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DDN
Drink and Drugs News

13 March 2006
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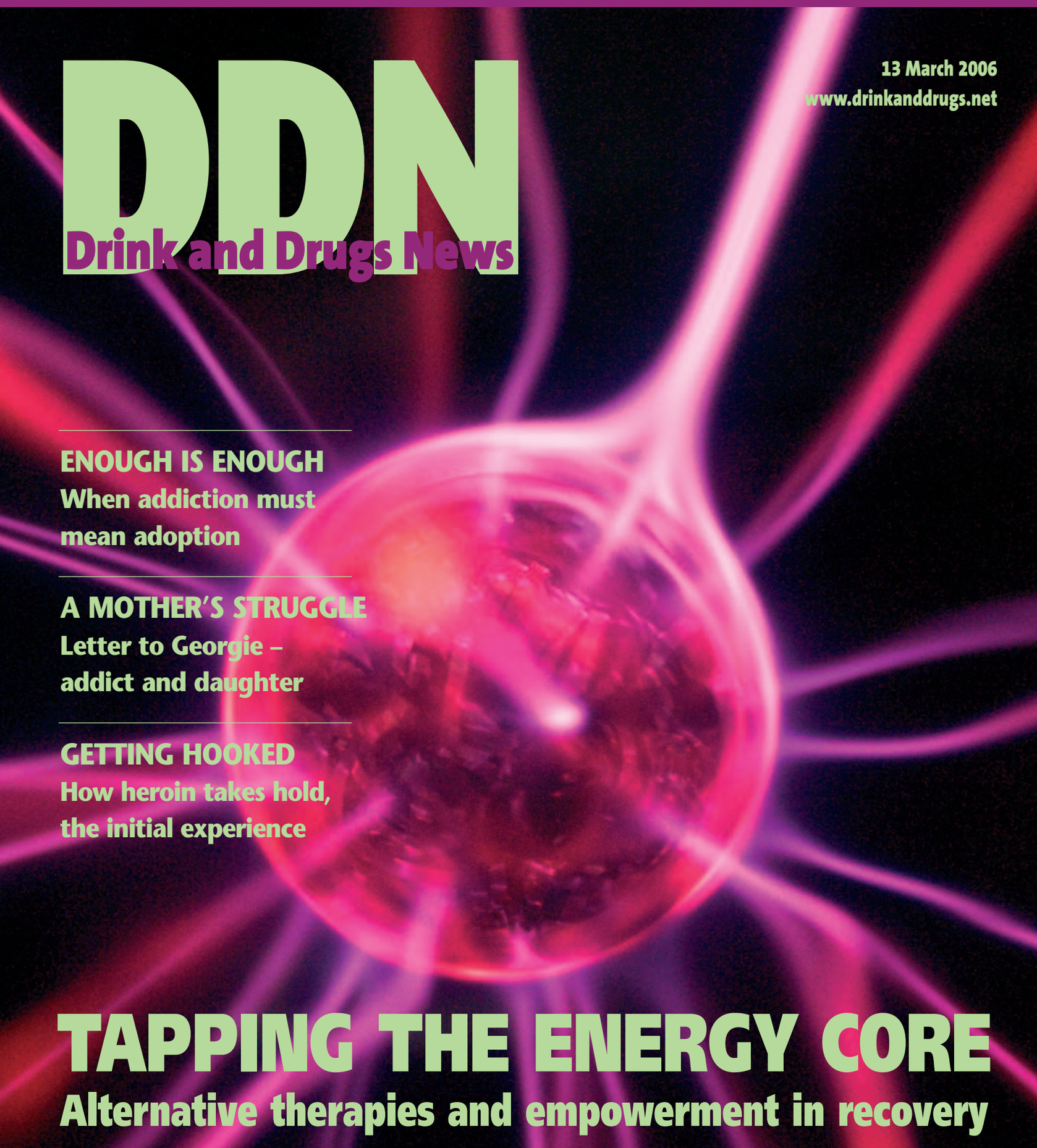

ENOUGH IS ENOUGH
When addiction must mean adoption

A MOTHER'S STRUGGLE
Letter to Georgie – addict and daughter

GETTING HOOKED
How heroin takes hold, the initial experience

TAPPING THE ENERGY CORE
Alternative therapies and empowerment in recovery

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On behalf of

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Federation of Drug and Alcohol Professionals

WIRED
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Drink and Drugs News in partnership with:

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Drink and Drugs News

13 March 2006

Editor's letter

At the Community Drug Project Conference (see page 5), Annette Dale-Perera said that the NTA's first user survey had shown that an overwhelming majority of the service users who had responded wanted to stop using drugs completely.

While most of us accept that abstinence can often not be achieved without a long hard struggle – if at all – it remains a determined goal for many. It's always interesting then, to hear about new ways of tackling the seemingly impossible, by reducing the stress and cravings enough to maintain a semblance of normal life.

Hearing about Cathy Dixon's 'energy therapies' opened a world of possibilities. In a situation where the service user often feels demoralised and bottom of the pile, this combination of ancient techniques and twenty-first century thinking can offer a sense of empowerment. The client starts to take active control over their wellbeing, instead of being passive to treatments and dependent on the specialist. The fact that these therapies seem very cost effective to introduce to a group setting must surely make them worth considering on activity programmes that aim to rehabilitate clients to be fit for a full life.

On a much more negative note, the last few weeks have brought child protection issues to the headlines in the worst context, particularly a Scottish toddler's tragic death through taking his parents' methadone. Prof Neil McKeganey is often contested for his forthright views on emotive issues around drug use, but on page 10 he gives the full context behind his recent comments on adoption.

Unfortunately many children cannot choose to turn a blind eye to their parents' drug taking, and are stuck with whatever consequences are their lot. It's hard to imagine anyone could think that was right.

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

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

Designer:
Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

Website:
www.drinkanddrugs.net
Website maintained by wiredupwales.com

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ

Printed on environmentally friendly paper by the Manson Group Ltd

Cover:
Ali Kabas / Alamy

In this issue

News in brief

Alcohol crisis

Problem drinkers will be forced onto the street by cuts in alcohol services, Alcohol Concern have warned. Director of policy and services, Don Shenker, said that lack of funds for residential services would cut off a life-line for some of the most vulnerable people in society. A survey by AC had shown that at least 20 residential projects expect to lose out in April as a result of local Supporting People spending reviews. Mr Shenker called on government and local decision-makers to act urgently to fill the gap that withdrawing funding would create.

Somali support

A drug education video has been produced to raise awareness in the Somali community, and will be launched at the end of this month. Produced by Ocean Parents Against Drugs (OPAD) Project, the video has already been distributed to residents of Tower Hamlets to give parents guidance on issues relating to drug misuse. It has now been replicated for the growing Somali community, to include information on the use of khat and its effects. OPAD works in partnership with Nafas, an organisation that addresses the substance misuse needs of Tower Hamlets' Bangladeshi community. For more information email Alibor Choudhury at Nafas, email aliborchoudhury@btconnect.com or call him on 020 7729 0044

Tobacco conflict

The Royal College of General Practitioners (RCGP) has announced it is to lobby government to tackle retailers who provide smoking cessation services at the same time as selling tobacco. The decision, proposed by Dr Clare Gerada and supported overwhelmingly by RCGP council, does not affect outlets that only sell nicotine replacement products, but is intended to highlight the contradiction of some supermarket pharmacies.

Safer pregnancy

Female ex-drug users have contributed to a pregnancy leaflet, distributed in Gateshead. David Brady, service user development worker for Gateshead primary care trust, said there was a call for information from staff and patients, who were relying on peers for word of mouth information that was often inaccurate. The leaflet is being distributed through local doctors' surgeries and drug treatment services.

Tragedy sparks methadone debate

The death of a two-year-old Scottish boy from drinking his parents' methadone has prompted fierce debate on the vulnerability of children of drug-using parents and a review of Scotland's methadone policy.

Members of the Scottish Parliament have called for methadone to be taken only under medical supervision, criticising the practice of allowing the drug into the home. Amid the reaction to the story, which broke in the Scottish *Sunday Mail* on 5 March, the Scottish Drugs Forum's director David Liddell has warned against condemning methadone treatment wholesale.

'Many people do benefit from the breathing space which methadone can offer in terms of letting them stabilise and regain control of their lives,' he said. However, the drug was 'only part of the solution', which could 'only be successful when used as part of a comprehensive package of measures to help people overcome the traumatic experiences which often lie at the root of their drug use'.

First Minister Jack McConnell has announced a review of methadone policy, which will be conducted by Justice Minister Cathy Jamieson.

Around 60,000 children in Scotland are thought to be living in drug dependent households, and *The Glasgow Herald* reported this week that the number of children being placed in foster care has doubled in a decade, because of problems with drug and alcohol addiction.

Last month, when an 11-year-old schoolgirl from Glasgow passed out at her desk and was found to be addicted to heroin, addiction expert Professor Neil McKeganey said addicted mothers who failed to kick their habit within a year after giving birth should be made to give their children up for adoption.

Prof McKeganey explains his viewpoint in detail on page 10.

Alternative livelihoods to be viable, says Narcotics Board

More attention needs to be paid to developing alternative livelihoods for communities dependent on drug crops, according to the annual report of the International Narcotics Control Board.

'The focus of alternative development... needs to be broadened, paying greater attention to the needs of marginalised and neglected populations in both rural and urban areas,' the report recommends.

'Legitimate livelihoods', that are 'both viable and sustainable' are an important focus. Programmes of economic and social policy are seen as key to generating lawful options, but joint strategies between governments and regional bodies are judged essential to understanding the impact illicit drugs have on the local economy, so that an alternative livelihood strategy can be put in place.

The report recommends 'greater involvement of local women and men' in developing and proposing solutions to the drug problems that affect their daily lives, and calls for governments to identify populations that are vulnerable to drug abuse, so that appropriate policy can be targeted.

The report can be viewed on the web at: www.incb.org/incb/annual_report_2005.html

Success for partnership working: The team from Positive Steps Oldham celebrates being named in the Sunday Times' Top 100 Best Small Companies list. The independent sector company provides an integrated range of support services for young people, via Connexions, Oldham Youth Offending Service, Oasis@Connexions and Highways to Opportunities. The team's approach recognises that young people may face many interconnected barriers, including family or relationship issues, health problems or offending behaviour.

'Change in attitude required' on user involvement, says LDAN

'Some elements of user involvement are very achievable,' writes Roseanne Sweeney, London Drug and Alcohol Network's communications manager in a special edition of LDAN News, dedicated to user involvement.

'But substantive user involvement at higher decision-making and strategic levels will not be easy to implement, as it requires a change in attitudes and working practices right across the sector.'

LDAN found that service providers were also critical of the way services were being implemented in London, with commissioners accused of 'hijacking' the user involvement process and 'parachuting' service users onto committees without giving any consideration to their support needs.

At the same time as the NTA stresses user involvement is 'not about ticking boxes', the Alliance's Daren Garratt warns of stifling target-driven approach. User involvement 'should develop organically from a grassroots level,' he says.

The special user involvement edition of LDAN News is available as a pdf on LDAN's website, www.ldan.org.uk.
LDAN with be holding a meeting on what user involvement means for service providers on 26 April – visit the website for details.

NTA develops new tool for equality and diversity

An interactive CD-rom has been developed to help drug and alcohol services evaluate and build their equality and diversity requirements.

The NTA has joined forces with the University of Central Lancashire (UCLAN) to create the package, which gives advice on current legislation, case studies showing best practice, action planning tools and guidance on self-assessment.

Developed in response to requests from the field, and as part of the NTA's commitment to effective treatment for all, the tool has already been piloted to positive feedback.

The NTA hopes it will help services to develop care packages and planning tools that 'reflect the individual needs of service users with better consistency in the sector'.

Copies available from the NTA. Email communications@nta-nhs.org.uk for more information.

Community Drug Project conference: 2012 and beyond

Not ready for cocaine's 'unstoppable growth'

'We're not good at treating cocaine problems. We need to raise our game substantially,' Dr John Marsden of the Institute of Psychology told the Community Drug Project conference on designing crack and stimulant services for the future.

'Criminal justice funding has brought in huge increases in the workforce, but a huge decrease in competency,' he said. With cocaine use heading for 'unstoppable growth' in over the next six years, we had to find a way of engaging people in treatment, particularly in the critical first 12 weeks.

We also needed a reminder that 'abstinence has to be the way forward' for treatment, according to Dr Marsden.

Technologies of the future offered new possibilities, such as drugs that imitated chemicals in the brain, implants, and vaccines. In the meantime we had to ensure that services were attractive, and that we were advocating effectively 'on behalf of people in desperate straits'.

'Forget community involvement at your peril'

Community engagement should play a vital part in tackling drug culture and gun crime, said Patrick Lewis, Head of the Neighbourhood Renewal Team for Harlesden and Stonebridge in the London Borough of Brent.

Harlesden, the 'gun capital of Britain' in 1999, represented particular challenges. While it was a very diverse neighbourhood, around 90 per cent of perpetrators and victims of gun crime were young black men. But these were not minority issues, as they had 'huge repercussions for the community and an impact on the fabric of life,' said Mr Lewis. Fear of crime meant that few businesses would locate in the area.

Most gun crime was carried out in daylight – acts of bravado that resulted in a 'cloak of silence' around the black community.

An active community group was now making dialogue with the police possible, said Mr Lewis.

'There need to be messages to the community that action's taking place,' he said. The community was being involved in evaluation of services – a process that should not be skipped, he emphasised. 'People complain that community involvement elongates the process. But it takes what it takes.'

Over-emphasis on government grants and targets risked damaging community involvement. Local area agreements were a good opportunity for finding common ground between community organisations and local authorities.

Involving local people in policing was also effective, said Mr Lewis, who emphasised that he was not talking about 'twitching curtain' syndrome, but in strengthening community security.

'Forget community involvement at your peril,' he warned. 'The community needs to be a safer place for all of us to be – or it won't be safe enough for any of us.'

Need to be more responsive to complex needs

London has a huge range of drug markets, most of them in the inner city, according to Mark Edmunds, senior researcher at the Government Office for London.

With falling prices since the mid-1990s, there were found to be 45,000 problematic drug users in the capital when the survey was carried out in 2001. Criminally involved users were found to be spending around £500 a week on crack cocaine, and there had been a steady increase in crack cocaine seizures.

There had been an increase in treatment demand of 45 per cent – representing an extra 20,000 problematic drug users. Those presenting to services had complex needs, said Mr Edmunds.

Annette Dale-Perera, the NTA's director of quality, said the demand for services was likely to increase towards 2012.

'Much of the treatment will be stimulant or crack based – but not all people will need full-on services,' she said. There was a much greater demand for brief interventions, so we needed a variety of different, evidence based treatments.

London had more stimulant users than anywhere else in the country, with many people using opiates at the same time, said Ms Dale-Perera. 'So we need to change the type of treatment we are providing.'

Results of the NTA's first user survey, conducted last year, showed what users wanted from their treatment. From 7,000 responses from service users, 81 per cent of heroin users and 77 per cent of cocaine and crack users wanted to stop using completely.

We need to take more account of requests for abstinence-based treatment, said Ms Dale-Perera. Many clients – particularly black services users – wanted abstinence, and 'crack only' services were attracting poly drug users who came looking for an alternative to methadone, she said. The NTA recognised the need for more abstinence-based services in every area, that responded to service users' needs.

Another crucial factor for service user engagement was a successful relationship with their key worker. 'They need to be treated with respect, and with optimism,' Ms Dale-Perera said. 'They need to be energised. They said they didn't want boring drugs workers.'

Media Watch

Government drug policy is undermining headteachers' efforts to ban cannabis in school, according to David Chapman, headteacher of Hampshire Collegiate School in Romney, who is also chairman of the Society of Headmistresses and Headmasters of Independent Schools. In an interview with the paper, he said that 'the government's dithering confirms in the minds of our young people that adults don't know what they are talking about when it comes to drugs.'
Sunday Telegraph, 5 March

Edinburgh's drug tsar, Tom Wood, has urged the Scottish Executive to consider prescribing heroin on the NHS. Mr Wood, who is chairman of Edinburgh DAAT and former chief constable to Lothian and Borders Police, said a controlled supply of the class A drug could be more helpful to addicts than giving them methadone. His suggestion received support from many drug abuse support groups, but condemnation from one pressure group that called it 'legalised drug dealing'.
Edinburgh Evening News, 7 March

Children as young as 11 are being arrested for illegal drug use in the South West. Most arrests were for cannabis possession and supply. Others were for supply of amphetamines and supply and use of class A drugs. Figures were highest in urban and holiday areas, but the figure of nearly 50 arrests was consistent with the rest of the country, police said.
BBC News, 7 March

Cocaine is replacing ecstasy as clubbers' drug of choice. With prices as low as £30 a gram, record numbers of young people are snorting the drug; more than three quarters of Ibiza clubbers said they had taken cocaine, compared to just half last year. Increase in ecstasy use has slowed to just a small percentage.
The Independent, 9 March

No Smoking Day on 8 March had the theme 'serious about stopping… you can do it'. Each year, on the second Wednesday in March, more than a million smokers are persuaded to join in the day, and around 60,000 quit the habit. Specialist counsellors are available on helplines, on the following numbers: 0800 169 0169 for England and Wales; 0800 848484 for Scotland; and 0800 858585 for Northern Ireland. More facts and advice are on the website www.nosmokingday.org.uk
BBC website, 9 March

Kate Moss is modelling two tiny squares of plaster in her right inner ear – signs of taking her battle with drugs seriously by taking a course of acupuncture to control cravings. *The Times* compares Ms Moss, whose ex-boyfriend Pete Doherty has just appeared in court to report on his own progress, as half of the most famous pair of hard-drug abusers since Nancy Spungen and Sid Vicious.
Times, 9 March


Community services | RAPt

Drug and alcohol users are finding help within their own community through RAPt's new day programme in Tower Hamlets. DDN went to see a service already in demand.

Bringing services to the door

'Congratulations to everyone at RAPt for their initiative in setting up the Island Day Centre... Their work and dedication is a standard to which we all should aspire, and makes a refreshing, indeed exhilarating change, from all the rubbish we read about so called "harm minimisation" and "safe using of drugs". There are no safe drugs, especially alcohol.'

A campaigner's view

I wanted to respond to Danny's piece in *DDN* ('Facing Demons', *DDN* 13 February, page 11). I'm not about to do a dissection of what he writes, as I have very little criticism of it, and politically agree that we need that kind of a radical shake-up of our current drug legislations internationally, not just here in the UK.

My question is about one of the things which I think is a stumbling block to confidently changing these policies. My many years of writing, campaigning and listening to other commentators about these issues always leads me back to a few frustrating questions, none of which have been answered yet – either by Danny or the hundreds of other reformers around the world, who speak on these issues regularly.

What will become of the many thousands of personnel who are currently engaged in law enforcement, security, customs and excise, prison guards, militaries, who will become unemployed (at least for a while) when the drugwar ends? We can say, who cares? A part of me certainly feels that way, but I think it's a critical stumbling block to shooting the prohibitive model down finally, given its very clear failures.

Indeed, I would go as far as to suggest that it is their jobs and/or votes that are key in upholding prohibition and it's their having, as Gary Sutton once put it, 'a road to Damascus' about drug policy, that will be fundamental to seeing any real end to this punitive system.

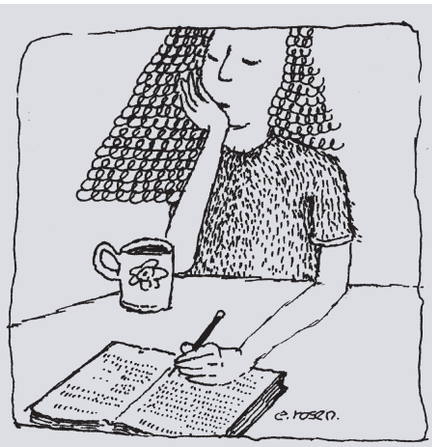
We need an article about Law Enforcement Against Prohibition in here: one of the only bodies that gives me hope, strength and an answer to this troubling question.

With respect and thanks for DDN,
Andria Efthimiou-Mordaunt,
www.usersvoice.org.uk

No nonsense approach

Congratulations to everyone at RAPt for their initiative in setting up the Island Day Centre (*DDN*, 27 February, page 10).

Judging by their results, their no nonsense approach focusing on abstinence and recovery from day one is, as one would expect, successful. Their work and dedication is a standard to which we all should aspire, and makes a refreshing, indeed exhilarating change, from all the rubbish we read about so called 'harm minimisation' and 'safe using of drugs'. There are no safe drugs, especially alcohol. To suggest that there are ways in which they can be safely used is a contradiction in terms, and



Frankie goes to work

Frankie reports on how she's getting on with compiling her professional portfolio – the first stage in her quest for promotion.

Thanks *DDN*, for the article on how to compile a professional portfolio. I promised I'd let you know how I got on with mine – so here's my first progress report!

I have to admit, it wasn't all that easy getting started. I did every rotten task I'd put off for months before I finally sat down to it. I felt completely daunted by the idea of having to present a ring-binder full of experience.

So I decided to start at the beginning, by looking at DANOS standard AA1. It said that I had to 'recognise the indications of substance misuse and refer individuals to specialists.'

I started to think about occasions in my current job, where I've brought members of the public in contact with treatment services.

Then I remembered what you said about using my experience – and that it doesn't have to be from the role I'm in now, as long as it's not from my dim and distant past.

Well before I became a drug and alcohol worker, I worked as a nurse in Accident and Emergency.

I thought about a time that a drug user presented himself for treatment with a large abscess in his groin, as a result of injecting into the femoral vein. My job was to assess him, then pass him on to the doctor for treatment with antibiotics. He then continued his journey to a specialist treatment service, and then on to a local needle exchange and harm reduction service. This seemed to demonstrate perfectly that I had achieved standard AA1.

I used my experience from this episode for my portfolio, by giving a brief summary that mirrored the nursing assessment and plan I made at the time. (If I had still been in this job, I would have just photocopied the actual plan and removed the patient's name.)

My assessment had covered his physical and psychological health; social functioning; smoking, drinking and drug use; a description of his drug use and the risk it presented to him; and an assessment of his understanding of the problem, the

those who preach that gospel are part of the problem, rather than part of the solution.

Good Luck to those people at RAPt and thank you for showing us the way.
Peter O'Loughlin, The Eden Lodge Practice.

Nurse prescriber

I read with great interest about Robbie Corrie's experiences as a non-medical prescriber within the field of drugs and alcohol (*DDN*, 27 February, page 8). I am, myself, a nurse prescriber having qualified in 2003 from the Anglia Polytechnic University in Chelmsford and practised until recently within the prison service. My experiences as a nurse prescriber working with patients who have drug and alcohol issues was most favourable, and my additional qualification was considered an absolute asset by my nursing colleagues, doctors and (by no means least) the patients.

I have recently taken up a position working in the community with clients who have drug and alcohol issues and look forward to using my qualification to similar benefit in the very near future.
Gary Millhouse, GP liaison nurse

risks, and local services that could help.

I also wrote a brief account of my discussion with the patient about the harm reduction service, and would have photocopied the referral letter to the treatment agency if I was compiling evidence from my current job. That made me realise that I needed to start collecting any bits of paper that would save me writing up my experience – punching two holes is much easier!

The whole exercise also made me think about confidentiality. If I'd been using real patient records, I think I would have included reference to the A&E department's confidentiality policy (or maybe a copy of it) to show that I worked within expected protocols.

So that's my portfolio off the ground. I'm actually getting into this, and have started asking colleagues and friends what they're using for theirs. (Hey, why don't I get asked to many parties any more..?)
More soon,
Frankie

Comment

Are we minding the gap? Responding to diversity can become meaningless if the group in question doesn't fit the usual stereotypes. Ismael Mahamedally of the Thames Reach Bondway Resettlement Team explains from the perspective of London's Mauritian population.

The Mauritian population in London forms part of the influx of foreign travellers from the late 50s, coming to the UK, alongside Asian, African and West Indian citizens, as part of the employment and economic push that that era highlighted for those with British Citizenship status from previously colonised countries around the World.

For at least the past 50 years the Mauritian population in the UK has enjoyed integration into the urban and residual population, which undoubtedly has, with other cultures and races formed part of the fabric of London in the ever-growing patchwork of growth that Britain's inner cities continually attract.

Historically, alongside other small island cultures, Mauritians have proved to be leaders in business, entrepreneurs and found in all levels of class, social standing and professional employment. The problems of social exclusion, effects of family breakdown, addiction(s) and the general problems that can face the wider general population, also face Mauritians as a greater percentage per capita.

The Seventies brought the old problem of whose side were you on, the Black side, White side or Asian side. Due to the complexities in the make-up of the home country, most selected the Black side, with others feeling more represented by the Asian voice. This caused a huge identity problem that exists to this day and rears its head in differing ways – especially in the world of addiction, social exclusion, rough sleeping and service representation.

Since the 60s there has been an ever-growing significant heroin problem within the island, mainly driven in the Creole and Muslim sections of the Community. The link between the acceptability of the drug within culture has been mainly due to the way this is administered and culturally accepted. Smoking became more prevalent, as people travelled and were exposed to new ways of use – as did injecting, most probably due to cost. In terms of harm minimisation, it can be argued that this section of drug users could be more positively engaged in keeping away from needles, something that is getting more prevalent day by day.

In the whole of the UK, there is not one service that is directly geared toward Mauritian clients, in the form of informal drop-in services that could aim to deal with issues such as benefits advice, housing, substance misuse, relationship counselling, health advice, training for employment *etc*.

In the age of the multi-cultural society, I accept the need to signpost mainstream services for the benefit of the greater society, but engagement in a meaningful way is the key. At the moment, Mauritians are not fully utilising the resources available to them, either due to a lack of knowledge of their availability or not having enough 'pre work' done to assist, support, advocate and signpost to local authority services.

Due to the changing nature of our society, older clients are experiencing a greater dislocation of accessing available services and are less likely to engage with them, based on their perceptions of meaningful engagement. As service users become older and experience relationship breakdowns, the emotional and social fallout, lack of wider family connection and substance use, (mainly alcohol, marijuana and heroin) and the general wellbeing of older Mauritian people is seriously put in jeopardy and hidden.

'Historically, alongside other small island cultures, Mauritians have proved to be leaders in business, entrepreneurs and found in all levels of class, social standing and professional employment. The problems of social exclusion, effects of family breakdown, addiction(s) and the general problems that can face the wider general population, also face Mauritians as a greater percentage per capita.'

While most have resigned themselves to the fact that the closest meal on the high street to their own will be the West Indian takeaway, they also have a culture that isn't the same as the West Indies, but close. Their Roti's a little bit different and the music isn't Reggae, its Seggae – and sorry, but the Patois is just a little bit too French. Can't they have the respect that's due and have a day centre too?

If your organisation could give practical advice in terms of funding and pushing the plight of London Mauritians to the forefront, we'd love to hear from you.

Email the author at ismaelmahamedally@trb.info

No drugs, no special equipment, just tapping into your own hidden energy system. Can 'energy therapies' really help people out of addiction? In the first of a series investigating alternative therapies, DDN hears about a route to empowerment.

Empowering the core

I am sitting in a low-slung chair in Cathy Dixon's house in Acton, West London. There's a large chart on the wall showing the energy channels for shiatsu massage. There's another showing ear acupuncture points and I'm amazed to see how each of the many labels on the giant ear relates to parts of the body – including the liver, the kidneys and the spleen. I am starting to see how these therapies have become a relevant treatment option for clients trying to replace drug or alcohol addiction with a feeling of wellbeing.

The room is light and calming, and just one of the places that Dixon, a qualified therapist and trainer, uses to practise her range of therapies for private clients. Her other sessions are conducted at group venues – and it is in this context of group treatment that she believes alternative therapies can have an important role for drug and alcohol clients.

Many clients begin with auricular (ear) acupuncture, because that's the treatment they have heard of, and they are seeking ways to relax, sleep better and feel less stressed.

'It's just one tool, but a really nice entry point,' she explains. 'It gets them in touch with their energy.'

Through transforming a local community centre with candles and music, Dixon creates an atmosphere that is 'nurturing and very non-judgmental… welcoming, calm and inclusive. Not talk-based at all.' Many people are not sure what to expect when they first come for acupuncture, she says. It's been recommended to them, but they are not sure how it's going to help. The group environment can be very reassuring, she says, particularly for those who might come with a fear of needles. They see from others that the needles don't hurt, and learn to relax over a series of treatments, at their own pace.

Many people do well with auricular acupuncture, and decide that it will be their core treatment. For Dixon, the needles are just the starting point, and she encourages clients to see it as a way of creating change that will affect the rest of their lives.

There's a necessary stage of clearing away life's clutter, she explains. 'Think about someone who wants to create a beautiful garden, but it's full of rubbish. You have to do a bit of weeding to clear the space. Acupuncture and meditation clear the space.'

Getting to a calm, clear, relaxed state is important, 'so they can start to think "OK, if I can feel like this now, maybe I can feel like this more in my life",' she says.

The therapist doesn't have to know a lot about the client before treatment. They fill out a health form to confirm that they're suitable to have treatment, and that they've eaten something.

Their involvement with the therapy then unfolds at their own rate. A therapist of Dixon's experience is normally familiar with 'a matrix of possibilities' that will reflect the way the client is feeling – 'a template of feelings, beliefs and emotions that have got them into the space they're in', so can guide them gently through

Many people do well with auricular acupuncture, and decide that it will be their core treatment. For Dixon, the needles are just the starting point, and she encourages clients to see it as a way of creating change that will affect the rest of their lives.

their reactions to therapy.

Dixon is interested in a client's history – not the detail of their background, but how they feel about themselves so she can help them put past traumas behind them. Everything is confidential, everyone moves at their own pace, and there is no pressure to reveal anything they don't want to. She emphasises she is there to understand, not to judge.

Starting a programme with ear acupuncture can help people unlock a lot of positive feelings, she says. But this can be just the beginning. She is interested in tapping further into these feelings of energy, and believes that through devising a programme of different therapies, drug and alcohol clients can achieve a remarkable sense of self-empowerment. Having seen many private clients take on board techniques that have helped changed their lives, she does not see why the substance misuse field should not benefit more from techniques that are not yet considered as mainstream options.

'Energy is something we've all got,' she points out. 'If we look at ourselves as energetic beings, and our emotions and beliefs are also energy, then maybe we can make changes in our own energy system to effect changes on a deep level.' In other words, it's down to how much we understand our own energy and develop it.

This is where the ancient practice of Chi Kung (also spelt Qi Gong) comes in. Dixon teaches, and trains others to teach, this combination of stretching, flowing movements and calming breathing techniques, developed from ancient martial arts and Chinese medicine.

It's also where Dixon introduces the idea of empowerment and the treatment stops being passive. By learning a few simple Chi movements, the client is shown how they can calm themselves down.

'You can teach people bits and they can feel it, especially in a group environment,' she says. 'And they're working with their own energy.'

'It's the same field as acupuncture,' she points out, 'but it's not an intervention – they're just doing it themselves.'

Group therapy has a very obvious advantage – that it is economical. But can it tackle people's deep-rooted problems in the way that one-to-one counselling and psychotherapy can? Dixon responds by explaining another weapon in the armoury – one that she believes is 'where it's at' in terms of twenty-first century healing.

Emotional Freedom Technique, or EFT, is just starting to be talked about as a new 'energy medicine'. It's based on the same system as acupuncture, of acupoints around the body, but there are no needles. First, the client is talked through an issue that's bothering them, which the therapist maps out on paper. Then the therapist helps them to turn the problem into a positive thought. As the client focuses on the thought, they are shown how to tap acupuncture points, mainly on their fingers, head, face and neck, while repeating affirmations.

A group setting makes this therapy even more powerful, says Dixon. 'These people are already in the same boat; they're already having group treatment. They're there for the same purpose – and it's actually quite reassuring that other people have these feelings too.'

Combining the tapping on the body and the affirmations on the psyche can be a powerful combination, she explains. It's like peeling layers from an onion, she says, where the layers are beliefs, opinions, life experience, traumatic memories. 'At the heart is you – all the dreams, all the creative bits.'

For someone who has become overcome by addiction, to the point where 'suddenly the addiction is the person', this can be a revelation. If you've grown up in an alcoholic family, and in turn become an alcoholic, it can be all too easy to assume that that's your lot in life, says Dixon. The empowering technique is a reminder that the addiction began at some stage, as just a habit that grew out of proportion – a behaviour that can be changed.

And because you are in charge, you can go back to the core of your addiction, which is at the heart of all healing, according to Dixon. 'Any intervention that just scratches the surface and doesn't go any deeper is going to have a limited rate of success.'

With a mission to encourage empowerment, and the message that 'it absolutely has to come from you', Dixon is interested in helping to introduce 'change programmes' that provide clients with the environment and tools to take control of their lives.

The three tools – acupuncture, Chi work with energy fields, and EFT – are three therapies that can be introduced to a group of up to eight people. When they are feeling more energetic and more in control, clients might think about what else they might need to sustain recovery, such as homeopathy, crystals, meditation or other complementary medicines. But the group energy work is an affordable starting point, with a shared therapist and no special equipment.

Dixon is also keen to point out that energy therapies can easily be taught: 'members of staff can get that training. It's not locked in the expertise of the therapist.' The reaction she's had from people during sessions has convinced Dixon that energy therapies could catch on in a big way, when more people experience them.

Evaluation of a recent 'relaxation and wellness clinic', held every Tuesday for 12 weeks for the Alcohol Resource Centre, gave feedback to Dixon's combined therapy approach. A substantial majority of clients reported reduced dependency on alcohol and drugs after the sessions, reduced cravings, significantly less stress and feeling much more relaxed. Comments included: 'made me much calmer and able to get on with things'; 'for raising moods 10 out of 10… feeling good in myself and more able to cope'; very good for stress levels and relaxation'; and 'I have been waiting for my usual anxiety attacks but they have never occurred.'

Understanding they've got an energy field is pretty way out stuff for a lot of people,' says Dixon. 'But then comes the reaction – "all I've got to do is some movement, I've just got to tap a few points. And I can actually influence the way I feel." They're amazed.' **DDN**

Cathy Dixon, registered therapist and trainer, can be contacted by phone at 020 8896 3978; email at info@energyroots.co.uk; or through her website, www.energyroots.co.uk

Professor Neil McKeganey hit the headlines recently for suggesting that parents must choose between their children and drugs – and should be prepared to put their children up for adoption if they cannot kick the habit. Here he explains the reasons for his view.

Enough is enough:
when addiction must mean adoption

The case of the 11-year-old girl admitted to hospital in Glasgow following a possible heroin overdose has ignited concerns in Scotland about the impact of parental drug use on children and whether services should use adoption more readily in circumstances where a parent is addicted to illegal drugs. These are enormously emotive issues that challenge fundamental ideas about families and the rights and responsibilities of parents and children.

Drug addict parents will always tell you that they love their children. Loving your children though is not the same thing as keeping them safe, keeping them fed, keeping them clothed, taking them to school, helping them with their homework or imbuing them with a sense of right and wrong. It is not the same thing as always being there for them 24 hours a day, seven days a week, month after month, year after year. Caring for children is not the same thing as exposing them on a daily basis to the chaos of drug addiction; taking them on late night journeys to buy drugs, or leaving them alone for hours at a time while parents seek the money to buy the drugs they so desperately need. It is not about exposing children to the petty and sometimes serious criminality and violence associated with maintaining a drug habit. Nor is it about a parent lying asleep in a drug-induced coma while their children wonder whether they are alive or dead.

These are the things that parenting should not be about; but for increasing numbers of children in the UK today, that is exactly what their parenting has become. The best estimate we have is that there may be as many as 350,000 children in the UK with one or both parents dependent upon illegal drugs.

Children are profoundly damaged by their parents' drug addiction. To many people that is stating the obvious, but to some practitioners, experts, social commentators and politicians, it is an unhelpfully extreme statement. Many drug users make model parents they will say. But given a choice, who would choose a drug addict for a parent? The absurdity of that question is only in part in its formulation (who, after all, ever chooses their parents?). It is also rooted in the deep knowledge that for the most part, someone addicted to illegal drugs is barely able to look after themselves let alone a dependent child. Individuals who are addicted to illegal drugs make terrible parents – not because they are bad people but because too much of their focus is taken up with the drugs they need and too little is taken up with their children.

In interviews carried out by Dr Marina Barnard and Joy Barlow at the University of Glasgow Centre for Drug Misuse, children spoke about the impact of their parents' drug addiction on their lives. The experiences these children recounted were nothing short of heartbreaking. One child had woken alongside the corpse of his overdosed father; another had been hung from a balcony of a tenement block by a drug dealer demanding repayment of a drug loan. One child sat with tears rolling down his face as he watched his mother inject, and another sat silently at the locked bathroom door as his mother lay inside experiencing the effects of the drugs she had just injected.

Surely, you might say, these are untypical examples chosen to shock not to inform. In fact

most of the children in the Glasgow University research were living in families that were still intact. If the researchers had focused upon children who had separated from their parents, the stories they would have heard would very probably have been even more shocking. For so many of the addict parents interviewed in the Glasgow research, heroin had become not just the most important thing in their life, but the only thing. As one parent put it, 'if I could have sold ma weans (children) for drugs, I would have'. That, in a nutshell, is what heroin addiction can do to the most loving of relationships.

Within the UK we have increasing numbers of children who, from infancy, are growing exposed to the reality of problematic drug use. They see their parents using illegal drugs and they may see other adults visiting their homes to use drugs. They may see the drugs themselves and the paraphernalia associated with their use. They may witness illegal drugs being bought and sold. Growing up in the midst of such serious drug abuse, it is perhaps inevitable that a proportion of these children will go on to use illegal drugs themselves. It is perhaps for this reason that research carried out with preteens in Glasgow and Newcastle found that those who had started to use illegal drugs by age 12 were six times more likely than their peers to have a drug user as a close relative.

The question then, is how are we going to intervene to protect these children? We can say that we will support these families for as long as possible and work to keep them intact. There is an army of social work staff and voluntary agency staff who can provide near 24-hour a day support to these families. They can call round in the morning to get the children out of bed and they can give them their breakfast. They can take them to school and pick them up at the end of the day. They can supervise them in the evening, feed them at night and put them to bed. They can provide extensive counselling to both the drug dependent parents and their children in the hope of rebuilding these families. They can do all this – but they can only do it for so long and for only so many families.

What the state cannot do is provide that level of support to anything like the number of families that need it, which leads to the inevitable fact that many families and children who are going to need that support are not going to get it, and the children within those families are going to be left on their own to cope with the impact of their parents' drug use.

Yes, addict parents can come off drugs and when they do that they can become the loving, caring parents that their children need them to be. But children cannot wait indefinitely for their parents to recover from their drug use. We know that these children can suffer long-term damage where their own needs have been neglected in preference to their parents' drug addiction. Addict parents need to make a choice between the drugs they are addicted to or the children that they love. I know that sounds harsh, but at the end of the day, if an addict is going to give up drugs, and take on their rightful parenting role, it is only going to be because they are determined to make that happen.

The obligation on us is to make sure that we have the level of treatment and support services in place to help addict parents in their efforts to become drug free and to build their relationships with their children. The responsibility on the parent is to work to an agreed time frame to overcome their drug addiction. Where they cannot do this, or are reluctant to do this, and where the children are suffering, we should set a time frame after which we should say that enough is enough, and we should seek to place the children within non addict families who can give them the care and the love they need.

The object of such a policy is not to remove thousands of children from addict parents but to convey the clear message to parents that their drug use is causing intolerable and unacceptable harm to their children, and that only by overcoming their drug dependency will they be able to provide the care and nurturing support that their children so plainly require.

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

'Children cannot wait indefinitely for their parents to recover from their drug use. We know that these children can suffer long-term damage where their own needs have been neglected in preference to their parents' drug addiction. Addict parents need to make a choice between the drugs they are addicted to or the children that they love.'

FACT FILE

Service User Groups

This issue: GASP Gravesham Addiction Striving for Progress

When and why did you start your group?
GASP was started by three service users who had been though inpatient detox and day programmes and felt there was no aftercare in the area. They would have benefited greatly from somewhere they could have gone in the early stages of recovery, after leaving treatment.

With the help and support of Kent's Service User Support and Training Team (SUST) we opened a service user led drop-in centre in Gravesend, in March last year.

How many members do you have?
We've helped over 50 people so far, linking them to local services, and to training opportunities through the SUST Team.

How did you obtain funding?
We're supported by the SUST Team, who are funded by the Kent and Medway Drug and Alcohol Action Teams.

Where, and how regularly, do you hold meetings?
We're at the drop-in centre, which is at 2 Brewhouse Yard (off Queen Street), Gravesend, Kent DA12 2EJ (tel 01474 564 769). It's an ideal location as it's in a side street, which is good for anonymity. But it's also near to the train station, bus routes and carpark.

We also hold a Carers Support Group at GASP on the second and fourth Wednesdays of every month, between 7pm and 8.30pm.

What do you hope members get from attending?
We provide advice and information to users, carers and significant others, when all routes seem closed to them. People come to us for advice in a non-judgmental atmosphere, to chat, and to find out about opportunities.

How do you keep it going?
GASP has gained momentum from playing an active role in promoting changes for service users. They have had a chance to give feedback to local treatment services and know that their opinion counts. We've created a bridge between service users and services in the area and have a good partnership working approach. We know we are needed as the voice of Gravesham, Dartford and Swanley PCT areas' service users, and active participation in various meetings concerning drug and alcohol issues throughout Kent makes us ever more involved. Our active role keeps us going.

What have been your highlights so far?
Gaining the trust of local services users – and influence with decision-makers on their behalf.

How do you communicate with your members?
We publicise our location and make the environment as welcoming as possible. There's free tea and coffee here and computer access, as well as all kinds of local information.

SUST produces a user newsletter called 'Substance', which communicates useful information on harm reduction, as well as articles, art and poetry by service users.

Have you any tips for others starting a service user group?
Make sure from the outset that the group feels safe, confidential and non-judgmental. Show that there is no pressure and no hidden agenda – just a climate of support.

Letter to Georgie

Last month Brigitte wrote to our Q&A pages, asking for advice in coping with her son's heroin addiction. Another mother realised how far she had come in coping with a similar situation, when she wrote a letter to her daughter in prison. Both mother and daughter have given permission for us to print this letter in the hope that it helps Brigitte, and others in her situation, to realise that they can come through the bad times without losing each other.

Dear Georgie
It must be at least five years since I realised that you had a problem with drugs. It was Christmas day and you were feeling too ill to get out of bed. Your sisters tried to cheer you up and spent most of the day at your bedside encouraging you to eat a little and open the odd present. Sadly your face remained looking very pale and you just did not want to know.

Things went from bad to worse, your weight started to take a nosedive and your behaviour was just not right. You kept rushing off out at anytime of day or night in the freezing cold, not to return for days or weeks at a time. You will never know how much I worried with each passing day. I could not eat, I could not sleep. The police were very understanding but could do nothing to ease my pain.

As time passed I discovered that you were shoplifting and driving a car with no licence, tax or insurance. On occasions I was able to locate your whereabouts and you promised to meet me for lunch. We drove for an hour and a half and then waited and waited. When you did turn up I hardly recognised you, your clothes were so dirty hanging off your skeleton frame. People would stare at us but I would not think that you were aware as you were away with the fairies. Sometimes you never arrived at all I would have to stop the car a few miles up the road and have a good cry.

Months and months would pass, spring into summer, summer into autumn. I heard nothing from you. I locked myself away from the outside world with images in my head of your drug-ridden body and alienated mind.

How was I going to cope if you were to die? Thoughts of your funeral with wild flowers adorning your coffin. I tried to prepare myself for the worst, but at the same time keeping the rest of the family happy, continuing with the usual daily routines.

Out of the blue came a telephone call from you. You asked me how I was and how were your sisters? Your voice sounding controlled and as well-spoken as ever. The next sentence was such a shock: you announced that you were in prison. I tried to remain focused but I felt as though my heart was about to explode. I sat through supper, forcing every mouthful down. Later that evening after dark, I went out for a stroll to take in some fresh air. I only made a few steps before collapsing in floods of tears, I could not accept that my child was going to be confined to a prison cell.

We are country folk, outdoor people who thrive on fresh air, we live for nature in all its simple glory. I did not know how I was going to cope anymore. I wrote to you nearly every day and promised that at 9 p.m. we must look out at the stars and say 'goodnight, God bless' to each other. Some evenings it would be cloudy with no stars, oh how I would panic. I wanted to feel as close to you as I could.

You came out of prison the week before Christmas, looking really well and quite focused. We had a great festive couple of weeks. You were free of drugs and I had my three beautiful daughters larking around me once again.

It did not last. You quietly slipped off again one very cold afternoon. You were going for a walk and returning in time for tea. This time you had taken your little sister's mobile phone, C.D. player and C.D.s. Also pocket money was gone, you must have been desperate. I was devastated, once again feeling angry, sick and sad all at the same time. I had to break the news to the rest of the family. My health was taking a complete battering. I was emotionally and physically wrecked. I prayed to God to help me, walked through my favourite wood, sat down at the base of the big oak and wished that I could die.

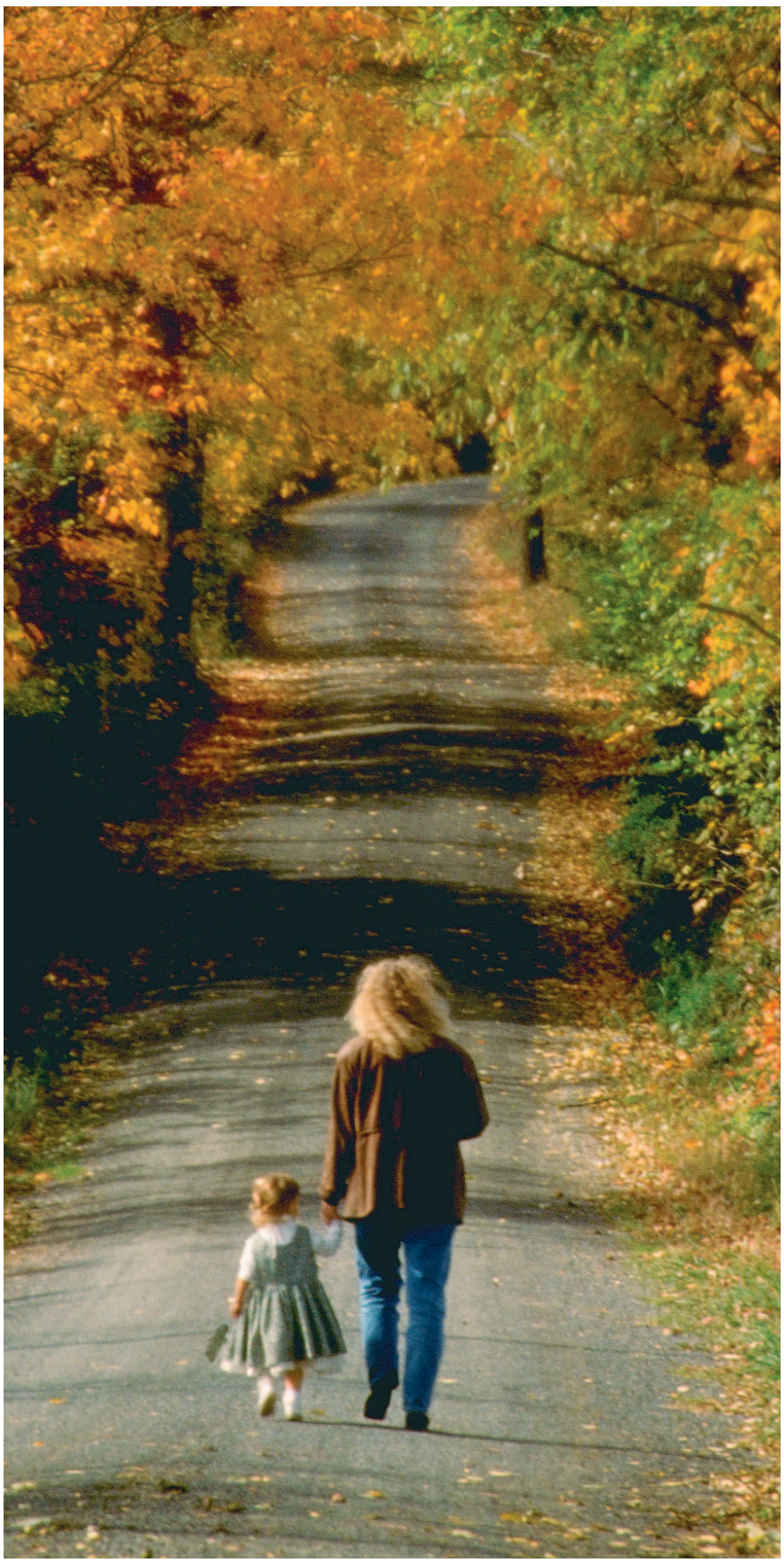
How could I fix your heroin addiction, how much more could I take? I could not think straight, everyday life was torture and my health was in ruins. It was another year before my prayers were answered. I was sitting in the doctor's surgery when I spotted a leaflet on display – Families Plus, specialist help for families affected by alcohol and drug dependency. I picked up the leaflet and put it in my pocket.

Almost two years later, after more heartache from your addiction, I made the telephone call to Families Plus. The support group has turned my life around. I know that I cannot personally fix your problems for you Georgie, you are the only one who can do that. I am learning to try and look after myself now, taking a few steps in the right direction.

Families Plus is the perfect prescription for me, no more feeling isolated, no sleeping tablets, no pills to calm my nerves. A simple get together with others who like myself have been and are going through so much pain. My life still feels very fragile because I do not know what the future holds for you my darling. I pray that one day soon you will seek as much help as you can and be strong enough to walk away from the drugs that have been ruining your life.

I am beginning to appreciate days when the sun is shining, noticing the wonders of the countryside, walking in my beloved forest. I love to see and hear the birds, keeping a note of all the wild flowers growing at my feet. Do you remember that autumn poem that you wrote when you were about nine years old? We had it hung in the hallway. One day we will walk in the forest again together and enjoy the simplicity of life. Here is to the future Georgie. I am still here for you as I always have been, but now I am feeling much stronger and pray that you pull through.
Love you always,
x Mum x

Clouds Families Plus can be contacted at – tel: 01722 340325; email: admin@familiesplus@clouds.org.uk; website: www.clouds.org.uk/family.htm

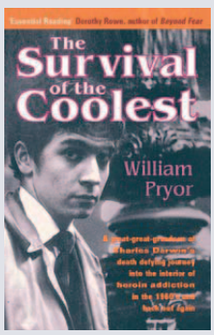


Book Review

The survival of the coolest

By William Pryor

Published in 2003 by Clear Press Ltd. ISBN 1-904555-13-6.
Price: £9.99. Available from www.clearpress.co.uk



When I began reading 'Survival of the Coolest' I wasn't sure I cared much about what happened to young Pryor. The opening pages remind us constantly that he is the great great grandson of Charles Darwin, and as his baby picture stares loftily from the 'authorial pram', he begins recounting a tale of the poor little rich boy who chased away the boredom of privilege by dabbling in drugs, travel, music, performing art, and whatever else distracted him.

His cultured, baffled (and loaded) parents haul him out of various scrapes, and in so doing share the blame for their part in transferring the genes that both damn him and set him above us mere mortals.

Then just as I was about to put the book down for a while to go and do something else, I realised I couldn't. For the first part of the book, Pryor has been strutting his stuff, hanging out with the cool, stepping over anything and anybody that got in the way of his kicks. Having been taken into his confidence from page one, we know how he feels about pretty much everything, especially himself.

Then suddenly his addiction takes the upper hand and we watch him become slave to heroin, prescription drugs, alcohol and pretty much anything that will alter his wretched state. By the time he begins to lose everything that is dear to him, the reader cares very much what happens to him because Pryor has been clever enough to keep them close throughout. The lows when they come are shocking, and the pain – particularly where his family is concerned – is sharp.

His story moves through every stage of addiction and recovery, and Pryor becomes the hero intent on conquering a hopeless circle of addiction before it closes in and kills him.

But this is no gloomy introspective. Pryor's writing has a spring in its step that makes it hugely enjoyable; he writes about himself as if he were examining a curious creature through a microscope; constantly surprised at his own reactions and appetite for self-destructive behaviour.

Neither is this a book without serious messages. The first is one of enormous hope for any addict in tackling recovery – and for all his near death experiences, Pryor is an energetic writer and entrepreneur these days. The second message is bounced throughout the book and lobbed at us at the end: that all drugs should be legalised and licensed to bring them out of the dark and hopeless alleyway of criminality and hidden suffering.

Pryor is as busy as ever examining the nature of addiction; at his forthcoming conference (see www.unhookedthinking.com) he invites people from all kinds of backgrounds to explore and debate why we become addicted. This book is a fascinating insight to his personal struggle. **DDN**

We'd like to provide a better service in our rehab for people with learning difficulties or cognitive impairment. Can anyone advise me on inspiring programmes, materials or methods that would help us?
Meg, North Yorkshire

Low-literacy approach

Hi Meg,
I suggest that you use some low-literacy approaches that involve no, or minimal, reading or writing for your clients.

Collect some examples of legal drugs, facsimiles of illegal drugs and drug paraphernalia and put them in a bag. You can then use them as a lucky-dip type activity.

Also you can use photographs of drugs, people (good for stereotyping activities) and people using drugs and in drug-related situations.

Both physical objects and photos can be discussed (what is it, what do you know about it, what is happening, what might happen next, *etc*), sorted into groups (safe/dangerous, legal/illegal *etc*), placed on line continuums (most/least) and used as the basis for role play and drama activities.

HIT have recently published my 'Drug Education and Training Photo Pack' that contains A4, colour photos of drugs, people and people in drug situations, together with a manual that describes how to use the photos with groups and individuals. Further details from www.hit.org.uk or by ringing 0870 990 9702.

If anyone is interested in discussing similar approaches with me I can be contacted at julian.cohen@virgin.net

Best wishes
Julian Cohen

Complex needs – vulnerable people

Meg,
Unfortunately, there's not enough information out there on helping people with the kinds of complex needs you describe – a lot of people don't think that a person with a learning disability could have an alcohol or drug problem too.

The reality is that people with learning disabilities can be particularly vulnerable to substance misuse because of other related factors such as lower incomes, social exclusion, low self-esteem, lack of friends, partners or general peer acceptance, unemployment and poor access to transport and social and leisure activities.

Providing good services for people with learning disabilities is about not making assumptions.

Someone with a learning disability can understand important information and make significant gains in treatment. However, if you have doubts as to the person's ability to understand information, such as a rehab program, or whether they have the capacity to give consent to treatment, there are a number of things you can do.

- Ensure information is provided in a format which is accessible to the user. For example, using pictures can be useful.
- Make sure you involve carers, families, friends, advocates, and 'circles of support' in all stages of treatment. This will help people with learning disabilities understand the issues, as well engage with and remain in treatment.
- Routine is especially important for people with learning disabilities, so you and your staff should consider carefully the implications of any changes to treatment.
- It is also important for your service to develop good links with local agencies and community and leisure facilities.

As an organisation that provides services for both substance misuse and people with learning disability, Turning Point is hoping to produce materials to help people supporting people with a range of needs, as at the moment there is not enough information available about supporting this client group.

Yours,
Ayesha Janjua, policy and campaigns officer – Learning Disabilities, Turning Point.
www.turning-point.co.uk

Resources here

Dear Meg
While I can't offer any advice on new programmes or methods to improve services for people with learning difficulties I am pleased to see that organisations are keen to address this issue. Although it is not directly focused on rehabilitation, you may find some of the education resources provided at www.educari.com/SNADE/useful. The site helps to round up the guidance on good practice on drug education for young people with learning difficulties as well as providing links to research and reports.

Kind regards
Ian

Start at the beginning

Dear Meg
I feel it worth stating at the beginning that providing a better service for people with learning difficulties or cognitive impairment can start with the quality of the initial assessment and screening process. This is needed to ensure that the individual has the capacity to cope with the treatment programme and also informs decisions regarding treatment planning.

Once admitted, a continual assessment of ability will be important, especially as this can change over time. With changes to medication regime, physical health and emotional wellbeing it is not unusual for cognitive functioning to improve and with it an ability to concentrate, understand and communicate more effectively. Consequently expectations of both staff and patient may change.

At Broadway Lodge, most patients coming into treatment will work on a programme that involves varying amounts of reading and writing – however we acknowledge the need to avoid a 'one size fits all' mentality. There has to be, as your question implies, some flexibility and imagination applied in order to respond to differing needs and maximise the opportunity for all patients entering treatment to benefit from it.

To convey information and concepts regarding the Twelve Steps, if patients have some literacy skills but might struggle with more complicated and academic texts, the Hazelden *Keep it Simple* series of Step workbooks has proved to be helpful. Where this might not be suitable, presentation of the information in audio or visual format using DVDs or CDs can provide a valuable and effective alternative.

Central to our work is helping patients to understand and express themselves and their emotions in a way that is more healthy and productive than has been the case in active addiction. With this in mind, we have found that poetry, painting, drawing, clay modelling, dance and drama have all been useful media through which patients have discovered satisfying outlets for their expression.

We are also keen to encourage learning through the development of healthy relationships, and key to this in treatment is the interaction between patients. This provides opportunities for significant personal learning and development and can be generated through 'assignments' requiring communication with others. As a result, using the peer group to seek feedback or advice and to explore and learn from them is a valuable resource and needs to be harnessed at every opportunity.

My suggestion is be imaginative, creative and find out what works for that patient – and bear in mind that there is no single answer; what works for one patient might not work for another.
Peter Smith, head of counselling, Broadway Lodge
www.broadwaylodge.org.uk

Reader's question

I'm an ex-service user, clean now. I feel that my experiences could deter young people from taking the route that I did. Do readers have any suggestions on how I can get involved?
Paul, Nottingham

Email your suggested answers to the editor by Tuesday 21 March for inclusion in the 27 March issue of DDN.
New questions are welcome from readers.

The drug experience: heroin, part 2

In his latest Background Briefing, Professor David Clark describes the initial experiences of heroin users who go on to have their lives seriously affected by their drug use.

Heroin can have a devastating effect on human lives, although as we described in the last article, evidence indicates that it has this impact on only a minority of people who first try the drug.

In this Briefing, we start to describe the experiences of people whose lives are seriously affected by heroin. The experiences are based on those described in the seminal book *Beating the Dragon* by James McIntosh and Neil McKeganey, and our own research with clients on the Peterborough Nene Drug Interventions Programme.

The majority of people in these studies committed crimes to fund their heroin habits. In fact, the Peterborough project recruited many of the highest level offenders in Peterborough. However, we emphasise that this does not mean that all people who take heroin commit crimes.

Many people who use heroin describe a steady progression from use of legal substances (alcohol, solvents), through to softer drugs such as cannabis and then on to heroin.

The most frequently cited reasons for trying heroin are curiosity and a desire to comply with the expectations of others, particularly of a peer group. However, there is little indication that heroin users are pressurised to take the drug for the first time – the vast majority feel that they have made their own decision.

However, this decision is often not well-informed. Many of our interviewees emphasised that they were naïve about the effects of heroin before they first tried the drug. Some believed that it was no worse than other drugs; others were not even aware that they were trying heroin.

Some people admit to not thinking about the consequences of their actions, and in fact do not think much about their drug use at all. Many others, when they first start taking heroin, are confident that they will not become addicted. A common belief is that, 'addiction is not something that could happen to me; it happens to other people'.

Many of our interviewees discussed the ease of availability and frequent exposure to various substances, including heroin. Drugs were rife on the housing estates in Peterborough on which some of our interviewees had been brought up.

Many people who first try heroin will say that they experienced a feeling of great relaxation and detachment from the outside world. They may feel drowsy, experience a clouding of mental functioning, and feelings of warmth (from dilation of blood vessels). They may also experience feelings of euphoria, particularly after intravenous injection.

'The most frequently cited reasons for trying heroin are curiosity and a desire to comply with the expectations of others, particularly of a peer group. However, there is little indication that heroin users are pressurised to take the drug for the first time – the vast majority feel that they have made their own decision.'

Heroin also reduces anxiety and emotional pain – it helps people escape from reality.

There is a reduction in respiration, heart rate and pupil size. Many first time users feel sick and vomit, although this vomiting is often not enough to stop them using again, as the pleasurable effects far outweigh this negative side effect. This vomiting subsides in many people after the first few experiences of heroin.

Many first-time users try the drug again because they enjoyed the first experience. Others, some of whom may even have had a bad initial experience, continue taking the drug because they remain in the same social circles that led them to their first use.

Some people very rapidly move towards daily use of the drug, while others may continue to use on a periodic basis over a period of weeks or months. Our Peterborough sample, whose lives were badly affected by heroin, all ended up using the drug daily.

Heroin users develop a tolerance to the drug, such that increasing amounts of the drug must be taken in order to achieve the same positive effects. This tolerance results in the drug habit becoming more costly. Some users will shift from smoking heroin to injecting the drug because the same effects can be achieved with much smaller amounts of the drug.

They may also start injecting the drug as part of a continued desire to experiment and to find new 'highs'. As part of this process of finding new 'highs', some people use multiple drugs, sometimes at the same time. Use of benzodiazepines, legally and illegally obtained, is common among heroin users.

Many heroin users recognise the decision to inject as having been a significant step in their drug using career. Injecting is an invasive process that heightens the risk of overdose and introduces additional risks such as contracting HIV, Hepatitis C and other blood-borne infections.

Often, these are not the factors that make people reluctant to start injecting. Rather, they appear to be apprehensive about the actual process of injecting. Many users have a fear of injections and, of course, generally people do not know how to inject. Other users help first-time injectors and continue to do so until the latter person feels confident in the process.

There are variations in individuals' experiences when they first inject heroin. Many people experience a pronounced euphoria almost immediately after injection. Other people do not experience this rush, while others report feeling very ill.

However, many of those who initially have negative experiences continue to persevere taking the drug and eventually became intravenous drug users.

In our next Background Briefing, we will continue to look at the experiences of those people whose lives are seriously affected by heroin, focusing first on the withdrawal syndrome.

Recommended Reading:

Aimee Hopkins and David Clark (2005) Using Heroin, Trying to Stop and Accessing Treatment. www.wiredinitiative.com/pdf/Nene1.pdf

James McIntosh and Neil McKeganey (2002) Beating the Dragon: The Recovery from Dependent Drug Use. Prentice Hall.

Tam Stewart (1996) The Heroin Users. Rivers Oram Press.

UNIVERSITY OF KENT

Training for Drug & Alcohol Practitioners

Kent Institute of Medicine and Health Sciences

Programmes from 2006/07

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

Certificate in Substance Misuse Management (Stage 1)

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

18 month programme from September 2006 or by negotiation

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

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

18 month programme from September 2006 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

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

2 year programme from October 2006

BSc in Substance Misuse Management (Stage 3)

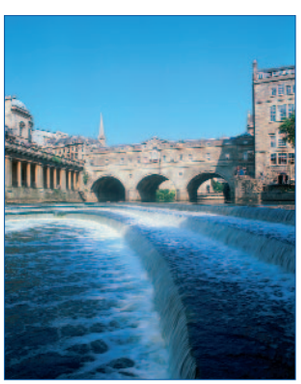
The BSc programme provides in-depth study of the psychological, environmental and biological aspects of addictive behaviours, this includes training in ethics, research methods and the development of a research proposal. You will be encouraged to develop a detailed understanding of client assessment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

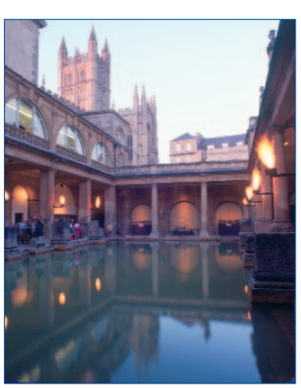
2 year (top-up of Diploma) or 4 year programme from November 2006

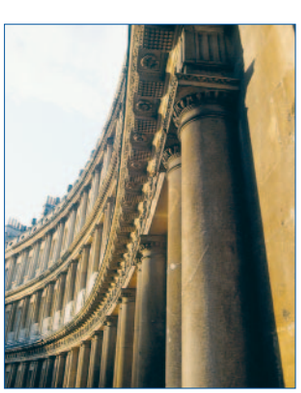
For further information and an application form, please contact:
Teresa Shiel, Programme Co-ordinator, KIMHS, Research and Development Centre, University of Kent, Canterbury, Kent CT2 7PD
Telephone: 01227 824330 Email: T.Shiel@kent.ac.uk www.kent.ac.uk

unhooked thinking

An unusual, international and multi-disciplinary conference enquiring into the nature of addiction







April 19th-21st, 2006

Bath, Somerset, UK

www.unhookedthinking.com

Supported by DDN

Places selling fast! Book Soon!

Given the date, you can pay from the end of this year's budget or from next year's.

Unhooked Thinking starts with a civic reception in Bath's historic Pump Rooms and a dinner on April 18th 2006, then moves to the equally historic Assembly Rooms for 3 days of discussion, illumination and examination of the roots and culture of addiction. For all you need to know and bookings go to the website.

There will be a host of breakout sessions — creative, informative and serious — too many to list here, but the plenary sessions go like this:

April 19th

The Greedy Addict Self
A conversation with Professors Jim Orford and Stanton Peele

The Self, Mysticism and Addiction
William Pryor

Addiction and Relationship
A chat-show with Professor John Davies, Dawn Hart, Tim Leighton and Professor Richard Velleman

Pandaemonium – friendship and betrayal between opium-addicted Coleridge and Wordsworth
Julien Temple introduces his film

April 20th

Medicalisation and Addiction
A conversation with Professor Peter Cohen and Dr Gordon Morse

Addiction to Conflict
A conversation with Yaqub Murray and Dr Alan Rayner

Addiction and Modernity
Professor David Courtwright

Good Addicts; Bad Addicts
A chat-show with Dr Stefan Janikiewicz, Danny Kushlick and Harry Shapiro

Pure – a 10 yr-old North London boy tries to get his mum off smack
Gillies MacKinnon introduces his movie

April 21st

Rat Park Heaven
Professor Bruce Alexander

What is there to cure?
A chat show with Professors David Clarke, Peter Cohen and John Davies

Real Addicts
Professor Stanton Peele

Addiction: Physiological State or Language Game
Professor John Davies

Where is Addiction Going
A Multimedia Theatrical Event

www.unhookedthinking.com

Safer Middlesbrough Partnership

ALBERT CENTRE

PRIMARY ALCOHOL SERVICE working in:
James Cook University Hospital A&E Department

The Albert Centre in conjunction with the Safer Middlesbrough Partnership and James Cook University Hospital are working together to develop an alcohol service in the Accident and Emergency Department of James Cook University Hospital.

The service aims to provide early intervention and support and to engage individuals who have been admitted to the A&E Dept with an alcohol related illness or injury into specialist treatment and reduce further alcohol related harm. The service is an integrated part of the wider Middlesbrough alcohol treatment strategy.

This new and exciting project requires the following vacancies:

- **SENIOR ALCOHOL HEALTH WORKER** (37 hrs), £20,460 – £21,500 per annum pro rata, depending on qualifications & experience
- **ALCOHOL HEALTH WORKER** (37 hrs), £18,872 – £20,000 per annum pro rata, depending on qualifications & experience
- **ADMINISTRATION WORKER** (18 hrs), £12,100 – £13,000 per annum pro rata, depending on qualifications & experience

ALL POSTS FUNDED BY NEIGHBOURHOOD RENEWAL FUND FOR 2 YEARS.
Job descriptions and application form are available from the Human Resource Department. Send 46p s.a.e and specify which post to: The Human Resource Officer, c/o The Albert Centre, 3 Albert Centre, Middlesbrough, TS1 3PA.
Please enclose current C.V. with returned form.

Closing date for completed applications: 5.00pm, Monday 27th March 2006. Only short-listed candidates will be contacted for an interview, provisionally in April.

Enhanced Criminal Record Bureau checks will be conducted on all successful candidates. The Albert Centre is actively working towards Equal Opportunities for all.

The Priory Hospital Woking is an independent psychiatric hospital situated in Knaphill, Woking. We are currently looking for the following positions to join our team:

THE PRIORY

Addiction Treatment Programme Co-ordinator

37½ hrs per week
Salary C£27k dependant on experience & qualifications
We are currently looking for an ATP Co-ordinator to lead a team of highly skilled Addiction Therapists providing a 7 day treatment programme to in, day and out patients. Abstinence based 12 step programme is the core of the service.
Candidates will be qualified as an Addiction Counsellor or equivalent and have a minimum of 5 years experience in facilitation of group and individual therapy within the addiction field. FDAP membership and accreditation is required and Management and/or leadership qualifications and experience would be an advantage.

Therapists

Part time up to 22.5 hours per week
Salary £17,000 - £22,000 pro rata (Depending on Experience)
We are currently looking for a part time therapist, to facilitate group and individual work with patients who are completing the 12 step process.
You will need to have a minimum of 2 years working in the addiction field, with an understanding of and experience in dealing with the 12 step abstinence based process.
We also offer excellent working conditions, benefits, including excellent training opportunities, a contributory pension scheme and subsidised meals.

If you meet the above criteria for either position, please call Joan Bendy for an application form and job description on 01483 489211 or email joanbendy@prioryhealthcare.com

The closing date for applications is Friday 24 March 2006.

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

www.priorygroup.com

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warrington

Invitation to tender
LIFESKILLS PROJECT
Commencement 1st June 2006

Major implemented initiatives by the Government to tackle social exclusion include promoting equal opportunities for all & the push to reintegrate people who have experienced more extreme forms of social exclusion.

The DAT Lifestyle project would offer accessible equal opportunities for client's, removing barriers & supporting their journey back to social inclusion by providing education, training, & employment support for adult substance misusers as part of the through & aftercare programme, in order to initiate a continuous support framework for personal development.

Tender packs available from:

Warrington Drug Action Team
Units 1-4, Warrington Business Park, Long Lane,
Warrington, WA2 8TX
Tel: 01925 631 765
Email: afinch@warringtondat.org.uk

Closing date: Noon on the 31/03/2006

Product Specialist

£23,000 basic
+ bonus
+ car
+ share options

Altrix
Simply Accurate Solutions

Dedicated Professionals, Substance Misuse, Expertise and Passion... make a difference

Scotland/Edinburgh

Altrix Healthcare PLC is a rapidly growing healthcare company marketing a revolutionary range of testing and reporting technologies for use in substance misuse clinics and the criminal justice system. The company has over 250 sites using its products and is now launching blood borne virus testing services in its current markets.

This newly created role represents a unique opportunity to enter the commercial world, where you'll spend your time with existing customers, working and building relations with a wide range of professional staff at the sharp end of substance misuse. The role will place a great deal of emphasis on the provision of training as well as the provision of management information.

A dedicated professional in an area such as health, probation or social care, you'll be passionate about providing outstanding customer service with a desire to make a real difference. With excellent communication skills, you'll be curious and inquisitive, well organised, self-motivated, analytical and service oriented. Naturally we'll provide all the necessary training but it's essential that you have a full driving licence and a flexible approach to your working hours.

To apply please contact our retained recruitment advisers COLIN SMITH or ANDREW EVANS, quoting ref. E873 by sending full career details to The Recruitment Management Group, The Maltings, Wilderspool Causeway, Warrington, Cheshire WA4 6PU. Fax: 01925 650088, email: recruit@rmg-uk.com or telephone: 01925 655222 for an initial discussion. Interviews will be conducted in Scotland.

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excellence in executive search & selection