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Drink and Drugs News

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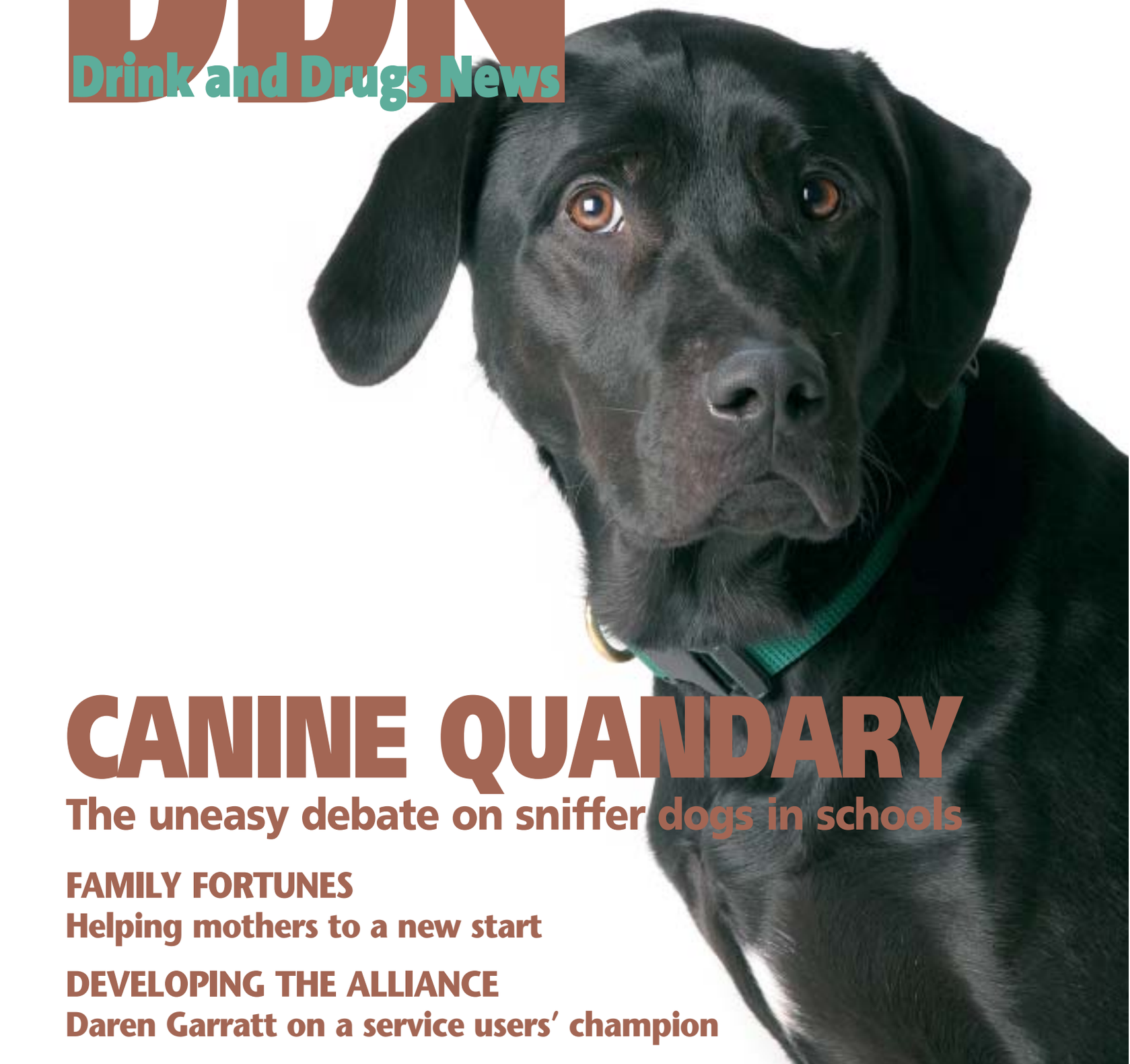

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The uneasy debate on sniffer dogs in schools

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The 21st Century approach to tackling substance misuse

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Drink and Drugs News

2 May 2005

Editor's letter

There's been no shortage of opinion on the rights and wrongs of drug testing in schools, and the concept of 'sniffer dogs' brings with it its own set of issues.

Visiting Buckinghamshire for a report on their pilot scheme (page 8), I was not at all comfortable about the thought of children being lined up and investigated by dogs that had been trained to detect drugs on them. But the pilot exercise had been very carefully planned and constructed, with opinions canvassed every step of the way with parents and pupils. Head teachers reported that the schoolchildren enjoyed having the dogs visit school – but for some of the grammar schools in leafy Buckinghamshire I suppose it's a bit of a welcome diversion.

Participants at the DrugScope debate, the week after, brought the uncomfortable aspects of the idea right back into relief. There's an issue of trust here, of dignity, and respect for cultural sensitivities. There was a sense that we've failed with drugs education, if things have to come to this – and strong concern that the fear of detection in school would only drive the problem further into recreation time. Jenny McWhirter from the Drug Education Forum seems to offer fair comment, when she says that the Buckinghamshire schools did what was right for them – but that it would be a mistake to generalise from this exercise that it would work for all schools.

Interestingly, the Buckinghamshire head teachers were dead set against going the Faversham route, of random drug testing in the classroom, citing 'strong human rights issues' as the reason for their objections.

It's a tricky one this. But whatever the rights and wrongs of drug detection in schools, there seems far too much at stake to be experimenting.

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In this issue

Families are often forgotten casualties of drug misuse

The devastating impact of drug problems on families has been overlooked by drug treatment and prevention services, according to a new report for the Joseph Rowntree Foundation.

Resources have been concentrated on problem users, while ignoring the impact the situation can have on other family members – including younger brothers and sisters, who can go on to develop drug problems themselves, says author Marina Barnard.

Interviews with heroin and crack cocaine users revealed the extent to which families can be affected by stress from family rows; neglect of other family members as the drug user absorbs the parent's attention; the effects of stealing to fund the habit; and the strain on relationships from obsessive, self-centred behaviour.

The research highlighted the extent to which parents were thrown into shock and disarray by the discovery that their child had developed a problem with drugs. Typical reactions were confusion, panic and shame that often deterred them from seeking help from outside agencies.

The effect on siblings varied, according to Marina Barnard, a research fellow at the University of Glasgow's Centre for Drug Misuse Research: 'Some younger brothers and sisters in this study saw their siblings as sad, angry people who were being destroyed by their drug habit, but others had either become curious enough to experiment with drugs themselves or had been deliberately encouraged to try them.

'Some younger brothers and sisters in this study saw their siblings as sad, angry people who were being destroyed by their drug habit, but others had either become curious enough to experiment with drugs themselves or had been deliberately encouraged to try them.'

The study underlined the difficulties in trying to help families, as they tended to focus on the drug-affected child rather than themselves, she said. Early intervention and mentoring programmes were a possible way forward, and policy-makers needed to 'respond to the challenge with compassion and imagination', giving 'careful thought to the ways in which better family support can most effectively mesh with existing treatment ands prevention services.'

Peer educators bring alcohol messages to the classroom

Peer education projects are being developed to bring home messages to secondary school children about the dangers of alcohol.

Voluntary sector organisation, Tacade, have been involved in projects with more than 30 secondary schools to challenge the culture of binge drinking. Models for rolling out the project more widely were developed through in-depth work with four schools in England and Wales.

The project developed in response to Tacade's findings that while there were education projects about drug education and sexual health, few projects focused on alcohol education. Sixty per cent of 11 to 15-year-olds drink alcohol, according to Tacade, with 39 per cent of young men and 33 per cent of young women considering themselves regular drinkers.

A partnership between Local Education Authority advisory teachers, pupils, school teachers, learning mentors, Connexions advisors and school nurses have been crucial to the success of project, Tacade reports.

A peer educator from one of the schools commented on the two-way benefits of mentoring: 'I'm less inclined to get drink now – I think it is less normal now I know all the stuff behind it.'

Parenting project offers support to treatment services

A Parenting and Alcohol Project has been launched by Alcohol Concern, with a grant from the Parenting and Research Fund. The project will offer training and expertise to professionals working with alcohol and parenting, with the aim of strengthening capacity of treatment services.

An overview of the project is at www.alcoholconcern.org.uk/doc/922

Alcohol Focus Scotland tackles binge-drinking trends

Creating a culture where 'moderate, responsible drinking is the norm, and drunkenness has become socially unacceptable' is among the aims of the Alcohol Focus Scotland strategy.

The charity's manifesto offers a six-point vision statement that tackles alcohol fuelled disorder, family break-ups, treatment and support, responsible retailing, and health.

The policy statement is in response to spiralling trends: a 100 per cent increase in drinking by 13-year-olds in the last decade; 100 alcohol-related hospitalisations every day in Scotland, alcoholic liver disease up by 41 per cent since 1997. 100,000 children in Scotland were living with a problem-drinking parent and 42,000 people had been to their GP with an alcohol-related problem in 2003.

Proposals for action concentrate on challenging public attitudes to drunkenness – better education, starting at primary school age; curbs on sponsorship; more funding for alcohol counselling services; and a hard-hitting national TV campaign.

Visit www.alcohol-focus-scotland.org.uk for the manifesto.

Call for police officers to be drug tested

A call for all police officers to be drug tested has been made by their union, the Scottish Police Federation.

Detective Sergeant Kenny Simpson, drug squad officer and representative of the Federation's Strathclyde branch, said that a strict policy was needed to deter young recruits in particular from using drugs.

'New recruits, by virtue of age, are more likely to have been exposed to the drug scene. We have to acknowledge this fact and take steps to ensure we provide an effective deterrent.'

The initiative would not be about catching people out, but about maintaining minimum standards, said DS Simpson. He told the Federation's conference that there should be testing for all officers, particularly during the selection process and during their two-year probation.

'There is no scope in the police service for drug-taking officers,' he added.

Plan with partners – but don't get lost in structure

Drugs are an issue for every child, not just those who use or whose families use, Dr Chris Hanvey, Barnado's director of operations, told DrugScope's regional event in London, on young people and drugs. 'They invade real spaces – parks, high streets, lift shafts, pop songs.'

Barnado's dealt with the overlapping agenda of sex exploitation, mental health, and substance misuse, issues which often interrelate, said Dr Hanvey. 'Substance misuse challenges spill out.'

Nearly 90 per cent of the 360 services that the charity worked with dealt with substance misuse in the course of their work.

920,000 children lived in families with alcohol misuse and 16 to 24-year-olds were the heaviest drinkers. 18 per cent of 11 to 15-year-old pupils had tried drugs in the last year, according to Dr Hanvey. The conference was about partnership work and finding some solutions.

Planning is only useful when it's useful planning, he said. 'The real work is done by people on the ground.'

Prompt intervention and support for families was essential and workers needed to feel sufficiently informed and skilled to carry out their roles. It was vital to get the structure of children's services right, said Dr Hanvey, but he cautioned that vital links between children's and adults' services could easily get lost in the development of services. With all the talk of reorganisation there was a danger that 'the needs of children and young people could fall between welfare nets', he warned.

Structural preoccupations and the 'huge emphasis on getting things right' could be to the detriment of services, he said. Effective planning between DATs, children's services and partnerships were an important part of achieving early interventions. 'You need to be in all planning groups from the outset,' he told delegates.

'Drugs are an issue for every child, not just those who use or whose families use'

'Treat the person, not the addiction'

'When it comes to education, we need to go beyond "just say no",' Martin Barnes, DrugScope's chief executive told the charity's London conference.

Education needed to be evidence based and the harm reduction approach was now widely supported. It was essential to be responsive and alert. 'Few can say the war on drugs has been won,' he said.

The drugs debate had stepped up with the election looming. Media headlines were frequently political, such as reactions to drug testing in schools and claiming an explosion in cannabis use.

'Contrast these headlines with the reaction to reports on children's drug use' said Mr Barnes. Statistics had shown a fall in drug use, but this was 'largely ignored by the media'.

Drug use differed in different groups – vulnerable groups, children of drug using parents, those in poverty, bad housing or sex exploitation. But there was a growing acceptance that treatment worked best when you understand the individual, according to Mr Barnes. 'We must treat the person, not the addiction.'

Neither should we be afraid to learn, he told delegates. The recent study from Glasgow University, that showed some heroin users lead a 'normal life' had been treated out of context by the media, who had ignored the main message about the importance of social factors on the effects of drug use.

Investment in effective education and prevention would go a long way towards making sure that children did not become problem drug users, said Mr Barnes:

'If you have interests and goals, drugs needn't become a problem or an escape.'

The NTA had ambitious targets on young people's involvement, but why was it so difficult to get them into treatment? The *Hidden Harm* report was welcome, but why had it taken two years to produce – to then be published without fanfare?, he asked.

Much had been done by the government on drug strategy, but challenges remained.

'The Prime Minister has said that the challenges are immense. These are promising words,' said Mr Barnes. 'But they must be matched by deeds, and support, and funding.'

D-world website launched for young teens

DrugScope launched their new website for younger teenagers at the Young People and Drugs Conference.

D-World is aimed at 11 to 14-year-olds and was developed and tested with teenagers.

Sections on the site include background information and drug facts, advice and ideas, information on drugs law and health and safety advice. Its interactive style and 'weird and wacky' elements are designed to hold the attention of this age group long enough to impart valuable information.

Teenagers taking part in the website trial said it was bright, easy to use, and 'has everything a teenager would want to know about drugs'.

D-world is at www.drugscope.org.uk/dworld

Media watch

A thought-provoking advertising campaign has been launched across Scotland to warn people of the health risks associated with cocaine use.
The *Know The Score* adverts are highlighting the damaging effect of cocaine on the heart, warning users they are 24 times more likely to have a heart attack after using the drug. David McGrouther, head West Lothian's Drug Action Team, said the campaign was a useful tool in trying to stop people taking cocaine.
West Lothian Courier, 18 April

Drug users in Warwickshire are being warned not to use a new and potentially lethal form of heroin called 'red heroin' or 'rosylea'. Detective Chief Inspector Mike Slater of Warwickshire Police warned users of its dangers: 'At first sight it looks normal, but possibly due to the detergent it's mixed with, it turns red when heated.' Two people have died and three others were taken to hospital after using the drug.
Coventry Evening Telegraph, 28 April

'No booze needed for beer goggles': According to a study of undergraduates the mere thought of beer or wine can influence your sex drive. A group of undergraduates was shown words relating to alcohol and then asked to rate photos of women in terms of attractiveness. Those men who had previously stated that alcohol boosted their libidos rated the women more favourably; those who expected alcohol to reduce their performance rated the girls less attractive after the alcohol related images. 'What is most surprising is that mere expectancy can influence perception,' said Markus Denzler, a co-author of the report.
Addiction, May

In an attempt to curb drunken violence and under-age drinking, police in Sunderland want shopkeepers to sign a voluntary agreement refusing to serve alcohol to anyone under 21 on Friday and Saturday nights. The plan has met with a mixed reaction from shopkeepers.
Sunderland Echo, 27 April

'Booze doc says start 'em young': Dr Paul Skett, a senior lecturer in pharmacology at Glasgow University, wants kids to be served in pubs to educate them about the dangers of binge drinking. Dr Skett claims the idea would solve Scotland's binge-drinking culture by normalising alcohol.
Daily Record, 27 April

FDAP Counsellor accreditation

In February FDAP launched its DANOS-based Drug and Alcohol Professional Certification aimed at workers across the field – but they also run a more 'traditional' accreditation scheme specifically for Drug and Alcohol Counsellors. Simon Shepherd, FDAP's chief executive, tells us more.

FDAP's National Counsellor Accreditation Certificate (NCAC) scheme for drug and alcohol counsellors is designed to provide a similar level of professional accreditation to that offered by the British Association for Counselling and Psychotherapy (BACP) – while taking account of the particular specialism of counsellors working in our field.

Our NCAC accreditation is the only accreditation for drug and alcohol counsellors recognised by the (BACP-administered) UK Register of Counsellors. It is also recognised for the purposes of Drug and Alcohol Professional Certification as providing complementary evidence of competence in a number of units from the Drug and Alcohol National Occupational Standards (DANOS).

Unlike generic counsellor accreditation schemes, NCAC recognises that the role of a counsellor in the drug and alcohol field extends beyond counselling *per se* – and includes a range of additional 'core functions' including screening, intake, orientation, assessment, treatment planning, case management, crisis intervention, client education, referral, reports and record keeping, and liaison with other professionals.

Under the standard route to accreditation, applicants must demonstrate: competence in the full range of 'core functions' of drug and alcohol counselling; a clear personal philosophy and approach to counselling; and an on-going commitment to professional development.

In addition, they must have: four years of work experience as a counsellor (at least 2.5 yrs in substance use field); 600 hours of supervised face-to-face individual, couples or group counselling (at least 400 hours in substance use field); a further 300 hours of supervised experience related to other 'core functions' (at least 200 hours in substance use field); and 450 hours of training relevant to the counsellor's role in the drug and alcohol field.

For more information see under 'professional certification' at www.fdap.org.uk

We've come a long way... and there are more good things to come

'The next five years will see an amazing change in treatment ... there's an enormous role for pharmacies.'

Training on treatment for drug users has come a long way in the last ten years, Dr Clare Gerada told the Royal College of Practitioners conference on the management of drug users in primary care.

'I came into general practice knowing nothing about drug treatment,' she said. 'Then in the mid 90s that all changed. All over the country, pockets of GPs were getting their act together.'

The Royal College of General Practitioners administered the Certificate in Substance Misuse in the UK, and had just launched the certificate in Scotland.

Many more GPs were involved in substance misuse in the UK, but there were still a lot of problems, said Dr Gerada. Most GPs were still prescribing sub therapeutic levels, and the Shipman inquiry was likely to further inhibit the freedom to prescribe large doses without scrutiny. 'This will affect us and we need to be aware of it,' she warned.

There were good things on the horizon, however. Nurse and pharmacy prescribing was a real untapped resource, said Dr Gerada. 'The next five years will see an amazing change in treatment... there's an enormous role for pharmacies,' she said.

Specialist GPs, more imaginative use of IT, the rise of expert patient and more community based treatments were all steps in the right direction.

New book gives practical advice on treating substance misuse

The Management of Substance Misuse in Primary Care is a new book written by experts and edited by Dr Clare Gerada. It provides health professionals with practical advice on a range of treatment interventions for opiate, stimulant, tobacco alcohol users, and includes special considerations relating to young people, pregnant users and the homeless.

The book is a 'ground-breaking text from leaders in the field', according to RCGP chairman, Dr Mayur Lakhani.

Available from the Royal College of General Practitioners, price £24.95. Visit www.rcgp.org.uk/acatalog/

A decade of change for drug treatment

The last ten years have seen considerable changes in knowledge, skills and attititudes, according to Dr Stephen Willott, a Nottingham GP.

Innovations such as Subutex – 'another tool in the toolbox' had changed many people's lives. Advice on hepatitis had changed. Computer systems had developed. 'But there's no substitute for experience,' said Dr Willott.

Glenda Daniels, service co-ordinator at Oxford User Team, was grateful for the developments of the last decade – particularly in giving her information to make choices about her maintenance treatment. A programme of methadone maintenance enabled her to get her life back together; being informed about Subutex, by a doctor who took time to explain her options, completely changed her life.

Education on drug effects and a trusting relationship with her GP had enabled her to take control of her treatment and brought her back into mainstream life and employment.

Dr Steve Brinksman had helped to bring about innovative changes to shared care in Birmingham over the past year, through a partnership scheme with GPs and the DAT. Integrating with pharmacists was the next exciting development, he said.

Education and knowledge were the key to the future, added conference chair, Dr Chris Ford. 'Involving users in their own treatment engages them and things will move forward,' she said.

'In April 1996 in preparation for the 1st conference of Management of Drug Users in General Practice, SMMGP began life as a simple word-prcessed newsletter, enthusiastically written and hastily stuffed into 254 envelopes at Brent and Harrow Health Authority,' write Jean-Claude Barjolin and Dr Chris Ford in their latest edition of the *Network* newsletter, celebrating ten years of SMMGP. The organisation has grown from strength to strength in supporting GPs to get to grips with substance misuse management. This year's conference was fully booked with 600 delegates from all areas of primary care and the substance misuse fields. Congratulations SMMGP – and here's to the future!

Changing the family fortunes

Last issue we looked at the painful subject of hidden harm. Here, Angie Brooks talks to DDN about helping mums to break the cycle and restart family life outside the shadow of substance misuse.

When a mum arrives at Trevi's it's very often her last chance to keep hold of her child,' says Angie Brooks, manager of Trevi House. For the last 12 years, the residential rehab has offered a lifeline to mums with a history of drug or alcohol problems, who have come face to face with having their children taken into care.

Back then, Angie and two friends realised there was a gap in services in Plymouth for mums with children, and a need that the local day centre was unable to meet. Taking the initiative to approach Devon and Cornwall Housing Association, they managed to get a property and opened Trevi House – initially with enough space for six people. Three other empty properties followed, and a year later they were registered for 12 women and 16 children. The growth continues: they've just secured another bit of property and can house 13 families. The staff has grown in proportion; 22 staff now keep the home running 24 hours a day.

When a woman first visits Trevi House, she's likely to have been referred by a drug agency or social services. She will arrive for an assessment not really sure what to expect, and be shown around and introduced to staff and residents.

'After their assessment, they go away and have a think about us,' says Angie. 'We take the case to our team, and if Trevi feels that we can meet all the needs of this family, then we'll offer them a place.

Meeting the needs of the family can be a detailed and intensive process. Many of the mothers who arrive have already had a child taken off them for 'failing' to cope with their substance use. Trevi offers a safe environment and a different approach, and the process of building trust begins from day one. Understanding the behaviours that come from the user's lifestyle has informed the programme at Trevi. The children go into the nursery from 9am until 4.30pm, so mums can join their programme, which includes group work and one-to-one sessions with their key workers. 'We also bring in creativity, go to the gym, have acupuncture… we try to incorporate an ordinary way of life for the families. It's important for the children,' says Angie.

Living with other mothers who are in a similar situation does wonders for confidence, she explains. As soon as they arrive to live at Trevi, they will be introduced to a 'responsible resident' – someone who's been here for quite a while – and they'll work closely with them for a couple of weeks. They will be given a key worker – a drugs counsellor, who will work with the family from the start of their rehab to the end. The programme is tailored to the individual; 'what works for one family would not necessarily be right for another,' says Angie. Some women are on scripts; some are pregnant and need help with stabilising. 'They can come in on a methadone script and we work out a reduction programme.' A local doctor manages Trevi's scripts.

Typical rehab at Trevi is six to nine months. Angie explains that they like to get funding confirmed for at least six months as there's a lot to do and plenty of issues to unearth as part of tackling the past to make changes for the future. Their care plan is likely to involve looking at their own childhood and how they became involved with drugs 'and the guilt and the shame around where they've taken their children'.

'And because some of our mums have already lost children to adoption, they have to work with that as well, to make a difference to the child they bring to Trevi.'

The work with the children who come to Trevi, aged up to eight, is no less intense, but very carefully structured to make sure they are supported, reassured and never stigmatised. The local school is wonderful, according to Angie, with a supportive headmistress who treats the children from Trevi no different from any others – 'in fact they get more support, a bit more one to one.' If the mums are having a difficult couple of days, very often the children reflect that, says Angie, so they ring the school and explain they might see a difference in the child that day.

The children also have one-to-ones with their key workers, which often gives an unexpected breakthrough in understanding behaviour. 'We couldn't understand why one little girl was scared of the colour green,' says Angie. 'But it turned out to be because of the methadone her mum took. So we had to do some work around that.'

Preparing the families to leave Trevi is about equipping them to live a stable life back in the community. 'We'll encourage them to take on voluntary work, or they might want to get back into education – they might even want to take on a course.' Trevi helps with finding housing, and even with the decorating, and a resettlement worker helps with a community care grant.

After they have left, the support is there in home visits and the offer of one-to-ones with their key worker for the next six weeks, 'because that's very often when they get 'triggers', and issues come up'. The phones are manned 24 hours for support, and Angie facilitates an aftercare group that meets once a week.

Since opening, Trevi has supported more than 600 women and 700 children – giving the next generation a set of options they didn't know they had.

Many of the mothers who arrive have already had a child taken off them for 'failing' to cope with their substance use.

Testing times

Any issue involving young people is likely to provoke strong opinion – and drug testing in schools is no exception. DDN visited a sniffer dog pilot scheme in Buckinghamshire and a DrugScope debate in London, and found we're a long way from consensus on whether it's acceptable.

Before a posse of journalists and cameramen, a panel of head teachers, police, and the Local Education Authority presented a united front on the 'overwhelming success' of a Buckinghamshire pilot scheme that introduced 'sniffer dogs' in schools. A jaunty spaniel cheerfully sniffed out some cannabis hidden behind a pipe, and a black Labrador identified the drug carrier planted in a demonstration line-up, sitting down in front of her to indicate that she was in possession of drugs. A line of smiling schoolchildren was presented to the press conference as happy to be interviewed about how the scheme was working in their schools, as long as we talked to them in the presence of an adult.

The morning's presentation was a model of working in partnership, and the culmination of several years' organisation and research. The concept had been introduced to staff, pupils and parents; their permission sought, and a protocol built with all the parties involved.

Back in 2001, PC Paul Sorensen, a police schools liaison officer in Buckinghamshire suggested a programme of action to local schools, in response to their concerns about drugs on school premises. The resulting pilot scheme was launched by six local schools, in partnership with the county's Local Education Authority, Thames Valley Police, Grosvenor International Services (GIS) – a private company that provided dogs and handlers, and the charity Addaction, which advised on appropriate support for any pupil found with drugs.

The schools in and around High Wycombe have a range of pupils of different abilities. They're not exactly akin to inner London comprehensives, but their Ofsted reports show evidence of some behavioural difficulties, and 41 per cent of pupils said they knew other children were taking drugs. A survey by the National Centre for Social Research in 2000 reported that by the age of 15, 61 per cent of schoolchildren have been offered drugs. According to the head of one of the schools taking part in the pilot, 'we wanted to concentrate on prevention, making the school a safe place, and also to put in place a very robust policy for dealing with incidents'.

Consultation and planning for the pilot exercise took two years, according to Professor Allyson MacVean, co-author of the report commissioned by the partnership to evaluate the pilot scheme. 'The project management actually took a huge amount of time, because dealing with such issues you need proper support and instruction,' she said.

The tone of the exercise also had to be made very clear, Prof MacVean explained. 'It wasn't about criminalising young people. It was actually about children who were at risk, or potentially at risk.'

The involvement with Addaction was very important, she said, as everyone was aware of the sensitivities. 'Finding drugs wouldn't necessarily mean the child had been involved with drugs. It's about support.' Police officers confirmed that the main aim was to look at harm reduction, and a teacher emphasised that sniffer dogs were 'just a small part of primary education that started at primary level.'

Presenting the findings of the pilot, head teachers, police and the LEA lined up to give their unanimous support for the exercise. They confirmed that the pilot scheme 'has proven a hit with pupils, parents and teachers across Buckinghamshire' and discounted early concerns from parents and pupils as natural fears that were, for most people, easily sorted out in the early stages of the pilot.

'Parents were reassured and 97 per cent of them thought the project should continue', according to Prof MacVean. The report on the pilot also states that '92 per cent of staff thought it was a good idea to have drug dogs in schools', and reports that '82 per cent of pupils stated it was an excellent idea as a method of prevention and detection'.

Some of the pupils interviewed for the report were less convinced, with comments such as: 'my civil rights are being eroded', '[I'm] disappointed at the school that they obviously do not trust pupils', 'I felt some of the processes were immoral and unethical'. The report comments that this may be down to the experience being new, and suggests 'concerns may be allayed with future visits or with future discussions'.

The panel presented to the press conference was convinced that bringing dogs into schools represented a fair preventative measure to keep drugs out of school. When asked if they would consider following the example of the Faversham school in Kent, and introduce random drug testing in schools, the response was 'no'. The Buckinghamshire head teachers were extremely suspicious of random drug testing, considering that it was 'not helpful' and said that there were 'strong human rights issues'.

'The line we took was a fair one', said one head teacher. 'We have the interests of parents and pupils at heart. Our approach echoes the government's *Every Child Matters* report – and it's strengthened our relationship with parents. Random testing would damage this.'

> There is a risk that any strategy that sets teachers against pupils in an adversarial way can undermine good education,' said the Forum's Chair, Jenny McWhirter. 'There may have been specific factors in these schools which led police and others to adopt this approach, but it is a mistake to generalise from this to all schools.'

The same week, The Drug Education Forum issued a direct warning against making the use of sniffer dogs in schools more widespread, in response to the Buckinghamshire initiative.

'There is a risk that any strategy that sets teachers against pupils in an adversarial way can undermine good education,' said the Forum's Chair, Jenny McWhirter. 'There may have been specific

factors in these schools which led police and others to adopt this approach, but it is a mistake to generalise from this to all schools.'

She went on to comment that the perceived success of the scheme would not necessarily change children's behaviour out of school – and could actually be damaging to teacher-pupil relationships, 'establishing a climate of mistrust for drug education, where openness and trust are vital building blocks for sensitive developmental work'.

In her role as head of education and prevention at DrugScope, Jenny McWhirter chaired a debate on the issue at last week's DrugScope conference on young people and drugs. Participants came from drug action teams, local education authorities, councils, police, charities, rehab centres, government departments, prison, probation and youth offending services, schools and social services.

From the beginning of the debate there was a great deal of caution: 'We want to get to kids before they are excluded. But I'm not sure drugs dogs are the way to do this.'

Some were worried or angry about the ethics of getting pupils to line up and be sniffed by dogs: 'Young people think "why would they do that to me?" It's highly abusive. I wouldn't allow my son to go through that assault on his dignity.'

The issue of 'false positives' was a concern for many: 'Passive drugs dogs in the prison service deal with many false positives. The experience of being indicated by a dog is quite full on. Young people are not equipped to deal with it. How do they prove their innocence?' (And possibly the best quote: 'False positives happen all the time. Dogs are only human!')

There was frustration at having to resort to using dogs, and a feeling that drugs education was failing: 'We don't need dogs to tell us young people are using drugs… It's absolutely crazy. Schools are for educating, not for carrying out police work. Schools are afraid to tackle the drugs problem – it wouldn't happen if they had a proper drugs education programme.'

One participant, from a London LEA, said that his workplace had resisted the idea of using dogs, but when they had talked to police about different ways of working, 'it hadn't matched their targets'. He was among those who were concerned that once a programme had taken shape, it was no longer up for negotiation: 'When you put a sensible position forward, they don't want to know. Is this so-called partnership working?'

There was also strong resistance to bringing in 'costly private companies' to administer the schemes, charging £500 for half a day's work bringing dogs into the school. Could this money not be better ploughed into drugs education?, was the question.

If the methodology came under fire in the debate, the verdict on the effectiveness of using sniffer dogs fared little better. A drugs worker from Kent shared findings of a study that indicated that children would turn to other substances, such as solvents, to avoid detection. 'You may take away some problems, but you find yourself with a whole new set', she commented.

There were also important cultural issues, that weren't really addressed by just giving parents the opportunity to opt their children out of the scheme: 'Muslims will cross the road to avoid dogs. The saliva of a dog is seen to be unclean.' While these sensitivities are acknowledged in the Buckinghamshire report, it provokes the question of what could happen in a more representative community.

The future direction favoured in the debate, was the need to put resources into better education and prevention, and to get parents involved. 'Many parents don't realise what a difference they can make – how effective they can be in educating their children about drugs and alcohol,' said a schools liaison officer from Kent. 'Parents can find it difficult to come into schools – there's the barrier of school gates. Schools need to work at how they can get their parent population into schools.'

For schools that were going down the drug detection and testing route, there was agreement that clear protocols were essential, setting out what should and shouldn't happen. While the Buckinghamshire pilot appeared to have been carried out with the utmost care and determination not to make anyone feel accused, there was real concern that everyday reality outside a pilot scheme could be very, very different.

Drugs: Guidance for Schools, the DfES document on good practice published in February 2004, is at www.teachernet.gov.uk/wholeschool/behaviour/drugs

Developing the Alliance

For many service users, the Alliance has not only provided a lifeline to better treatment, it has given them skills, knowledge and the inspiration to get back into mainstream life and employment. Daren Garratt, the Alliance's development manager, tells DDN why the work of this small but dynamic organisation is more vital than ever.

When I first became aware of Bill Nelles and the then Methadone Alliance at their inaugural conference at the Purcell Rooms in the late 90s, they encapsulated everything that I had become involved in drug work for: they were a respected, proactive and influential professional body that placed the health, dignity and well-being of drug users at its core. They were not afraid to highlight, address and tackle the injustices, inaccuracies and misguided, blinkered, and occasionally downright dangerous opinion-based practices that were allowed to pass themselves off as accepted drug treatment programmes at that time. They fought to ensure that the evidence-base informed and influenced substitute prescribing, and not an individual's moral viewpoint or received wisdom. They wanted to prove that drug users and health and social-care professionals could work together as equals to improve the conditions that many users (and workers) found themselves locked in, and bring greater cohesion, benefits and stability to society as a whole. And they were successful. Who wouldn't want to be a part of that?

I'd come to the attention of the Alliance largely due to the work I'd done as DAT Coordinator in Walsall, West Midlands. I was fortunate enough to work for, and with, a DAT that embraced and encouraged the philosophy of harm reduction, and understood that our main duty of care was the preservation of life, and that we should take every step to prevent the unnecessary transmission of diseases and other avoidable drug-related harms. This was a DAT that had as its chair of the joint commissioning group a wonderfully pragmatic, no-nonsense director of public health who came out with the immortal line, 'when it comes to public health, there's no such thing as morality' (apologies Sam, if I've misquoted you!). So in 2001, as a fresh-faced idealist (I would say 'romantic', but I'm from Dudley), adapting to my first few months of employment, I was allowed to introduce citric acid sachets when it was still technically illegal, supported in developing emergency response protocols with the police, coroner and ambulance service, and tasked with coordinating a peer-led, Injecting Drug User (IDU) Research Project, where current or ex-IDUs would be trained in research methodology by Staffordshire University, and paid to conduct research into the nature of IV use in the borough. They were good, exciting, effective days, culminating in a major DAT-organised Harm Reduction Conference at the Bescot Stadium (home of Walsall FC), at which Bill Nelles was invited to be our keynote speaker.

There was, however, a distinctly noticeable sea change in the air. The government had produced a white paper proposing that DATs and Crime and Disorder Reduction Partnerships (CDRPs) merge, and duly established a consultation process. Unfortunately, when the consultation process was complete, and the vast majority of DATs had responded saying that although closer working arrangements would and should be welcomed and encouraged, full mergers would be unfavourable, largely unworkable and possibly even detrimental, we were told that we'd either misunderstood or been misled. The question now was no longer if we should merge, but how.

So now my role became one of enabling two vitally important, yet largely aesthetically alien, bodies to breathe as one. My role became one of ensuring the chief executive of our PCT got his star rating. My role became one of establishing effective, robust data collection and transfer systems that allowed the NTA to hit the targets they were tasked with. My role appeared to have less and less to do with supporting users or improving the wider well being of our communities. My role was, to me, about keeping people with much more important titles and much bigger salaries than me in employment. My role was lost.

And then, as if from nowhere, an angel in an off-white t-shirt and grey, sloppy-Joe jogging bottoms spoke to me, offered me a path and delivered me from limbo. I was saved!

And I did feel saved. I felt – and will always feel – honoured, humbled and proud to serve the Alliance, because I know what the Alliance does, I know what the Alliance has the ability and talent to do, and I know that we need the Alliance possibly more now than ever before.

I have known friends grow in the user involvement movement and facilitate workshops at National Conferences thanks to the 120ml methadone maintenance script that the Alliance helped them secure – scripts that, two years previously, would have been unthinkable.

I have seen users attend our practical advocacy training courses, overjoyed, and sometimes overawed, that they've finally met Alan Joyce; a man who, in their own words, saved their lives.

I have had the privilege to work alongside dedicated, enthusiastic, NHS employed (read 'paid') user involvement and advocacy workers who achieved stability thanks to the Alliance's intervention, and developed their skills, knowledge and professionalism thanks to the Alliance's volunteer and mentoring programmes.

I have had the honour of standing shoulder to shoulder with the Alliance's Chair, Dr Chris Ford, as she has worked with users to improve services and fought for the rights of drug users. I'll reiterate: who wouldn't want to be a part of that?

But for all the Alliance's international reputation and sterling work, it's been achieved with a minimal staff team operating on a shoestring budget built on unsecured, short-term, hotchpotch financial agreements. We need to secure, expand and develop our national model of advocacy so that we can devise, support and manage four tiers of local, regional and national advocacy provision and ensure that all users, regardless of their geographical area, have the opportunity to access peers who have the ability, knowledge and professional backing to negotiate and secure individualised treatment programmes, doses and modes of administration that are right for them.

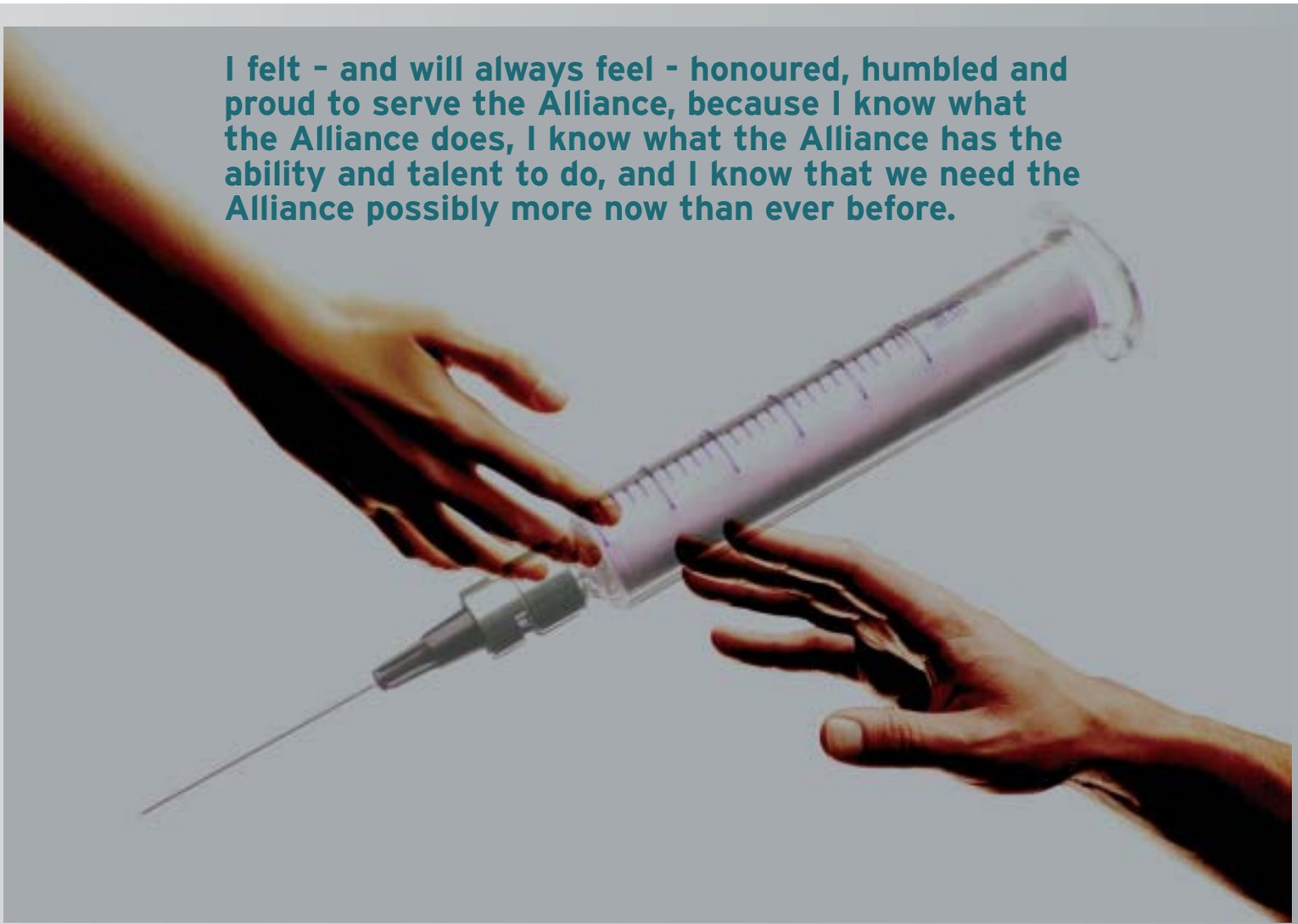
We need to secure, expand and develop our volunteer provision and helpline programme in order to ensure that users have access to the employment opportunities they want, and the evidence base they need.

We need to secure, expand and develop our management team, not only in relation to our core strategic and operational areas, but crucially, in our advocacy training and active provision.

We need to find effective avenues to impart knowledge around supporting, training, mentoring and coordinating user involvement initiatives, and we need to formalise our ability and unique position to devise, conduct and disseminate research proposals from a user perspective, with user-relevant outcomes in mind.

It is, however, difficult to achieve the achievable with a salaried staff team of three, six part time volunteers, a one day a week user-researcher coordinating the random control tests into injectable opioid treatment, and no substantial, dedicated, long-term financial investment.

I felt – and will always feel – honoured, humbled and proud to serve the Alliance, because I know what the Alliance does, I know what the Alliance has the ability and talent to do, and I know that we need the Alliance possibly more now than ever before.



This is a story no different to the one that every charitable organisation has to settle down to bed with, and it's an accepted fact of life that small, voluntary organisations have to invest most of their time and energies into keeping themselves afloat, often to the detriment of the proactive work that they're seeking funding for.

In the case of the Alliance, the worry is that we will become so bogged down in bid writing and money chasing that it will supplant our coalface work and activism, on which we've built our reputation and helped turn so many lives around.

This cannot be allowed to happen. Not in an increasingly punitive and coercive state-controlled system that puts users in the very real and unnecessary position of facing a jail stretch, should they dare to use on top of their sub-optimal, ineffective dose.

Not in a society and culture that allows three policemen to dump a known 25 year old 'drug addict' (and, coincidentally, mother of three, daughter of two) in wasteland, on 'another force's' patch, in the middle of winter, undiscovered for three months, and for there to be no charges brought against them because, 'no expert evidence had been brought forward to explain questions such as whether heroin addicts should be referred to a doctor or what obligations the police have when releasing people from custody without charge in towns where they do not live.' (*Daily Telegraph*, 19 April 2005).

Not when people's lives are being arbitrarily and willingly lost and destroyed in a game that seeks only to win the political and moral high ground.

Our aims and objectives are simple. We want to support those currently in drug treatment, those who have accessed drug treatment in the past and those who may access drug treatment in the future. We will do this by:

- establishing the right of people receiving treatment to be consulted about changes that concern them and to participating in the making of decisions relating to their care
- providing accurate information, advice, and support to people receiving prescribed drugs for the treatment of their drug dependency and educating users about their rights to effective treatment
- providing advocacy and representation to people receiving poor care, and helping improve their situation and their experience of treatment
- lobbying for prescribing practices that are validated as 'evidence-based' by reputable scientific bodies and ensuring that drug users are actively involved in the debate about their treatment and care at every level
- supporting 'drug-of-choice' prescribing regimes where these would clearly benefit the individual
- providing a structure through which users can address the needs of their own community
- promoting a harm-reduction approach to the treatment of drug use

We've come a long way, but there's still a long way to go. The Alliance is here for the long-haul.

For training or other admin queries, please contact Ursula Brown on 020 7713 6222 or email malliance@btconnect.com
The Alliance Helpline : 020 7837 4379
Noon to 4pm Mon-Fri
www.m-alliance.org.uk

Diary of a heroin addict

In part four of his story, David Wright gets his first taste of the psychiatric ward and comes face to face with the painful prospect of detox.

I remember being filled with a great deal of fear and trepidation that I was about to enter a world of drooling lunatics – or so I thought. But there was also a feeling of relief that I was going to hand over the untidy suitcase of my mind to a load of shrinks and get it back all washed and ironed.

Sandra the receptionist took me onto the ward. As we were walking towards the big double doors that led to the ward I nervously said to her that I was not looking forward to this; to which she replied, 'David it's not what you think'. And she was so right.

I was led to a T.V. room where a patient approached me and asked if I was in here for drink and drugs, to which I replied 'yes'. She shook my hand and said, 'me too, and my name's Pat'. I was then introduced to a smartly dressed young guy called Murray, who was in for the drink. My fears dissolved. After about an hour in the T.V. room, smoking cigs and talking with my new friends, I began to wonder if the staff knew I was there.

Now that is a feeling you get used to in psychiatric hospitals – being ignored. I had come onto the ward at 7pm and at 10pm I heard the sound of a trolley. What I did not know then, was that this sound was the drugs trolley being wheeled out and my heart would lift every time I heard it; in fact I can still hear it today when I close my eyes.

'Medication' was announced and people began to appear that I had not seen before. I could tell most of these people were mentally ill. When you have been in a psychiatric ward for a few weeks, and if you are being given sedation, you stop walking and develop a shuffle. It is known as the Largactil shuffle. Largactil or Chlorpromazine is the most widely prescribed anti-psychotic. Horrible stuff; I was given two once to check out the buzz, but all it does is cloud your mind so you can't think straight and when you walk it's as if you're walking through water.

As the medication was handed out, I could here the nurse say to each patient 'do you want your sleepers?', to which they all said yes, so mainly Temazepam was being given out with their other medication. But when it got to my turn, I was told the doctor had not written me up for any sleepers and I would have to discuss it with him in the morning.

If you're on a detox, your mind is going 100 miles an hour, you're agitated and you will give anything to sleep. So I'm in the queue, waiting for my night-time meds; there is a guy in front of me who can hardly keep his eyes open and he is given two Mogadons – and I get jack shit. Eventually I managed after four days without sleep to get some service.

The alcohol withdrawals were really kicking in, but I did not know at that time what was happening to me. I was swaying backwards and forwards, banging my head against the wall. Agitation was building up in me that I was about to explode. The trainee nurses were going into the office, where the morning staff nurse was saying to them, 'tell him he's got to go through it'. The afternoon shift took over, and straight-away the staff nurse took one look at me and brought me extra medication. It's called PRN, meaning 'as needed, or in the nurse's judgement', and I have since found out that all detox patients have to be written up for PRN because when the withdrawals get severe, you will need extra medication. That staff nurse also got the doctor to write me up for 20ml of Temazepam. God Bless you Helen.

So detoxes can be a lottery, depending on the nurses. If you are referred by a G.P., you will see a junior doctor who knows nothing about drug and alcohol addiction. So my advice is to find a sympathetic nurse and she will get the doctor to write you up drugs.

One day a guy was brought into the hospital by ambulance. He had a raging habit of two grams a day, which he fed by dealing. He'd had enough of heroin, so out of desperation he put a rope round his neck, waited for the ambulance to arrive then jumped off the chair. The doctor came to him in hospital and told him not to worry, he would give him a big dose of methadone to stop the withdrawals. The guy was sat next to me when the nurse brought in the methadone. As she gave it to him she said, 'I'm sorry about this'. The doctor had given him 10ml of methadone! The guy broke down and cried. It was lucky for him that the next morning the community drug consultant was around; she examined him and wrote a script out for 80mls of methadone.

The other risk about doing a detox on a psychiatric ward is that some nurses don't want you there. In their minds you're not ill – you've done it to yourself, so you deserve the pain and discomfort. Thank God for nurses like Helen.

As for the consultant psychiatrist... I spent four years going in for detoxes on the ward, and when not on the ward I went to the day hospital, which I used to joke was for us part time loonies. We did stuff like art therapy and woodwork. At night I would meet Scott and score heroin, or there would be a wrap waiting for me at our 'opiate den'. In the four years I attended the hospital, the consultant only saw me once. I got to look at my file and he had written one sentence about me: 'Seems to be obsessed by trivia.' And he was right. That is what drugs can do to you, you look at yourself under a microscope. In a room full of people, you count how many steps there are to the door. You work out whether you are going to say something when you leave the room. You believe that people are going to pay that much attention to you, but of course they don't.

Eventually the doctors at the hospital got fed up with me as I was using smack daily and drinking heavily, plus methadone. To tell the truth I had had enough as well, so when rehab was suggested I jumped at the chance. The drug worker came to see me with about eight leaflets on different rehabs to look through.

Being a believer in fate, I closed my eyes and picked one. It happened to be Ty Palmyra, Newport, South Wales. My life was about to go through a dramatic change.

Part five in DDN next issue

Historical Perspectives: Opium, morphine and opiates (part 2)

Professor David Clark continues his brief history of the opiates, which includes describing the different responses of the United States and Britain to opiate problems in the earlier parts of the century.

Opiate-containing patent medicines proliferated on both sides of the Atlantic during the 19th century. However, American legislators began to see opium as a dangerous Oriental custom that was threatening the morality of their people. The moralistic propaganda of the Temperance Movement began to include anti-drug statements:

'To get this heroin supply the addict will not only advocate public policies against the public welfare, but will lie, steal, rob, and if necessary commit murder. Heroin addiction can be likened to a contagion. Suppose it were announced that there were more than a million lepers among our people. Think what a shock the announcement would make. Yet drug addiction is far more incurable than leprosy, far more tragic to its victims, and is spreading like a moral and physical scourge.' *Richard Pearson Hobson, anti-drug campaigner.*

A growing concern about morphine and opium addiction in the US added to the pressure for new legislation. It is estimated that there were 250,000 problem opiate users at the turn of the century. In 1914, the Harrison Narcotic Act in the US effectively banned the use of opium and morphine. But there was one major omission: heroin.

Heinrich Dreser had synthesised diacetylmorphine in 1898, which he called heroin because of its heroic possibilities for treatment. The company Bayer marketed it for coughs, for which it was effective with less side effects than morphine. After the passing of the Harrison Act, regular users of other opiates and cocaine switched to heroin. The drug was not considered addictive for some time. Intravenous injection of heroin became increasingly popular in the US from the mid-1920s.

In 1924, the US Government banned the import and manufacture of heroin and banned its prescribing totally from medical practice. The US Supreme Court had earlier (in 1919) banned doctors from prescribing other opiates to addicts for maintenance of their addiction – doctors were liable to prosecution if they tried to help their dependent patients. The rhetoric of anti-drug campaigners helped to influence public opinion about heroin and other opiates.

'Heinrich Dreser had synthesised diacetylmorphine in 1898, which he called heroin because of its heroic possibilities for treatment. The company Bayer marketed it for coughs, for which it was effective with less side effects than morphine.'

Opiate use, in particular heroin use, was driven underground. A moral panic about heroin developed across the nation – the drug was credited with a bottomless capacity for evil. The first Commissioner of the Bureau of Narcotics, Henry Anslinger, had a tough approach to addiction. He led the fight against drugs, relying on a simple principle: 'We intend to get the killer-pushers and their willing customers out of buying and selling drugs. The answer to the problem is simple – get rid of drugs, pushers and users. Period.'

For many years to come, application of the criminal law, rather than any sort of medical treatment, was to be America's prime response to its opiate problem.

An American-inspired international narcotics control movement developed, beginning with a meeting in Shanghai in 1909 and the First Opium Convention in The Hague in 1912. American attitudes and prejudices were to play a significant role in shaping international drug policy in the coming decades.

In the UK, emergency drug controls were introduced under the wartime Defence of the Realm Act in 1916, restricting possession of cocaine to doctors, pharmacists and vets. Opiates were not its central concern. The Dangerous Drugs Act of 1920, forced upon the country by the pressure of international obligations, made it illegal to possess opiates and cocaine unless they had been supplied or prescribed by a doctor. A further Act in 1923 provided for heavier penalties for infringements.

Due to ambiguities in these Acts centred around prescribing, the Home Office asked the Ministry of Health to provide guidelines. This resulted in the Rolleston Report of 1926, which concluded that when an opiate addict could not easily be got off drugs, it was medically legitimate to continue with maintenance prescribing. Addiction was classed as a disease and a drug could be prescribed to 'relieve a morbid and overpowering craving'. The Rolleston report also concluded that opiate addiction was rare in Britain, with the majority of addicts being introduced to the drug in the course of medical treatment. The scale of the opiate problem in Britain at this time was certainly far lower than that seen in the US.

The Report's recommendations were accepted by the Home Office, and Britain settled down for about 40 years to a way of dealing with opiates which came to be known as the 'British System'. Individual private practitioners prescribed drugs to their addict patients without fear of prosecution. Whilst possession of opiates without a prescription was still the subject of criminal law, the number of prosecutions was remarkably low. For the so-called manufactured drugs heroin, morphine and cocaine, the number was 45 in 1926 and it did not exceed 100 until 1964 (101).

The bureaucracy created in Britain to support the implementation of the Dangerous Drugs Act was much more amateurish and passive than the style of operation occurring in the States. By 1929, the Federal Narcotics Agency in the States employed 250 agents and enjoyed a generous budget. In the UK, the Home Office Drugs Branch was for many years staffed by only two inspectors. The senior Home Office official responsible for overseeing Britain's drug policies was also charged with the responsibility for the protection of wild birds.

Concluded next issue

Have trailblazers gone mainstream?

It was with some surprise and confusion that I read John Wilkins letter (*DDN*, 21 March 2005) challenging the 'misquoted' HOT Employment Policy and stating that the service only employs users who 'have recovered from substance misuse problems' and live 'drug-free' lives.

I found this retraction so surprising because, prior to my current employment with The Alliance, I was DAT Coordinator for Walsall PCT and approached HOT for support with policy development prior to developing our user involvement strategy and employment policy. HOT were known to me as an exemplary beacon of best practice, particularly with regard to their approach to user involvement and engagement, and I was keen to contact them and share examples of best practice.

And share they did!

What I found most impressive with what was the HOT Employment Policy (circa 2002) was the common sense pragmatism that it afforded to the issue of an individuals own drug use, namely:

'It is important to note that many individuals drug use or alcohol use may not come to the attention of the organisation, never have any impact or bearing on their work and ultimately never becomes an employment issue.'

Furthermore, whilst the HOT Policy was robust and clear in its assertion that 'all employees are expected to be fit for work and able to carry out their duties. They should not be under the influence of drugs or alcohol in working hours', it also had the strength and courage to acknowledge that 'there is a firm distinction to be made between what a member of staff does whilst at work and whilst representing the organisation and what they do in their own time. HOT cannot hold jurisdiction over an employee during their own time and unconnected to the work of the organisation'.

This policy was, to my mind, not only integral to shaping and guiding the way in which Walsall developed and managed its system for user involvement and engagement, but – more importantly – was later given crucial backing and validity by the revised Enhancing Drug Services document (Drugscope / NTA 2003) which explicitly states that 'a drug service seeking to engage with active drug users and provide them with harm reduction information and services, may encourage current users to be involved in their service as employees' (Page 22). How sad, then, that one of the country's leading harm reduction agencies appears to have now abandoned a respected, trailblazing employment policy that evidenced active, proactive and effective user involvement and engagement, and replaced it with a more mainstream, average stance that sees user involvement as a process of mere 'service planning, delivery and evaluation'.

Very sad indeed.

Daren Garratt,
Development Manager,
The Alliance

Innovative treatment deserves support

I am writing in response to the article that appeared in *DDN* 4 April 2005, *Young people strategy gets regional focus in 'pioneering project'* (news, page 4). I am a volunteer at the Foundation Drug and Alcohol Service in Reading Berkshire, and one of the treatments offered to heroin addicts is a rehabilitation programme through a charity called East-West Detox. The clients are taken out to a monastery in Thailand, where they undergo a five-day herbal detoxification. With much talk of the many success stories from this treatment, which has achieved 100 per cent completion rates and 70 per cent long-term success rates, there is much excitement and interest in this programme.

I am also involved in a project with Wokingham Youth and Community Services, and we are looking for funding to take six young people out to Thailand to evaluate the programme and its effectiveness in treating young people. From the trip we aim to produce a peer led educational DVD to raise drug awareness amongst young people, which will be shown in schools throughout the country. From the International Youth Exchange scheme we have learnt that there are significant advantages to taking young people out of their environment when tackling behavioural issues and negative attitudes, supporting our belief of the East-West Detox programme being just as successful for young people as for adults.

Even more exciting, is that when compared to the existing three month methadone programme currently available to young people in this country, East-West Detox can take a young person out to Thailand, provide pre-counselling and aftercare for up to one year, and at only a quarter of the cost of the methadone programme.

This would be a fantastic opportunity for the government to support innovative ideas for both preventative and rehabilitative drug action. The project needs funding and publicity, and any exposure that you can provide the project through your magazine, would be a great benefit.

Rebecca Andrews,
Volunteer Project Worker,
Foundation Drug and Alcohol Service

An article on detox at Thamkrabok Monastery, Thailand, appeared in DDN, 24 January.

'We are not naive parents and having been teenagers ourselves we are fully aware what these young people are capable of getting up to. We have seen for ourselves... the increase in drinking and smoking between these young people. They seem to be unaware of the many dangers that come along with these experimental years. Although we want the youths to have a good day at our Youth Village, we also would like some expert advice on drinking and drug abuse.'

Can you offer drug advice for young people?

We are organising a Youth Village within our annual summer festival in Sandy Bedfordshire.

The Youth Village is our own project at the festival aimed at the youths of our small but fast expanding town.

We came up with the idea to bring these young people together, give them something to look forward to, as well as contributing towards performing behind the scenes. We would then like to take them on a coach trip to the coast in the summer holidays with the proceeds.

We are two parents of teenagers, and we have other parents that are as enthusiastic as we are about this venture.

We are not naive parents and having been teenagers ourselves we are fully aware what these young people are capable of getting up to. We have seen for ourselves, especially in the recent Easter holidays, the increase in drinking and smoking between these young people. They seem to be unaware of the many dangers that come along with these experimental years. Although we want the youths to have a good day at our Youth Village, we also would like some expert advice on drinking and drug abuse.

If you could offer us any support in the way of posters, leaflets, or someone for them to talk to on these subjects, it would be appreciated so much. It would also be beneficial to some of these young people.

Could you could even give us information on any groups that would come along and support this project – real people that these issues have affected, who have pulled through? We feel this is always a good way for the young people to connect with reality, better than someone just reading from a book.

We are on a short time span (Youth Village is on 18 June) so any help would be fantastic.

Dionne Woolford and Ann Madine,
by email

Can you offer any help, information, or suggestions? Please email claire@cjwellings.com and we will pass on your details.

Cracking the code on user involvement

Jaye Foster spoke at the RCGP 'management of drug users in primary care' conference this week, to raise service user issues with GPs. He shares his thoughts on how a change of attitude from all parties can go a long way.

Drug and alcohol professionals consistently fail to view people who use drugs and those that use drug services as 'customers'. Thus drug and alcohol services, and those commissioning them, fail to deliver or purchase services that meet customer needs or approval. The barriers to user involvement are often located within a judgmental, discriminatory class system, which does not support users' or patients' rights and freedoms, and views users as the problem and not a solution.

Professionals are often unwilling or afraid to relinquish the power conferred by their 'expert' role, and equally fail to see that users have expertise of their own in managing problems associated with drug or alcohol use. On the one hand users are often socially excluded, and on the other, professionals fail to deliver socially inclusive services. Consequently there is a concerning gap between what is being provided and delivered and what is really needed.

An underlying purpose of user involvement 'is to campaign for the inclusion of people excluded from mainstream society', yet time and time again users have too many doors shut in their faces.

Grid 8 treatment plans submitted by Drug Action teams to the National Treatment agency raise eyebrows and concern on whether, when and how such work and interventions with drug and alcohol using communities actually takes place. It is suggested that it is more rhetoric than actual practice, a case of ticking the boxes and aiming for an amber light (although green lights have been seen on treatment plans there is firm belief [and evidence], that none of this work has taken place within certain DAT areas). However this is not to unjustly criticise all those out there who effortlessly campaign (and often work for nothing or a pittance) to get users involved. Furthermore drug and alcohol communities also need to take responsibility; it's a two way partnership.

Users are a heterogeneous group, coming from widely differing environments, subcultures, identities, health and social circumstances and economic backgrounds, and face a range of social injustices. It takes professional, political and social bravery for drug and alcohol professionals to acknowledge that user empowerment must work with the community not just in it; it is hopeless if user involvement takes place in a vacuum.

Services tend to be developed from a 'top down' process in which professionals identify what they perceive to be user's problems, and then provide solutions – solutions that tend to be as overly ambitious and poorly focused towards the problems as users perceive them.

'Involvement should be democratic; both internally and externally, while both sides need to be clear about what can be achieved, ensuring that there are common goals and vision.'

Honest, open discussion is required to look at what the real problems are, in developing and delivering sustainable user involvement that is of quality. Both central and regional NTA management have a responsibility to ensure that DATs, commissioners and service providers are strategically planning user involvement in a way that is both cost effective at a strategic level and effective at the community level.

At the present time (although I am informed to watch this space) there is no guidance or toolkit to help professionals and users alike to get started. Therefore, the majority of the time, there are no foundations in place and user involvement cannot grow organically at a local, regional and national level.

The problem being faced is that within the drug field sector there is limited evidence-based practice. There is a responsibility by all to fund and develop user involvement to ensure that public health is maximised and not compromised by criminal justice agendas and the political agenda.

Sustainable working partnerships between users and professionals need to be developed so they can see the world through each other's eyes. The participation of users must take place at all strategic and decision-making levels. True participation involves people being involved in decision-making and leading projects, not just token involvement.

Approaching the development and delivery of services based around the needs of service users enables them to become involved and take ownership of those services, as involvement has the potential to give people a sense of identity and belonging which is known to produce better, more effective treatment outcomes.

Within patient and public involvement strategies, obtaining views and feedback of patients is a key government component in modernising the NHS. Such strategies need to be extended further to ensure that they are socially inclusive of all members of communities, not just political voting-aware individuals.

Involvement should be democratic – both internally and externally – while both sides need to be clear about what can be achieved, ensuring that there are common goals and vision. They need to be clear about what is trying to be achieved, ensuring that the infrastructure is in place to develop sustainable change and progress. They must ensure that there is equitable access to training for both users and professionals and share their skills with peers, which then enables myths to be broken down and gives the opportunity to work with one another.

Once working together, opportunities should be taken to understand the problems of each group. Effort must be made to sustain the dialogue and disseminate all good practice that has come out of working together. Professionals need to be given the time off work to attend training courses to understand the benefits and pitfalls of user involvement. They must also be open and willing to commit to user involvement; those that do not, need not apply.

User involvement is not an end in itself; it can be used to empower the disenfranchised, and to also help direct and develop policy and organisational developments. Above all, it should be used as a quality control to ensure that drug services and those commissioning drug services are meeting the needs of drug users and performing efficiently.

Half of all violent crime is alcohol related

30% of men and 15% of women on Wirral drink above recommended levels

ALCOHOL STRATEGY PROGRAMME MANAGER

PERMANENT POST

Wirral Drug & Alcohol Action Team (DAAT) is seeking to appoint a self-motivated enthusiastic professional to manage the development and implementation of the National and Local Alcohol Strategy targets focusing initially on Neighbourhood Renewal wards. The post holder will be based and managed within the successful Wirral Drug and Alcohol Action Team. Working with a range of local service agencies including health and social care, police, youth services, education, the community/voluntary sectors and licensing authorities, this post offers an exciting opportunity to be involved with a rapidly developing policy field.

Applicants must have experience of working within health and social care business, community, regeneration or criminal justice services for a minimum of three years and demonstrate ability in, and experience of, multi-agency working with a range of partners.

The hours of work are 37.5 per week.

Salary subject to job evaluation circa £30,553k

This post was previously advertised as a temporary post in November 2005 and previous applicants will be automatically reconsidered.

For further information/informal discussion please contact:
Andy Mills (0151-651 0011 x 255) or
Mindy Rutherford (0151-651 3884).

The Primary Care Trust recognises diversity and is committed to equal opportunities in employment.

Application pack and job description can be obtained from the Human Resources Department, Birkenhead and Wallasey PCT, St Catherine's Hospital, Church Road, Tranmere CH42 OLQ (0151 488 7759).

Closing date: 27 May 2005.

Wirral DAAT Drug & Alcohol Action Team
Birkenhead and Wallasey NHS
Bebington and West Wirral NHS
WIRRAL

mind
For better mental health

Colchester Mind

Project Worker
(Specialist in Substance Misuse) – The Junction

Full time: 37 hours per week,
including some evening and weekend work
Scale 5: £17,922 – £19,656

The Junction provides support to young people aged 11-24 with emotional, behavioural and substance misuse problems. Our aim is to provide a creative and innovative young person focused service. The postholder will be based in Colchester with outreach work to the surrounding areas. The ideal candidate must have at least 2 years experience of working with young people with substance misuse issues and experience in delivering structured and non-structured programmes of activities. Specialist training in this area and a relevant professional qualification i.e. social work, nursing, counselling or youth work would be an advantage. Most importantly, they must be creative, flexible and young person focused.

If you would like an application pack please contact Katherine Abbie by email: katherine.abbie@btconnect.com or on (01206) 579080.
Closing date: 16th May 2005. Interview date: 27th May 2005

Colchester Mind is an equal opportunities employer
Registered Charity No. 1064309

SEFTON PARK

a residential home for the treatment of alcohol and drugs dependency

Manager Therapeutic Community Weston-super-Mare Somerset
£ 38,000

We wish to recruit an outstanding individual who has the skills, ability, and experience required to lead our highly motivated staff team and the commitment and determination to develop the service to higher levels of professionalism.

The Manager will have a good deal of autonomy to manage the 28-bed home providing an abstinence based, Integrative programme of treatment. They will liaise with referring agencies and purchasers and represent Sefton Park within the local community.

- Related work experience providing services for people with Alcohol & Drug addictions and related complex needs
- Experience of working in a residential setting and an understanding of the dynamics of a Therapeutic Community
- Committed and passionate about providing high quality treatment
- The ability to understand the requirements of Service Commissioners, and develop good relationships with other partner agencies
- Evidence of staff management experience
- The desire and ability to make a strong contribution to policy and service development

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

Written applications with a detailed CV setting out your experience and qualifications to
Graham Maguire, Sefton Park Rehabilitation Centre, 10 Royal Crescent, Weston-super-Mare BX23 2AX
or by email to: enquiries@sefton-park.com

Closing date for applications; 12th May

www.sefton-park.com

YMCA

CONTINUING CARE SUBSTANCE MISUSE

YMCA Bridge is seeking to appoint the following posts to offer holistic, flexible programmes which recognise and support the needs of substance misuse service users including non offenders, offenders and ex-offenders.

These posts are Fixed term initially funded for 12 months

SUPPORT WORKERS

Two Full-time Posts	*37 hours per week*	*£19,500 per annum*
One part-time Post	*18.5 hours per week*	*£19,500 per annum (Pro-rata)*

GROUP FACILITATOR

Full-time	*37 hours per week*	*£19,500 per annum*

The right candidates for these posts will have:

- Experience of working with vulnerable clients
- Ability to demonstrate an understanding of the issues that face recovering drug users
- Ability to identify and seek appropriate networks of support and implement care packages
- Possess excellent interpersonal skills

For the post of group Facilitator you will also be required to have obtained a C & G 730/7

ADMINISTRATOR POST

Full-time	*37 hours per week*	*£11,000 per annum*

You will be required to provide a range of clerical and administration duties including:

- Data Input
- Tracking
- Monitoring

These posts are subject to an Enhanced CRB check.
Wolverhampton YMCA is an Equal Opportunities Employer

CLOSING DATE FOR ALL APPLICATIONS – 13TH MAY 2005

For an application pack please apply to Human Resources, Wolverhampton YMCA, 29-31 Temple Street, Wolverhampton, WV2 4AN
Or telephone01902 371553 or 371559. E-mail: ymca-personnel@ukonline.co.uk
(please specify which post you wish to apply for)

Westminster Drug Project

WDP

JOB OPPORTUNITIES IN HACKNEY, ENFIELD, REDBRIDGE, WALTHAM FOREST AND WESTMINSTER

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 (subject to skills & experience)

We are looking for people who are able to communicate effectively with 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 right across London.

The successful candidates will work with clients in the criminal justice system either in police stations or at court. In return you will be part of developing a treatment system that responds effectively to the needs of service users.

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 e-mail to jobs@wdp-drugs.org.uk or ring our 24 hour answerphone on 0207 421 3131.

Closing date for completed applications is Tuesday 17th May 2005.

Interviews will be in the week beginning 23rd May 2005.

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

Solutions Action Management
Recruitment & Consultancy

Are You Looking For Staff?

We have a comprehensive database of specialist substance misuse personnel

DAT Co-ordinators ● RoB Co-ordinators ● DIP Workers Counsellors ● Project Workers ● Commissioning Managers ● PPO workers ● TCAC workers ● Case Managers

Consultancy, Permanent, Temporary

"We have found Solutions Action Management to be a focussed professional and responsive provider of both Consultancy and interim management support as well as helping with our permanent DAT coordinator/recruitment. They have been able to target our own specific needs and have provided high calibre candidates for us."
Chief Executive- Slough PCT

Contact the Director to discuss your recruitment needs:
Samantha Morris Tel/Fax 020 8995 0919

www.SamRecruitment.org.uk

North Sheffield
Primary Care Trust

NHS

User Involvement Worker

Full Time: 37.5 hours per week
(unless subject to agenda for change protection)
Salary £21,549 - £25,212 (A&C6)
(subject to agenda for change review)
Post Ref: N/C/05/143

Sheffield Drug & Alcohol Action Team is seeking an enthusiastic and self-motivated person to increase the involvement of users and ex-users of substance misuse services in all aspects of service development and service improvement. The post requires excellent communication skills and the post-holder will need to be diplomatic and sensitive to issues of diversity and discrimination, with good interpersonal skills.

A sound knowledge of effective approaches to, and commitment to, empowerment and service user advocacy is essential. So is understanding and experience of the effects and impact of drug or alcohol use on individuals, their families, friends and communities. Basic counselling skills, training skills and knowledge of the main types of service used by drug and alcohol misusers and of substance misuse services in Sheffield, would be advantageous. Experience in one or more of these areas is desirable.

The post-holder will be based within the Drug & Alcohol Action Team.

Applicants should note that service users will be involved in the selection process, including short-listing and interview.

Further enquiries are welcome to Pene Rowe or Adrienne Wright at the DAAT office on 0114 2736851, but please read the information pack supplied with your application form first!

SHEFFIELD DRUG & ALCOHOL ACTION TEAM IS ACTIVELY WORKING TOWARDS EQUAL OPPORTUNITY. APPLICATIONS FROM MEMBERS OF UNDER-REPRESENTED GROUPS ARE PARTICULARLY WELCOME.

Closing date for applications is: Thursday 19th May 2005 @ 12pm
Interviews to be held on: Tuesday 31st May 2005

An application pack is available from Sheffield and South Yorkshire Human Resources Service, 5 Old Fulwood Road, Sheffield S10 3TG or telephone 0114 271 1340 (24 hour answer-phone) or fax details on 0114 2711188 or email personnel@sheffieldsw-pct.nhs.uk. Application forms and further details can be accessed from our web site on www.sheffield.nhs.uk/vacancies Please quote the relevant reference number.

The Primary Care Trusts are committed to promoting diversity and equality in the workforce and welcome applications from all sectors of the community.

POSITIVE ABOUT DISABLED PEOPLE

www.nhsborders.org.uk

NHS Borders

Mental Health and Learning Disability Network
Drug Treatment and Testing Orders

Charge Nurse 'G'

£24,629-£28,975 pa

An opportunity has arisen through Scottish Executive funding to work within this exciting multi-agency service, taking a lead for the delivery of innovative health care input designed to meet clients' drug dependency needs.

Within this autonomous DTTO scheme, you will work beside a Criminal Justice Service Social Worker and a Drug Worker – employed through Turning Point Scotland. You will be responsible for assessing, implementing and monitoring treatment programmes aimed at breaking the link between drug taking and offending.

The service will be managed through the local Criminal Justice Services. You will be employed and managed within the Borders Community Addiction Team but seconded and based within the service. In this exciting and challenging post, you will offer innovative programmes of care whilst working within a statutory legal framework. The service will be truly multi-disciplinary and will need to work jointly and cohesively.

Informal enquiries to Lee Davie, Clinical Nurse Manager on 01896 664430.

Application packs are available from the Human Resources Department, NHS Borders, Borders General Hospital, Melrose, TD6 9BS, tel: 01896 826151 quoting ref: MHLD217. Closing date for completed applications: noon on 20 May 2005.

'Please note that contractual conditions are under review and may change pending the implementation of agenda for change.

We operate a no smoking policy

North Dorset
Primary Care Trust

NHS

Young Persons Liaison Outreach Nurse Band 6

Ref: ND083.05

CADAS 28 High Street, Dorchester
£22,328 - £30,247 pa 37.5 hours per week

CADAS is an innovative multi agency community based team in West Dorset. We offer treatment, advice and support to people with drug or alcohol problems. We have no direct medical input as we work entirely under the philosophy of GP shared care.

You will need to be RMN/RGN preferably with two years' post registration experience in the substance misuse field. You will be working with young people only, aged 10-21 and will work in partnership with the Social Care and Health 'ASSIST' team. Full driving licence essential. Some assistance with relocation may be available.

For further information please telephone Fran Abbott-Hawkins, CADAS Manager or Lorraine Tritton, Clinical Team Leader on 01305 265635.

Join us and enjoy NHS benefits – supportive employers, competitive salary, the final salary Pension Scheme, generous annual leave and more.

For more details and to apply online visit our website: www.dorsetnhsjobs.nhs.uk Alternatively telephone us on 01305 252817 for an application pack.

Closing date for applications 16th May 2005.
Interviews planned for 9th June 2005.

Committed to equal opportunity & flexible working practices, all full time posts are suitable for part-time working/job share.

RAPt

REHABILITATION for ADDICTED PRISONERS TRUST

'STOPPING ADDICTION, STOPPING CRIME'

Following the recent Prison Service re-tendering exercise, RAPt, has been successful in securing contracts to provide CARAT Services and its accredited 12-step based Substance Abuse Treatment Programme in HM Prisons across England. We have been awarded 14 new drug service units, and are therefore undergoing a major expansion, offering many exciting opportunities to become part of one of the country's foremost providers of drug treatment services in prisons. We are currently looking for staff in the following positions and locations:

CARAT Teams

CARAT Managers: London HM Prisons (Wandsworth, Holloway); HMP Winchester, Hants; HMP Bullingdon, Oxon
Starting Salary £27,000
(plus £1,000 London Weighting for units located within M25)
We are looking for a CARAT Manager to oversee all aspects of the RAPt CARAT Service in the above-mentioned establishments. With three years' experience of providing line management to a minimum of 2 other staff, you will also have experience of supervision of the therapeutic work of others and comprehensive knowledge of different approaches to working with drug users. An understanding of prison culture and the criminal justice field are essential.

Senior CARAT Workers: HMP Coldingley, Surrey
Starting Salary £24,000
(plus £1,000 London Weighting for units located within M25)
We are looking for a full time Senior CARAT Worker to join our team at HMP Coldingley. For this position a good understanding of the drugs field and experience of working with this client group is essential, as is line management experience. Previous experience and a clear understanding of the CARAT system is highly desirable. You will also need to be efficient, enthusiastic and determined, with the ability to work in a challenging, sometimes pressurized environment.

CARAT Workers: London HM Prisons (Wandsworth, Holloway, Wormwood Scrubs, Pentonville); HMP Winchester, Hants; HMP Bullingdon, Oxon; HMP Grendon & Springhill, Bucks; HMP Standford Hill, Sheppey, Kent; HMP Elmley, Sheppey, Kent; HMP Highdown, Surrey; HMP Downview, Surrey; HMP Send, Surrey
Starting Salary £21,000
(plus £1,000 London Weighting for units located within M25)
We are looking for CARAT workers to join our teams at the above-mentioned establishments. For these positions, a good understanding of the drugs field and experience of working with this client group is essential. Previous experience and a clear understanding of the CARAT system are also desirable. You will need to be enthusiastic and very determined to be able to work within the challenging environment of a prison.

Alcohol Counsellor: HMP Holloway, London
Starting Salary £21,000
(plus £1,000 London Weighting for units located within M25)
We are looking for a specialist Alcohol Worker to join our CARAT Team at HMP Holloway. For this position you will need a recognised counselling qualification and experience of working within the criminal justice field. A thorough knowledge of the 12-step process of recovery from alcohol dependency is also required. You will need excellent communication skills and experience of facilitating therapeutic groups.

Sessional CARAT Workers: All RAPt CARAT Units – Various Locations
£10-£14 per hour

Trainee CARAT Workers: All RAPt CARAT Units – Various Locations
From September 2005, RAPt will be running accredited training coursed for CARAT Workers. If you are keen to develop a career in the drugs field but do not yet have qualifications or experience, we can offer you a salaried period of training and entry into the profession. For more information, please contact Jane or Leanne in our training department on 020 7582 4677

Primary Rehabilitation Treatment Teams

Treatment Managers: HMP The Mount, Herts; HMP Bullingdon, Oxon; HMP Swaleside, Sheppey, Kent (temporary 6 months)
Starting Salary £27,000
We are looking for a Treatment Managers for our primary rehabilitation programmes at the above establishments. You will need experience of working in a primary addiction programme and have a thorough knowledge of, and commitment to 12-step drug treatment and knowledge of other addiction approaches. A recognised counselling qualification and experience of clinical supervision of others is essential as is previous experience of working within the drugs and/or criminal justice field. You will need to be highly motivated, efficient and determined to work in the challenging and environment of a prison.

Counsellors: HMP Swaleside, Sheppey, Kent; HMP Coldingley, Surrey; HMP Send, Surrey (8 hours per week)
Starting Salary £21,000 (pro rata for part time)
We are looking for counsellors to join our teams at the above establishments. To be successful, you would need to have a thorough knowledge of, and commitment to 12-Step. Counselling qualifications and experience are essential, with experience of working with addicts desirable. Some level of training will be provided for staff with limited experience of working with this client group. You will also need to be efficient and determined, with the ability to work in a challenging environment.

Programme Liaison Worker at HMP Swaleside, Sheppey, Kent
Starting Salary £21,000
To be successful, you would need to have a thorough knowledge of, and commitment to 12-Step. Counselling qualifications and experience are essential, with experience of working with addicts desirable. Some level of training will be provided for staff with limited experience of working with this client group. You will also need to be efficient and determined, with the ability to work in a challenging, sometimes pressurized environment.

Sessional Counsellors: All RAPt Treatment Units – Various Locations
£10-£14 per hour

Trainee Counsellors: All RAPt CARAT Units – Various Locations
From September 2005, RAPt will be running accredited training coursed for 12-step addiction counsellors. If you are keen to develop a career in the drugs field but do not yet have qualifications or experience, we can offer you a salaried period of training and entry into the profession. For more information, please contact Jane or Leanne in our training department on 020 7582 4677

The Island Day Programme

We have successfully been awarded the contract to deliver and innovative abstinence-based 12-step programme on the Isle of Dogs for the London Borough of Tower Hamlets. We are looking to recruit:

Treatment Manager: Starting salary £27,000 (plus £1,000 London Weighting)
Senior Counsellor: Starting salary £24,000 (plus £1,000 London Weighting)
3 x Counsellors: Starting salary £21,000 (plus £1,000 London Weighting)
Administrator/Receptionist: Starting salary £19,000 (plus £1,000 London Weighting)

If you are interested in any of the advertised positions and would like to receive an application pack, please send an SAE for 42p to Amanda Pearman, RAPt, Riverside House, 27-29 Vauxhall Grove, London, SW8 1SY, clearly stating which position you are interested in.

Closing date for completed applications: Monday 23 May 2005

RAPt strongly encourages applications from Black and Minority Ethnic individuals and from those in recovery from addiction.

NO AGENCIES PLEASE **www.rapt.org.uk** **Registered Charity no. 1001701**