DDN
Drink and Drugs News
26 February 2007
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LICENSED TO BOOZE
Has legislation changed our drinking culture?

BRISTOL TO KENYA
Maggie Telfer OBE shares inspiration

DRUGS IN PRISON
Can we break the cycle?

A FACE IN THE CROWD

Can we find the 400,000 sufferers who need treatment?

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Drink and Drugs News

26 February 2007

Editor's letter

With an estimated 400,000 people with hepatitis C in the UK, it might seem the most logical move to introduce compulsory testing for anyone entering treatment services. Many people don't know they have the virus, which can manifest itself years later in debilitating symptoms that need expert medical care.

Talking to Siobhan Fahey, a viral hepatitis clinical nurse specialist (page 6), brings some important considerations to light. Compulsory testing can be counterproductive, she points out, driving clients away from services. There is a lot of ignorance surrounding hep C, and much ground to be made up – from raising awareness about the virus to helping people tune into their symptoms.

The Scottish Executive has bitten the bullet by committing an initial two years' worth of funding to a detailed action plan, with a promise of further resources in the future. With one per cent of Scotland's population – that's 50,000 people – thought to be infected with hep C, the chief medical officer has acknowledged an urgent situation and is backing a target-driven approach that involves agencies throughout the country. The hope attached to the plan is in its accountability: a co-ordinating group has been set up, and regional leads have been designated to make sure the promised action is not forgotten about in their area.

If the plan falters, there are enough stakeholders involved to ask why, and to push progress along to the next gateway for funding in two years' time.

For the drug users and former drug users who make up most of the hep C caseload, there has to be a breakthrough in the rates of supportive testing, care and treatment – not just in Scotland, but all over the UK – and plenty of scope for a strong multi-agency approach. Recovery is hard enough, without having to contend with the frightening burden of a mystery illness.

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Tier 4 capital funding announced...

Tier 4 capital funding has just been announced for 2007/8. The government has allocated £54.3m to improve in-patient and residential drug and alcohol facilities – a 1.1 per cent reduction on last year's budget.

The money will be distributed to strategic health authorities, following a regional bidding process. Investment will go towards more improvements to buildings and more women-only facilities, provision for women with children, families, people with disabilities, offenders and those at risk of offending, and black and minority ethnic clients.

Announcing the funding, Public Health Minister Caroline Flint said that the government was committed to increasing the availability of inpatient treatment and residential rehabilitation for substance misusers.

She added: 'Today's announcement is a clear sign that drug treatment remains a key priority for government funding... This funding will help to provide a life away from drugs for the user and a new future for families, friends and communities affected by the impact of drug addiction.'

Information on the tier 4 placements being made by local partnerships and providers will be published on the NDTMS website, www.ndtms.net on 28 February.

The announcement follows confirmation of the pooled treatment budget, which was released on 26 January.

A rap artist performs at a community awards ceremony held by Birmingham drug action team (BDAT). Awards included community champion, drug worker, drug project, former drug worker, outstanding contribution and lifetime achievement. Former service users contributed to the entertainment programme, which included an animated film, screened on the night, showing snapshots of participants' lives when they were addicted to drugs, through to their new drug-free status. Winner of the lifetime achievement awards was BDAT's crack strategy manager, Grantley Haynes, who said: 'How we spread the word about drug safety and get the message across is one of the key factors in reducing the harm caused by drugs.'

FDAP launches workforce development programme

FDAP is today launching 'Developing the Workforce' – a programme of training, competence-assessed qualifications and resources designed to help DATs and services develop their staff and meet the requirements of the Joint NTA/Home Office (DSD) Workforce Development Plan and the NTA Workforce Targets.

The new programme includes:

- 'DANOS demystified' – a 90-minute introductory e-learning course for all workers and managers on DANOS, role profiling, appraisal and competence-based qualifications;
- a range of training and competence-assessed qualifications for workers and managers;
- training and support on developing and implementing local workforce strategies;
- online guidance, a database of training and qualifications, specialist application software, and a free expert helpdesk.

For more information see the flyer enclosed with this issue or visit FDAP's website – www.fdap.org.uk

Police chief backs heroin prescribing to addicts

Heroin should be prescribed to more addicts to reduce crime, a senior police figure has stated.

According to various media reports, Ken Jones, president of the Association of Chief Police Officers, called on the government to make the drug available to 'hard core' users so they were no longer forced to commit crimes to fund their habit.

'We have to find a way of dealing with them and licensed prescription is definitely something we should be thinking about,' he said.

Mr Jones is not the first police figure to back such a proposal. Heroin prescribing has in the past been supported by Howard Roberts, chief constable of Nottinghamshire, Richard Brunstrom, chief constable of Wales, and Sir David Phillips, Mr Jones predecessor at the ACPO.

The government did announce plans more than five years ago to expand the existing heroin prescribing scheme, which supplies users with medical grade heroin. The number of users in the scheme, however, has remained static.

Government review claims FRANK is working

FRANK has firmly established itself as a 'credible' and 'non-judgemental' source of information about drugs and their effects for young people and parents alike, a government review has found.

The review – *The development and performance of all things FRANK* – stated that through various advertising, sponsorship and public relations campaigns, awareness of the service was now at an all time high.

Research found that there was a 68 per cent prompted awareness level among young people, and a 49 per cent prompted awareness level among parents. More people than ever before are also likely to call the helpline – 29 per cent of young people and 43 per cent of parents said they would use the service. In 2005, the helpline answered an average of around 1,350 calls a day, and throughout 2005/06 more than 2 million people visited the talktofrank.com website.

The campaign, according to public health minister Caroline Flint, has exceeded many of its key performance indicators and has established itself as an important element of the government's strategy of prevention and early intervention on drugs.

'With its innovative use of media and continued support for stakeholders, FRANK is well-placed to contribute to the government's goal of improving the lives of children and young people by helping them to choose a positive and healthy future,' she stated.

Throughout the coming year, FRANK is aiming to build 'deeper relationships with its target audience, in particular through developing more interactive communications'. A new set of drug literature is planned for both young people and parents, including a new leaflet specifically on cannabis. Also planned is a new range of attention-grabbing postcards, featuring jokes and quizzes, with the aim of prompting discussion around drugs.

For further information see www.drugs.gov.uk

Drink spike victims more likely to be binge-drinkers

Most people presenting to accident and emergency departments claiming their drink has been 'spiked' are likely to have simply consumed too much alcohol, a Welsh research study has found.

For 12 months, beginning in October 2004, researchers from Wrexham County Borough monitored all patients attending the A&E department of Wrexham Maelor Hospital alleging their drink had been tampered with.

A total of 75 patients presented during this time, and samples from 42 patients were tested. Eight of these samples tested positive for drugs, however none contained ketamine, GHB or rohypnol – substances most commonly associated with drink spiking. Most patients presenting to the department did so on the night of the alleged incident, so even drugs with a short detection window should still have shown up.

Cocaine, ecstasy, amphetamine and opiates, specifically codeine and morphine, were detected. Researchers did also note that some of the patients may have had their drinks spiked with alcohol.

'Our study showed a much higher detection rate for alcohol,' the researchers stated. 'Claiming their drink has been spiked may also be used as an excuse by patients who have become incapacitated after the voluntarily consumption of alcohol.

'There have been a number of publicity campaigns in recent years to raise awareness of drink spiking. Emphasis should also be laid on how excess alcohol consumption makes people more vulnerable to assaults and injury.'

The research findings have been published in the latest edition of Emergency Medicine Journal.

'Career criminal' exit programme hailed as success

A Home Office programme aimed at helping the most troubled offenders – particularly problematic drug users – exit the cycle of crime, has been hailed as a success.

The Prolific and other Priority Offenders programme was launched in England and Wales in 2004. It aimed to identify 'career criminals' and then help them stop re-offending using a variety of strategies, from close monitoring to provision of practical support such as training, accommodation and, importantly, drug treatment.

Last week the government released the first evaluation report on the programme. It found that among the 7,800 offenders who had been through the programme, conviction rates fell dramatically. Overall, conviction rates among the group dropped by 62 per cent after 17 months on the scheme.

As part of the evaluation, 60 interviews were carried out with prolific offenders. With the exception of one, all of those interviewed had used illegal drugs and three-quarters stated that their main reason for committing crimes was to fund a drug habit. More than half of those interviewed said they found the drug treatment aspect of the programme to be helpful.

Statistics on the drop in re-offending were also supported – anecdotally – by offenders themselves, the majority of whom claimed to have reduced or stopped their criminal activities.

The evaluation recommended that the worst offenders should be entered into the programme as often as possible.

Home Office minister Tony McNulty said the evaluation clearly showed the government strategy was working. 'The results of this evaluation are very impressive,' he said. 'They show that if we can focus on dealing with the small number of problematic offenders – including problematic drug addicts who are responsible for large numbers of crimes – we can improve the quality of life for communities.'

Scots at 'twice the risk' of alcohol-related death

Scots are twice as likely to suffer an alcohol-related death when compared to the UK population as a whole, according to latest figures from the Office of National Statistics.

An analysis of the geographical variations in alcohol-related deaths between 1991-2004 found that both Scottish men and women were at significantly greater risk. Between 2002-2004, the death rate for Scottish men was 39.1 per 100,000 population, compared with 17.4 across the whole of the UK's male population. The figures also revealed that, strikingly, Scottish women were more at risk than English men of suffering such a fate, with 15.7 alcohol-related deaths per 100,000.

Fifteen of the top 20 areas with the highest number of alcohol-related deaths could be found in Scotland. Glasgow City tops the list with 83.7 deaths per 100,000 people, and Inverclyde was second with 77.8 per 100,000.

Overall, the figures showed a significant rise in alcohol-related deaths across the UK as a whole. In 2004 there were 8,122 such deaths, nearly double the 1991 figure. The gap between the genders was significant – in 2004 the male death rate was 17.6 per 100,000, compared to the female death rate of 8.3 per 100,000. The vast majority of these deaths – 85 per cent – were attributable to cirrhosis.

Older people appear to be more at risk. Men aged 55- to 74-years-old consistently had the highest death rates across all regions. The same age group was most at risk among women. Interestingly young people – often the target of many government strategies – were the least likely to suffer an alcohol-related death.

Deprivation appeared to play a key part in these deaths. In England and Wales, alcohol-deaths among men in deprived areas were more than five times higher than those living in the least deprived areas. For women, the difference was just over three times.

Many of the estimated 400,000 people with hepatitis C in the UK struggle with symptoms but don't yet know they have the disease. So how do we find them and pull them into treatment? The NTA is tackling the crisis in England through compulsory testing; the Scottish Executive has gone much further by committing resources to an action plan. DDN reports.

Finding faces in the crowd

In October 2005 David Wright wrote in *DDN* about his response to finding out he had hepatitis C. Living in a hostel while on a methadone script, the hep C test had been offered alongside routine blood tests at his local drugs service. He'd had no objection to going along with the test and didn't worry, because he'd 'always tested negative for all the other tests'.

When he phoned back later about his script, he was called in and ushered through straightaway to the doctor, where he remembers this scene took place:

'I was sat next to the doctor, who said, "we have had your blood results back", pointing to something in my file. There it was in black and white: hepatitis C positive". My response was confused, not really understanding, as I said, "what is hepatitis C?" She

was telling me what they knew about the virus, which was going in one ear and out of the other. Then the alarm bells started to ring as I blurted out, "am I going to die?"'

This scenario is not unique. There are an estimated 400,000 people in the UK with hep C – and many of those have no idea that they are carrying the disease. Transmission of the virus is high among injecting drug users, as demonstrated by recent studies of injectors in Glasgow, which found that between 44 and 62 per cent of them were infected with hep C. The Health Protection Agency's 2006 update on hepatitis C in England, showed newly diagnosed cases increasing from 2,116 cases in 1996 to 7,580 in 2005. A 60 per cent increase in testing over the last four years has confronted many more people with the question David Wright had to face: If I have hep C, what does this mean for me? What's my outlook?

In the same month that David had his news, the NTA announced a change in hep C testing policy. Replacing the recommendation in the 2002 *Hepatitits C strategy for England*, that routine testing should be 'offered' to injecting drug users, the NTA set a new target of testing all injecting drug users, past and present for the hep C virus.

But there are concerns that this target-driven approach to hoovering people into services could be counterproductive, and that it risks giving a label without a care programme to those who test positive.

'This 100 per cent target is problematic; it takes no account of ethics,' says Siobhan Fahey, a viral hepatitis clinical nurse specialist, who divides her time between working at Calderdale substance misuse service and Calderdale Royal Hospital in Halifax.

Fahey's worries for the many clients who come into the service with concerns other than hep C on their minds, who will not be geared up to receive traumatic news about their health. Furthermore, she fears that pressing them into being tested before they are ready could drive them away from treatment and support.

'We have a responsibility to vulnerable clients,' she says. 'We need to weigh up what the benefits are of knowing, compared to possible risks of them not being able to handle the information at that time in their life.

'There is anxiety around waiting for the result, then around what to do with this information. What treatment do they go for, and what is its chance of success?'

Working within Calderdale's substance misuse service has given Fahey strong views on how testing services should be run. While acknowledging that it can score successes, she feels that 'passive testing', where clients are invited to opt for a hep C test while attending other services – such as a genitourinary medicine (GUM) clinic – can be a hit and miss affair. There is no tie-in to follow-up treatment, and no substance misuse specialist on hand.

An alternative 'opt-out' model – where clients are routinely tested on entering services, after being given the choice to opt out – is being increasingly used in HIV testing and could be applied to hep C. It seems a better option to Fahey than compulsory testing, but she is worried that too many drug users do not know enough about hep C to make this decision, and are again left vulnerable with test results they are not ready for.

With Fahey at the helm as specialist nurse, Calderdale's preferred option has been to develop an active model for hep C testing, with the focus on encouraging the client to take a test when they are ready. Testing is available whenever the client attends, and their decision to go ahead is cushioned by expertise and support from the drug team, before and after the result.

But the ingredient that makes the service truly active has been training drug workers to carry out hep C tests, supported and supervised by Fahey, equipping them to support the client at every stage of their care plan. They are on hand with information and leaflets, then carry out tests using oral mucosal transudate swabs, saving an appointment with the phlebotomist, and keeping the client's treatment journey intact. After a positive result, Fahey will refer them on to a consultant and make sure they can cope with what's happening to them, as well as putting them in touch with a local support group.

The drug worker training, mapped to DANOS, includes personal and reflective skills, such as how to break bad news, as well as the technical nuts and bolts of knowing all about hepatitis A, B, C and HIV and how to conduct a test.

'We have a responsibility to vulnerable clients... We need to weigh up what the benefits are of knowing, compared to possible risks of them not being able to handle the information at that time in their life.'

While the NTA testing targets loom large, the active model is proving a successful approach to increasing testing rates, without compromising the essential climate of support. Eighteen months ago – with comparatively poor record-keeping, Fahey admits – only 15 per cent of clients were recorded as having been tested for hep C. By October last year, 38 per cent had been tested; 24 per cent had been offered tests but had refused; and 38 per cent had been offered tests at assessment stage, but had not yet been tested.

'It's slow and steady growth,' says Fahey. New paperwork and better data inputting is improving the system all the time, building on the training of the drugs team.

But she is determined not to put NTA targets before her clients' holistic wellbeing, and calls for urgent research into opt-out and active models, to validate their use as a more realistic alternative to coercion.

Alongside the push for more testing, the Department of Health's hepatitis C awareness campaign, 'FaCe It', has been rolled out across England, accompanied by an exhibition featuring photos of people living with hep C.

Scotland's new action plan on hep C, published last September after detailed consultation, relies on active participation from everyone involved in prevention, treatment, care and support.

The Scottish Executive has allocated £4m to NHS boards to cover a first phase of action, until August 2008. It promises that a second phase of action will be constructed on the foundations of these initiatives, a pledge backed by chief medical officer, Dr Harry Burns, who adds:

'It will require a firm commitment to co-operation and action from a large number of organisations, groups and individuals across Scotland. My intention is that the publication of Scotland's first *Action plan on hepatitis C* will galvanise this commitment, and will provide a focus for tackling this serious health problem.'

The two-year first-phase of the plan draws on a wide range of expertise and sets a specific timetable for action. Health Protection Scotland are taking the lead, and have begun by setting up a hepatitis C Action Plan Co-ordinating Group (APCP) to represent all who have a stake in its decisions.

With an estimated 1 per cent of the population of Scotland infected with hep C – twice the number in other parts of the UK – the group is tasked with constructing urgent action to tackle a complex issue.

Action will be channelled to local level by a senior executive lead, identified by each NHS board area, who will liaise with community health partnerships and drug and alcohol action teams to improve care services, treatment, testing and prevention in their area.

A key strand to the action plan is improving awareness through education and training right across the board, from health and social care professionals, to prison staff, to children in secondary schools.

'There is no easy solution to this problem,' says the Scottish Executive. 'But it is a problem which we cannot afford to ignore any longer.' **DDN**

The Hepatitis C Action Plan for Scotland is at *www.scotland.gov.uk/Publications/2006/09/15093626/3*

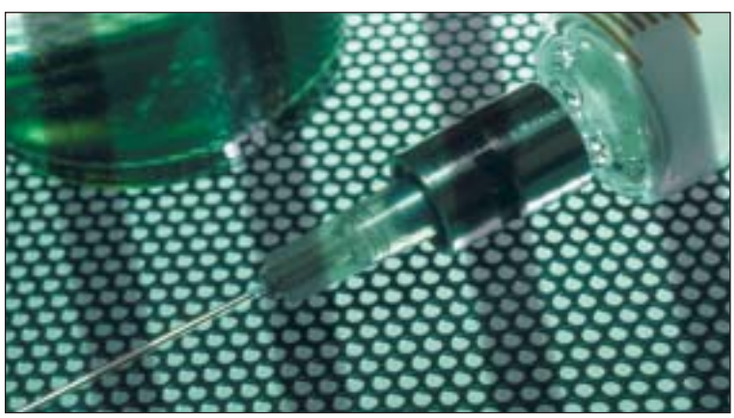
The Health Protection Agency's report, Hepatitis C in England – an update 2006, is available at *www.hpa.org.uk/publications/PublicationDisplay.asp?PublicationID=66*

The Hepatitis C trust has a comprehensive website that gives information on all aspects of hep C, advice on coping with symptoms and where to go for more support. Visit www.hepctrust.org.uk . It also runs a national telephone helpline manned by volunteers with personal knowledge of hep C.
Call 0870 200 1 200 for advice.

Comment

Drugs in Prison: who's controlling who?

Drugs are taking over the prison system and a strategy overhaul is dangerously overdue, suggests Professor Neil McKeganey.



'There is another solution... you stop sending your addicts to jail in the first place.'

In the classic nineteen seventies TV series 'Porridge' cigarettes are the common currency exchanged between prisoners, and drugs are not even mentioned at all. If the series were being remade now it would be illegal drugs that were being exchanged between prisoners and the laughs would be a good deal fewer. Drug abuse, in a way that was not even anticipated in the seventies, has virtually taken over our prison system to the point where the system itself is under severe threat.

There are numerous estimates of the number of inmates in Scottish prisons with a drug problem and the number who are actually using illegal drugs within prison. The eighth Scottish Prison Service survey found that out of the 23,206 prisoners admitted in 2005, 62 per cent were referred to addictions services. Some 50 per cent of those with a drug problem had used drugs in prison, with heroin being the second most commonly used drug after cannabis. Alarming as those figures are, the situation in certain prisons may be even worse. In the case of Corntonvale, Scotland's only all women prison, it has been reported that on occasion, approaching 100 per cent of women prisoners have a serious drug problem. The dangers associated with the extent of drug abuse in Scottish jails are manifest.

First, there is the danger that some individuals will be entering the prison system drug free and acquiring a habit by the time they leave. In this situation the fact of living day by day alongside other prisoners who are using illegal drugs may have led some prisoners to start to use drugs as a way of coping with prison life. Second, there is the danger that individuals who enter the prison system with a low level drug habit find their habit escalating in the face of the sheer availability of drugs in prison. Third, there is the real danger that the growth of the drug economy in prison starts to corrupt the prison system itself. A recent leaked report from the English Prison Service's anti-corruption unit and the Police estimated that there may be as many as 1,000 corrupt officers working within English prisons. Much of that corruption is associated with the trade in illegal drugs and the provision of mobile phones to prisoners. We would be naïve not to recognise the potential for similar corruption within our own prison system and the very strong likelihood that it is already occurring. Illegal drug use has an unparalleled ability to corrode and corrupt because of the enormous sums of money involved and the capacity to bribe and intimidate those that stand in its way.

The fourth problem when drugs take over, is the fact that a custodial sentence may come to be seen by the addict not as the loss of their individual freedom, but an opportunity to renew old acquaintances and establish new contacts that may assist the individual's drug habit on the outside. Prisons may not become the schools of diverse criminality that many once feared, but the breeding grounds for an escalating drug problem.

If these are the problems, what are the possible solutions? The first thing you need to be able to do is to reduce the flow of drugs into prison. That inevitably means much closer supervision of prison visits as well as prison staff. But what would a prison look like, that carried out such a high level of supervision? It would be immeasurably more unpleasant for the prisoners as well as the staff, and in its own way that much more difficult to manage. There would also almost certainly be much wider use of drug testing of prisoners.

But simply finding out if a prisoner has used illegal drugs is not enough. We also have to ensure that the very best treatment services are available within prison. But if you are going to provide drug treatment in prison you have to be clear about the aims of that treatment. For years methadone was largely unavailable within Scottish prisons because the focus of those prisons was on detoxing prisoners rather than stabilising them. The prison service, however, was criticised for the substantial number of addicts who overdosed when they left prison and resumed their drug habit. Under the pressure of that criticism, the prison service has come to focus more on stabilising addicts than detoxing them, and in that context methadone had come to be much more widely used. However, stabilising addicts is not going to reduce the scale of the prison population with a drug problem, and if you don't do that you run the real risk of watching the numbers of addicts in prison steadily rising to the point where prison itself becomes the place where you temporarily house your addict population.

There is another solution which is no less controversial – you stop sending your addicts to jail in the first place. This is an understandable response when you consider that much of the crime that addicts commit is to fund their drug habit. The trouble with this solution though is the fact that it leads you down the road of operating a parallel criminal justice system with individuals who commit their crime to fund a drug habit being treated in a different way to those who commit their crime for financial gain.

While this may suit the addict it hardly seems fair to the non-addict, and it actually may send out the entirely wrong message that you are better off committing your crimes to fund a drug habit than for any other reason. While we may come to accept the greater use of non-custodial sentences for those who commit their crimes to fund a drug habit, that acceptance will only last for as long as there is clear evidence that such sentences are indeed reducing the scale of addict criminality.

In the past we used to talk about creating drug free areas in prison. That notion seems now to have been dropped as little more than a chimera. If that is the case, then the problems we face are even more acute than we realise. Tackling illegal drugs in prison may involve an investment in treatment and security well beyond what is currently occurring. However the dangers of failing in this area may be a prison system that starts to be controlled by its drug problem rather than controlling that problem.

Neil McKeganey is Professor of Drug Misuse Research at the University of Glasgow.


Summing up

'Why have the voluntary sector, primary healthcare, secondary healthcare, probation and social services invested so heavily in all these sophisticated computer data recording processes and yet the government expects us to complete these NTDMS forms? They have all the information they require... surely we can be allowed to actually get on with our work once in a while. Mr Hayes et al encourage closer work with different agencies – well perhaps that needs to start at Whitehall.'

Opportunity not judgement

When I first started taking heroin and crack cocaine I didn't know anything about it except that it is illegal and I liked taking it – by which time it was too late. Nine years later I learnt it was the devil himself!

In October 1998, I admitted myself to rehab for an opiate detox, which I completed successfully and have remained clean since.

In January 2003, I started working as a healthcare assistant for the National Health Service, in a drug and alcohol detox and rehabilitation unit. After that I was offered a job in April 2004, as a drugs outreach worker for health promotion, where I worked with IDUs – I really enjoyed this line of work and found it very rewarding. Not only was I helping drug and alcohol misusers and being able to give something back to the community, but I also found it therapeutic.

During my time at the NHS, I was very fortunate to work for two excellent and very supportive teams in Surrey – The Windmill Drug and Alcohol Team and The Health Promotions Outreach Team. I gained a lot of valuable knowledge and skills from both my work colleagues and clients. Unfortunately, in May 2006 I had to resign because I was remanded in custody.

Currently, I am serving a 30-month custodial sentence at HMP Wellingborough in Northamptonshire and will be released in August – though I'm hoping to leave earlier in April. This is my first time in prison and I see this experience in my life as 'another hurdle' I've had to overcome. But I will learn from it.

On my release, my aim is to find a job back in the substance misuse field and also to enroll on a relevant course to develop my knowledge and skills. I would like to put the past behind me, and work for an employer that will not judge me on my background, but will employ me on the basis that I am suitable to fulfil a position within their organisation.

My goal is to eventually work with children, helping them to understand the risks and harm associated with drugs and alcohol. I feel this is an important issue that needs working on. I also would like to work with the Asian community, or both.

Being a 33-year-old Indian male born in England, I have a good understanding of the 'difficult barriers' the Asian community has to face concerning treatment services. During my prison sentence, I spoke to the Asian inmates in several prisons and it is perfectly clear that they still face the same difficulty barriers I once did 15 years ago.

I would be very grateful for any advice and guidance from anyone working, or who has worked in the substance misuse field, on finding employment and training and getting myself back on track.

Binn Chahal,
HMP Wellingborough Prison

On another planet with you

Your interview with Paul Hayes (*DDN* 12 February, page 9) is interesting reading – but that, perhaps, is all it is.

I really do wonder where this person resides, because I have the sense it is not the same world as where us workers are. I'll start with these wretched NTDMS forms: does Mr Hayes realise that while he may wish to 'catch out' the minority of agencies who 'fiddle' their books, the rest of us pay the price for this? An NTDMS form is a nightmare; in my view it is an infringement of civil liberties and takes away confidentiality. But not only do I have to wrestle with my conscience, I also have to complete these wretched things – that is in between actually seeing clients, answering phone calls, supporting and advising peers *etc*. The less Mr Hayes trusts us, the more bureaucratic we become – but that seems to be in keeping with this government.

As a social worker my social service records have to be kept up to date, so why, if Mr Hayes is so hell-bent on monitoring our every movement, can he not gain access to our computer systems and extract the information he requires? Why further burden us with threats and realities of funding cuts, so we are more limited in what we can do while he has the expectations for us to do so much more?

Then there is alcohol. My caseload comprises 90 per cent alcohol cases, and what do we get? More bureaucracy, more debate – and no funds. When are these people actually going to re-enter the realities of working with individuals? If Mr Hayes needs to know the extent of the problem, he should look at police statistics, look at the hospitals, look at the number of cases generic social services have, that are alcohol linked. Look primarily at GPs: this information is readily available Mr Hayes, and yet you expect us to perform miracles with limited resources and criticise us when we don't fill out your wretched NTDMS forms properly.

I am aware that this is going to get nowhere. When you are confronted by faceless bureaucrats who have no idea what a substance misuse worker has to deal with on a daily basis, what chance have you? Why have the voluntary sector, primary healthcare, secondary healthcare, probation and social services invested so heavily in all these sophisticated computer data recording processes and yet the government expects us to complete these NTDMS forms? They have all the information they require – it might need some 'tweaking' but surely we can be allowed to actually get on with our work once in a while. Mr Hayes *et al* encourage closer work with different agencies – well perhaps that needs to start at Whitehall, Mr Hayes. Stop being so 'tough' on us; we really are trying our best, but you ain't helping.

Yours sincerely, an overworked, seriously underpaid, blighted and maligned social worker – with a far too heavy caseload and other duties – whose government has abandoned him to the fate of breakdown by bureaucracy.

Name and address withheld

Has the Licensing Act simply reinforced our heavy drinking culture?, asks **Don Shenker**

Licensed to BOOZE

The Licensing Act 2003 came into effect in November 2005 placing alcohol licensing under local authority control. The principle aims of the act were to allow pubs and clubs to open later, allowing drinkers to leave 'naturally', thereby creating less crime and disorder at peak times. The act also allowed greater flexibility for off-licence trade, meaning supermarkets and petrol stations could sell alcohol for literally 24 hours.

Local authorities now took over from magistrates in granting licences and the act placed a duty on them to meet four aims when granting them: prevention of crime and disorder, public safety, public nuisance and protection of children from harm. One criticism of the act has been its failure to include public health as one of its objectives, as has been the case in Scotland.

In addition, under the new legislation, authorities were meant to consult and inform the public about how to complain about rowdy establishments and give the public greater control in shutting them down.

More than a year on, what has been the impact of the act? Has crime and disorder reduced? And have authorities successfully enabled the public to stand up to off-licences, pubs and clubs that make areas unsafe?

Alcohol Concern carried out a survey of 46 licensing teams across England and Wales to measure the impact of the act and to hear their views on how the new licensing arrangements were going. We also held a focus group with members of the Institute of Licensing to look at some of the issues they face.

When the act was implemented in November 2005, much concern was expressed in the media and elsewhere about the effects on binge drinking, anti-social behaviour and crime, which would result from this perceived liberalising of the licensing laws. The key question since implementation has been the impact on crime and disorder. Licensees in our study did not appear to think that alcohol-related crime had worsened; on the other hand no-one could say that it had improved.

The act was meant to reduce alcohol-fuelled crime and disorder, but measuring to what extent this has happened has been extremely difficult. Recorded crime since the introduction of the act has been stable – the total number of offences recorded in the 27 forces has remained at around 80,000 per month since October 2004. Similarly, the proportions of offences occurring between 11pm and 2am are consistent with the same months in the previous year.

A common police tactic to combat alcohol-related disorder has been to use fixed penalty notices (FPN) and penalty notices for disorder (PND) in the early evening to quell future trouble. However data on the number of FPNs and PNDs issued since the act was introduced is hard to come by. We don't know therefore if unrecorded crime, dealt with by penalty notices, has actually meant that disorder has increased.

Similarly, it has been hard to judge if authorities have managed to reduce harm in line with the four licensing objectives. Data collection by authorities is quite under-developed, making it difficult to judge if objectives are being met. Little data other than crime statistics is being collected, in particular health data from A&E departments and social services data on domestic violence is being largely missed out, making it very difficult for authorities to know if they are meeting their licensing objectives.

From our study there was equivocal evidence that objectives were being met, with almost as many

Tricia de Courcy Ling

authorities saying they were confident they were meeting the objectives as not. Licensing teams were slightly more confident that they were managing to prevent crime and disorder, but only one third could say they were protecting children from harm.

Concern has been expressed by various sources, including those in our study, that the level of awareness among the public on how to complain about irresponsible or rowdy pubs, clubs and off-licences is still too low and that authorities did not take effective measures to inform people of their rights. By far, the commonest way that authorities informed their residents about the act was via their council website. It is worrying that some authorities have missed the opportunity to consult more widely and over-relied on website information as a means of consultation.

Our focus group recognised that people from more socially disadvantaged areas were therefore less likely and, probably, less able to make representations or seek reviews. Enfield demonstrated this pattern very clearly with a marked difference in the number of representations between the more and less affluent areas.

Even when licensed premises are being forced to close following reviews, or police action, the system is stacked against the public and in favour of the licensee. Police have powers to close a premises that is disorderly or causing a nuisance as a result of noise. However, once a licensed premises has been issued with an order to close, the licensee has 21 days to object during which time the pub/bar can stay open. Continued appeals can further extend this process, wholly undermining the purpose of the closure powers.

One further area of increasing anxiety is the degree to which the large supermarkets are lowering their alcohol prices and fuelling the rise in home sales – up 50 per cent in the last ten years. There is still very little point-of-sale information in bars, pubs or supermarkets promoting the sensible drinking message. Also, despite the industry's reassurances, drinks promotions are still rife throughout the country in both on and off-licences.

'The act was meant to reduce alcohol-fuelled crime and disorder, but measuring to what extent this has happened has been extremely difficult.'

In fact a key marketing technique within supermarkets is to sell alcohol as 'loss leaders' to encourage greater footfall on the shop floor.

This partially explains the greater affordability of alcohol since 1980, and the consequent rise in excessive alcohol consumption at home, and in some instances on the street. Pricing alcohol so inexpensively means young people can afford to buy it and are often able to. The latest figures from the Alcohol Misuse Enforcement Campaign (AMEC) still showed one in five supermarkets selling alcohol to under-18s, and the figure for off-licenses is probably much higher. Smaller licensees may indeed face issues of youth intimidation and lack of police support, but the act was meant to iron out this practice and so far appears to have failed.

The rise in youth drinking and its associated links with unsafe sex, teenage pregnancy, mental illness, school exclusion and youth crime is creating a dangerously high level of underage drinkers who require treatment interventions and services which in many areas just do not exist. In some town centres arrest referral services are regularly receiving referrals from 16 to 17-year-olds who appear destined to become the next generation of problem drinkers with no access to services.

It has been stated by many that the *Daily Mail et al*'s prophecy of mayhem once 24-hour drinking was introduced, did not materialise. I would argue that the mayhem already existed and the act has done little so far to combat it. We can find no evidence that the act has reduced alcohol-related crime and disorder and all other indications are that overall consumption, health problems and youth drinking are increasing.

Having said that, the act in itself has not created Britain's drinking crises, it has possibly compounded an already critical situation, allowing the industry to increase its profit while the health burden from alcohol misuse becomes further exacerbated.

So can the situation be improved? Our focus group revealed some improvements that could be made to meet the act's objectives. Firstly, much more work is required to ensure that all sections of the community are empowered to tackle alcohol-related harm by raising the public's awareness of their rights to seek reviews and make representations. Particular work is required to help less socially advantaged sections of the community to exercise these rights.

Awareness-raising could include the development of a national leaflet on making representations and seeking reviews. Work is also required to ensure that consultations on future licensing policies make efforts to contact hard-to-reach communities *eg* minority ethnic communities or socially excluded groups.

Monitoring at a local level needs to improve. More work is required to help licensing authorities to access data from health sources, such as accident and emergency units or the local ambulance service. In addition, a national review of closure powers is required to ensure that disorderly premises cannot stay open pending appeal.

But how about some more adventurous ideas? Why not provide incentives for pubs and bars to sell more food, cheaper soft drinks and to have more chairs? Why can't the industry use some of their profits on buses to get everyone home safely, and what's stopping us making it mandatory to have safer drinking messages in all pubs and clubs.

The act fails to attach public health measures onto licensing legislation, leaving it to informed individuals to change their habits on their own, or to individually seek action against rogue licensees. The onus is not on the 'polluter', but on the consumer. Unlike tobacco, alcohol impairs your judgement and, once inebriated, one more drink frequently appears a very reasonable proposition. It is only later in the cells, ambulance or the STD clinic that the benefit of hindsight develops.

The Licensing Act has therefore been a missed opportunity to try and change our heavy drinking culture. Work can still be done to improve its implementation, but at its core we may need new legislation to get to grips with our favourite national pastime.

Don Shenker is director of policy and services at Alcohol Concern

Maggie Telfer OBE tells *Marc Leverton* about her mission in helping people to help themselves – at a drug project in Kenya and back home, where she is director of Bristol Drugs Project.

Architect of change

Bristol Drugs Project sits in a Georgian square just outside of the city centre. The national media profile of the area is rarely positive, despite the many charities, environmental and housing organisations being situated here.

There is much to talk about with Maggie Telfer, the director of BDP. In March the organisation will be celebrating its 21st birthday; Telfer has recently received an OBE 'for services to people who misuse drugs'; there is news on extra funding for Bristol – and there is also The Omari Project, a free treatment and rehabilitation service in Kenya, which has benefited from Telfer's input over the last ten years.

Today it is hard to imagine life without drugs services but this was the scenario in Bristol pre-BDP. 'There was nowhere to go, there were no services', she explains. 'Just a couple of GPs doing six-week detoxes, but most users were only getting help through probation officers which is how BDP came into existence. BDP was set up in 1984 by two groups of people – probation officers and ex-users. There was little or no help available in Bristol at the time, and so they got together and did something about it.'

Telfer was the first paid member of staff in November 1985, having previously been the manager of a homeless hostel in Swansea. After a lot of planning, there was huge pressure to get things off the ground and moving. The fledgling organisation was granted a budget of £70,000 and they were to serve the county of Avon, which at that time was three-quarters of a million people.

'We started small with a counselling service and a drop-in centre much like it is today,' she says. 'The drug problems back then were very different; amphetamine sulphate was the big problem. Heroin was about, but only in central Bristol.'

It's not just the types of drugs that have changed in this time, but also the quantity. 'The whole problem was so much smaller when we began, around 1,800 people in the whole Avon area – and now we are looking at 8,000 just in Bristol itself,' says Telfer. From a population of 400,000 that makes one in 50 local people a beneficiary from BDP's services.

Over the last 21 years, Telfer has seen some significant changes.

'Things changed dramatically in 1992; the heroin market expanded very quickly and amphetamine was largely replaced by heroin,' she says. 'We started to see a lot of young people when previously we had only seen kids with a parent in tow. By 1994-5 we were seeing a constant stream of under-18s.' The explosion came about partly because of Bristol's central location in between London, the South West, Wales and the Midlands.

It didn't stop there. 'At the end of the 1990s crack markets expanded quickly, although crack had been around for a decade. You couldn't buy heroin without getting crack too,' Telfer explains. 'We then had a group of people who were addicted to both, which made things more complicated for us.

'It isn't just the drug markets that have changed. 'Society's attitudes to drug users has also changed dramatically,' says Telfer. 'When we started out, politicians at the time would say things about the "deserving" and "undeserving" poor. People would not say that anymore, and people wouldn't believe it any more.'

Telfer is quick to point out that although attitudes have largely improved, it isn't all plain sailing: 'There was a case in this last year of Bristol Specialist Drug Service being denied permission to work from premises in Clifton.' The proposed service in one of Bristol's more affluent areas was objected to by local residents.

In the new years honours list Telfer discovered that she had been granted an OBE. 'I was very surprised… I still don't know who nominated me,' she says.

Her diverse work with people who use drugs has included The Omari Project in Kenya – 'the only free treatment and rehabilitation

centre in East Africa and one of only two in the whole Sub Saharan Africa', and a challenge to say the least.

'Some things are exactly the same; many, many things are just another world. It is very interesting to work where there are no services or free health care. Some estimates say that half of the injecting drug users out there are HIV positive,' Telfer explains.

The project aims to empower local people to help themselves: 'We have given them the skills we have learnt from here… the big struggle is to get everything structured enough.'

'I know that the work we have done has really made a difference,' she adds. 'We have counselling as a basic intervention but the culture there is that you don't talk about problems, so introducing counselling there has really helped.' There is so much more to be done, Telfer acknowledges: 'needle exchanges are desperately needed'.

Back home it has just been announced that Bristol is to be getting an extra £1.3 million of funding for drug treatment services. But despite celebration in some quarters, Telfer thinks more still needs to come. The 37 per cent increase leaves Bristol as 145th in the funding league table of 149 drug action teams.

'The national average is twice what Bristol gets [so] it is great news. But it needs to be the first step of many to close that gap, she says. 'This is postcode lottery at its worst.'

In real terms, this means a rise of £200 per head to £1,000 – where some others are getting as much as £4,000 per head, she explains.

As part of the funding boost, BDP have just been given support to mentor the children of drug using parents, an extension of the service's work with parents and their maternity drugs service. 'Previously, users would avoid antenatal care as they felt they were being incredibly judged,' Telfer points out.

Supporting inclusion of drug users has been important to the service's ethos over the past 21 years. 'One of the most important things we have done, along with others, is to set up the shared care service, so people can get their scripts from GPs and not mental health services and it is very normal for users,' says Telfer. 'GPs should be able to cope, but if not they can refer people on.'

'This partnership model shows that if you make treatment very accessible then people will come and use it,' she adds.

Bristol now has over 70 per cent of GPs that will prescribe, which means services like BDP don't get completely overloaded like many other areas of the country.

There have been other, community-based successes for the project. Launching a drug and alcohol-free social event, based on the Community Reinforcement Approach, helped service users avoid relapse by filling leisure time.

With the therapeutic value of gardening now acknowledged, BDP has also taken inspiration from Monty Don's TV programme, 'Growing out of trouble', by providing a free allotment and a memorial garden for their clients.

Telfer anticipates some of the challenges on the horizon: 'Cocaine use is huge now and we haven't seen the impact from that yet, but it is inevitable that it will with the level of use we are seeing.

'Methamphetamine is a huge problem in other parts of the world and the only logical answer as to why it isn't here is that it is being kept out by the gangs that control the drug trade. But it can only be a matter of time.'

Looking ahead to 2008, BDP are planning a conference reflecting on what has changed for drugs and drug treatment over the last 21 years. For the immediate future though, there is the birthday event to organise with Baroness Doreen Massey, Chair of National Treatment Agency coming to open the partly refurbished drop-in centre on 9 March.

Marc Leverton is a journalist based in Bristol.

Post-its from Practice

Good drug, bad drug?

Benzodiazepines are not always the bad guys, says Dr Chris Ford

One of my partners at the surgery came to ask me to see a patient he was concerned about. Imran was a 34-year-old Asian man, who had been housed temporarily around the corner from the practice, in bed and breakfast. He suffered from depression and was receiving methadone from one of the local specialist drug services. His behaviour at the surgery was also causing problems. He was attending erratically, seeing a variety of doctors and demanding benzodiazepines. On some occasions he received them and then over-used them, on other occasions he didn't and then verbally complained.

I said I was happy to see him and assess the situation. When Imran attended he seemed frightened. He talked rapidly and appeared distressed. On discussion he told me he had had a benzodiazepine problem for nearly 20 years. He was receiving 80mg of methadone from the drug service and using no opioids on top. They had assessed that he did have a benzodiazepine problem but their policy, like many other drug services, was only to prescribe for a short-term detoxification. Admittedly this is also the advice given in the last clinical guidelines, but I feel it doesn't deal with the reality of this problem[1].

He explained that Valium had been his first addiction after a traumatic childhood and that he had used it for over 20 years consistently. It had even been prescribed during his two short periods in prison, although his methadone wasn't! He also explained that his alcohol intake dramatically increased when he couldn't get them. As he is hepatitis C positive this is important. His whole story was confirmed on talking to the drug service, even including that they were increasingly concerned about his alcohol intake and that all urines taken had been positive for benzodiazepines!

Imran said he was taking on average 30mg a day of diazepam but found them hard to manage when he bought or got them from the surgery. We consequently agreed as he was picking up his methadone daily that we would prescribe him 30mg of diazepam on a daily pickup also. He was very relieved and grateful as he left the surgery with his instalment prescription for diazepam and the benefits of this decision have since become very apparent.

Illicit benzodiazepine use, particularly by opioid users, is prevalent and a major problem for users in and out of drug treatment. Up to 90 per cent of people attending drug treatment centres reported benzodiazepine use in a one-year period and there is a high prevalence of benzodiazepine use in methadone maintenance patients. Some GPs are still more comfortable with prescribing benzodiazepines than methadone to problem drug users, whereas the reverse should be true[2]. There is still no 'gold standard' treatment for benzodiazepine dependency and little evidence for the value of substitute prescribing of benzodiazepines, which I feel allows most of us to resort to opinion-based medicine. But does the lack of evidence mean it is bad?

Clinically, I find maintenance benzodiazepine prescribing very useful in certain selected patients and feel that a policy of never prescribing them creates enormous difficulties for some, for whom they are a serious problem.

Imran, I feel, is one of those. He now attends the surgery regularly, usually early for his appointment with the counsellor or myself. He never over-uses, his mood has improved and he has stopped drinking altogether! He is very grateful and his view is that he has been given back his life.

Benzodiazepine addiction is a serious problem and I am not underplaying it, but they are also incredibly useful drugs so let's not throw the baby out with the bath water.

Dr Chris Ford is a GP at Lonsdale Medical Centre and Clinical Lead for SMMGP

1. *DOH (Department of Health) (1999). Drug Misuse and Dependence – Guidelines on Clinical Management. London: The Stationery Office.*
2. *Ford, C., Roberts, K. and Barjolin JC. (2005) Guidance on Prescribing Benzodiazepines to Drug Users in Primary Care. Substance Misuse Management in General Practice. Available online from www.smmgp.org.uk/download/guidance/guidance006.pdf*

Working lives

Sarah Morgan, substance misuse developmental manager at Styal Women's Prison

Working with drug users in a women's prison is not an easy career choice, but Sarah Morgan is motivated by being part of a workforce determined to bring about positive change.

Working inside a prison is very challenging, and working in HMP Styal Women's Prison with drug users might rank as more challenging still – and not without interest from the outside world.

From November 2002 to August 2003 there were six deaths, all of whom were drug users and who died within a short time of being admitted to prison. In 2003 methadone was introduced, and this has contributed towards a steady decline in self-harm, suicide and mental health problems with drug dependent women. Since then the eyes of the outside world have definitely been watching our every move in addressing the care that is provided to these women.

Although I qualified in 1992 as a Registered General Nurse and experienced a variety of nursing jobs from scrub nurse to a hospital nurse bank manager, there always seemed to be a career void that was never fulfilled until I started working as an agency drugs worker in Liverpool Drug Dependency Clinic in 2003. My eyes were opened immediately to an inner city world of illicit drugs, gun crime, prostitution and child abuse and I spent weeks developing a new 'drug user' language which came from direct and quite often challenging clients. Within two years, I had been promoted to a senior drugs worker within shared care.

In 2005, I started my 'time' in HMP Styal as the clinical substance misuse manager. Although methadone was being prescribed, and there was a well-established CARATs (Counselling, Assessment, Referral, Advice, Throughcare) team, methadone maintenance regimes were not being 'promoted'.

Within two to three months, all women on a methadone regime were given the option to be 'maintained', whether sentenced or on remand, during which time the CARATs team had time to refer them to community prescribers for continuation of treatment. Although the total number of women increased on methadone from approximately 32 a week in 2004 to 160 a week in 2006, 95 per cent were referred to community drug teams, self-harm had decreased further and so had the illicit drug use within the prison. Treatment was continued, on transfer to other female prisons.

Working within the prison is like working in a self-contained town. The population capacity is 440 and half of these women are drug dependent. Many are experiencing mental health issues, housing problems, illiteracy and educational needs and also have a lack of parenting skills. There is a vast dedicated workforce that tackles these issues head-on each day, and I believe that in some circumstances, the women are more supported within this prison regime than in the community. It sounds corny, but lives are saved every day by prison officers and healthcare staff who are called to ligature and suicide attempts, but these heroic stories are never shared with the 'outside' – perhaps because there are too many.

HMP Styal has been successful in being identified as a 'new wave site' for the National Treatment Agency's 'Integrated Drug Treatment System' (IDTS), due to be launched early this summer. Funding has been ring-fenced to improve the current substance misuse service within the prison, promoting a joint working relationship particularly with CARATs and healthcare – but also including our other prison colleagues, without whom our work could not be done. This will be a 28-day psycho-social regime in which CARATs will be the key workers, ensuring that the prisoner follows an agreed care plan, attends group work, has a range of methadone regimes to choose from and is transferred to a community service on release.

I believe the emphasis should be on a holistic client-led care planning approach, aiming to mirror the care received in the community. There is also a belief that the service should not improve without the input of the service user, and over the past 12 months the Substance Misuse Service User Group (ADDS) has worked closely with myself and a prison officer to provide a one-to-one listening service for drug dependent women, particularly within the first 28 days of admission.

I am currently aiming to develop specific services for individual drug user needs, with the help of my colleagues in the community. These include The Alcohol Service, being developed with the help of Liz Burns of Manchester Health Promotion; the Young Person's Service, being supported by Liz Cotticelli and Vashti Marriot from the Cheshire area; and the Street Workers Service, which is being developed with the help of Graham Dobkin from MASH (Manchester Action for Street Health).

There is optimism that the substance misuse service will continue to develop and improve the service for these drug dependent women in HMP Styal. I continue to be challenged and sometimes emotionally drained from listening to such emotive stories; but it is all worthwhile, and the motivation and enthusiasm remains because a small thank you goes a long way.

I run a house for four people recovering from drug and alcohol problems. They all attend treatment during the day and I offer support in the evenings. I would like to offer more help and in time work on the treatment side. The organisation I work for has offered to put me through training. Could anyone advise me on the best route or suggest appropriate counselling courses to get me started?
Thank you
Chris Gibbons, by email

Short-term effect

Dear Chris,
I am a prison officer working in the drug support unit at a high security prison. Several years ago, I contacted Hull University regarding short-term courses that could help me with work. I eventually settled on a four-day counselling skills course. It didn't turn me into a fully qualified counsellor but it gave me a good foundation to work from.

The skills that I acquired have been invaluable to my work as a prison officer and a drug/alcohol worker. You might also want to ask about short-term courses in motivational interviewing which I have also studied and it has made me more confident and increased my skills when working with clients with substance misuse issues.

Good luck Chris I'm sure you will succeed. You seem to be a very motivated and caring person.
Ian Bowerman, Full Sutton.

Definitely maybe

Hi Chris,
We get lots of questions like this and it is hard to give you a really definitive answer to your particular situation I am afraid. However, perhaps I can give you some general pointers.

The first thing to do is to try to clarify exactly what it is that you want to be able to do. The best place to start here is with the Drug and Alcohol National Occupational Standards (or DANOS for short), which include a list of most of the activities which someone working with drug and alcohol users may need to perform – and the knowledge, skills and understanding required to do so properly. You can use these to develop what's called a 'role profile' for the particular role you are envisaging.

Once you have done this, you need to sit down with your manager and try to identify any development needs that you might have if you are to expand your role in the way you'd like.

When you have done that, you and your manager can then put together a development plan for you on how your development needs might best be addressed. This might include some formal training, but it might also involve other elements, such as mentoring and supervision.

And in time you might also want to look at getting a qualification based on an assessment of your competence – so you can get your knowledge, skills and understanding properly recognised.

We have put together some more detailed guidance on DANOS and workforce development in the 'training and development' section of the www.drinkanddrugs.net website. However, it can be quite hard to follow when you look at it 'cold' I am afraid, and it might be worth starting with a new online training course, which we have just launched, called 'DANOS demystified'. It only takes an hour or so to go through and covers most of the main points which you and your manager will need to know about. You can find out more about it in the 'training' section of the www.fdap.org.uk site.

I hope this is helpful. I know it sounds a bit complex, but once you get your head round it it's not too difficult and if you follow the process through you should be able to develop your role in the way that you would like, and so also enhance the service offered to your clients.

Good luck and best wishes,
Simon Shepherd, Chief Executive, FDAP

Local top-up

Dear Chris
You would be well advised to do a counselling certificate or diploma through your local FE college, and then a course such as the Effective Drugs Worker (see our website) to top up your drugs and alcohol knowledge.
Tim Morrison, www.alcohol-drugs.co.uk

Reader's question

Someone I know has been included on the shortlist for a job at my agency. We have a strict 'clean' policy here, but I know this person socially, and he is well-known for his drug-taking. Should I advise my manager of the situation, or keep my nose out?
Rose, Birmingham

Email your suggested answers to the editor by Tuesday 6 March for inclusion in the 12 March issue.

Media Watch

Scottish minister, Jack McConnell, calls for neuro-electric therapy (Net) to help users break free from opiate dependency. The Net treatment consists of a weak electrical current applied to the brain and is a drug-free way for people to overcome a heroin addiction. A mother of two, who was using drugs for seven years, was 'amazed' at how quickly her drug cravings disappeared after being treated with Net. Mr McConnell, who aims to see the therapy on the NHS soon, wants Scotland to have an open mind to different treatments. 'If this is successful, then Net could operate on a scale that can make a huge difference to people's lives', he said.
The Herald, 14 February

Smokers could find themselves under the watchful eye of the council, as undercover officers will be patrolling bars, pubs and other public buildings, following the smoking ban in July. The 'smoking police', who don't have to identify themselves on entering premises, can mingle with drinkers and diners, handing out on-the-spot fines of £50 to anyone breaking the law, as well as taking film and photographic evidence. English councils have received £29.5m, from the Department of Health, to train council staff to manage the ban. Ian Gray, policy officer for the Chartered Institute of Environmental Health (CIEH) said that although most councils will initially take a 'softly, softly approach', there will be some occasions where action has to be taken.
Caterer & Hotelkeeper, 22 February

One of the UK's leading department stores has been selling drug paraphernalia in an overseas branch. Hundreds of pipes, bongs, bud cases and water pipes have been displayed in the front window of the Debenhams' store in Prague to the alarm of holidaymaker, Paul Rushden from Nottingham. 'One wonders how the shareholders of this public company would feel about profiting from the drug trade,' he said. A spokeswoman for Debenhams found the matter 'unacceptable' and has instructed their Franchise Partner, who manages the store in Prague, to remove the items immediately.
The Sun, 22 February

Early drug intervention in Northern Ireland, is needed for kids as young as eight. According to project manager for Lifematters, Raymond McKimm, mules are bringing alcohol, cannabis and solvents into primary schools, to be used regularly by pupils. 'I am currently working with a child with an entrenched problem at 11 years of age that goes back three years,' he said.
BBC News, 20 February

A ban on alcohol advertising could help to reduce Britain's binge drinking culture, according to a senior doctor. Professor Ian Gilmore said that adverts for booze send out the wrong message, and that Britain should follow the example of the French, who have seen a fall in drinking levels, because they do not advertise or have alcohol sponsorship of sport.
The Metro, 23 February

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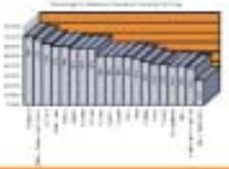

I schools | II intervention | III treatment | IV pro

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Features	Kiosk	Intervention	Treatment	Pro	Benefits
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Data tracking	/	/	/	X	Target resources and measure effectiveness
Monthly data charts*	/	/	/	X	Easy-to-read unique street-level data
Quarterly trend charts*	/	/	/	X	Measure progress & spot emerging problems
Annual report*	/	/	/	X	Qualify performance of your service
Service & Agencies					
24/7 contact info	X	X	/	/	Kept up-to-date electronically
UK map of drugs agencies	X	/	/	/	Unique & easy-to-search – all the services in UK
Individual log-in*	X	X	/	/	Treat the individual securely – wherever they are
E-mail link to workers*	X	X	/	/	Encourage engagement with treatment & help
News & alerts service	X	X	/	/	Keep everyone up-to-date & informed
Useful documents	X	/	/	/	Quick access to source info – all in one place
Useful websites	X	/	/	/	The leading websites all in one place
Drugs					
Drugs info	/	/	/	/	Factual and accurate
Drugs street names	/	/	/	/	Kept up-to-date electronically
Risks	/	/	/	/	Awareness education & specific to each drug
First Aid	/	/	/	/	Emergencies and how to avoid them
Law	/	/	/	/	Clarity for different situations
Help	/	/	/	/	Localised options & helplines
Quiz					
Knowledge quiz	/	/	X	/	Testing & fun – compare results
Experiential quiz	/	/	X	/	Tracking the local drugs scene
Parent/Teenager/Work quiz	X	/	X	X	Test yourself before you talk
Intervention					
Therapy overview	X	/	/	/	Awareness to make the right choice
Alcohol screening tool	X	/	/	/	Check your drinking – and what to do next
Drugs screening tool	X	/	/	/	Check your behaviour – and what to next
Intervention techniques	X	/	/	/	How to talk – be an effective parent or friend
Workplace info & law	X	/	/	/	Protect your staff and your organisation
Drugs Testing info & issues	X	/	/	/	Explore the issues & know the facts
Pathways to treatment	X	/	/	/	Make the best choice – for you or to help others
Extras					
Survey Tool*	12	25	25	X	Conduct your own surveys very easily
System Hardware					
Kiosk	/	/	/	X	Truly engaging communities – goes anywhere
Networkable	/	/	/	X	Ideal for schools and the workplace
Foyer	/	/	/	X	Mounted on a floor-stand for foyers & receptions
Mobile Phone and PDA	X	X	X	/	In-your-pocket service for busy staff

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Clinical Supervisor/
Addiction counsellor

07733 286 397
caracrossan@hotmail.com

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DDN is now giving individual practitioners the chance to advertise their services to the drug and alcohol field

If you are a counsellor, consultant or an alternative therapist who wants to work in substance misuse, we can offer affordable advertising in DDN magazine and on www.drinkanddrugs.net

To find out more contact Ian Ralph
e: ian@cjwellings.com
t: 020 7463 2081

www.drinkanddrugs.net

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To minimise our environmental impact we want to ensure that each copy is needed, and being read.

If you have excess copies please email subs@cjwellings.com and we will remove them. The whole magazine is also available as a virtual publication if you would rather read it online!

www.drinkanddrugs.net

drink, drugs and edp

Exeter, East & Mid Devon Adult Services

EDP is well recognised as THE leading non-statutory service provider for drugs work within Devon. All staff are fully committed to evidencing the highest standard of service provision and outcomes for service users.

Structured Daycare Co-ordinator – Maternity Cover - Ref: 04/07
(9 months, with potential for extension)
Based: Exeter
Hours: 35
Salary: £25,437 rising to £28,220 (NJC Scale:32-36)

This is an exciting opportunity for an experienced, creative individual to work in close partnership with local agencies to deliver relevant treatment and aftercare services in the Exeter, East and Mid Devon area.

The successful candidate will be experienced in delivering group work, working with substance users and multi agency working as well as staff supervision & appraisal. You will be responsible for delivering Structured Day Programmes (including Relapse Prevention and Preparation to Change) in partnership with local agencies. This post requires skills in assessment, planning and reviewing care, groupwork facilitation and multi agency working. A full driving licence and access to a car is essential.

Tier 2 Substance Misuse Worker, Exeter, East & Mid-Devon Adult Services - Ref: 05/07
Based: Exeter
Hours: 35
Salary: £20,894 rising to £24,708 (NJC Scale 26-31)

The Exeter, East and Mid Devon adult services are commissioned to deliver Tier 2 Advice & Information, Safer Injecting Services (including Needle Exchange), Tier 3 structured case-work, Street Homeless Outreach services, Criminal Justice services via DIP and Structured Day Programmes. We are looking for a motivated and dynamic person to join the team.
Due to the expansion of our centre-based Tier 2 services, we are looking for a skilled individual who is able to contribute to the further development of a well established open access drug service. The successful applicant will need to be a skilled communicator with knowledge and experience within the substance misuse field. You will need to be familiar with Tier 2 drug services including the provision of advice and information to drug users, their parents, partners, carers and other professionals. You will particularly need to have an appreciation of 'Harm Reduction' strategies including the provision of safer injecting services and needle exchange. You will have the skills to carry out client triage assessments, safer injecting assessments and have knowledge of the range of interventions available to those who approach the service. You will play a key role in actively engaging drug users and assisting them to make decisions about their drug use in an environment that can be challenging and unpredictable.

EDP employs individuals who possess:
A motivation to achieve, a commitment to evidencing professional responsibility and accountability in all that you do, a desire to learn, develop and reflect upon practice and an enthusiasm for working in this sector.

EDP will provide you with:
Training, support, supervision and opportunities for career development within the organisation. An excellent employee package, including 5% employer pension contribution and annual leave entitlement which rises to 30 days per year

EDP is committed to equality of opportunity, aiming for the widest possible diversity in its workforce drawing recruits from every part of the community. In accordance with the Police Act 1997 these posts are subject to disclosure through the CRB. A criminal record is not necessarily a bar to employment in these posts.

Application forms available from:
Katy Edmondson, Human Resources Administrator, EDP Drug & Alcohol Services, Dean Clarke House, Southernhay East, Exeter, EX1 1PQ).
Or E-mail recruitment@edp.org.uk quoting the reference number.

Enquiries to: Caroline Moore, Head of Exeter, East & Mid Devon Adult Services, after receipt of the application pack (01392 666719)

Closing date for applications:
16th March 2007 12noon

Stockton Drug Action Team

RESEARCH

Stockton Drug Action Team are inviting suitably experienced researchers to undertake two pieces of research work as follows:

1. *A study into the prevalence of blood borne viruses, amongst substance misusers within Stockton.*
2. *A study to identify support systems to be put in place within Stockton, to prevent people who return to Stockton following an out of area residential placement, from relapsing back into the misuse of drugs.*

Any individual/organisation wishing to undertake either (or both) of the above studies should submit their outline proposals by **midday on 12th March**. Specifications detailing the outline proposal requirements for each of the above topics can be obtained by email from **drugactionteam@stockton.gov.uk**

Care Co-ordinator

This is your chance to make a difference. Life Works, a leading private addiction treatment centre in Surrey, is recruiting for a part-time (20 hrs pw) Aftercare and Alumni coordinator. The ideal applicant has excellent interpersonal and organisational skills, is computer literate and has a strong interest in helping others. Salary: £11-£12 per hour.

Please visit www.lifeworkscommunity.com and email your CV to: lcervio@lifeworkscommunity.com

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Email: SamRecruitment@btconnect.com Or register online

HAMPSHIRE DAAT
Drug & Alcohol Action Team

Open Access Shop Front Services

The Hampshire Drug & Alcohol Action Team are seeking written expressions of interest from providers with proven experience in delivering drug misuse treatment services for the provision of Open Access Shop Front Services.

The services will be an access and triage point for Service Users to enter the local Treatment system, the services will also provide brief interventions, low threshold information & Support, Aftercare and a static Needle exchange service.

There will be two separate contracts, each awarded as a pair of services:

- One Pair of services in the North and North East of Hampshire
- One Pair of services in the South & South West of Hampshire

The services will be required to commence in November 2007.

A restricted tendering procedure will be followed with the criteria for award of the contract to be:

- Business and financial standing.
- Organisations experiences of the provision of substance misuse treatment services
- Service User Involvement
- Organisational capacity & capability to deliver this Open Access Shop Front Service
- Price & Best Value

Process for application

1. Written Expressions of Interest must be received by the DAAT by **16th March 2007**
2. Upon receipt a Pre-qualification document will be sent to **ALL** interested parties to be completed & returned by **12 noon on 5th April 2007**
3. The Hampshire DAAT invites **ALL** organisations expressing an interest for this tender to attend a consultation meeting on **27th March 2007 for the North & North East and 28th March 2007 for the South & South West**
4. Following assessment of the Pre-qualifying document, **FIVE** organisations will be invited to tender for completion and return by **12 noon on 11th May 2007**.

To register your interest please contact Richard Curtis, Hampshire DAAT, Capitol House, 12-13 Bridge Street, Winchester, Hampshire SO23 0HL

HAMPSHIRE DAAT
Drug & Alcohol Action Team

Structured psychosocial intervention and treatment service

The Hampshire Drug & Alcohol Action Team are seeking written expressions of interest from providers with proven experience in delivering drug misuse treatment services for the provision of a peripatetically delivered structured psychosocial intervention and treatment service for drug users.

This service will work with the six Community Drug Teams and the Drug Intervention Programme team based across Hampshire to provide care planned psychosocial interventions and treatment for those clients in greatest need. The service will also link in to existing mainstream counselling and therapy services to provide extended care pathways for clients.

A restricted tendering procedure will be followed with the criteria for award of the contract to be:

- Business and financial standing
- Organisations experiences of the provision of substance misuse treatment services
- Service User Involvement
- Organisational capacity & capability to deliver this structured psychosocial intervention and treatment service
- Price & Best Value

Process for application

1. Written Expressions of Interest must be received by the DAAT by **16th March 2007**
2. Upon receipt a Pre-qualification document will be sent to **ALL** interested parties to be completed & returned by **12 noon on 5th April 2007**
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Operations Manager

THE CAUSEWAY

An exciting opportunity has arisen for an exceptional person to take up this newly created post, to shape the development of our drug and alcohol treatment centre on a private 400 acre island which is situated 44 miles from central london.

You will develop, lead and manage key aspects of the service, using your leadership and strategic skills to achieve financial efficiency, ensure excellent service standards.

The successful applicant will have knowledge, understanding and experience of managing responsibility for contractual and regulatory compliance. They will also have a thorough understanding of management issues including the ability to manage and supervise an experienced staff team who are responsible for delivering the programme to clients; extensive experience in managing change and an ability to lead and be part of a team of professionals.

We strongly recommend a visit to The Causeway prior to interview. Formal interviews in London March 30th.

Salary – dependent on experience.

We welcome c.v.'s from 12-step counsellors, clinical nurse specialists and complimentary therapists.

Contact: 0207 100 7260 **E-mail: bquinn@oseaisland.co.uk** **Web: www.thecausewayretreat.co.uk**

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TfL is tasked with the management, integration and development of the capital's transport infrastructure. This includes responsibility for the Underground, London's bus services, the Congestion Charge, Docklands Light Railway and the regulation of taxis and private hire vehicles.

When it comes to drug and alcohol abuse, we operate a firm but caring approach towards our employees. It's a policy that seems to work, as our Drug and Alcohol Assessment and Treatment Service (DAATS) has some of the best outcome rates in Europe.

Counsellor – Initial Assessment and Training (10 hours per week)
c. £33,000 pro-rata + benefits

You'll manage the screening process of people referred to the team, assessing their clinical needs and gauging any safety related implications. At the same time, you'll ensure interventions are supported by accurate and up-to-date information and that confidential records are securely stored. Ref: TfL3537.

Counsellor – Group Work and Case Management (17½ hours per week)
c. £33,000 pro-rata + benefits

You'll be responsible for the therapeutic and clinical content of group sessions, taking account of the relevant policies and procedures. The day-to-day case management of clients will also form part of your remit, as will the design of tailored treatment plans to meet individual needs. Ref: TfL3538.

Counsellor – Women's Services (17½ hours per week)
c. £33,000 pro-rata + benefits

You'll devise the content of the women's group sessions and ensure that the special issues facing them are addressed. Managing client cases on a day-by-day basis, you'll conduct comprehensive assessments either on a one-to-one or group basis, as well as taking part in team supervision. Ref: TfL3539.

For each of these roles you'll need to be a qualified counsellor, with hands-on experience in the addictions field or another helping profession.

To apply on-line for any of these vacancies, please visit **tfl.gov.uk/jobs** If you do not have access to the Internet, please call **0800 0155 072** and speak to a member of our Recruitment Team. Please quote the appropriate reference.

Closing date: 14th March 2007.

We want to be as diverse as the city we represent and welcome applications from everyone regardless of age, gender, ethnicity, sexual orientation, faith or disability.

MAYOR OF LONDON

Transport for London