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Drink and Drugs News

3 October 2005
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3 October 2005

Editor's letter

When you're a patient receiving regular treatment related to drug or alcohol addiction, it's easy to assume that each health professional along the line talks to each other. In fact you probably think the only one in danger of being left out of information loop is you.

The prescribers give their side of the story on page 12: did you really think the doctor had time to pop round to the pharmacist for a quick chat about methadone doses? The RCGP's pioneering course, where doctors, nurses, pharmacists, social workers and service users train together, really brings home the value of face-to-face communication between all parties involved in treatment. Their comments speak volumes about the value of feedback on what works and what doesn't, from the patients themselves.

The Association of Nurses in Substance Abuse (ANSA)'s annual conference reinforced the need to talk (see page 5). It's clear that the role of substance misuse nurses is changing at a pace that can only be good for the field: more options on prescribing, better support for hard-pressed primary care teams, and high hopes for better patient interventions at an earlier stage. This has to be a hopeful sign for alcohol treatment. With so much to do and so little funding for the almighty task of tackling the nation's binge drinking, it surely makes sense to join forces on meaningful public health initiatives and help at an earlier stage.

And for something a little different, read the cover story on page 6. We're so used to being regimented by the right and wrong ways to do things, performance targets, correct procedures... that it's an interesting exercise to cast aside perceived wisdom and explore the real nature of addiction. Whatever your view, it'll certainly make you think.

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Notes from the Alliance – Methadone and beyond

In the wake of the Shipman Inquiry, and the proposed introduction of amendments to the Misuse of Drugs Regulations (2001), there have been some understandable anxieties that it may be more difficult for service users to access treatment and controlled prescription drugs in the future, writes Daren Garratt.

While this is a real concern, it is in fact possible that one of the proposed pilot schemes suggested in the action paper *Safer management of controlled drugs* (December 2004), could actually enable the drug field to advance two areas of service development that have caused concern and frustration for far too long.

The Shipman Inquiry discovered that there was a lack of any effective audit trail for controlled drugs once they have been dispensed to patients in the community. This, it is believed, allowed Dr Shipman to take some of the unused, leftover prescribed diamorphine for his own purposes, as there was no record of what had been dispensed or what had been received in the patient's home.

In order to address this issue there is going to be a pilot study to evaluate the effectiveness and feasibility of a proposed 'Patient Drug Record Card' (PDRC) scheme between now and May 2006.

The idea is that a PDRC will be dispensed alongside such Schedule 2 drugs as injectable morphine and diamorphine, when they are administered in the community or home settings. Any health worker attending the patient would be responsible for keeping the PRDC up to date and making a record of each time a new ampoule was administered or returned unused. It is hoped that this will ensure that there are no future discrepancies between the number of amps issued, used and returned.

So far, so good, but how does this impact on drug users who don't rely on someone coming to administer their Schedule 2 prescription for them?

Do we make them an exemption to the rule because it's difficult to monitor and audit trail a self-medicator, or do we call for the introduction of legalised Drug Consumption Rooms as a means to support this initiative, monitor the distribution of controlled drugs within a recognised hard-to-reach client group and reduce the possibility of both professional malpractice and accidental death?

Further, if there is going to be a national pilot study of PDRC's between now and May, then it must surely mean that there is some intention to dispense diamorphine before the study is evaluated and presented to ministers? Given that the current crisis isn't due to end until at least February 2006, is this an indication that we may see the resumption of some stocks earlier than anticipated?

I can't answer either of these questions, but if you favour the introduction of Drug Consumption Rooms and are concerned about the resumption of effective diamorphine prescribing, you may want to raise these issues during the current period of Public Consultation.

See feature on page 9

Sex workers need better service

More specialist services are needed to treat the drug problems of sex workers in Scotland, according to the Scottish Drugs Forum.

Around 5,000 workers in the industry are dependant on fewer than 10 specialist services, which are expected to deal with specific and special needs of drug users in indoor and outdoor sex work.

Links between sexual and emotional abuse, drug use and street prostitution were highlighted at an SDF conference on drug use among sex workers, held last week.

David Liddell, SDF director, told delegates: 'Many women become involved in sex work to pay for the drugs which they depend upon to block out other issues they would otherwise find impossible to deal with.' The irony was in having to take drugs to endure the hardships of their work, then needing the cash to sustain drug use – a cycle which became core to their lifestyle.

Being involved with the sex industry brought special problems, both in terms of how their needs were met by existing projects, and how they were viewed by other drug users.

Specialist treatment services needed to introduce more outreach health protection, offer more flexible 24-hour services for needle exchange and heroin substitute prescribing, and begin to tackle underlying issues and trauma that brought people into drug use and sex work.

Mr Liddell was realistic that such measures may not end prostitution, but said that improvements to services would make sex workers better informed and 'capable of making a decision about their lifestyle which is not based on their need to make money to fund out-of-control drug use'.

New guidance clarifies doctors' role in drug treatment

New guidance will help to end confusion about the role of doctors in drug treatment and ensure their skills are used fully, according to the Royal College of Psychiatrists and the Royal College of General Practitioners. The two colleges carried out the work over three years, with input from the NTA and Department of Health.

The report seeks to clarify the role of different specialists and the skills they need to work with drug and alcohol users, and is a resource for doctors, treatment commissioners and providers. It demonstrates that doctors with a range of competencies, from psychiatrists to GPs, can work together to provide a comprehensive range of services.

Dr Emily Finch, the NTA's clinical psychiatrist, said the report had been produced to address the 'mixed picture' of individual doctors working in different ways with a variety of competencies, which had resulted from the large increase in doctors working with drug users in recent years.

It also highlighted 'need for all doctors to be part of a proper clinical governance structure, with regular supervision and appraisal', according to Dr Finch.

Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers is available from the Royal College of Psychiatrists' website, www.rcpsych.ac.uk. A summary for drug treatment providers and commissioners is at the NTA website, www.nta.uk

Peter Martin leaves Addaction

Peter Martin has stepped down as chief executive of Addaction, after 15 years in the role.

Addaction's chair, John Harding, said he was sad to see Mr Martin leave a charity he had 'largely brought into being' – the charity now has 70 services in 46 locations from Scotland to Cornwall.

Commenting that he had loved his work at Addaction, Mr Martin said that he would maintain his interest in drug and alcohol treatment, following a break.

'The time is right for me to step down and allow someone else to steer the organisation through the new demands and complexities of the coming years,' he said.

Acting chief executive, William Butler, who is Addaction's chief operating officer, said there had been reactions of dismay and loss on the news of his departure, but commented: 'Peter is not going to be lost, he will be back to the field. We plan to give him a really good send-off around Christmas'.

Cannabis reclassification

The government's Advisory Council on Drugs has met to review cannabis classification and consider whether there should be a reversal of the decision to downgrade it from a class B to class C drug.

Home Secretary Charles Clarke requested the review, following recent studies that link cannabis with mental health concerns – specifically the development of psychosis.

The range of experts giving evidence included Danny Kushlick, Director of the Transform Drug Policy Foundation, who opposed reclassification as 'all about politics and nothing to do with new evidence of cannabis-related health risks'.

The lobby for reclassification on mental health grounds has frequently been emotive, with evidence from parents of teenagers. On 18 September *The Sunday Times* printed a story, 'Mental problems soar among children using cannabis', which blamed cannabis smoking for quadrupling the numbers of children being treated for mental disorders. The story attributed statistics to leading drug charity Addaction, but was rebutted by the charity's director of communications, Rosie Brocklehurst, who said it 'bore little relation to any information supplied by Addaction' and was factually wrong.

She added: 'Addaction is not a mental health charity and is not qualified to treat psychosis… we suspect the story was influenced by the *Sunday Times*' wish to write a piece before the imminent deliberations by the ACMD.'

ANSA Conference – Health improvement: Our agenda for change

Clarify roles for clearer provision of service

We need to clarify the role of the substance misuse nurse – particularly to commissioners and service providers, Shan Barcroft, the NTA's clinical team nurse, told the Association of Nurses in Substance Abuse annual conference.

'There's a feeling of marginalisation – but we've got to be clear about what we're providing,' she said. There was a need to look at training issues, and the RCGP was developing Part One Certificate level training for nurses.

Working with the field would help to identify priorities for developing specialist skills in substance misuse nursing. Nurses also needed to be encouraged to feed into decision-making at policy and social level, according to Ms Barcroft.

Recruitment and retention issues and changes in the structure of service provision were having an impact on the role of nursing in substance misuse, and there was a huge growth of generic posts accompanied by changes in the field's skills mix.

The NTA was looking at how nurse prescribing worked in practice, and the impact it was having on caseloads and treatment effectiveness. It was also working with nursing bodies to develop a vision for nursing in substance misuse, she said, and would value views from nurses on what was needed to maximise the impact nursing could have on the field.

Engagement in planning vital to commissioning

Engaging nurses and substance misuse workers in planning is a vital part of the commissioning cycle, according to Cheshire DAT's Anne Lloyd, who gave an insight to the joint commissioning process for adult drug treatment services.

'We need to look at outcomes – do services match clients' needs, are they equitable, efficient, effective... are clients satisfied?'

Key partners included PCTs, public health, treatment providers, community safety partnerships, police, probation and service users. Sharing reports was key to a good communication strategy with partners, said Ms Lloyd.

Cheshire was on course to achieve NTA targets to double numbers in treatment by 2008, but Ms Lloyd was aware that improving health and social functioning of individual drug users, involving housing, employment and a wider range of social support, was needed to help people achieve results.

Service user involvement had become a vital part of care planning, throughout engagement, delivery and completion of treatment, to reintegration with the community.

Although Cheshire had service users' forums across the county, when asked 'do you have a care plan?', too many of them were asking 'what's that?', she said.

Ambivalent attitude to alcohol deaths

'Most of your clients will die of alcohol,' said Richard Phillips, director of services at Phoenix House, updating delegates on the NTA Alcohol Strategy.

'The strategy has not made a lot of difference in a year – but that's not grounds for despair,' he said.

The costs of alcohol to society were immense: £20 billion, according to the Alcohol Strategy – 'that's £2,500 for each person who drinks above recommended levels.'

Yet 300 times as much was spent per drug related death compared to alcohol, amounting to an 'ambivalent attitude towards the nation's favourite drug'.

The NTA's belief that drugs were related to crime had instigated heavy investment in treatment. Yet there was very little going on for the UK's 9.7 million hazardous drinkers to encourage them to drink less. Eight out of ten people in accident and emergency on a Saturday were there because of drinking, Mr Phillips pointed out, and there had been a steady increase in average consumption in the last 20 years.

'Whole population approaches' to the problem should be considered, he said – yet the Alcohol Strategy had not taken into account World Health Organisation evidence-based recommendations that taxation was the most effective way of reducing average drinking.

The subsequent review of the licensing regime had confirmed the Alcohol Strategy as a 'magnificent failure of joined-up government' – with input from different departments behind closed doors, and later influenced by the licensing industry.

'The strategy doesn't have public health at its heart, nor is it to protect communities. It's about opening up the entertainment industry,' he commented.

Practice nurses had a significant role to play in reversing the estimated 6 million failures to treat in primary care, through carrying out brief interventions and screening, and championing training for health staff.

There would never be 'massive big spend' on alcohol, like drugs, but services were likely to be 'mainstreamed' through Primary Care Trusts. This would give useful links with other areas of the *Choosing health* strategy, sharing ideas on people who drank too much and ate too much. With alcohol money unlikely to come from central government, alcohol would have to compete with other healthcare funds, said Mr Phillips. It was therefore vital that we made sure alcohol was a priority for PCTs.

Consultation on *Models of Care for Alcohol Misuse* (MOCAM) and the *National Audit of Treatment Need* would be published soon: 'We need to look at these and review alcohol services,' he told delegates.

Nurses bring dignity to damaged users

There are going to be huge changes in the next few years for nurses, said Dr Stefan Janikiewicz, clinical director at Wirral drug service.

'A lot of people have damaged backgrounds, and primary care picks this up better than anything else,' he commented.

Nurses had plenty of skills to offer in treating drug users, he said, and were often better at communicating and finding out essential introductory information, according to Dr Janikiewicz. There were misconceptions among some doctors that drug users were 'manipulative, demanding, abusive and time-consuming' – but they are no more so than anyone else, he said. GPs' lack of drug knowledge sometimes hampered communication, but nurses' involvement could help to treat patients with dignity.

Shared care gave the opportunity for a named worker at the community drug team; rapid assessment (being seen within seven days); better training; and organisation of clinics to accommodate the drug surgery.

Opiate withdrawal was 'not a medical emergency' he stressed, and nurses were well equipped to carry out initial screening tests and make sure patients started methadone safely.

The only cases not suitable for shared care were poly or chaotic drug users, said Dr Janikiewicz, as treatment could be far more complicated than for straightforward opiate use.

Encourage GPs towards harm reduction

Primary and secondary care have very different ways of working, but shared care is getting bigger, according to Suzanne Corrigan.

A shared care co-ordinator at Brent PCT's Substance Misuse Project, Ms Corrigan said GPs should be encouraged to do harm reduction.

The Royal College of General Practitioners and SMMGP had been looking at how services worked, and shared care had become an important part of the annual GPs' conference. Shared care in London worked differently in two boroughs, Brent and Harrow, but the Substance Misuse Management Project had had support from the PCT and they had quick access for pharmacy advisors.

Advantages of being based in primary care included being able to keep clients on their books, even if they dropped out of treatment – 'they don't get discharged like in secondary care,' said Ms Corrigan.

As well as being cost effective, shared care enabled them to treat drug users in 'quality, not numbers, treating them like anyone else, not like drug users'.

The only fly in the ointment was that GPs had to opt in to treat drug users, she said.

Letting go

A Philosophical Approach to Addiction by William Pryor & Alan Rayner

We are both outsiders, in our different ways. William, an ex-heroin addict, writer, film producer and entrepreneur, fascinated by, but outside, the addiction treatment industry. Alan, an academic biologist, artist and non-Darwinian evolutionary thinker with obsessive compulsive disorder whose theories of 'inclusionality' take him to the edge of scientific respectability. We both feel the need to challenge orthodoxies and mythologies, and the field of addiction is particularly prey to such 'hooked thinking'. We are brought together by the observation that addiction is, beneath its drama, more a philosophical and metaphysical problem than anything else. Its medical, psychological, neurochemical, sociological and criminal manifestations are waves on the surface of a much deeper and darker ocean. Our disreputable outsider status enables us to say such outrageous things and brings an interesting resonance to the development of a philosophical understanding of why people adopt the extreme outsider position of addict, or of why it adopts them. Welcome to 'unhooked thinking'...

William – Letting Go of Insecurity

The addiction industry – whether it is treating, criminalising, therapising, studying or prescribing – strikes me as an odd enterprise. Few of its workers or scholars can agree, let alone adequately explain what addiction actually is. Some think it's an illness, some a genetic weakness, some the expression of brain biochemistry and others that it's down to social and familial environment. It's an odd industry for this very reason: it's concerned with a condition of being whose very nature is a mystery. Of course this disagreement as to the very nature of the 'thing' also means that there are widely divergent dogmas as to how, if, when and why it should be treated.

But addiction is not a mystery in the same way that cancer and AIDS are. No one really believes (do they?) that a complete science of addiction will ever be found in the laboratory or even the treatment centre, and if not there, then where? No, addiction is a philosophical mystery, more like that of, say, happiness. Neurochemists imagine happiness can be reduced to a chemical; most of us know it is far more elusive, the proper subject of mysticism, philosophy, psychology, literature, film, music and art. We need to apply these arts to develop a philosophy of addiction, not purely analytical science.

If, as I think many would agree, it is at least insufficient and at most downright wrong to explain addiction in terms of illness, neurochemistry, sociology, psychology or any combination of these, then we need to look at the base of the iceberg whose tip these approaches represent.

Is there something endemic in the human condition that leads so many to become addicts, or should I say: leads so many to adopt the role of addict to explain, act out, dramatise and make real their unhappiness, frustration and pain?

My answer is a qualified yes, qualified because the endemic something has always been there, even though addiction in the usual sense has only been around for the last hundred years (the first recorded use of the word in this way, according to the OED, was in 1906). The endemic something has been called weltschmertz, world-weariness, melancholy and in India, bireh or longing. The Lebanese author, Mikhail Naimy, called it the 'great nostalgia'. It is the pain of being human, no more, no less, the pain of having the chaotic self-awareness of human consciousness chained by its attachments to the mundane. Despite the 12-step understanding that there is a spiritual dimension to recovery from addiction, the 'thing itself' is still regarded as an 'illness', not as a collection of symptoms of some deeper malaise, some inability to tolerate the great nostalgia.

The addiction industry is an odd enterprise because it is concerned with a shell, a mythology, a drama of symptoms, not a thing in and of itself. It is not an illness that can be caught or inherited. Addiction is the map, not the territory. When I was a junky, I learnt to present addiction, to be labelled an addict, because what lay beneath was too difficult, too unacceptable to express or deal with. So medicalised has become our inner life, so distanced and handed over to figures of authority, that we find it hard to go beyond the map to find the territory within ourselves. So we have this burgeoning industry of carers, doctors, social workers, psychologists, policeman, gaolers and therapists all spending vast amounts of time and money on 'solving' the 'problem' of 'addiction', when this 'solving' is, in fact, no more than a metaphysical bandaid. Yes, the mythology of addiction is so entrenched, so powerful, that we have to deal in the apparent and pressing reality of the miseries of addiction, but the more it gets treated, the more policies are developed, the tighter the grip of the mythology. We talk ourselves into believing what Alan would call an 'objecti-fiction'. As Virginia Woolf wrote, no doubt in reference to her own mental affliction: 'On the outskirts of every agony sits some observant fellow who points'. The addiction treatment industry is pointing in the wrong direction.

To become an addict is to enter an interesting metaphysical realm where there are just two conditions of being, or 'functions' in William Burroughs' 'algebra of need': strung out, in need, on the one hand and drugged, satisfied, replete, under the influence, on the other. According to Vedantic philosophy and the new scientific logic of inclusionality, the rest of humanity knows three conditions, or gunas, variously described as 'becoming, being and decline'; 'birth, life and death'; or, 'creation, sustenance and destruction'.

We flit between these conditions continuously as our attention wanders from project to project, worry to concern, delight to lust.

The addict wants to avoid the middle condition, which is that of dynamic balance or simply being open to what is. The drama and chaos in the addict's lifestyle result from the one-pointed avoidance of the pain of being that can most readily be experienced in this middle mode. In Burroughs' algebra, strung-out plus drug equals bliss, except that it is a bliss that soon flips back into strung-out, an unsustainable bliss that can only transiently mimic the timeless quality of the middle mode. The fact that 'addiction' has in the last 30 years come to be used to describe any unhappy and obsessively repetitive behaviour, whether it be sex, eating, gambling, work or shopping, reinforces this metaphysical model. It doesn't matter what experience you are addicted to, it is all about avoidance of the dark night of the soul.

To be human, to have a self, so Hindu and Buddhist philosophers tell us, is to be attached – attached to people, ideas, things, places, most fundamentally our own bodies. Transcend those attachments and you transcend unconsciousness to find unattached contentment – beyond pleasure and pain, not of this world, whilst still in it. But in the busyness of our being in the world, we are prone to define ourselves only in terms of our attachments. We are what we own, what we love, what we possess, what is precious to us. These are our limitations: they make us who and what we are. The things I am attached to make me different from you. But attachment is the source of all our unhappiness, our suffering, the pain of being human as well as the pleasure and excitement.

The words 'addiction' and 'attachment' are used in similar ways: they both signify emotionally charged relationships over which we imagine we don't have much control. They have us; we are 'possessed', the slaves of the things, ideas and people to whom we are addicted or attached. We can't help it. Maybe the only difference between the two words is one of degree: to be addicted is to be absolutely attached.

The addiction industry is, as I said, an odd enterprise, treating people in obvious distress for a condition that is all smoke and mirrors, generating medieval prohibitions of 'evil' substances, when those it sanctions do far more damage. We need to look beneath the surface explanations.

Next issue: Over to Alan for a different, and equally challenging, view.

A Balanced Approach

My recent comment ('Methadone maintenance – for better or worse?' *DDN*, 5 September) brought forth some interesting responses from the methadone lobby. I find it fascinating that if someone in this field questions the virtues of methadone, there's an army of harm reduction protagonists waiting in the wings to stifle the heretic.

Let me make it abundantly clear, I do not believe that abstinence and harm reduction should be viewed as polarised concepts. I do believe that methadone is an important tool and that maintenance therapy alongside psycho-social interventions constitutes legitimate treatment. Peter McDermott presents himself as a 'success story' for methadone maintenance and of course no right minded person would question his right to remain on methadone for life, should he choose that. Likewise, Peter claims to recognise the importance of abstinence based treatment and that everyone is entitled 'to take a shot at it' – he just believes that not many will make it. Herein lies part of the problem; if we have such low aspirations for our clients, believing that abstinence is an unrealistic goal for them, is it any wonder they don't believe in themselves and go for the methadone option? There are many skilled and dedicated workers in this field, but there are also many whose philosophy is 'give them a script and let them get on with it'. Currently we have an insane situation, where if a drug user comes to us for help, he or she at the end of an hour long assessment, is more than likely to be placed on a prescription for a powerful addictive drug that will be much more painful to withdraw from than heroin. Consequently they could be on it for years. In my eyes it's shameful that we don't make an effort to pro-actively encourage every drug user to consider abstinence and then if they are willing, put together a first-rate treatment package. The reality is, if someone wants abstinence services, in most cases they have to fight for them. The system is upside down and back to front!

'If we have such low aspirations for our clients, believing that abstinence is an unrealistic goal for them, is it any wonder they don't believe in themselves and go for the methadone option?'

Peter accuses me of falling foul of cyclical trends and harking back to a time when the pervading philosophy was abstinence. Not guilty! In this country, abstinence has never been put forward as a realistic option for drug users. It's no good promoting abstinence without the investment in services to make it achievable. Anyone who's worked in good abstinence based programmes knows that they work: I regularly speak to clients of our own abstinence services, ARC and the Higher Bridge Project, whose lives have been transformed. There are thousands of recovering people out there to prove it, they just don't hang around needle exchanges and prescribing clinics, so many who work in such places have never met them. This is the first time in our history real money has been made available to help drug users and it's being poured into methadone, based on a policy that we all know that is driven by crime reduction, not the welfare of the individual drug user.

So I'm not anti-methadone, I'm just calling for a more balanced approach. I'd like to see drug workers believing that clients can achieve abstinence (surveys have shown if you bother to ask drug users, it's what most of them want anyway). I'd like to see commissioners ensuring that every person has access to a range of abstinence-based treatment options including residential, community detox and day care programmes. The next couple of years are vital if we are to achieve this, as the pooled budget increases may be the last opportunity to build a more ethical treatment system.

Ultimately, the prescription pad should be the last choice treatment option, not the first.

Jon Royle, ADS Area Director, Manchester

Comment

The new licensing laws will come into effect on 24 November and government says the legislation will 'recognise that the vast majority of people should be treated like the adults they are'. Alcohol and drug worker Terry Jones fears a completely different outcome.

'Sink the 24 hour bill'. That seems to be the order for the fleet (street) at the moment. There are salvos fired every day now from almost every newspaper around and it is hard to find any reports of approval for it – except from the people who are going to make a lot of money from it, of course.

We have a constant barrage of news bombshells all hoping to convince the government to rethink, or suspend the bill for the time being. Even some of the more politically tolerant tabloids managed a few clouts at the bill, be it only with knotted scarves. The obvious problem is of course 'it's too late'. The horse has not only bolted but is now married, has a family and is staying in the Cotswolds. No-one in Parliament would have the courage now to stand up and say 'let's stop this, we have made a mistake'.

No. Like smoking, thousands more people are going to have to die before the political damage outweighs the financial benefits. By the year 2025, 1,000,000 will have died prematurely because of alcohol abuse – that's taking government figures of 33,000 per annum and counting the real figure of 50,000 per annum researched by a team at Oxford University. Thousands more assaults will take place purely because of this new bill. I don't say this lightly; I know this will happen without a doubt. There will be much more drinking in what is already an epidemic of alcohol abuse.

How can people afford to drink so much? The fact is they can't.

Part of our service's assessment takes in a client's financial situation, and I can say around 80 per cent of people have amassed sometimes vast debts. These can range from £1,000 to £60,000 and I am not including mortgages here; these are usually loans or credit card debt – I would say the average is £5,000. These are not chronic drinkers we are talking about, just ordinary people who have been drinking too much, sometimes because of the financial problems.

Of course not all of these debts were accrued by spending money on alcohol, but alcohol abuse is often involved in bad financial decisions. Also, if already in debt, abusive drinking can make it harder for a person to get their act together to try and find a way out. You can have a scenario of a person spending £100 a week on alcohol while in £15,000 worth of debt.

Take a person who likes a nice wine with every meal – very common nowadays. One bottle of £5 wine per night would be £35 a week, £140 a month. That's just one bottle. On average, most binge drinkers that go out to pubs and clubs would spend £100 a week, no problem. That's £400 out of your income before you even start to buy food and pay bills, and for some people that is a third or half of their wages. And a lot of people spend more than £400.

The connotations are obvious for people with debts who like to drink a lot. It's a self-defeating cycle that can be very difficult to get off. The more they drink, the more debt they can't pay. They get fed up with that, so what better way to bury your head in the sand than sedate yourself with alcohol you can't afford? The people that can afford it financially are even worse off – they never have to worry about running out of cash, and can drink steadily most days. No alcohol free days for them because they're skint – the saviour of many a drinker.

Unfortunately those who already drink too much are going to drink even more when they have more access to alcohol in November. There is no doubt in my mind that there will be a rise in debts as well. When drinkers get drunk, they tend to buy drinks for people they hardly know, then cry about it in the morning (if they can remember). Parties that run out of alcohol and would usually then wind down will be refuelled by a quick visit to the nearest 24-hour supermarket – more cost to pocket and body. Domestic violence will increase because of the increase in financial difficulties; this is already one of the main causes of alcohol related violence at home.

I do not think all these things are unconnected, the binging, the debt, the anger and violence. When you get under the surface of most people who binge drink, you find depressed people that really don't want that type of life but are carried along on a tide of attitudes and tradition bolstered by mixed messages; namely: 'binge drinking is bad for you. You are all drinking too much, so we are going to give you more access to alcohol to help you drink less'. What can you say?

No ID – **no methadone?**

At the end of July, the government opened consultation on their proposed changes to legislation on the misuse of drugs. It is the latest stage in an action programme to change the law following the Shipman Inquiry, and aims to protect patients from the inappropriate use of controlled drugs. The big question for our field, and one which must be balanced very carefully with all issues of patient safety, is: can we be sure that changes to the law will not have a negative impact on access to treatment? Kevin Flemen has taken a detailed look at the proposed changes, and raises some issues we should scrutinise before the consultation period ends on 21 October.

The proposed changes to legislation are intended to improve the prescribing, audit trail and safe handling of prescribed controlled drugs, and involve changes to the Misuse of Drugs Regulations 2001.

They were drawn up after consultation with the ACMD (the Advisory Council on the Misuse of Drugs – the independent body established to advise government on drug misuse issues) and several other agencies drawn from medical disciplines. But this list does not appear to include the National Treatment Agency, DrugScope, Homelesslink, or any other agency primarily concerned with the needs of drug users engaging with treatment providers.

This could mean the proposals have a negative impact on access and adherence to treatment. The following paragraphs are, in our view, in need of revision.

Controlled drug prescriptions (paragraph 15):
The government proposes that any prescription for controlled drugs will need to carry an identification number unique to each prescriber, and a unique patient identification number (their NHS number), to identify any 'double scripting' (patients obtaining supplies of controlled drugs from more than one prescriber).

Effectively, this proposal represents a return to a 'register' of addicts, recording and identifying all users of prescribed controlled drugs. A key concern must relate to homeless and transient patients who do not currently have, or do not know, their NHS numbers.

The proposals note a need to consider 'the obligations on prescribers and dispensers faced with patients who are unable or unwilling to supply their NHS number'. We would go further than this and propose that, given the risk of further excluding this vulnerable group, those engaged in the treatment of drug dependency should be exempted from this requirement for three months, while they acquire an NHS number. Treatment should not be withheld from them during this time.

Dispensing controlled drugs (paragraph 22):
The government proposes that the dispenser will be required to ask for the name, address and some form of personal identification of people collecting Schedule 2 controlled drugs. This proposal is mediated by a clause ensuring that pharmacists still have discretion to dispense where a person has no form of identification.

We are concerned that this proposal needs more careful attention to ensure that those who are homeless, transient, or in temporary accommodation are not treated unfairly by this proposal. Many such patients will not have formal documentation to prove identity or their address. We propose that patients attending agencies for drug treatment are issued with an ID card which includes their patient number and photograph, which would be an agreed form of identification to local pharmacists. The system would be extended to patients receiving treatment from GPs within a shared-care scheme.

Controlled drugs in the community (paragraph 27):
The proposals relate to appropriate storage of controlled drugs, and refer to 'categories of people' deemed suitable to deal with them.

We have contacted the Home Office on previous occasions requesting clarification of the regulations relating to the storage of prescribed controlled drugs in non-medical settings. It has been our ongoing concern that the storage of such drugs by hostels, day centres and other allied professionals is not robustly legal (see the KFx guidance document *On Storage*).

To enhance the safe handling of controlled drugs in the community, we are making the following proposals:

- Hostels and day centres should be given the authority to store prescribed controlled drugs on behalf of service users, and return such drugs to the named patient.
- While being given this authority, such services should not be obliged to store prescribed drugs for users or residents.
- Organisations who wish to store controlled drugs should be able to demonstrate that they can operate to agreed standards, covering storage facilities, record-keeping, staff references, and joint working with prescribers.
- The provision would be audited by the Pharmacy Inspectorate, who would furnish a Certificate of Compliance, authorising the storage of such controlled drugs.

While it is essential that there are effective strategies in place to monitor the use of prescribed drugs, it is vital that such measures do not have a negative impact on patient care, reducing access and continuity of treatment.

The low-key launch of the consultation at the end of July may mean that it escaped the attention of key agencies, when the proposed changes may have important ramifications for the drug treatment and social care field. We urge agencies to respond to the consultation by the deadline of 21 October.

Kevin Flemen runs the drug consultancy initiative, KFx. You can read his comments in full at the KFx website, www.ixion.demon.co.uk.
To read the government's proposed changes to the Misuse of Drugs Regulations, visit www.homeoffice.gov.uk/docs4/consultation-_mdr_amendments_final_28072005.pdf

Harold Shipman was convicted in January 2000 of murdering 15 of his patients, as a GP in Greater Manchester and West Yorkshire. A public inquiry later decided he had killed at least 215 patients in around 25 years.

Shipman preyed on vulnerable patients, often elderly and living alone, and murdered mainly by injecting with fatal doses of diamorphine. He had previously been sacked from a medical practice for making out drug prescriptions to feed his own addiction to morphine-like drug pethidine, but had not been struck off the register. The UK's most prolific convicted serial killer, Shipman hanged himself in prison in January 2004.

The Shipman Inquiry was set up to establish what changes should be made to current systems to safeguard patients in the future, and is reviewing procedures for prescribing, dispensing, collecting, delivering, storing and disposing of controlled drugs.

Reaching past violence

A client's experience of domestic violence can often have detrimental and devastating effects on drug and alcohol treatment, argues Michelle Newcomb of the Stella Project.

We've all heard the same stories:
'No, he's the one who always scores,
I just earn the money.'
'If I leave, he's going to let social services know…'
'Sorry I'm late, can I still get an appointment? She didn't tell me the new time.'
'He's not usually like this, he was just off his head and lost his temper.'

In a setting where a sense of crisis or complexity often looms, it's easy to hear these statements without giving them much thought. But step back and look harder, what are they really saying? As your client walks out the door, many are walking into coercive, abusive and violent situations, not just on the street, but often within their own homes.

The Alcohol Harm Reduction Strategy states that up to 30 per cent of men who physically abuse their partners do so under the influence of alcohol. Meanwhile in 2002, the Home Office report *Women drug users and drug service provision* stated that 50 to 90 per cent of women in treatment were survivors of violence. It therefore seems inevitable that many of our service users are experiencing domestic violence. It is, however, important to remember that few are likely to disclose without direct questioning, due to the stigma and shame associated with the issue.

When talking about domestic violence and substance use a crucial point must be raised: drugs or alcohol do not cause domestic violence. Many people happily misuse substances without ever being violent to their family or partner. Most perpetrators are abusive, with or without drugs or alcohol. Substances, especially alcohol, can however act as a powerful disinhibitor, allowing the user to feel it is appropriate to engage in violent behaviour.

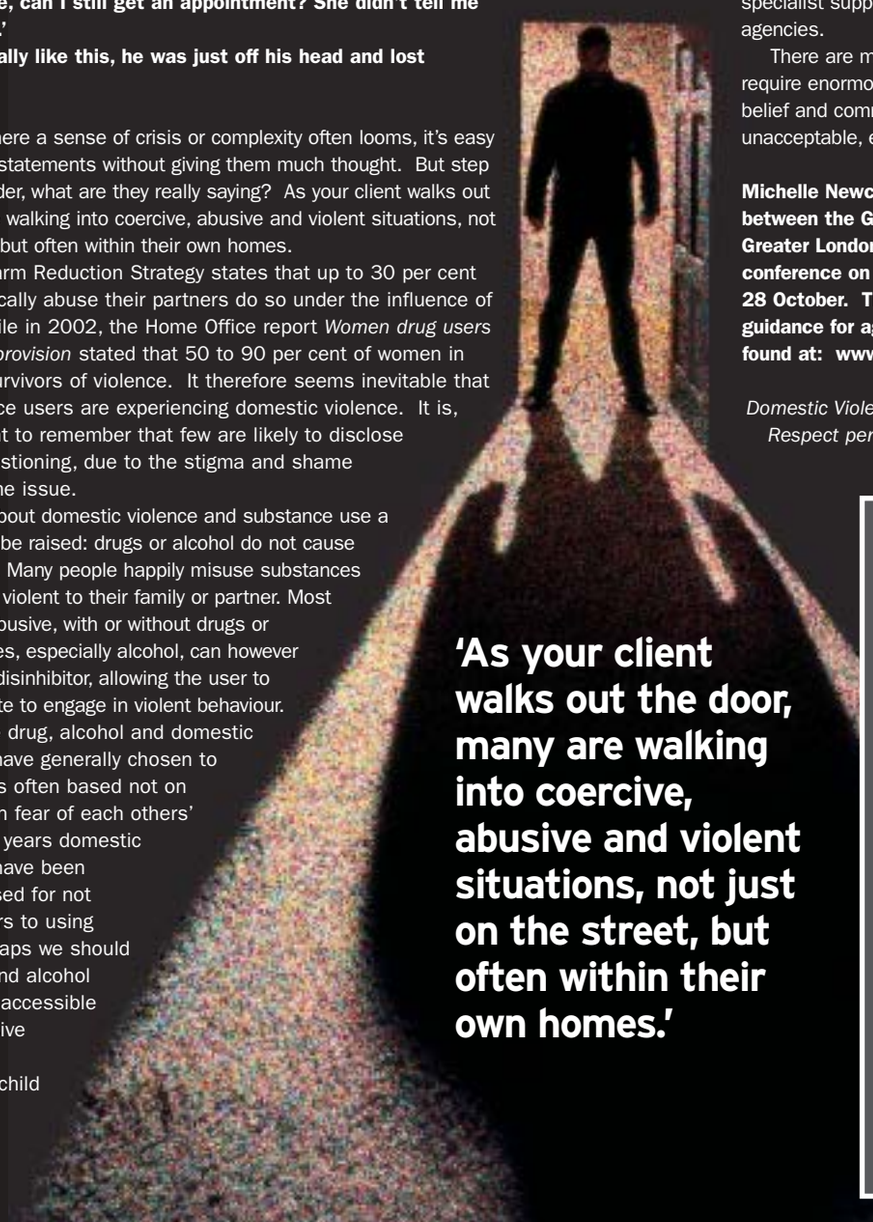
Historically the drug, alcohol and domestic violence sectors have generally chosen to work apart. This is often based not on client need, but on fear of each others' issues. In recent years domestic violence refuges have been particularly criticised for not opening their doors to using women. But perhaps we should also ask if drug and alcohol services are truly accessible to women in abusive situations. Most services have no child care facilities, inflexible opening times and limited gender specific spaces which allow for safe discussions about violence and abuse.

Yet some services are rising to the challenge, making great strides to fill gaps in service provision. Specialist domestic violence workers are now based in treatment services in Islington, Haringey, Newham and Neath. Drug and Alcohol Services for London (DASL) has been doing this work for around three years, alongside training and assessing for domestic violence as clients enter treatment. Refuges throughout the country are attempting to work in partnership with drug and alcohol services to provide satellite or gender specific services. This model has worked successfully in both Nottinghamshire and Hackney, proving women with drug and alcohol problems can be safely housed by refuges. Local authorities are devising specific forums or posts to develop guidelines and training programmes for both sectors. Tower Hamlets in particular has been leading the way, providing specialist support to local domestic violence, drug and alcohol agencies.

There are many options for working together; most do not require enormous resources or time. What they do require is a belief and commitment that domestic violence is preventable and unacceptable, even for those of us who misuse drugs or alcohol.

Michelle Newcomb works for the Stella Project, a partnership between the Greater London Domestic Violence Project and the Greater London Alcohol and Drug Alliance. They are holding a conference on domestic violence and substance misuse on 27-28 October. The Stella Project has also produced practical guidance for agencies working with these issues. All can be found at: www.gldvp.org.uk

Domestic Violence Helpline: 0808 2000 247
Respect perpetrator's phone line: 0845 122 8609



'As your client walks out the door, many are walking into coercive, abusive and violent situations, not just on the street, but often within their own homes.'

Key indicators that a client maybe experiencing domestic violence in a treatment setting

- A partner acting as the sole source of supply of substances, making it difficult for a victim to access substances or money elsewhere.
- Forcing a partner to use. This can also manifest in the abusive partner forcing poly or injecting drug use.
- Threats to disclose. This is particularly common if children are involved.
- Limiting access to information or treatment. For instance only allowing someone to attend treatment at set times or with their presence.
- Sabotaging treatment. Constantly calling a client in rehab or attempting to encourage relapse.
- Using the non abusive partner's earnings to buy substances.
- Taking out frustrations during detox or withdrawal on the victim. Remember there is no excuse for domestic violence, regardless of the perpetrator's state of mind.

Back – **from the brink**

Nick learned about using drugs the hard way. By the time he had his wake up call, it was almost too late.

It's one of those strange anniversaries of mine today. Seven years ago today I botched a hit in my groin that almost cost me my life. It did cost my left leg, but ultimately it probably saved my life as it led me to stop using drugs.

At that point in my life after 20 odd years of using various drugs, I had a very big habit and had given up any idea of ever stopping. Sooner or later I knew the drugs would kill me (as they had already, for most of my close friends) but I couldn't see any way out. I'd had countless attempts at stopping, but these were all followed by failure and an even greater sense of hopelessness.

Immediately following the hit, I knew I was in serious trouble with a pretty good idea that I was going to lose the leg. It had become completely immobile and was turning a dark purple colour – and it was accompanied by a level of pain that I had not believed possible.

Throughout that day and night in hospital I was given massive doses of diamorphine without any relief. The surgeons operated the following morning to try and unblock the arteries in my leg, but it was no use and my kidneys had now packed up as a result of poisons from my leg. Into the bargain, my liver function was poor due to hepatitis, I had shingles running right around my chest, unhealed sores at various locations round my body and I needed daily blood transfusions, as I was so anaemic.

Apparently, my sisters, brothers and my Mum were telling each other that maybe it would be for the best if I did not make it. Anyhow, at that point I decided that if I lived then maybe this would be my last chance to stop, as I knew I'd be in hospital for a number of months. I was put on a large dose of methadone and after some difficulties with the local Substance Misuse service I was allowed to control when I reduced my methadone. I was in hospital for three months and managed to come off the methadone completely in that time, although I did use on top a few times in the early weeks. When I look back now I think that it was probably not the best time to detox, as I was still quite ill and had to have dialysis every second day. But it worked out, and I haven't used drugs since.

The first year was hard as I had daily cravings, and at times I just could not think of anything but drugs. I still did not believe that I could stay clean and thought that I would inevitably 'fuck up' at some point. As time went by I started to realise that it really was just up to me whether I used drugs or not. I have coped with many things without using drugs.

'Apparently, my sisters, brothers and my Mum were telling each other that maybe it would be for the best if I did not make it... At that point I decided that if I lived then maybe this would be my last chance to stop.'

I've faced up to disability, my partner's death, constant physical pain and some very traumatic brain surgery and not returned to heroin.

I feel proud of what I have got through and of what I have achieved in the last seven years. One of the best moments for me was when my Mum told me how proud she was of me. At last I have started to make up for all the pain, worry and misery that I put her through.

In some ways the last six months have been the most difficult, as my health has been bad and I had to take a step back from some of the things I was doing in my life. I've had to start taking strong painkillers, which have had unpleasant side effects. At times, this has been depressing, but I am just starting to feel like I may have turned the corner.

Drug addiction really does not even feel like an issue for me any more. I do not use drugs as my life is better when I don't use them. I do not need any convoluted theory of what addiction is or is not; nor do I need complicated programs or religion. My life is better when I don't use drugs, so I don't use drugs.

Converging courses

What happens when you put GPs, pharmacists, nurses, social workers, psychiatrists, shared care workers – and drug using patients themselves, on the same course, to learn about management of drug use?

It's an unusual idea and quite possibly the first time it's been attempted, but it's exactly the concept behind the Royal College of Practitioners' Part Two Certificate in the Management of Drug Use in Primary Care.

Candidates, whatever their background, need to apply for the course with a full account of relevant experience and explanation of why they want to do the course. In the case of a patient, this will mean describing any experience they have already had as an advocate in a drug service, and any training in the substance misuse field – just as medically trained professionals will need to list details of previous drug-related training and experience.

Once accepted, candidates embark on six full study days, spread over six months. A mixture of activities includes a regional conference; local master class (a tutor-led workshop with between 10 and 15 participants); a two-month self study period that can include shadowing a colleague and specialist coaching, and a second local master class that includes assignments and relates the learning on primary care to local services and networks.

Dr Clare Gerada – known as 'the power and passion behind the course' – is motivated to campaign for further government funding by the enthusiastic response of participants. But along with her colleagues at RCGP and SMMGP, she has a driving purpose behind getting busy health professionals to make time for the training.

'It's embarrassing to admit, when you've been going for 10 years, that you don't know what you're doing.'

'There's an enormous backlog of GPs and nurses that know not a jot about substance misuse,' she explains. 'For too long they've pretended to know what they're doing – even experienced doctors. It's embarrassing to admit, when you've been going for 10 years, that you don't know what you're doing.' With the course, she says, 'they don't have to pretend – they can just get on with it'.

The course was initially just for GPs, says Dr Gerada, 'but then we slipped in nurses, pharmacists and prison doctors, even though we weren't funded for them'.

The inspiration and the unique learning experience came from introducing expert patients, to take the course alongside medical professionals. The coursework and master classes were adapted to relevant knowledge, such as advocacy for fellow users, and supportive mentoring was put in place.

But despite the care taken to support service users on the course, Dr Gerada is quick to emphasise that they had to do the work and there is certainly no element of 'dumbing down' its content.

For all those on the course, the mix of participants gave a chance to challenge their own preconceptions – and those of others from different backgrounds with diverse experience. **DDN**

How was it for you?

John, service user

I found it excellent, really good. I went to my first regional master class and was a bit daunted really; I didn't know what to expect – it's a long time since I've been in education. But everyone involved was so laid back, there was a really good atmosphere. There were four pharmacists in my group and the rest GPs. We were sharing information, seeing things from every angle. You get different perspectives. I was surprised at the GPs' lack of knowledge on some aspects of substance misuse – but that's why they were doing the course, to build on that bit of knowledge. I've had some very bad practice from GPs – if you're feeling quite nervous and vulnerable, you can come out of the surgery feeling worse.

But it was a two-way thing. I could see how much pressure GPs are under at times with safety issues, overdoses and so forth. There's still such fear and a lack of knowledge about optimum doses.

A lot of GPs where I live are already in shared care. But for those that aren't, they can be out on their own and feel vulnerable if they don't have anyone to turn to on a difficult case. It can reassure people if there are proper measures in place.

Barbara Rennells, nurse

I've been working with service users for about five years now, but the course really formalised what I've learned over the years. It was good having multi-disciplinary people there – I was able to interact and talk to pharmacists.

I found it interesting to talk to service users 'from the real world'. As a service provider you can get used to a very narrow view of who service users are if you're used to dealing just with homeless people. You learn about different approaches – and how punitive approaches don't work. It's about contracts and working together.

The course was always pitched perfectly. It neither assumed knowledge, nor was it at an insulting level. It's a really good, well-put together course.

The only thing was, my course tutors happened to be nurses, and their knowledge was unquestionable. But they got a bit of stick from doctors – 'you're nurses, how are you teaching doctors?'

I hope the course is expanded to include more service users.

Veena Rai Dhadwal, pharmacist

The multi-disciplinary experience was fantastic – I picked up a lot of information. The input from patients was really shocking and surprising.

The level and depth of knowledge, and the way the portfolio was done, were excellent. The course was very

Drug misuse knowledge of GPs and drug users might be poles apart – but what happens when you put prescriber and patient in the same room for a shared learning experience? DDN investigates.

flexible around a busy schedule.

It's very important to work alongside service users. We try to get service users involved locally, but it's not always easy. You need to be focused around patients' needs.

Patients really helped to fill in the gaps in knowledge, during the master class.

I was nervous at first, working with GPs. But they also have gaps in knowledge, and the patients felt that too. On the whole everybody was supportive of everybody else. The network of contacts gave us a signpost to other clinicians we can direct patients to.

Dr Jens Ludders, GP

I've just completed the course and I found it excellent. It was the right combination of your own studying and structured learning.

You have the opportunity to meet people from other specialist services who you would otherwise never meet. Community pharmacists were a whole new world for me! Although we work together with the local drug service, a lot of it's done over the telephone or through letters. Normally during working hours I'm seeing patients and in meetings. The opportunity to just talk to others in the drug-prescribing field is virtually zero.

I had the opportunity to bounce ideas off other people from other areas of the drugs field, all bringing their own experiences and opinions. I found that incredibly rewarding.

I think going on the course should be a definite 'must' for anyone working with the drug field in pharmacy or general practice.

It was interesting getting drug users' views on how GPs are seen – and realising how far we've actually moved ahead. There have been incredible advances. When you hear some of the anecdotal histories, you think 'my god'.

The attitude of users, former users or people wanting to access the service is very useful. It gives you an insight to something you don't really know about. And it shows how many people are actually interested in wanting to help.

There's a lot more communication nowadays than there used to be and a lot more people interested in working in this field. I thought it was a very encouraging and a very positive experience.

I don't think we, as GPs, should work in isolation. The course changed my attitude towards pharmacists and specialist nurses working within the field. We're in contact with services and the more we understand each other's culture and background, the better our working relationship will become. **DDN**

Next intake of the course for the Part 2 Certificate will be spring 2006. For more information visit www.rcgp.org.uk/drug/certificate.asp

Fact file

Service User Groups

This issue: Ben Holtom from **Wiltshire Service User Group**

When and why did you start your group?

A service provider was looking to set up a user group. We discussed the possible options. After a number of discussions to plan and prepare, I was deemed to have the skills and was voted in as chair.

We did some groundwork by attending and talking to other user groups, which were very interesting. With the knowledge gained we chose to have a group that was far more focused on positive outcome, service improvement, and self help. The Avon and Wiltshire Partnership (AWP) senior management was keen and supportive of the key objectives to positively tackle, and provide feedback on, the needs of users.

How many members do you have?

Currently we have 12 members with others interested in attending, but they have inherent difficulties in doing so: the community served is rural with poor provision of public transport; some were unable to attend because they have children. Most are unemployed and have no money.

How did you obtain funding?

At present there is no funding available. I have so far funded the printing, and my time is freely given. The AWP paid for the hire of the Town Hall and coffee.

Where, and how regularly, do you hold meetings?

We are holding monthly meetings at Calne Town Hall.

What do you hope members get from attending?

Practical help advice and sharing experiences that are positive. Creating accurate awareness of the needs of service users ranging from GPs to the community as a whole. Educating statutory services and providing better understanding of issues relating to drugs and alcohol. Giving members a feeling of self worth.

How do you keep it going?

By ensuring meetings keep existing members and encourage new ones. By giving the AWP, service providers and other organisations positive feedback, as they will support the user group and encourage new members. By getting organisations to acknowledge the extensive range of users' experience. By securing funding – I understand that three out of four user groups fail due to lack of it. By building on positive responses from users: this means others will attend to build a strong group. Through professional PR – which requires funding.

What have been your highlights so far?

Positive feedback and commitment from the first meeting, from users and service providers.

How do you communicate with your members?

At this stage I am the focal point, but we have agreed to primarily communicate by telephone as individuals gain trust in each other – this is also supported by the service providers with regard to circulation of minutes and information as a confidential third party.

Do you have any tips for others starting a service user group?

Through involvement with AWP, the service providers provide professional advice and have the contacts to link with other support groups such as Social Services and the DHI (Devizes Homeless Initiative).

Talk to the service providers who deliver the service, as they are aware of the needs and difficulties of the users, such as advice regarding alternative prescriptions.

Above all, plan a series of different relevant topics and information via newsletters so the users retain an ongoing interest in attending as it is of benefit to them – such as safe sex, healthy living (good nutrition on a budget) and so on.

My brother has completely lost it. I first did magic mushrooms with him a few years ago and, whereas my use of mushrooms is just a couple of times a year his usage has ballooned and now includes a lot of LSD. He also smokes a lot of skunk. He has become paranoid, reclusive, secretive, won't talk to me, it's like he's turning into another person. I suspect he's on the edge of some kind of psychosis but I seem powerless to do anything about it. I am so scared of getting any doctors or medical advice as I do not want him sectioned or given any of the chemical coshes I read so much about. Our mother seems to be in denial and is convinced there's nothing wrong and, as we're both in our early twenties, she would have no legal power over him anyway. What should I do?
Danny, Gloucestershire

Start by talking

Dear Danny
It is hard to comment without knowing a bit more about your brother's situation.

From the information you have given, it would seem unlikely that your brother would be sectioned under the Mental Health Act unless he has a mental disorder which is causing him to be a danger to himself or others.

It is important for your brother to try to talk to another person, in a non-confrontational way, about his substance use and the issues that may be connected to it. It is often harder to speak to close family members and if he is reluctant to approach his GP, he could contact a mental health or substance misuse voluntary organisation in your area or contact a helpline in confidence. The National Advice Service run by Rethink (020 8974 6814) can also offer information and support to you.
Caroline Hawkings
Mental Health Policy and Campaigns Officer, Turning Point

MIND resource

Dear Danny
Mind offers information through our website, www.mind.org.uk and booklets, and may be able to point you in the direction of further expertise (organisations such as DrugScope) through our info line on 0845 766 0163.

The following booklets may be of help to you:
www.mind.org.uk/Information/Booklets/Understanding/Understanding+the+psychological+effects+of+street+drugs.htm
www.mind.org.uk/Information/Booklets/Understanding/Understanding+dual+diagnosis.htm
www.mind.org.uk/Information/Booklets/Understanding/Understanding+addiction+and+dependency.htm
Best wishes
Ruth Goldsmith, Mind

Close to home

Dear Danny
I read your question with interest in the last issue of *DDN* and while I can't offer any professional advice, I do have personal experience of a similar situation that I thought might be of some help to you.

Several years ago I was heavily involved in the party scene, spending every weekend in a different field or warehouse taking various cocktails of ecstasy, LSD, amphetamines, weed (just about everything we could get our hands on). Keeping a grip on reality was a struggle for everyone but I had one friend (we'll call her Mary) in particular who was getting noticeably more and more 'vague'.

We tried to talk to Mary several times and tell her to take it a bit easy or have a weekend off, but she refused any such suggestions and continued to go downhill to the point where 90 per cent of the time it was impossible to have a rational conversation with her. She withdrew into herself, would mumble incomprehensibly and was extremely paranoid with everyone including her closest friends and family. She lost her job and her flat and ended up moving from squat to squat, only staying for short periods before being chucked out for being 'too weird'. We discussed trying to get professional help, but no one knew who to turn to and even if we had done we feared for the consequences, the 'chemical coshes' and 'them locking her up' *etc* in much the way you worry for your brother.

Eventually Mary was arrested (for a driving offence). While in custody the police had her examined and her parents were contacted and convinced to give permission to have her committed. Far from being the end, this was the moment that turned things round for her! They did not 'lock her up and throw away the key' as we had feared, nor did they 'drug her up to the eyeballs and turn her into a zombie'. Instead she spent six weeks receiving quality care and attention, being helped to move on for the right reasons and with experts administering the right drugs for her (without a chemical cosh in sight). Not only did they help her stabilise her mental state, they were extremely active on her behalf, helping her find new housing, and guiding her through the maze of forms required to claim benefit. Following her discharge she had a well-structured care plan and received lots of 'hand holding' until she was back on her feet again. Mary has never looked back from this and now has a house and a job and has returned to being the outgoing person she was before 'losing the plot'.

I guess what I am trying to say is, don't be afraid of seeking help. The mental health service and the social care system might not be perfect but they are there to help. You shouldn't believe all the scare stories you hear. I hope things haven't got so bad for your brother and I would urge you to speak to someone before they do.
Name and address supplied

Drugs just a trigger

Dear Danny,
It sounds as though your brother is mentally unwell. It may well be that the problem is caused by his drug use only, and would go away if he stopped using. Or it may be that he has a psychiatric condition independent of (but perhaps triggered by) his drug use. Either way, however, there is a limit to what you can do here. You can't get him sectioned even if you wanted to – you need two doctors to do that. And he may indeed not need to be sectioned in any case. The best case scenario would be for your brother to go voluntarily to see a local drug service – who should be able to support him, and refer him on as appropriate. This may seem a remote possibility right now, but lots of people in his position do eventually look for help. You and your mother may be able to help encourage him along these lines – but you may well get the brush off, at least at first. It might also be a good idea for you to find out as much as you can about services in your area – and give him whatever information you can find (contact details, leaflets if you can get any, and so on). And look after yourself in all this too. It must be very difficult to see your brother going through this, but there are services which can help people in your situation also. To find out more about services in your area – for both your brother and yourself (and indeed for your mother too) – try calling the Frank Helpline on 0800 776600. There are also a number of online resources, details of which you can find at www.drinkanddrugs.net (see under 'getting help').

Best wishes, and good luck,
Andy Beecham, drug and alcohol worker

Reader's question

I'm a drugs worker and really enjoy my job. I've had training and a lot of support from my workplace. The problem is, I'm slipping back into using again. I don't want anyone to know, as I'm really worried I'll get the sack. I think someone at work suspects, and we have a strict employment policy here – my contract says I have to remain clean. I don't want to risk losing my job – what should I do?
Lisa, London

Email your suggested answers to the editor by Tuesday 11 October for inclusion in the 17 October issue of DDN.

New questions are welcome from readers.

The normalisation of recreational drug use

In the next two Briefings, Professor David Clark looks at a seminal research study conducted by Professor Howard Parker and colleagues which provided essential insights into British youth culture and the role of drugs and alcohol among adolescents during the 1990s.

Only a small minority of people who try an illicit drug develop a problem. Many people who try an illicit drug do so on one or a few occasions and decide the experience is not for them. Some may use one or more illicit drugs on a periodic basis, while others may use more regularly; but still their use is recreational and controlled.

The use of illicit drugs has increased greatly over the past 20 years, in particular during the 1990s. As an example of this change, a large-scale annual survey by the University of Exeter's Health Education Unit (involving 30,000 children from 150 schools in England and Scotland) revealed that the proportion of 15- and 16-year-olds that reported ever having tried an illicit drug rose from 10 per cent in 1989 to 40 per cent in 1996.

In 1991, Professor Howard Parker and his colleagues initiated a unique piece of research, which tracked a large sample of young people (14 to 18 years old) from the North West of England over a five-year period. The study confirmed the widespread recreational use of illicit drugs, and provided essential insights into British youth culture and the role of drugs and alcohol among adolescents.

This study took place against the backdrop of a 'youth-drugs-crime-danger' message both from media and politicians. When John Major, the then Prime Minister, announced his new drug strategy (Tackling Drugs Together) in a speech to the Social Market Foundation (9 September 1994), he chose 'yob-culture' as the soundbite he wanted the media to highlight.

'Tackling Drugs Together' was about offenders and crime, indeed 'no single crime prevention measure would be more significant than success on the front against drugs'.

One premise of the strategy was that young people were 'at risk of drug abuse' and succumb because of peer pressure. The second premise was that drugs are dangerous and a menace. The third was that because drug use leads to crime, local communities are at risk from drug users.

The war-on-drugs rhetoric of the Tory Government, and the desire to link drugs and crime, was later hijacked by the Labour Party in opposition. It was continued once Labour came into power.

In their book *Illegal Leisure*, Parker and colleagues emphasised that this political discourse has an 'energy' of its own. It promotes public fear and anxiety about crime, drugs and youth,

which in turn it then uses to interfere simplistically, and with apparent public consent, in drugs and criminal justice policy and practice. This process, because it can barely be challenged, thus spins along reinforcing itself.

But this simplistic rhetoric ignored the question as to why the majority of young people try illicit drugs and a significant minority continue to use them regularly.

In trying to understand this situation, Parker and colleagues emphasised that that the very nature of adolescence was changing – the context and the conditions in which young people were growing up were very different to generations before.

The research study involved a sample of over 700 14-year-olds being tracked annually for up to five years. Each year, they were asked about their personal and family circumstances, their disposable income, use of leisure, and perspectives on personal and social relationships. They were asked in detail about their use of tobacco, alcohol and illicit drug use.

'The findings suggested that recreational drug use had become widespread amongst British youth. Over 36 per cent of the sample had tried an illicit drug by age 14, and this increased to 51 per cent by age 16, and 64 per cent by age 18.'

As they matured, more complex issues were pursued, including their attitudes towards drug use and drug users, their assessment of health education they received, and their experiences at parties and nightclubs.

Five annual self-report surveys were undertaken, and 86 interviews were conducted when respondents were 17 years old. Eight co-educational state secondary schools in the North West metropolitan area of the UK were used. The questionnaires were distributed in the classrooms with teachers absent.

The overall aim of the study was to assess how 'ordinary' young people growing up in England in the 1990s developed attitudes and behaviours in relation to the unprecedented ready availability of drugs, alongside other consumption options such as alcohol and tobacco.

The findings suggested that recreational drug use had become widespread amongst British youth. More than 36 per cent of the sample had tried an illicit drug by age 14, and this increased to 51 per cent by age 16, and 64 per cent by age 18. More than 60 per cent and 90 per cent of the sample had received drug offers at age 14 and 18 years, respectively.

The most commonly tried drugs by age 18 were cannabis (59 per cent tried), amyl nitrites or 'poppers' (35 per cent), amphetamines (33 per cent), LSD (28 per cent) and ecstasy (20 per cent). Only 6 per cent had tried cocaine and 0.6 per cent had tried heroin.

Females were almost as likely as males to have tried an illicit drug by age 18, and there were no differences between youth from working and middle class backgrounds. At age 18, nearly one-quarter of the sample had tried an illicit drug in the past week.

The study also revealed that young people reported many more positive experiences of drug use than negative outcomes.

By age 14 years, 90 per cent of the sample had tried alcohol, with 30 per cent claiming to drink on a weekly basis. This latter percentage rose to 80 per cent in 18 year-olds, with a mean consumption of ten units on the last drinking occasion. At age 18 years, just over a third of the sample were current smokers.

In the follow-up Briefing, we look at the drug journeys that young people in this study took, and explore why adolescent recreational drug use became normalised.

The reader is strongly recommended to read the book, 'Illegal Leisure: The normalization of adolescent recreational drug use' by Howard Parker, Judith Aldridge and Fiona Measham; Routledge, 1998.

DipHE/BSc (Hons) Substance Use and Misuse Studies

Starting February, June and October 2006

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Modules can be taken in isolation or combined leading to a Diploma or Degree.

This multidisciplinary programme has been mapped against the Drug and Alcohol National Occupational Standards (www.danos.info).

Who can apply

The programme is suitable for a wide range of professionals working with alcohol and drug users including nurses, social workers, drug and alcohol treatment workers, those who work in homeless and youth services and in the criminal justice system, in both the statutory and voluntary sector.

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On the occasion of the inauguration of
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'PERSPECTIVES ON SELF-CHANGE FROM ADDICTIVE BEHAVIOURS'

FRIDAY 28th OCTOBER 2005

Venue: The Keyworth Centre, London South Bank University

Seven leading researchers will present and discuss relevant evidence from contrasting psychological perspectives - biological, cognitive, self, social-community & spiritual.

Professor Ian Albery: Professor of Psychology at London South Bank University, a cognitive psychologist specialising in unconscious cognition and addiction.

Professor Christopher Cook: University of Durham, a psychiatrist with major research interests in spirituality and addiction.

Professor Robin Davidson: A clinical psychologist at the Gerard Lynch Centre, Belmont Park Hospital in Belfast, specialising in the psychology of recovery from addiction.

Professor Michael Gossop: From the National Addiction Centre, Kings College, London, who is the Principal Investigator on the National Treatment Outcome Research Study (NTORS).

Dr Marcus Munafo: A biological psychologist in the University of Bristol and specialising in the genetics of addiction.

Professor Geoffrey Stephenson: Emeritus Professor of Social Psychology at the University of Kent with interests in self-reflection and response to treatment in recovery.

Alma Thomas: A sports and counselling psychologist who has specialised in processes of self management in the performing arts, athletics, and more recently in addiction counselling specifically.

Registration Fee: £25 - Includes Lunch & Refreshments
Please send a cheque made payable to PROMIS along with your registration form to:
PROMIS, The Old Court House, Pinners Hill, Nonington, Kent CT15 4LL
Registration closes on 14th October 2005

For all enquiries contact 01304 841700 or e-mail m.williscroft@promis.co.uk

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We are a modern enterprising voluntary sector organisation with over 30 years experience and a proven track record of delivering the highest quality alcohol and drug treatment services. We are a registered charity and company limited by guarantee with our head office in central Manchester and have two residential rehabilitation care homes and 18 service centres covering Greater Manchester, Lancashire and West Yorkshire.

We exist to prevent and reduce the harm caused by alcohol and drugs to individuals, their families and the community which we aim to achieve by working in partnership with other specialist and generic agencies to provide services which are needs-led and empower and enable clients to end their dependence on drugs and alcohol and fulfil their full potential.

We have a turnover of nearly £6m per annum and employ circa 200 paid staff and over 200 volunteers.

The current Chief Executive, Elizabeth Smith, will retire in August 2006 and we hope to have her replacement in post by around 1st June 2006.

Therefore we require an inspirational and strategically oriented individual with a demonstrable commitment for people with or affected by alcohol and other drug problems achieving their full potential and with a successful track record of organisational leadership and management.

Full particulars may be requested by email : ads@alcoholanddrugservices.org.uk

Applications must comply with the specification given in the post particulars and must be received no later than Friday 28 October 2005 at 4.00pm.

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(DipSW/CQSW)

£27,411 PA

An exciting opportunity for an experienced addictions professional wishing to play a lead role in an important regional service. Minimum 2 years addictions experience necessary. Additional relevant qualification desirable.

For further information and an application form please contact: Mick Davies on 0191 5235516
Closing date: 14.10.05

Haringey DAAT Drug and Alcohol Action Team

London Borough of Haringey

Expressions of interest for the provision of Haringey Drug Interventions Programme

Haringey Drug Interventions Programme works to reduce drug-related offending by referring drug using offenders out of crime and into treatment.

Expressions of interest are invited from suitably experienced organisations for selection to tender to deliver Haringey DIP. The contract, to be managed by Haringey Council's Drug and Alcohol Action Team, will include accommodating and running the programme. The value of the contract will be approximately £1m. Ongoing evaluation criteria will be the Key Performance Indicators in force at the time, as laid down by the Home Office, National Treatment Agency as well as meeting the financial, managerial and other requirements outlined in the agreed service contract.
The expected term of the contract will be until 31 March 2009 and the contract should commence on or around 1 July 2006.

Expressions of interest are invited for all or for specific lots, from individual organisations or from agencies acting in partnership.

Lot 1	Provision of a beginning-to-end support programme that follows and manages offenders as they pass through the criminal justice system, covering the following areas: Police custody The courts Prison Treatment
Lot 2	Provision of Low Threshold Prescribing, 'Rapid Prescribing',
Lot 3	Provision of a Day Programme for people on a Drug Rehabilitation Requirement Order
Lot 4	Drug Rehabilitation Requirement Treatment Workers (supporting the Probation Team in treatment and rapid prescribing of statutory clients)
Lot 5	Provision of an 'Out-of-hours'/ 24/7 telephone Helpline for substance misusers
Lot 6	Provision of a comprehensive Throughcare and Aftercare Service Team for substance misusers, including the following elements:
Lot 6.i	Provision of an Employment Placement Worker as part of the Throughcare and Aftercare Service
Lot 6.ii	Provision of a CAB Advice worker as part of the Throughcare and Aftercare Service.

Written expressions of interest and requests for the tender documentation should be made to: Paulette Haughton - DIP Project Manager, Civic Centre, High Road, London, N22 8LE

Fax: 020 8489 2992
E-mail: paulette.haughton@haringey.gov.uk

The closing date for Expressions of Interest is 13.00 on 17 October 2005 and packs will be sent out on 20 October.

Are You Looking For Staff?

We have a comprehensive database of specialist substance misuse personnel to meet your needs

DAT Co-ordinators ● RoB Co-ordinators ● Project Workers
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Drug and Alcohol Team Manager
Swindon Community Safety Partnership

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

We're Addaction, a leading UK charity working solely in the field of drug and alcohol treatment. With over 70 services, we work within communities and individually with clients from all backgrounds, helping to reduce substance misuse and to combat the harm it causes. Now we want you to help us evolve our services further and in the process find far-reaching solutions to one of the major social issues of our day.

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You should have a strong understanding of drug and alcohol misuse and the commitment to lead and develop a professional team. With demonstrable knowledge of funding streams and a working knowledge of relevant legislation and drug and alcohol policy, your excellent oral and written communication skills will assist you in delivering winning presentations to stakeholders and the wider community.

In return for your dedication, aside from our competitive pay and benefits package, we can offer you the opportunity to manage diverse services at a senior management level, and the option to further develop your skills through our management training programme.

For further information please contact Jerry Stokes on 07904 184233.

For an application pack please call 01332 254520 quoting reference ADDN20.

Closing date: 21 October 2005.
Interviews: w/c 31 October 2005.

Expressions of interest for providers of substance misuse services to be included on Bristol City Councils preferred providers list.

Bristol City Council wishes to set up a Preferred Providers List for citywide provision of community based Tier 2 and Tier 3 substance misuse services

The list will be for a period of 3 years and will consist of suitably experienced community based substance misuse service providers

Selection for the inclusion on the list is no guarantee of work, selected providers will be invited to tender for community based substance misuse services

Initially providers will be asked to tender for a citywide Tier 2 and Tier 3 service, to be commissioned from April 2006 for 3 years.

Organisations wishing to submit expressions of interest should contact Sue Bandcroft at the address below for an outline service specification and a pre qualification questionnaire by 10th October 2005

The closing date for the return of the completed questionnaires is 12 noon, 28th October 2005. Submissions after these dates and times will not be considered

Drug Strategy Team, Bristol City Council
Princess House, Princess Street, Bedminster, Bristol BS3 4AG
Tel: 0117 9142222

Willowdene Farm

Residential Rehabilitation & Training

Psychotherapists (1 full & 1 Part time)

£24,000 - £30,000 p.a. depending on experience

Willowdene Farm, one of the most successful residential drug rehabilitation units in the country is seeking to appoint two Psychotherapists (1 full time & 1 Part time) with potentially immediate start to join the care team.

Willowdene Farm is a medium sized, Christian based residential unit offering nine month residential placements to drug dependent males within a therapeutic environment. The model for delivery is well established gestalt based, and has operated successfully for the last 18 years. We provide a vast array of accredited work based skills training and a full range of leisure and life skills development. For more details visit our website; www.willowdenefarm.org.uk.

We are looking for qualified (accredited) and experienced individuals who can deliver therapy within our model and contribute to other care work as part of an integrated therapeutic model (this could include some evening and weekend duty). Willowdene Farm is an equal opportunities employer and therefore invites applications from anyone who may be interested and qualified.

Closing date for applications: 21 October 2005
Send a personal letter of application with a detailed CV to:
Willowdene Farm Ltd, Chorley Nr Bridgnorth, Shropshire, WV16 6PP
Or contact Jenny for an information pack on: 01746 718658

WEST LONDON MISSION SOCIAL WORK MINISTRY

St Luke's First Stage

A registered therapeutic centre based in London SE11 is seeking

A QUALIFIED AND EXPERIENCED COUNSELLOR in the field of addiction with Danos training

NJC Scales, SCP 25 to 30, plus Inner London Weighting (currently £22,668 to £26,277 pa inclusive)

St. Luke's First Stage is a primary treatment centre providing an intensive 13 week residential programme for men and women. The therapy integrates the strengths of a psychodynamic perspective, incorporating cognitive/ behavioural approaches and drawing on the strengths of the 12-step model as the basis for treatment.

We are looking for a dynamic and enthusiastic qualified Counsellor to join our team of five skilled clinicians. We need you to have experience of working with addictions, providing group/individual therapy, presenting psycho-educational workshops, and ideally experience of working with personality disorders, family work and people with complex needs.

We offer in return, an opportunity to develop your skills and knowledge in a highly professional working environment, where staff are supported with on-going training, complementary therapies and both internal and external supervision.

If this describes you, please apply for an information pack by EITHER faxing your request to 020 7487 3965 OR writing to The Director of Social Work, 19, Thayer Street, London W1U 2QJ, OR e-mail to carol.turner@wlm.org.uk.

Completed applications must be received by 5.00 pm on 21 October 2005

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The Swanswell Charitable Trust is an established and expanding addictions agency providing quality Alcohol & Drug Services in Coventry, Warwickshire & Birmingham. We are funded by and work in partnership with statutory agencies.

DRUG SOLUTIONS, BIRMINGHAM

Providing Shared Care Criminal Justice & Housing Support Based Drug Services

Shared Care Service

Our Shared Care Service provides highly skilled and trained drug workers to support GPs in their management of patients with a drug misuse problem. We have built successful linkages with over 140 GPs and the scheme continues to develop. DSB workers provide structured evidenced based interventions for people experiencing problems with illicit drug use within an assessment & care management framework. Further expansion within Primary Care setting means that we are again increasing our capacity and are recruiting to the following positions.

Team Managers Level 2 (4 posts)

Shared Care Drug Services
NJC Point 37 – 40 (£28,179 - £30,747) p.a.

Working to a Locality Manager and supported by a senior practitioner, Team Managers hold day to day responsibility for one of DSB's four teams of primary care based drug workers. High quality staff supervision and effective staff deployment are central to quality service provision and are therefore central to this role.
You will be required to oversee case work and case load management. Highly developed interpersonal skills will be used to work collaboratively with GPs and other partner organisations to deliver and further develop Shared Care Services. The successful applicants will have previous social care/health management experience including staff supervision and appraisal. Previous experience in drug and or alcohol treatment services is an advantage. However, we welcome applications from those with relevant management experience with transferral skills wanting to move into the substance misuse sector.

Senior Practitioner

NJC Point 35 – 37 (£26,703 - £28,179) p.a.

The Senior Practitioner role is key to ensuring effective service delivery to individuals with complex needs. The post-holder will share their knowledge and expertise with drug workers providing case work support, mentoring and training. Senior Practitioners support the Team Managers with the day to day running of the team and are instrumental in setting up clinics with new GPs joining the shared care scheme.

Shared Care Drug Worker (2 posts)

NJC Point 26 – 31 (£20,295 - £24,000) p.a.
with possible progression to point 34 (£26,157) p.a.
Starting salary is related to experience and qualifications

Shared Care Drug Workers provide support to GPs working with drug users by offering therapeutic support, harm minimisation advice and care planning to improve the health and social functioning of service users. While experience in providing drug services would be an advantage, we equally value transferable skills. Therefore, we will accept applications from people with 12 months paid experience in relevant health, education, social care or criminal justice settings.

A full driving licence and availability of a car is essential for the above posts.

For an informal discussion regarding any of the posts please call Pip Yardley Bennett or Steve Sanger on 0121 233 7400.

Closing date for applications for these posts: Friday 14th October 2005

Further details about our service can be found on www.swanswelltrust.org

For a job application pack please contact:

SWANSWELL CHARITABLE TRUST
Swanswell Centre, 44a – 46 Regent Street, Rugby CV21 2PS

Tel: 01788 565970 Fax: 01788 565988
Email: vicky.horne@swanswelltrust.org

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Education

Drug and Alcohol Education Service (DAES)

This new County service is intended to provide a consistent and co-ordinated approach to children and young people in education settings in Hampshire.

The service will operate at Tier 2 level and will provide a range of targeted approaches to drug and alcohol education and support interventions.

We have a number of exciting opportunities to join this new team:

Drug Education Team Leader

- £29,004 - £31,557
- Home-based
- Ref: 8194

You will provide professional leadership for the Drug Education Workers and take a lead in policy development and working protocols for service delivery, as well as maintaining an active caseload.

You should have a nationally recognised qualification in youth work, education, social work or health, or other relevant qualifications and experience, and have successfully completed Tier 2 Substance Misuse Training and worked with young people in education settings for at least two years.

Drug Education Worker

- £26,157 - £28,179 (pro-rata)
- Term-time only
- Home-based
- Ref: 8192

You will work in education settings, undertaking initial assessments to identify the needs of young people and prepare and deliver appropriate intervention plans at individual and group levels.

You should have a nationally recognised qualification in youth work, education, social work or health, or other relevant qualifications and experience, and have 2 years' experience of working with young people and substance misuse.

For further details of the posts, please contact Stephanie Durrant on 01962 847178.

To apply online or view further details of these or any of our current vacancies please visit www.jobs.hants.gov.uk Alternatively you can contact the Resourcing Centre on 0845 850 0184, or e-mail us at resourcing@hants.gov.uk for further information. Please quote the appropriate reference. Textphone users only can call free on 0808 100 2484.

Closing date: 17 October 2005.

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