DDN
Drink and Drugs News

18 June 2007
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Keeping young people engaged and motivated

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INVISIBLE DRINKERS

National Alcohol Strategy: getting sensible drinking messages home

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18 June 2007

Editor's letter

It's going to be difficult to get through to the drinker who doesn't feel they've got a problem. The reasons why it's bad to drink too much for our health are plain enough (page 6), but until the body shouts 'no', who's going to take any notice? Our drinking habits are usually inextricably bound up with seeing friends, relaxing at home, forgetting work, having a good time. How does suddenly monitoring your alcohol units fit in with that, if you like a drink?

I have no answers, but it seems to me that clear and consistent information would be a start. For instance, a story in this week's *Independent*, referring to the updated alcohol strategy, says: 'It will be aimed at people who regularly drink two bottles of wine a day at home. Caroline Flint, the Health minister, said there were adults who were drinking twice the recommended safe level...' Might the reader assume that it's OK to drink one bottle of wine a day then?

I'm not suggesting for one minute that we have any control over information in the national media, but it strikes me that information campaigns need to be consistent. Why, for instance, base calculations on 9 per cent alcohol by volume (ABV) when most bottles you buy are around 12 per cent? One of the most helpful calculators I've found in this regard is the Drinkaware Trust site, at www.drinkaware.co.uk, which lets you tot up units in main brands without any aggravation. OK, the Trust is funded by the alcohol industry, but it has active backing from respected alcohol experts and is a practical example of arming the drinker with information.

It will be interesting to see how the public information campaigns roll out. I've yet to see anyone checking their units on a laptop in the pub, and I'm wondering how the unit labelling system will work on drinks served without bottles... flags on cocktail sticks in our pints perhaps?

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In this issue

Young people and 'hidden' drinkers targeted

Young drinkers are among the target groups of the government's next-steps strategy on alcohol harm reduction. In the document *Safe, sensible and social*, under-age drinkers and binge-drinkers aged 18- to 24-years-old are two of the three main groups named as causing significant harm to themselves and others, while the other main focus is adult drinkers unaware of the seriousness of their drinking patterns.

Building on the original strategy which was released in 2004, the new document has education and enforcement at its heart. Public information campaigns promoting sensible drinking are planned, along with guidance for parents to enable them to discuss the issue with their teenagers. Young people's minister, Parmjit Dhanda, said given evidence suggested young people were drinking more and at an earlier age, education and information was crucial. 'To help young people and their parents make informed decisions on drinking, the government has signalled its intention in the alcohol strategy to provide authoritative, accessible guidance about what is and isn't safe and sensible,' he commented.

Education will be complemented by stricter monitoring of underage sales and harsher criminal justice penalties for those who commit drink-fuelled offences. A review of NHS spending on alcohol is also included as a 'key action'. The aim, according to public health minister Caroline Flint, is to assist the government in making 'smarter spending decisions to reduce the number of people with alcohol-related illnesses'.

The strategy has received a mixed response to date. Turning Point chief executive Lord Victor Adebowale welcomed the new measures, and said the government was right to prioritise alcohol education. 'Turning Point looks forward to working with the government on campaigns to promote responsible drinking and to provide support and treatment for those affected by alcohol misuse,' he said.

Drug Education Forum chair Eric Carlin was more reserved. While the government focus on young people was welcome, he said, there was not enough focus on the role of school-based education. Also, there appeared to be no consultation of young people on what kind of campaigns and education would be delivered.

'Many young people are worried about alcohol and don't feel that school drug education focuses enough on it,' said Mr Carlin. 'We would have expected that the government would have wanted to talk to children and young people about this and about how to improve their alcohol education.'

Safe, sensible and social is online at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075218

See feature on page 6.

Tish Morris (right) celebrates a double success in becoming student of the year, on top of receiving her City and Guilds Progression Award in Community Justice for Drug and Alcohol Services. Ms Morris, a recovering alcoholic for more than three years, said: 'Winning the award has given me self-belief and self-assurance in my abilities. I now have the confidence to further my studies, specifically in the field of human rights, which means I can play a continuing role in helping others.' Elizabeth Flegg (left), workforce development manager for West Sussex DAAT, set up the training with Chichester College and Sussex Downs College, set up placements with local services, and arranged to sponsor students. She nominated Ms Morris for her £500 national student of the year prize. Pat Arculus, West Sussex County Council cabinet member for adults' services, congratulated Ms Flegg 'for making this possible, not only for Tish, but for many others in the county'.

DTTOs 'effective in reducing drug use'

Court-ordered treatments for drug dependence can be effective in reducing offending and drug use, according to new research. The team of researchers from the University of Kent and King's College London compared a group of drug dependent offenders who had been handed drug testing and treatment orders from the court with a group of drug dependent users who accessed services voluntarily.

The results showed that people on DTTOs were equally as likely to reduce their offending and drug use as those who entered treatment voluntarily, explained King's College senior research fellow Tim McSweeney. 'We discovered that offenders on DTTOs were as motivated to change as those who volunteered for treatment,' he said. 'There were ongoing problems in the delivery of DTTO programmes, particularly in coordinating the work of the courts, the probation service and the treatment agency. But even with these problems, it seems that the treatment provided to drug dependent offenders was effective in reducing their offending and drug use.'

On average, those sentenced to a DTTO reported a 71 per cent reduction in the frequency of offending between the time of their arrest and 18 months after they started treatment. There were similar reductions in the frequency of drug use and in the money they spent on drugs.

The study is published in the latest issue of the British Journal of Criminology, http://bjc.oxfordjournals.org/

MEP support for decriminalising cannabis

Around one-third of British Members of the European Parliament support the decriminalisation of cannabis, according to a joint study by three UK universities.

Researchers from the University of Manchester, the University of Aberystwyth and the London School of Economics contacted all 732 MEPs for their study, with 272 responding. The study, carried out in 2006, found that overall one-fifth of MEPs believed in decriminalising cannabis. Support among British MEPs was higher than average – but not as high as the support among the Dutch, with 83 per cent of these MEPs in favour of the action.

Website tackles young alcohol use

The Northern Ireland Health Promotion Agency has launched a new website and competition in a bid to educate young people on the serious health consequences of alcohol.

Aimed at 11- to 14-year-olds, the new website, Up-2-You, provides the 'real facts' on smoking, alcohol and drugs, as well as dispelling some of the more common myths about these substances.

Statistics show that six out of ten young people in Northern Ireland aged 11- to 16-years-old have consumed an alcoholic drink, and that the average age for young people to have their first drink is 11 years old.

The website is at www.up-2-you.net

Move the focus from poppy farmers, says IDPC

International efforts to reduce the supply of drugs should not concentrate on those who grow crops, but should instead aim to disrupt the activities of those more directly involved in the drug trade, according to a new position paper by the International Drug Policy Consortium.

A clear distinction must be drawn between farmers and those engaged in the actual drug trade, and law enforcement should focus on disrupting the activities of drug laboratories and drug traffickers, says IDPC.

Farmers of coca and poppy crops should be treated as partners in the fight against drugs – and had to be offered viable sources of alternative income. Working with local communities to improve their quality of life and life opportunities was also an essential first step.

Current efforts, focusing on eradication, had had little impact on the drug market, the paper noted. With no other alternative income, farmers quickly replanted or relocated their crops. Eradication could also cause much social harm. Research from UN Office on Drugs and Crime found that eradication of poppy crops in the Kokang Special Region of Myanmar led to a 50 per cent drop in school admissions in 2002/03.

Crop eradication could also have the unwanted effect of driving up farm-gate prices, making it more profitable for farmers to continue and more enticing for others to begin.

The eradication policy had not worked, the report concluded. Coca cultivation had remained 'remarkably constant', while in Afghanistan, drug traffickers were looking forward to a 'bumper' poppy crop for 2007.

However, a reduction in cultivation was possible, the report stated – noting that Thailand was now virtually free of poppy crops. Lessons should be learned from this country's experience, where sustained participatory economic development and nation-building efforts proved the key to success.

The IDPC position paper, 'Drug policy objectives should increasingly focus on the consequences of drug use', is available at www.idpc.info

Revised clinical guidelines out for consultation

Draft clinical guidelines for the treatment of drug misuse are now out for consultation.

Developed by an independent working group on behalf of the four UK health departments, the updated guidelines will replace the previous guidelines, known as the 'Orange Book', published in 1999.

Group chair, Professor John Strang, welcomed feedback on the draft guidelines. 'Since the clinical guidelines were last updated we have seen many important changes in the availability and nature of, and evidence base for, drug misuse treatment,' Prof Strang said.

'The working group has tried to reflect these changes in the draft update but recognises there are still some aspects of clinical practice open to differing views. This consultation period is an opportunity for a wide range of views to influence the shape of the update.'

The consultation period is open until 27 July and the final version of the update is expected to be published in September 2007. The draft update is available on the National Treatment Agency for Substance Misuse website, along with standard forms for submitting comments.

Visit www.nta.nhs.uk to contribute.

Drug classification 'antiquated and politically motivated'

The current drug classification system is antiquated, arbitrary and ripe for revision, according to Phil Willis, chair of the select committee on science and technology.

Speaking at last week's debate on the system, Mr Willis stated that decisions on a drug's classification were often politically motivated, and were not a true reflection of its comparative harm to users and society. He pointed to the government's continued refusal to downgrade ecstasy from a class A drug, despite recent evidence from the Medical Research Committee that the drug was 'at the bottom end of the scale of harm'.

The drug classification system was in desperate need of review, and the Home Office and Advisory Council on the Misuse of Drugs should consider a more systematic approach to classifying individual drugs. Drugs should also have their status regularly reviewed.

In response, home office minister Vernon Coaker said the ACMD was looking into conducting a systematic review of individual drugs, and as part of that, the status of ecstasy would be considered. However, there would be no review of the classification system because the government did not believe there was another system of structuring drug harm classification that was obviously better than the present one.

West Lothian redirect funding to alcohol services

Alcohol services in West Lothian are anticipating a boost after the local drug action team announced it will seek to redirect funding to help the neediest and most poorly served groups.

Two major research studies into the area's substance misuse problems revealed that alcohol was the drug of choice. A significant proportion of the local community regularly exceeded recommended drinking limits. Alcohol-related deaths among young women were also on the rise.

Yet funding was incongruous with this – a large proportion of it directed into providing services for problem drug users who make up less than 3 per cent of the population. The West Lothian Drug Action Team is now looking for ways to redistribute their funding into alcohol services.

Alcohol labels agreed for end of 2008

New labels will appear on alcoholic drinks by the end of next year following an agreement between the government and the drinks industry. The aim, according to public health minister Caroline Flint, is to help people calculate how much alcohol they are consuming and stick to sensible drinking limits.

Government research showed that while 69 per cent of people were aware of the recommended daily guidelines, only 13 per cent kept a check on how much they drink.

'Although most spirit and beer labels... do carry some information on unit content, people can miscalculate and lose track of how much they are drinking,' said Ms Flint. 'We want to make it as simple as possible for people to keep an eye on how much they are drinking and help them take responsibility for lessening the impact excess alcohol can have on their health.'

The memorandum of understanding between the government and alcohol industry meant labels would carry information on the drink's unit content and the government's recommended safe drinking guidelines. The industry was also being encouraged to place warnings on the labels directed at pregnant women.

This followed new government advice that pregnant women, or women trying to conceive, should avoid drinking alcohol altogether. If they did, they should not consume more than one to two units of alcohol a week, and should not get drunk.

The advice, said deputy chief medical officer Fiona Adshead, was strengthened to ensure that no-one underestimated the risk that alcohol posed to a developing foetus.

An update to the National Alcohol Strategy will look beyond criminal justice measures to present the idea of sensible drinking to the masses. **DDN** weighs up the challenges of a culture change.

Ask any social drinker to count up the amount of units they drank last week. Now get them to recalculate, bearing in mind that a small glass of wine at 9 per cent is one unit; but their large glass of 13 per cent wine was actually 3.2 units. A pint of Fosters lager might have been 2.3 units, but their pint of stronger Stella lager was 3 units. Many people know that the recommended weekly limit is 21 units for men and 14 units for women; but how many realise that they drank more than their entire week's allocation last night – and again the night before?

The government's new strategy goes beyond criminal justice measures to tackle anti-social behaviour and underage drinking. The document, called *Safe, sensible, social*, targets 'harmful' drinkers – the pub regulars and home drinkers who do not monitor their alcohol intake accurately, or do not see why they should. The focus on being 'sensible' may beckon 'nanny state' jibes, but to many professionals working in this field, the statistics within the document are all too familiar.

In 2005, 4,160 people in England and Wales died from alcoholic liver disease – an increase of 41 per cent since 1999. Men who regularly drink more than eight units a day (or more than 50 units a week, when calculated to fit regular social bingeing patterns) and women who drink more than six units a day (or more than 35 units a week) have been shown to greatly increase their risk not only of liver disease, but also stroke, coronary heart disease, pancreatitis, diabetes, kidney disease, high blood pressure and depression. In areas of high deprivation, the proportion of death and illness intensifies.

Costing an estimated £1.7 billion in healthcare a year in England and Wales, it is easy to see the economic sense in tackling alcohol related harm – and difficult to understand why it has not been done sooner. With research indicating that the total cost could be in the region of £20 billion a year, if crime and disorder and loss of work productivity are added to healthcare costs, the resources needed to improve education and awareness and provide treatment and support for all stages of alcohol misuse look extremely modest by comparison.

Some early reactions

'Welcome change in emphasis – but much still to be done'

'Alcohol Concern welcomes the next steps for the alcohol strategy,' says Alcohol Concern's director of policy and services, Don Shenker. 'There is a welcome change in emphasis and objectives to reduce alcohol related ill health and raise awareness across the board. In this sense, the new strategy is now much more strategic and focused than its predecessor. However, there is once again no reassurance for alcohol services that their funding will be at least maintained, in spite of a recognition that demand for treatment outstrips supply in all Government Office regions. Likewise, once again there is no mention of specific services for young people or of the need for alcohol education. Most worrying is that in spite of welcome objectives to reduce harms, there is an absence of specific targets to measure this by. How can we measure progress if there is no target to reach? For those in the field battling to reduce harm and fighting for resources to achieve this, it appears there is much persuading still to be done. Alcohol Concern will be producing its briefing on *Safe, sensible, social* in the next few weeks.'

'A move in the right direction'

'The all-encompassing alcohol strategy is a move in the right direction in the fight against alcohol addiction,' says Lesley King-Lewis, joint chief executive of Action on Addiction. 'We are delighted that the government is focusing on excessive and dependent drinkers in all age brackets. There has been a great deal of attention on underage drinkers, but we also need to look at problematic older drinkers who aren't so visible in society. We are particularly concerned about stay-at-home excessive drinkers who may be sitting in their living room watching programmes about youngsters binge drinking completely unaware of the damage they are doing to their own health.

'As well as lobbying the government on health warning labels on all alcoholic beverages, we are asking for long-term funding for an alcohol worker in every hospital and a tax based on the percentage of alcohol in a drink. We believe this would have a significant impact in reducing alcohol consumption in a short space of time.'

Safe, sensible, social… and effective?

Around 8.2m people in England are drinking more than is good for them, according to the Alcohol Needs Assessment Research Project (ANARP), commissioned by the Department of Health and published in November 2005. At the furthest end of the scale, 1.1m people are dependent on alcohol – but only 63,000 people were receiving treatment for alcohol related disorders when the survey was carried out.

New initiatives have been directed through the Department of Health's guidance on local interventions, aimed at local authorities, health bodies and groups with an interest in working with the NHS to tackle alcohol misuse. The DH and National Treatment Agency's *Models of Care* followed in June 2006, outlining a framework for commissioning and providing preventions and treatment. By November last year, we had the NTA's review of alcohol treatment effectiveness, which confirmed that treatment can be cost-effective as well as clinically effective, and served up best available evidence for commissioning local alcohol services to the practitioners, service managers and commissioners who could make it happen.

The new document summarises areas of progress since the Alcohol Harm Reduction Strategy for England was launched by the Prime Minister's strategy unit in March 2004. It mentions campaigns tackling 'irresponsible' advertising and promotions from the drinks industry; education and awareness initiatives, including TV adverts against drink driving; and measures that have been implemented to deal with alcohol-related crime and disorder. It outlines specific strategies currently being targeted at prison and probation services, pregnant women, those who come into contact with A&E, and at those at risk from alcohol-fuelled violence by partners or parents.

But there is much to do: deaths caused by alcohol consumption have doubled in the past two decades, with more people becoming ill and dying younger. The alcohol treatment field is desperate for resources to help those who need support now, and for whom early interventions are too late.

The new document focuses heavily on tackling our complacent drinking culture. National Media have picked up the message that 'middle-class wine drinkers are at risk' and Home Office Minister Vernon Coaker was reported as wanting to change the public's attitude that it's acceptable to drink to get drunk. But it remains to be seen whether campaigns planned for next year, such as teaching the public how many units are in their drink, will have any impact.

Reaction to the newly launched document has been cautious from those still working through its detail – and there is a detailed plan of priority actions and next steps in its appendix. It will be interesting to see how it is received by those working in alcohol prevention and treatment. **DDN**

"…deaths caused by alcohol consumption have doubled in the past two decades, with more people becoming ill and dying younger. The alcohol treatment field is desperate for resources to help those who need support now, and for whom early interventions are too late."

'Safe, sensible, social: The next steps in the National Alcohol Strategy' is available online at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075218

'Still a chronic shortfall in alcohol services'

'Alcohol is a serious social problem and the government should be applauded today for looking at a spectrum of different groups affected,' says Turning Point's director of policy, Richard Kramer. 'However, there remains a chronic shortfall in alcohol services: this is preventing dependent drinkers getting the support that they need to overcome the damage that alcohol does to their lives and to those around them.

'Eight million people in England have alcohol problems: they and their families are often in a desperate situation and they need support. Many people with alcohol problems have concurrent mental health or other drug issues and are often turned away from services that cannot cater for their complex needs. The government is right to focus on education and preventing problems happening in the first place, but more services are needed.'

'No consultation with young people'

'I am disappointed with the lack of consultation on the next steps in the national alcohol strategy not only with drug prevention agencies such as ourselves, but with young people who are key to minimising the problem of future alcohol misuse,' said Eric Carlin, chief executive of leading drug prevention charity, Mentor UK.

'Although the need for early intervention is already recognised at government level, with guidance issued from the DfES that education should start in primary schools before drinking patterns become established, there is no focus on prevention initiatives and the younger age group in this alcohol strategy.

'Because prevention is better than cure, Mentor UK launched the Alcohol Misuse Prevention Awards in 2006, recognising the best projects and activities influencing children's attitudes, their skills and their behaviour so that when they are older they can avoid the damage that the misuse of alcohol can cause. With the majority of the government drugs funding being spent on criminal justice interventions and treatment, rather than prevention, many of the projects who were shortlisted in our awards scheme will struggle to survive.'

What do you think of the alcohol strategy update? Email your thoughts to the editor for our letters page: claire@cjwellings.com or write to us at the address on page 3.

Media Watch

Low doses of ecstasy can cause lasting damage to the brain, according to a study by the University of Amsterdam. Researchers first tested 188 non-drug users on attention and memory, then several months later re-tested those who had since taken at least one ecstasy tablet. The team found that there was a small but statistically significant drop in the volunteer's ability to remember words after using the drug.
The Guardian, 5 June

Businesses across England are being urged to spy on their employees to enforce the smoking ban, from 1 July. Under new government regulations, employers will be able to keep written accounts of anyone lighting up, as well as use undercover devices such as hidden cameras to provide sufficient evidence for town halls to levy £50 fines. Companies who fail to stop employees smoking can face a fine of up to £2,500.
Daily Telegraph, 14 June

The growing use of cannabis has caused admissions to mental health hospitals to rise by 65 per cent in the last five years, according to figures obtained by shadow health secretary Andrew Lansley. Professor Robin Murray, of London's Institute of Psychiatry, said that the increase in figures might be down to better recognition, but were likely to be 'just the tip of the iceberg'.
BBC, 14 June

Smokers will be banned from adopting children under five to protect them from developing associated health risks such as asthma and lung cancer, a move approved by council chiefs in Portsmouth. Luke Stubbs, a Conservative Councillor, called the ban 'unfair' saying that people who smoke are not bad people, 'they just have a bad habit'. The ruling will apply to new applicants and will extend the present ban, which restricts smokers from adopting children under two.
Daily Telegraph, 14 June

New powers given to police will see mandatory drug testing carried out in prisons across Edinburgh. Introduced by the Scottish Executive, the powers will enable police to carry out saliva tests on prisoners for heroin and cocaine. The results will then be used to refer drug misusers onto treatment, as well as to inform bail and sentencing decisions. Chief Supt George Simpson, divisional commander for Edinburgh, said that the results would help authorities deal more effectively with drug users who fund their habit through crime.
BBC, 14 June

Q I'm on a degree course, studying to become a counsellor and one of my friends, who I'm living with, is binge drinking to excess. When I try to speak to her about it she laughs and says she can handle it, but I can see it's starting to affect her life dramatically. She doesn't seem to think it's a problem – how can I convince her that it is?
Charlie, Manchester

It's up to her

Dear Charlie
You can't convince her, she is an adult and it is up to her to make her own decisions. All you can do is provide her with the evidence on the ill effects of excessive alcohol consumption and allow her to make up her own mind.

You also need to take a step back; just because you are training to be a counsellor doesn't mean you are an automatic expert on how much is the right level for individuals to be drinking at a particular stage in their life.

A lot of people drink more than the recommended daily alcohol levels when they are at university, and yes this sometimes leads to them doing things that they may regret, but it doesn't necessarily mean that they will continue drinking too much and will do themselves harm.

While I applaud your concern for your friend you must remember that, as a counsellor, you will be dealing with people who have approached you for help. So far your friend has not done this.

Finally you owe it to yourself to have fun and not create a situation where what you are doing can be seen as preaching and you can be branded a complete killjoy. Look out for your friend, have fun with your friend, and be there if she needs you.
Grant, via email

Back off

Dear Charlie
The fact that you're training to be a counsellor is almost irrelevant – it's your role as a friend that is the key here. And the fact that you're so worried and concerned suggests to me that you're a pretty good one!

You don't say whether your friend is also a student. If she is, it's possible that she's just enjoying her student years and that she will calm down afterwards when she starts work. It must also be said that she is a free agent and is largely entitled to do as she wishes.

However, you are her friend and are clearly worried. I'd suggest taking her for a coffee and talking to her about it one more time, stressing how concerned you are. If that fails, I think you may have to back off and let her work it out for herself.
Ian, by email

DDN received a late reply to Amy (originally published last issue); here is the original question followed by Rosie's response.

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

Dear Amy
The first thing to say is that you are not alone. Relapse is part of the journey to recovery, and many former users working in our field have faced personal challenges like this. I have remained alcohol free now for over 24 years, but only because I kept to a 12-step programme which required rigorous honesty, particularly being honest with myself.

I have worked outside the drug treatment field, with employers who had wonderfully supportive employment practices, and others where drug and alcohol misuse was often hidden in the workforce partly because of a lack of enlightened policies. But in truth, I have also worked with a few in the drugs field who had not got much of a clue about addiction and dependency. However, what you have to recognise is that if your drug use had continued without any intervention by yourself or others, your actions may well have affected not only the reputation of your employer, but you may well have posed a risk to those users with whom you worked.

There have been many times in my life when I felt emotionally off the wagon. Remaining drug and alcohol free is not easy when life gets difficult. But each time I felt wobbly I looked at the triggers that lay beneath and talked to people who understood. I can understand how you feel, of course. Sometimes it may seem that some colleagues who have never had a drug dependency themselves, can't understand the courage it has taken to stay drug free. But most are supportive and wise, even if they haven't fully experienced the same challenges.

The counsellor who you say is 'threatening' to reveal your situation is in a difficult position. This counsellor has a duty of confidentiality but also a wider one to the client group. She is not the one who should talk to your employer but you should. You may find that they already suspected you had relapsed and were waiting for you to face up to it. You are hopefully back on track now, and I understand how frightened you must be feeling. But, ultimately this is not about job security, it is about you remaining drug free and growing in strength and experience to become the best person and best drug worker you can be.

It is fantastic that you took yourself off for treatment. You will have tremendous and invaluable insight gained through this experience. Any sound employer in this field will understand relapse issues, will appreciate your honesty and offer you support. Your employer will want to be assured that you can fulfil your work and that you have support networks yourself. If this particular employer is unsupportive, and your story is as straightforward as it sounds, then they should not be involved in running drug treatment services. Talk to them, and do keep *DDN* informed of what happens and what you learn from it. I for one will be rooting for you.
Rosie Brocklehurst, Rosie Brocklehurst Communications Ltd (rosie.brocklehurst@zen.co.uk)

Reader's question

My son is a university graduate, who's doing well at work. He drinks now and again, and is a non smoker who exercises regularly. He has admitted to me that sometimes on a night out he takes cocaine and other drugs. He doesn't see this as a problem and tells me that it is just part and parcel of modern Britain. Should I be concerned?
Marian, Merseyside

Email your suggested answers to the editor by Tuesday 26 June for inclusion in the 2 July issue.

'The fact is, many people are uncomfortable with accepting the truth about non-harmful dependency because it either offends their morality, upsets their own vision of self-worth or (as in the case of some workers) makes their appointed role quite literally redundant.'

Control is the crux

In response to Peter O'Loughlin's letter (*DDN*, 4 June, page 9), I feel I must firstly state that as an out and proud harm-reductionist I neither endorse nor condemn the use and/or legalisation of addictive psycho-active drugs (APAD), but I do care passionately about highlighting actions, habits or beliefs that perpetuate the state-sanctioned discrimination of drug users; mainly because I'm one of them.

Further, although I understand that some people have to maintain the status quo in order to make them feel better about themselves (*ie* 'I call myself "clean" as it proves I am no longer "dirty"'), this cannot be justified in the treatment field where effective therapeutic relationships between users and workers have to be developed in order to enable users to take control of their own treatment journey.

Control is crucial in this context and is the crux of my assertion that many people can use drugs without it harming themselves or others. My empirical evidence may be lacking somewhat, but that's largely because we haven't yet reached the point where people can talk openly about their drug use without the risk of being vilified or condemned to a punitive drug treatment regime.

The fact is, many people are uncomfortable with accepting the truth about non-harmful dependency because it either offends their morality, upsets their own vision of self-worth or (as in the case of some workers) makes their appointed role quite literally redundant. But although resistance to the concept is inevitable, for Peter to call it a denial is both disingenuous and seemingly at odds with his own subjective 'hope that your drug(s) of choice just provide enjoyment, without harming anyone else' (www.edenlodgepractice.com/index.htm), which actually reads like a tacit acknowledgement of the fact to my drug-addled brain.

This is not a pointless, pedantic, propagandist rant about politically correct semantics or the joys of drugs. It's about respecting ourselves and those we support or are being supported by, nurturing a climate of mutual tolerance, understanding and honesty and acknowledging that drug use is not always harmful but inappropriate drug treatment frequently is.

Daren Garratt, the Alliance

Eradication not the answer

Neil McKeganey paints a dismal picture of the road we would travel should we consider buying opium from Afghanistan (*DDN*, 4 June, Page 14). According to the professor, we would hand money to crime lords who would, in turn, brutalise the peasants who grow the crop. We would be blackmailed into paying an increased price every year. We would further de-stabilise an already unstable country. In short, we would be opening Pandora's box. The only option is to apply the ultimate scorched earth policy and simply eradicate all opium production from the country and cut off 90 per cent of the supply on which the world's heroin addicts currently depend, although professor McKeganey fails to give much thought to what the consequences of that might be.

I don't think it has to be that way and, because it hasn't been done before – certainly not on a large scale – I don't see how the professor can be so convinced by his own arguments. We already buy narcotic raw materials from other countries in a tightly controlled market. In fact, the USA sources 80 per cent of its supply from just two countries; India and Turkey, hardly the most historically stable regimes in the world. India still cultivates the poppy to extract raw opium, making diversion to illegal markets far more likely than it is via the concentrate of poppy straw production method used in other countries, yet this regulated legal supply has gone on for years without anything apocalyptic happening. So, shouldn't we even consider trying a similar approach with Afghanistan?

The consequences of obliterating their livelihood by eradicating the opium crop would be dire indeed to poor Afghan farmers and their families and I would not like the results of such a policy on my conscience. Look at the soil quality in the biggest areas of poppy-growing and you'll see the idea of cultivating cabbages and corn is simply not realistic.

Closer to home, the consequences of a policy of eradication would be horrendous. I don't know where Professor McKeganey lives but, in the urban jungle that I inhabit, the prospect of what thousands of dependent heroin users might get up to, when suddenly deprived of their gear, does little to aid restful sleep.

Steve Mitchell, by email

Notes from the Alliance

Divide and conquer..?

Is there really a place for New Puritanism in drug treatment, asks Daren Garratt.

I was listening to a song called 'New Puritan' by The Fall and when Mark E. Smith croons, 'and all hardcore fiends will die by me, and all decadent sins will reap discipline', I was struck by how it reflects a creeping ideology underpinning drug treatment... I'll explain.

We've been running a lot of the Alliance's Basic Advocacy training courses recently and it's amazing to hear about some of the illogical practices that are still being perpetuated.

Take, for example, the case of a London user who was involuntarily moved from buprenorphine to methadone because his urine had tested positive for crack cocaine.

The move was sanctioned because the key worker and GP were worried about the risk of overdose, and so switched him to methadone while he continued to smoke crack; he'll only be moved back to his preferred medication when he stops using.

Or what about the drug service in the south west that will not dispense legal, life-saving medication to users arriving even a couple of minutes late for their appointments, regardless of transport, childcare, mobility or general life issues that disrupt all of our best intentions from time to time.

There is absolutely no evidence-based, operational justification for these practices and I can only assume it's some covert form of punishment: 'Be good, do as we say and you can get what you want.'

It's unethical, but unfortunately I don't think these are isolated incidents.

We appear to be living through a quiet revolution at the moment that thrives on divide and conquer politics, is fuelled by personal moralism, and, despite any best intentions to the contrary, will serve to only jeopardise the undeniable advancements made by the drug treatment field over the last ten years.

Organisations like the NTA, RCGP and SMMGP are regularly issuing best practice documents that provide an unparalleled body of evidence and support for workers and clinicians to access and inform their work. Unfortunately, it appears that some parties are still willing to overlook and disregard accepted medical or operational guidelines and enforce their own interpretation of 'what works'. Worryingly, this is often informed only by their individual preferences or experiences, and pays little or no heed to research, or the needs of clients.

And I would contest that this approach has been legitimised by the increasing lurch into criminal justice culture, where 'drugs and crime' and 'crime and punishment' are inextricably interlinked, and where any transgressions are routinely reprimanded.

Furthermore, if we follow this argument even further, then it's no wonder that many harm reductionists are increasingly chastised as irresponsible and ineffective because they are seen to collude with deviant, criminal activity.

Is there a place for New Puritanism in drug treatment? It undoubtedly works for some, but unregulated, individual ideologies can't be allowed to displace accepted, clinically governed evidence based best practice as the dominant intervention, otherwise it will undermine all recent attempts to make the field more professional, effective and accountable. And that would be wrong.

Daren Garratt is executive director of the Alliance

Paving the way

With a leaner, more focused team, DrugScope is using its information gathering skills on its members to find what they want from the new drug strategy. **DDN** talks to chief executive Martin Barnes.

Martin Barnes is remarkably Google-able. Enter his name in the search box alongside 'DrugScope' and you will find him being delighted, welcoming, surprised, concerned, and hugely disappointed, as reported in a wide variety of media.

This is one aspect of the DrugScope chief executive's job: to be accessible to the media, whether it's Radio 4's *Today* Programme wanting him on air before 7am ('Not my natural routine') or a deadline-bitten journalist seeking confirmation that we're on the verge of a crystal meth epidemic.

Damping down media hysteria – and where possible, educating journalists that approach them for a sensational quote – is a regular part of DrugScope's work.

'Trying to inform ways that issues are covered in the media is important,' says Barnes. 'We aren't just rent-a-quote. Sometimes we see part of our role as encouraging journalists not to do a story that could add to hysterical coverage of some issues.'

This side of the work can be frustrating, he says, as 'good news is rarely reported… Drug use is coming down, but people don't realise that. The media report it as spiraling out of control.

'Part of our role as an organisation is to create spaces to try and get a calmer and more informed debate,' he adds.

Since the recent move to offices near London Bridge, DrugScope has been shaking off the aftermath of restructuring, and publicly redefining its role. 'After our merger [of the Institute for the Study of Drug Dependence and the Standing Conference On Drug Abuse] in 2000, we took our eye off the ball,' says Barnes. 'Now we're recruiting a membership development post and strengthening our representative role. We have a grass roots approach to supporting people who are affected by problem drug use.'

Recovering from a period of 'quite difficult financial pressures' over the last two to three years, the charity has recently concluded a further restructuring – 'very clearly strategically driven this time, instead of financially driven'. Locked-in funding from government for the next three years will enable them to be more responsive in taking members' concerns to policymakers, Barnes explains.

'Our main interest area is what's making a difference to people receiving treatment,' he says. In tune with this, DrugScope is holding a conference next month to canvas views on the future of the drug strategy. Results of a recent round of regional consultation events will stimulate debate, and participants will look at what's working and what's not.

Barnes says they hope to use the occasion to rekindle passion in the drugs field, and he is willing to risk discontented outpourings to get there: 'If what we have is an angry mob, that's telling us something,' he says. At least we'll know why it's important. We will reflect and learn from that.'

He hopes for robust debate, inside or outside the formal conference sessions. 'There's a lot of fear around people speaking up,' he says. 'It's as if a slab of granite has fallen between people at the frontline delivering and policymakers.'

DrugScope intends to take issues forward from the event, he says: 'Where issues are challenging, we will be challenging – and not just for the sake of it.' They have booked a fringe meeting at the Labour Party conference, and are hoping to attend the Conservative Party's event.

Party political treatment of drug policy issues has a habit of being 'incredibly polarised' he says, demonstrated by Home Office response to the Joseph Rowntree Foundation's report on safe consumption rooms last year.

'It was a very good solid piece of work, putting forward what I think was a very modest proposal: let's look at piloting these schemes to see whether or not they will work in the context of the UK.

'The Home Office's response was fairly immediate: no, we're not going to consider it. The debate was closed down, when actually what the report was trying to do was create space for that discussion to happen.'

Signs of interest from the Conservative Party have given him hope of a meaningful dialogue. 'If I wear my optimistic hat, what I hope is that the Conservatives will take a far more pragmatic, evidence-based approach, reflecting some of the positions that David Cameron supported when he was on the Home Affairs Select Committee as a backbench MP.'

Acknowledging that 'Gordon Brown has been clear that the next spending round will be tight,' Barnes hopes to steer DrugScope with a balanced approach, highlighting and disputing cuts where necessary, while being realistic about challenges.

While seeking to influence politicians and the public, information and evidence-based research will still be firmly at the heart of everything they do, he says. They are in the process of digitalising key resources from 'the biggest library of drugs information in the English language', housed in DrugScope's offices; are redesigning the website, looking at podcasting and video links; and are developing an effectiveness database with *Findings* magazine, Alcohol Concern and the National Addiction Centre.

'I see our role as essentially distilling information, making it easier for people to access it,' says Barnes. 'It's about challenging stigmatisation and fear… we need to make sure local partnerships and decision-makers are fully informed.' **DDN**

Details of the conference on 12-13 July are on DrugScope's website at www.drugscope.org.uk

The next step

Keeping young people engaged can be a difficult task. Fran Hardman, from Fairbridge, tells **DDN** how they keep their clients coming back for more.

'It's a struggle to get a lot of the young people that we work with in for just one day,' says Fran Hardman, project manager for Fairbridge's Kilburn Centre in London. 'But that's what we're here to deal with – to re-motivate them to the point where they're ready to engage with the next step.'

Funded by a range of sources, including trust funds, organisations and a 'dedicated team of fundraisers', the national charity works with young people who have become disengaged or disenchanted with the education system at some point in their lives – which can lead them to a life of substance misuse, criminal activity and violence.

Working in 15 of the most disadvantaged urban areas in the country, Fairbridge aims to reach 13-25 year olds who are not in education, employment or training, and in the last couple of years has been working with schools to help those at risk of exclusion. Hardman believes that this preventative approach will give young people opportunities earlier and make sure there is less need later on for services to pick up the pieces once problems have developed.

'We're not an education provider but we're able to stimulate young people and give them the opportunity to learn about themselves,' she says.

After referral, each young person has an induction tour of the centre, which includes DVD footage and photos of what they offer. They meet with the staff to identify their individual development needs, before being put onto the Access Course. 'When they see with their own eyes what we do, they find it appealing,' she says. The real test is whether they can actually commit to the course: 'It can be quite difficult to engage them particularly if there's a question of territory – some don't want to be seen going to a certain kind of provision on their doorstep; others may be put off if it's in another postcode.'

'But we are very determined to be here for them and to work with the issues that they bring us – and there aren't many organisations that can really work with young people at that level,' she says.

Fairbridge offers programmes of personal development and helps clients to realise that their lives could be very positive if they made some different choices.

Those attending the centre can get hands-on experience of the business market through the 'Learn to Earn' 12-week course, which involves training sessions on promotion, IT skills or finance; or express their creativity through the 'Offbeat Studio' course. Other extra-curricular activities include caving, developing their own web pages, or spending a week learning to sail on a 92ft replica Victorian Pilot Schooner – all of which challenges their behaviour and perception of themselves.

'On each course, the focus is on the young person,' says Hardman. 'So in a cooking session it's great that they can make a nice apple pie, but at the end of the day it's about whether they came on time, did they work in a team, did they clean up afterwards, and did they achieve what they set out to achieve?'

After the Access Course, the majority of young people will meet with their key worker to set future goals in an action plan and decide which further sessions and projects will give them the opportunity to reach them. Every few weeks their progress is evaluated and more goals are set.

'For some young people this process goes on for a matter of weeks, for others a matter of months. But each person does it at their own pace until they get to a stage where they're ready to commit to something else and take it a step further,' says Hardman.

Many of the young people that enter Fairbridge are living without the support of their families, in care, or feel that they are on the margins of their local community. They may not have people who are setting boundaries for them and teaching them about the consequences of certain actions – which is something the charity tries to provide for them.

'Our responsibility is to encourage young people to experience the "buzz" out of life by giving to others, achieving something and taking part in activities,' says Hardman. 'Once they discover this, it then encourages them to use that skill elsewhere, when previously they might not have seen the attraction in doing so.' **DDN**

For information on Fairbridge's regional projects, visit the website at www.fairbridge.org.uk

Breaking the learning barrier

Alcohol and drug services have come a long way in recent years in identifying and catering for a wide range of service users with complex needs – but not far enough to help vulnerable adults with learning disabilities, says Mike Delaney**.**

During my years working in mainstream residential treatment I have seen many clients referred for treatment via statutory agencies such as police, probation or social services. Many of them had histories involving numerous short prison sentences for minor crimes such as theft or possession, but underlying many of their needs was an often undiagnosed learning disability. This prevented them from engaging in the recovery process, rendered the treatment experience ineffective, and created yet another sense of failure for the client.

The causes of this lack of engagement can be as simple as a basic cognitive impairment, which can prevent interventions such as group therapy from having any benefit. Indeed I have seen group-work have very negative consequences when clients felt pressurised to engage in the process but didn't know how to. There is also the possibility that they will display episodes of challenging or antisocial behaviour, which may not be deliberate in nature, but which generally provoke clinical teams to discharge clients because of the disruptive effects on others.

While they are themselves extremely vulnerable to exploitation and abuse, such clients often seek security through a sense of 'belonging' to a peer group and gain acceptance and approval through behaviour that pleases the group. They are often the scapegoat when police involvement occurs and can be left to face the consequences of their peers' behaviour.

Recent news reports have also highlighted the high levels of anti-social behaviour orders that are being placed on adults who have learning disabilities. Instead of being further marginalised and shamed within their communities, these people need specialist services to offer them support with their behavioural needs.

Having spent 20 years of my life working professionally within the learning disability and mental health field, and in the substance misuse field since addressing my own addictions ten years ago, I feel I have been able to look at services from a different angle and to see the shortfalls for this client group.

In 2004 I was involved in setting up and managing Stepps, a mainstream detoxification and treatment service – part of the Stepping Stones Group who, for many years, have provided specialist residential care for adults who have learning disabilities and challenging behaviour. When a client with an undiagnosed learning disability began to challenge the service in Stepps, I started to research the subject with the chief executive, Dominic Quinlan. I was astounded to discover that there were not only no specialist services whatsoever, but little or no acknowledgement that this particular client group even existed.

Some time later, after Dr Adam Huxley had published an article in *DDN* (3 July 2006, page 12) about this very subject, Dominic and I met up with him to discuss his research and insights into the situation and decided that the time was right to move forward with a more responsive treatment model for these clients. He introduced us to Dr Jeremy Tudway from Phoenix Psychological Services, who has many years' experience across the learning disability spectrum and a specialist interest in this very client group, having worked within secure services.

Together we explored mainstream treatment models and how they may negatively impact on adults with learning disabilities, further diminishing self-esteem and confidence and helping to create the familiar revolving door between treatment services or the criminal justice system.

We identified the need for specialist staff to deal with the complex issues and behaviours which may accompany substance misuse, and we looked at new ways of managing these challenges.

The result of this work is 'The Dorabella Model', a specialist model of residential treatment that is totally focused on the individual needs of each client. Following a modular system, it addresses all potential areas of need including educational needs, life-skills, cognitive skills, behavioural needs, emotional needs and social skills.

Clients entering the service are given various forms of encouragement and motivation to actually engage with and trust the process.

Failure is not in the vocabulary of the programme and only positive reinforcement is used to modify behaviour, as negative reinforcement has shown not to be successful in managing behaviour change.

The model is underpinned by an incentive scheme, which rewards positive change on a daily basis through the earning of points, which can be redeemed weekly for a range of activities such as cinema outings and bowling.

The staff team come from a variety of different professional backgrounds, including specialist mental health, learning disability and substance misuse nurses; clinical and assistant psychologists, therapists and treatment workers.

The treatment model's success depends on staff being able to understand and manage complex behaviours, so staff are trained and experienced in a range of communication skills, low-arousal and de-escalation techniques, designed to manage behavioural risks without the need for physical restraint. We have also designed an in-house training package, which brings all staff together and addresses teamwork, quality standards, continuity of care, supervision and future training goals.

The client assessment process is pivotal to the efficacy of the model, so clients are admitted for an assessment period before full admission to the programme is agreed. This enables the clinical team to gather information and to further observe the current mental, physical and behavioural states as opposed to relying on historical information which may no longer be relevant.

The detoxification process can begin at this point and may be for an extended period to take account of the re-emergence of feelings and behaviours that may have been dormant during self-medication. Adults who have a learning disability will generally struggle to understand or verbalise this frightening process and will be provided with a range of different interventions to alleviate and support some of the anxiety and confusion they may be feeling.

The intense nature of the work and the deeply ingrained nature of some behaviour patterns can mean the primary treatment element lasting from six to nine months; however this is extremely flexible and client led. The need for post-treatment support is even greater within this population and we are keen that the throughcare element is also at a higher support level and is slowly reduced as confidence builds.

As this is the first model of its kind in Europe, we will be creating an evidence base as the programme develops. Although there is a longer term goal of abstinence, we are realistic in our short-term expectations for this vulnerable group, so our treatment philosophy includes many elements of harm reduction as opposed to total abstinence. Again, this should help to avoid the expectation of failure – not only from adults with learning disabilities themselves, but sadly also from professionals who do not have knowledge or skills in this area.

'While they are themselves extremely vulnerable to exploitation and abuse, such clients often seek security through a sense of "belonging" to a peer group and gain acceptance and approval through behaviour that pleases the group. They are often the scapegoat when police involvement occurs and can be left to face the consequences of their peers' behaviour.'

We will be measuring a wide range of outcomes so we can quantify the efficacy of interventions. Evidence may include positive changes in behaviour; improved interactions with peers, staff and family members; increased confidence; decrease in staff intensity; greater independence and a reduction in frequency of substance-using thoughts or behaviours.

Although this client group may not rapidly achieve what others in mainstream treatment centres can, they have a right to the opportunity to change and improve their lives in whatever ways we can support them, and over a time period which allows change to take place effectively.

Having worked in various services in both the statutory and private sector, I have maintained a realistic expectation of the difficulties which a new treatment service could face – primarily, who is going to pay for this?

DAATs are under financial pressures to reach targets within budgets, community learning disability teams are also facing budgetary cuts and may not be aware of the existence of these clients, many of whom have slipped through the social services net or who have managed to avoid the label of 'learning disability'. Many of them are better known to criminal justice services and have difficulty accessing any specialist service. In my personal experience, professionals can sometimes be guilty of avoiding responsibility for clients who do not have a convenient label, leaving them prone to being abandoned by services.

We feel that the best way forward is for involved agencies to talk to each other and to come up with funding partnerships so that a specialist service can be provided to this group. As with most specialist services, this may appear to be an expensive option in the short term.

But in the longer term, the financial savings across a whole range of service provision could be substantial as, with the proper professional support, previously misunderstood and vulnerable adults will be able to attain a higher level of self esteem, confidence and independence – removing the need for them to be involved with plethora of inappropriate services such as police, probation, prison, lawyers, bail hostels... The list goes on.

Mike Delaney is clinical director at Dorabella House, based at Pfera Hall in Gloucestershire. To arrange a presentation to your team or informal visit, email mike@steppingstonesru.co.uk, call 01531 650880, or visit www.pferahall.co.uk.

A radical solution to the Afghan opium problem

Are morphine-free poppies the answer? asks **Percy Menzies**

The United Nations has reported that the opium poppy harvest in Afghanistan has reached record levels and is not likely to abate in the near future. The United States alone has pledged tens of millions of dollars to eradicate poppy cultivation and provide incentives to Afghan farmers to grow alternative crops, but this policy is facing the same failure as the war on coca plants in Latin America.

The bottom line is that the poppy is a reliable, drought-and-disease resistant cash cow in a country where the average daily wage is two dollars. On the other hand, the typical family farmer made $3,900 growing opium in 2003, according to the UN's own figures.

Although illegal opium is grown to extract morphine and convert it into heroin, the poppy is a vital source for the morphine and codeine used in pain medications and other legal products. It also contains a relatively inactive compound called thebaine, which is converted into a wide range of pain medications including oxycodone, hydrocodone and buprenorphine.

Despite the negative press sometimes surrounding these medications, they are indispensable for the treatment of acute pain. Thebaine, an alkaloid, is also the starting material for a number of highly effective medications like naloxone and naltrexone that are used for the treatment of addictions to opioids and alcoholism.

Unlike the opioid pain medications, naloxone and naltrexone have no abuse potential and no street value. Some communities are distributing naloxone syringes to street addicts to reverse heroin overdoses and save lives. Naltrexone is a non-scheduled medication that produces no high and is not habit-forming. In the US, it is primarily used to treat 'motivated' patients like physicians who are addicted to opioids. Naltrexone is also the first anti-craving medication approved by the FDA for the treatment of alcoholism. The FDA also approved an extended release injectable form of naltrexone to improve patient compliance. Australia is studying the efficacy and safety of a naltrexone implant.

Scientists in Australia have succeeded in producing opium poppies that yield a higher content of thebaine but contain no morphine. Although thebaine can be converted to heroin, the chemistry required is far too sophisticated for jungle laboratories. Grown by farmers in Tasmania, these modified poppy plants are a major source of thebaine which is converted into a wide range of medications.

The UN has said that the Afghan Government, Parliament and partner nations have made it clear that buying up the opium crop for medical purposes is not an option under current circumstances because the price differential between legal and illegal use is too great and increased production would be diverted to the black market. Opium growing is inextricably linked to the Afghan economy. The attempts to get the Afghan farmers to switch to crops like wheat are likely to fail. But what if Afghan farmers were given incentives to grow the modified variety of the opium poppy with a guaranteed purchase price? The crop would have little value in the black market and increased availability of thebaine could have several benefits to mankind.

Pain medications such as oxycodone and hydrocodone, with proper safeguards to regulate dosage and prevent tampering could be made available at affordable prices to countries that presently ban these products for fear of diversion. These safeguards, such as the reformulation of buprenorphine as a sublingual tablet containing naloxone, would prevent abuse and provide relief to thousands of cancer patients and others suffering from chronic pain.

With increased thebaine production, naltrexone and naloxone could be made available at substantially lower costs. Alcoholism is the fifth leading cause of death worldwide. Addiction to opioid pain medications is on the rise in the US and Europe, and heroin addiction in Iran, Russia, Pakistan, India and China is reaching staggering proportions, contributing to the spread of HIV and hepatitis C. Buprenorphine sublingual tablets and naltrexone may be even better suited medications for Third World and Islamic countries than they are in the West because most patients live with their families and medication compliance is less of an issue.

Much work will have to be done on several fronts, of course, involving the governments of many countries, national and international agencies, and law enforcement. The so called '80-20 Treaty', which stipulates that 80 percent of the world's opium for legal medicinal use should come from India and Turkey, will have to be renegotiated in the United Nations. India and Turkey may initially resist giving up their near monopoly on supplying opium, but their farmers could also switch to the modified poppies and reap considerable benefits not only from processing the raw opium, but also converting the thebaine into a dozen or more products for the treatment of pain and addiction to opioids and alcoholism.

Think tanks will have to look into every aspect of the proposal, including the potential involvement of the international drug cartels in thwarting any attempts to cut off their lucrative markets.

No, it won't be easy. Naysayers will say it's naive politically and unfeasible economically. Nobel Peace Prize winner Norman Borlaug faced stiff opposition himself in bringing the Green Revolution to Latin America, South Asia and Africa, saving an estimated one billion lives from starvation in the process. This is another opportunity for modified poppies to save lives and relieve misery. It's also a chance for Afghanistan to transform its reputation as a narco state into being a healing state.

Percy Menzies, M. Pharm. is the president of Assisted Recovery Centers of America LLC, a treatment centre for addictive disorders based in St. Louis, Missouri.

What the science shows, and what we should do about it (Part 5)

Professor David Clark completes the main 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. Professor David Clark completes the main 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.

On the basis of discussions at a 'think-tank' conference, leading US addiction experts proposed a set of ten recommendations for 'designing programs, systems, and social policy to reduce drug and associated suffering, societal harms and costs'. We look at the last four of these recommendations.

Recommendation 7: Enhance positive reinforcement for non-use and enrich alternative sources of positive reinforcement.

Stopping the use of substances removes one source of reinforcement. If the person giving up substances does not have alternative sources of positive reinforcement, they are likely to start using or drinking again. It is important to organise treatment efforts around helping people to develop meaningful and rewarding lives.

People with substance use problems are often cut off from alternative sources of reinforcement. A significant task for them is to establish or re-establish contact with social networks that favour abstinence, and to sample and gain access to sources of non-drug reinforcement.

Gaining employment and a range of social responsibilities can be important sources of reinforcement that are incompatible with substance use. Connection or reconnection with spiritual/religious organisations, or involvement in 12-step support groups, can be helpful.

'In essence, the goal is to develop a rewarding drug-free life that competes successfully with the allure of positive and negative reinforcement that drugs can provide.'

Recommendation 8: Diminish the rewarding aspects of substance use.

Pharmacotherapies represent one effective means of doing this. Various medications (*eg* methadone, buprenorphine, naltrexone) undermine the pharmacological incentives for taking drugs by blocking, replacing, or offsetting drug effects. A principal problem in their therapeutic use has been medication compliance. Drug use is also responsive to monetary and social reinforcement.

In treating an individual, it is important to consider what reinforcement the person is receiving for drug use, beyond the pharmacological incentives of the drug itself.

With proper support and coaching, families can learn to reinforce behaviour incompatible with substance use, and most of the time can engage an initially unmotivated loved one in treatment. Conditions that protect people from the natural negative consequences of their own substance use can be removed.

'An unsuccessful outcome is a failure of treatment, not the person, and warrants trying a different approach.'

Recommendation 9: Make services easily accessible, affordable, welcoming, helpful, potent, rapid, and attractive.

'Common obstacles include waiting lists, stigma, geographic inaccessibility, cost, restricted hours, and limited program goals that do not match the individual's priorities. All of these obstacles can be addressed in redesigning service systems.'

Intake systems should be welcoming and attractive. A professional should be seen from the outset, and questions in the initial consultation should be kept to a minimum. 'Half an hour of listening, letting people tell their story and express their concerns and goals, is a good start before asking questions and completing the forms needed for administrative purposes.'

Programs and practitioners are there to meet the needs of the client, not vice versa. Drop-out in early stages of treatment often occurs because the person sees a mismatch between what is on offer and their own needs and priorities.

'Services should take into account, respect, and address the client's own goals, needs, priorities, and values. Offer a menu of alternative services and goals from which people can choose what best meets their needs and preferences. Express clearly that there is no one effective approach for all affected individuals and make a commitment to keep working with the person until you find what works and his or her goals are met. An unsuccessful outcome is a failure of treatment, not the person, and warrants trying a different approach.'

Recommendation 10: Use evidence-based approaches.

There are large differences in outcomes depending on the services provided. Some forms of treatment are ineffective or harmful. Treatment services should concentrate on those approaches with the best evidence of efficacy. 'It is long overdue for science, rather than opinion and ideology, to shape interventions for drug [substance use] problems.'

Learning a new treatment approach involves more than reading a book or attending a workshop. It requires training involving supervision and coaching, as well as support from administrative officials and funding sources. Learning a new complex skill rarely occurs without feedback on actual practice, but this rarely happens in the treatment system.

Attention should be given in hiring to the qualities of the practitioner (*eg* accurate empathy) that are associated with better outcomes. 'One of the largest determinants of how clients will fare in treatment is the clinician to whom they are entrusted.'

It is important to have 'a system that monitors the ongoing outcome of treatment services, providing timely, accurate, and reliable feedback to treatment providers, managers, and funding sources as well as to affected individuals and their families'.

The experts do not recommend reducing practice into a list of 'approved' evidence-based treatments, since this would stifle creativity and limit services to the practices of the past. 'While interventions with a good evidence base are a good starting point, a creative system will also encourage innovation to accomplish specified goals and to monitor outcomes to know which practices do, in fact, promote the achievement of those goals.'

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

Working with Anger

New Leaf offers bespoke training courses to organisations helping them devlop stratergies in working with the anger of indivdiduals.

Becky Wright MSc PGDip Couns MBACP also works on an individual basis in her Wellington Therapy Centre.

Enquires and Booking: New Leaf 01823 660426
www.newleaf.uk.com new.leaf@virgin.net

SUBSTANCE

Drug, Alcohol and Domestic Violence Training and Consultancy
Bespoke training tailored to your organisations needs

Substance is an association of highly qualified, independant professionals with a wealth of experience across the Social Care, Drugs, Law, Alcohol, and Domestic Violence fields.

Key personnel include Frances Potter, Greg Poulter, Rachel Hassan, Jai Hart, Ian May, Chris Newman and Kate Iwi

Contact Frances Potter on 020 8847 5437
or email franepotter@hotmail.com

Cara Crossan

Clinical Supervisor/
Addiction counsellor

07733 286 397
caracrossan@hotmail.com

IAAAC/FDAP Accredited member,
Hazelden – Diploma addiction studies
Hazelden – Diploma Addiction counselling,
Registered licensed NLP practitioner,
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Specialising in: Clinical Supervision, Drugs, Alcohol, Gambling, Eating Disorders, One to One, Group Work, Relapse Prevention.

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If you want to stop smoking then one session may be all you need.

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Very high success rate

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DRUGLINK

QUALITY SUBSTANCE MISUSE SERVICES

An organisation dedicated to quality drug services, development and training, meeting DANOS requirements.

Developing or implementing a new strategy?
Need a coordinated training programme to underpin successful outcomes?

Existing training programmes
- Peer led injecting and crack smoking workshops
- Safer injecting and crack smoking workshops for drug workers
- Pub Watch training and development
- Workforce and management training

Programmes can be tailored to your specific requirements

Pharmacy Based Needle Exchange
- Consultancy
- Management
- Data performance framework
- Service user involvement

Our service will give complete demographics, numbers sharing, numbers inoculated. We manage all areas of the service from pharmacy payments to equipment purchasing and delivery.

Druglink has been delivering drug treatment services for twenty-five years. Establish a partnership and make change happen.

For further information please call
Sue Green 01923 271786
E mail sue.green@druglink.ltd.uk
www.druglink.ltd.uk

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FIRST NOTICE

First National Day Programmes Conference

Evidence and practice

Thursday 18th October 2007
Central London

Aim of the conference:

To examine a range of day programme models that have been developed to meet the diverse needs of substance users.

To provide practitioners, managers and commissioners with opportunities for the exchange of ideas and good practice that relate to the provision of day programme services.

To consider the research that underpins current practice and identify any areas where the evidence base for day programme delivery could be better developed.

K·C·A Training & Workforce Development

To register for details contact:
KCA Training and Workforce Development
43A Windmill Street, Gravesend, Kent, DA12 1BA
Tel: 01474 326168 Email: tcw@kca.org.uk

oxfordshire
drug & alcohol action team

Provision of the Oxfordshire Drugs Recovery Project
TENDER ADVERT

The Oxfordshire Drug and Alcohol Action Team (DAAT) are inviting expressions of interest for the provision of the Oxfordshire Drugs Recovery Project (DRP).

The DRP will be a specialist residential Tier 4 service providing an intensive mid length treatment programme (3 to 6 months) that includes assisted withdrawal/detoxification, 7-days a week. The service will also provide the option of an intensive short stay programme (4-8 weeks) for those who are assessed as suitable. The DRP will accommodate between 5-8 service users at any one time, depending on premises.

The primary aims of the service are to assist service users in achieving abstinence from illicit drug use by providing assisted withdrawal/detoxification and psycho-social interventions.

The service will provide a flexible programme of therapeutic activities and interventions that will include treatment services provided by organisations within the Oxfordshire Treatment System. The programme will meet the support needs and goals identified with the service users during the assessment and care planning process and will include one to ones, group work and psychosocial intervention.

Clinical input at the DRP will be provided by a dedicated Addictions Nurse from the Specialist Community Addictions Service (SCAS) who will be an integral part of the DRP team.

The programme will be fully integrated in the Oxfordshire Drug Treatment System providing exit routes at the end of the treatment episode that will include; access to move on and aftercare support, residential rehabilitation, structured treatment in the community, education and employment.

The contract period will be for 3 years with the option to further extend for 12 months plus a further 12 months. The value of the contract per annum will be in the region of £200,000 - £240,000. This does not include costs for premises, there will be an expectation that premises will be provided by the successful organisation under this contract.

Process for application:

1. Written Expressions of Interest must be received by the DAAT by 12noon on Friday 13th July 2007.
2. Upon receipt a pre-qualification questionnaire will be sent to all interested parties to be completed and returned by 12noon on Friday 27th July 2007.
3. Following evaluation of the pre-qualification documents the DAAT will expect to invite between 3 and 6 organisations to tender.
4. Organisations that are short-listed to tender will be notified during the week commencing 6th August 2007.
5. The deadline for completed tender bids is 12noon on Tuesday 16th October 2007.
6. It is envisaged that the start date of the service will be mid February 2008, depending on premises.

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

TENDER FOR NEW SUBSTANCE MISUSE TREATMENT GATEWAY SERVICE

Southend-on-Sea Borough Council is inviting experienced Drug Treatment Providers to tender for its new Drug Service. This service is for open access, community-based, non-care-planned interventions and structured-care-planned Counselling and Day services for adults with problems relating to primary drug use. The service will act as the first point of contact for substance misusers in Southend on Sea and provide specialist psychosocial interventions for those clients who need it. The service will be expected to target problematic drug users currently not accessing any treatment services.

If you wish to tender for the above requirement, please contact Karley Burchell to request a prequalification questionnaire (PQQ) at -

Address: Corporate Procurement, 2nd Floor, Civic Centre, Southend-on-Sea, Essex, SS2 6ER
E-Mail: karleyburchell@southend.gov.uk
Phone: 01702 534816
Fax: 01702 215110

Closing date for document requests is 5pm 13th July 2007.
Completed Questionnaires should be returned by 3pm 27th July 2007.

SOUTHEND-ON-SEA BOROUGH COUNCIL

DDN/FDAP workshops

fdap DDN

Healthy Eating for a Better Life – 3 July, London
This one-day workshop will provide practitioners with the knowledge to address clients' dietary needs – to improve their health generally and help minimise the risk of relapse.

Brief Interventions on Alcohol – 23 July, London
This one-day interactive workshop will examine screening tools and short motivational interventions. This workshop is mapped to DANOS and provides vital information for all drug and alcohol workers.

The essential drug and alcohol worker – 17-21 September, London
This five-day course provides a full introduction to the elements of effective drugs and alcohol work. This workshop is delivered in association with DDN and DrugScope.

All one day workshops cost: £110 + VAT per head
Five day workshop cost: £635 + VAT per head
(15% reduction for FDAP members/affiliates – rates for groups on application)

Contact Ruth Raymond
e: ruth@cjwellings.com, t: 020 7463 2085

www.fdap.org.uk/training/training.html

Commissioning News Summer School

BOOST YOUR SKILLS with the Commissioning News Summer School

Commissioning News presents a range of courses run by experts from the Centre for Public Innovation and the legal firm, The Projects Partnership.

Courses

3 July: Refresh your commissioning skills in health and social care
A one-day course covering technical skills and legal advice on business cases, tenders and contracts. *£195 plus VAT*

10 July: Outcome-based commissioning and contracting
An intensive one-day course introducing outcome-based tenders, contracts and monitoring. *£195 plus VAT*

11 July: Leading for results within multi-agency partnerships
A one-day course on the behaviours and tactics required for successful multi-agency working in partnerships for substance misuse, crime reduction, and health and social care. *£145 plus VAT*

19 July: Innovation and change – creating and buying new ways of working
A one-day workshop on fostering innovation and new ways of working from providers. *£145 plus VAT*

To book: Telephone Ruth Raymond on 020 7463 2085 or email ruth@cjwellings.com

HMP LINDHOLME>

EXTRAORDINARY JOBS.
EXTRAORDINARY WORKPLACE.

HM PRISON SERVICE

Public Sector Prisons

PASRO DRUG TREATMENT MANAGER G
£23,434 - £30,676

HMP Lindholme is a category C male prison situated North East of Doncaster approximately five miles from the M180.
A Treatment Manager G is required to oversee PASRO, a drug intervention programme with the philosophy of harm minimisation and relapse prevention. It also has an aim of reducing future offending behaviour. The role involves professional oversight of the programme, programme facilitation and supervision, as via individual work and facilitating the structured group work programme as part of a team as well as the Management of other facilitators.

The role requires individuals who possess one or more of the following:
- Psychology degree or equivalent
- RMN
- Drug and Alcohol Counselling Diploma
- Degree/Diploma in Social Work Probation Studies

Or
- Six months' experience of working with Substances Misusers or Offenders
- Experience of running Drug Rehabilitation Groups would be desirable

Candidates found suitable at the application stage will be invited for interview and required to give a short presentation and attend an assessment centre. Securing the post permanently is contingent on passing Prison Service PASRO training. This takes place initially over two days, followed by a two-week training course. Both are residential.
Benefits include 25 days annual leave plus 10.5 days public and privilege holidays and flexible working practices. The Prison Service also offers the choice of a final salary and stakeholder pension scheme that gives you the flexibility to choose the pension that best suits your needs.

For further information and an application pack please contact Mr Tom Stent, Personnel, HMP Lindholme, Bawtry Road, Hatfield Woodhouse, Doncaster, S Yorks, DN7 6EE. Tel 01302 524979. Fax 01302 524760. Email: Thomas.Stent@hmps.gsi.gov.uk

Closing date: 2nd July 2007.

Applications for part time and job share are welcome
The Prison Service is an equal opportunities employer

NOMS National Offender Management Service
Working together to reduce re-offending

PRIORY

The Priory Hospital - Altrincham is an independent psychiatric hospital with an established addiction treatment programme, working on a 12-step abstinence based model.

Addiction's Therapist

The Priory Hospital, Altrincham
Full time - 37.5 hours
Salary Band: £17,621 - £28,194

We are currently looking for an energetic and experienced Therapist to join our team providing 7-day treatment programmes to in-patients.

The candidate will be a qualified therapist and have experience in facilitation of group and individual therapy within the addiction field. FDAP accreditation or evidence of working towards this is required.

The successful applicant must enjoy working as part of a multidisciplinary team and be willing to be flexible to the needs of a busy unit. In return for your commitment and hard work you will work in a well-resourced, first class environment.

The successful candidate will be required to apply for a Disclosure at the Enhanced level from the Criminal Records Bureau. Further information can be obtained from www.disclosure.gov.uk

For more information and/or an informal visit please contact Jonathon Cooke, Lead Therapist, Addictions Therapy Programme on 0161 904 5617.

For an application form and job description contact Debbie Gauge, HR Advisor at: The Priory Hospital - Altrincham, Rappax Road, Hale, Cheshire WA15 0NX. Telephone 0161 904 0050 or via email on debbiegauge@prioryhealthcare.com

Closing date: 2nd July 2007.

We are an equal opportunities employer.

www.prioritygroup.com

We take action to disarm addiction. We do this through research, treatment, family support, education and training.

Our Day Treatment Centres are currently looking to recruit the following people:

- Counsellor (1 full-time and 1 part-time position) London
- Counsellor (part-time) Liverpool
- Admissions and Referrals Coordinator
- Receptionist & Admin Assistant
- PA to CEO and Principal Consultant

Counsellor to provide a counselling service to clients both individually and collectively and responsible for managing a caseload. Experience in the addictions field preferable but not essential. Admissions and Referral Co-ordinator to manage and coordinate the admission process of all clients into treatment. Receptionist & Admin Assistant to run an efficient and effective reception and provide comprehensive administrative support. PA to provide confidential support to the CEO and Principal Consultant.

For more information and to receive an application pack for any of the above roles, please contact Mardeen Willows on 01747 830 733 alternatively email Mardeen.willows@actiononaddiction.org.uk Closing date: 13th July 2007

Action on Addiction

The Chemical Dependency Centre has merged with Action on Addiction and Cloads. The new organisation is called Action on Addiction.
www.actiononaddiction.org.uk Charity No: 1117488

Alcohol Concern
Making Sense of Alcohol

Alcohol Concern is the national voluntary agency on alcohol misuse, working to reduce the harm caused by alcohol and to improve services for people with alcohol problems and their families.

Youth Provider Training Officer

London, £26,277 (inc LW)

Alcohol Concern is launching a national accredited training programme for practitioners working with young people to develop their knowledge and skills to work with young people around alcohol. The training is rolling out from September 2007 across England, Scotland, Northern Ireland and Wales.

The Youth Provider Training Officer will work part of a team and will be responsible for delivering training for the national training programme. The role involves travelling to different regions to deliver the training as part of the programme.

You will have a sound understanding of alcohol awareness and working with young people. You will have experience of delivering training to professionals.

Closing date for applications: 12 noon Friday 22nd June 2007
Interviews on: 2nd July 2007

For an application pack email: recruitment@alcoholconcern.org.uk
download a pack from our website: www.alcoholconcern.org.uk
or call our recruitment line on: 020 7264 0528.
For more information about the post please contact Hajra Mir on 020 7264 0522.

Alcohol Concern is committed to implementing a comprehensive Equal Opportunities Policy and we welcome applications from all sections of the community.