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Drink and Drugs News
7 May 2007
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Drink and Drugs News

7 May 2007

Editor's letter

The newly formed Drugs and Health Alliance are not the only ones to be calling for a complete rethink on drug strategy. This week they called for policy to be removed from the Home Office and planted where a public health focus could take root (page 4). It's easy to be blinded by new documents and deafened by calls for this and that at the moment, but it's crucial that we feed into new drug strategy as actively and constructively as we can.

The new alliance has drawn together diverse partners, some who temporarily abandoned their traditional lobbying posts to be at the launch. They wanted to make the point that, political differences aside, they share the goal of robust debate on any new drug strategy. There was plenty of dissent from the 2005 Drugs Act when it appeared, coupled with accusations that the field had not been properly consulted. With plenty of warning that the ten-year drug strategy expires next year, it seems entirely logical to try to influence policymakers with the weight of experience. We've seen the aftermath of enforced change on our letters page, since the magazine began. Please take the chance to contribute ideas, or respond to some of the articles we'll be running over forthcoming issues, examining ideas for new strategy. Active debate will surely be healthy for the quality of our services.

With changes to ring-fenced drug funding threatened, active service user involvement will be more important than ever. Talking to the National User Network, better known as NUN, revealed that they are shaping up to a force to be reckoned with (page 8). Catching up with Kevan Martin of the alcohol service users' network NERAF (page 9), gave useful tips on how to use a 'softly softly' approach to get impressive results in representing service users – and it's extremely encouraging to see how far Kevan's efforts have taken him over the past year.

Editor:
Claire Brown
t: 020 7463 2164
e: claire@cjwellings.com

Editorial assistant:
Ruth Raymond
t: 020 7463 2085
e: ruth@cjwellings.com

Advertising Manager:
Ian Ralph
t: 020 7463 2081
e: ian@cjwellings.com

Designer:
Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

Website:
www.drinkanddrugs.net
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In this issue

GPs call for collaboration, not competition

The Royal College of General Practitioners has put collaboration at the heart of its consensus statement, drafted with delegates at its recent conference on managing drug users in primary care. The full statement reads:

'Person-centred care is the main value underpinning all that we do in Primary Care.

'We believe that all individuals should be able to have access to appropriate and effective primary care based drug treatment and healthcare within a collaborative whole treatment system.

'All appropriate care options should be available wherever people are in the system and to all; on an unprejudiced basis, respecting diversity of human identity and experience. This can only be achieved in collaboration, and not in competition, with the whole community and its diverse elements including social, criminal justice and health.

'Prisons and secure environments are part of our communities and equivalence of opportunity (matched by resources and policy) must be available to allow unprejudiced access to healthcare and drug treatment.

'We respect the impact that monitoring and "standardisation" has had on improving quality, however this should not become an end in itself. Practitioners need support and medico-legal backing to use their experience, judgement and clinical scope to work flexibly with individuals. Additionally, pressures for quantity of intervention and expedient outcome measures must not lead to a dilution of quality.

'We call in particular on the media, and other sectors including government, GP and other practitioner colleagues, to develop a responsible and mature code of conduct in relation to the reporting, discussing and addressing of drug issues: to help promote a greater societal responsibility which acknowledges and respond to, rather than scapegoats, the vulnerability, disadvantaged status and genuine harm experienced by many members of our communities.

'We call on the Government to hear the voice of primary care, as a significant and progressive treatment community, in relation to the development of drug policy.'

More from the RCGP conference will appear in *DDN* next issue.

Drugs policy must embrace public health says new alliance

A newly formed Drugs and Health Alliance is calling for public health to be put at the heart of UK drugs policy.

Launching this week in London, representatives from lobbying groups, academia and treatment services spoke about the need for the criminal justice approach to be overturned. The group called for drug strategy to be taken from the Home Office and 'shifted to an evidence-based public health approach'.

'This is a momentous moment – a watershed for drugs policy,' said Danny Kushlick of the Transform Drugs Policy Foundation, spokesperson for the group. DHA's active recruitment has so far attracted The Alliance, the Beckley Foundation, the International Harm Reduction Association (IHRA), the Kaleidoscope Project, Release, the Socialist Health Alliance, Plymouth Public Health Development Unit and the UK Harm Reduction Alliance (UKHRA).

With 'no strong evidence base for continuing a criminal justice based strategy', there was need to underpin new strategy with evidence and consider how the £13bn annual costs of drug crime could be channelled towards health and wellbeing.

'The 2005 Drugs Act was not supported by the drugs field,' said Mr Kushlick. 'The Drugs and Health Alliance is the manifestation of concerns about where strategy might go, particularly because of the lack of public consultation.'

Gerry Stimson said his organisation, IHRA, was pleased to be part of the alliance, as 'we have to speak up for what we believe in'.

According to Prof Stimson, the public health approach to harm reduction was relatively simple, being 'facilitative, non-coercive and non-punitive'. The Labour government had downplayed public health while they got 'tough on crime' he said, but talk of 'war on drugs' was 'hurtful and harmful' in a number of ways:

'We're talking to a bunch of people who are already down. It's a policy trap and difficult for politicians to break away from, as they're then seen as weak on crime,' he said. It was a fundamental error to move drugs to the Home Office, away from public health, he added: 'It's clearly time to get back to what works for drugs policy and the wider community.

Researcher Neil Hunt acknowledged that the government had 'done a lot that's right' to improve drug treatment, but wanted drug strategy to be better at guaranteeing treatment for all who needed it. 'General, good, basic healthcare', from family planning to dental care, could make a big impact, he pointed out, alongside addressing patchy hepatitis C treatment, that was 'largely inaccessible in many areas of the country'.

'Research around good day programmes doesn't exist,' he said. Similarly there was lack of evidence on targeted prevention for young people.

'I'm seeing innovative, creative people having their funding taken away, but there's no spending to investigate which of these programmes work,' said Mr Hunt. 'We don't invest in the many things that work, and this needs to change in the drugs strategy.'

Martin Blakeborough, director of the Kaleidoscope Project and a member of the Advisory Council on the Misuse of Drugs (ACMD), said the DHA's agenda involved health in its widest sense, from housing to wellbeing.

'We should not be criminalising and stigmatising people,' he said. 'We need to look at why people want to get into that state in the first place.'

'I hope other services sign up to this alliance,' he added. 'Surely it's not that controversial to say that health is the most important thing.'

DHA's website is www.drugshealthalliance.net

Overdose prevention through better communication and 'duty of care'

Improved communication between drug users and service providers could prevent many deaths from overdoses, a recent study by the National Treatment Agency has concluded. The study examined 151 cases of fatal drug overdoses that occurred in 2003. In 97 of these cases, one or more witnesses were present, and the study noted that in nearly one-quarter of these cases, different or faster action by witnesses could have prevented a death.

The study suggested that a lack of communication between drug users, and the lack of the concept of 'duty of care' were responsible. Many drug users did not check on each other regularly, and even if they did, few were aware of which vital signs they needed to be checking.

The study suggested services for drug users should start to discuss more openly the issues of altered tolerance, sharing scores and assisted injecting, and educate drug users on how to check vital signs of others and what action must be taken once signs of trouble arise. Campaigns that encouraged a sense of a 'duty of care' for one another should also be considered.

A psychological autopsy study of non-deliberate fatal opiate-related overdose, available at the NTA website, www.nta.nhs.uk

Tough approach for underage drinking

An aggressive approach is needed to tackle Britain's growing number of underage drinkers, according to national charity Alcohol Concern. In a new report, *A glass half empty*, the charity reviews the government's current alcohol harm reduction strategy and finds it wanting – particularly for its lack of impact on young people.

The charity notes that the amount of alcohol consumed by girls aged 11- 13-years-old increased by 82.6 per cent between 2000 and 2006, while for boys the figure was 43.4 per cent.

'Binge drinking by children can have serious consequences for brain function, significantly raises the risk of alcohol dependency in later life and diminishes their life chances. Our report shows that we are simply not doing enough to protect our children from alcohol,' says chief executive, Srabani Sen.

Among other measures, the charity has called for it to be made illegal for anyone to provide alcohol to those under the age of 15 – including parents who may give their children glasses of wine at meal times. Setting this limit would send a strong message to parents about the risks of letting young people consume alcohol, the charity argues.

Education could play a significant role in forming young people's attitudes if alcohol education were made part of the national curriculum. The involvement of schools would be particularly relevant, given that alcohol use had been shown to have an impact on academic performance. Around 14 per cent of students excluded from school were suspended for drinking alcohol at school, according to the report.

Alcohol advertisements on television before 9pm should also be banned, says AC, as well as alcohol advertisements before films with ratings of less than age 18, and there should be stricter enforcement of the laws around underage purchase. The report calls for more local resources from police and trading standards, to be devoted to identifying and prosecuting outlets that break this law.

'A glass half empty: Alcohol Concern's review of the impact of the alcohol harm reduction strategy' can be ordered from Alcohol Concern's website, www.alcoholconcern.org.uk

Medical training 'patchy' on substance misuse

Substance misuse is one of the UK's worst health problems, which GPs will encounter on a daily basis, yet training for medical students in this area is 'patchy' and 'uncoordinated', a new report has revealed. Thirty-two medical schools were recently surveyed by the International Centre for Drugs Policy, and the results showed substance misuse was widely viewed as a specialism – meaning very little time was dedicated to training students on this.

And yet, according to statistics, a GP will see more than 350 heavy drinkers each year among their patients, and one in 12 of their adults patients will have used illicit drugs at some time in the past year. Hospital doctors will see the effects of alcohol misuse in almost every department – alcohol is responsible for up to 25 per cent of all hospital admissions. In the accident and emergency department, at peak times, alcohol is responsible for up to 70 per cent of admissions.

The report goes on to state that various studies have revealed that doctors often miss evidence of substance misuse in their patients, because they either 'lack the skills to detect and assess this rapidly or lack knowledge about how to intervene or refer for specialist help'. Stigmatising of people with a substance misuse problem is also common.

The ICDP has also published a complementary report suggesting that substance misuse topics should be incorporated in the medical schools curriculum. These range from treatment regimes for different addictions to how to deal with drunk and aggressive patients.

'Those who misuse substances will inevitably, at some stage, be seen by doctors, who therefore have a vital role to play in recognising substance misuse and in assessing and managing the problems associated with this,' said ICDP director Prof Hamid Ghodse.

'Substance misuse in the undergraduate medical curriculum' is available at www.sgul.ac.uk/depts/icdp/our-programmes/substance-misuse-in-the-undergraduate-medical-curriculum/substance-misuse-in-the-undergraduate-medical-curriculum_home.cfm

Alcoholics Anonymous celebrate 60 years

Alcoholics Anonymous has recently celebrated its sixtieth anniversary. From a meeting of five members at London's Dorchester Hotel in 1947, the fellowship has grown to 4,000 groups across the country.

AA's ethos of one alcoholic helping another started with a doctor and a stockbroker in America in 1935. More than 2 million members now meet in 150 countries to reclaim their lives from alcohol addiction.

The organisation does not require its members to reveal their surname or where they live; all they need is a desire to stop drinking.

'The great fact is that AA works,' said their spokesperson, John. 'It works through one alcoholic talking honestly to another, those who have recovered passing on the message of recovery to those who are still suffering.'

AA's national helpline is at 0845 769 7555. All calls are answered by a recovering alcoholic, and are strictly confidential.

Media Watch

The dance drug 'legal ecstasy' may face a European ban, following reports of deaths and injuries among its users. Europol and the European Monitoring Centre for Drugs and Drug Addiction called for an urgent risk assessment on the drug, benzylpiperazine (BZP), which can cause convulsions, abnormal heart rates and death. Because of a loophole in the law, the (otherwise prescription) drug can be sold to customers as a soil fertiliser, and is also imported illegally through foreign websites. John Ramsey, a toxicologist at St George's hospital in London, said: 'We have no real idea how widespread the use of this drug is. But it is quite clear it should be a controlled drug.'

The Guardian, 27 April

The UK has seen a fall in the number of women injured in alcohol-related violence, according to a survey by Cardiff University's Violence Research Group. The study looked at 33 hospitals across the UK in 2006 and found a two per cent drop in women treated for violence-related injuries, linked to alcohol. The number of men injured remained the same. Professor Jonathan Shepherd, director of the Violence Research Group believed the quick intervention of the police was a factor: 'It seems likely that street CCTV and better targeted patrols means police are getting to fights earlier.'

BBC News, 26 April

A drugs charity fears a rise in crime after losing a three-year contract to provide methadone to heroin users in Wales. If commissioned, Kaleidoscope would have provided service users with two drop-in centres in Newport or Tredegar to receive treatment. However as the £1.7m a year funding was given to a group of 10 GPs, they will have to go to a counsellor and then a GP before collecting their methadone at a chemist. Martin Blakebrough, chief executive of Kaleidoscope, is calling for an independent investigation into the decision: 'If we don't get it right, community safety is the first thing that suffers,' he said. The commissioning panel awarding the contract, said Kaleidoscope did not offer the geographical spread that the GPs could.

BBC News, 4 May

Over-the-counter drug misuse is being overlooked, doctors warn. In the *British Medical Journal*, Chris Ford and Beth Good speak of treating three patients addicted to drugs containing codeine in recent months – a drug found in low doses in some over-the-counter drugs that are combined with aspirin, paracetamol and ibuprofen. According to the doctors, the Over Count website shows that more than 4,000 people are currently misusing Solpadeine – a combination of paracetamol and codeine. Dr Ford said that it is only a small minority of people who take these drugs, but she fears it is a problem not picked up by doctors. 'We have no idea how big the problem is. We're just seeing the tip of the iceberg', she added.

BBC News, 3 May

Drug strategy loses its way

As England's ten-year drug strategy comes up for renewal next year, we begin a series of articles examining ideas for its replacement. Here, Howard Parker argues that the changing alcohol and drug use patterns and problems of younger people are not being reflected in policy, planning or commissioning services because the Blair administration cannot see beyond casting treatment as crime reduction.

The building blocks of England's drug strategy were laid down in the late 1990s, when responding to problem heroin use was appropriate for enforcement relating to drug market and supply, and as a reason for significantly uplifting treatment provision.

With the subsequent spread of crack cocaine and merging of heroin and crack markets and the gradual creation of the heroin and crack user, the classic 'PDU', or problem drug user, became central to the drugs strategy and delivery discourse. The PDU became shorthand for the heroin and crack using prolific offender – to be 'gripped' and coerced into treatment in order to reduce drug related, volume crime.

Under the misleading strapline 'for any £1 spent on treatment £9 are saved by the public purse', the National Treatment Agency, steered by Number 10, set about driving an ambitious programme of uplift and modernisation of mainstream services. While this process has been underway the crime reduction agenda has gradually gained primacy and indeed 'hegemony' – that is the drugs-crime-treatment discourse has shaped almost everything.

The centrepiece is the Drugs Intervention Programme. Its role is to target PDUs who are also offenders and use a carrot and stick approach to coerce them into drugs treatment and try and maintain engagement as they journey through the criminal justice system and in and out of custody. Most recently the focus is on bigger sticks and compulsion with the mandatory drug testing of arrestees via 'test on arrest', which is being rolled out in high crime areas across the country. Arrestees who test positive for an opiate (usually heroin) and cocaine (cocaine or crack cocaine – the test can't distinguish) now have to see a drugs worker for a Required Assessment and a follow-up interview. Not to attend becomes an offence in itself, and most police services are diligently re-arresting non-compliers.

In short, the English drugs strategy around treatment has become disproportionately 'target' focused on the heroin-crack profile. This is not to ignore the wider and impressive modernisation of drugs treatment provision via the NTA. We have seen a doubling of treatment places and workforce numbers. Services are better commissioned and organised and in general terms more attentive to service user needs. The problem however is that all this is being shaped by the drugs-crime-treatment discourse. That public health and harm reduction initiatives focusing on heroin-crack injectors have been sidelined and thus have failed to prevent a massive increase in the spread of hepatitis and HIV among problem drug users, is one example of distorted priorities. Similarly, under-18s Tier 3 provision has not been proactively developed and is frighteningly uneven in scope and quality, mainly because it doesn't fit the crime reduction priority. In fairness, this issue is finally being officially recognised – not that this has prevented this year's substantial funding cut.

Most importantly, drug-using trends among under-30s have been changing for several years, but the significance of this has been drowned out by the ceaseless political noise of heroin-crack-crime. A rethink is required.

The ACCE Profile

Most areas of England are now at, or reaching the end of, their heroin cycle. The first heroin outbreaks of the 1980s and the second regional wave of the 1990s have been unexpectedly extended by crack cocaine. However there is now finally clear epidemiological evidence that the incidence – that is the number of new starters – is falling rapidly. This means fewer young heroin users and the established heroin-crack user population gradually getting older.

An important symbolic measure of this is a cultural view developing in younger drug users, which sees 'smackheads' and 'crackheads' as folk devils and as dirty scummy people. As discriminatory as this view is, its now widespread articulation is a highly protective factor. Far fewer vulnerable young people, who a decade ago would have turned to heroin, will now not even try this drug. They now use and misuse different substances and via a complex repertoire namely the Alcohol, Cannabis, Cocaine, Ecstasy repertoire.

The ACCE profile has been bedding in for several years. Today's teenagers who drink are drinking twice as many units a week as the children of the 1990s. Young women now drink as much as young men and 'binge' drinking has established itself in the young adult population.

Cannabis use is normalised and for those that take drugs (but not heroin) is the mainstay of their repertoire. With the wide variety of increasingly strong strains of cannabis, notably skunk, the very regular use of and self-medication with cannabis is producing a range of problems not previously seen in services. Cocaine use however is the biggest worry because there have been constant increases in consumption rates, even evidenced in the underpowered British Crime Survey. Only the price of cocaine is falling. Finally ecstasy, although no longer much associated with dance music, remains a readily available and cheap drug, widely used by those that take drugs. Drug-related deaths around ecstasy and cocaine are rising, whereas heroin deaths are falling.

The critical issue with the ACCE profile is not that one substance is used in moderation but that a minority of younger people are using all four drugs in purposeful combinations and to achieve specific effects including self-medication. Within this population is a further minority that are developing a wide range of problems with use and significant degrees of dependency. A new 'post-heroin' PDU population is being created, which looks certain to grow in size.

This poly substance profile, especially among vulnerable young people such as care leavers, is well known to under-18s' (Tier 2 and 3) substance misuse services in England because these teams are allowed to work with alcohol and drug presentations and referrals. The majority of these services around the country deal primarily with cannabis and alcohol-related problems and in most areas are seeing fewer young heroin users, while cocaine problems are climbing rapidly. Yet while alcohol is a critical part of problem substance use, these services are not allowed to record alcohol as the primary problem in the National Drug Treatment Monitoring System, which is used as the national monitor of drug use trends. Officially alcohol is not a drug. This is just one of many ways the drugs strategy apparatus is in denial and losing coherence and evidence-based planning ability.

However it is when we look at younger adult (over-18s) provision that we see the heroin-crack paradigm undermine recognition of, let alone responses to, changing substance misuse trends. England has totally separate alcohol and drug strategies and this bifurcation extends to commissioning and service provision. If your town actually has a functional alcohol service the chances are it will not be able to treat you if you are, say, a Jack Daniels drinking weekend cocaine user who's lost the plot and become violent towards his partner. Exactly the same scenario is highly likely to be repeated if you present to an adult drugs service.

There are exceptions, but few are well-geared to deal with the alcohol misuse elements of your poly use profile. This all stems from the primacy of the politicised drugs discourse, whereby the growth in alcohol misuse and responsive funding is denied and all resources are channelled to war on the heroin-crack user. Thus alcohol misuse, even if in combination with drug use, is usually left unattended through the Drugs Intervention Programme.

The same problem occurs within Probation Service provision, whereby community based Drug Rehabilitation Orders are being widely used by the courts but alcohol rehabilitation or treatment requirements have not been funded or set up. We need one poly substance treatment requirement to respond to the actual realities of substance profiles among younger offenders.

Ironically, it is mandatory drug testing which is inadvertently tripping over the ACCE profile. Secondary analyses of drug test results around the country are showing the younger the arrestee, the more likely they are to test positive for cocaine and negative for heroin. In short, the cocaine element of the ACCE profile is showing up. The problem of course is what has current treatment provision to offer? There may be methadone but there's no cocadone. The younger arrestee is required to meet a drugs worker, but will rarely engage.

The best match therapeutic intervention for stimulant dependency is Cognitive Behavioural Therapy (CBT), preceded by a process of motivating the subject to recognise the need for help and fairly intensive talk therapy. The basic principles of CBT require an empathetic relationship between client and worker in a safe and secure environment. While a custody suite Required Assessment certainly offers security, it is not likely to produce the other building blocks to engagement. Unsurprisingly, high rates of non-engagement via mandatory drug testing interventions are beginning to show.

'The critical issue with the ACCE [Alcohol, Cannabis, Cocaine, Ecstasy] profile is not that one substance is used in moderation but that a minority of younger people are using all four drugs in purposeful combinations and to achieve specific effects including self-medication... A new 'post-heroin' PDU population is being created, which looks certain to grow in size.'

Moreover, where referrals to adult drug services are made these teams, having been monopolised by heroin-crack users, have not much developed skill around working with stimulant and cannabis users even if we can engage the ACCE profilers. Finally in terms of voluntary presentation by young adults with any or all the elements of ACCE, their disdain for smack-crack heads means they are unlikely to see their local community drug service as a place to visit believing it to be full of dirty junkies.

Strategic review

I undertook a formal review of Northern Ireland's alcohol and drug strategies in 2005. The Executive have accepted my report's recommendation to integrate the two strategies and to continue to develop provision and interventions whereby alcohol is set alongside other drugs like cannabis and cocaine. Northern Ireland's drugs consumption patterns are already dominated by ACCE and they now have the strategic and commissioning templates to respond effectively. This is the strategic rethink required in England, whereby alcohol and illicit drug misuse would be tackled holistically and drugs like cannabis taken seriously.

The focus on heroin and crack and the classic PDU needs maintaining in moderation, but provision for a different kind of PDU needs piloting and developing. An ACCE service will need to be underpinned by voluntarism, non-prescribing and empathetic engagement. This means that the NTA's performance indicators and narrow prescriptive targets will need revising. Primary alcohol referrals must score points, waiting times need to be zero but retention goals far more flexible; and 'numbers in treatment' goals will need to be replaced by engagement and outcome targets. Reducing poly substance use should be an acknowledged positive outcome.

The trick will be to maintain provision for heroin-crack users but develop a second type of service platform, initially for young adults as the ACCE profile emerges. The current politicised drugs discourse has already delayed a strategic review of the drugs strategy's salience in line with changing alcohol-drugs consumption trends. Recognition of the need to adapt is unlikely to emanate from Whitehall beyond isolated public health messages about alcohol or cannabis.

However, from this year, each Drug Action Team area is being asked to do a needs assessment based on local realities and unmet need. While they are, as ever, being pushed to focus of heroin-crack there is an opportunity to signal cannabis and cocaine issues – and with ring-fencing hopefully coming off drugs budgets, there is also a chance to define alcohol as a drug and challenge the tunnelled vision of central government to begin the necessary debate and redevelopment.

Howard Parker is Emeritus Professor in the School of Law, University of Manchester. His website is www.howardparker.co.uk

The National User Network, better known as NUN, is gearing up to make sure user involvement emerges from the drug strategy review with a stronger voice than ever. **DDN** talks to NUN's chair Jimi Grieve and vice chair Francis Cook.

Together we stand...

Service user groups have been springing up all over the country for some years now, and the idea of regional forums is not new. The National Drug User Development Agency (NDUDA), then the National Treatment Agency's National User Advisory Group (NUAG) tried to harness the passion of service users for fair treatment and a place at the policymaking table.

But somehow it didn't last. NUAG representation was patchy. Some reps spoke up for their region, some were there by default because no-one else put themselves up for the job. So the group was in danger of mirroring the postcode lottery that they were there to cancel out by campaigning for better treatment.

Enter the National User Network, also known as NUN, formed by a handful of service users who wanted to take over a flagging programme of user involvement and inject some grass roots autonomy. With more than a handful of 'the usual suspects' on board – people who had previously voiced frustration at the way things were, including some who have become part of the backbone of the harm reduction movement – feelings were running high that there should be strong user representation coming up to the end of the ten-year drug strategy. Grant McNally, founder of the UK Assembly on Hepatitis C; Andrea Ethimiou-Mourdant of the Mourdant Trust; and Eliot Albert of UKHRA identified the need for NUN and orchestrated its 'call to arms', according to current chair Jimi Grieve.

With John Howard of Reading User Forum and Simon Parry of Southampton-based user group Morph as its first (joint) chair, NUN set about drawing up a detailed plan for a national movement that would survive beyond any changes to the NTA. With rumours rife that the NTA would dissolve in 2008, the group minuted that 'we need to ensure there is some sort of "treatment watchdog" in place to check DATs *etc* are providing good treatment services and aftercare'.

With robust debate ('the usual process of arguments, fights and squabbles – you know how it goes!', according to Grieve) NUN agreed on a mission statement: 'To promote and support user involvement in all aspects of care, treatment and service development.' Their remit covered drug use in its widest sense, whether licit or illicit, alcohol, volatile substances or prescription medication. They made a commitment to sharing safer practice, support anyone who needed it, challenge prejudice and discrimination – and make sure they had an active dialogue with policymakers that would ensure their views counted.

As an umbrella body for other user involvement groups, NUN was determined from the outset to nurture a supportive network. The agenda would come from challenging bad practice countrywide, while providing 'a network for upcoming groups and individuals to "plug into" when starting up'. They declared their determination to foster a professional approach, building bridges within the current UK user movement at the same time as getting users included in NHS patient involvement initiatives.

Looking ahead to their long-term survival, NUN's early brainstorming drew up objectives for a full-time fundraiser, a career structure for volunteers who got involved in the group, and plans to establish a National Service Users Charter. 'Obviously some of these goals are easier to achieve than others – but we

need to know what they are and nothing is impossible!,' declared chairs Parry and Howard in minutes of their second meeting.

Taking the chair in the second year, it's been Jimi Grieve of Hertfordshire User Group's job to keep up momentum, step up the group's profile, and 'up the ante' in a period of uncertainty. With his vice chair Francis Cook, Grieve realised he needed to gather practical and tangible support to make sure the group was rooted firmly enough to be effective. Setting up a Yahoo group to make communication easier, Grieve held elections online, resulting in a new board with eight trustees.

Meeting with trustees at the National Drug Treatment Conference in March gave the group the impetus they needed. Being 'fully formed', with legal processes reviewed, and charitable status applied for, has brought plans for funding bids closer, says Grieve.

'We want to find best practice, collate it and distribute it, whether it's about blood-borne viruses, overdose prevention or relapse prevention. We want to be a supermarket of innovations, with a range of tools on our shelves for harm reduction.

'When new guys pop up and say "what do we do, where do we go?", we'll send them to one of the services in our network and say "have a look at this"... we find good practice, innovative projects with a proven track record that are supplying local demand or unmet need, and just try and network.'

Apart from sheer enthusiasm, the other element that's fertilised their growth has been legislation obliging all health-related agencies to consult service users and carers, Cook points out. From being one of the 'pacesetters of the 80s and 90s', campaigning for change, he's now come across groups 'who've used consultants to get user involvement on board'.

With the direction of travel clear, there's just the small matter of funding to find and sustain. Drug testing company Altrix have given 'a big hand up' with the money for a dedicated website. Exchange Supplies and the Conference Consortium have donated conference places, which has helped the group 'piggyback onto national events', and have given space for the group to meet at their events. There are plans afoot to apply to the Big Lottery to get enough money to support mentoring.

Plans are ambitious, but Grieve is keen to emphasise that 'we are highly holistic and solution focused – and that starts locally, regionally, nationally.

'We are about supporting the little guy in his locality, enabling him to network, get funds, get training, and get templates for better practice.

'We're also about keeping user involvement going when all the money disappears,' he adds. 'Because we'll get swept under the carpet if we're not careful.' **DDN**

Get in touch with NUN by emailing Jimi Grieve, chair, at jamesgrieve@ntlworld.com (tel: 07757 826744) or Francis Cook, vice chair, at francis.cook@ntlworld.com (tel: 0151 647 2162).
To join NUN go to *http://health.groups.yahoo.com/group/nationalusernetwork*

Glass getting fuller

Last year we talked to Kevan Martin about his fight to start up the North East Regional Alcohol Forum, to give much-needed support and representation to alcohol service users. Sixteen months on, NERAF has become a force to be reckoned with. DDN catches up with him.

'Over the past year we've gone very, very proactive, and are putting things right in the appropriate ways,' says Kevan Martin. 'Rather than just criticising, we're taking practical steps. And what we're aiming to do is ensure that everybody going into treatment is offered effective aftercare.

'We work with the providers and the PCT, sitting down with all of them, spotting things that are going wrong and doing what we can to amend them. The PCT's now listening to the advantages of peer support, and all the agencies are now referring onto us. We've got NERAF available alongside the 12-step model, an alternative to AA – so people have a real choice.

'Service providers like us, because it's another avenue for them. I've heard instances of service providers being very dubious about user involvement, but it's been accepted like a breath of fresh air up here, because it's making practical differences.

'We haven't set up to criticise, but to help out. We've been invited to the table on our merits, not because we've demanded it. People have come to our meetings to hear what we're doing, then wanted to support us.

'The PCT has just given us £15,000 a year for the next three years – purely for user involvement. New Deals for Communities have allocated us £150,000 over three years to provide a detox and aftercare service, with a detox nurse from the PCT to do home detox in the community. One of our mentors will make sure people have long-term peer support at home.

'When people are setting up groups such as ours, they have to be careful that they're more professional than the professionals. When our lot go to meetings people are expecting alcoholics to walk in the room. When they see someone walking in smartly dressed and articulate, they're welcomed with open arms. And that's the reception we're getting up here – open arms.

'If you go in with a confrontational attitude, it's going to have an adverse effect, the opposite of what you want. It would have been easy to just have a pop at everybody, but it would have done nobody any good, particularly the service users needing treatment. What we're good at, is saying "look, we're here to help you out". And that's the way it's got to be, because if people try to set up groups with their own agendas, saying "we're best", they're going to get laughed at.

'We've got four paid staff now, and 18 mentors. Mentor training gives people the motivation to learn more. We've got one gentleman, a retired coal miner who was made redundant when the pits shut down, and turned to drink. He's stopped drinking, has done the mentor training, and is now in college brushing up on reading and writing skills.

'We've had other people who are doing counselling and complementary therapy courses, following mentor training. Some are now doing their first year in social work training. What we're saying, is that while you're trying to address your drinking problems, you've got to replace your time drinking with something else. People are finding out that there's life after addiction.

'It's little steps all the time, but if you look at how we've developed over the past 12 to 18 months in particular, we've come on in leaps and bounds. I'm still very conscious that it's early days, and still holding on tight to the reigns. If we go too quickly, we're going to have a diluted service, which affects quality – which affects the people we're working with. We've got a quality service and we want to retain that.

'More and more people are getting in touch with us now, and since speaking at the Drugs and Alcohol Today conference this week the number of hits on our website has gone through the roof! But it's great.

'If we can offer advice, we'll do it. Just pick the phone up and we'll tell you how we've done it, because we don't want to be a stand-alone agency – we want this going all over the country.

'I think really it will be up to us to try and kick something off nationally – and we'd be willing to do it, because if it's benefiting people in the North East, it's going to benefit people in other areas of the UK as well. I can't wait for the day that NERAF becomes the National Executive of Regional Alcohol Forums!'

To get in touch with NERAF, visit the website at www.neraf.org or call 0191 5656688/5145852

DDN's interview with Kevan Martin, 'A glass half full' (30 January 2006) is on our features archive at www.drinkanddrugs.net

'What sort of culture is it that stops people revealing their details – presumably for fear of recrimination in some way? Have we got to the point where we can't have a robust and open debate any more, because of the possible consequences?'

Culture of fear

I was surprised and shocked that out of four letters last issue (*DDN*, 23 April, page 8-9), three had the name and address of the authors withheld.

What sort of culture is it that stops people revealing their details – presumably for fear of recrimination in some way?

Have we got to the point where we can't have a robust and open debate any more, because of the possible consequences?

Of course I may be naïve about the precarious position some people are in with regards to their employment and corporate line-towing, but are things really that bad?

If so I believe we should highlight the issue and support those who wish to have their opinions heard, rather than accept the apparent *status quo* lying down.

Dr Joss Bray

Performance pressure

I was interested to read last issue's letters, commenting on data collection (*DDN*, 23 April, page 8). I work for a mental health trust, commissioned to provide the adult Tier 3 services in South Essex. My job role is to ensure the timely submission of drug and alcohol information for this area.

I agree with bits and pieces, although I don't think anyone has mentioned the effect of performance pressure. I have been in post since the first NDTMS Dataset. I thought the change from Dataset B to Dataset C was challenging enough for the teams, but the change from Dataset C to D has been even worse; we have even had to change software for the coming Dataset E.

Roll in NDTMS with performance indicators like the 12-week retention, and you get services that panic. Services worry about the funding for next year, so they make sure they hit their targets. I believe that some agencies have had to, shall we say, 'watch' their figures very closely to ensure they reach their targets and don't loose any funding. If they don't 'watch' their targets they will not hit them.

Is this what we want to be worried about when we are trying to piece someone's life back together? Does the NTA really want to know where money is going? On staff, wasted time on these figures (both at clinical and management level), and meetings discussing the implications that this will have on other ratings.

The NTA is only there now to further the image that Britain is taking drug treatment forward. It should be disbanded and something 21st century put into place.

One question I would like Paul Hayes to answer if he reads this: What information or feedback do you have for us from NDTMS? All I've heard are numbers treated and in treatment. Is there anything more meaningful to tell us seeing as the Dataset is going up to 70-odd fields, at the end of 2007? I'm guessing that we will know the sexual orientation of our drug-misusing nation before we get any real meaningful numbers.

Well I've had enough, and I'm leaving the drug and alcohol field at the end of this month – before I start pulling my hair and developing a problem!

Luke Kelly, information officer

Freedom or addiction?

Given the number of people in the addictions field who appear to have a considerable grasp of the theories of addiction, yet judging by their comments do not have any insight into the thinking processes of addicts, William Pryor (*DDN*, 23 April, page 14), replete with pseudo metaphysical language, offers a great deal of useful information.

His opening comment is a classic contradiction in terms, yet clearly shows the distorted thinking following brain changes caused by addictive, psycho active drugs. Addicts are locked into the prison of addiction, which although offering the freedom to avoid reality, deprives them of their ability and natural motivation to fulfil their duties and obligations.

Addiction is never ceasing in its demands for the pursuit and consumption of its drug(s) of choice, while completely oppressing any sense of personal values the addict might once have held. Attempts to escape its clutches seem only to result in mental, physical and emotional pain, thus the addict feels helpless. 'The freedom to be addicted' is a phrase for 'nothing else to lose'.

As Professor Clark points out in the same issue (page 15), no one sets out to become addicted. The majority those who are unfortunate enough to develop it, yearn for the freedom to be able to say yes or no, but locked into the warmth of their drug induced 'cells' are unable to see a way back to freedom and normality. The thought of abstinence, leading to recovery, seems too painful to contemplate; therefore their only hope of release is death or insanity. If that, as William Pryor would have us believe is freedom, how many of us would consciously choose it?

Peter O'Loughlin,
The Eden Lodge Practice

How far is down?

I was a drug user and in the end a fully blown alcoholic, lost everything and ended up on the street. I've been in hospital over 30 times and nearly died twice. I, like most of the professionals (if not all), didn't think I would make it.

I will be clean two years in July, yet I am no closer to a drink than anyone who has been sober for one day or 20 years.

I have always struggled, and have asked people who are in good recovery: 'Why are we the lucky ones?' None of us can actually pin it down to anything.

So I was very interested to read Professor David Clark's article (*DDN*, 23 April, page 15), although I do believe alcohol is a disease.

I like the idea that change involves a kind of click decision, ie 'rock bottom' – yet for me and many others I know, what is rock bottom? Every time I went there it was a different, and usually worse, experience.

I certainly believe the best treatment on the market is down to 'the individual person', not rehabs, counselling or group therapy. Anyone can lead a horse to a trough, yet you can't make it drink the water.

I would never condemn any support whatsoever that is out there for us addicts – far from it. What works for one might not work for another. I put my journey down to a total learning process. (Basically I had no choice, went to the gates of hell, and it was full! So I had to come back and sort my head out.)

Which brings me back to the question: 'Why are we the lucky ones?'

I have just finished with my councillor, who I have had for nearly six years, and in all her experience and wisdom she honestly believes three to five people make it out of 100, and she thinks it could be less for drug addicts.

Today alcohol is not in my head; it's not an issue. Yes, I have had to make a lot of changes, yet although I believe (as the article states) that the individual might have a click decision, I do not know anyone who has managed to give up

drugs and alcohol on their own.

There are so many links to everything, like the family, and the possibility that alcoholism could be inherited. My illness has been a question of life or death, so maybe science can contribute to implications for treatment and prevention. I don't actually have an answer, so I enjoy life now and am grateful I am one of the lucky ones.

Sean Rendell, by email

Open letter to drugs workers

What are we? We work with people referred to us by GPs, courts, social services, by themselves; who come into contact with us due to their drug use, or their drinking, or both. To some we are engaged in harm reduction, that curious, slightly double-edged concept that strives to embrace 'social harm' and purports to address the incidence of drug-related petty crime, while medically weaning the person off harmful drug-related behaviours: to others we are practitioners of the 'case-management' approach, playing a numbers game to describe how we address social ills.

So are we therefore to be counters of substance misusers? What do we actually do with these people we meet as clients? Our masters, those who employ and commission us, appear to regard us as figure producers, and measure us by the numbers of people we see. There are no measures for engagement. There is some sense of a 'movement towards' being involved, but no clear definition of what a successful outcome includes. Even around the substance misuse itself the goal is unclear, whether it be some kind of abstinence (be that neo-puritanical or just plain and simple), or some kind of mythical state in which the subject drifts happily off into the ether exercising measure and control.

And as we all know, even that last may require quite substantial change in the person being treated, both in lifestyle and operational behaviour.

What is our job to do then? Is it simply to monitor the drug use of our clients, be medical and regard them as patients, or what? It can be to do something that complements the medical expertise to which we have access. Also we are human beings; chances are we are here doing this work for a reason. As people we want something to happen for our clients, some movement towards freedom from what limits and threatens them.

Often, successfully address the substance misuse and this happens – it is then the substance itself that is the problem, and there is an underfunded though well-established treatment route for this. But this is not always the case. Very often the substance misuse is symptomatic, a response to something else, some other ill that ails the client. Or it is circumstantial, aetiological as some have called it, the result of a combination of life-circumstances that have somehow become overwhelming – and need blotting out. So many clients, when asked, say they 'just want it all to stop': they want something to change.

Our job, then, is to work with this in a way that produces outcomes; for our clients, for ourselves, and for our masters. And what more measurable outcome is there than an episode or period of abstinence from the substance (and its associated behaviours), achieved by the client – a time when they stop doing what brought them to us? Though by no means suitable for every client, this is at least something to work towards, a framework of sorts. A period of abstinence allows the client to meet themselves, take stock, and decide what to do next.

Working towards this involves therapy, and to achieve it is a therapy goal.

In this sense, therefore, therapy is not a minor part of our job, therapy is our job. When we are successful with clients, it is central to what we do. Therapy is the bridge between competent case management and successful outcomes, when clients, having effected the changes they need, move on from our services because they no longer require us. So let us call a thing by its name. For our clients to achieve positive change and our services to produce positive outcomes, we need to practise therapy.

Many of us do this already, and do it well, but often we lack training. Is it not time, therefore, that the more farsighted of our services recognise and foster this need as an integral part of our work, rather than block and impede it on financial or DAT commissioning grounds, as so many of our services currently do? Let us become therapists. Let us recognise that we practise therapy, let us be commissioned to do this, and we will improve our service statistics.

Toby Lloyd, Somerset Drugs Service

And the eagle-eyed reader award goes to...

I was disappointed that your magazine stereotyped last issue's cover model by inverting the pictures of him (cover and page 7) to show him as right handed – I think your broadminded readership could cope with the sight of someone writing with their left hand.

Tony Margetts, substance misuse commissioning manager, Safe Communities East Riding

Your views count!
Please email your letters (up to 350 words) to Claire Brown, editor: claire@cjwellings.com, or write to the address on page 3.

Q A

I work as a Methodist minister in post-industrial areas of South Yorkshire/North Nottinghamshire, where there are many people coping with drug issues. I am looking for a course that will begin to equip me to help such people in a practical way. Can anyone point me in the right direction?
E Mackey, by email

Life for the world

Dear Rev Mackey
It's excellent to see the church wanting to be more involved in helping people with substance misuse problems. It is a hard area but very rewarding when you see people's lives changed for the better.

It is absolutely right that there needs to be some practical equipping to be able to help people in the best way and particularly to avoid being overwhelmed by the work and issues involved.

May I suggest 'Life For The World' which is an organisation with a christian ethos that is involved in training across the country. Their aim is to 'equip the Church and community to help victims of drug abuse and addictions'. The contact is Sheila@lftw.org and 0845 214 0973 and the website is www.lftw.org

Please feel free to contact me if you wish to talk about the issues further at jossbray@aol.com. I am a doctor specialising in substance misuse and I am also involved in church life. Best wishes.

Joss Bray

SMART acupuncture

Dear Rev Mackey
I would like to suggest you take a course in addiction specific auricular acupuncture. Four-day courses are run by SMART UK and information can be gleaned by email at info@smart-uk.com. I and some of my colleagues have completed this course and the results gained by using the acupuncture on drug, alcohol and tobacco users have been excellent. It is also specific to alleviating withdrawal symptoms and helps with relaxation, whether a person is a user or not.

I would also like to add that SMART UK have trained other clergymen and also nuns who have found the use of auricular acupuncture useful within their field if work.

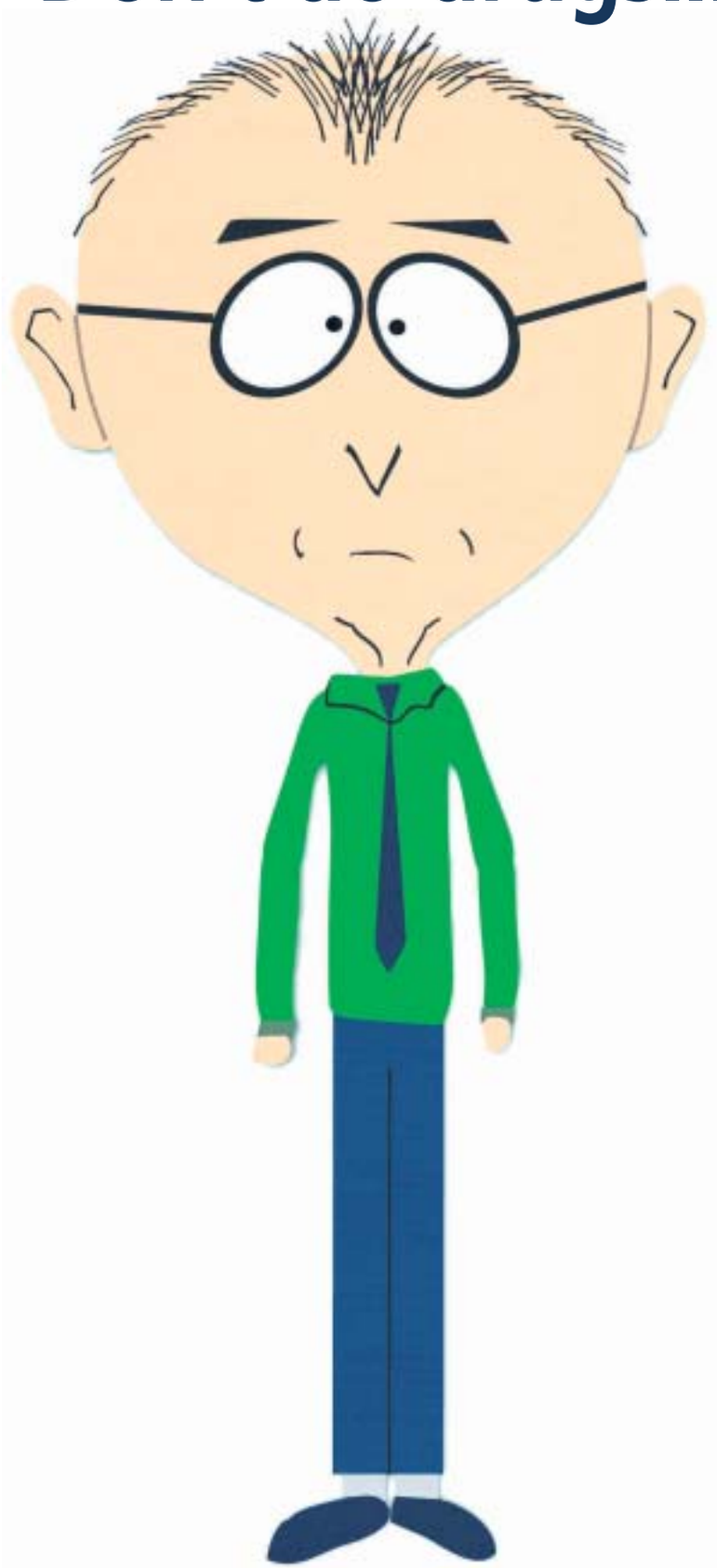
Ian Bowerman, Full Sutton

Reader's question

I used to have a drug problem, but since getting clean have enjoyed my job as a drugs worker. A few months ago I relapsed for the first time. I took leave from work and booked myself into treatment, determined to sort myself out. My problem is that my counsellor at rehab is threatening to tell my employer about my relapse, saying that she has a duty to protect my future clients. I am horrified, as I thought my confidentiality was protected when I went into treatment. Please can anyone advise me on my position?
Amy, by email

Email your suggestions to the editor by 15 May for the 21 May issue.

Don't do drugs... Drugs are bad... Mkay?



Let's learn from the failures of drug education and change the emphasis to prevention, says **Richard Ives**.

In English schools, drug education is statutorily included in the science curriculum and is a part of the recommended personal, social, and health education curriculum. There is clear guidance from DfES on content and conduct of school drug education. A major Home Office-funded research project ('Blueprint') is testing a multi-component model of drug education in 23 secondary schools.

Big claims have been made for drug education, but research fails to confirm these, demonstrating, at best, small gains in knowledge and attitude change, and, where programmes are skills-based, some skills development. Changes in future drug-using behaviour are difficult to measure, but are limited.

This paucity of positive evidence has led to calls for a rethink. Some groups have ignored school-based education altogether; for example, the Alcohol and Public Policy Group in their widely-quoted report, *Alcohol: no ordinary commodity*, does not have preventive education in their 'top ten' policy options suggested for tackling alcohol abuse.

The recent RSA report on drugs is very critical of drug education, saying: 'Much of it fails to achieve its objectives. Too much of it is inconsistent, irrelevant, disorganised, couched in inappropriate language and delivered by people without adequate training.'

The influential Home Office-based but independent Advisory Council on the Misuse of Drugs (ACMD), in its 2006 report, *Pathways to Problems*, concluded: 'The expectations placed on school-based drugs education programmes need to be more realistic.' They went on to recommend that: 'There should be a careful reassessment of the role of schools in drug misuse prevention. The emphasis should be on providing all pupils with accurate, credible and consistent information about the hazards of tobacco, alcohol and other drugs – including volatile substances.'

The ACMD's recommendations for the drug information that should be included in the curriculum are a long way from much of current drug education, which focuses on illegal drugs. The Committee would like to include the addictiveness of tobacco; the danger of using volatile substances; links between alcohol intoxication; violent behaviour and unsafe sex; and damage to the unborn child due to smoking or drinking during pregnancy.

While the ACMD's analysis of the evidence was, as usual, thorough, its recommendations were off-beam. Their analysis had demonstrated that the provision of information was ineffective in changing drug-related behaviour, yet this was the very thing that they recommended 'emphasis' on! Nevertheless, teachers should welcome the proposal – with one wording change – from 'prevention', to 'education'. Some educators have been unhappy with the idea of schools being enlisted in the 'drugs war' – trying to stop drug use, rather than educate pupils about drugs. They insist that their job is to inform and assist their students to make a critical examination of the topic of

drugs; and whether or not the students choose to try drugs is a matter for them, not for the educational institution.

Some even describe most drug prevention in schools as 'propaganda, not education', and say that these approaches seek to: 'censor information, exaggerate dangers, limit discussion, perpetuate stereotypes and tell young people what to think. This discourages the development of informed decision-making [and] increases the likelihood of young people feeling that drug education is irrelevant, that they are being patronised and that they are not being told the truth or given a balanced picture.' (J Cohen, writing in *DrugLink*, July/August 2002)

Nevertheless, educators cannot abandon all responsibility for alerting young people to the dangers of drugs. After all, in other areas of the curriculum risks are addressed – it would be an irresponsible teacher of physical education who did not communicate to students the various risks associated with different sports.

But PE teaching is not assessed on a measure of risk reduction. As Adrian King points out in the same issue of *DrugLink*, the requirement for schools to achieve reductions in drug use through drug education is as if 'we were to measure the success of teaching Shakespeare at school by a reduction in the sales of cheap love novels'. King suggests, instead, that drug education should aim to develop their self-esteem, readiness to seek help, and communication skills – leading to less conflict with parents.

These are important areas for the development of competent adults, but with so much misinformation about drugs in our culture, it's essential to correct misperceptions through the provision of information. Or is it? There is an enormous amount of drugs information available to young people from a range of sources.

For an illustration, consider Network TV cartoons. *The Simpsons* has tackled drugs issues on many occasions. Some examples: Homer drinks a lot of beer, but in one episode gives it up for a month. Barney sees a video of himself drinking and is so shocked that he gives up. Homer tries medical marijuana and joins the campaign to keep it legal. He grows 'tomacco', an addictive cross between tomatoes and tobacco. He eats the Guatemalan insanity chillies and has a 'trip'. Marge gets addicted to gambling. Elsewhere, she drinks spiked water and trips; in another episode, so does Lisa. Bart and Milhouse get high on an all-syrup squishee sold at the Kwik-E-Mart; in another episode the Kwik-E-Mart owner, Apu, experiences a hallucination in which he thinks he's a hummingbird. In an episode where the child protection services take Bart and Lisa away, Marge tests positive for crack and PCP (phencyclidine – also known as Angel Dust). In the episode where Bart gets an elephant, Homer is cleaning the basement, inhales the fumes of cleaning products, trips out, and is attacked by product logos. Bart is diagnosed with attention deficit hyperactivity disorder (ADHD) and must take a drug that boosts his attention span (and there are many more – see www.erowid.org and www.simpsoncrazy.com).

What characterises these references, apart from the humour, is their accuracy and level of detail. Any one of these would provide a fantastic starting point for discussion about drugs issues. Yet what do schools actually do? The less family-oriented – and therefore more credible to young people – cartoon series, *South Park*, also has a lot to say about drugs, and about drug education. The *South Park* boys have a sophisticated approach to drugs and drug abuse but the messages they get from school are presented as laughable and pathetic.

For example, Mr MacKay, the school counsellor, harangues the class about drugs, telling them 'drugs are bad'. This message is repeated *ad nauseam*. Because he passes marijuana around the class and doesn't get it back, Mr Mackay loses his job, becomes a drug user, and gets better informed about drugs. But back in the classroom all he can do is repeat the mantra, 'drugs are bad, kids OK'. In another episode, 'Butt out', anti-smoking education by external providers is mercilessly lampooned. Teachers to whom I've shown these clips sigh with recognition.

In a *South Park* series six episode, 'My future self and me', Stan's parents attempt to scare him into not using drugs. The episode refers to some of the USA government's anti-drugs advertisements aimed at young people, which suggest that people who buy drugs fund terrorism. When Stan confronts his parents, his Dad tells him: 'Well son, we've just been trying to make sure you know how dangerous drugs like pot are.' Stan replies, angrily: 'I've been told a lot of things about pot, but I've come to find out that a lot of those things aren't true! So I don't know what to believe.'

'Some even describe most drug prevention in schools as ''propaganda, not education'', and say that these approaches seek to: ''censor information, exaggerate dangers, limit discussion, perpetuate stereotypes and tell young people what to think. This discourages the development of informed decision making [and] increases the likelihood of young people feeling that drug education is irrelevant, that they are being patronised and that they are not being told the truth...'''

His Dad responds: 'Well, Stan, the truth is, marijuana isn't going to make you kill people and most likely isn't going to fund terrorism, but, well son, pot makes you feel fine with being bored, and it's when you're bored that you should be learning some new skill or discovering some new science or being creative. If you smoke pot, you may grow up to find out that you aren't good at anything.' Stan's reply is: 'I really, really wish you could have told me that from the beginning.'

His Mum joins in: 'He's right; if we use lies and exaggeration to keep kids off drugs, then they're never going to believe anything we tell them.'

But Stan, in an earlier episode, is presented as knowing a lot about drugs. When Chef asks the boys if they know why 'drugs are bad', Stan replies, at machine-gun speed, 'Because they're an addictive solution to a greater problem causing disease of both body and mind with consequences far outweighing their supposed benefits.' And when the boys meet 'Towlie', a drug-using robotic towel, they hang out with him and help him while refusing his (repeated) offer of drugs. With sophisticated storylines like this, it is no wonder that worthy, good intentioned-but-boring school drug education fails to make an impact on young people. But the wrong conclusion would be to suggest that school drug education needs 'spicing up'.

Providing accurate information about drugs is important, and schools have a role in educating children about some aspects of drugs. But when it comes to individual decisions about drug use, school classrooms are not the place to communicate complex messages that should be tailored for individual circumstances. Anyway, most teachers lack sufficient detailed knowledge about drugs, and they don't want to teach about them. The government's Frank campaign, albeit in a limited way, provides general drug information to anyone who wants it.

The most significant part of the ACMD report, and the bit that gets the wholehearted endorsement of the profession's 'trade association', the Drug Education Forum, is the call for more drug education out of school: 'Information, advice and guidance to young people should have a specific drugs element.' It's here, working with potentially vulnerable young people in advice and guidance contexts, that appropriate, one-to-one and small group discussions can take place that address the specific drugs issues that concern these young people.

So let's focus resources on these areas and encourage schools to forget about drug prevention, and concentrate on drug education – such as the history of drugs, the role of drugs in society, and drugs advertising. And let's give schools time to address the personal, social, and health curriculum without the distraction (and impossibility) of having to demonstrate drug-related outcomes.

Richard Ives (www.educari.com) is a speaker at the Unhooked Thinking Conference to be held in Bath on 9-11 May (www.unhookedthinking.com).

Challenging the fast-fix culture

For a young person from a migrant community, getting help with a substance misuse problem can be a challenging ordeal, complicated by cultural and language barriers. **DDN** talks to Perminder Dhillon of the Drug and Alcohol Action Programme (DAAP) about making the process easier.

'Migrant young people will certainly do what ever young people here are doing – including experimenting with drugs,' says Perminder Dhillon, chief executive officer for DAAP. 'That is why we work with the community that they relate to the most, so that they feel empowered and educated about addiction and related issues.'

Commissioned by the Ealing Primary Care Trust and local DAT, DAAP was set up in 2002 with the main aim of bringing together diverse communities to educate them on substance misuse in different local languages.

According to the Office for National Statistics, 2006 saw more than 314,000 migrant young people attend secondary school in the UK. One of the ways in which DAAP has been successful in accessing some of these young people is through their Ealing Drug Education Project (EDEP).

Part of the EDEP scheme looks at working with pupils who may have been excluded from schools or colleges for substance misuse. 'It's direct intervention,' says Dhillon. 'This means working within a small group where we'll get the young person to look at their offending behaviour and why they were suspended'. This can mean delving into their personal lives and issues surrounding them – their family, personal identity, self-esteem and any instances where they have been involved in crime.

DAAP's officers and volunteers provide drug and alcohol sessions in Gurmukhi Punjabi, Mirpuri Punjabi, Urdu, Bengali, Gujrati, Somali and Farsi as well as English. Literature and resources are also translated, such as a video intended for the African-Caribbean community, which tackles black-on-black crime as well as crack use by featuring the Black Police Association, the London mayor's race equality advisor, and poet Benjamin Zephaniah.

'We try and use positive role models and household names that people will recognise and identify with,' says Dhillon.

'You will find Benjamin Zephaniah admitting to drug experimenting, but saying that he gets high on his music. Some young people watching the video might think, "if he comes from the 'ghetto of Handsworth' and he's now a Cambridge chair [of poetry], then maybe there's a possibility for someone like me"', she says.

With a growing Somali community in Ealing, DAAP is increasingly coming into contact with problems related to khat, the stimulant plant whose leaves (when chewed) have been linked to psychosis. In some cases, fathers are spending child benefit on khat. In others, families complain that fathers are often absent because they are at khat chewing housing known as merfrishes. 'Rather than having a chew for an hour, the men might sit there longer if they're unemployed or have other problems,' says Dhillon. 'What kind of role model does a young man growing up in such a family have?'

According to Dhillon, it is usually a member of the family that approaches the organisation to ask for information on someone else's behalf. 'It is not uncommon for a parent to come to us and say, "my child is using drugs" or "could you please ring our son for us?" in which case we do, providing we get the permission from him first.'

Other referrals come from youth offending teams, with the aim of diverting their young clients from a life of crime. As part of a one-day workshop, DAAP takes them to Coldingley Prison in Berkshire, where they get to see what life is like behind bars. A response tends to be: 'Oh my God, is that where I will end up? Can I get further help on what I've been using so I don't end up here?' says Dhillon – DAAP's cue to refer them onto specific rehabs, counsellors or detox centres.

Keeping young people engaged once the work has started is among the service's biggest challenges. 'It's not just a question of peer pressure,' says Dhillon. 'Young people can't wait to be adults; they socialise around pubs and clubs. How many young people have got enough money to go to a restaurant and have a sit-down meal for example? The whole of society is geared towards fast living, fast food, fast fixes... a lot of young people are caught up in that no matter how much work organisations like us do.'

With many of DAAP's young people coming from families with a low income or unemployment, extra-curricular and self-development can come way down the list – a gap that the service tries hard to fill.

'A lot of drug agencies are so busy with providing a service that they don't have the capacity to deal with wider issues. I think we're quite fortunate as we can work on different areas,' says Dhillon. 'The crime diversion scheme is not just about taking them to the prison, it's working with them before and after and giving them the opportunity to get involved in different initiatives.' **DDN**

DAAP's website is www.daap.org.uk

Perminder Dhillon is awarded the Drug Worker for London at the Home Office's Tackling Drugs, Changing Lives Awards 2006. She is also short-listed for the Asian Women Achievement Award on the 23 May.

What the science shows, and what we should do about it (Part 2)

Professor David Clark continues to describe the main findings and recommendations from a major new book based on the views of America's leading clinicians and researchers of how treatment would look like if it were based on the best science possible.

Leading US addiction scientists met in 2004 at a 'think-tank;' conference to share research findings in their respective areas and discuss possible implications for treatment and prevention interventions.

The conference resulted in a seminal book, in which the authors draw together the wealth of scientific understanding from the range of topic areas considered to produce a set of ten cross-cutting principles, and then reflect on their implications with ten recommendations for interventions.

I continue beyond the first three principles I described in the last Briefing.

Principle 4. Motivation is central to prevention and intervention

There is abundant evidence indicating that motivational factors (in their broad sense) are central to our understanding of substance use, and also in preventing and treating substance use problems.

Motivational factors are involved in patterns of change. If people who have stopped substance use on their own, without formal treatment, are later asked how and why they did so, they will often refer to a choice or a decision point.

Life events can instigate a change in problem substance use. Reduced use or abstinence can be triggered by relatively brief interventions, the impact of which are thought to reflect the clients' motivation and commitment to change.

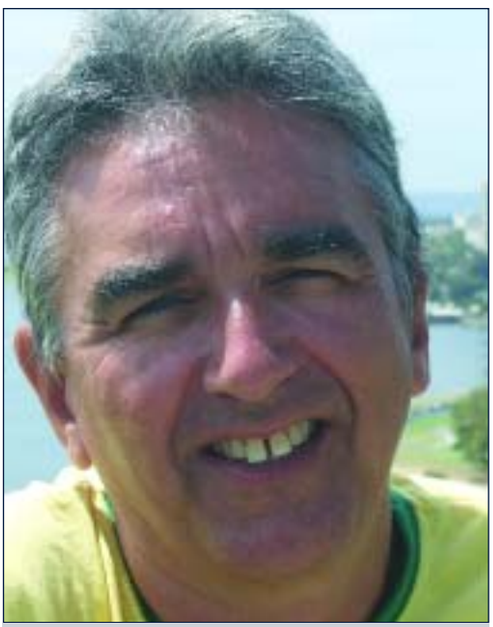
The transtheoretical model of change posits a sequences of stages through which people pass, starting with increased concern or motivation to change, decisional consideration, commitment, planning, taking action, and maintaining this change.

'The decision or commitment to change appears to represent a final common pathway through which change is instigated. Often, once personal commitment has emerged, the individual may require little additional help towards making change.'

Taking action also predicts change. Better outcomes occur when a person stays longer in treatment, attends more fellowship meetings, adheres to treatment advice, or takes their medication. It appears that actively doing something toward change may be more important than the particular actions that are taken. The traditional wisdom that 'it works if you work it' appears to be true of many routes to change.

Motivation for change is malleable, and can respond to even brief interventions. The idea that there is nothing that one can do until the person 'hits bottom' is simply wrong.

Positive reinforcement, unilateral intervention through family members, and brief motivational counselling and advice, have all been shown to instigate change in seemingly unmotivated people. It is not necessary to wait until the person has developed a serious substance use problem before trying to help.



'It appears that actively doing something toward change may be more important than the particular actions that are taken. The traditional wisdom that, "It works if you work it" appears to be true of many routes to change.'

5. Drug and alcohol use responds to reinforcement

Preferred substances are powerful reinforcers, chosen from a range of options. However, even dependent substance use is highly responsive to immediate contingent non-drug reinforcement.

Since stopping substance use eliminates one source of positive reinforcement, long-term change typically involves finding alternative reinforcers – 'in essence, developing a rewarding life that does not rely on drug [and alcohol] use'.

One complexity is that drug use tends to be associated with a foreshortening of time perspective, so that longer-term delayed rewards are discounted in value relative to the immediate effects of the substance.

6. Substance use problems do not occur in isolation, but as part of behaviour clusters

Among adolescents, drug use often represents one part of a much larger cluster of problems, including poor school performance, precocious sexuality, mood problems and antisocial behaviour. Drug problems in adults are often linked to a variety of other health, social, employment and criminal justice issues.

Interventions that target a broader range of life functions are more successful in resolving drug and alcohol problems. Drug use occurs in the context of life problems, and abstinence is often well down on a client's list of priorities.

If recovery is promoted by having a more generally rewarding life that does not rely on drug use for reinforcement, then we must not focus solely on drug use in treatment programs.

7. There are identifiable and modifiable risk and protective factors for problem substance use

There are risk and protective factors that affect the initiation, progression and maintenance of drug use. This means that we can identify subgroups who are likely to be at higher risk for substance use problems.

Hereditary factors contribute to risk for alcohol problems, and evidence is mounting for a role of genetic predisposition in problematic drug use.

People with more access to non-drug positive reinforcement, stimulating environments, and stress-buffering resources are at lower risk. Having close, high quality relationships with people who are not involved in substance use is one protective factor. Social and other coping skills that increase access to other forms of reinforcement and modulate stress are also protective.

Substances are often used as a response to stress, but also tend to exacerbate stress in the long run. Escapist reasons for substance use and avoidant styles of coping are both associated with increased risk of substance use problems.

[to be continued]

'Rethinking Substance Abuse: What the science shows, and what we should do about It' edited by William R. Miller and Kathleen M. Carroll, Guilford Press, 2006

UNIVERSITY OF KENT

Training for Drug & Alcohol Practitioners

Kent Institute of Medicine and Health Sciences

Programmes from 2007/08

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 people currently working with problem substance users, or expect to be in the near future. The programme is delivered in Canterbury & across the UK where there is a cohort of 10 or more students. It is a recognised benchmark for those who seek an accredited qualification. The programme also benefits social, health and education professionals in all sectors whose work includes significant contact with problem substance users

18 month programme from September 2007 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 2007 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

The Diploma provides a framework for understanding the nature of substance misuse and addiction processes from biological, psychological and social perspectives, and focuses on the settings and approaches within which treatment is provided. The Diploma is appropriate for practitioners working in Tiers 2, 3 and 4a services for drug users or people with alcohol problems.

2 year programme from October 2007

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 development of a research proposal. You will be encouraged to develop a detailed understanding of client assessment and outcome monitoring, skills required by project workers, managers and commission. POST-GRADUATE RESEARCH OPPORTUNITIES are also available in this area of study.

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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

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Interview date: Wednesday, 6 June, 2007

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£42,468 - £48,777 **Ref: ACS3707**

Southend Drug and Alcohol Action Team has undergone a comprehensive restructure. As a result of this we are now recruiting to a number of exciting new posts. As Drug and Alcohol Strategy Manager you will finalise and consolidate this restructure.

Responsible for a small team of staff, your role will encompass the planning and commissioning of a full range of substance misuse services. You will provide leadership to the DAAT support team and to the Southend Treatment System. You will also provide recommendation to the local strategic partnerships and assist the partnership with achieving their targets and ambitions.

Your sound knowledge of national substance misuse strategy and treatment priorities will be essential as will your skill as a Relationship Manager.

For further information on this position please contact Mike Boyle, Interim Director of Adult and Community Services on 01702 534612.

To apply online or find out information on all our vacancies go to **www.southend.gov.uk/jobs**

Application packs for both posts are available from the Customer Contact Centre, Civic Centre, Victoria Avenue, Southend-on-Sea SS2 6ER or telephone on 01702 215000 to collect a pack. The opening hours are 8.45am - 5.15pm Monday to Friday. Please quote the reference.

New Deal applicants will be considered.

Application packs are available in alternative formats.

We are an Equal Opportunities Employer and operate a no-smoking policy.

This authority is committed to safeguarding and promoting the welfare of children, young people and vulnerable adults and expects all staff and volunteers to share this commitment. Applications are welcomed from people wishing to job share or work flexible patterns.

Closing date:
Friday 11th May 2007.

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Oxfordshire drug & alcohol action team

Provision of a Women's Service in Oxfordshire

TENDER ADVERT

The Oxfordshire Drug and Alcohol Action Team (DAAT) will commission a Women's Service that will be fully integrated within Oxfordshire's drug treatment system and linked to the Oxford Drug Interventions Programme. The diverse needs of women drug users will be addressed by the Service through the delivery of gender-sensitive treatment interventions.

The primary aims of the Women's Service are to improve equity of access to, and engage more women in, drug treatment, and to provide a specialist service that works closely with other agencies accessed by drug-using women.

The Women's Service will provide, or broker the provision of, appropriate services in relation to the treatment needs and goals identified in an individual's care plan. It will offer a structured programme, including one-to-one sessions, groupwork and open access sessions, focusing on therapeutic interventions.

The Service will have a flexible user-focused approach and will incorporate peer support to complement the activities of paid staff providing ex-service users with personal development opportunities.

The contract period will be for 3 years with the option to further extend for 12 months and then a further 12 months. The value of the contract per annum will be in the region of £160,000 – £200,000; this includes rental costs for premises.

Process for application:

1. Written Expressions of Interest must be received by the DAAT by 12 noon on Friday 25th May 2007.
2. Upon written receipt a pre-qualification questionnaire will be sent to all interested parties to be completed and returned by 12 noon on Friday 8th June 2007.
3. Following evaluation of the pre-qualification documents the DAAT will expect to invite between 3 and 6 organisations to tender.
4. The deadline for completed tender bids is 12 noon on Friday 3rd August 2007.
5. It is envisaged that the start date of the service will be mid November 2007, depending on premises.

To register your interest please contact:
Sarah Roberts, Oxfordshire DAAT, 29 New Inn Hall Street, Oxford, OX1 2DH.

inclusion
working in partnership with service users

NHS
Midlands and South of England

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Inclusion Drug Alcohol Services *has a reputation for providing high quality, innovative drug treatment services, to the Prison Service as a provider of CARAT and rehabilitation programmes and to local communities by providing community based clinical drug services: but we are not stopping, we have created two new senior leadership roles:*

Criminal Justice Operations & Development Manager
NHS Agenda for Change Band 8 (a/b) **£35,232 - £50,733** (starting salary dependent on experience)
We require an operational leader for our criminal justice services including CARATs, prison based Rehabilitation Services and DIPs. You will lead through a management team of two Area Managers, ten prison based Locality Managers and over one hundred staff. A key part of the role is to prepare tender documents and proposals.

Community Services Operations & Development Manager
NHS Agenda for Change Band 8 (a/b) **£35,232 - £50,733** (starting salary dependent on experience)
Part of our strategy is to develop our portfolio of community based Tier 2, 3 and 4 clinical drug services. Your brief will be to push the boundaries further by overseeing the management of existing clinical services and preparing competitive tender documents and proposals.

Your background could be Probation, Social Work, Clinical Psychology, Nursing or Ex-Service User but you must have:

- A strong values base, which includes a commitment to, service user involvement and harm reduction methods.
- People skills – to influence and inspire teams.
- Organisational skills – to provide arms length management and support to teams based over wide geographical areas from the South Coast through to the West Midlands.
- Advanced writing skills – to contribute to successful outcomes for Inclusion in national competitive tendering opportunities.

Salary offers will be based on a successful track record of tendering and operational management in the drug field. Your work base could be a home office based package: however one of the posts must be based in the West Midlands. **For an informal discussion please contact Alistair Sutherland, Director on 01276 501222**

Inclusion, as part of the NHS, offers all staff, personal development programmes; first rate support, supervision and training; final salary pension scheme and occupational health services. We are committed to achieving equality of opportunity in employment. **For an application pack please call Jan Smythe on 01785 221488 or E mail: Janet.Smythe@ssh-tr.nhs.uk**

Closing date for return of completed applications: Monday, 28th May, 2007.

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Ref: PP002/DDN

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Known for your drive and determination, you will have proven experience of working with young people together with an understanding of the impact of drug use on them and the wider community. A proven track record of managing performance and projects and providing policy advice will also be essential.

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Alternatively call 01296 383366 or email: recruitment@buckscc.gov.uk for an application pack.

Please quote appropriate reference number.

Closing date: 12 noon, 25th May 2007.

Interview date: 5th June 2007.

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