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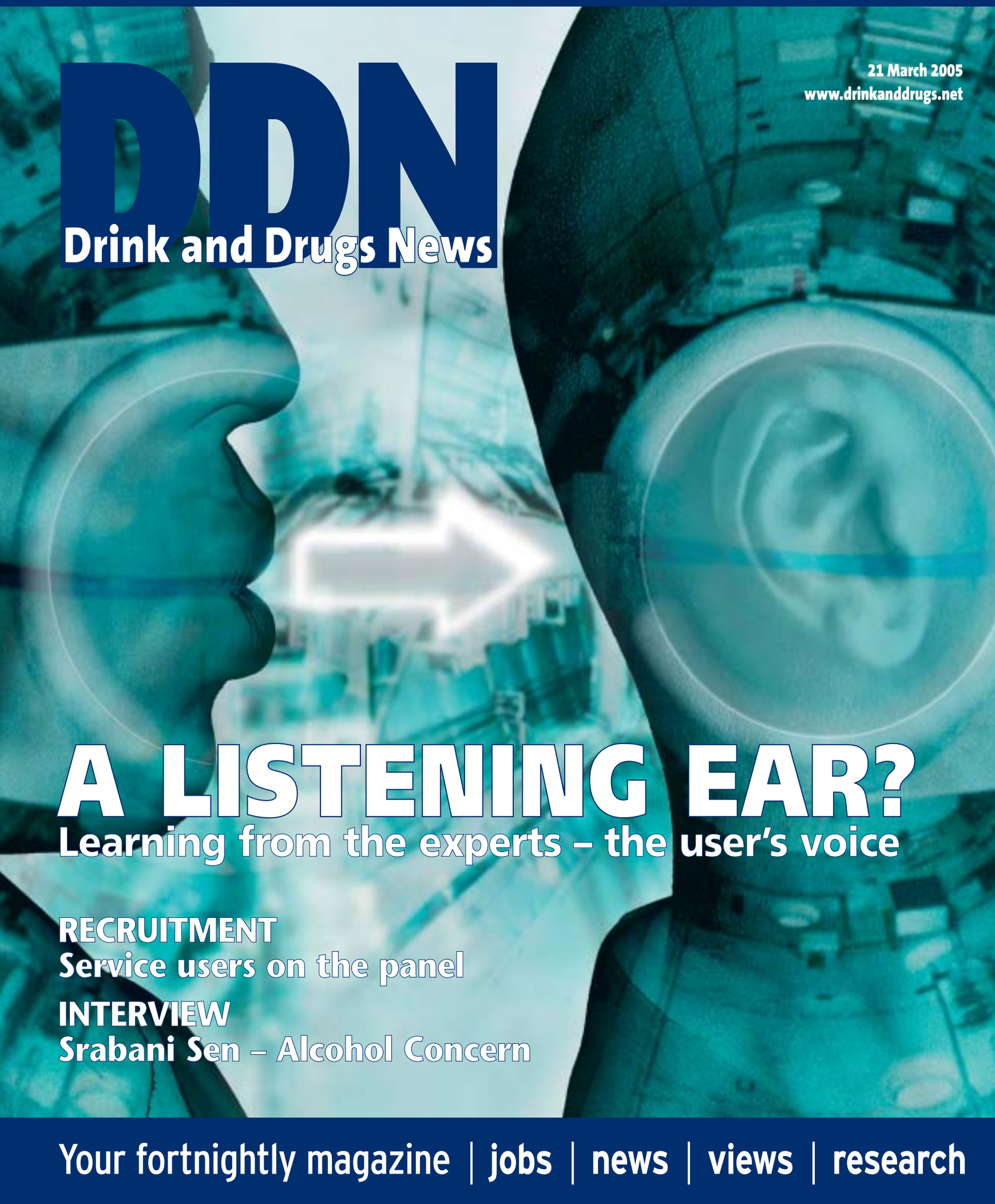

DDN
Drink and Drugs News

21 March 2005
www.drinkanddrugs.net

A LISTENING EAR?
Learning from the experts – the user's voice

RECRUITMENT
Service users on the panel

INTERVIEW
Srabani Sen – Alcohol Concern

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The 21st Century approach to tackling substance misuse

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Drink and Drugs News

21 March 2005

Editor's letter

'I'm still very much in the listening phase,' Alcohol Concern's new(ish) chief executive Srabani Sen told me, when I interviewed her for this issue. Talking to people in treatment services, and the service users themselves, has been a crucial part of Srabani's induction, and has informed her strategy planning for the coming months.

All very logical. So when do we stop listening? When we're busy, and pressured, and under-resourced and over-targeted.

The Wired team make a solid case for listening on page 8. Listening to service users' views is surely the best way of finding out what will ring the right bells in changing patterns of behaviour and arming people with devices for coping.

Involving service users in the recruitment process for new staff, takes the concept a stage further (page 10). A nice idea – but a practical one? See how two different sized organisations got on when they tried it for themselves. It may not be possible for everyone, the authors acknowledge – but you may be surprised at the very positive spin-offs of giving it a go.

Paul Hayes from the NTA and Paul Wells of UKHRA debate the controversial issue of coercive testing and treatment, on page 6. Let us know what you think.

And if you need reminding why you're doing the job, take a look at the opening part of David's story on p14. It's a while before he heads towards treatment, but I'm sure it'll ring bells with many of your own service users.

If only he'd read Prof David Clark's Background Briefing, and realised that heroin activates opiate receptors in certain areas of the brain, increasing electrical signals in the dopamine-containing neurons and enhancing the activation of dopamine receptors by dopamine... it might all be a different story.

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In this issue

'Tackling drugs, changing lives' gets regional focus

New home office branding for the 'Tackling drugs, changing lives' initiative was launched this week by Caroline Flint MP. 'Tackling drug misuse is a key priority for this government', according to Ms Flint, who said that they were committed to doing this, despite the opposition they were sometimes faced with.

'Taxpayers want the problem sorted, but don't want to fund it,' she said. Ms Flint was speaking in London, as part of a regional tour that included Cambridge, Manchester, Birmingham and Newcastle before the end of March. She had begun her day by visiting a drug link project in Shepherds Bush as part of her aim to speak to service users and frontline-workers, which was, she said, the reason the Home Office were running theses regional events.

The initiatives run by the government have had impressive results stressed Ms Flint: 154,000 people accessing treatment in 2003-4 rising to 200,000 by 2005. The drug intervention programme and 'Operation Crackdown' were both having an effect, with 12,000 offenders now in treatment. This had resulted in a 13 per cent reduction in crime related to addicts according to home office figures. This was all part of the government's aim to 'break the cycle, putting users in treatment and dealers in prison'. This government was committed to improving the effectiveness of treatment and to 'providing high quality treatment for all'.

Caroline Flint visiting a drug link project in Shepherds Bush as part of her aim to speak to service users and frontline-workers.

There had been a decrease in drug use of all types, with a reported 2 per cent reduction in cannabis smoking in the 11-15 year old age group. Programmes like Positive Futures and Talk to FRANK were having an effect, but there was still a lot to do. With almost 20,000 new young people using drugs every year, it was a priority to promote joint working between children's services and drug services.

There was a need to thank everyone involved in the provision of drug services and to highlight the progress and successes made over the last two years, said Ms Flint. She hoped these events would serve to highlight these successes while providing an opportunity for practitioners to network, share ideas and good practice.

Prime Minister Tony Blair recorded a video message for delegates at the regional seminars. Mr Blair stressed that 'great progress is being made' and pledged 'record investment' for the field, drawing attention to the current 55 per cent increase in resources to the Department of Health for drug services and the increase in police powers enshrined in the Drugs Bill. Mr Blair highlighted how 'addiction fuels crime and antisocial behaviour' and said 'the vision is clear: reducing harm to individuals and their families.'

Partners in Prevention Conference

AdFam has given voice to prison families

Prisons give a chance to intervene in drug and alcohol addiction, Mike Trace, chief executive of RAPt, told delegates at 'Partners in Prevention', a conference held by AdFam in partnership with the Prison Service.

More detox programmes were now carried out by the prison service than the NHS, said Mr Trace. It was now easier to access drug services in prison than anywhere else, with the rise in government funding over the last ten years.

Time in prison could represent a 'holiday from chaos' for prisoners who chose to tackle their addiction, and for those willing to get help, there was a good chance of getting successful support. Maintaining a regular habit was risky to health and personal safety, and many prisoners submitted to treatment when facing a regime of regular drug tests.

Mr Trace was less convinced of the benefits of using the criminal justice system to coerce people into treatment, and was worried that we may have 'gone too far' down this route.

'Until the individual has made the decision for themselves, you end up with only game play,' he commented.

The massive government investment in drug treatment services since the late 1990s – £50m a year now, compared to £6m in 1997 – had meant a gradual change in experience for families and friends of drug-using prisoners, who in the past had found it hard to get specialist help.

'We've come a long way,' said Mr Trace. 'There's now a lot of talk about how families can be supported.' AdFam had played a significant role in this process, raising awareness of visitor centres and enabling their development; putting pressure on governors to provide family facilities, and pressure on treatment providers to respond. The charity had 'made sure the voice of families was heard during the massive expansion of services', he said.

The results spoke for themselves, with better reconciliation between prisoners and families, and more effective resettlement in the community.

It was important to get this process right, said Mr Trace. His organisation, the Rehabilitation of Addicted Prisoners Trust (RAPt) would be asking for AdFam's help in conducting a review of services.

FDAP launches website Q&A

Last month's launch of FDAP's DANOS-based Drug & Alcohol Professional Certification scheme attracted an enthusiastic response across the field. To help make things easier for those interested in applying for Registration or Accreditation as a Drug & Alcohol Professional, FDAP have published a 'frequently asked questions' page on their web-site, giving answers to some of the more common questions received since the scheme's launch, such as: 'what's the difference between registration and accreditation?', 'how detailed does a 'workplace assessment' need to be?', and 'how does FDAP's scheme fit with the Health & Social Care NVQ/SVQ?'.

For more details see under 'Professional Certification' at www.fdap.org.uk

Partners in Prevention Conference

Prison service DG gives picture of drug use inside

'We have a reasonable, though not perfect, picture of what's going on with drug use in prison,' Phil Wheatley, director general of the prison service told the Partners in Prevention conference.

Commissioned research had helped to confirm the scale of the problem: a quarter of the prison population had used drugs last month. Testing had proved to be a good way of identifying regular use, and had brought cannabis use down sharply. Opiate use remained steadier, at around 4 per cent in the last few years. There was little indication of crack cocaine use, nor amphetamines – 'people don't want to heighten the experience, but deaden it,' he said.

Mr Wheatley was pleased that needle exchanges had been kept out of prisons, and claimed that this had cut the risk of needles being passed around.

There were significant deterrents to continuing drug use in prison. For those who had serious drug problems when they entered prison, most found it too difficult to keep a street habit going. The risks of debt were substantial if they carried on using – which were likely to be passed on to families outside.

Some drug users brought a small amount of drugs into prison with them, but the prison service was not looking to conduct intimate searches. 'This is not the answer,' said Mr Wheatley.

Supplies often found their way in through visitors, and there were sophisticated ways of transferring drugs, sometimes for paying off debts inside, that meant prison staff could 'become very twitchy' about visiting time.

There was also very sophisticated drug smuggling at the top end – staff and official visitors were sometimes paid off to smuggle drugs without suspicion. These instances only came to light if there were higher incidences of drug taking within a prison, provoking an inquiry.

Smuggling drugs into prison was an escalating business, said Mr Wheatley, and the prison service needed to constantly try new methods to keep a step ahead – putting nets over the perimeter and yards to catch any drugs thrown over, improving intelligence, and using CCTV to monitor visits. Drugs dogs were 'still better than much of the fancy equipment', he said.

The numbers of prisoners entering detox suggested that efforts to keep drugs out of prison were working. Last year 58,000 prisoners entered detox, though they were 'not all done to the standard we would want', said Mr Wheatley. Detox was an expensive business, he said, but a partnership with the Department of Health was giving drug users access to nurses. Only 2,500 had completed treatment programmes, out of the 75,000 prison population – 'so we've some way to go before we get proper coverage.'

There was also much to be done in making detox bearable, he said. The despair of being without drugs had driven prisoners to suicide: 'Can we help people to live, as well as stop them drug taking?, he asked.

A further crucial challenge was to get those who had managed to get clean inside prison, to enter life outside without starting again. Families could play a crucial role here, and be the main source of support – unless they were on drugs themselves, and part of the problem.

Treatment services had a duty to take a holistic approach to ex-prisoners, said Mr Wheatley. 'We need to make sure they have somewhere to live, a way of making money and some variety,' he suggested. 'They need a lifestyle that meets some of their needs.'

Nurses likely to take on controlled drug prescribing

Nurses could soon be given the go-ahead to prescribe controlled drugs, such as methadone, according to an NTA briefing, published this week.

Changes to NHS prescribing regulations are expected by May 2005, if they receive parliamentary approval. This could enable an estimated 2,150 nurses working in the drug and alcohol treatment sector to train as nurse prescibers, with the authority to initiate, continue and adjust doses, within the parameters of a plan agreed with a fully trained nurse prescriber.

The proposals would enable nurses and pharmacists to manage prescribing for people on maintenance programmes, in partnership with doctors, allowing doctors to concentrate on more complex prescribing cases.

NTA clinical nurse, Shan Barcroft, hoped enough nurses would take up the opportunity to train as nurse prescribers, to make the scheme work. The initiative had 'huge potential for the treatment sector in terms of helping to improve access and quality for clients,' she said.

Nurse prescribing training involves a taught component of 26 days, with a further 12 days of supervised practice.

For more information, visit the clinical guidance section of the NTA website, www.nta.nhs.uk

How to obtain 'Using Women' report:

Further to the news item on DrugScope's campaign to tackle numbers of women drug users sent to prison (DDN, 7 March), the correct link for the form to order copies of the report is the DrugScope website at www.drugscope.org.uk or contact Natasha Vromen on 020 7922 8609 / natashav@drugscope.org.uk Apologies to anyone following the incorrect link published in our last issue.

London project shows 'treatment-resistant' homeless addicts can benefit from methadone

A new study has shown that populations seen as 'hard to reach' may simply be being approached in the wrong way. Endell Street hostel's story, told in the latest issue of *Drug and Alcohol Findings* indicates that a systematic, client-centred focus on improving access radically improved the penetration of treatment services without sacrificing clinical safety.

Before the team from Camden and Islington Substance Misuse Services set up their clinic, just ten of the 93 homeless residents at the Endell Street hostel were in treatment with local NHS services. Over the six months it was piloted, the new methadone clinic quickly filled its 30 slots and for most of the time ran at maximum capacity. All but two of 33 clients were still in treatment eight weeks later; and at 16 weeks, all but three of 22. The transformation of 'treatment-resistant' homeless drug users into enthusiastic patients wasn't magic – the key step was simply to ask them what stood in the way.

A preliminary survey of the residents identified seven main barriers to treatment which the team then set out to circumvent. The most common impediments were a general sense of chaos (forgetting, not realising the time or the day) or competing priorities (having to beg or score). To overcome these the clinic was set up as a drop-in service. Clients could pick up their scripts any time the clinic was open and pop in even when their prescriptions weren't due. It was also important that the clinic was sited at the hostel and that the team enlisted the support of a nearby pharmacy.

With access as its theme, *Drug and Alcohol Findings* also includes Can we help?, the second part of the *Manners Matter* series. It explores the neglected parts of service delivery – how to help people get there. Research shows that without practical help the people most in need of treatment will never receive it. On the same theme, *Wet day centres in Britain* offers research-based guidelines on establishing centres for people unable to use services which ban drinking. 'Getting these right is not easy but they reach people with multiple and severe needs who would otherwise be unreachable,' says the journal's editor, Mike Ashton.

To order a copy of issue 12 of Drug and Alcohol Findings, to subscribe or for a sample copy and downloads including the Endell Street article visit www.drugandalcoholfindings.org.uk

This house believes that we need **more coercive testing** and treatment services

PAUL HAYES, chief executive of the National Treatment Agency, proposes the motion

Despite the title of this debate, no-one is actually forced into treatment for being a drug misuser.

Convicted offenders whose offending is related to their drug misuse may be given a sentence which includes treatment (*ie* a DTTO). If they do not cooperate, they will usually receive the same sanction that a non-drug user charged with a similar offence would have received. Rather than being coercive, this is a way of increasing routes into treatment and maximising the use of community rather than prison sentences.

Under the drugs intervention programme (DIP), offenders charged with trigger offences (*eg* shoplifting and burglary) are tested and offered treatment if appropriate. Again, there is no coercion – it's an opportunity to tackle their drug problem – probably earlier than they would otherwise. Furthermore, as young men and people from Black and ethnic minority backgrounds are over-represented in the criminal justice system, this offers hard-to-reach populations a route into treatment. No-one is given treatment unless they need it and the treatment offered via DIP/DTTO is at least as high quality as that offered elsewhere. It yields public health and individual health gain as well as reducing crime.

So if this debate isn't really about coercion, what is it about? It's about the discomfort felt amongst some traditionalists about criminal justice involvement in drug treatment, *per se*. But let's face the reality of the situation – drug misusers are an unpopular client group, unlikely to attract additional funding in their own right. Taxpayers are interested in the harms related to drug misuse – including crime. This gets politicians and money moving, and more money enables drug services to treat more clients – be they offenders or not.

> 'The impact on treatment services is that drug users coerced into treatment are less likely to access or sustain contact. For coerced clients their, often first, contact with drug services can often be 'an expensive precursor to imprisonment', rather than an alternative to imprisonment.'

Resources for drug treatment have grown following concern about the spread of blood borne viruses in the 1980s and drug related crime today. Of the £700m that will be spent on treatment in 2007/08, £500m is attributable to the Prime Minister's determination that drug treatment should be accessible to all drug misusing offenders.

This unprecedented investment is bringing massive benefits to the whole treatment system. 54 per cent more people are in treatment than in 1997, waiting times are a quarter of what they were in 2001, and there's been a 48 per cent growth in the treatment workforce, and these improvements are better and faster in DIP areas.

This would not have happened without increased government funding. The increase would not have been made available other than to reduce crime. To deny that is unwise, naïve, dishonest and potentially unfair to all drug misusers who can benefit from the continuing expansion in treatment.

PAUL WELLS, a director of UKHRA, opposes the motion

Before we look at expanding or extending coercion in drug treatment; we need to examine the effectiveness of the current arrangements. The current system was introduced on the basis that 'Treatment Works' and there is good evidence to support this statement for drug treatment, but is this the same as saying coerced treatment works?

There is now a significant investment for the criminal justice elements of the overall treatment allocation. Criminal justice funding now accounts for 35 per cent of the overall spending on drug treatment, yet only delivered 17 per cent of people accessing drug treatment – 83 per cent accessed treatment through non-criminal justice routes in 2003-04.

Seventy per cent of those seen by arrest referral fail to enter treatment and currently the overall DTTO completion rate is 34 per cent, though in some areas only 11 per cent finish the order. In the pilot DTTO study, 80 per cent were reconvicted within two years. At a cost of between £5,258 – £7,592 for each order (according to the National Audit Office) this seems an expensive means to deliver an unsatisfactory outcome.

NTA research shows that 'those referred from the criminal justice system were 2.7 times more likely to drop out early than those referred via other routes'. Only 34 per cent of clients referred from the criminal justice system were still in treatment six months later compared to 56 per cent of those coming from other referral sources.

The impact on treatment services is that drug users coerced into treatment are less likely to access or sustain contact. For coerced clients their, often first, contact with drug services can often be 'an expensive precursor to imprisonment', rather than an alternative to imprisonment. It is also not conducive to establishing a healthy therapeutic relationship that is fundamental to effective treatment. The things that generally make life better for people, work in the treatment context – an individualised response employing empathy, understanding, respect and responsiveness. Standardised highly prescriptive responses do not allow for this flexibility.

Models of Care is designed to standardise elements of care – and thus improve treatment efficiency, effectiveness and value for money. Coerced treatment, defined by centrally prescribed requirements – national standards *etc* – is another example of this standardisation. The systems that seem to deliver efficiency, through standardisation, have resulted in a high failure rate and an inability to reach a known positive outcome – retaining people in treatment.

Motivation is the most important factor in retaining people in treatment and retention in treatment is the only consistent predictor of a successful outcome. Rather than relying on further coercive means to get drug users into treatment, we should be putting the available resources into expanding the 'treatment bubble', and be looking at motivators for encouraging access and retention.

Both drugs and crime are likely to be more greatly affected by wider social policies (*eg* employment, housing, education, welfare) and the efforts of drug services are better concentrated on providing treatment that not only includes drug therapies but also

develops clients' social capital.

However, onerous or restrictive treatment requirements can interfere with clients drawing on the social resources available to them. Frequent and regular compulsory attendance at treatment services has been associated with higher drop rates from treatment. Enforcement of coercion through the early use of penalties undermines the programme because starting the programme is not a solution – finishing it is.

Person centred care planning is limited. Procedures that precipitate transgressions of probation national standards at an early stage into breach proceedings, are unlikely to lead positive outcomes. They are more likely to deliver the penalty of a prison sentence and are not the best way to change behaviour.

FROM THE FLOOR

This debate was aired at the National Drug Treatment Conference, last month. Here are a selection of delegates' views.

'Drugs and crime have become inextricably linked – we've demonised users. We have already gone too far. It's getting difficult to support users proactively.'
Daren Garratt, The Alliance

'Criminal justice is just one way into treatment that improves treatment all round.'
Gary Seaton, criminal justice project co-ordinator

'If this is something the US government supports, we should approach with great caution.'
Robert Newman, professor from the US

'Criminal justice has just one option – of locking you up. He who pays the piper calls the tune – this is not the way to have a discussion about treatment.'
Conrad Spencer, manager of a DIP service

'People have to commit a crime to get into the treatment service.'
Doctor from Sussex

'The objectives aren't smart.'
Ex-probation officer

Delegates voted to defeat the motion by a substantial majority.

'It is important that applicants are able to demonstrate that they have recovered from any substance misuse problems. Whether this is the 'two-year rule' or for a shorter period has to be judged on a case by case basis.'

Cover Story: 'The Two Year Rule', DDN, 7 March 2005

Can I congratulate you on last issue's stimulating Cover Story: two-year rule. It is critically important that these areas are debated widely.

In relation to the model of good practice and the Healthy Options Team's [HOT] employment policy quoted in your article, it should be noted that the HOT team is a part of our Trust's East London Specialist Addiction Service. The Trust's policy was incorrectly quoted in the article and therefore I would like to state the correct position:

- All staff are expected to be drug-free when employed;
- The Trust does not accept that staff may use illicit drugs whilst under employment;
- Relevant life experience is taken into account; however applicants would still need to demonstrate that they meet the criteria as specified within the job description and person specification.

The participation and involvement of current and former substance misuse service users within the planning, delivery and evaluation of services is critical and without this input we cannot develop culturally sensitive and responsive services.

Service users who have recovered from substance misuse problems and wish to become employed by health and social care agencies are also, in my view, to be welcomed, since their personal understanding of substance misuse issues provides a unique perspective. However, it is essential that any applicant is able to cope with the challenges and responsibilities that any job brings with it, and because of this it is important that applicants are able to demonstrate that they have recovered from any substance misuse problems. Whether this is the 'two-year rule' or for a shorter period has to be judged on a case-by-case basis.

The Trust does however have policies in place to support staff if they are experiencing difficulties and individuals' problems are addressed on a case by case basis in a confidential and understanding manner, in line with NHS guidance and good practice.

John Wilkins, Director of CAMHS, Specialist Services and Modernisation, East London and The City Mental Health NHS Trust

Let's drop this two-year rule nonsense and move on

An average stay at Phoenix in the 1970s, including re-entry was about 12 months, and there was always an expectation that a proportion of 'graduates' would eventually work in Phoenix House, on staff. In order to prevent that assumed Phoenix dependence, the two-year rule was established. 'Phoenix Graduates' who wanted to return and work as staff were expected to either find paid or voluntary work in the community or attend college, whilst maintaining a cursory level of contact with Phoenix for at least another 12 months. This created a two-year period, drug-free before working in the 'community'.

The reasons behind this were based on pragmatism not evidence. However, an urban myth soon developed around the two-year rule and a SCODA policy was adopted in 1997. (There had been an informal adopting of the same policy at a SCODA conference in 1979-ish).

There was no sound reason for adopting the two-year rule outside of Phoenix House, at that time. Nevertheless, they did.

I would suggest that if we have so little faith in the treatment services ability to assist people to change, then we need to question our ability to commission and provide them.

I know there will be those out there in DANOSland who feel that less than 12 months is 'too close' and we need to ensure that former users are not put 'unduly at risk'. This smacks of being a wee bit 'nanny state-ish'. Call me a buff old traditionalist, but I think we need to accept that people can apply for posts on there own merit. If they fit the essential criteria, interview them; if they are appointable, do it. I'm sure that we are not permitted to discriminate on the grounds of someone suffering from a chronic relapsing condition if they demonstrated that they are the best person for the post. I think we might even be on dodgy legal grounds if we start asking people to declare their past drug use, as a way of filtering out particular candidates. Nor should anyone be expected to declare it voluntarily on an application form. I know I didn't.

Let's drop this two-year rule nonsense. It's an anachronism that has no place in this world. Phoenix House has changed, drug treatment has grown up, and former drug users know what they want and it isn't patronising. Let's move on.

Andy Fox, Drug & Alcohol Action Team Manager, Calderdale MBC

Do coke and methadone create heroin effect?

In the article 'Best environment for long-term support is primary care' (DDN, 7 March, p5) there is a statement that 'poly drug use seemed increasingly commonplace, such as adding coke to methadone to create the effects of heroin'.

Neither I nor some of my colleagues had heard of this mix before, and wonder why adding a stimulant to an opiate should mimic the effects of another opiate. One suggestion was that the coke produces the heroin 'rush' that is not present with methadone. Could you please confirm this, or explain the reason if this is not the case?

Ian MacDonald, Cheltenham Parent Support Group, www.cpsg.org.uk

The article was a news report on Dr Chris Ford's speech to the National Drug Treatment Conference. Dr Ford responds:

'Poly drug use is more common, probably mainly because of availability of drugs. Methadone by itself is fairly non-euphoric, particularly oral methadone, and there may be some evidence that some people take additional drugs to supplement the effects. Commonly used are alcohol and benzos, both depressants, and cocaine, a stimulant – which may have more logic: the coke 'peps up' the methadone, giving it a more euphoric effect, similar to poor heroin but not the same.

If you look at Swiss trials prescribing heroin, cocaine use went down. Looking at the National Treatment Outcome Research (NTORS), crack use with people on methadone went up.

Learning from the experts

In the last issue of DDN, Allan Johnstone, the NTA's new user and carer programme manager, emphasised the importance of listening to the views of service users. The research being conducted by Professor David Clark's team on the experiences and views of service users, involving a number of treatment programmes, is informing practice. He describes the findings from one of their early studies with clients on an abstinence-based, structured day care (community rehabilitation) programme in the Burton Addiction Centre (BAC).

The participants in our study had many unsuccessful attempts to change their substance use before joining the structured day care programme. During our interviews, they reported that various treatment experiences in the BAC produced a range of positive effects in terms of their drug and/or alcohol use, physical health, confidence levels, isolation, and coping methods, as well as an altering of the person in terms of their lifestyle, perspective, identity, and awareness of their substance use problem.

Various positive factors were reported to be essential or beneficial for successful treatment. One of the clearest positive factors was that of common experience, both in terms of being around other addicts in treatment and the fact that many of the counsellors had some kind of personal experience with addiction. Common experience was reported to be beneficial in providing a more empathic and understanding environment, where clients (and counsellors) could positively relate to each other and provide more useful support and advice as they could all draw from their own experiences. Common experience was also important since participants were less able to 'blag' treatment or conceal what was going on, as well as serving to reduce isolation.

Many participants described the benefits of being surrounded by people at different stages of their addiction, with new and relapsing addicts serving as a reminder of the negatives effects of using, and successful recovering addicts (*eg* people in aftercare) providing hope and serving as potential role models or goals to which one could aspire.

Another crucial component of treatment was having a welcoming, friendly and safe environment. Considering that one of the difficulties of treatment highlighted in our study was that participants often felt nervous, scared, lost and unsure of what to expect at the start of treatment, the presence of a welcoming and supportive environment is especially important in helping to ease some of the apprehension experienced.

Education also emerged as a crucial component of treatment, both in terms of the various aspects of addiction, and regarding the availability of treatment services. Some participants felt that earlier education may have been beneficial in engaging them or others earlier in the development of their substance use problem.

Participants also described how treatment provided them with the benefits of talking about problems and getting feedback and advice in both one-to-one counselling sessions and group therapy. Much of the emphasis was placed on the positives of group therapy. The group environment seemed to provide a situation in which participants could get intimately involved, through the two-way process of feedback. Participants strongly advocated the process of both receiving and giving advice and opinions. Often this setting seemed to enhance confidence and self-esteem, as well as reduce feelings of isolation, *eg* through bonding with peers. Participants highlighted the value of being able to talk to others about the stresses and strains involved in trying to recover from their substance use problems.

Many participants reported having previously received substitute prescribing without any other form of help. They emphasised the need for some kind of therapy (one-to-one or group) alongside substitute prescriptions, along with education, advice on how to deal with the addiction in the long-term, and to manage potential cravings.

A further factor reported to be influential in producing positive effects was the adoption of an holistic approach, whereby the 'whole package' of the person was addressed in treatment, and not simply the substance use problem. The range of targets included behaviours, coping methods, physical and psychological/emotional problems, practical problems, social and relationship difficulties, and self-awareness.

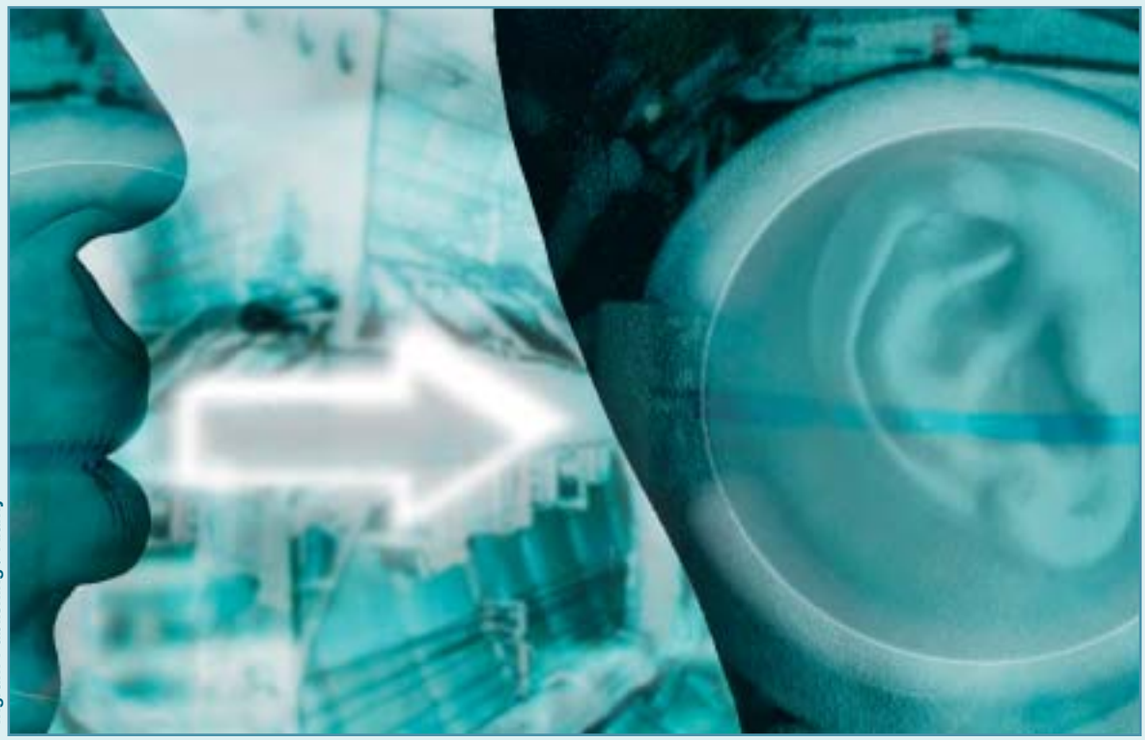
The use of alternative therapies in treatment, such as acupuncture or relaxation, or alternative activities such as exercise or fun days out was also supported. Participants reported that such therapies and activities were beneficial in numerous ways, such as increasing self-awareness, distracting the participant from their substance misuse problem, and providing valued time away from therapy to prevent overload.

An additional component that was considered integral to successful treatment, was good support networks. Practical support, in particular, was beneficial to some participants, which is perhaps unsurprising considering the amount of practical consequences that occurred for participants as a result of their substance use problem (*eg* housing, child care).

The particular structure of treatment was also crucial to some participants, who emphasised the benefits of an abstinence-based, structured day care programme over a relatively long period of time. Some participants described the need for specialist treatment rather than general help, *eg* medical assistance to detox, and others referred to the need for both an individualistic and realistic style of treatment, which should be easily accessible when required.

A further element that was considered necessary for successful treatment related to personal factors, such as effort, hard work and commitment. This is fundamental, since without the effort and commitment of the individual, treatment cannot be effective no matter how good it may be.

Participants reported a range of expectations when they started treatment, although one feeling experienced by most was that of being unsure of what to expect. Another less common, but seemingly important



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'Various positive factors were reported to be essential or beneficial for successful treatment. One of the clearest positive factors was that of common experience... and the fact that many of the counsellors had some kind of personal experience with addiction.'

expectation, was some kind of false belief in a 'miracle cure'.

Our analysis revealed a number of potential barriers to accessing treatment, the most common being a lack of services or lack of awareness of existing services. Other common barriers included long waiting lists, which potentially deterred people from accessing treatment, or personal circumstances or feelings (shame, pride, fear), which stood in the way of asking for help.

The interviews also revealed numerous difficulties that participants experienced through their experiences in treatment. The clearest difficulty was the need to accept complete abstinence. Many participants described experiencing continued desire to use some sort of substance, most commonly cannabis, while attempting to give up their substance of choice. Generally, however, participants did concede that the acceptance of complete abstinence was an important requirement for recovery.

Another difficulty experienced in treatment was related to various contradictions participants had with treatment services – for example, when receiving advice about controlled use despite wanting abstinence-based treatment, engaging in a service that would only treat a client's drug problem and not the alcohol problem, or having contradictory feelings with an agency regarding how the detoxification should be managed.

Our participants emphasised the need to change their behaviour for themselves, rather than others. A range of other factors also seemed to be influential in motivating participants in their recovery, including the fear of death from resuming their use, the potential guilt or shame associated with a relapse, as well as the support of significant others, and the positive effects of their change on others, *eg* family, children.

The interviews also revealed various factors which had helped, or were helping, participants to achieve or sustain their abstinence beyond the main treatment programme. One of the factors considered to be of most value was the continued use of post-treatment aftercare and counselling, and the importance/security of having a safe environment to return to if required. Interviewees valued the ability to drop in to the Centre without prior arrangement, since challenges to their recovery could occur at any time.

Another highly important factor assisting recovery was the learning and use of a range of strategies to combat the numerous factors or reasons for use. These strategies were either learned through treatment, or over time by experience, and included strategies such as reducing high availability of drugs and alcohol by avoiding users; changing social circles from users to non-users to reduce temptation, and using distraction to avoid boredom, which may trigger use.

Interviews revealed that a particularly important strategy was the acceptance and expectancy of cravings and other problems associated with addiction. This preparation helped participants to avoid panicking when they experienced them, and they could arm themselves with effective ways to cope with them.

Finally, our study found that many participants experienced, or were experiencing, numerous changes in their recovery. In the same way that using seemed to produce changes in the user as a person, the process of recovery seemed to begin to restore these changes, altering the person, in terms of their lifestyle, identity and perspective. Many participants referred to the actual rebuilding of a new kind of person and lifestyle, whilst others (presumably at earlier stages in recovery) expressed the desire to rebuild their lifestyle. These desires or actual changes generally involved a happier life without various substances, and with a college/work place, a new house, and/or new or improving relationships with others.

This research was conducted by Gemma Salter, with the assistance of Sarah Davies.

The research involved semi-structured interviews – covering initial use of substances through to current situation in treatment or aftercare – with 15 clients of the Burton Addiction Centre. Interviews were analysed using a qualitative analysis known as Grounded Theory. Seven major themes emerged from the analysis: the nature of addiction and its development; the reasons/factors for use; the negative effects of use; the process of realisation; behaviour change; treatment; and recovery. The results were integrated to form a model, which aims to provide a picture of the processes involved in developing a substance use problem, the processes involved in behaviour change, the role of treatment, as well as the potential path to recovery. Of course, these findings reflect the experiences and views of a population of clients undergoing one specific treatment programme. We are working in various other treatment settings, in order to enhance our understanding of the role of treatment processes in facilitating behavioural change and recovery.

A more detailed report on the research, and more information about the Burton Addiction Centre can be found on www.wiredinitiative.com in the Research and Agency Profile sections, respectively.

Welcome to the team...

Consulting and involving service users in the activities of drug and alcohol services is now a statutory expectation under the NHS and Social Act 2001 – but is it possible to do it meaningfully? Jaye Foster, Karen Tyrell, Vanessa Cropper and Neil Hunt look at two services that took the challenge, and uncover a number of benefits that justify the effort.

The NTA requires agencies to become more accountable to service users and carers through a variety of mechanisms such as involvement in planning services, satisfaction surveys and complaints processes. However, there appears to be no guidance concerning service user involvement in the recruitment of the staff that work in drug services. For example, the NTA document, *Staff development toolkit for drug and alcohol residential services*, describes standard practice relating to the recruitment of staff, but does not address service user involvement in the process.

Anecdotally, service users may have been involved in the recruitment of staff within a variety of drug services for some time. However, there is little discussion of the way this is managed, the benefits it produces and the challenges that occur, in a way that helps define and share good practice.

Looking at staff recruitment within two different-sized organisations gave a useful insight to how user involvement can work. The smaller of the two, the Healthy Options Team (HOT), is part of East London and City Mental Health NHS Trust and employs around 12 staff to provide low threshold, harm reduction services such as needle exchange. The other organisation, KCA, is a non-statutory service employing about 200 staff across Kent, Medway and parts of South London, to provide a range of interventions including needle exchange, day programmes, counselling and community prescribing.

Service user involvement has been a core value within HOT's development and practice since its inception in the early 1990s. Towards the end of the 1990s the service began involving service users within staff recruitment. Initially this happened sporadically, as it was not always possible to find people who were willing or confident to fulfil this role. Gradually a process for preparing people evolved to include only people who could commit to at least half a day's preparation and training. Training addressed the following aspects of the interview process:

- Confidentiality and equal opportunities.
- Understanding the job description and person specification.
- Developing role play scenarios to assess candidates.
- Generating interview questions in accordance with service users' priorities (as opposed to those of paid staff).
- How to introduce themselves to candidates at interview. Early experience showed that service users could sometimes be quite perplexed about how to present themselves within what was an altogether different role to the one they are more familiar with – as recipients of services.
- Asking interview questions and probing for information.
- The use of internal scoring forms for rating applicants.

Even with the benefit of the training and preparation, it was evident that service users sometimes felt nervous and inhibited within the interview role. Nevertheless, they asked questions that may not have been considered so readily by professionals and were able to contribute a service user's perspective within the final evaluation of candidates. In particular, they paid close attention to applicants' ability to develop good rapport – a core skill within low threshold services. Having a service user on the panels allowed some direct evaluation of how

Benefits to the participating service users

The acquisition of new skills

Participation gave service users an improved insight into the way job applicants are short-listed, what happens in the interview process and the way that potential employees are assessed and evaluated. This has direct relevance to the needs of those people who will later be applying for education or employment places.

Raising self esteem and self efficacy

The process offered opportunities for service users to draw upon their life experiences and use largely unacknowledged knowledge and skills. In cases where people had consistent involvement, their confidence and role security seemed to grow perceptibly.

Increased service 'ownership'

Participants appeared to feel valued and to appreciate an opportunity to have a genuine influence on a key element of the delivery of services.
The process seemed to have symbolic importance to all concerned. Through their discussions with other current and prospective service users, this seems likely to have a wider impact on the way that services are perceived by the people for whom they are provided.

Benefits to the service

Communicating a service user orientation to staff and service users

The introduction of these practices gave a practical and tangible way to involve service users that meaningfully reinforced organisational commitments to user involvement, that are made within more abstract mission and value statements. It helped create an additional environment where the service user voice can contribute in a valid way.

Recruiting the right people

The process enabled services to draw on the rich stock of knowledge and experience within drug users' lives. Involving service users appeared to improve the quality of decision-making and was especially helpful for evaluating crucial competencies around interacting with service users. We noted that applicants with strong academic qualifications were not always the ones who could best relate to service users.

Complementing the service's 'social reintegration' goals

Social reintegration is a broad aim of drug services. Involvement in staff recruitment provided an immediate and authentic setting, in which it was possible to help equip service users with relevant skills. The 'real life' nature of the role sometimes seemed to offer some advantages over simulated, skills-development activities and can complement these.

applicants interacted. Besides direct involvement within the interview process, in three cases applicants were asked to spend time in a drop-in setting with a group of service users who assessed their engagement skills and gave structured feedback to the interview panel. This group activity seemed to have some advantages, as it largely circumvented some of the anxieties felt by service users within the more formal interview setting.

During 2003, drawing on the experience and protocols of HOT, service users from KCA's day programme were asked if they would be interested to participate in staff recruitment. Three agreed and the local service manager then arranged an information-sharing session followed by similar training to that offered by HOT, which led to the gradual introduction of service user involvement within staff recruitment.

Service users were included in the process of shortlisting candidates, where possible. The application forms were anonymised to service users and staff alike, as part of KCA's equal opportunities policy. Service users took part in the formal interview process and were sometimes involved in role-plays that particularly assessed applicants' interactional skills. They were then involved in the decision-making process after the interviews.

Where necessary, on the day of the interviews, service users were assisted with special arrangements for picking up their methadone and the times of interviews were scheduled to facilitate this. Whenever possible, interviews were held at the service centre they attended to facilitate their involvement. For each recruitment episode, participants were paid £15, plus all travel expenses.

Before the interviews, candidates were informed that service users would be on the interview panel. One candidate commented that they found this reassuring because of the message it conveyed and said that, in the event, they did not know who was a service user.

Before drawing conclusions about the benefits of this process, it is important to note that we are largely describing our impressions and observations of a process in which we have ourselves been involved, with the limitations and potential biases that this implies. In future, it would clearly be desirable for more independent research to investigate the benefits (and any drawbacks) of this practice in order to identify ways in which it might be improved.

The most important thing we learned, is that including the users of drug services within staff recruitment is possible. The fact that drug users are a highly stigmatised and often disenfranchised population need not be an impediment to meaningful involvement in staff recruitment within agencies that have a genuine commitment to making this happen. Besides this fundamental point, we think that a number of overlapping benefits to service users and services can be identified, which are shown below.

Our contrasting experiences, between a relatively small service and a larger organisation, are informative about the way that best practice might need to vary according to setting. Despite prior training and rehearsal, people who were only involved once in the formal interviewing process, did not develop the same degree of confidence and role-security that we observed in the setting where people could be involved in a series of interviews. There are probably no hard and fast rules, but small organisations, or those with low staff turnover, may not generate enough opportunities for people to consolidate preparation and training and properly benefit from the process. In these circumstances, considered and planned use of group discussions with service users during recruitment may be a better way for them to be involved.

Implementing this process was not always easy. Considerable effort was required on the part of both services and service users to develop and undertake this work to what were judged to be safe and proper standards. Although it has seemed worthwhile, it is also clear to us that, if done improperly, there are risks to both service users and drug services. For this reason, organisations that cannot commit the time and resources to doing this carefully may do better not to try it at all.

Nevertheless, our experience suggests that involving the users of drug services in staff recruitment is both possible and worthwhile. Despite this, it seems important to recognise that even where there is a clear desire to do so, this may not always be possible. Within KCA, an organisational target has now been set to involve service users in 50 per cent of appointments. Given the statutory requirement to involve service users within drug services and the corresponding vagueness about how best this should be achieved, it may be that area could be considered as a possible performance indicator for services that should be adopted more widely.

'Social reintegration is a broad aim of drug services. Involvement in staff recruitment provided an immediate and authentic setting in which it was possible to help equip service users with relevant skills. The 'real life' nature of the role sometimes seemed to offer some advantages over simulated, skills-development activities and can complement these.'

Jaye Foster is at the Healthy Options Team, East London and The City Mental Health NHS Trust; Karen Tyrell and Vanessa Cropper are at KCA; and Neil Hunt is Director of Research for KCA and an Honorary Research Fellow, Centre for Research on Drugs and Health Behaviour, at Imperial College, London.

The authors are grateful to the service users from HOT and KCA who have contributed to our staff recruitment practice and the learning on which this paper is based. As is often the case, concerns about privacy and confidentiality mean that service users do not receive the proper credit that they are due.

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What we learned from user involvement in recruitment

- **Involving the users of drug services in staff recruitment is feasible and appears to offer a number of potential benefits for service users and treatment agencies.**
- **A considerable investment of time and effort is required initially. However, direct costs are low.**
- **Practical factors, such as an urgent need to recruit staff rapidly and keep services operating, may make it difficult to involve service users on all occasions.**
- **Methods for involving service users need to be tailored to local circumstances and the size of the organisation.**
- **Involving service users in staff recruitment can complement the wider development of user involvement activities.**
- **The involvement of service users may be a practical and meaningful performance indicators for user involvement in drug services.**

Plenty of BOTTLE

Four months into her new role, Srabani Sen is getting her feet under the table as chief executive of Alcohol Concern. *DDN* found her quite at home with the idea of upping the ante on alcohol issues.

'Two things really attracted me to the job at Alcohol Concern,' says Srabani Sen, the agency's chief executive since last November. 'I could see that the organisation was very high profile, very energetic, a good place to be.

'But also, importantly, I felt that alcohol issues were ready to fly. There were the beginnings of a recognition of the impact of alcohol and what alcohol was about. It just looked like an area that was ripe for success.'

At her office in Southwark, London, Sen exudes enthusiasm. She is constantly prioritising her 'to do' list as she talks, and is ambitious for the next phase of Alcohol Concern. But alongside her optimism, she keeps reminding herself that she has much to learn.

The first four months in post have been very much a listening phase, she says, 'finding out what people think about real issues and trying to get a sense of what the key priorities are'. Over the last six weeks, she has been visiting centres, 'getting to really understand the issues on the ground'. She has been struck by the commitment of those working in the field: 'It's clearly an area where there are people willing to make a difference,' she says. 'To be surrounded by that degree of passion is just fantastic.'

Sen's immediate background was as head of communications, then acting director of nations, regions and campaigning at Diabetes UK, where she worked for five years. Before that, she was public affairs manager at the Chartered Institute of Housing, where she set up from scratch the charity's public affairs function. Working with these organisations has given her a useful reference point for engaging professionals across different sectors.

Coming from another sector herself, has also given her objectivity in her new job. 'When you come to an organisation for the first time, you end up asking the "why" question quite a lot – "why do we do things the way we do?". I think this can be quite valuable, because one of the jobs of a national agency like Alcohol Concern is to step back, look at the big picture, and ask "what's the vision? What should we be aiming for?"'

While it's a 'fantastic time to join' Alcohol Concern, Sen has settled in enough to be concerned that the government's agenda on alcohol is driven by crime and disorder.

'There seems to be a sense that if alcohol hurts other people, such as a 20-year-old getting involved in a fight on a Saturday night, then that matters. But if alcohol affects the individual, it doesn't matter so much.'

Putting the health aspects back on the map became an early priority, and a chance to improve the public's understanding of the impact of binge drinking.

'There isn't really an understanding of how binge drinking impacts on a massive range of people's lives,' says Sen, who is optimistic that Alcohol Concern is uniquely placed to make a difference. It is, she says, the only alcohol policy organisation that embraces all the agendas on which alcohol impacts.

'We tend to say either you're a young binge drinker – or you're a chronic drinker – a homeless person drinking white lightning. But there's a complete section of people, the hidden drinkers, who go home and drink a bottle of wine a night, and think that's OK...'

'We need to start shifting the balance of where people's attention is. It's not just about government departments – we also need to reach out to bodies responsible for areas of social policy, and demonstrate to them that tackling alcohol is actually to the benefit of their stakeholders as well.'

Sen is obviously well experienced in communicating with policy-makers, and can make her point eloquently. But how will she make sure that Alcohol Concern's messages reach those who need them – the one in three men, and one in five women who drink too much?

The focus should be on putting out simple messages, because they haven't got through yet, she says. 'You need to have somebody voicing these very simple messages, articulating them, powerfully and regularly. You don't just say something once and it enters consciousness. You say something again and again, until finally people wake up. It's about the long game.'

It takes a lot of courage to be that simple, to say things in a simple way, she reflects. 'Because in a way, it's easier to be complicated, you can hide behind complexity of messages. You can't hide behind a simple message. It is what it is. It says what it says.'

The simple message is that alcohol is a drug which has the potential to kill people, says Sen. The second part of the message is not about saying that nobody should drink, ever again, she adds. 'It's about people having the knowledge to make an informed choice about their drinking.'

A crucial element to getting heard, and the only way to begin to communicate to someone how alcohol affects them, she says, is to identify who it is you're trying to get the message to, and what it is that gets their engine running.

Not taking time to consider this step is an easy trap to fall into, she explains. 'You can sit there and say "levels of liver cirrhosis have grown over the last 20 years, alcohol can cause cancer and heart disease and high blood pressure, and blah blah blah… but an 18-year-old down the pub with their mates doesn't care that 20 years down the line, they might end up with liver cirrhosis. You need to understand that an 18-year-old lad is going to be far more concerned about brewer's droop.'

Similarly, the debate about whether you talk about units, and how much a unit equals, can become 'almost a subsidiary issue'. The only way to motivate people to do anything, is to think about their own drinking, and their own patterns of behaviour. It's back to Sen's simple, very clear messages.

While simple messages are Sen's chosen weapon of combat, she is keen to point out that she is fully aware of the might of the enemy. The alcohol industry not only has money to create messages in every facet of modern culture; it also has 'very very sophisticated marketing people, who understand how to position and market drink, to make it sell the most'.

Tens of billions of pounds are pumped into maintaining the level of interest in alcohol, and into making sure that health warnings are kept 'lame and watery, and without substance', she says. 'And that's something I think we do need to challenge – something that Alcohol Concern is in a position to challenge.'

Alcohol appears on the television screen every six or seven minutes, she points out. The message has become part of life's backdrop: drinking is normal, it's an everyday part of life, it has no negative consequences. From the subtle visual references (alcohol in the backdrop of a tv drama) to the crass (Friday night tv's 'slightly sozzled celebrity' slot on the 'hideous programme, Friday Night Project, where they feed a micro celebrity huge amounts of alcohol and get them to describe something that the studio audience have to guess'), the prevailing culture is of drink equalling a good time.

Put like that, it seems an uphill struggle for a physically small organisation like Alcohol Concern to put out the message that actually, alcohol can be damaging to you, and you need to drink safely. But Sen insists that she is excited about the challenge of making their voice heard, and can see 'the beginnings of an understanding of the impact of drinking'. The government's concentration on crime and disorder is 'an opportunity to wedge our way into the debate,' she insists. 'And once we're wedged in, it's about pushing open that gap and bringing through the other side of the picture.'

Confident as she is, she doesn't pretend to have all the answers. But she is willing to think outside traditional stereotypes and speaks out against the tendency to compartmentalise.

'We tend to say either you're a young binge drinker – or you're a chronic drinker, a homeless person drinking white lightning. But there's a complete section of people, the hidden drinkers, who go home and drink a bottle of wine a night, and think that's OK. Having that simple message about the impact of drinking is really important.'

Early intervention is a key motivation, and Sen sees it as crucial for Alcohol Concern to engage with professionals in different sectors, 'so we can spot the people who are potentially having problems with their drinking, but not recognising that'. This might be their GP, a nurse in the surgery, somebody who sees them as they walk in the door of A&E, their social housing provider who spots problems in keeping up rent payments, or their social worker dealing with an issue with their family. 'It's about gearing up all these people to recognise that there's a problem in the first place, and to know what to do with it.'

Sen is equally keen to gear up government – to support drug action teams to incorporate alcohol and become DAATs, and to light the policy fuse following the 'painfully slow' alcohol strategy.

'Where we've made progress, it's not been as powerful as we would have wanted it to be,' she says. 'Some targets have been met, but we're sitting behind on other things. In that sense, the game's only just begun; we've got to actually find ways of using the Public Health White Paper and strategy on drinking responsibly. We're really only at the start of the process of getting alcohol to matter.'

Sen describes Alcohol Concern as the national voice for alcohol, and obviously has no intention of letting it pipe down. 'We're about campaigning to keep issues up the agenda,' she says. 'We're a noise-maker. That's our job.'

Alcohol Concern has recently publicised two web-based initiatives to get the safe drinking message across. The *'How's Your Drink'* site at **www.howsyourdrink.org.uk** gives a short, interactive test, to help you decide if you're drinking too much, and offers tips for cutting down. The project shows the positive face of working with the drinks industry: drinks company Diageo gave financial support to Alcohol Concern, to develop the site. Srabani Sen says that 14,000 people did the test in the first week of its launch, in January. If you seem to have a more serious drink problem, you're directed to *'Down Your Drink'* at **www.downyourdrink.org.uk** for a six-week online programme to become a 'thinker drinker' and develop safer drinking habits.

Diary of a heroin addict

No-one sets out to be a fully fledged heroin addict. David Wright's nightmare all started as a bit of fun. This is the first part of his story.

'I remember the day like it was yesterday. In fact it was the summer of 1983, a hot August day. Normally we would shoot up speed in the kitchen but this was different, heavy shit, and Mickey had not long been busted so we went upstairs. The powder was split into three equal piles and we got Mickey to hit us up as we we're shaking with excitement.'

It all started for me with Evo Stick and ever since then I've been fixed. The year was 1979, the tail end of punk, but glue sniffing was high on the menu. I was fascinated by this substance that could transport me to another dimension; no other drug has come close to the interactive hallucinations.

Like so many people at this stage of their drug career I was searching for the meaning of life. Drugs were the way to that, so I thought. But as it slowly dawned on me, not only good doors of the mind get opened, you have to pay back everything positive thrice over. And the pan piper of paranoia came for me.

I remember as if it was yesterday. Three of us had taken around 80 mushrooms each and two hours into the trip everything was as I had previously experienced. But this was intense; rainbows of every colour surrounded me, I was blissed out. We were sat on top of a railway bridge of a long disused railway line. I looked down at my jeans and they had scorch marks on them, as if they had been on fire. Still that was OK, until I looked at the floor where we were sat and there was a pentagram and some other occult instruments. At that very moment an icy hand grabbed my throat and began to squeeze. My friends looked at me as I started to choke. The hands loosened and I managed to tell my friends to get me out of this place.

It was a good job I was with real friends, I hate to think if I was with... Anyway, they dragged me back the way we had come through a deeply wooded area, but the friendly trees were now clawing hands of demons. They got me into a taxi and headed for a guy who was ten years older than us and had a lot of experience with drugs. They got me in his kitchen, he felt my pulse and then poured me a glass of scrumpy cider from a big barrel. He told me to drink it down in one, which I did. He poured me another and I downed it in one. The third I drank half way down and I began to feel the familiar sedating affects of alcohol. Five pints later I was laughing my head off, but it was the start of the slide.

It was around this time I found the needle. It gave taking drugs a whole new perspective. Instant gratification. I had been coerced into going to a Northern Soul all-nighter and they needed to fill the minibus, a fiver a seat. In the all-nighter I was given a wrap of speed and a 2ml barrel and told I needed to get a spike off someone. I joined the long queue for the gents but no-one wanted a piss. As I got near the cubicles someone shouted from behind the one nearest me, 'has anyone got a barrel?' so I piped up that I had and I needed a spike. The door opened and I was summoned in. He took the barrel off me and prepared his fix.

I had never seen anyone inject before, I remember the track marks all down his arm. I thought I wouldn't get like that I'm just doing it once, and I believed it. When it came to my turn I was shaking so much he sussed it was my first time. So he got my hit together and gave me my first fix, and I'm 99 per cent sure Hep C. In those days there were no exchanges, and needles were hard to come by. Well, clean ones.

There is a magic spell to find your lucky word. It involves saying a few words whilst turning a dictionary round and round (so you don't know which way up it is). Open a page with eyes closed and touch your finger on part of the page that feels right. My lucky word was HOOKED!

The paranoia became part of my life. I had no confidence, no self-esteem, I did not know who I was, what I was supposed to be. The speed made things worse. I had stopped enjoying it. I could not relax in company. So when my partner in crime showed up with a wrap of smack, I jumped at the chance. We went to Mickey's – remember the guy who helped me when I was having a bad trip.

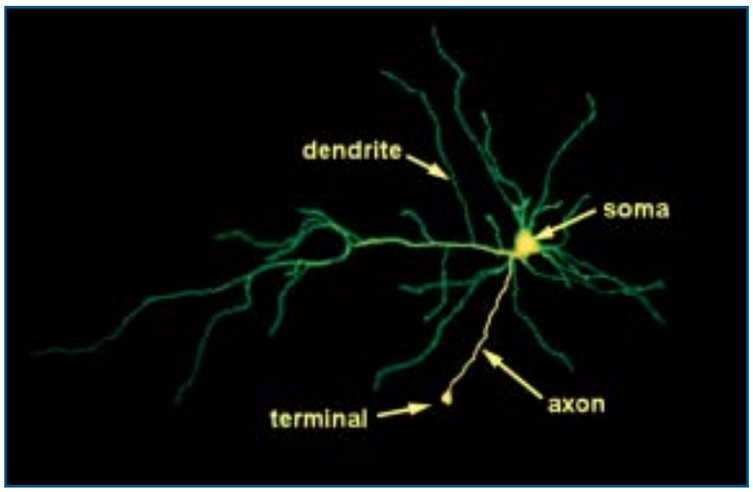
I remember the day like it was yesterday. In fact it was the summer of 1983, a hot August day. Normally we would shoot up speed in the kitchen but this was different, heavy shit, and Mickey had not long been busted so we went upstairs. The powder was split into three equal piles and we got Mickey to hit us up as we we're shaking with excitement.

At last my turn, he found the vein straight away and pushed the plunger. As the chemical comfort blanket enveloped my brain I knew I was a heroin addict. It was lovely, for the first time I did not give a shit what people thought of me. It was just what the doctor ordered.

Part 2 in the next issue of DDN

Drugs, chemicals, the brain and behaviour

Professor David Clark looks at how drugs of misuse influence chemical and electrical events in the brain, and how these changes may relate to their effects on behaviour.



Neuronal structure

Psychoactive drugs produce alterations in mood, thinking, perception and behaviour by altering chemical messenger systems in the brain. The most widely discussed of these chemicals – or neurotransmitters as they are called – is dopamine, but others involved include serotonin, GABA (gamma-aminobutyric acid) and glutamate.

The brain comprises billions of nerve cells (or neurons) which communicate with each other using electrical and chemical signals.

A neuron comprises a cell body (soma), dendrites and an axon. The dendrites and soma receive chemical information from neighbouring neurons. This chemical information is converted to electrical currents that travel along and converge on the soma. A major electrical impulse (the action potential) is then produced and this travels down the axon to the end of the neuron, the presynaptic terminal.

The presynaptic terminal is separated from another neuron by a small gap, known as the synapse. In general, the action potential cannot jump across the synapse – communication between the two neurons is by chemical neurotransmitters such as dopamine. The dopamine is stored in vesicles in the presynaptic terminal – these vesicles protect the dopamine being broken down by 'scavenger' molecules that exist within the free space of the presynaptic terminal.

When an action potential reaches the terminal, the vesicles move towards the presynaptic membrane, fuse with it, and release their contents (dopamine molecules) into the synapse. Once in the synaptic cleft, dopamine molecules can bind to specific recognition sites or proteins (known as dopamine receptors) on the postsynaptic membrane of neighbouring neurons.

This interaction can be thought of in terms of a keyhole and lock. The dopamine molecules enter the keyhole (receptor) and turn the lock. In biological terms, this means a dopamine molecule binding to a receptor activates or inhibits enzymes, or increases or decreases the flow of ions. Whatever the mechanism, the net result is an increase or decrease in the generation of electrical impulses (action potentials) in the neuron being impinged upon.

Once the dopamine molecule has activated the receptor, it is broken down (or deactivated) in one of several ways. The most common mechanism involves dopamine molecules being taken back up into the presynaptic terminal by an uptake pump (also a protein). Once in the presynaptic terminal, dopamine molecules are destroyed unless they have been taken back into a storage vesicle.

Drugs can be synthesised that bind to dopamine receptors and mimic the actions of the neurotransmitter – these drugs are known as agonists. On the other hand, there are drugs that bind to dopamine receptors but have no intrinsic activity of their own. However, by virtue of the fact that they bind to the receptor, they can prevent the neurotransmitter exerting its functional effects. These drugs are known as antagonists.

Our understanding of the relationship between the brain neurochemical events and behaviour has been enhanced by research undertaken in laboratory animals, in particular the rat.

This research has shown that drugs of misuse such as amphetamine, cocaine and heroin alter chemical and electrical events in neurons containing dopamine as a neurotransmitter, and this is the major mechanism by which they alter behaviour.

Amphetamine increases the release of dopamine in sets of neurons (or a neuronal pathway) that involve(s) dopamine as a neurotransmitter. There is an increase in dopamine receptor activation – and an increase in certain behaviours.

Cocaine binds to dopamine uptake pumps and prevents them from removing dopamine from the synapse. This leads to an increase in synaptic levels of dopamine, and an increase in dopamine receptor activation. Heroin and morphine activate opiate receptors in certain areas of the brain, where they increase electrical signals in dopamine-containing neurons and enhance the activation of dopamine receptors by dopamine.

The fact that laboratory animals such as the rat will self administer drugs such as amphetamine, cocaine and heroin has allowed us to greatly enhance our understanding of the mechanisms underlying their rewarding effects and their abuse by humans.

There is one particular neuronal pathway that has been shown to be associated with the rewarding effects of drugs of misuse – a pathway projecting from an area of the midbrain containing dopamine cell bodies called the ventral tegmental area, to a structure in the forebrain known as the nucleus accumbens.

Interestingly, this mesoaccumbens dopamine pathway has also been shown to be associated with natural consummatory behaviours, such as eating, drinking and sexual behaviour. Research has also led to suggestions that drugs of misuse not only act upon brain pathways involved in natural consummatory behaviours, but they actually hijack these pathways. They operate in a way that ultimately involves a person choosing drugs as a means of satisfaction, rather than behaviours that satisfy more natural human needs.

The mesoaccumbens dopamine pathway is thought to be involved in the rewarding effects of all drugs of misuse. However, since the brain is organised in circuits, a drug exerting direct effects primarily on one neurotransmitter system in a specific brain region will indirectly influence the activity of other neurotransmitter systems in other parts of the brain. Drugs of misuse cause a cascade of events in the brain that underlie their psychological effects. Of course, trying to understand the way that pharmacological effects at a cellular level are translated into psychological experiences is extremely complex and fraught with difficulties.

And we must also remember, as described in a previous Background Briefing, the drug's ultimate effects are not just dependent on their pharmacological actions in the brain. There is also the influence of set and setting.

You can read more about the neurobiology of addiction at www.nida.nih.gov/pubs/Teaching.

FAMILY CONSTELLATIONS
The Hellinger Approach

WORKSHOPS 2005
HELD IN LONDON, HERTS & BRISTOL

Work through your Family of Origin Codependency & Relationship Issues in an innovative effective workshop

BRIEF SOLUTION FOCUSED THERAPY
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Further details, dates, information & enquiries
Ask to go on Mailing List

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Counselling Skills Course validated by COSCA

(Counselling & Psychotherapy in Scotland)

This course which comprises four modules is aimed at workers in the helping professions who wish to become more effective and competent in their interactions with their clients and service users.

Module 1 – 7th, 8th, 14th, 15th, 21st and 22nd April 2005
Edinburgh – Cost £255 per module

Mairi Nye, Cert. in Social Work, Advanced Diploma in Counselling validated by COSCA (Counselling & Psychotherapy in Scotland) & Napier University, COSCA Accredited Trainer (with many years experience in the drug and alcohol field)

Phone: 01968 661389
Email: mairi.nye@btinternet.com

drugsandalcohol today

Society Guardian

Date: 6 April 2005
Venue: Business Design Centre, Islington, London

The only event to bring together all those working within the drugs and alcohol sector under one roof.

The Drugs and Alcohol Today exhibition will include 50 key exhibitors, over 1,500 drugs and alcohol professionals, a full day's seminar programme as well as a Training Zone, a Drugs Zone and a Relaxation Zone.

Advanced booking exhibition tickets –
Only £18 (inclusive of VAT) £15 for FDAP members
Group discount:
Buy 5 tickets for only £60 (save £30)
Tickets on the day: £20 per ticket

Supported by DDN

If you would like to attend this event
visit: www.drugsandalcoholtodayexhibition.co.uk
or call our customer service team on: 0870 161 3505
If you are interested in exhibiting at this event contact Graham Hoare on 0870 161 3505 ext 222 or **email:** grahamh@pavpub.com

Call Pavilion's customer services team today to secure your ticket: 0870 161 3505

Sponsored by

The Training Exchange

Drug & Alcohol Training Programme 2005

Half day courses (£65 + VAT)	
Crack Awareness	10th May
Benzodiazepines Awareness	7th June
1 day courses (£95 + VAT)	
Introduction to Drugs Work	20th April
Alcohol & Poly Drug Use – *What you need to know*	27th April
Bins & Needles – *Safer Injecting & Harm Reduction*	16th May
Crack Awareness & Users Needs	25th May
Personality Disorders	8th June
Hepatitis B & C – *Routes and Pathways*	15th June
Drugs & Housing	16th June
Working with Diversity	24th June
2 day courses (£180 + VAT)	
Motivational Interviewing	11th & 12th May
Brief Solution Focussed Therapy	19th & 20th May
Relapse Prevention	26th & 27th May
Dual Diagnosis	20th & 21st June

All the courses in this programme are mapped to DANOS.

All courses take place in Bristol.

For further details and full course outlines contact
The Training Exchange,
Easton Business Centre,
Bristol BS5 0HE
Tel/Fax: 0117 941 5859
email: admin@trainingexchange.org.uk
www. trainingexchange.org.uk

The Training Exchange is an independent training and consultancy service. We focus on issues that affect health, young people and communities.

Westminster Drug Project

WDP is committed to connecting with service users at all stages of the drug treatment system.

We have a track record of:

- Maximising staff autonomy
- Caring for staff and service users
- Promoting a learning environment through training and career development
- Valuing partnerships

DRUGS REFERRAL WORKERS
£23,088 – £26,386

We are looking for people who are able to proactively sell the service within that system, engage drug users and refer them into the treatment they need. You will be part of an experienced team that has built up excellent referral pathways across London.
The successful applicants will be able to work some unsociable hours and have the commitment to build a lasting relationship with the Metropolitan Police Service, Courts and Treatment Providers. In return you will be part of developing a treatment system that responds effectively to the needs of service users.

WESTMINSTER OPEN ACCESS WORKER
£20,505 – £25,075

WDP delivers a successful model for providing an inclusive open access service that engages hard to reach service users.
You will have experience of providing one-to-one interventions and have the skills to deliver a harm minimisation approach to service users and other professionals.

WESTMINSTER PRISON LINKS WORKERS
£23,088 – £26,386

WDP has been commissioned to work with Westminster's Through-Care and Aftercare Team to provide a prison link service.
You will be able to work in a multi-agency environment, creating pre-release care plans and then linking people up with appropriate services upon their release into the community.

YOUNG PEOPLE SUBSTANCE MISUSE WORKER £23,088 – £29,822

WDP delivers a successful model for engaging service users that are in the criminal justice system. This service works in close partnership with the YOT, Connexions and other young people support networks in Newham. You will have the skills and personality to engage and support young people within the community.

Working at WDP you will be part of a diverse, inspiring and highly skilled team. To maintain and enrich this diversity we warmly welcome applications from all ethnic communities.

For full details and application form please ring 24 hour answerphone on 0207 421 3131 or write to: Westminster Drug Project, 103 Kingsway, London, WC2B 6QX.

The closing date for completed applications is: Tuesday, 29th of March 2005

For more info on WDP visit our website www.wdp-drugs.co.uk

Farm Place, Oxley Surrey - a dedicated addiction treatment unit
Coach House, a secondary care unit - stepping stone between primary treatment and a return to the Community
The Priory Hospital Woking, a hospital with a busy Addiction Treatment Programme

PRIORY

Counsellors x 2 Full Time

We are looking for skilled Counsellors to work full time at Coach House and Farm Place. We are also looking for **Bank workers across all 3 sites.**
Applicants need experience in a substance misuse setting, a good working knowledge of 12 step addiction work, FDAP accreditation or similar.
Please call Sue Rossetti on 01483 489211 or email suerossetti@prioryhealthcare.com
The successful candidate will be required to apply for a Disclosure at the Enhanced Level from the Criminal Records Bureau. Further information can be obtained from www.disclosure.gov.uk

www.priorygroup.com

PROVIDENCE PROJECTS

Helping you find the way

The Providence Projects

Based in Bournemouth The Providence Projects are providers of Quasi-Residential Treatment and supported Sober Living Houses offering detoxification and a full time 7 day week therapeutic treatment programme.

Due to expansion we are currently looking to recruit

- an experienced full time counsellor
- a part time counsellor and
- a trainee counsellor

The ideal candidates will be looking for a challenging and rewarding career in the field working with the chemically dependent in a 12 Step abstinent based setting.

Salary will be based upon experience and qualifications.

For information please telephone Carole Spiegel on 01202 555000 or email info@providenceproject.org

The Providence Projects are an equal opportunities employer

Substance Abuse Subtle Screening Inventory

The psychometric test which identifies substance misuse problems even in clients who are unable or unwilling to acknowledge the existence or symptoms of a problem

adult and adolescent versions

identifies – analyses – engages – motivates

NEW TRAINING DATES AVAILABLE NOW

www.sassidirect.co.uk

SASSI Direct Ltd
Telephone 0115 964 8200
Email sassi@sassidirect.co.uk

www.DANOS.info

This course has been mapped to the DANOS standards and can be found on the DANOS Learning Resources Database. It helps people develop their knowledge, skills and competence in the following DANOS units: AA2, AC1, AF, AG, AI1, AI2, AJ, BA, BB1, BC, BE, BG1, BG3. BG4, BI2, BI4, CA, CB,

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DDN
Drink and Drugs News

RFEE REFE EFER FEER REEF FERE EEFR EERF EREF

How many ways do we have to spell it out?

It's FREE

DDN is a **FREE** circulation magazine for everyone working in substance misuse and related fields. Email your postal address to **subs@cjwellings.com** or call **020 7463 2081** to be added to the circulation.

Equinox

HOPKINSON HOUSE is a 36 bed space high care hostel for street homeless people with alcohol problems and complex needs. Situated in London SW1 the team of twenty three staff work in partnership with statutory and voluntary organisations to provide a flexible range of housing, care and resettlement services. After recently completing its Supporting People Review and gaining a Grade B we wish to appoint a:

Service Manager (Salary £33,579 - £35,934 pa inc.) who will manage the project, provide vision and strategic direction, contribute to policy and service development, liase with purchasers and the local community and effectively establish the project within the network of statutory and voluntary bodies in Central London.

Key Skills

- Minimum of three years staff management experience including team building skills
- Minimum of three years work experience providing services for people with alcohol problems and complex needs
- Experience of working in residential hostels.
- Understanding of harm reduction techniques
- The ability to meet the requirements of Commissioners and other partner agencies
- Experience of managing a budget alongside knowledge of Supporting People and the requirements under the QAF
- Excellent communication, networking and problem solving skills
- Commitment to Equal Opportunities

REF SM/HH

Closing date: 12 noon 8th April 2005

We offer a pension scheme, flexible employment policies, a commitment to staff development and a supportive working environment.

Information and application forms are available from the recruitment line on 020 7939 9813. Or you can email your request to recruitment@equinoxcare.org.uk or look at our website www.equinoxcare.org.uk CV's will not be accepted.

Please quote relevant reference

Putting Enfield First

COMMUNITY HOUSING AND SOCIAL SERVICES

ENFIELD DRUG ACTION TEAM

Drug Interventions Programme

The Drug Interventions Programme is an innovative and exciting multi-agency project aimed at improving the lives of all Enfield's communities by reducing drug related crime. From April 2005 Enfield will be included within the third phase of the national Drug Interventions Programme.

Drug Interventions Programme Manager

£33,777 - £36,123

You will lead a multi-disciplinary team designing and delivering interventions that increase access to treatment, enhance treatment quality and reduce the rate of unplanned exit from treatment of substance misusers within the criminal justice system. You will have significant experience of working effectively with substance misusers and offenders, a track record of working to targets within a performance management culture and a clear understanding of assessment, care planning and referral processes.

- **Ref: SSG/166/DDN.**

Data Officer

£21,267 - £22,584

As Data Officer you will be responsible for managing information sharing and data collection in and between Criminal Justice and Drug Treatment agencies in Enfield. The new information will improve the service delivered to clients and help inform future commissioning of drug services. You will have experience of data collection and database systems and be able to work to tight deadlines and prioritise your workload accordingly.

- **Ref: SSG/165/DDN.**

These posts are offered on a fixed term contract until 31st March 2006 with the prospect of extension depending on future funding.

- **Closing date for returned applications: 5pm, Friday 1st April 2005.**
- ***For information about the benefits of working for Enfield and to download an application pack, please visit our website at www.enfield.gov.uk quoting the relevant reference number. Please note our preferred method of communication is electronically, therefore wherever possible we encourage the submission of application by email. Alternatively you can telephone our recruitment line on 020 8379 4709 to request an application pack by post. A textphone (minicom) is provided for those with a hearing or speech impairment on 020 8379 4419.***

An equal opportunity employer

ENFIELD Council

Service Development Manager

ARP
ALCOHOL RECOVERY PROJECT

SCP 46 – 51: £37,491 – £44,361 (Incl. ILW)

Are you an experienced and highly skilled manager able to take lead responsibility for ensuring that all our services represent best practice in the substance misuse field?

If so, you could be a leading light in our drive for high standards, value for money and quality.

Criteria for this post include:

- Excellent understanding of quality systems including the QAF and QUADS
- Experience of policy development and implementation at a senior level
- Ability to develop, manage and monitor projects with clear targets and milestones.

Closing date: 1 April 2005.

For an application pack, please contact ARP on 020 7940 0603 or write to the HR Department at 68 Newington Causeway, London, SE1 6DF.

Email: recruitment@arp-uk.org

ARP is one of the largest alcohol service providers in the country. We are particularly known for our shopfront services, specialist services for women, our work in the community and ground breaking client involvement arrangements. Our housing and tenancy support services are primarily funded through Supported People.

ARP is an Equal Opportunities Employer and all applicants must show an understanding of equality and diversity and a commitment to anti-discriminatory practices.

Association of London Government

This organisation is funded by London Borough Grants