery', and noticed that it had not been used by any speaker before him.

It would be naive of me to think that all the woes suffered in the world could be cured by offering an abstinence programme for all alcoholic or addicted people and recovery from addictive behaviours as the daily goal for them all. However, the government, various agencies, and the general public seem to be at odds with cost-effective treatment outcomes, dis and mis-information about the effectiveness of treatment, and exactly what treatment means. We are caught in a blizzard of language that is at best confusing, and worst deeply unhelpful to the suffering population and the rest of the community as well.

The NTA talks about treatment for heroin addicts as methadone maintenance – or by 'hosing them down with methadone', to use Dr Mike McPhillips' analogy. Cost, the quality of life and the continued dependency issues seem to be swept under the increasingly lumpy carpet. Successful outcomes for government agencies seem to be drinking less units of alcohol a week (measured how?), and still seeing people's health deteriorate and lives never being fulfilled to the potential that abstinence could create.

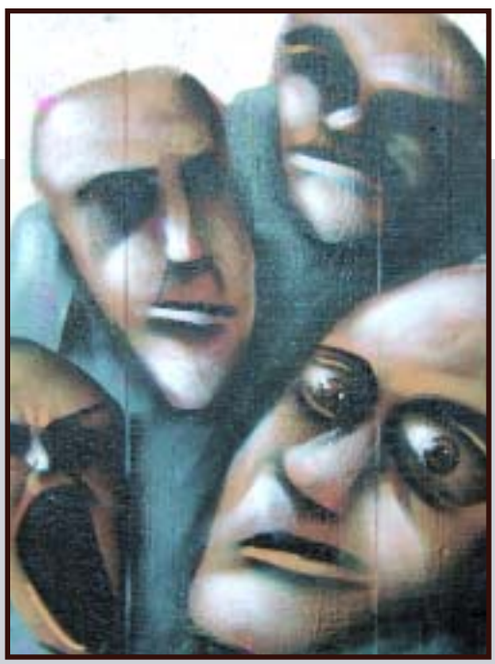
How much of the general population truly understands the nature of mind and mood altering substances and the effect they have on brain chemistry – and why would they in reality? If the information we now have about the changes that occur in the brain with continued use of cocaine, alcohol, cannabis, heroin, codeine, and all other prescribed and illegal class A, B, and C drugs was generally available and used in education, we might dispel the myth that people who end up addicted bring it on themselves.

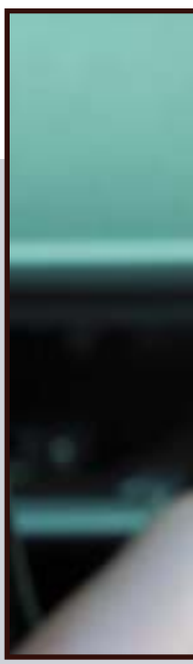
Abstinence is not easy. It is a real challenge for most. Relapse is likely without continued support of the change process; it is almost to be expected, but not judged. We, as practitioners, and those in recovery need to come forward and speak the truth loudly about the benefits of abstinence as the treatment of choice. Speak of the cost benefits for those *Daily Mail* readers, lowered hospital admissions, lower crime rate, and lower antisocial behaviour on our streets. It works, and is so much better than maintenance with another substance, which costs money and, often, lives.

Richard Renson,
learning and development specialist,
The Priory Group

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.





Face the facts

Are drug and alcohol services accessing and engaging black and minority ethnic users in treatment? LDAN News' editor **Roseanne Sweeney** looks at the evidence.

Findings have just been published of the most extensive research project yet into the needs of black and minority ethnic drug users. The Black and Minority Ethnic Drugs Needs Assessment Project trained 179 community groups to conduct needs assessments of their communities between 2001 and 2006, and the National Treatment Agency will publish briefings based on the findings over the next few months.

Research carried out by the London Drug and Alcohol Network (LDAN), a membership network for drug and alcohol agencies in London, however, suggests that drug services are finding it increasingly difficult to work with BME users. Practitioners working with minority ethnic communities have told LDAN that the current class A focused, target-driven system does not promote work which accesses and engages these very marginalised groups.

Problems identified by practitioners include:

- The emphasis on getting and retaining large numbers of Class A dependent users in treatment. Many BME users are hazardous rather than dependent users, and are misusing substances like khat and cannabis.
- Not enough priority is attached to drug education and outreach work. This work is essential as BME communities have a low awareness of health services and may be reluctant to seek help for religious or cultural reasons.
- Minority ethnic clients often approach services with related problems – for example around housing – which provides services with an opportunity to work with them. However services are not funded to do this work.
- Specialist services say that mainstream services are not yet accessible to minority groups. Though mainstream services may have workers from minority ethnic backgrounds, BME specialists say their working practices and culture are still very much geared towards the majority population.
- There are few resources attached to alcohol treatment, something that impacts on all BME communities.

This criticism of the way the treatment system impacts on minority ethnic users, builds on an already complex picture of BME drug and alcohol use and service provision.

For some time there has been agreement that minority ethnic groups are misusing substances and in need of help, but face considerable barriers to treatment. Models of Care for Drugs itself admitted as much when it stated there were 'institutional failings' in meeting black and minority ethnic drug users needs – 'especially true for residential rehabilitation facilities, but also of the whole treatment system' – while in 2002 an Alcohol Concern commission said BME alcohol users were not being catered for adequately either.

There was consensus about what the barriers to treatment were: opiate-focused services; Eurocentric treatment approaches including a focus on the individual; an inability on the part of staff to understand and respond to the needs of BME users; too few BME workers; language barriers; poor awareness among BME groups about services available; concerns around confidentiality; and anxiety among refugees and asylum-seekers about being reported to the authorities.

The chief remedies prescribed were better ethnic monitoring; more outreach work, community engagement and working with families; targeted literature; and the substantive implementation of equal opportunities policies. It was also recognised that more minority ethnic workers needed to be recruited in diverse areas like London. Mainstream services though, staffed with culturally competent workers, were to drive forward improvements on BME access.

But are things getting any better? Lennox Drayton, manager of New Roots, a specialist BME project run by Rugby House, believes mainstream services are not yet fully accessible to BME groups, and that it is becoming increasingly difficult to work with diverse communities. 'With a lot of our clients there is a lack of awareness around treatment and building up relationships with them takes time. There is also a stigma around drug and alcohol use, which needs to be addressed sensitively to build up confidence in the community. But that's not recognised by the current system which is all about numbers,' he says.

Harrinder Dhillon, service director at DASL agrees. He says generic services have to do tier one and two work consistently if they are to increase the numbers of minority ethnic users in treatment, but if services are already oversubscribed this is unlikely to be a priority for commissioners, especially as many BME users are hazardous rather than dependent users.

When he started working at DASL as an Asian development worker in the early nineties, it was easier to do targeted work with marginalised groups, he says. 'It took me six months to get into some groups. Do people have the time to do that now? I'm not sure in the current climate they do, there is so much emphasis on results.'

A recent NTA report however, suggests progress is being made in London. Based on National Drug Treatment Monitoring System data, it says many minority ethnic users in the capital are accessing and being retained in treatment. While Asian drug users are under represented, the report states the black population has been 'successfully engaged by

Pics by I-Sore

treatment providers'. In fact, it says that based on a comparison between the treatment population and overall population, black users are over represented in some London boroughs. Blacks and Asians are also more likely to be retained in treatment than other ethnic groups.

Trevor McCarthy, NTA best practice manager, says that while there is room for improvement, many mainstream services are effectively catering for BME communities. 'Many people are happy with mainstream services and just go and use them,' he says, adding that those using specialist services may be disproportionately critical of mainstream services because of a bad experience they have had in one. 'They may not have liked staff or how they were treated there,' he said.

Professor Jane Fountain from the University of Central Lancashire's Centre for Ethnicity and Health is in the process of writing up the results of the Black and Minority Ethnic Drugs Needs Assessment Project. The university has coordinated the project for the Department of Health over the last seven years.

Part of the reason why progress on service provision is difficult is because it is very complex area, she says. 'There are a lot of barriers to access other than the obvious ones like language. Black Africans often don't want to come out as a drug user in case they will be reported to the Home Office. The idea of services being confidential is completely alien to them. Some will have come from less than democratic countries and will have spent several years getting to the UK. The last thing they want is to be sent back. For South Asians on the other hand, the issue is often about gossip in the community and not wanting to let the family down.'

Fountain says it is difficult to accurately measure whether BME groups are adequately represented in treatment, but straightforward statistical comparisons between the treatment population and overall ethnic minority population in a given area, do not give the full picture. Many black users are in treatment because they are over-represented in the criminal justice system, due in part to discriminatory stop and search procedures, she says. Other communities like the Bangladeshis have a very young population so would have more people at risk of drug use than the older white population – another factor that should be taken into account.

Overall, she says the key to improving access is cultural competence. One of many complicated definitions defines this as, ensuring the 'knowledge, information and data about individuals and groups is integrated and transformed into clinical standards, skills, service approaches, techniques and marketing programmes to match the individuals culture and increase both quality and appropriateness of health and health outcomes'. So not easily achieved, especially when, as Fountain points out, diversity training is more often than not a 'one-off' exercise.

The London Drug and Alcohol Network has published a special edition publication looking at BME drug and alcohol use and service provision. The publication can be downloaded from www.ldan.org.uk or contact Jim Bishop on 020 7704 0004 for a copy.

Book review

Crack Cocaine: The open door

Every now and then you come across a book that challenges the way you think. Christopher Robin and Kenneth Jordan's book, 'Crack Cocaine: The open door' takes preconceptions around crack cocaine and gives them a good launder.

From their experiences of working with crack cocaine clients, they state that 'in reality crack cocaine is no more addictive than tobacco or alcohol' and consider how drug workers can give their clients the practical armoury they need to change their behaviour.

The techniques are well described and will be easy to pass on to the client: they describe in detail how to help them develop a self-questioning approach to understanding and resisting their cravings, and put them in control of their own behaviour.

I set out expecting to read this textbook a few chapters at a time, then devoured it at one sitting – not because the ideas aren't complex, but because it's immensely readable and it's written in an engaging conversational style.

Take the explanation of the term 'confluence'; this could be boring and convoluted. Instead we are given an image:

'Take a painting palette. Place two dollops of paint, one colour is red and the other is blue. On the palette the red and blue coloured paints are separate. Mix the two colours together. A new colour is created that has its own distinct nature. It has become one. That one is now purple. This is confluence. A great service has confluence, in which the service user, drugs professional, the team and the service environment operate well together.'

The authors achieve a direct style without patronising the reader. Where diagrams are useful they are used, such as in the explanation of The Jo-hari Window. There is also good use of dialogue to draw on examples with the authors' own clients, which works particularly well in demonstrating how well (or badly) workers' interventions might work.

At the start of the book the authors state their intention to dismantle myths surrounding crack cocaine – myths that stand in the way of treating this group the same as any other kind of drug user. The resulting text achieves more, in that it would serve any drug worker well as a stimulus to trying new ways of working and communicating better with their clients, whatever their substance misuse problem. **DDN**

Crack Cocaine: The Open Door, by Christopher Robin and Kenneth Jordan of Janus Solutions. Published by Janus Publications, 2007. 198 pages. Order at www.janussolutions.co.uk

A year in headlines

From preparing for a new drug strategy and battling with budgets, to getting problem drinking taken seriously, there was plenty to write about in 2007. **DDN** looks back over the year.

January

Weak commissioning, patchy prescribing, black holes in care planning and spasmodic service user involvement were highlighted by the Healthcare Commission and the NTA in their survey of substance misuse services across England. Up in Scotland the *Sunday Herald* declared 'the political addiction to tough talking has failed us all', warning against 'a bidding war of hard-edged rhetoric and simplistic solutions'.

Dire stories of America being ravaged by methamphetamine prompted Home Office minister Vernon Coaker to announce an upgrade to class A, and the 'severest penalties' for users and dealers.

Public health minister Caroline Flint kept budget speculation to a minimum, by announcing an overall increase in the pooled treatment budget at the start of the year. Funding would be more fairly distributed among areas this year, which meant there were winner and loser DATs. The NTA promised to work with areas with cuts to make sure their service delivery was not jeopardised.

February

Some good work on *Hidden Harm* was being hampered by lack of specific targets on child protection and welfare, an ACMD audit concluded.

The BMA warned that prison health care was sliding towards crisis. Four out of ten prisoners had used illegal drugs at least once in prison and staff had little chance of tackling dependency while struggling with scant resources and a burgeoning prison population.

Scotland's misery at having double the alcohol death rates compared to the UK as a whole was underlined by latest statistics, which showed older men most at risk.

Tier 4 capital funding was announced – a 1.1 per cent reduction on last year's budget – but was still hailed by Caroline Flint as 'a clear sign that that drug treatment remains a key priority for government'.

FDAP launched a programme of competence-assessed qualifications and resources – part of a drive to help DATs and services meet NTA/Home Office workforce development targets that gathered momentum throughout the year with the activities of the newly formed Competence Group (CoG).

March

A radical rethink of drugs policy was proposed by the RSA, following its Drugs Commission's two-year study. Labelling a policy that focused on criminal justice 'no longer fit for purpose', it called for strategy to centre on health and social support and to embrace harm prevention and reduction.

Current A, B and C divisions should scrapped so that drugs could be classified by the harm they do, according to an expert panel that published a league table of harmful drugs in the *Lancet*. Surprise, surprise – Alcohol and tobacco beat cannabis, LSD and ecstasy to the top of the table.

A revamp of Scottish drug education strategy was announced. Research had indicated that existing teaching was not necessarily having any impact on children's behaviour.

As anonymous pharmacies from all over the world continued to spam us, The International Narcotics Control Board drew attention to the fast-growing scourge of prescription drug abuse, which had surpassed heroin and cocaine in some parts of the world. The public 'are putting themselves at significant risk of ill effects, not least because of the increasing quantity of counterfeit products entering the market,' added DrugScope's Martin Barnes.

A Euro-poll reminded us that the UK are among worst binge drinkers, while British cannabis cultivation soared to record highs.

April

The UK Drug Policy Commission sprang into life to provide independent and objective analysis of drug policy. 'We don't know enough about which elements of policy work, why they work and where they work well,' said Dame Ruth Runciman, chair of the charity, which is funded for the next three years to fill the gap in evidence-based research.

A 10 per cent cut in young people's funding prompted warnings that local projects were being jeopardised – at the same time that the Department of Health announced prevention strategies and projects seemed to be working for many young people.

The British Crime Survey reported that overall crime in England and Wales had fallen – but among the statistics nestled the finding that drug offences were up 3 per cent.

May

A new Drugs and Health Alliance, with members from lobbying groups, academia and treatment services, added its voice to a growing call for drug strategy to be moved from the Home Office and 'shifted to an evidence-based public health approach'.

GPs called for collaboration within the treatment system to give patients 'all appropriate care options' at their annual 'drug users in primary care' conference. They wanted media, government and other practitioner colleagues to develop a code of conduct that responded to, instead of scapegoating, vulnerable people – a call underlined by the International Centre for Drugs Policy's criticism of 'patchy' medical training on substance misuse, published the same month.

Alcohol Concern published *A glass half empty* to take the government's Alcohol Harm Reduction Strategy to task, and compiled specific objectives to cut advertising, raise alcohol tax, and improve the quality of public health information and interventions through better professional training.

Homeless link offered research on integrated housing and care pathways for homeless drug users, and the NTA announced that real outcomes for clients in drug treatment in England would soon be measured by its new Treatment Outcome Profile (TOP).

June

Prompted by the increase in overdose deaths and the spread of bloodborne viruses, including hepatitis C, the government pledged nearly £2m towards drug harm reduction. A health promotion campaign, vaccination programme, training, and better data would all feature in the plan.

Turning Point launched an attack on existing BBV policy, highlighting that less than a quarter of drug users who contracted viruses were able to access treatment and services, and called for more public health initiatives.

An independent working group on drug consumption rooms concluded that DCRs offered 'a unique and promising way to work with the most problematic user, to reduce the risk of overdose, improve their health and lessen the costs to society' and recommended that pilots should be set up and evaluated in the UK.

Young people and 'hidden' drinkers – adult drinkers who were unaware of their dangerous drinking patterns – were targeted in *Safe, sensible and social*, the government's 'next-steps' strategy on alcohol harm reduction.

July

The global drug abuse epidemic was stabilising, according to the United Nations Office of Drugs and Crime. But the good news was offset by negative trends elsewhere – including an increase 'at alarming rate' of cocaine use in Western and Central Europe. The UK was in the top ten for all drug consumption. The Transform Drug Policy Foundation accused the UNODC of dressing up drug failures as success, highlighting that Afghan opium production was breaking new records.

With adult hospital admissions relating to alcohol doubling, Alcohol Concern criticised government for lack of targets in its alcohol harm reduction strategy. North of the border, the British Medical Association Scotland unveiled a five-point plan to tackle Scotland's escalating drink problem: new statistics showed alcohol was claiming the lives of six Scots a day.

Failure to treat prisoners with dual diagnosis – substance misuse as well as mental health problems – was highlighted by the Sainsbury Centre for Mental Health, which called for specialist training, policy guidelines and national standards. Inreach teams were under-resourced, overwhelmed by referrals and limited in the range of interventions they could offer, the report pointed out.

The government launched its drug strategy consultation, hoping to engage everyone 'from professionals through to those with everyday experience' in replacing the existing drug strategy that will end in March 2008. Home Secretary Jacqui Smith said the next strategy would focus on educating the young and protecting the vulnerable.

New NICE guidelines recommended combining social and psychological techniques to motivate substance misusers towards a drug-free lifestyle. The idea of contingency management programmes, such as using shopping vouchers as an incentive for negative drug tests, were seized on by media.

August

The NTA announced results of its user satisfaction survey. From nearly 9,000 returned questionnaires, service users were generally satisfied with their treatment and credited it with making a difference in their lives. Care plans, key workers, comprehensive assessments, and being treated with respect all made a huge difference to their treatment experience.

The Health Statistics Quarterly showed the busman's holiday to be thriving in the bars of Britain: bar staff and publicans were among occupations with the highest proportion of alcohol-related deaths among men.

September

Grim statistics from Scotland's General Register Office showed drug-related deaths up by a quarter.

English statistics showed a fall in drug use among secondary pupils and also revealed that more than half of pupils had tried alcohol, mostly given by family or friends. The figure rose to 82 per cent among 15-year-olds.

Workplace drug and alcohol testing was on the rise, said the Chartered Institute for Professional Development – mostly in cases of poor performance or inappropriate behaviour.

DrugScope's annual *Street Drugs Survey* identified a two-tier cocaine market, with dealers selling 'luxury' cocaine to affluent customers for £50 a gram and a heavily cut 'economy' version to students and pub customers for £30 a gram. The two-tier system was also applied to ecstasy, with cheap amphetamine-based pills containing little or no MDMA.

October

The NTA published latest figures showing more drug users in treatment – then had to dodge fire from Radio 4, whose *Today* programme accused Paul Hayes of perpetuating a drug treatment programme that was not working. The NTA later countered the attack, accusing the BBC of misinterpreting figures and not checking facts. The exclusive emphasis on completions without considering all stages of treatment was unfair and misleading, said the NTA. Our letters page is still reflecting impassioned debate from all sides.

The middle classes came under the gaze of the North West Public Health Observatory, who found them top of a league table of hazardous drinking, with intake of more than 50 units a week. While most health campaigning was aimed at binge-drinkers, one in five adults was routinely drinking enough to put their health at significant risk, said Prof Mark Bellis.

Meanwhile, in the *DDN* office the Royal Mail threw a spanner in our works and we had to cancel an issue for the first time, because of the postal strike.

November

A review showing that prisoners with mental health issues, including those with substance misuse problems, were being failed by prison services coincided with our 'prison special' that examined many aspects of treatment in the criminal justice system.

A study from the Joseph Rowntree Foundation added research to the theory that cannabis use can exacerbate social problems in vulnerable young people, and added to the media coverage on the dangers of 'skunk'.

December

Detailed responses have flooded in to the government's drug strategy consultation, triggering debate from many stakeholders. *DDN*'s letters page shows that while the old arguments about treatment rage on, the voices calling for a public health led approach grow louder. Meanwhile *DDN* strengthens its resolve to remain an independent vehicle for debate throughout the coming year. Happy Christmas! **DDN**

Inventing the wheel

In common with many loving parents, seeing her youngest son in the throes of alcohol addiction drove **Sue H** to despair and the point of illness. Constructing her own 'Recovery Wheel' gave her a way of coping, as well as highlighting the professional support that would have made a difference earlier on.

It's a November evening and I am sitting in the Bristol Hippodrome watching *Cats*, a wonderful production, people all around me with looks of sheer enjoyment on their faces. So why is it I feel so sad? So very sad that I feel tears starting to roll down my face.

It's just one of the many confusing feelings going on for me right now. Next week my youngest son enters treatment for his addiction to alcohol. Why am I sad? Because of 12 years of living with addiction in the family. It's something that as a parent I never thought would happen to us – particularly with alcohol, a legal substance, that lots of people have a great time with.

My youngest son's drinking has taken our family down a road of darkness I would never have dreamed about. Sadness is only one part of it. Guilt and shame, anger, frustration, hate, loss, fear, isolation, confusion, despair, and the big one – powerlessness – all take their part on a daily basis. For a long time I did not cope. I went into a deep depression, a black hole that I could see no way out of. Looking back now it feels scary that I was so close to ending my life because I just could not stop my son from drinking. I had reached the point of giving up because I could not find the help I needed.

But something happened that put me on the road to where I am now. It feels good to be alive now – I have a serenity in me that I thought did not even exist. I was asked to speak at the SGDAS (South Gloucestershire Drug and Alcohol Services) three-day Family Forum as a family member. I had to speak for about 15 minutes on what I needed, and perhaps what I did not get.

How could I illustrate 12 years and the pieces of the puzzle that had got me to where I was now? This was how my Recovery Wheel began. Armed with board and coloured pens, I stepped back in time 12 years and began my journey once more. The feeling of desperation for help felt as real as it did then. One particular memory of a visit to the GP sprang to mind. I was in absolute surrender for help and it brought me nothing. When I left that day if I had thought of it, I would have laid down in the main road outside of the surgery. I had hit my rock bottom and I hope that no family member now would ever need to feel like that. I changed my GP.

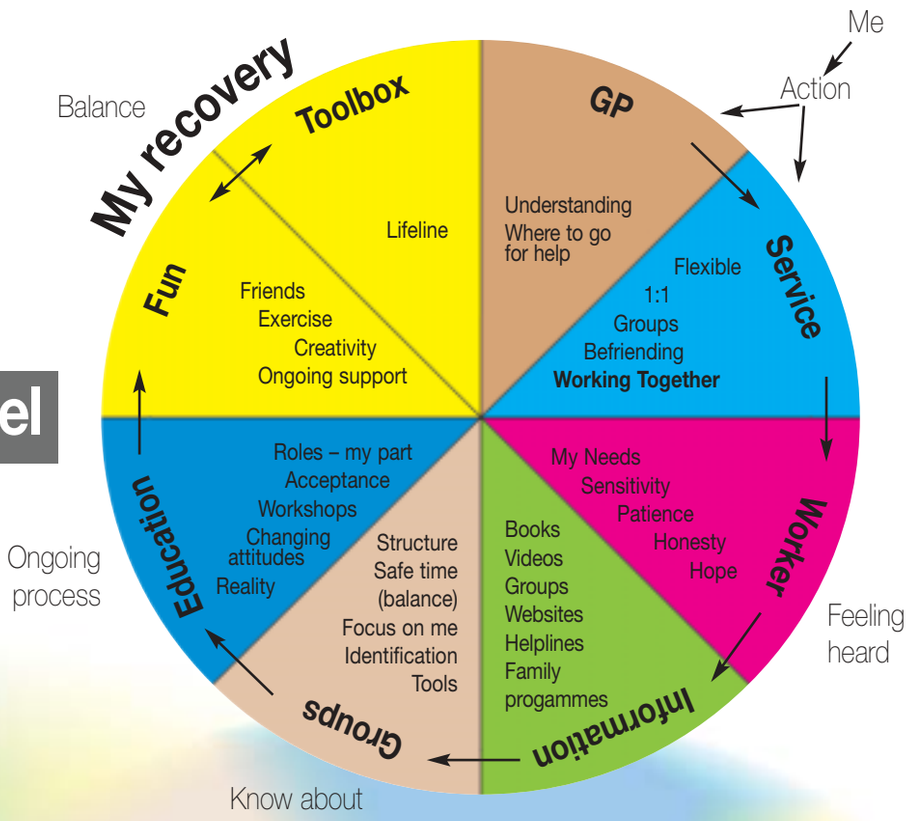
So what do I need?
This is the beginning of My Wheel…

I need an understanding GP. If you are a GP, please listen, acknowledge my pain, and have access to at least one service or a 12-step fellowship that you could direct me to for help. Take responsibility for trying to keep in touch with new services for family members – in the long run it could make your job much easier!

I need a service that will fit me. If you have a service, please let me know it is there. This is the place where I am ready to take action. Many family members find this the hardest thing to do. I am ready – be there for me, help me find the right support. Be flexible, don't just expect me to fit the service. We are all unique and have different needs. Opportunities for one-to-one, group work and a 'buddy' system will encourage me to share my experience with other family members and help me to help myself. If your service does not have what I need, then direct me to one that does. Give me options and choices, and be a service that does that willingly.

I need a support worker that has sensitivity and patience. I may know what I need to do, but it can take a long process to get the courage to do it. I need ongoing support to enable me to make small changes – fear can keep me doing the same things over and over; I used to fear that if I stepped back or detached, my son could get worse or even die. Help me to focus on my own needs and stop me spending the whole time talking about the 'other person'. Getting me to focus on myself for maybe an hour a week is a huge start. I need to build a very special rapport with you, so I can be totally honest with my feelings; the slightest hint of feeling judged and you might not see me again. You may experience my incredible anger or unpleasantness – my life is in chaos and I am full of emotional distress. Please not only listen, but hear what I am saying! I also need honesty from my worker, it's no good giving me false promises. I need to be facing reality not hiding from it. But at the same time, help me have hope. Take me to an open Alcoholics Anonymous or Narcotics Anonymous meeting to help me see that people do and can get better.

Recovery wheel



I need as much information as possible. I need to know where to find local groups for family members like Families Anonymous and Al Anon, good literature like books on co-dependency, informative websites, and any national organisations with publications. Twenty-four hour helplines can help in the middle of the night when the fear is too much to bear. Help me to build a library of information for when I need it.

I need education on family roles. I need to know about enabling, controlling, changing my attitudes, listening, communication, acceptance. How do you learn to accept that someone you love so much is slowly destroying themselves and you are unable to stop them? Acceptance of reality is so hard; I need to learn how to put the focus back on me, and how to say 'no' and set boundaries.

I need groups to empower me. I want to feel safe in my group and know that anything I say there stays there. Attending a group can be scary for all sorts of reasons. When you get me at your group, try and ensure that I stay. If I am too dominant, shut me up. If I am quiet, please see me; don't assume I am OK. And please give me 'tools' to help me cope with my situation – don't let me leave feeling more depressed than when I arrived.

I need to have some fun again. Fun got lost very early on. How am I going to get any of that back in my life? It's not easy to begin with, so help me to do that. I need pushing, I need to see the value of having fun.

I need tools to help me along. Over 12 years I have built my own toolbox. It's a silver bag with a label that says 'thanks for being there', sent from another family member who shared a similar experience. In the bag I have a range of objects – a bottle of HP sauce, which reminds me I need a Higher Power to 'help me along', as well as headphones, spinning top, an acceptance card, candle, earplugs, battery, rubber, and a small ladder – all of which have their own significant meaning to me. Help family members to build their own toolbox and they will be able to help themselves. Living with someone who has an addiction is like being on a rollercoaster – at its highest and then its lowest within seconds. The rollercoaster can be just as big for family members: So many professionals think we do not need support when someone goes into treatment, but it is often needed more, so that family members can continue to change alongside the person in treatment.

This brings me back to the beginning of the wheel, and it's an ongoing process. My journey into the past comes to an end, I am back in the moment. I shall enjoy the rest of *Cats* – I know I can, because I have the 'tools'. I know that in reality I shall have many moments of sadness, and that's life. But I also have my Recovery Wheel, and it is achievable.

Let's help family members to help themselves, and by doing so give them a healthy way to help the one they love.

'My youngest son's drinking has taken our family down a road of darkness I would never have dreamed about. Sadness is only one part of it. Guilt and shame, anger, frustration, hate, loss, fear, isolation, confusion, despair, and the big one – powerlessness – all take their part on a daily basis.'

Fact file

Service User Groups

This issue: Richard Pike from

Portsmouth Users Self Help (PUSH)

When and why did you start your group?
The group was started in February 2006. Danny Sullivan the service user coordinator outlined to a small group of us what service user involvement was all about. We needed to be involved in the planning, policies and provision of all our services and the group started meeting regularly from there.

How many members do you have?
We have a committee of eight people and an average meeting attendance of about 15. We have had as many as 40 people that have been involved over the 19 months that we have been running.

How did you obtain funding?
Our funding at present comes from our Drug Action Team (DAT), which has been supportive in all our work. We also have some funding from young people services.

Where and how regularly do you hold meetings?
Our weekly forum takes place every Tuesday, 2.00pm until 4.00pm, in our office at 22-24 Kingston Road. This is in Central Point, a Homeless Project in Portsmouth.

What do you hope members get from attending?
We hope our members feel that their views are heard and respected. We have a very supportive environment that has been evolving from our time together. Our members can also access training to develop themselves. We cover all travelling and childcare expenses to attend.

How do you keep it going?
By fostering an attitude of care and support, and finding a place for all to be involved.

What have been your highlights so far?
Our involvement at every level of planning, policy and provision. Members are on joint commissioning groups, clinical governance, Drug Intervention Project, tenders, interview panels, drug action groups and monthly meeting with the managers from providers in our city.

'Keep a check on your ego and don't ever sell the service users short... be the change you want to see.'

We have the treatment-specific advocacy contract for our city, and hold four weekly satellite clinics in our services. We've done more than 30 cases this year, with 20 trained advocates.

In January we launch a buddy scheme that will support people's journey from their Tier 3 prescribing service into residential rehab, and then introduce them back into the services so they have maximum support.

We've also been part of a team offering drugs education in schools. The team held a one-day event for pupils from eight schools, to hear what young people want from drugs education. This is ongoing within schools in the Portsmouth area.

How do you communicate with your members?
We communicate with members by telephone, by letter or we will arrange a visit. Our members are very good at attending because of the environment we create. If they miss a week, there are minutes of the last meeting.

Have you any tips for others starting a group?
Have all members be equal and treat them with dignity and respect. Value their time and avoid tokenism. Be independent of your services and remember: 'I can't, but we can'. Keep a check on your ego and don't ever sell the service users short. To sum up, be the change you want to see.

Post-its from Practice

One size does not fit all

Staying with patients on their journey is essential, says Dr Chris Ford.

Gabby came to see me glowing, with a huge smile on her face. She came to tell me that she had been accepted on a course to begin her counselling training, which was the first step to achieving her dream of becoming a drugs counsellor.

It was almost impossible to think that she was the same woman who had rung me from the local hospital not five years before, asking if she could register and get an injectable methadone script. Gabby had then told me that she was in hospital with bacterial endocarditis (infection of the heart valve). She had been getting her script from a private prescriber until then, but could now no longer afford it. For a few seconds I was indignant – what am I? A free drug dealer? But then I thought yes, in a way that is one of my roles – I had the power to provide clean safe free drugs, as well as providing her with healthcare.

So I agreed, and since then we have been on a journey together. It has had many ups and downs. Many times during the first months she missed appointments, overused her prescription and on one occasion ended back in hospital after a fight. But we stuck with her and slowly she settled, managing to remain on methadone maintenance for three years. During that time she got her own flat, remade contact with her family and began having regular counselling with an excellent local agency, also joining their women's group.

Then one day she came to see me and said 'I'm now ready to stop'. She chose to self-detox at home with a lot of support from friends, a little help from prescribing and the odd visit for an injection to help with her vomiting. Gabby succeeded and then chose to attend a skill-based day programme.

Since that time she has had a number of extremely difficult events to deal with, including her brother being killed in the Iraq war and her long-term partner dying of fulminating pneumonia. But she has stayed on her individual journey of recovery. Since stopping drugs she has remained a patient and overcome breast cancer, a mastectomy and breast reconstruction, but she has remained committed to her drug-free life.

It is a real privilege to support people and work with other providers wherever patients are on their journey, and to be able to provide flexible responsive care that is appropriate for each individual over time. People need different treatment at different points in their drug-using career, and one size definitely doesn't fit all.

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

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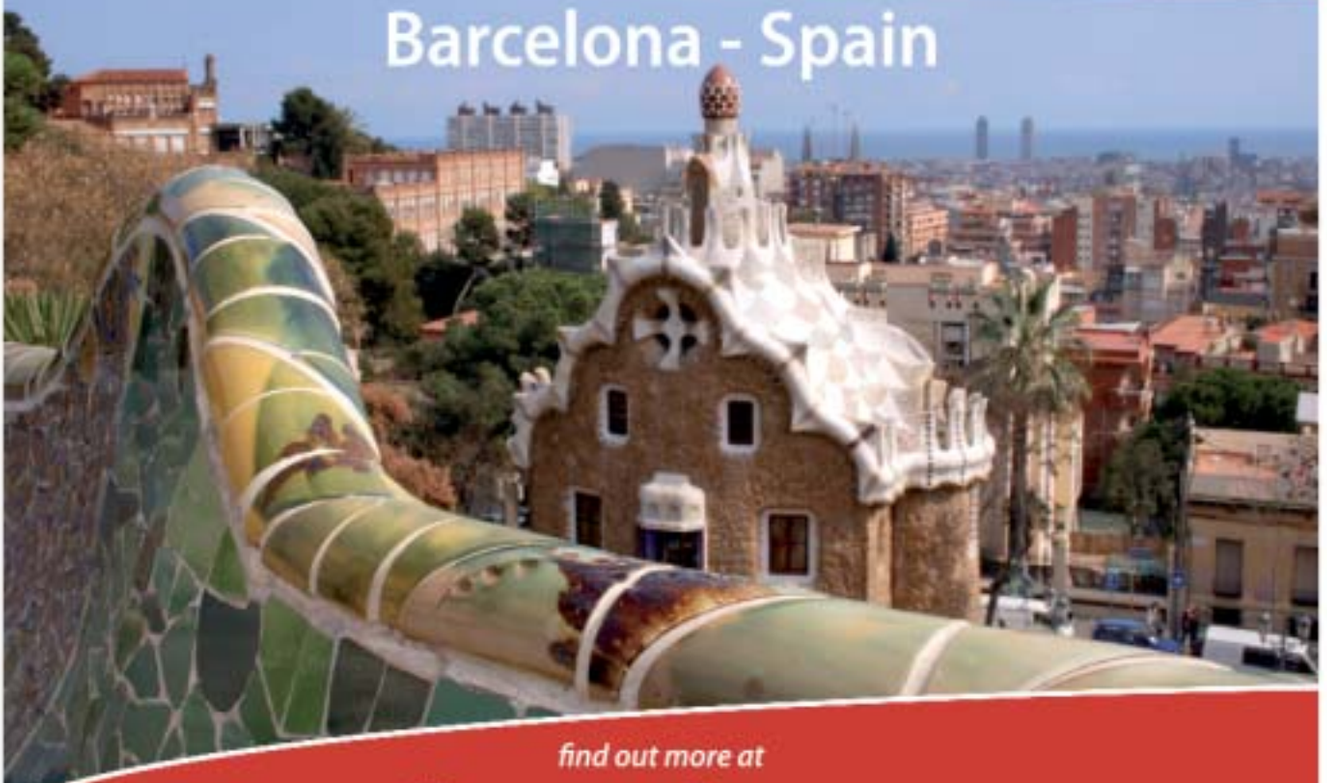

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or email franepotter@hotmail.com

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NHS

National Treatment Agency
for Substance Misuse

Promoting service user involvement

We are pleased to support the Nothing about us without us! user conference

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Women and addiction

"A conference on the policies, the issues, justice and the family."

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Speakers include:

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- Dr Chris Ford
- Anna Millington
- Annie Darby
- Tony Birt
- Mirelle Martin
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Workshops include:

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- Exploitation and violation
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- A way out, rebuilding your life

Cost £125 +vat per delegate
£50 + vat for service users supported by their local Drug Action Team
Limited places so book early. Call 01902 444261 for booking details

Wolverhampton Service User Involvement Team

Wolverhampton City NHS Primary Care Trust

Wolverhampton YMCA

Middlesbrough NHS Primary Care Trust

Safer Middlesbrough

Middlesbrough Primary Care Trust
(on behalf of the Safer Middlesbrough Partnership)

TENDER FOR THE PROVISION OF SERVICES WITHIN A LOCAL DRUG TREATMENT MODEL

Middlesbrough PCT (on behalf of the Safer Middlesbrough Partnership) is inviting expressions of interest from suitably experienced organisations for the provision of one or more of the services below.

Harm minimisation Services
A community focused, harm reduction service, including the following key elements of service

- The provision of sterile equipment and the safe disposal of used equipment via a central needle exchange
- The coordination of a pharmacy needle exchange service
- Harm minimisation and health promotional advice, signposting, and ongoing support for providers and users of services.
- Open access information, advice and support services to drug users, concerned others and professionals.
- Outreach facilities which encourage engagement with local communities
- Services appropriate for all problematic drug users, including stimulant users
- The provision of both tier 2 and tier 3 interventions where appropriate

Care Coordination Services
A team focused on improving the care coordination of clients in local services, building on lessons learnt from the Drugs intervention program and care coordination in other areas of work. The key elements of service to be offered will include :

- Care coordination of complex clients who cannot be care coordinated elsewhere
- Initial screening assessment
- Joint comprehensive assessment of complex clients
- Development of care pathways between services
- Initial TOPS questionnaire of all complex clients
- All current clients in service reviewed over 12 month period, assessed for care coordination and assigned appropriate level of support.
- Carry out all relevant processes related to DIP.
- Testing of DRR clients

Assertive Outreach Services
Many clients are at risk of dropping out of treatment or the criminal justice system because of various social, psychological or criminal reasons. The Assertive outreach Team will be expected to work with these clients and include the following key elements of service:

- Developing processes to improve retention of clients in services
- Processes to Identify and engage with treatment naïve clients
- Interventions that can be targeted at hard to reach groups

It is anticipated that each contract will commence on or shortly after 1st April 2008 and will run on a rolling annual contract up to a maximum of 4 years. The contract will be awarded on the basis of the most economically advantageous tender in terms of price and quality.

Expressions of interest in tendering for these contracts should be submitted in writing by Friday 14th December at 12 noon and should be sent to: David Jackson, Joint commissioning Manager, Safer Middlesbrough Partnership, 2 River Court, Brighouse road, Middlesbrough,TS2 1RT Email; d_jackson@middlesbrough.gov.uk

Kent and Medway NHS
NHS and Social Care Partnership Trust

KENT & MEDWAY ALCOHOL SERVICE
ST MARTIN'S HOSPITAL, CANTERBURY

Senior Community Alcohol Worker

Band 6: £23,458 - £31,779 p.a.
Fixed term contract for one year **Ref: R411**

We are looking for an experienced and enthusiastic individual to join our multi-disciplinary and multi-theoretical team in order to extend our excellent services to the populations of Maidstone and Medway. The project is funded for one year and there are good prospects that the service will be extended in both duration and geographical coverage at the end of this period.

Ideally, you will have experience in the addictions field, a core professional qualification and to be able to show evidence of a commitment to working with this client group. Diploma level qualification in Addictions studies is essential.

Managing your own caseload of clients, you will be based initially at the Headquarters of Mount Zeehan in Canterbury but will be based eventually in West Kent/Medway. You will need to demonstrate an ability to balance autonomous working with effective teamwork.

Tier 2 Alcohol Workers

Band 5: £19,683 - £25,424 p.a.
Fixed term contract for three years **Ref: R412**

This is a chance for enthusiastic individuals to join our multi-disciplinary and multi-theoretical team in providing a new service to the people of east Kent. We are aiming particularly to help those who will benefit from briefer and less intensive forms of intervention, as well as those who can be assisted in accessing Tier 3 intervention where this is needed.

Ideally, you will have experience in the addictions field, a core professional qualification and to be able to show evidence of a commitment to working with this client group. Diploma level qualification in Addictions studies would be an advantage.

You will be based initially at the Headquarters of Mount Zeehan in Canterbury but will be based eventually in one of six localities within east Kent. You will need to demonstrate an ability to balance autonomous working with effective teamwork.

For an informal chat or visit please call Bill Reading, Service Manager on 01227 761310.

Please note that if you are successful in obtaining an interview you will be notified via email.

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MINDFUL EMPLOYER

Working Towards Equal Opportunities

BAVO is the County Voluntary Council for Bridgend County,
in partnership with Bridgend Substance Misuse Action Team,
we are looking for a:

Substance Misuse Development Officer
(Children and Young People)
37 hours – NJC scale pt 27-30 (£22,122 – £24,545)

2 year fixed term (subject to ongoing funding)

The successful candidate will lead on the local implementation of the Welsh Assembly Government's Substance Misuse Framework for Children and Young People. He/she will have experience of working in the specialist area of substance misuse and will work in partnership with key agencies to develop and promote age-appropriate and child-focused models of intervention. They will also be working with Development Officers across South Wales to explore opportunities for cross-authority working and will be involved in service commissioning locally. The post-holder will also have excellent interpersonal skills and in-depth knowledge of partnership working.

For a full application pack, contact BAVO on 01656 810400, go to our website www.bavo.org.uk or email bavo@bavo.org.uk.

Closing date for applications: December 19th 2007, 12 noon

Ceredigion Cyswllt Contact

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- Driving license

Desirable:
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- Fluent in the Welsh language

For an informal discussion please telephone
Nicky Webb/Marty Spittle on 01970 626470.

For an application pack please contact 01970 626470 or enquiries@recovery.org.uk, write to Contact Ceredigion, 49 North Parade, Aberystwyth, SY23 2JN or download the application pack from recovery.org.uk.

The closing date for applications is Monday 24/12/07.

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INNOVATIONS IN DRUG SERVICES

SMART is a well established Thames Valley substance misuse organisation that directly engages problem drug users through their contact with the criminal justice system.

D.I.P. Worker (Reading)
£ 21,438 – 24,609 (Contract type: 6 months)
You will provide a range of tier 1 and 2 interventions and support to clients in accessing services. Closing date 7 December 2007.

D.I.P. Worker (Oxford)
£ 21,438 – 24,609 (Contract type: 12 months)
You will provide a range of tier 1 and 2 interventions and support to clients in accessing services. Closing date 19 December 2007.

Aftercare Case Manager (Oxford)
£ 21,438 – 24,609
Experienced in delivering recognised relapse prevention interventions and familiar with the Community Reinforcement Approach, you will support clients and liaise with partner agencies. Closing date 19 December 2007.

Senior Practitioner (Reading)
£25,602 - £ 27,696
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For an application pack please contact
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Sandwell Partnership
MAKING CHANGE HAPPEN
Safer Sandwell Partnership

NHS

Invitation to Express an Interest

SANDWELL DRUG & ALCOHOL ACTION TEAM

Sandwell DAAT is seeking Expressions of Interest from suitably experienced and qualified providers as part of a tendering process for Tier 2 Adult Open Access Drug Treatment Services. The services will be delivered from July 2008 for a period of 2 years with an option to extend for a further year.

The successful applicant will be required to work as part of a clearly defined treatment system with other providers in the Borough across the commissioned tiers of provision. Organisations with a track record of innovative and dynamic provision of services and a demonstrated capacity to respond to change and success in engaging users from diverse backgrounds are sought. Sandwell is estimated to have 2,400 Problematic Drug Users (PDU) and identified patterns of need show both increasing trends of stimulant use and a significant proportion of treatment naïve opiate users.

Expressions of Interest should be made using the 'BravoSolution' Electronic Sourcing system via **www.lifesource.bravosolution.com** and must be received by **21st December 2007**.

Should you have any queries please contact Debi Tingle on 0121 687 1419.

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11 February 2008 – central London

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