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DDN

Drink and Drugs News

12 December 2005
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Drink and Drugs News

12 December 2005

Editor's letter

Looking back over the year makes you realise how much has happened during 2005. At the beginning of the year we were bracing ourselves for the Drugs Act and a change to Licensing Laws. The Drug Interventions Programme meant more change, and more debate about the focus on the criminal justice system. School drug testing provoked a frenzied ethical debate.

Yet some things remained disturbingly the same. At home and abroad, the 'war on drugs' left major supply chains unbroken. A diamorphine shortage has rumbled on all year without resolution. Hepatitis C casualties continue to rise, despite dire warnings from medical experts that we're not doing enough on diagnosis and treatment.

You always want to approach a new year with optimism and there's plenty to feel positive about. This field is in no way apathetic about changing things for the better. Communications are stronger; service users are making their voices heard; and well-reasoned arguments come from people with very different views and diverse backgrounds. The government knows it will never be short of feedback on its consultations – this field is not backward about coming forward.

Which makes for another interesting and challenging year ahead for us. If you haven't let us know what you're doing in your area yet, make it your New Year's resolution to write to DDN...

Thank you for all your support throughout 2005. Have a great Christmas and New Year!

This is the last issue of DDN before the Christmas break – our next issue is published on Monday 16 January 2006 (with an advertising booking deadline of Thursday 12 January).

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In this issue

Home Secretary in rally for next stage of DIP

The government is committed to focusing on the individual and seeing everyone reach full potential, Home Secretary Charles Clarke told a Home Office conference on 'Delivering the Drug Strategy: progress made, challenges ahead'.

'Drugs represent destruction, felt often by the youngest and most vulnerable,' he said. 'It is critical we prevent today's vulnerable young people from becoming tomorrow's drug user.'

Much more needed to be done, he told delegates, particularly in harnessing opportunities to reduce crime. Drug strategy had to be 'a common thread in all we do in our communities', with fighting drug abuse 'at the centre of all strands'.

The Drug Intervention Programme was being used effectively to achieve interventions, according to Mr Clarke. More than 500 drug misusing offenders a week were being offered a route out of crime and into treatment. The next stage was to bring programmes together at a local level and give continuity of care.

'It's not just about treatment, it's about entirety,' he said, emphasising the importance of wraparound services such as housing.

Mr Clarke urged delegates to 'be a bit humble about treatment itself', recognising that people needed different types of treatment – and not just in prison. 'All of this package has to be available in the community as well as the criminal justice system,' he said.

The government's drug strategy had 'made the right inroads' to date, he said. A more joined-up approach was needed next, with new ways of partnership working.

The future represented 'a fantastic challenge', said Mr Clarke. 'We all have to re-dedicate ourselves to make sure drug strategy is at the centre of the government's policy.'

Police powers of drug test on arrest come into force

New police powers allowing drug testing on arrest came into force on 1 December – one of the measures introduced by the Drugs Act 2005.

Police will test for heroin, crack and cocaine when arresting for acquisitive crime and will direct those who test positive to attend a compulsory drug assessment by specialist drugs workers. Even if they are not charged, they will then be helped into treatment and support. Offenders who refuse the test could be given a fine of up to £2,500 and/or three months in prison.

The scheme has been started in Greater Manchester, South Yorkshire and Nottinghamshire, and will be expanded next March.

Consultation is also underway on setting specific limits for personal possession, which would categorise as a dealer anyone caught carrying more. Sent to 17 agencies and police bodies, including the Advisory Council on the Misuse of Drugs, the consultation letter suggests limits of: 7g heroin or 10 wraps (each wrap containing 0.1g heroin); 7g or 10 (0.1g) wraps of crack cocaine; 7g or 10 (1gm) wraps of cocaine; 10 ecstasy tablets; 14g or 10 (1g) wraps of amphetamines; 113g or 10 individual pieces or wraps of cannabis resin; and 0.5kg or 20 individual 2 inch by 2 inch bags of cannabis leaf.

Some politicians have already suggested that the suggested thresholds are too high, and will encourage dealers. During the same week in Brixton, south London, police announced they would reverse their previous policy of cautioning but not arresting people caught with small amounts of cannabis, and have declared their intention to arrest anyone with any amount in their possession.

Scottish study to trace links between homelessness, mental health and addiction

Links between homelessness, alcohol, substance misuse and mental health will be investigated through an 18-month study in Ayrshire and Arran.

The study, by NHS Ayrshire and Aran Addiction Services in collaboration with East, North and South Ayrshire Councils, will track the experiences of homeless single adults. Researchers will look at the pathways that lead to homelessness, and the cycles that keep them there.

Through in-depth interviews, Faye Murfet of the Addiction Services' information team will gather information, alongside reviewing literature to build a picture of local and national good practice.

Addiction Services manager Pat Lerpiniere hoped results of the study would give recommendations that would be useful in developing services. 'Our aim is to try to prevent single adults entering into homelessness and, where they do, to help them find a long-term sustainable route out of homelessness,' he said.

Olga Clayton, Head of Housing at North Ayrshire Council, added that the research would not only add to the council's progress in preventing homelessness, but would help them to direct support services and resources to where they were most required.

Shropshire campaigns for safer nightlife

Shropshire's safer drinking campaigns include appealing to parents to use common sense in supervising children and alcohol.

The Drink Safe campaign, developed by Shropshire Drug and Alcohol Action Team's Safer Nightlife Group and the Safer Shrewsbury Pub Watch Group, has devised a list of tips for parents that encourage sensible drinking in front of children and an open and informative approach to their questions and behaviour relating to alcohol.

Another strand of the campaign offers safety tips to drinkers – on moderating intake, not being vulnerable to strangers, and avoiding drink driving. Practical measures on drink spiking involve the campaign members distributing free bottle tops donated by Safeflo, preventing spiking in bottled drinks, to pubs and clubs in Shrewsbury town centre.

Shropshire County Council's DAAT is distributing a survey to 2000 licensed premises in the county to find out more about drug and alcohol problems, to assist the Safer Nightlife Group's future planning.

'We want to find out more about local problems from those selling alcohol so we can work together to solve problems,' said Shropshire DAAT's Sarah Dodds. Information from questionnaires will be fed to police, trading standards, district community safety partnerships and licensing officers to make Shropshire's nightlife safer.

FRANK talks through teenage website

Partnering with a teenage website gave the government's FRANK campaign a link to young people's questions, during 'FRANK on Drugs Week'.

An online agony uncle answered questions on the website www.mykindaplace.com, which uses interactive discussion forums to tackle a range of issues relating to growing up and popular culture.

Through targeting people in the South West, the campaign, which ran from 28 November to 4 December, also challenged teens and parents to find out three new things they did not know about drugs.

James Robinson-Morley, FRANK spokesperson, said the campaign was addressing myths and misinformation about drugs and drug taking, 'from the downright silly to the seriously dangerous'. Misconceptions included 'cannabis cleans the lungs' and 'taking speed makes your teeth fall out'.

The FRANK helpline receives on average 35,000 calls a month and has received over a million calls since being set up in May 2003.

FRANK helpline: 0800 77 66 00; website: www.talktofrank.com

Lothian targets young people through drink safety messages

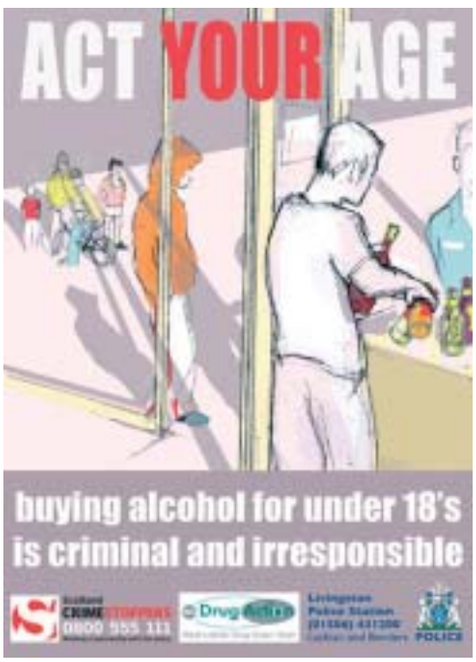
Adults who buy alcohol for under-18s are being targeted by West Lothian Drug Action Team.

In partnership with West Lothian Drug and Alcohol Service and Lothian and Borders Police, the DAT is distributing posters to off-licences, shops and supermarkets throughout the region, urging the community not to buy alcohol for young people.

Hilary Smith, the DAT's research and development officer said the campaign aimed to make adults realise that buying alcohol on behalf of a young person was 'illegal and irresponsible'. West Lothian Drug and Alcohol Service's manager, Margot Ferguson, said it was a timely initiative, in view of the current publicity on changes to licensing legislation.

Lothian and Borders Police recognised that most shopkeepers in the area took their responsibilities seriously in actively preventing underage sales, but added their support for an initiative that would help to reduce illegal sales and supplies to young people.

In another partnership with Lothian Police, Edinburgh Council and NHS Lothian, who make up the partnership Action on Drugs in Edinburgh,



launched a short film to warn young people about the dangers of spiked drinks.

Tom Wood, chair of the partnership explained that the film was 'not meant to alarm young people' but would encourage them to think carefully about their safety on a night out. It will be distributed to schools and youth work agencies, and has an accompanying toolkit for practitioners working with young people aged 16 to 24.

Mums tackle drugs with power of knowledge

A group of Asian mothers have taken a new route to tackling drugs, by training alongside healthcare professionals.

Manchester City Council's drug and alcohol strategy team extended their workshops to the wider community, after local parents showed interest in wanting to know how to recognise illegal drugs and their symptoms.

One of the 14 graduating mothers, Yasmine Dar, said the course was a positive way of equipping parents with the knowledge to talk to their children about drugs. 'The issue of drugs is definitely a taboo in my community, but it is something that we can't ignore if we want to look after our young people,' she commented.

Sessions included looking at replica drugs, examining the reasons why people use illegal drugs, and challenging common drug myths by looking at the law alongside hard facts about levels of risk.

Cllr Jim Battle of Manchester City Council said the council had realised they needed the involvement of residents if they were to win the battle against illegal drugs in the city, and were using education as 'the backbone of [their] efforts'.

Home Office research showed recently that 96 per cent of Mancunians want to know more about what is being done locally to tackle drugs. Almost 20 per cent of the city's population is made up of Black and Minority Ethnic communities, driving the DAAT's commitment to catering for its diverse population.

FDAP launches online evidence checker

FDAP has launched the online 'evidence checker' facility that will make it easier for practitioners to check their evidence against the criteria for their drug and alcohol professional certification scheme. (See DDN, 28 November, page 13.)

Through using the facility, practitioners will be able to enter details of their qualifications, discover their current eligibility to registration and accreditation, and find out what additional evidence, if any, they will need.

View the evidence checker at www.fdap.org.uk (click on 'professional qualifications', then 'professional certifications' and the evidence checker logo).

Is a new advanced qualification needed?

Research is taking place to find out if a new advanced qualification is needed by practitioners in the drug and alcohol field.

A first stage of research, until January 2006, reviews existing provision and consults with key stakeholders, commissioners, employers and workers to assess the level of need and what an advanced qualification should cover. An expert group will consider the content of any new DANOS units required.

If the project's steering group and the Cross-Sector Forum for Drugs and Alcohol decide there is a strong enough case for developing the new qualification and standards, a second phase running from February to May 2006 will involve a full range of parties in developing and testing them. Final documentation will be prepared for approval and accreditation during June and July.

Research and development is being carried out by Trevor Boutall and Fiona Hackland of The Management Standards Consultancy, for Skills for Health, with funding from the UK Co-ordinating Group.

Readers are invited to contribute views on whether a level 4 qualification is required and what it should contain. Visit www.skillsforhealth.org.uk/danos to complete a brief questionnaire. *DDN* will publish the survey's initial findings in the new year.

Your views wanted on prison drug treatment

The National Offender Management Service (NOMS) is inviting views on how treatment and throughcare of drug using prisoners can be improved.

A debate will be held at the conference 'Prisons and Beyond' in February, but NOMS is keen for ideas and feedback to shape the focus of conference sessions. Two interactive debates, under the banner 'If I ruled the world…', will focus on how to improve systems to deliver more effective services, and how the range and quality of services can be enhanced.

'We want this to be an opportunity for workers and managers in the field to tell us their ideas on how we might improve the range and quality of drug treatment services in prisons and beyond,' said Martin Lee, head of the NOMS Prison Drug Strategy Unit.

Opening the debate before the event would give those unable to attend the conference a chance to air their views and contribute to the feedback for NOMS.

The 'Prisons and Beyond…' conference, organised by NOMS in association with FDAP and EATA, will be held in Leicester on 16-17 February. For more information on the event visit www.fdap.org.uk

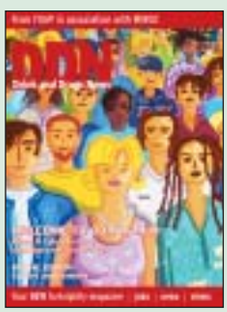
To contribute to the debate, email your thoughts to nomsconference@fdap.org.uk

Review of the year

January

The year the licensing laws change begins with wrangling between ministers and warnings about boozed-up Britain's runaway binge-drinking culture. While Prime Minister Tony Blair and his Culture Secretary Tessa Jowell say that staggering closing times will diffuse city centre mayhem and bring new maturity to our drinking culture, police warn of extra resources needed and doctors produce frightening statistics on liver disease.

Pupils at a Kent school start the new term as subjects of a random drug testing trial. Head teacher Paul Walker finds himself at the centre of heated media debate, but insists the mouth swab tests, which detect cannabis, speed, ecstasy, heroin and cocaine, will only be used to guide any miscreants towards counselling and support.



February

New commissioner of the Metropolitan Police, Sir Ian Blair, declares his intention to get tough on dinner-party cocaine users, instead of just targeting street dealers. The middle-classes need to realise they are not above the law, and are morally accountable for the 'trail of blood back to Columbia' – 'People who wouldn't dream of having a non-organic vegetable don't seem to notice the blood on their fingers,' he says.

Researchers at Glasgow Caledonian University find themselves in the spotlight for a study that suggests that well-educated, employed people can take heroin over a long period of time without it destroying their lives – a conclusion that some campaigners complain is irresponsible.

Meanwhile, the United Nations announces Britain as the 'heroin capital of Europe'.

March

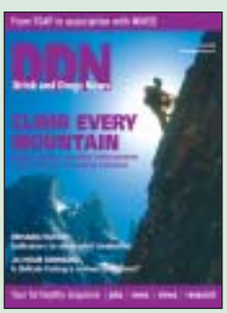
Scotland publishes its Licensing Bill, tackling underage and binge drinking and making it easier for local communities to have a say in whether licences are granted. Minister Tavish Scott says it will tackle Scotland's 'shocking record' on alcohol.

The International Narcotics Control Board

announces that a British-led attempt to persuade Afghan opium farmers to grow other crops has failed. A bumper 4,200 tonne crop – 800 tonnes more than the previous year – will contribute to 90 per cent of the heroin sold on Britain's streets.

There is panic the following week at the UN's annual commission on narcotic drugs meeting in Vienna, when the US announces it will not endorse needle exchanges or heroin substitution programmes, in reaction to the growing heroin epidemic. Britain is among EU countries that are deeply concerned at the effect this will have on the spread of infection, particularly HIV and Aids.

Back home, Alcohol Concern warns of a 'chronic lack of progress' on the first anniversary of the National Alcohol Harm Reduction Strategy for England, and the government publishes 'Every Child Matters'.



April

Models of Care for Alcohol Misusers (MoCAM) goes out to consultation for three months.

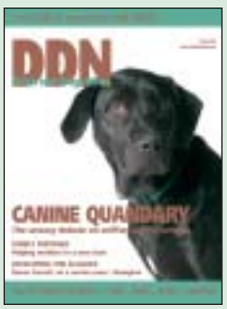
Reactions to the Drugs Bill grow fiercer and the row over mushrooms keeps mushrooming: the government is accused of rushing through legislation to reclassify magic mushrooms as a class A drug without proper debate, and there is talk of it being an election deal between the three main parties.

Release and Transform publicise their concerns about the Drugs Bill, accusing it of being overly focused on criminal justice interventions, and containing populist 'tough on drugs' measures that could be counter productive.

May

UK Sport, the national anti-doping organisation, announces a policy and set of model rules to promote doping-free sport in the UK and clamp down on those who fail drugs tests. Many of sport's big names, including Paula Radcliffe and Jonny Wilkinson, join the '100% ME' drug-free sport education campaign.

Alongside a growing debate about cannabis and mental health, Home Secretary Charles Clarke asks



the Advisory Council for the Misuse of Drugs to debate whether 'skunk' varieties should have a higher classification.

GPs announce their wish to work more closely with drug treatment services in managing drug users in primary care, and The Royal College of General Practitioners reports keen uptake of their training for GPs on treating drug users.

June

The US pushes the UN further to block the use of needle exchange programmes in countries where drug use drives the spread of Aids, arguing that such schemes encourage drug use. Britain is among countries continuing to oppose the US position, arguing that harm reduction measures are essential.

Scotland's Health Minister launches an action plan to tackle Hepatitis C, calling on health professionals from all backgrounds to get involved in tackling the 'hidden killer'.

First Minister Jack McConnell announces a 'historic day for Scotland' with approval of a Smoking Bill that will become law next March and make Scotland the first part of the UK to become smoke free in all enclosed public places.

July

A leaked Downing Street report shows a failing war on drugs, as researchers find that police and courts' action relating to hard drugs are having little effect on production and supplies – powering the case for legalising drugs so they are not controlled by criminal operations. Only half of the report is released to the public, provoking an outcry that evidence is being suppressed to avoid government embarrassment.

The law change on magic mushrooms comes into effect, giving them the same classification as heroin and cocaine. Transform is among those to comment that 'the outcomes of this change will be all bad'.

The Liberal Democrats request government figures on alcoholic liver disease, to demonstrate the folly of new licensing laws. Alcoholic liver disease is shown to have nearly doubled in less than 10 years, at a cost to England's health service of more than £71 million a

The highs have been inspiring – more funding, more joint-working. The lows have been disastrous – creeping levels of alcoholism and Hepatitis C; shortages of life-saving drugs. DDN takes you on a whistle-stop tour of 2005.

year. Patients are getting younger and doctors are treating the type of liver disease in 20 and 30-year-olds that they have previously seen only in patients in their 50s and 60s.

Ofsted, the education standards watchdog, reports that a growing number of primary schools are giving drugs lessons to children as young as seven. The chief schools inspector says children need guidance to prevent them following celebrity examples like Pete Docherty and Prince Harry.

In the middle of the UK's three-year term leading US, European and local forces in the fight against Afghanistan's drug trade, the British government suffers the embarrassment of levels of opium cultivation reaching an all time high of nearly half a million acres. America criticises Britain's 'softly-softly' approach.

The NTA is displaying more optimism: chief executive Paul Hayes announces a 27 per cent increase in the number of people in contact with drug services during the past year.

August

Former labour MP Mo Mowlem loses her battle against cancer. Speaking out against the farce of recent cannabis debates, she had called for an end to the current 'hypocritical and confusing situation' through legalising cannabis and taxing it to help pay for addiction treatment.

Scottish Drugs Forum's drugs death conference attracts interest and controversy from those at opposite ends of the abstinence versus harm reduction scale.

September

Supermodel Kate Moss finds herself headline fodder when the Daily Mirror publishes grainy pictures of her allegedly snorting cocaine in a recording studio, with Pete Doherty and entourage. Her modelling contracts teeter as fashion giant H&M, with whom she had a £1.2 million deal, initially say they will stand by her – then topples, as H&M, Chanel and Burberry fire her to make a clear statement to a very interested public about their 'no tolerance' policies on drugs.

Doctors warn the government of underestimating a looming public health disaster, as a study reveals that 500,000 people are likely to be carrying the Hepatitis C virus in Britain – double government figures, which could cost the NHS £8 billion over the next 20 to 30 years. Diagnosis and treatment must improve dramatically as we head towards a crisis, says Prof William Rosenberg, a consultant at Southampton General Hospital.

Britain announces extra funding to curb opium production in Afghanistan, taking this country's contribution to £270 million. Half the money will be spent on law enforcement to counter smuggling; half will go towards developing alternative livelihoods for opium farmers.

Meanwhile, a shortage of diamorphine (prescribed heroin) escalates to desperate levels. Problems with the factory that supplies 70 per cent of the UK's diamorphine was announced at the beginning of the year – but no alternative supply has been found. In the meantime long-term patients, including those prescribed diamorphine maintenance treatment for drug dependence, are left waiting for a solution that is nowhere in sight.

UKHRA is among harm reduction groups calling for swift resolution by importing alternative supplies – but politics prevail and the government refuses to change to a supplier from another European member state. 'The current situation will continue until at least February 2006,' says the NTA.

October

David Cameron overtakes David Davis in the Conservative leadership contest, but can't shake off questions about drug use in his past. At a Blackpool fringe meeting he refuses to answer a question on whether he has ever taken drugs. Media questions come thick and fast, to be fielded with his statement that 'what's private in the past should remain private' and an admission that he had 'erred and strayed' at university. Eventually he was riled enough to answer 'no' to the question 'have you ever snorted cocaine as an MP?', but still becomes 'Cannabis Cameron' to the tabloids.

November

The risks of methamphetamine, known as crystal meth, are reviewed by the Advisory Council on the Misuse of Drugs, in response to Home Office concerns about its rising popularity in the UK, particularly on the gay club scene. The ACMD advises that the drug should remain a class B drug, despite horror stories from the US where its use has become increasingly widespread.

As concerns about new licensing laws reach a crescendo, round-the-clock opening times arrive on 24 November. Tough new measures to deal with any alcohol fuelled disorder have been waiting for Britain's boozers to lurch into action and fears for the nation's livers propel safer drinking campaigns to teach the unfamiliar habit of moderation. Alcohol Concern launches a 'Spend £1, Get £5 Free!' campaign, calling for investment in alcohol treatment to save health, social and criminal justice costs.

Cocaine is identified by the EU drugs agency as the 'stimulant drug of choice' for many young Europeans, with Britain at the top of the European league table for cocaine use.

DDN celebrates its first birthday, as circulation rises to over 10,000.

December

All suspects arrested for 'trigger offences' such as burglary, theft and handling stolen goods will be drug tested by police for heroin, cocaine and crack. New powers are part of the Drugs Act 2005, which requires those who test positive to attend a drug assessment, even if they are not charged with the offence. New thresholds are also proposed for personal possession – the amount that a person can carry without being charged for dealing in the drug. Cannabis controversy rears its head again with police announcing a reversal of the 'softly softly' approach to those caught with the drug. Worried by the increase in cases of possession and trafficking in Brixton, where a more liberal policy was trialled, the Metropolitan Police are discussing plans with the community to get tougher again.

Psychosis continues to make headlines, with a Danish study concluding that cannabis smokers have a high risk of developing severe and lasting psychiatric disorders. **DDN**

Good idea... bad practice

I am not surprised that DIP was so widely criticised but I can also understand the dismay expressed by the chief of EATA (*DDN*, 28 November, letters). The DIP has had a positive effect in prompting drug agencies, prisons and probation services to increase communications between them concerning the care planning for individuals with drug problems.

However, the negative effects have outweighed the positive benefits in many cases. The amount of administration is exorbitant. The forms are unwieldy and difficult to fax or copy. They waste an enormous amount of space and time. The large amount of space devoted to current or recent drug use is out of balance with the miniscule space for history. The whole system also creates an artificial distinction between alcohol and other drugs and presents obstacles to treatment for people with alcohol problems. It duplicates inefficiently the details in the initial and full assessment forms that many agencies have adopted along Models of Care guides. The activity sheets are even more wasteful.

The DIP form is neither a good assessment and care planning tool nor a good communications tool. The failure of the design is in my view the result of a failure to consult. If people on the ground had been consulted and the objectives described they would have designed the form and processes differently. The communications aspect would have been a distinct part of the form and procedure, and the assessment and care plan would have been better defined. It would have been easy to send a communication with some basic information separately from all the details needed to deliver the care plan. The forms would have been uploadable and downloadable so we could send them to each other by e-mail. They would have been on paper that was standard size and easily copied for fax or post. A control sheet for single point of contact would have been integral.

The big advantage of additional communication has been outweighed by the disadvantages of an inept implementation of a good idea.

Eleanor Levy, substance misuse officer, Surrey Probation Area.

(These are personal views and not the official policy of Surrey Probation Area or its substance misuse team.)

Can you offer information on Meth?

I am writing to *DDN* in the hope that readers will be able to offer me some assistance in my quest for up-to-date information regarding Methylamphetamine production and use within the UK. I am a third year BSc Social Work student at Portsmouth University and I am currently on placement in ANA drug and alcohol treatment centre in Portsmouth, I am also a recovering addict who used drugs and alcohol unsuccessfully for many years.

I am in the process of planning and writing my dissertation which will be focusing on Methylamphetamine within the UK – however finding any literature is proving difficult. The recent Methylamphetamine Review from the Advisory Council on the Misuse of Drugs is an obvious starting point, although their decision to maintain Meth as class B is a little concerning.

There is no shortage of information from the US, but while this is obviously important, it doesn't provide me with the information I need.

Part of my research will include the media's impact on promoting Meth and its effects to susceptible user groups, using the development of crack and ecstasy within the UK as obvious comparisons. I am also hoping to develop an anonymous questionnaire that clients of various drug agencies across the UK who are in treatment at ANA will be able to complete. I hope this will provide me with some figures that may highlight hotspots of activity within the UK.

One small point of interest: the first time I typed Methylamphetamine into my search engine I was given its chemical formula with detailed instruction on how to produce it. This I found slightly alarming, but somehow amusing.

Any help or information would be most helpful.

Mark Springer, c/o ANA Treatment Centre, 161 Elm Grove, Southsea, Portsmouth PO5 1LU.
Tel: 02392 837837.
Email: markspringer37@aol.com

Surely the first principle of human relations, and the right way to engage clients in treatment is to offer a non-judgmental environment that is warm and welcoming? The majority of clients we see, 23,000 of them, are stigmatised enough, without blaming them for ravaging their bodies etc. Yes, we need users to take responsibility for their actions, but we won't do that if we don't first engage them in treatment.

Plenty of sound data on 'what works'

While abstinence is a vision we can all agree with, for many users to get there, it takes time. Unfortunately, Peter O'Loughlin, a private practitioner, seems to sit in high judgement on efforts to provide multiple responses for multiple needs. (*DDN*, 28 November, letters).

Firstly, surely the first principle of human relations, and the right way to engage clients in treatment is to offer a non-judgmental environment that is warm and welcoming? How can he infer criticism of that? Therapeutic work also includes challenging clients' behaviours. The majority of clients we see, 23,000 of them, are stigmatised enough, without blaming them for ravaging their bodies *etc*. Yes, we need users to take responsibility for their actions, but we won't do that if we don't first engage them in treatment.

Mr O'Loughlin asks about the evidence. The evidence of what works is manifold – and that includes offering harm minimisation, to reduce harms from blood-borne diseases. I would also rather that he was sensitive enough not to mention Ron Hubbard's name in the same breath as AA and NA.

'What works' may form an eclectic body of data – but it is sound data. (I offer a few references: NTORS [UK], DANOS [USA] downloadable on the internet and summarised in back issues of *Drug & Alcohol Findings* – see 2002, UKATT 2005). Of course, what we know about the human brain is limited, and any 'science' will be evolving. There is still more to learn. Twelve step programmes are part of those large studies. Narconon is not. It is not helpful if narrow opinions are offered without homework being completed.

As to wet houses and consumer rooms – street drinkers and intravenous injectors need a wide variety of interventions as much as anyone, and also a level of dignity that should be afforded to any human being. Consumer rooms are as much about safety for both user and public as anything else.

Secondly, Ian Robinson in the same issue of *DDN*, gives us a well reasoned response to the somewhat polarised and bunkered vision offered at the FDAP conference about the Drug Interventions Programme (DIP). The Minister, Paul Goggins' remarks are very welcome. Offering pathways into treatment which prevent people leaving prison for example from falling through the gaps in care, is a world first, and is working, and something the government should be proud of. It does not mean thousands of non-offenders are not accessing treatment through other routes. It is also good news that government is working on developing more housing support – a real gap.

DDN readers may like to know that Addaction will be offering two conferences in April about aftercare, based on research undertaken for the Department of Health, aimed at practitioners who want to share good practice. The dynamic of large numbers of dedicated workers gathering together to improve

delivery is so much more valuable than ill-informed opinion emanating from fixed positions and silos.

Rosie Brocklehurst, Director of Communications, Addaction

Re: The road to hell...

Peter O'Loughlin asks for evidence on Drug Consumption Rooms (*DDN*, 28 November, letters). A good place to start looking is the international review by the European Monitoring Centre on Drugs and Drug Addiction.

The EMCDDA's mission includes the provision of independent, objective critical appraisal of responses to problem drug use, of the kind Mr O'Loughlin quite reasonably seeks. The review summarises the evidence that existed in 2004, as well as some of its limitations, and lists about 150 papers that he may wish to consider. It concludes that DCRs can realise each of the main benefits for which they have variously been established, including:

- decreases in high-risk drug use, morbidity and mortality (in particular supervised drug injecting facilities);
- increased uptake of health and social care, including drug treatment;
- reductions in public drug use and neighbourhood nuisance.

Since the publication of the EMCDDA review, there have been further important additions to the literature – notably from Vancouver – that begin to address some of the recognised limitations of the evidence base. In some respects these use more robust designs than earlier studies allowed, and provide more evidence of the role of DCRs in reducing the sharing of injecting equipment, public injecting and the public disposal of needles.

While on the subject of evidence, why does Mr O'Loughlin state that 'drug-related crime continues to increase' when the crimes that are most commonly linked to dependent use of illicit drugs have fallen significantly in the last decade?

Alex Stevens, Senior Researcher, EISS, University of Kent

Comment

A Target is for life. It is coming up to Christmas – a time of giving and sharing with our partners. This year, drug services can give back to the NTA a Christmas Target (ACT), writes Dr Ian Telfer.

'The best Christmas presents always arrive in small packages, so I suggest something small: 'The named NTA officer to respond to all written correspondence within one week'.
I don't think we need to pad out our gift with any further explanations or definitions. To add a little Christmas spice, let's only assess the most delayed response, accept no explanations or excuses, and promise the NTA with disinvestment should they fail.'

Over the years, the NTA have been especially generous in handing out unsolicited gifts (targets) of waiting times, retention rates, diversity targets etc etc. So, in a small way, it is our time to grasp this seasonal opportunity and give back.

The best Christmas presents always arrive in small packages, so I suggest something small: 'The named NTA officer to respond to all written correspondence within one week'.

I don't think we need to pad out our gift with any further explanations or definitions. To add a little Christmas spice, let's only assess the most delayed response, accept no explanations or excuses, and promise the NTA with disinvestment should they fail.

A target is for life, not just for Christmas. A well-chosen target can be enjoyed throughout the year and for years to come.

Firstly, there will be opportunities for social get-togethers. Each regional office will have the pleasure of each separately defining what a week is (five days or seven days) and when the clock should start ticking (when the letter is dictated, signed, posted or received) and when the clock stops (as above). Solving this puzzle will give regular opportunities of meetings with colleagues and the employment of a dedicated admin worker to collate the figures and e-mail them to Tony Blair by the last Friday of every month.

But there is more! NTA officer will no longer be inconvenienced by attending training events, going on holiday with their families (who tend to fight and bicker anyway) or be forced to take time off sick (when you are poorly, it is much better to keep yourself busy).

Working lives will become so much easier. From now on, the only priority will be writing letters and so NTA officers will no longer be troubled by attending tedious meetings, assisting local services or thinking up even more, mutually exclusive and incomprehensible targets.

It gets better and better. No longer will letters have to make any sense. If you don't know the answer; make it up – guess. With only one week to respond, you won't have time to think, discuss with colleagues, do the research or seek additional information. Remember, the target is responding within a week, not the quality of the response.

Sorry, got to dash, I've cancelled my clinic because I've got an urgent meeting with the DAT co-ordinator to decide what colour paperclips we will use next year. Apoplectic purple is a nice colour, don't you think?

Happy Holidays.

Dr Ian Telfer is consultant psychiatrist at Oldham/Tameside CDT

Opening doors for alcohol treatment

The shortage of treatment options for people dependent on alcohol puts unfair strain on mental health services and fails to address the real nature of alcohol dependency. We need more appropriate facilities for those who do not fit into the bracket of mental health treatment, says Gabrielle Tracy McClelland.

There is a shortfall in treatment options available for alcohol-dependent people. Currently, treatment responses typically lie within mental health services, which are inappropriate for people who do not have mental health problems.

The Alcohol Harm Reduction Strategy for England recognised in 2004 that current treatment structures for alcohol dependency lack clarity relating to standards and routes into care. The NTA's recent *Models of Care for Alcohol Misusers* is addressing the appropriateness of treatment settings and integrated care pathways.

Choice and autonomy over treatment in relation to where the detoxification will take place are significantly reduced for those people who are alcohol dependent and have either a physical health or social complication. While community psychiatric nurses support people in the primary care setting, this is a relatively recent development and requires further exploration to maximise the potential of their role.

The question is frequently raised as to the most suitable, safe environment to detoxify for alcohol-dependent people who have an element of risk, but do not have a mental health problem. Current arrangements, locally and nationally, appear to span from self-care, to primary care, to inpatient care. Many general practitioners support community detoxifications for alcohol-dependent people by prescribing a reducing dose of benzodiazepines (usually chlordiazepoxide) for one to two weeks. This practice works for some, but it offers little more than a time-limited medical intervention. The safety elements are as unsubstantiated as the efficacy of this regime. Many people openly admit to consuming alcohol and taking the chlordiazepoxide simultaneously, which is potentially dangerous due to the combined effects of two central nervous system depressants.

Acute mental health wards may have dedicated beds for the purpose of detoxification. However, the beds are frequently used for acutely mentally ill people and occasionally for the detoxification of those who are dependent on opiates. These factors contribute to the often lengthy waiting times for a hospital detoxification from alcohol, which contravene the current National Treatment Agency recommended waiting time of two weeks.

Other options include admission to an alcohol rehabilitation unit where detoxification is included in the treatment package – and some do not offer this facility. However, funding for a rehabilitation place is not guaranteed and this option means that the person must live away from their home, which may in itself be problematic. Alternatively, the patient may choose to pay to attend a private detoxification unit, where the current approximate cost is £2,500 per week and the average stay is two weeks. It is reasonable to suggest that the majority of clients seeking support for alcohol dependency do not have £5,000 to spare, although it has been known for a GP to achieve funding through a primary care trust.

General medical wards facilitate alcohol detoxification, although it is acknowledged that this tends to be on an ad hoc basis rather than a planned event and is usually secondary to an admission for a physical health condition.

For some people, anxiety is generated by the prospect of an admission to an acute mental health unit. Paradoxically, this may mobilise the person's coping strategy (which is likely to be alcohol) and result in a subsequent increase in alcohol consumption, challenging the person's physical and mental health resources.

As psychologist Carlo de DiClemente pointed out in 1991, the ideal conditions to improve dependency behaviour are to establish a therapeutic alliance between the client and the therapist to encourage motivation and to promote self-efficacy. Removing a person's choice is likely to damage the therapeutic alliance – it is not empowering to be asked to receive treatment in a mental health unit when one does not consider oneself to be mentally ill. Often the result is de-motivation and a loss in self-efficacy with a negative outcome expectancy (*ie* 'they think I'm mad!').

The frequent result is that clients will withdraw themselves from alcohol and cease to enlist support from a nurse or doctor. This is potentially dangerous, as abrupt withdrawal from a central nervous system depressant such as alcohol may induce a seizure. Others agree to a hospital detoxification in a mental health unit and take their own discharge before the treatment is complete – some as early as day one. Some people disengage from services completely and view their options as being either to accept a label of mental illness or continue drinking. From an addiction perspective, we may interpret this disengagement as a decline in motivation or the person's lack of readiness to change. However, it also symbolises the closure of a window of opportunity for that individual, who has demonstrated their commitment to address their problematic use of alcohol and been provided with an inappropriate treatment option. The person may or may not re-present to a dependency service at a later date; however, if hope is lost – albeit temporarily – progress is slow.

There have been numerous documents produced with the intention of improving services within health systems, such as The Department of Health's *National service framework for mental health* in 1999. Specific documents have been produced to engineer the shaping of substance misuse services into bedrocks of quality, worthy of the claim that we are appropriately addressing and meeting the needs of our clients. Recent government literature relating to substance misuse service provision, *eg Dual diagnosis good practice guidelines* in 2002, *Tackling drugs to build a better Britain* in 1998, and the *Alcohol harm reduction strategy for England* in 2004, contain comprehensive guidelines and recommendations relating to various care pathways and treatment options for a range of

dependencies. However, the issue of where an alcohol-dependent person with no mental health difficulties and either a history of seizures or limited social support receives detoxification, remains inadequately addressed.

Primary care teams tend to focus upon those people who are consuming alcohol above the recommended range of safe limits and who are likely to respond to brief interventions. However if the brief interventions do not have a positive impact and alcohol use escalates to the level of dependency, then the person is likely to be referred to a mental health or substance misuse team for a treatment regime which involves an alcohol detoxification. This practice assigns a stigmatising label of mental illness to the person.

It is important to recognise that the majority of alcohol dependent people (with or without mental health difficulties) are supported in their own homes to detoxify from alcohol. However, for those people for whom this is not an option, suitable alternatives need to be considered. Only then can treatment services claim to be offering a quality service that endorses the essence of clinical governance and the concept of best practice.

Clinical governance is not purely concerned with the quality and efficacy of care; it also addresses cost effectiveness. A hospital alcohol detoxification costs the National Health Service considerably more than a community detoxification. The cost to the client is probably less straightforward to measure. Within the specialist area of substance misuse we use cost-benefit analysis as a strategy to facilitate an introspective view of the client's relationship with alcohol and other elements of their life. Perhaps, as nurses, doctors and others who work with dependency, we should apply the same strategy to calculate the cost and benefit to the client. By definition, an alcohol-dependent person is a seeker of support, is likely to be feeling vulnerable and is then asked to consider opting into the mental health system for a while.

Problems are easier to identify than solutions, particularly when we enter into the debate of humanity versus economy. A logical starting point is to engage in meaningful dialogue with alcohol-dependent people who enlist our support. Appropriate treatment choices are more likely to promote autonomy and to assist in the person experiencing a sense of control and achieving their goals. A positive interaction with services is more likely to procure a positive outcome. Subsequently, the risk of relapse is potentially reduced, as the person is more likely to engage in relapse prevention following detoxification.

The way forward may be to invest in separate facilities for those alcohol-dependent people who have specific needs and do not fit into the existing service structures (mental health detoxification facilities) to avoid the routine and sometimes inappropriate practice of referring alcohol-dependent people with the absence of mental health problems to a mental health setting for detoxification.

Gabrielle Tracy McClelland MSc BA (Hons) RGN RMN teaches at the University of Bradford.

Better standards in drug testing: part three

Adulteration – how to cheat the system

Effective drug testing depends on a clean sample. In the third of his six-part series, Phil Houldsworth tells you how to spot signs that someone's trying to cheat the system.

It doesn't matter which sample type you take to monitor a client's drug status, all are open to cheating and manipulation. But, with a properly designed collection system in place for sample collection, it should be very difficult – if not impossible – to cheat.

So how might you try and cheat the system?

Drug tests can be cheated in one of two ways – by either substituting or adulterating the sample. For substitution, there are devices that can be purchased on the web which promise to deliver 'normal drug free urine' at the point of urination. These devices are difficult to spot unless you directly observe the individual, which isn't recommended. It is more difficult to substitute an oral fluid and hair sample, but it has been done. In the US, a study was carried out which showed that several oral samples, apparently of human origin, were in fact from dogs and cats.

When it comes to adulteration of the sample, the individual is trying to alter the drugs in the sample or to produce naturally 'clean' samples. Here the donor can either take something or do something to themselves. This is termed internal adulteration. External adulteration is when the donor adds something to the donated sample. With external adulteration we have to watch for individuals adding substances to the sample. Salt, bleach and water added to urine or oral fluid samples will either destroy the drug or affect the testing process itself. Indeed, various 'washing solutions' can be applied to hair to wash out drugs in hair samples.

For internal adulteration, you have to look at the different pills and potions that can be purchased. The vast majority of these do not by themselves work as they are just 'herbal' drinks with little or no effect. With urine samples, it is more effective to drink large volumes of water than it is to take pills or potions. Eight pints or more may dilute urine to a point that the drug falls below detectable levels, but the dilution can be detected, either at the point of collection or in the lab. For orals fluids, you can purchase gums or drinks that stop the individual from salivating or change the acidity of the mouth to stop drugs from being excreted.

So how can such cheating be countered?

You have to have a properly managed collection process that respects the dignity of the donor as much as possible but minimises the chances of cheating. For instance when collecting oral fluid samples wait and observe the individual for a full 10 minutes before putting the swab in their mouth and then watch the client for the duration of their sample provision.

'Salt, bleach and water added to urine or oral fluid samples will either destroy the drug or affect the testing process itself. Indeed, various 'washing solutions' can be applied to hair to wash out drugs in hair samples.'

For urine samples try and keep the collection beaker in sight, make donors wash their hands before you hand them the beaker and if it's a concern, add dye to the toilet water. If you suspect that an individual has tried to cheat then check the temperature of the sample. You can also purchase test devices that will tell you if the sample has been adulterated. In addition, there are various tests that can be carried out in a laboratory on samples to check for cheating.

Now that we have our sample and we are pretty certain that it's genuine, we need to have it tested. This is what we will move onto next.

Phil Houldsworth is managing director of Tackler Analytical Ltd, which sets up and administers drug testing quality assurance programmes.

Adfam: supporting families for 21 years

On Adfam's 21st birthday, Jennifer Clark reflects on the charity's achievements in supporting families affected by drug and alcohol use, and looks at challenges for the future.

Adfam estimates that up to 3 million families in the UK are affected by drug and alcohol misuse. The charity is in contact with about 300 support services for families across the country, but the scale of the problem, relative to the help available, remains quite daunting. Much of the support is provided by dedicated, often unpaid, individuals and groups, so campaigning for further resources and a higher priority for families remains Adfam's champion cause. Through support and education, families can be informed and empowered, often allowing them to regain the hope which drugs and alcohol have taken from their lives.

Adfam was established in 1984, by the mother of a heroin user who found herself unable to access the support she needed. From its inception, the charity sought to confront the stigma and isolation that family members often experience when trying to find support and guidance. The last 21 years have seen dramatic improvements to the provision of treatment for drug and alcohol problems, but this has not been matched by a similar improvement in the services available for family members.

At the time of Adfam's founding, large swathes of the country were either hostile to, or ignorant about, the effects of drug and alcohol use – towards both the individual and the families involved. There was a strong current of belief that the problems caused were entirely self-inflicted, and for this reason, drug and alcohol issues were marginalised. Responses to the problem tended to focus quite narrowly on the substance user, rather than dealing with the problem holistically; they did not examine the full impact substance misuse was having on families and communities to provide them with support in their own right. According to Vivienne Evans, Adfam's chief executive, support available to families was 'next to nothing' in 1984. Great strides have been made in the last 21 years, she says – 'however, a sustained effort is needed to ensure families get the recognition and support they need.'

From the beginning, Adfam strived to overcome stigma faced by families seeking help when they had been affected by alcohol and drug use, and has sought through vigorous campaigning to change society's views. As long as stigma remains, many families will be unwilling to access support. Through setting up training programmes in 1987, Adfam has armed individuals with practical knowledge of the problems families face; these trainees are then well placed to educate those they come in to contact with.

The constant struggle to secure funding is a continuing obstacle. Like many organisations that work within the voluntary and not-for-profit sector, the need to secure funding continues to hamper Adfam's desire to reach its full potential. Time and energy devoted to bid writing and fundraising means less time and energy is spent meeting the needs of families, whereas securing regular core funding would mean more staff hours could be devoted to ensuring that the voices of families are heard and their needs met.

In 1989 Adfam established the first national helpline to offer anonymous support and guidance for families. After only a year, the service needed to be expanded - testimony to the fact that family members were actively seeking support. The helpline statistics allowed Adfam to further its influencing and policy work, by proving that families need support in their own right.

> 'Drug and alcohol treatment outcomes can be vastly improved if families are involved in substance users' care plans.'

Building on the success of the helpline, the first prison project was established in 1993. Seeing prisons from the point of view of the family was a new perspective for the drug and alcohol field and helped to highlight just how confusing and daunting the criminal justice system can be. Recognising the involvement of families and attempting to integrate them into offenders' resettlement has often resulted in reforming family ties, improving family relations, and a greater understanding of how drugs and alcohol affect family dynamics. By working in prison visitors' centres, Adfam continues to offer families objective advice and information. The organisation now offers services in most of London's prisons and plays an important role within a system that has become better geared to intervene in offenders' drug and alcohol use. Prison visitors' centres can be a primary point for engaging drug and alcohol affected families and it makes sense that those closest to prisoners with drug and alcohol problems are given information and support for their own sake, to enable them to support offenders upon release. Involving families from the outset can form the foundations of more effective resettlement strategies.

Since 1989, Adfam has produced publications to meet the needs of specific family members. The latest series, the *Journeys* booklets, were produced using a steering group representing the booklets' target audience; for example, the grandparents' booklet was steered by grandparents, and draws on the personal experiences of others in the same situation to fulfil the specific needs of that group. The *Journeys* publications demonstrate a core Adfam belief: that it is not up to us to dictate what families need; rather, that services in the drug and alcohol sector should listen to those they serve and seek to fulfil their needs. Adfam works towards making choice and options a reality for every family that needs them in the UK.

Through organising conferences and lobbying, Adfam has increased public awareness about the difficulties families face when dealing with a loved one's substance use. While various parliamentarians have supported Adfam's cause over the years, it is by working closely with service users that the charity has been able to present the real difficulties faced by drug and alcohol affected families to politicians and the media. Families' personal stories are often the most compelling way of conveying the importance of family support, and Adfam's work has provided a platform for family members to speak out about their experiences and influence policy.

This year Adfam was involved in producing *We Count Too*, a good practice guide and quality standards for work with family members affected by someone else's drug use. Collaborative work involves groups such as Grandparents Plus and Fathers Direct, and the NTA has funded Adfam to develop a commissioning guide for family services. This kind of work helps to explore the best ways for families to

be supported in the future and be an integral part of DAAT services, rather than a 'bolt-on' extra. As Chris McEvoy, a family support worker funded by Leicester DAAT comments, 'Adfam's tireless campaigning and awareness raising work is finally being recognised. It is clear that involving and supporting families is good in its own right, and also translates into important help for drug and alcohol users'. It has become clear that drug and alcohol treatment outcomes can be vastly improved if families are involved in substance users' care plans.

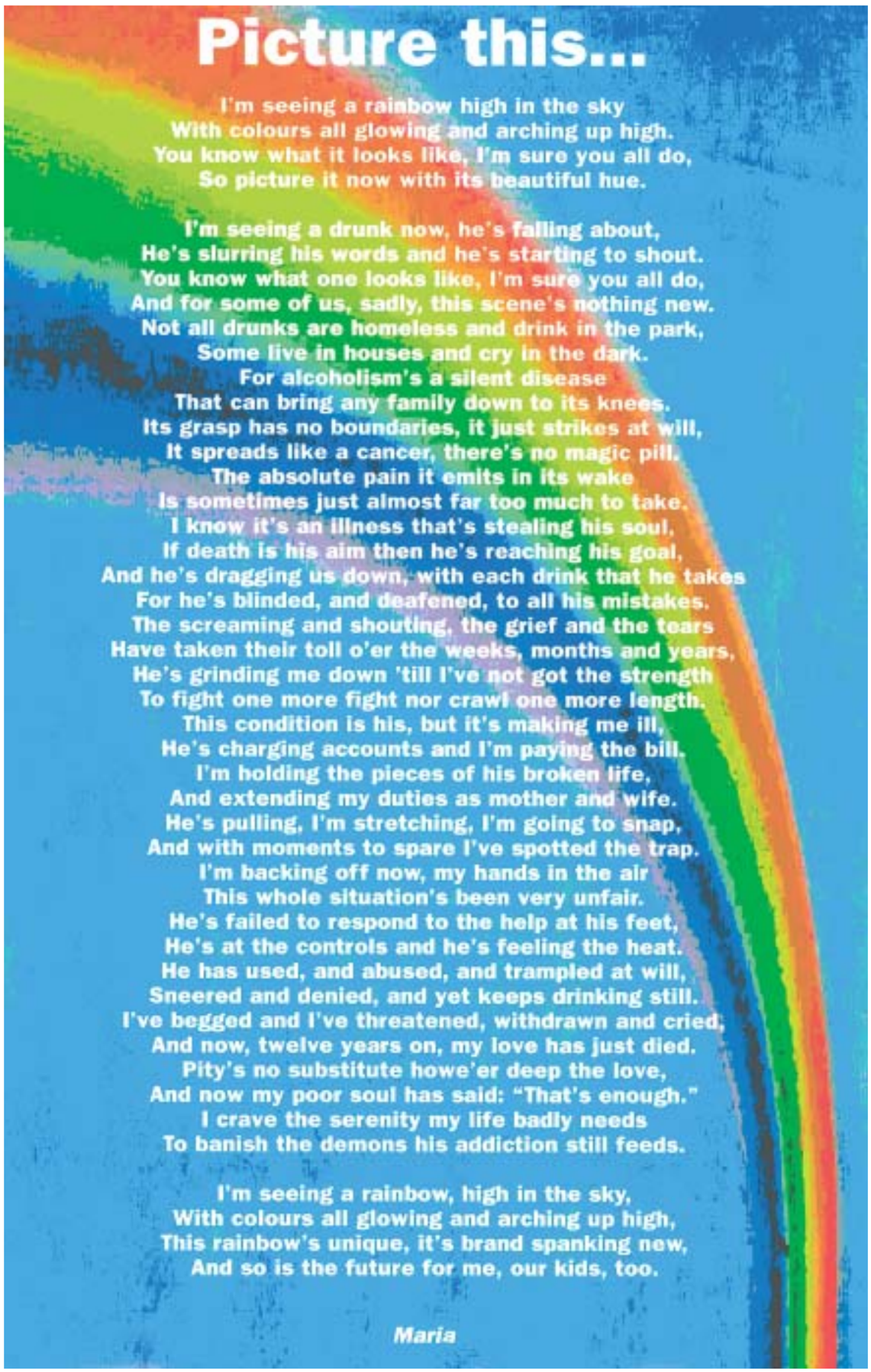
With 2006 around the corner, and the increasing awareness that the current drug strategy has only two more years to run, there has been renewed interest in families and their role in delivering effective treatment outcomes.

Allan Johnstone, the NTA's User and Carer Involvement Programme manager, says that families have moved up the agenda: 'More than ever there is a real desire to improve the situation of families and carers and look at their needs – even beyond the needs of users.' If targets are to be met, the role of families, and the effect that problematic drug and alcohol use can have on family members, can no longer be marginalised and ignored.

However to bring about change, many challenges have to be overcome. Until secure funding can be guaranteed, the work of Adfam and others in the field will remain unstable. Over the last 21 years, the treatment provision for users has been increasingly addressed and funding of the sector dramatically improved; but development in support for families remains minimal by comparison. We now need to build upon past work to step up provision for families. As Adfam's Vivienne Evans points out: 'Until families are properly acknowledged and their needs addressed, a strategy which will fulfil its potential to reduce the impact of drug and alcohol use on individuals, communities and society as a whole, will remain elusive.'

Jennifer Clark is communications assistant at Adfam.

Maria won this year's 'Family Voices' , Adfam's annual creative writing competition. Her poem (right) was read by Sue MacGregor at last week's candlelit carol service at St Bride's Church, Fleet Street. *DDN*'s editor was one of the judges of the competition.



Picture this...

I'm seeing a rainbow high in the sky
With colours all glowing and arching up high.
You know what it looks like, I'm sure you all do,
So picture it now with its beautiful hue.

I'm seeing a drunk now, he's falling about,
He's slurring his words and he's starting to shout.
You know what one looks like, I'm sure you all do,
And for some of us, sadly, this scene's nothing new.
Not all drunks are homeless and drink in the park,
Some live in houses and cry in the dark.
For alcoholism's a silent disease
That can bring any family down to its knees.
Its grasp has no boundaries, it just strikes at will,
It spreads like a cancer, there's no magic pill.
The absolute pain it emits in its wake
Is sometimes just almost far too much to take.
I know it's an illness that's stealing his soul,
If death is his aim then he's reaching his goal,
And he's dragging us down, with each drink that he takes
For he's blinded, and deafened, to all his mistakes.
The screaming and shouting, the grief and the tears
Have taken their toll o'er the weeks, months and years,
He's grinding me down 'till I've not got the strength
To fight one more fight nor crawl one more length.
This condition is his, but it's making me ill,
He's charging accounts and I'm paying the bill.
I'm holding the pieces of his broken life,
And extending my duties as mother and wife.
He's pulling, I'm stretching, I'm going to snap,
And with moments to spare I've spotted the trap.
I'm backing off now, my hands in the air
This whole situation's been very unfair.
He's failed to respond to the help at his feet,
He's at the controls and he's feeling the heat.
He has used, and abused, and trampled at will,
Sneered and denied, and yet keeps drinking still.
I've begged and I've threatened, withdrawn and cried,
And now, twelve years on, my love has just died.
Pity's no substitute howe'er deep the love,
And now my poor soul has said: "That's enough."
I crave the serenity my life badly needs
To banish the demons his addiction still feeds.

I'm seeing a rainbow, high in the sky,
With colours all glowing and arching up high,
This rainbow's unique, it's brand spanking new,
And so is the future for me, our kids, too.

Maria

At the crossroads of reform

Visiting an international conference in California gave Release's legal expert Katy Swaine a fascinating insight to the US drugs war – and some valuable lessons for policy-makers back home.

Last month, I joined nearly 1,000 others from all over the world for the 2005 International Drug Policy Reform Conference in Long Beach, California. The conference was staged by the Drug Policy Alliance, the USA's leading organisation working to end the war on drugs.

The theme of the conference was 'building a movement', and it provided an opportunity for drug policy reformers from all over the world to meet and share their experiences. As drug policy in the UK faces another crossroads, with the potential looming for further changes in the law on cannabis possession, this was a fascinating time to see how the drugs war – and the reform movement – is going in the USA and across the world.

Ethan Nadelmann, the Alliance's charismatic director, opened the three-day event with a performance of the kind more often seen in a Baptist church than a conference hall. His rousing speech set the tone for much of the event. No-one can do focused emotion like the Americans.

The scale of the event was impressive. Faced with a bewildering array of session choices, I was reminded more of a music festival than a conference – although instead of choosing between Coldplay and Rufus Wainwright, I was agonising over 'Ayahuasca: Research and religion', 'The War on Youth: Drug Policy Reform and Juvenile Justice' or 'Mexico and Narco-Democracy'.

The event's practical attitude and its focus on reform were refreshing. I have little patience with discussions that aren't rooted in practicality (the expression 'blue sky thinking' brings me out in a rash), and I was glad to find that in the many sessions I attended in Long Beach, I heard virtually no self-indulgent discussion. Instead there were exchanges jam-packed with useful information and practical ideas – a teenage student who had successfully challenged his school's introduction of random drug testing; political activists who had successfully lobbied their state legislature to legalise medical marijuana.

At the heart of discussions was the damage that prohibition can and does cause, in so many ways and for so many diverse communities. Particularly powerful was a panel presentation by Mexican lawyers, social workers and academics, describing how the illegal drug market has ravaged their country – from indigenous farmers growing opium on a tiny plot of land to earn a meagre living, to the 30,000 children estimated to live on the streets of Mexico City, including many polydrug users, with an average life expectancy of 25 years.

Race featured prominently in many of the debates. The discrimination against ethnic minorities that is perpetrated by the war on drugs was encapsulated in a statistic that I heard more than once: although African Americans comprise only 12.2 per cent of the US population and 13 per cent of drug users, they make up 59 per cent of those convicted of drug offences. This community faces added injustice from the removal of many basic rights for those who have committed a felony, including the right to public housing and welfare benefits, student educational grants and even the right to vote.

The US Bureau of Justice Statistics reported last year that the population of the nation's state and federal prisons had risen to a record 1.47 million, with (according to USA Today) both pro-prisoner and pro-law enforcement groups agreeing that this growth was the result of the Bush administration's policy of aggressively enforcing federal drug laws. According to one conference speaker from California's Youth Justice Coalition, young people in the USA are routinely held in custody prior to trial – some as young as eight years old – making them about 12 times more likely to re-offend than those who have not been incarcerated. The soaring prison population represents a large and growing community of second-class citizens, with dramatically reduced chances of leading happy and useful lives.

There are many areas of drug policy in which we certainly have it better over here than in the US. However, there are many common problems, and we would be fools to think that our progress is irreversible. As Mr Blair's government appears increasingly to look to the USA as an example, I can only hope that they share my alarm at the state of America's war on drugs, and that they are determined not to let our country go the same way.

There are some signs that this is the case. Last year, the government took the relatively courageous step of reclassifying cannabis to Class C. Since then, arrests for possession of cannabis have fallen by one-third. Given the damage that can be caused by any involvement with the criminal justice system – let alone the public money wasted on police and court time – this is very good news.

Some time in the next few weeks, the ACMD will publish its recommendations as to whether cannabis should be returned to Class B as a result of concerns over its relationship with schizophrenia. It is expected to give the sensible advice that the possible link with mental health problems is only likely to affect a tiny minority of users, and that the correct response to such concerns is not further reclassification, but effective health education.

The government must not take a step backwards but should again find the courage to leave cannabis at Class C, and keep moving forward.

Katy Swaine is head of legal services at Release. You can hear Ethan Nadelmann speak at the Release Drugs University in London on 27 January 2006.

I have a client who's now doing really well in treatment. He's reached the stage when he really needs to reconnect with and have support from his family. The problem is, his family are less than keen to come in, saying they have 'heard it all before'. Has anyone got ideas on how I can persuade them to give him another chance?

Colin, Manchester

Family support critical

Dear Colin

Your dilemma highlights the need for a family support element in all drug treatment services, something that Adfam campaigns strongly for as a vital component in assisting the maintenance of recovery from drug or alcohol addiction.

I am a former drugs worker and currently a family counsellor in the addiction field so I really identify with you wanting to help your client reconnect with his family and your struggle with their resistance to this idea. It sounds like this family may have felt genuinely let down, and disappointed at similar moments in the past when your client has said he is doing well in recovery. Their capacity to trust could have hit a real low. It may only be salvageable through careful and gradual support rather than an effort on your part to 'persuade' them to get involved again.

You could try empathising with their despair and resignation about the future and their fears of further disappointment and pain. You could also try some motivational interventions such as 'It seems that you don't feel your relative is ever going to make real changes?' These kind of open, non-judgmental statements may encourage them to share more about the events that have led to their lack of willingness to engage with your client today.

By reflecting back their statements, they may realise that they do still have some faith in the possibility of his recovery. From there you can explore the 'unfinished business' that they still need to resolve. It also affords the opportunity to explore what it might be like to have contact again while also acknowledging the real risk of lapse or relapse in the future.

If the family is to engage fully in a dialogue with you, they will need to trust that what they tell you is confidential and that you are acting as a mediator rather than an advocate for your client. Ask the family what they need in order to consider reconnecting with their relative. You can then talk to him about what he can do to demonstrate more clearly that he intends to maintain the changes he has made. By mediating in this way a negotiated outcome might become possible.

If the family does decide to make direct contact with the client or participate in his treatment, it is important they feel it is their choice and that it happens in a way that they feel comfortable with. If their contact is driven by a sense of guilt or coercion, it is more likely to breed further resentment rather than benefit your client. Along the way there may be a real pull for you between the client's interests and those of the family. I have found it helpful to talk to a supervisor or manager about how to manage these kinds of dilemmas.

I also wonder if your client might like to explore what is driving his need to reconnect so quickly with his family members? Often this journey after treatment is far longer and more painful than one would wish and this reality could be acknowledged and addressed as part of his work with you. He may never get the kind of support he most craves from his family. Perhaps he needs to consider how he will cope without a satisfying reconnection rather than allowing this unmet need to grow into a potential trigger for a lapse or relapse.

Often clients emerge from treatment with a new or heightened awareness of their family history and the dynamics of their relationships. The family meanwhile may still feel as they did prior to treatment – despondent, angry or scared. They may also find the change in their relative unsettling if it challenges the pattern of behaviour that the family has grown used to.

It is a huge task for the client to navigate these dynamics. The more they are enabled by you to reflect on what is happening for them, weigh up the possible outcomes and support themselves, the more likely his family is to reconnect with him at their own freewill and build genuinely supportive relationships.

Emily Holt, Counsellor, Adfam

'It sounds like this family may have felt genuinely let down, and disappointed at similar moments in the past... Their capacity to trust could have hit a real low. It may only be salvageable through careful and gradual support rather than an effort on your part to "persuade" them to get involved again.'

Danger of isolation

Dear Colin

The solution to the problem of the parents not wanting to come into treatment with their son may be difficult because of feeling let down. But they need to help him by telling him they will never give up on him, and hopefully he will stay on the right track. If they give up, he is sure to go back to his isolated world of drugs.

Good luck with your help.

Julie, by email

Family values

Colin

Well done, the connection you have made with your client is evident and I too have come across similar problems in respect of family members who are unwilling or unable to move forward with the client, for fear of rejection and turmoil again.

One solution I have found to be successful in the past was to turn the tables round and invite the family to attend, not on the basis of how it could be of value to the client, but how you are interested in their feelings, thoughts, fears etc. In this way they may feel valued for their opinion, even if it initially does not appear to be the one your client is seeking.

Surely it is not about giving the client another chance, but the other way round – all too often we focus on our clients' needs and are blind to those around them. The family members often experience the same pain and confusion as the clients, but this can be exacerbated when all their previous efforts are thrown back in their faces (their perception).

Let them know that you value and welcome their input; negative input has a way of turning situations around when people are able to be open and honest and the counselling process should allow this to happen naturally.

It sounds like all members of the family are needing help and assistance and I am sure you will find a way.

Good luck.

Katie Macdonald
Alcohol Counselling Inverness

One last chance

Dear Colin

I don't know if you can persuade them to give him another chance – they may be 'at that stage' where they don't want to know. Their reaction might be reasonable in the circumstances.

The way to encourage them could be for him to get on with his treatment and his life showing them that he is staying clean. In time they may come round, they may not.

If they do or don't, is he relying on their support for him to continue with his recovery – and is that wise?

Regards

Simon Bull, Manager, Vita Nova

Reader's question

I work in a rural area and am trying to think of ways of interesting local youth in drug safety messages. Many of the young people in our county are spread out without easy access to a youth centre. Can anyone suggest how to get drug and alcohol messages across to young people in rural areas?

Hugh, Cumbria

Email your suggested answers to the editor by Tuesday 10 January for inclusion in the 16 January issue of DDN.

New questions are welcome from readers.

NDTC06

2006 National Drug Treatment Conference

Thursday 9th and Friday 10th March 2006
The Glasgow Radisson SAS Hotel, Scotland

Five major themes will be addressed by the conference:

- **Marginalised groups**
- **Key clinical issues**
- **Prison healthcare**
- **Commissioning**
- **Pharmacy services**

Over 50 plenary and parallel sessions will include:

- Understanding discrimination
- Young people and drug treatment
- Vocational rehab and social integration
- Drug treatment and the prison/community interface
- The role of service users in service planning and evaluation
- Choosing medication
- Crack and amphetamine use
- Meeting the needs of women drug users and BME communities
- Effective working in rural areas
- Key clinical issues for drug users – pregnancy, dental health and pain management

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Supporting organisations

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Black Poppy
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FDAP
National Addiction Centre
National Treatment Agency
Release
Royal College of General Practitioners
Royal College of Psychiatrists
UK Harm Reduction Alliance

Exchange tools for harm reduction

The Alliance

Conference website:
www.exchangesupplies.org

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Introduction to Drugs Work	25 April
Mental Health Awareness	28 April
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Alcohol & Poly Drug Use	10 May
Personality Disorders	8 June
Working with Loss & Change	9 June
Crack Awareness & Users' Needs	29 June
Steroids	4 July

Two day courses (£180 + VAT)

Relapse Prevention	21 & 22 March and 6 & 7 July
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For application forms contact:
KCA (UK), Dan House, 44 East Street, Faversham, Kent ME13 8AT.
Telephone 01795 590635, Fax 01795 539351,
Email marina@kca.org.uk, www.kca.org.uk

Closing date: 3 January 2006
Interview date: to be confirmed

KCA (UK) is committed to the principles of equality of opportunity for all and welcomes applications from people with experience of substance use or who have had previous problems with substance misuse.
Charity No: 292824

Devon Partnership NHS
NHS Trust

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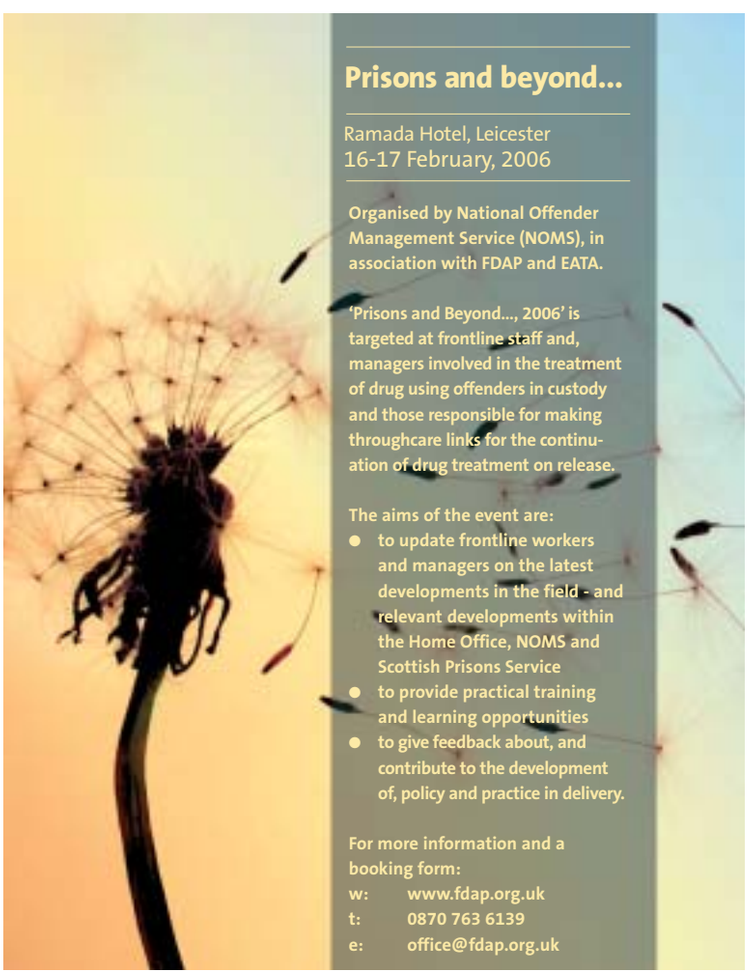

Prisons and beyond...

Ramada Hotel, Leicester
16-17 February, 2006

Organised by National Offender Management Service (NOMS), in association with FDAP and EATA.

'Prisons and Beyond..., 2006' is targeted at frontline staff and, managers involved in the treatment of drug using offenders in custody and those responsible for making throughcare links for the continuation of drug treatment on release.

The aims of the event are:
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