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DDN
Drink and Drugs News

19 June 2006
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SAVE OUR REHABS
Responses to Nick Barton's call to arms

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Drink and Drugs News

19 June 2006

Editor's letter

The message came in loud and clear this issue: save our rehabs. We've heard many times that residential treatment is considered a cost-effective and long-term option. Last issue Nick Barton highlighted the crisis; on page 6 and 7 we hear from managers trying to keep these much in demand premises going.

The story that keeps surfacing is of long waiting lists but – of course – no funding. The media watch on page 4 again highlights the lottery of one Welsh centre landing a grant and another in Southampton having to shut its doors for the last time, despite a long waiting list. The tragedy is underlined when you read some of the case studies managers have sent us. Places like Trevi House, for mothers with their children, are few and far between. Middlegate Lodge is dedicated to turning young people's lives around, yet is staring closure in the face if things don't pick up soon. There's no mystery to whether or not these residential services are wanted or needed: merely a baffling danger of letting them succumb to forces outside their control. It didn't take long to get this feedback. There was no complicated survey and no costly consultation excercise – just straightforward response on the situation as it is. I hope those with the purse strings have a read.

Tough as it all is at the moment – and many of us seem to be battling on until budgets are settled – there are inspiring stories to remind why it's so crucial not to lose heart. Hasan Sidat (page 14) is proactive in making contact with those who can benefit from his advice and support, and makes himself accessible to Muslim teenagers who might otherwise find the drugs education on offer irrelevant.

It's a necessary antidote to the story on page 12 where we get a disturbing glimpse into the world of families unable to access treatment without a fight.

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In this issue

Media Watch

Residential rehab The Rhoserchan Project, near Aberystwyth, has won a £550,000 European grant, enabling them to double the number of client places to 24. Having faced closure two years ago for failing to meet the care standards' inspectorate's standards, the charity is now planning a programme of secondary treatment to help clients back into society.
BBC News, 13 June

Southampton's last purpose-built rehab unit is due to close at the end of June, through lack of funding. Closure of the Bourne Road service, which offered a week to fortnight detox programme, followed by six weeks of aftercare, will disappoint a long waiting list of people waiting to get a place. Simon Mantle, chief executive of Two Saints Housing Association, which runs the service, said 'it's very regrettable, but in the end it's a business decision.'
BBC News, 9 June

Drinking coffee every day may shield the liver from alcohol, according to a study of more than 125,000 people. Arthur Klatsky of the Kaiser Permanente Medical Care Programme in California, who led the study, said 'the more coffee a person consumes, the less risk they seem to have of being hospitalised or dying of alcoholic cirrhosis.' People drinking one cup of coffee a day were 20 per cent less likely to develop cirrhosis; 40 per cent less likely with two or three cups, and 80 per cent less likely with four or more cups.
New Scientist, 13 June

Barnardo's Scotland has launched a 'one-stop shop' to help young people in Aberdeenshire to overcome drug, alcohol and solvent abuse. The Gemini initiative, a partnership initiated by Aberdeenshire Alcohol and Drug Action Team will put project workers in touch with young people aged 12 to 18, and will give support, education, advice and guidance.
The Buchan Observer, 16 June

More than half a million needles were handed out to drug addicts in Glasgow last year, but more than 200,000 were not returned to the needle exchange scheme. Tory MSP Bill Atken said the number of needles handed out painted a 'depressing and horrifying' picture of drug abuse in Glasgow, and called on the Scottish Executive to recognise its drug policy is failing.
Evening Times, 13 June

A heroin addict who had been on the drug for five years has claimed he has been cured by revolutionary Neuro-Electric Therapy. Barry Philips, aged 24 from Kilmarnock, said the treatment had helped him quit in five days, by sending electric pulses through his brain. 'I'm back to feeling amazing again, waking up with a smile on my face,' he said. The Scottish Executive is backing further research.
BBC News, 16 June

Crystal meth upgrade to class A

Methylamphetamine, also known as crystal meth, is to be reclassified to a class A drug, on the advice of the Advisory Council on the Misuse of Drugs (ACMD).

Drugs Minister Vernon Coaker said the decision had been taken on the basis of the drug's 'potential to be extremely damaging', based on international experience, although it was not a serious social problem in this country at the moment.

Crystal meth, a derivative of amphetamine, is a potent drug when smoked, and gives an intense 'rush' similar to crack cocaine. It can be highly addictive, and is associated with psychotic behaviour.

The ACMD's advice, which was supported by the Association of Chief Police Officers of England, Wales and Northern Ireland, was drafted on the basis of evidence from countries outside the EU, namely Australia, China, Japan, Philippines, Thailand and the USA, where violent behaviour and health problems associated with the drug have been widely reported.

ACPO's lead on the drug, Simon Bray, said the reclassification would make dangers associated with the drug easier to combat.

'It will also become possible to close down, for long periods, premises used as illicit 'meth' laboratories,' he commented.

DrugScope has welcomed the news as a sensible cautionary measure, based on the risk of serious health and social harms.

'Moving crystal meth to class A enables the police to direct resources towards monitoring its production and supply, and it can be included in drug tests for people charged with drug related offences,' said chief executive Martin Barnes.

Mr Barnes added a caution that suggestions that we may be on the verge of a crystal meth epidemic would be 'without foundation and alarmist'. Sebastian Saville, director of Release, attacked the 'over hasty official response' as unhelpful when working towards harm reduction.

(See DDN letters, page 10)

Welsh events in July for user support

A new peer support group is opening in Newport, Gwent – the first of its kind in the area. RAPS will be staffed by eight volunteers who have completed a peer support training programme, and is funded by the Millennium Stadium Charitable trust.

Volunteers' training was facilitated by Make a Change, who run drama sessions for young people on Drug Treatment and Testing Orders. The idea for the new group came from young people attending Make a Change theatre sessions, who felt that peer-led self help groups could fill a gap in service provision on leaving prison and ending DTTOs.

For more information on the group or the grand opening on Tuesday 4 July, call Angela at Make a Change on 01873 854619, or Anneliese at RAPS (via Kaleidoscope) on 01633 24590.

Bridgend Substance Misuse Action Team (SMAT), a multi-agency group driving forward the Bridgend Substance Misuse Action plan, is holding an open forum for service users, carers and providers. The team wants to hear what works well in the area, and how services could be improved or delivered differently, and will be offering advice on healthy living and community activities.

For information on the event, to be held on 14 July, call Anghard Evans on 01656 754400 or email angharad.evans@bridgendlhb.wales.nhs.uk

Peter Martin awarded CBE

Peter Martin, former chief executive of Addaction has received a CBE in the Queen's Birthday Honours list for his contribution to the drugs field.

Earlier this year Mr Martin stepped down from his role at Addaction after 15 years, during which the national treatment charity developed 70 services in 46 locations, ranging from Addaction Scotland to Cornwall.

He is still in close touch with the field through being a board member of both ACMD and Wired, and is now developing a coaching practice for chief executives to help them manage change.

Commenting on his CBE, Mr Martin told *DDN*: 'I'm touched by the honour – it's good for the field. When I receive it I'll be thinking about people coming to terms with drug and alcohol problems, and I'll be receiving it on their behalf.

'I feel privileged, but there are so many people involved. It's about everybody, especially users – and I was one myself.'

Teams aim for goal of safer drinking during World Cup

'Enjoy it – but don't overdo it!' Sefton tells residents planning to watch the World Cup with a few beers.

Health, local authority and police professionals (below) have joined forces to promote safe drinking throughout the competition, reminding viewers to eat before the match, drink plenty of water, and give themselves time to recover before the next session.

The health professionals appealed to vanity as well as health concerns: 'Exceeding recommended levels of alcohol on a regular basis or through binge drinking will build up your beer belly and your chances of developing diseases,' said Ian Canning, health promotion specialist. 'More serious effects can include memory loss, liver and brain damage,' he warned.

The Royal Borough of Windsor and Maidenhead DAAT (above) have adopted an unusual approach to the same message, by distributing 5000 packs to venues screening the matches in the town centres. Packs contain a card giving tips for safer drinking, a list of taxi numbers, a condom and a lollipop.

'We want people to enjoy themselves and the packs provide everything they need to stay safe and look after each other,' explained DAAT co-ordinator Di Wright.

Budget news

NTA promises announcement this week

In response to our article in last *DDN* (5 June, page 6), Paul Hayes has confirmed that the long awaited announcement on the Pooled Treatment Budget will be coming this week. This is his response.

The NTA works very closely with DATs, commissioners and service providers throughout England. Our regional offices are in daily contact with the people who deliver drug misuse treatment, and we all had an opportunity to hear the views of those involved in treatment delivery at our recent conferences in Blackpool and Nottingham. We are therefore well aware of the disruptive effect that the delay in announcing the Pooled Treatment Budget, and uncertainty over how much it will be, is having on people. We currently anticipate the PTB and the associated funding announcement will be made the week commencing 19 June.

The funding made available for the current year will be a very significant increase on the 2005/06 figures. Taking into account the pressures experienced within the NHS overall, this is strong proof of the continuing commitment to drug treatment of the Prime Minister, the Secretary of State for Health and the Home Secretary, and a vote of confidence in what the sector has achieved already.

The increase in the PTB will be sufficient for most partnerships to deliver most of their existing treatment plans. We will therefore expect partnerships to deliver their stretch targets for numbers in treatment and the Local Delivery Plan targets for retention, as well as to continue to meet Drug Interventions Programme targets to deliver 750 offenders a week into treatment. At the same time, it is important that partnerships maintain the many significant improvements already achieved and continue to focus on driving up the quality of drug treatment. These are challenging objectives, but we are confident that the PTB uplift will be sufficient for partnerships to deliver them.

Obviously, the more efficient partnerships will find it easier to deliver treatment within budget than the less efficient, and the huge variation in treatment cost is something we all need to address. Crucially, the higher spend does not demonstrate any improvement in the quality of treatment.

We need to work together to ensure we get the best value from every pound of our funding, and part of the NTA's role is to support partnerships in achieving that. The more efficient the use of resources, the better the services those resources can deliver.

Paul Hayes, chief executive, National Treatment Agency for Substance Misuse

Comment

Mixed messages create a united response: save our rehabs

In our last issue's cover story, Nick Barton of Clouds put out an SOS for residential rehabs, saying we need to act now or risk losing this essential resource. Here we publish responses to that article from rehabs all over the country, which illustrate only too well the scale of the crisis.

'Our local purchasers are using us less, based upon previous over-spend.'

I read Nick Barton's article with great interest and concern as I fully agree with the major points.

We have noticed that more of our purchasers are starting to negotiate block contracts with us. This is surely good housekeeping all round, rather than relying on spot purchases – which are based on what have become hollow promises of budgetary increases. The main problem at this time for us seems to stem from the fact that most of the purchasers we work with have no idea what their budget is for the forthcoming year. Our local purchasers are using us less, which they say is solely based upon previous financial over-spend.

I find all this strange as it was only a few months ago in London that the NTA were patting themselves on the back telling us all what a good job they had done and how more clients than ever were accessing treatment. This depends on what treatment is considered to be in the first place. To prescribe an addictive substance in order to maintain someone on it instead of them using heroin is hardly (in my opinion) treatment. It is merely a prescribing service for opiate users.

Steve Spiegel, founder, The Providence Projects

'It is time to understand that most of our clients will cost the NHS and social services in the long term.'

In Torbay we have a lack of funding for such residential care, so I don't take any placements from this area due to this – which upsets the GPs and the Local Health Trust. But what are we supposed to do? After all, even though we are in the care sector, we are specialists in our own field. This type of care is special and needs to be accepted as that. Most London boroughs do this, but the odd ones don't.

It is time to understand that most of our clients will cost the NHS and social services in the long term through A&E admissions and social services' time being taken up. So we are the go-betweens who are trying to provide services that will take most of the pressure off their funds.

We only get the local alcohol counselling services involved if the client walks through their doors. So it's down to our services to take up a case when it's close to far too late to help. This also needs to be looked at.

My speciality is Korsacoff's Syndrome and locally this is also treated with lack of funding support. So we have to go outside to get placements – which is a great shame because alcohol has no boundaries. Many people come from outside areas – but there are just as many locally not being funded for treatment, and living in hostels untreated.

Steven Todd, Manager, Vanehill Specialist Care Homes, Torquay.

'We are experiencing a drop… The merry-go-round continues.'

Nick Barton has his finger firmly on the pulse. As a registered provider, we are experiencing a drop in funded placements. The non-registered supported accommodation field has spawned an abundance of bed-spaces which, locally at least, run at capacity. Thus service users stay in their home area, with inherent difficulties, attending day care if it's available. The merry-go-round continues.

Dominic Castle,
Weymouth Aftercare Centre

'The biggest threat facing our service is now a seasonal lottery.'

Nick Barton has crystallised the main threats facing the residential treatment sector in a coherent and frank article. Our experiences echo those outlined and I would say that the biggest threat facing our service users at the moment is not only one of a postcode lottery for funding but now a seasonal lottery.

Funding often runs out by the end of the calendar year, never mind the following April. This leads to a situation of over demand in the first half of the year where the collective services are unable to meet demand, and half empty services in the latter half.

Firstly then, we need to be vigilant about the timing of surveys of demand and capacity that inform spending plans and secondly, seriously consider regional block purchasing which will ultimately serve the needs of our clients far more effectively than the current dysfunctional system.

Jon Harman, director, Ravenscourt Trust, Bognor Regis

'It poses a real threat to the survival of this unique project.'

Trevi House was established in 1993 to allow women the opportunity to undergo treatment and rehabilitation from drug and alcohol dependency in conjunction with their children.

In the last 12 years we have accommodated 600 women and over 700 children and have established a reputation for excellence in the field. We offer an environment in which women and their children can achieve rehabilitation and a rebuilding of their relationship.

During the next financial year, Trevi House will be completely dependant on operational funding to survive. Due to recent changes in funding structures the organisation has lost £72,000 in funding for the 06/07 financial year, comprising £36,000 from the Health Authority and £36,000 from Supporting People. As Trevi takes families nationally (as well as locally) we are now judged unentitled to local DAT funding.

This next financial year is dependant on 100 per cent occupancy. To date, in this financial year, we have not reached full occupancy, due to a drop in referrals both locally and nationally. This has occurred because of restrictions on budgets. This deficit poses a real threat to the survival of this unique project.

This is the first time in Trevi House's existence that we are solely reliant on full capacity – and in this day and age is this a reality?

Angie Brooks,
director, Trevi House, Plymouth

'I have been involved in having to close two residential treatment centres… I believe many more will follow.'

At Yeldall Manor, a 35 bed residential treatment centre in Berkshire, we face many of the issues that Nick Barton highlighted in his article, but I would like to focus on just two.

Firstly, we have been running for some time with empty beds, whilst hearing regularly from commissioners of their frustration in not being able to place clients due to long waiting lists. Having talked to other providers of residential treatment centres, it seems we are not alone in hearing this. All commissioners and providers want is to see clients placed into appropriate services. Surely we should be capable of putting the client and the empty bed together to provide the services that many of them tell us they need and want.

Secondly, no-one can doubt that the government has put a lot of money into drug treatment – but how much of it actually gets to those clients that need it, compared to the increased bureaucracy around the country? The vision of full cost recovery is a good one, but how important is it to those commissioners operating on very tight budgets? When you talk to commissioners about the need to increase fees to achieve full cost recovery, they appear to go deaf.

Finally, in the last two years I have been involved in having to close two residential treatment centres due to lack of funding, including one of only a handful in the UK working with women and their children.

Sadly, unless we resolve the empty bed syndrome and are able to achieve full cost recovery, I believe many more will follow.

Ken Wiltshire, director,
Yeldall Manor, Berkshire

'Residential care is approximately half the cost of day care, but delivers four times the provision.'

As a relatively new provider, our perspective accords with the difficulties

articulated by Nick Barton. Our experience of commissioners indicates reluctance on their part to commission residential services, often on the basis of 'cost benefit analysis'. Referrals invariably relate to clients with highly complex needs and/or those who have repeatedly failed to engage in other treatment environments.

A simplistic 'cost benefit analysis' often adopted by commissioners fails to recognise the following issues:

Residential services are required by law to be registered with the Commission for Social Care Inspection (CSCI) and are open to independent regulation and inspection. The registration process involves the comprehensive and independent vetting of organisations providing residential services.

The provision of National Minimum Standards (Care Standards Act 2000) gives a transparent quality-auditing tool, by which the quality of service delivery can be gauged; this is in addition to any other occupational standards (*eg* DANOS) or simply returning data to the NTA.

By adopting a more comprehensive analysis of comparable weekly fees, it is clear that residential services often provide truly cost efficient provision.

Assuming the mean average of a range of residential and day care weekly fees could give the following equations for residential and day care: A weekly fee of £700 for residential care, divided by 168 hours of care gives an hourly cost of £4.12. For day care, a weekly fee of £350 divided by 40 hours of care gives as hourly cost of £8.75.

Residential care is approximately half the cost of day care, but delivers four times the provision. Even when applying a simplistic cost benefit analysis that is not formulated on a 'like for like' basis, residential options still provide better value for money.

There is a very real possibility that under utilising the residential sector now, which is already resulting in residential closures, will signal a severe contraction of residential services in the future.

Ciara Aylett, treatment director, Wellington Lodge, Middlesex

'The unit is in jeopardy… this latest crisis is the straw that will break the camel's back.'

Middlegate is a unique residential substance misuse rehabilitation unit that has been caring for young people for 11 years with an 82 per cent success rate. It has treated well over 400 young people throughout the UK and Ireland suffering from the effects of substance misuse as result of abuse, peer pressure, family breakdown, boredom *etc*. We have the capacity for nine beds.

Over the last two years, because the government appears not to have followed its own policies on Every Child Matters, we have been forced to lay off ten excellent trained adolescent drugs/programme workers and mothball a four-bedded unit. Now, because of the current crisis in funding, largely as a result of financial lack of clarity in the NHS, it has only two young people on the remaining unit. The future of this unit and the care for young people in various tiers, including residential, is being put in jeopardy and will only be secured with the early release of funds.

The Middlegate team has responded to this crisis by reducing hours and being flexible, whilst remaining dedicated to the care and treatment of all young people placed in their care. Within eight weeks however, if referrals are not made and funding is released, Middlegate will be forced to close its doors for the last time.

We offer a unique method of treatment which is designed to build up a young person's confidence and self esteem in order that beneficial and positive choices are made in the future. We have a non-judgmental, holistic approach to working with young people and has a multidisciplinary team to support this.

Our workers are drug and children specialists and this is where the caring and true application of Every Child Matters occurs, using a mix of techniques designed to raise the young person's self esteem and developing skills, either on a one-to-one basis (behaviour rationalisation) or in group work or through activities.

Middlegate is registered as a children's home and is subject to at least two unannounced inspections by CSCI every year. The latest inspection saw our management being awarded six four stars in its report. This is equivalent to the best local authority or hospital rating and is quite an achievement. It requires hard work and dedication by all staff and management and has developed over the years since its inception.

This latest crisis is the straw that will break the proverbial camel's back. Unless funding is secured within eight weeks, then the expertise and skill that has been built up over the years in treating young people will be lost forever. Let us not forget the young people of today are the adults of tomorrow.

Chris Robertson, Middlegate Lodge, Lincolnshire

'We are now in receipt of fewer referrals… Staff are caught up in a demoralising cycle of anxiety.'

Cranstoun seconds the absurdity of a lack of strategic thinking in relation to residential provision, despite it being the most demonstrably effective intervention for specific client groups. Our experience so far this year has been dogged by low occupancy in certain services. Following very good occupancy for two years running, we are now in receipt of fewer referrals and of those referrals received, delays caused by detox waiting times. As a consequence, the notion of investing in a capital expenditure programme when existing bed spaces are under-utilised, appears nonsensical as a commissioning strategy going forward.

On the issue of cost of providing high care services, it could be argued this is perhaps more keenly felt by London-based and other 'city' providers. The costs of retaining staff in London and associated costs of living in the capital means that these services may well be relatively more expensive to operate. Furthermore, in a sector that has been subject to systematic reduction in, and disinvestment of, funding streams over many years, we are now required to seek full cost recovery from social services departments, and it is therefore understandable that they in turn are experiencing expenditure pressures.

In would appear that a DAT's interest in tier 4 services generally revolves around supporting 'their' numbers in treatment. More often than not it appears to be more by default than design that residential provision is included at all in planning, with little or no long-term strategic planning applied to the development of the residential treatment sector.

On the quality front, experience suggests that some commissioning/purchasing authorities have little understanding of what constitutes the basis for good quality residential provision, or the subtle differences between high care and supported housing services. There appears to be little in the way of comprehensive guidance on the quality agenda, *ie* with little movement beyond basic assessment of standards as dictated by QuADS.

'Best value' is often cited as a rationale for purchasing or commissioning with little in the form of criteria being made available as the basis used for assessing such. The same applies to notions of 'value for money' in terms of a lack of available criteria for assessment.

The issue of client choice seems to be diminishing as a principle, with placements appearing to be highly subjective. Furthermore, it is difficult to receive qualitative feedback from purchasers and/or commissioners as regards funding decisions.

When services are delivered from such an insecure and unstable funding base it can be difficult as a provider to remain focused on quality issues. Staff are understandably caught up in a demoralising cycle of anxiety about the future of their jobs and temporary staff are used more as a consequence of operating in a very 'temporary' environment.

Whilst there is some activity at the NTA around tier 4, is there really enough going on which suggests a strategic way forward *ie*, change in the right direction?

In 1991 John Marsden (*All change after the DSS*) undertook a comprehensive exercise to determine the actual and true cost of a residential placement. This exercise should perhaps be repeated now to determine the cost of high care rehabs and detox beds, as a starting point.

Mandy Reed, area manager, Cranstoun Drug Services, London

'Action needs to be taken before the system erodes.'

In response to Nick Barton's article, I have to say that in my experience of working in both Tier 4 services and private addictions, access to both beds and residential rehabilitation has become more problematic. Historically we have had good provision in our borough, but beds have been cut and access to rehab is increasingly limited.

We all know that those who have access to residential care fare better but, shockingly, many drug workers in maintenance clinics have never seen a client get clean. Effective residential care only works when the Models of Care and Integrated care pathways, which everyone agrees are desperately needed, are clearly defined.

I agree with Nick that action needs to be taken before the system erodes. We have to find a way of working together to provide quality and viable care that has been proven to be effective. More importantly, the friction between healthcare and social care needs to be addressed – we still see this as a major contributing factor to preventing timely access to care. There needs to be flexibility and we need to listen to the needs of clients and those around them.

Paulene Caesar, Ward Manager, Capio Nightingale Addictions Unit, London

'We have experienced a drop in referrals again… it's very worrying.'

We are experiencing exactly the situation Nick Barton mentions. Towards the end of last year, our numbers dropped to eight from 20 (our capacity is 22). We then filled up, but in the last three weeks have experienced a drop in referrals again and at present have 16 in the community, clients due to complete soon, and fewer coming in than we would expect at this time of year.

It is very worrying considering that the work we do is of a high standard, we have a very good reputation and have excellent Inspection reports from CSCI.

Anita Howard, Thurston House, London

William Pryor's first visit to a prison leaves him with mixed feelings. The RAPt programme is impressive and uplifting – but can he make any sense of a system that criminalises illness?

With my history of heroin addiction in the sixties and seventies, it is a wonder that I hadn't known Her Majesty's pleasure before now. When I went inside last week to visit a programme run by the Rehabilitation of Addicted Prisoners trust (RAPt) I met a man on their treatment programme. A few weeks before he had been released on parole with an electronic tag around his ankle, but when he got to the address designated as 'home', he quickly decided it was not safe, that his sobriety was threatened. There was too much gear around. He returned to the prison and asked to be let back in. Probably a mix of immense courage in preserving his sobriety with a degree of institutionalisation, wanting the security of being locked up again in the comfort zone that was the community of RAPt abstainers.

My visit was an emotional experience, though mostly and oddly an uplifting one. As Director of the Unhooked Thinking Conference that I set up to explore the nature of addiction, I had been invited by RAPt to experience their operation at HMP Bullingdon near Bicester.

Prison is where the drama of society's myths of addiction and prohibition start eating people's lives in earnest; I had to experience it first hand, even if only as a visitor. With 80,000 people locked up, the UK has the highest per capita rate of incarceration in Europe. Well over half of them have some kind of problem with and history of drug misuse. One could conjecture that most of this half wouldn't be there were drugs legal.

Bullingdon is a modern prison. Its full car park, mowed surrounds and enormous wall with bulbously unscalable top give the impression of a twenty-first century industrial facility; perhaps, with its 'bikini black state of alert', one that makes weapons of mass destruction. The Prison Officers that greeted me through thick plate glass are cheery and courteous as they check my passport to see I am who I say I am. I was patted down and asked to leave my mobile and packet of headache pills in a secure locker before progressing through an airlock with ponderously slow electric doors into what quickly transpires to be another country – no wonder they demand to see your passport.

Terry Bogg, Bullingdon's RAPt manager appears through a steel door and takes our small party on its journey to the centre of transgression. Thirty-foot high steel mesh fences topped with razor wire, long corridors of steel bars and concrete, the unlocking of inordinate barred gates. The similarity between the corridors and the cage-tunnels the lions would be prodded down before performing in Billy Smart's circus decades ago.

Eventually we arrive on the 'wing'. So far I've not seen a single prisoner, though we have passed several warders and other civilian staff. The sense of a clandestine government establishment harbouring some unspeakable secret is enhanced. The millions spent on this substantial fortress and on the legions of staff, to judge from the full car park, all say this is a project close to the government's heart. How strange that a society spends billions of its tax money on locking away those who transgress (from the Latin, 'to go beyond')! And, being a twenty-first century advanced liberal democracy, they are not locked away to suffer the degrading conditions of punishment, but, somehow or some vague other, to be reformed. And yet they nearly all re-offend.

The National Offender Management Service (NOMS to you mate), a 2004 Blairite initiative bringing together the Prison and Probation Services, has a 'Strategy for the Management and Treatment of Problematic Drug Users within the Correctional Services'. They would, wouldn't they! 'About one third of all problematic drug users [hereafter to be known as PDUs] in England and Wales are in the care of the correctional services at any one time, amounting to half their total caseload,' says the NOMS drugs strategy document. The correctional services 'are uniquely placed to tackle offenders' drug use and to break the cycle of re-offending'. Is that then the purpose of prison: to stop people re-offending? Odd, that.

On the wing, I thought, in my middle-class way, I might be frightened by the prisoners, but no – I've come into their territory and they don't seem to mind. Later I ask what the two knobbed metal devices bolted to a table are and am told they're tin-openers, to open cans of food the prisoners are allowed to buy. They are large and bolted down because anything else could be used as a weapon. There are two so that the one for Muslims can remain unpolluted with non-halal meat products. All religions are respected – pagans get to celebrate All Hallows Eve with appropriate solemnity. Such consideration for human rights in what could be such a brutal environment where humans are reduced to the acronym PDU!

The prisoners on the RAPt programme in Bullingdon have to share their wing with those with no commitment to abstinence and when there's a lot of gear on the landings, they look to their RAPt community for the strength to resist. I asked how the gear gets there in such a modern and secure environment. In visitors' bodily cavities, I'm told, which can't be searched due to respect for their human rights. Visitors adapt their clothes to give them quick and furtive access to the goods.

The paradox between the prison's respect for human rights and its 30 foot steel mesh fences topped with razor wire is profound: the addicts in the RAPt programme have been locked up for crimes committed as a direct or

CAGED RECOVERY

indirect result of their addiction. By providing the RAPt programme (though RAPt is an independent charity, it is funded by the Government – NOMS had a budget of £152.7m for its 2004/5 drugs strategy) we – society, government – are uttering paradoxes. We've made some substances illegal for complex irrational and mythic reasons and we've medicalised addiction, and yet, when someone suffering from this medical condition transgresses so he can feed his habit for those illegal substances, we lock him up only to then provide him with expensive treatment with high counsellor-to-client ratios. I can't help agreeing with William Burroughs when he said: 'After one look at this planet any visitor from outer space would say, "I want to see the manager".'

Lord Chief Justice Phillips recently opined that some people are committing crimes so they are sent to the only place they can get treatment for their addiction: prison. Even if he was repeating an urban myth, it's true in its fundamentals. The quickest route to free treatment for your addiction is to get banged up. And there are other advantages: the wing at Bullingdon is not altogether a bad place for these guys to be: it's more secure; they get more attention; and food and lodging are thrown in.

We get to sit in on a RAPt staff meeting, where the counsellors, the majority of whom are women in this all-male prison, share their feedback on the progress being made by individuals and groups in the sessions they have just been facilitating. The power of the RAPt team's optimism about and care for their clients moves me, sweeping me up in their love of transformation. Megan, a South African counsellor, talks about one of her client's need to stop trying to have any influence over his life outside. She thinks he is beginning to realise the extraordinary opportunity prison presents to reflect on the direction and meaning of his life. I think: metaphor, how we're all in prison, how we should concentrate on the relationship we have some control over, the one with ourselves. Prison as opportunity.

So far, so liberal and enlightened. As a visitor I only got to see a presented surface, but the darker forces were visible between the cracks. As well as the mandatory bunches of keys on long chains, some staff have truncheons in pouches and whistles. We were told that when the sex-offenders move outside their entirely separate block, all the other prisoners are locked into their wings. The cracks were more exposed in the community meeting later that afternoon, the community that is everyone concerned with the RAPt programme in Bullingdon: staff, prison officers, assistant prison governor and prisoners.

Run along adapted 12-step lines, the 20 or so rules for the RAPt group were read by members of the meeting in turn – except two of them couldn't read and were helped by their neighbours. Feelings were aired, complaints made and applause for months of dry-time given. Individual 'graduate' prisoners bravely voiced their misgivings, mostly their frustration at the despicable state of the showers on the landing and the way people cheated at RAPt graduation events to get more doughnuts than they were allocated. Small beer, but you could sense the muscles of value systems being flexed.

The philosophy and clichés of this adapted 12-steppery were the subtext and script for all the proceedings, filling in every gap in thought and word, explaining away any negativity, bolstering any flagging spirits. The RAPt team use CBT and other motivational therapies to encourage change and self-examination. It's inevitably more intense than treatment at outside residential treatment centres for two very obvious reasons: Firstly, the clients can't leave the building and are locked up in cells at night; and secondly, they share their landings with prisoners who are using gear. Terry said that it is wrong to call what they do REhabilitation (from 'habitare', make fit), since most of their clients were not fit for the rigours of being human in the twenty-first century in the first place. In retrospect, nor was I, back then.

I hold that the underlying, but usually unstated purpose of the addiction treatment industry is to teach its clients how to be human. This function inevitably has a core of spirituality, of human speaking to human. This spirituality is diminished when crystallised into the kind of religious dogma much of the 12-step movement relies on. The use RAPt make of the 12-step idea skates close to dogma, but manages to avoid it. They do not demand that their clients join the fellowship and they use whatever therapeutic tools help in the pressure-cooker environment of a prison.

But that's just RAPt, one of several agencies used to deliver treatment services. Overall, prison reveals the attitude of government as a whole (if it makes sense to use the words 'government' and 'whole' in the same sentence), their attitude to prohibition and addiction is revealed to be utterly confused and an accurate metaphor for the paradox of New Labour. Addiction has become not only thoroughly medicalised, but criminalised. It is both an illness for which the individual PDU is not responsible, but simultaneously a crime for which he must be corrected, treated and rehabilitated.

However much the reports from NOMS, CARATs and other acronyms hide behind and manipulate statistics, they cannot disguise the facts. Drug use is rampant in prisons. Well over half of all prisoners have a drug problem and have had treatment more than once. But that's not the point. The point is we deplore the size of our prison population, while simultaneously making this 'illness' a criminal act.

I am in awe of the RAPt workers I met in Bullingdon; their open-hearted, shoulder-to-shoulder reaching-out into the dark hells most of their clients bring with them is exemplary. They are exploring the depths and heights of what it is to be human.

I left Bullingdon oddly elated. You'd expect a visit to addicted human beings locked in what amount to cages, often for violent crime, would be depressing, if not frightening. But no, I look forward to my next visit to prison. What's so odd is that we have to resort to locking people up for doing what comes increasingly naturally, locking them up to transform them. Odd. I want to see the manager!

We've made some substances illegal for complex irrational and mythic reasons and we've medicalised addiction, and yet, when someone suffering from this medical condition transgresses so he can feed his habit for those illegal substances we lock him up only to then provide him with expensive treatment... I can't help agreeing with William Burroughs when he said: 'After one look at this planet any visitor from outer space would say, "I want to see the manager".'

'Drug Use and Prisons' by John B Davies and 'Survival of the Coolest' by William Pryor available from www.drinkanddrugs.net

Notes from the Alliance

Danger... danger... spin alert

The funding crisis is in danger of replacing long-term evidence-based treatment with flimsy exercises in spin, warns Daren Garratt.

The financial crisis which is currently affecting local partnerships and the pooled treatment budget has started to have knock-on effects on those harm reduction and user involvement services that are no longer seen as a priority in our 'tough choice' world.

It's already becoming apparent some of the commissioners who saw the projected uplift as a means to establish and improve their underdeveloped advocacy and user involvement services have been forced back to the drawing board to delete the initiatives that they intended to pilot this year.

This has meant that the Alliance's expansion of its own National Model of Advocacy has been seriously compromised, as it was our intention to integrate the model into local plans and service development by asking local partnerships to commission a one-off £5k advocacy training and support package.

In our naïvety, we thought that this would be embraced as a real value for money initiative, as it would enable all participating areas to develop 'networks of advocacy and support services aimed at drug users' and support 'service level agreements which require services to… promote access to advocacy for users', which are key requirements of the 2006/7 Treatment Planning Guidance. By supporting the development of peer led advocacy and wider user involvement initiatives by ensuring they grow from an organic, sustainable, needs-led position as opposed to a top-down, tick-box directive that proves to be neither relevant or workable, we can ensure that interventions are allowed to evolve at their own pace and to their own requirements and are relatively free from being compromised or sabotaged if local politics or targets change.

The Alliance and local groups supporting each other and developing a national network that doesn't rely on following political fashions to survive. It would have been ideal wouldn't it?

Unfortunately though, we're all still governed by a commissioning culture that is forced to collude with short-term, untested, cost-intensive, vote-winning exercises in spin, rather than long-term, evidence-based, cost-effective and inclusive interventions that can, over time, improve the social, physical and mental wellbeing of our communities.

Perhaps this is why the most senior people in the Home Office and the NTA are still unable to identify any funds (or even engage in dialogue) to support our national model of advocacy, despite the fact that it's been widely embraced in many quarters as an effective way to improve treatment effectiveness and reduce crime. When we asked the Home Office Drug Strategy Directorate to contribute money last year, we were informed that 'we support you politically but not financially'. Great, eh?

I think I'll try that the next time I receive a council tax bill! 'Well, yes of course I support the notion of a police force, and I appreciate that it provides a unique, essential service and could possibly save my daughter's life one day, but I'm not paying for it.' Don't think I'd get very far, do you?

Daren Garratt is development manager at The Alliance

'On TV last week, using methamphetamine was shown to turn you either into a gun waving madman or, more insidiously, into Hitler. Trying to scare people from using particular drugs has always had poor outcomes – particularly when the propaganda bears little relation to the evidence.'

Is there anybody out there?

I'm involved in the provision of a primary care alcohol service offered through 10 National Enhanced Service clinics. I'm keen to link up with similar services to exchange examples of good practice, share ideas, discuss problems experienced, *etc*. Please contact me at alan.alker@penninecare.nhs.uk.

Alan Alker, Tameside & Glossop Substance Misuse Services

No 'blind prejudice'

Nick Barton's plea (*DDN*, 5 June, page 8) to stop the mixed messages about the residential sector needs to be taken seriously. There is no place for 'blind prejudices' in the decision-making to decide residential placements or for many of the current barriers to exist. But we must look at new ways to help commissioners to make better use of Tier 4 NHS, Private and VCS in-patient and residential services.

We should take this opportunity to develop new funding models based on payment for results and other outcome based frameworks to support the growth and investment in this sector. The time is right for more innovative thinking to reform the way we fund and use these services. Perhaps one day when we review the *DDN* residential treatment directory, we might see a column that indicates something about outcomes achieved for the clients served, which would be helpful for both clients and commissioners.

Peter Mason, chief executive, CPI

Mixed messages go nowhere

While nobody doubts that using methamphetamine can be very dangerous, the over hasty official response and the subsequent media frenzy is unlikely to help.

On TV last week, using methamphetamine was shown to turn you either into a gun waving madman or, more insidiously, into Hitler. Trying to scare people from using particular drugs has always had poor outcomes – particularly when the propaganda bears little relation to the evidence. Reading some articles one could easily believe that methamphetamine use has reached epidemic proportions in the USA. This is simply not true.

We know that providing accurate, truthful information about drugs is a much more effective tool in reducing harm – why does this appear to mean so little?

Sebastian Saville, executive director, Release

News of our demise...

I felt compelled to write to you in response to Ben Holtom's comments (*DDN*, 8 May, page 12) and would like to bring you up to date with significant developments within service user involvement in Wiltshire.

Wiltshire Users Forum (WUF) was established in June last year. Based in Chippenham and accessible to the whole of Wiltshire, it has been quietly working to establish the necessary groundwork needed to have a considerable amount of clout at all levels of drug treatment planning and commissioning. It began with a small group of committed and passionate ex-service users and service users, all devoted to a simple mission: 'to improve the quality of lives of people in drug treatment'.

The rural nature of Wiltshire presented considerable problems regarding wide engagement, committed representation, and meaningful attendance at the influential levels of planning, monitoring, and commissioning.

It has been extremely hard work, so it is with some pleasure that I write to *DDN* with a positive message of achievement, and an opportunity to thank all the individuals, throughout the entire county who have given their time

and effort so willingly, having recognised the value of their own experiences, and now see how that can be directly applied to the benefit of others.

We now have a very supportive DAAT, and have worked with them to establish realistic funding for all of our activities, from mileage expenses to conference presentations. We have highlighted and challenged ineffective share charge discharge, provide effective 24/7 detox support, and have implemented a symptomatic relief program. We work closely with, but not for, all the specialist providers, and have an authoritative voice at joint commissioning and shared care monitoring groups. We are able to supply effective advocacy services and now have two fully qualified acupuncturists delivering a SU led service. We identify what works and what doesn't, and don't pull our punches when it comes to challenging ineffective treatment or service provision.

The good practice in place is being shared with our peers in neighbouring counties, and we now have sound and solid engagement throughout Wiltshire.

WUF had its first county conference in Trowbridge on 9 May, which was an inspiring and successful event. I am humbled to be a small part of a collection of passionate and committed people, and am excited to see what the coming year will bring.

We operate from our Chippenham office, and very much welcome any enquiries from other forums, service users, and professionals. Either phone on 01249 444880, mobile 07886 030724 or write to us at WUF Avonside, Westmead Lane, Chippenham Wiltshire.

I hope this letter will give a more complete picture of what's happening in Wiltshire. My respect and thanks to all who are making this possible – you know who you are.

Mick Webb, chair, WUF

Email your letters to claire@cjwellings.com or write to: Claire Brown, Editor, DDN, Southbank House, Black Prince Road, London SE1 7SJ.
Letters may be edited for reasons of clarity or space.

I have a friend who is worried about her son. He is showing an interest in drugs and they've had several arguments where he takes the line 'it's not use that's bad it's abuse'. His school work is slipping, he and his friends are increasingly dishevelled in appearance and we are convinced he is smoking cannabis, if not more. Whilst I can appreciate that experimentation is a teenager's right how on earth can we get him to stay on the straight and narrow for just one more year until he sits his GCSEs?
Lorraine, Bristol

Fooling ourselves

Dear Lorraine,
I think on one level it is hard to argue against your son's point about use and abuse. However, it seems to me that the patterns of behaviour he is exhibiting point to the fact that his use has already become 'abuse'. The problem of course, is that people become locked into dependencies on substances gradually and are usually reluctant to admit that until the cost to their wellbeing is too painful to avoid. This may well take a lot longer than might seem obvious to the outsider.

It is not at all unusual for your son to deny that his use of cannabis (if that is what it is, and you haven't said in your letter what has led you to believe this) is a problem: we seem, in the UK, to have fooled ourselves into thinking that this is a virtually harmless drug, despite the truth being played out in front of our eyes. A recent Danish study showed that cannabis users held these myths about the drug: Cannabis is harmless, at least relatively, and most of the negatives spoken about the drug are wrong or trivial. It is tranquillising and any feelings of paranoia it produces are temporary and unimportant. It improves your thinking and creativity, eases the weight of the demands placed upon you by your surroundings, and makes you free of worrying.

At the same time the user often feels misunderstood, unique and different from others, lonely and unsuccessful but internalises and owns these feelings: they do not associate them to the use of the drug.

Meanwhile they are often exhibiting many of the following behaviours: problems with putting words to feelings or emotions; feelings of boredom and emptiness, and of being misunderstood and lonely; externalisation of problems; difficulties in evaluating their own performance and the practice of self-criticism; problems in maintaining a dialogue, being attentive, and concentrating; difficulty with planning and having structure or routines in life; feeling different from everybody else, giving stereotyped answers and opinions; feeling incompetent and unsuccessful; and being forgetful and likely to miss appointments.

The task is clear: to connect the user to the realities of the second list by dispensing with the myths of the first. The challenge is to do this while the very cognitive processes that are required for such a realisation are themselves impaired by the use of cannabis.

Until you can be sure that your son is using cannabis it will be difficult to engage with this problem, but you might begin with asking him to define what he means by abuse: what would that look like; how would someone know that they were abusing a drug? Learn about cannabis yourselves and think about how you can discuss the issue without everybody ending up in immovable, conflicted positions. In-volve can provide you with appropriate literature with ideas on how to do this, as can a number of other agencies: try contacting FRANK or Drugscope. Talk to your local branch of Adfam who are there to support people like yourselves and not just the families of heroin users as many people assume.

Ideally, get your son to contact one of our services or your local young people's substance misuse service if there is one near you. However, I think you have some preparatory work to do first: he won't consider getting help at your behest if he won't even admit that he's using. There is, unfortunately, no quick fix that will ensure the problem is dealt with before his exams. Indeed many young people say the pressure of exams is one of the reasons they smoke cannabis.

We'd need to hear more about the specifics of your son's case before we could say anything more definite but do please feel free to contact us directly. Details are on our website.

Colin Cripps, deputy CEO, In-volve.
The website is at www.in-volve.org.uk

Fooling ourselves

Dear Lorraine
Communicating with teenagers is an extremely difficult thing to do. On the one hand if you try and talk to them from an adult's perspective and (you hope) give them the benefit of your experience, they will no doubt write you off as a patronising old fuddy duddy; whereas if you try and communicate with them on their level, you run a very great risk of sounding like you are trying to be 'down with the kidz' and run the risk of embarrassing both yourself and them.

The best thing that your friend can do is arm herself with information on cannabis (and all drugs) and make herself available if her son wishes to talk. By knowing the facts around the drug you are then able to pass on constructive measured advice that may be listened to and taken seriously. The worst possible thing that you can do is overreact, young people have a very sophisticated knowledge of drugs and telling a 15 year old that if he smokes cannabis he will fail his exams and ruin his life will not wash.

Good luck.

Mary, Northants

Reader's question

I've been having a relationship with one of my clients and now we're really serious about each other. I was trying to keep it secret, but the rumour mill's started up. How can I handle this without losing my job? 'Phil'

Email your suggested answers to the editor by Tuesday 27 June for inclusion in the 3 July issue of DDN.
New questions are welcome from readers.

Living in a treatment nightmare

When Maureen's son overdosed, she found herself pulled into a struggle with local services that made her determined to fight for better treatment for other service users.

My son's experience of heroin use made me aware of what was happening locally. The treatment just wasn't there.

They give them a urine test each time they collect a prescription, but do nothing when they test positive. My son overdosed. I can still hear his breathing and his body was transparent. He was in a bad way. We took him to hospital and they told him he was going to die. Fortunately for us, he didn't. He was put on a life support machine, and he was on that for about three weeks. He had a bad reaction to one of the drugs and was psychotic.

He gradually became more in control, but when he was discharged, they wouldn't give him any methadone. I said to the doctor, look, my son's very vulnerable at the moment, I can't give him money and send him to score. And he said, in that case, you go and do it! They had given him methadone all the time in hospital, and they knew he was methadone dependent, but they refused to treat him when he was discharged. That day we left the hospital, and me, his dad and his brother, went and bought 5000mls of methadone on the black market.

Because we'd had such a struggle until we gave up and paid for him to have private treatment, I established relationships with other users. I became their confidante. I started to say to the DAT, you'd better listen if you don't want people coming in your bedroom window. Treating drug users is the key to stopping crime. Services said I was unreasonable asking for methadone. But my sole concern was that users were treated with kindness.

I couldn't get any sense from my local DAT. Service users were being given compulsory urine tests every week, but there was no follow-up. I was being treated as a troublemaker and a nuisance for raising issues on service users' behalf.

Engaging with the private sector seems to be the only way users can get good treatment. The users going to our local service provider are all in chaos. Treatment is administered from the psychiatric unit, which immediately labels users.

But the DATs and the PCT pretend everything's wonderful. I'm treated like a whistleblower – but all I want is to stop them proving a square service for round people.

In this area there's a 40-week wait for treatment. I still keep hitting the same brick wall. Influence has to come from those providing a good service. In a town of 23,000 people, there are no doctors willing to prescribe. There's involuntary detox that's just not working. The waiting lists are clogged. The DAT's got a plan – but they don't see further than 'take it or leave it. This is what you're getting.' If you ask for titration you might as well ask for the moon. To get any more methadone is very very difficult.

There are good GPs out there. But people here need to be encouraged that they can live normal lives, with their kids. At the moment it's a nightmare. There's no mechanism to pick people up and they remain in crisis and I see so many instances of prejudice. Last week a woman in my area contacted me because social services had visited her and taken her baby away.

We're on a hiding to nothing. There's no motivation to move forward, and some people are just overcome. GPs in our area are actively encouraged not to prescribe.

It's barbaric – we're 20 years out of date. It's so easy to buy heroin. We're encouraging a cottage industry – it's easier to score than to get treatment. Nobody instils in users that life can be more fulfilling without heroin. We treat them as addicts, dirty smackheads who get what they deserve.

One of the saddest cases I know was a girl of 19 who'd been raped by seven men – and they said that she was only trying to circumnavigate the system. She died anyway, luckily for them. She doesn't matter anymore, does she? She was the nicest girl you'd ever meet. But she's in a place now where she can't embarrass anybody.

I provide a telephone service for parents. I know what's happening to them and can totally understand their situation. In 2004 I monitored my phonecalls. I received 1,800 calls from 1 July to 31 December – all of them from first time callers in my area.

There's a guy locally, user extraordinaire, in and out of prison. I was in town one day and we got talking. He said to me, 'you tell people what it's really like. Because I can't, I'm too far gone. My life's in chaos'. People show me bits of their life, show me how painful it is. And I've then got an obligation not to give an inch in trying to help them.

All they'd have to do to overhaul services is to listen to the users. To openly admit a waiting list is 23 weeks is unbelievable. If you talk to people, you know where they're at.

I had one lad a couple of weeks ago who was on a mission, back in chaos. He was here, in my house, talking about what was going on, and it took time to sort him out. They need somebody to listen and to say to them 'I know what you're doing'.

This was a lad 6ft 4, and when I first got my hands on him he was 6st 10. He was dying. People in the town I live in were stopping me and saying can you help him. He went away laughing and he was able to speak to his mum and dad, and say I know things aren't right at the moment, but it's in hand. His reign of terror's over. If you know somebody well and you care about them, you can overcome many hurdles.

When people come to me, I say the first thing I'm going to do is help you see two eight o'clocks in one day. The rest you have to do yourself. I can't change your life, I can only give you pointers.

It's about gaining trust to talk. They know they can ask me about testing for Hep C/HIV, difficult decisions they have to make, problems they're worried about, like loss of sexual desire, technical stuff about injecting sites and using more safely. If people are going to inject in sites in their groin whatever you tell them, then I'll say this is what you need to do to make it safer.

I talk to them about making bad choices and being where they are – and I've never met anybody yet who's addicted to heroin who's set out to be a heroin addict. They all thought they could control it. I don't have a problem with anybody using while they're on a prescription. But they have to be in control of using, rather than it controlling them.

Some services see me as a useful tool. But most see me as 'only a mother' or someone who's a bit mad. All I want to empower the user and their parents. I tell parents that drug use can be like schizophrenia – if his lips are moving he's lying. Their child will become nasty, unrecognisable. So they must put boundaries in as a consequence.

At the end of the day though, the service shouldn't be provided from my kitchen. When I started doing this, it was only a matter of turning up and saying 'look, this is what people are looking for'. I never visualised myself delivering a service – that was never part of the plan. I don't want to be a rehab service, I don't want to be anything. All I want is for them to provide the service they should. **DDN**

'At the moment it's a nightmare. There's no mechanism to pick people up, they remain in crisis and I see so many instances of prejudice. Last week a woman in my area contacted me because social services had visited her and taken her baby away... There's no motivation to move forward, and some people are just overcome. GPs in our area are actively encouraged not to prescribe. It's barbaric'

'Do I feel let down down? Just a little bit!'

For a parent, the struggle to get treatment for their child can be an exhausting non-stop process. It shouldn't have been so hard to find a service that would help her son, says Barbara.

My son had a letter last September saying he was being referred. And that was it. We heard nothing else whatsoever. This went on for eight and a half months.

I phoned everywhere we could possibly phone. All I did was hit a brick wall.

In April this year Dan had an assessment, and the drug worker turned round and said to him, because you're not homeless, because you're not stealing, and because you've got no mental health issues, you haven't got a chance yet.

I spoke to the man from the drug treatment agency. He was the most unhelpful patronising man I could hope to meet. He turned round and said to me 'because we've had this conversation, it does not mean he's jumping the queue. This was after seven months.

I said I wasn't asking for him to jump the queue. I just wanted to know when my son's appointment was going to be. So I ended up putting the phone down on him in sheer desperation and frustration, nearly in tears.

Then Maureen got involved, and she helped me a lot. We got him into another treatment service – but to get this appointment we had to change to a doctor in a different area and give a fictitious address. It's crazy for drug workers to say to Dan that because he's not stealing, he has to wait. I spoke to our local MP and she went to the PCT for me to find out what was going on. And she received a letter back off them, which was basically a load of rubbish, saying that the maximum waiting time was 23 weeks.

When you live with an addict it's very hard for the addict and it's very hard for the family. Without the support of his family my son would either be dead or in prison again. It's a very stressful situation and it's worn me out.

The reasons they gave for the delay were funding, and that they're short staffed. Some of the drug workers were very nice, they said we understand how you feel – we aren't happy with the situation as well.

The problem's doubled in this area – so why aren't they doing something about it? How much does it cost to send someone to prison? Methadone's so cost effective.

Dan's now a different lad altogether after six weeks in treatment. It's a brilliant place. He's gone for an interview this afternoon for a job.

I'm very very disappointed with the situation round here. What annoys me is that just six miles away, they have a six-week waiting list. We've had to do things deviously, moving addresses. They just could not give me a date when the appointment would be. They said he was seventeenth on the list – so what does that say after nine months?

If a pregnant woman comes in, or someone with mental health issues, they go before him. He didn't stand a cat in hell's chance of getting an appointment.

'They just didn't want to know...'

Dan has finally accessed treatment after a nine-month wait – but only by giving an address in a different area.

I've had enough, I just want to forget about it. Round here's crap for people with drug problems. That's all I can say. I'd been waiting nine months and I still didn't see anything from them. So I had to go somewhere else. I don't think it's just me. From what I can gather there are other people still waiting.

They just didn't want to know. I asked for a case worker and I still haven't heard anything about that. If we hadn't have kept phoning them, we wouldn't have been any the wiser. They didn't even tell us what was going on, they didn't even phone us up or take the phone call, they just left us hanging.

They said as well that if I wasn't ill or mentally disabled or anything like that, if I've got no DVT, and because I'm normal, I've got not injuries and I'm healthy, I'm lower down on the list.

The names in these two interviews have been changed to protect identities.

Culture **challenge**

Educating young people about drugs depends on being able to relate to their culture. DDN talks to Hasan Sidat about his work with Muslim communities in and around Lancashire.

'Sometimes when I go down town I'll see young people that go to the mosque, and they'll say to their parents "there's the drug man!",' says Hasan Sidat.

For Sidat it's all part and parcel of being drug awareness officer for the Lancashire Council of Mosques and goes hand in hand with unpredictable hours and making himself as accessible as possible to Blackburn with Darwen's Muslim young people.

This Lancashire borough has the highest Muslim population outside London and the third largest in the UK. Working in close partnership with Blackburn with Darwen DAT, Sidat has been involved with the Substance Abuse Awareness Project called Islamic Choices for the past five years. His role is to make contact with young people and their parents, and convey drug education in a way that is sensitive to their culture as well as being relevant to their needs.

Breaking down barriers to talk about drugs moves a step closer if you are on the same cultural plane, he explains. He began by contacting all the mosques in his area and met with community leaders. Working with the Local Education Authority and local Imam, he devised a drug policy similar to that of the LEA, which was adopted by the mosques, and by many of the schools that have a majority of South Asian students.

He needed to get a harm reduction message across, he says, and uses his powerpoint presentation, a magazine and leaflets to communicate with students. They need to know what drugs look like – and to have the confidence and training to say no if they are offered them. The visual materials are also a way of also reaching their parents when they take them home, he says.

The more proactive part of reaching parents is done through parents' evenings and school open days. Sidat is in favour of joining in with themed occasions such as a recent 'culture day' which gives scope to incorporate drugs education without having to confront parents with an issue 'with a lot of stigma attached to it'.

'We had it at the football ground and parents came,' he explains. 'The whole event was about diversity and community understanding, and I spoke to all of them about the project. They came for other reasons – but we got the message across about what we teach in schools and mosques.'

Most usefully, it gave parents a chance to ask questions, or say 'I know someone who was on this...' They open up and feel comfortable speaking, he says. Transition times when children are moving up from primary schools are also useful occasions to prime parents. Sidat takes the opportunity to explain to parents that their child will not only encounter more drug education, but are likely to meet people who are using drugs in high school. He offers the message that they can get help.

'I tell them they're not going to be able to wave a magic wand and make their problems disappear,' he says. 'But I can put them in touch with a service provider. At first they might not feel comfortable going to one, but my approach is that it's like an illness. I tell them, if your child had a kidney problem, you'd go and get help wouldn't you – and obviously assume they'd get better. If you look at this as similar, as a health problem, I think it works better.'

Effective communication is essential to Sidat's job, and he explains that he needs to be accessible at all hours. Young people are hardly likely to come to your service at 9am when they're at school or college, he points out. He gives out his mobile number and takes calls at weekends, if that's when he's needed.

In return for his time, he takes feedback from young people, to give to the DAT and to service providers. His recent report revealed that many young people would not use existing services in Blackburn, and some said they didn't even know of their existence.

'I took my research back to Blackburn with Darwen DAT and said it was their choice what to do about them, but they had recommendations in there. The report consisted of quotes from young people – it gave us very good feedback.' Service providers work closely with the DAT, he says, and he has good links with the local police, which all seems to help foster a culture of co-operation and understanding that can only be positive, he points out.

Sidat obviously finds his job rewarding, and strives for 'a service driven by service users'. There are unexpected bonuses from time to time: the other day he did a lecture with youths on the effect of drugs and alcohol on driving. At the end of the session, three of them came up to him and wanted to know how to become drug workers.

'That's positive because we don't have many South Asian drug workers in this field,' he says. It sounds as though his guiding influence could help a good few of them to see drug services from the right side. **DDN**

Hasan Sidat works for the Lancashire Council of Mosques. Their website, containing information on a wide range of projects, is at www.lancashiremosques.com

The drug experience: heroin, part 8

In his latest Background Briefing, Professor David Clark continues to look at the research of Patrick Biernacki in the mid-1980s showing that people can recover from heroin addiction without treatment.

In our last Briefing, we started to look at the research of Patrick Biernacki, conducted in the United States in the mid-1980s, which involved interviews with 101 people who had recovered from heroin addiction without treatment.

This research indicated that once people who have become dependent on heroin decide to stop using the drug, they are often unsure about what they should do with their lives instead. They may know what they do not want to do, but they are less certain about what they do want and how they can go about getting there.

This problem is greater for those who have immersed themselves in the world of addiction. They may have no money, no place to live, and no friends (other than other heroin users) and family to help them get out of their situation.

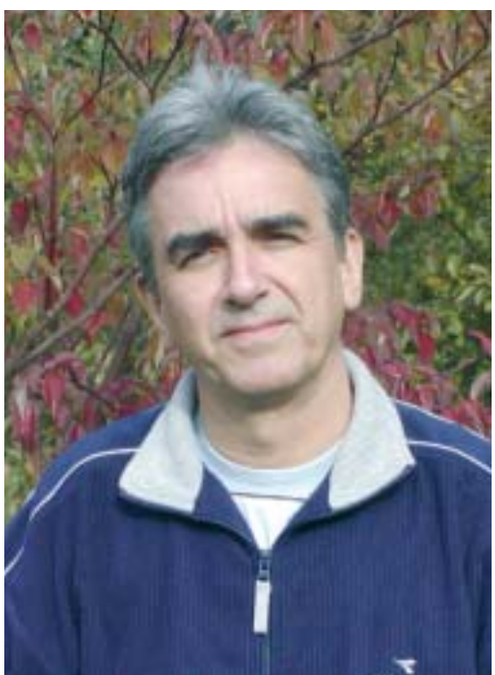
Resolving the uncertainties and self-doubts that users have when considering giving up the drug can occur in a variety of ways, some of them selected deliberately by the individual, some occurring fortuitously (*eg* through an accidental social encounter).

While nearly all of the participants in the Biernacki study considered treatment as a possible alternative, it was rejected by all of them. When asked why they did not use treatment, 35 per cent said they thought they could take care of themselves, 19 per cent did not believe that treatment would work, 14 per cent thought they would be stigmatised, 10 per cent said treatment was not available, and 9 per cent had a negative image of treatment programmes.

Moving towards abstinence generally entails literal or symbolic actions taken to sever connections with heroin and the heroin-using world. Biernarki provided examples of symbolic breaking away: the abstaining person who presented himself as a non-user to his drug-using friends, and the woman who presented herself as a born-again Christian.

Some people are not confident enough in their ability to maintain their resolve to quit, so they lock themselves in their homes and do not answer the door or telephone. Others feel that they have to change geographical location if they are going to stop using heroin.

Following a period of withdrawal, former users face a basic problem of occupying their time with positive activities, to replace their old drug-using lifestyle – in some cases, this may have involved a full day of shoplifting, selling the goods, buying the drug and using.



'The social relationships, interests and investments that develop in the course of abstinence reflect the gradual emergence of new identities and corresponding new perspectives. Now the abstaining individuals know what they do not want to do but also what they would like to do and become.'

Filling time with new activities may not be a great problem to a person who had maintained strong relationships in normal society, but is much more difficult for a person who lived almost exclusively in the world of addiction and may have been taking the drug from an early age.

In the Biernarki study, interviewees described a period in which the activities that filled this void – work, child care, religion, politics, or physical exercise – 'became almost the exclusive focus of the addict's life and are fervently performed'. During this time, which may last as long as a year, 'a moratorium takes place on what might be considered a "normal" round of life. The abstaining individual rarely ventures beyond the safe confines of the group or activities with which he is engrossed'.

During the time that the former user has removed himself from the drug scene, either literally or symbolically, changes gradually occur that increase the likelihood the person will remain abstinent. This can, however, take a long time, and some former users will not reveal their past lives to 'straight' people.

Former users share social experiences with non-users, and these experiences can provide the basis for a commonality of discourse. This can help ex-users overcome their fears that they cannot get along with non-addicts because they will not be accepted by them.

At the same time, ex-users may be forging new friendships, possibly a new intimate relationship, and acquiring material goods and a liking for a drug-free life. They start to gain a personal stake in the new things they have acquired since giving up heroin, and they do not want to jeopardise this by going back to heroin.

Biernacki also pointed out that the changing drug scene can increase the likelihood a former user will stay abstinent. He described how heroin social circles often change, as members drift away for various reasons, *eg* are jailed, hospitalised or die. A person might return to their usual drug scene to find it completely changed and experience it to be more difficult to obtain the drug. This difficulty may be sufficient to dissuade them from starting to use again.

As time goes on, the ex-user acquires emerging stakes in staying abstinent. 'The social relationships, interests and investments that develop in the course of abstinence reflect the gradual emergence of new identities and corresponding new perspectives. Now the abstaining individuals know what they do not want to do but also what they would like to do and become. They can begin to plan and work for a future unrelated to drugs.'

[to be continued]

Recommended Reading: Patrick Biernacki (1986) Pathways from heroin addiction: Recovery without treatment. Temple University Press, US.

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

Open all hours

The DDN bookshop located at *www.drinkanddrugs.net* provides an easy and cost effective way of purchasing publications focusing on all aspects of substance misuse.

All books are available at a discounted rate to DDN readers and there is a vast range to choose from. What's even better is that by clicking through from the DDN shop to the main Eclector site you can browse hundreds of thousands of titles on every subject, and they are all available at a discount.

In every issue of DDN we will suggest titles that complement the features, and may be of interest for anyone wanting to read more around the subject. When you see the DDN bookstore logo it means that those titles are available on the site at a discounted price. All you have to do is visit *www.drinkanddrugs.net* and follow the Drink and Drugs Books link on the left hand side of the page.

For example anyone interested in our feature 'Caged recovery' about William Pryor's impressions of the drug treatment available in Bullingdon prison *(see page 8)* may find *Drug Use and Prisons* by John B Davies a useful addition to their library. Readers wanting to gain an understanding of the authors perspective, can find out more by reading his engaging autobiography *'Survival of the Coolest'* available through the shop at 15 per cent less than the publisher's recommended retail price.

Readers who are following Professor David Clark's heroin series in our Background Briefings can search through over a dozen titles looking at the history of heroin use and the type of treatment available.

So next time you are looking to buy a book whether it's for work or study, try the Drink and Drugs News shop or (if you then click through to the main Eclector website) you can buy your summer holiday reading or maybe a late father's day present! Please give the Drink and Drugs News bookshop a try, as all the revenue generated will go towards funding the free circulation of DDN.

MANCHESTER DRUG AND ALCOHOL STRATEGY TEAM

Manchester Drug and Alcohol Strategy Team are inviting companies to express their interest in tendering for the following Term Contract:

Review of Needle Exchange Services **Ref: 735916**

Companies interested in tendering should request in writing to Ian Jeffery, Senior Contracts Officer, Drug and Alcohol Strategy Team, 4th Floor, Heron House, Brazennose Street, Manchester, M2 5EA.

Quote reference (735916)

Due to the nature of this contract, providers of Needle Exchange services are ineligible to tender. Tenders will be issued electronically therefore interested companies are required to provide an email address.

TACKLING DRUGS CHANGING LIVES

Applications will only be accepted up to 5 July 2006.

MANCHESTER CITY COUNCIL

Setting new standards for Social Care Professionals.

Specialising in the provision of Substance Misuse Personnel

Substance Misuse Workers
DIP Workers
Arrest Referral Officers
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Internet **www.rigsocialcare.co.uk**

REC Recruitment & Employment Confederation

New direction.

Drug Rehabilitation Care Home Manager

£26,405 - £29,621

Murray Lodge, Coventry Ref: MURL/345/DDN

Chatterton Hey, Bury Ref: CHAT/352/DDN

Langley House Trust specialises in providing ex-offenders with accommodation, support and drug rehabilitation within a supportive Christian environment. Now, we're changing the way we change people's lives - a transformation that begins with you.

The confident direction you bring to either project will create lasting and significant change in the way we work and in the lives of those we work with. By taking care of the strategic management, day-to-day running and marketing of the project, you'll enable the therapeutic team to focus on what they do best - the rehabilitation of clients in a residential, abstinence based programme.

It's a broad and influential role encompassing resource, budget and change management and one in which the support and custom of partner agencies will prove vital. As such you need to be skilled not just in the field of substance misuse but in building robust business relationships and marketing services. In return for the energy, focus and leadership you bring you'll find a unique opportunity to influence the development of the project and our wider organisation.

If you are a practising/professed Christian and wish to find out more, or obtain an application pack, please visit our web site at www.langleyhousetrust.org or telephone us on 01993 705999, quoting the appropriate reference number.

Closing date: 7th July 2006.

Regulation 7(3) of the Employment Equality (Religion or Belief) Regulations 2003 applies to this post.

Lht

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EVERY DAY IS A NEW BEGINNING

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You'll be there to help our clients address their substance misuse issues. Acting as both supporter and facilitator, you'll draw up care plans to assist them through and beyond the challenges they face, and work with them to make positive changes.

With experience in the substance misuse field, you'll have excellent listening skills balanced with a team orientated and proactive attitude.

We offer 28 days' annual leave, 6% contributory pension, plus excellent opportunities for personal development.

Please visit our website for further details and to download an application pack. Alternatively email j.boateng@addaction.org.uk or call 020 7017 2865 quoting ref. ADDLR84.

Closing date: 26 June 2006

Charity no. 1001557

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MANCHESTER DRUG AND ALCOHOL STRATEGY TEAM

Record Of Interest In Providing Services

Manchester Drug and Alcohol Strategy Team (DAST) is updating its Record of Interest. Suitably qualified and experienced organisations are sought to record their interest in providing substance misuse services for adults and/or children:

Organisations wanting information about specific areas where interest is being sought and the record of interest questionnaire should contact:

Ian Jeffery, Senior Contracts Officer, Manchester Drug Alcohol Strategy Team, Fourth Floor, Heron House, Brazennose Street, Manchester M2 5EA.

Telephone: 0161 219 6927 Email: i.jeffery@manchester.gov.uk

Quoting reference: DAST ROI.

NB. If you are already registered you will be contacted directly in order to validate your existing records.

TACKLING DRUGS CHANGING LIVES

MANCHESTER CITY COUNCIL

ADULT AND COMMUNITY SERVICES DEPARTMENT
COMMUNITY SAFETY AND PREVENTATIVE SERVICES

Drug and Alcohol Action Team

We have undergone a full redesign of all drug treatment services over the last year, to bring the treatment system into line with the Drug Interventions Project and Models of Care 2005. As part of this major change, the DAAT Support Team has themselves undergone a major restructuring. We are now looking to recruit to the following key post:

Joint Commissioning Manager

£38,286 - £40,782 **Ref: ACS020**
inclusive of London Weighting
Location: Riverside Barking **Hours: 36**

You will be responsible for ensuring that current treatment providers continue to provide high quality treatment to service users, as well as creating annual treatment plans for the strategic partnership which benefit the borough as a whole.

Experience of the substance misuse field and joint commissioning is essential, along with partnership skills and the ability to create and deliver a vision for Barking & Dagenham's drug treatment system. This is a challenging role which requires budget management and contract negotiation skills, with an understanding of the issues needing to be addressed by both the local strategic partnership and the National Treatment Agency.

Your creativity, drive and problem solving approach will be essential in ongoing development and consolidation of the treatment system.

You will have line management responsibility for the DAAT Resource Officer and be accountable to the DAAT Group Manager.

Please note that this is a politically restricted post in accordance with Section 2(1) (b) of the Local Government and Housing Act 1989.

This post is exempt from the Rehabilitation of Offenders Act 1974; and a comprehensive screening process will be undertaken on successful applicants including a Disclosure check (Applicant Declaration must be completed and returned with application).

To apply online please log on to our website at www.barking-dagenham.gov.uk Alternatively, call 020 8215 3001 to request an application pack or email us at request.applicationform@lbbd.gov.uk quoting the reference number above.

Closing date: 23 June 2006.

Interview date: 10 July 2006.

We are unable to process requests for application packs received later than 3 working days before the closing date.
The Council operates a No Smoking Policy and offers a smoke-free work environment.
Promoting equal opportunities and celebrating diversity.

Together we will build communities and transform lives.

The London Borough of
Barking & Dagenham

www.barking-dagenham.gov.uk

Community Drug Project

Providing quality services in response to the changing needs of diverse communities

CDP runs a range of high quality innovative substance misuse services based on our principles of partnership working, accessibility and harm minimisation. We are shortly to merge with the Blenheim Project to create a new organisation that will employ over 100 staff across London.

We offer a range of benefits including: contributory pension scheme, generous holiday entitlement, annual season ticket loan as well as a comprehensive training programme.

Project Manager

The Source Crack Service – Wandsworth SW8 **£28,449 to £31,191 pa**

The Source provides an extensive range of services for primary crack cocaine users resident in Wandsworth. Alongside direct access facilities, structured key works and a range of groups, workshops and activities, a range of complimentary therapies are also available.

You will have overall responsibility for the clinical management and day-to-day running of this service and directly manage 6 permanent staff. You should have extensive experience of working with service users in the substance misuse field and have at least 1 year's experience of staff management and supervision. **REF: CDP/04/DDN**

For an application pack please telephone on 020 7840 0099 or email: jobs@communitydrugproject.org.uk quoting the relevant reference no.
Closing date for completed applications: 5th July 2006.

www.communitydrugproject.org.uk

Reg Charity No. 293959.

DAF

Drug and Alcohol Foundation

Family Development Worker/ Counsellor

Part time post (hours negotiable) £22,000 – £25,000 pro rata

The Drug and Alcohol Foundation is a small charity, based in Westminster, offering specialist treatment options for clients with substance misuse problems, other addictive disorders and mental health problems. We currently provide individual counselling, group work and structured day programmes for clients at all stages of the recovery process.

DAF is looking to recruit an enthusiastic person to develop our Families programme. This will involve outreach into the local community to network with carers and families and establish pathways to DAF services. Additionally, the post holder will carry a caseload of individual clients who may be family members affected by someone else's addiction.

The post holder will be expected to hold a diploma level qualification in Psychotherapy or counselling, and have experience of working in the substance misuse field. An understanding of the issues faced by family members affected by another's addiction, and experience of community development, would be an advantage.

For an application pack and /or more information please telephone 020 7233 0400, or email admin@daf-london.com

The closing date for completed applications is Friday 30 June 2006

TASHA Foundation

2 X F/T Drugs Intervention Programme Aftercare Workers

£23,008.00 (Incl OLW)
Plus 5% Pension
36 hours per week

We are looking for motivated and experienced workers to provide aftercare support for drug misusing offenders who have been through the drug treatment programme. The successful candidates will need to demonstrate experience of working in partnership with a range of statutory and voluntary agencies. The post holders will have to display a good knowledge of drug intervention practices and will provide a variety of services including access to education, employment, housing and benefits.

For further info and application form tel : 0208 569 9933
Alternatively please email your CV and covering letter to: enquiries@tasha-foundation.org.uk

Closing date: 7th July 2006

Reg Charity No: 1062805