From FDAP in association with WIRED

DDN
Drink and Drugs News

18 April 2005
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CHILDHOOD'S END
Breaking the cycle of hidden harm

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Drink and Drugs News

18 April 2005

Editor's letter

The effect of drink and drugs on the children of substance misusing parents scarcely cuts across the news media's radar, says Rosie Brocklehurst, in our cover story. Addaction's pilot services, sending trained family workers out on home visits, will join the network of dedicated services throughout the UK.

Addaction's CEO, Peter Martin, is hopeful that the work could transform drug treatment in Britain – but making a difference depends on a co-ordinated approach. At the moment there is a lack of national data on the scale of the problem and, as yet, no overarching co-ordinating body. Let's get past laying bureaucratic tarmac, and onto making a real difference says Rosie. There's no time to hang about – childhood is all too short for many.

Thanks to all readers who are responding to our call for information on user groups. We've compiled some suggestions for how to start up a group in this edition, and would like to start including regular updates on regional group activities in future issues of DDN. So let us know what stage you're at, any problems and successes – and how you found your funding. Keep sending your user group magazines in; there'll be a feature coming up on how to set up a mag – so please share your experiences by calling or emailing.

With the election just around the corner, we took a look at the party manifestoes – and wondered whether some of the promises on drink and drugs had got jammed in the headquarter's printer and not made it to the outside world.

Our at-a-glance guide might give you a few clues on which way to vote – or it may not. Helpfully, we've put the correct labels on each party's proposals to save you the bother of identifying the Monster Raving Loony party for yourself. That could be more difficult than you'd thought.

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In this issue

'Ill-considered' Drugs Bill to become law

The Drugs Bill has received Royal Assent, meaning that it will now become law. It gives police new powers to test for class A drugs on arrest; ensures that those who test positive go for assessment and treatment; and gets tough on those suspected of dealing, including near schools.

Police will be able to order an x-ray or ultrasound scan for those suspected of concealing drugs in their body, and magistrates will be able to remand suspected swallowers in custody for up to eight days.

The bill has been the subject of widespread disquiet among many organisations concerned with drug policy, who have attempted to highlight legal, practical and ethical problems with its heavy focus on criminal justice interventions. Chief among concerns is that it has been rushed through the Lords without proper scrutiny, to get it through before the election.

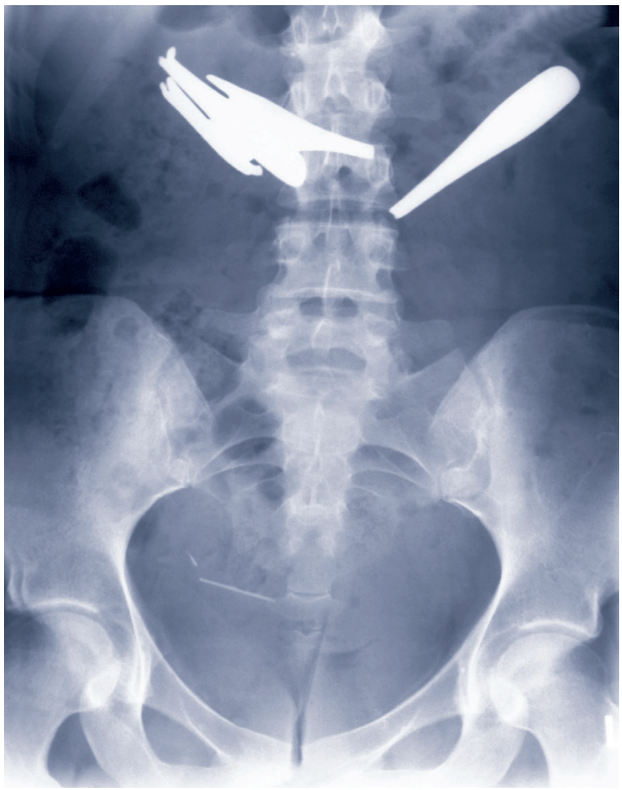
Danny Kushlick of the Transform Drug Policy Foundation, who has campaigned for the bill to be halted to allow proper debate, called the final stages of the bill's scrutiny 'shockingly inadequate' and the result of a 'backroom deal' between the three major parties to keep contentious drugs issues out of the election run-up.

The bill had previously been criticised by the Conservatives for being too soft, and by the LibDems for being too harsh, but any amendments were withdrawn. The only proposed amendment – to the clause that 'magic mushrooms' are illegal in any state, fresh or prepared –was put to the vote, but roundly defeated.

In a joint statement, TDPF and Release warned that the bill risked breaching the Human Rights Act by jeopardising people's right to a fair trial and respect for their private lives.

Their comment that consultation has been bypassed in favour of 'ill-considered, populist, "tough on drugs" measures' have been echoed by many others in the field, including Turning Point, DrugScope, the human rights organisation Liberty, and individual MPs and peers.

Follow the bill's journey through Parliament on the Transform Drug Policy Foundation website at www.tdpf.org.uk



Police will be able to order an x-ray or ultrasound scan for those suspected of concealing drugs in their body, and magistrates will be able to remand suspected swallowers in custody for up to eight days.

Three month alcohol consultation needs your views

The next phase of consultation on alcohol misuse has been announced by the National Treatment agency, with an invitation to respond over the next three months.

Models of care for alcohol misusers was promised in the alcohol strategy as the means to a programme of improvement on alcohol treatment.

Alcohol Concern has been contracted to consult with the treatment sector, commissioners and service users, and stresses the importance of responding before the deadline of 1 July 2005:

'MoCAM is an important document, key building block of the government's (as yet unfulfilled) promise of a "planned programme of improvement" for the treatment sector. As such it is vital that we all use whatever influence we might have to make this document as good as it can be.'

AC offers different ways to respond, through a discussion forum on their website, through an email based discussion group (see the link at the foot of the AC website home page) and through a series of events, north and south. Specific events for service users will also be announced shortly.

For more details visit Alcohol Concern's website at www.alcoholconcern.org.uk

Public responds to drugs hotline campaign

Crimestoppers Scotland have reported a fourfold increase in calls to their anonymous drugs hotline, in response to their six-week 'Dealers don't care, do you?' campaign.

Deputy Justice Minister Hugh Henry said the public's 'excellent response' had already yielded 77 arrests and seizure of more than £100,000 of drugs.

A direct mail campaign, which publicised the Crimestoppers number – 0800 555111 – targeted 220,000 homes in 15 areas, including parts of Scotland hardest hit by drugs.

The campaign, costing £1.062m, was funded through assets seized from criminals under the Proceeds of Crime Act 2002.

Mr Henry commented that 'drugs devastate communities and they devastate lives. Our message to the dealers who peddle them is that crime does not pay and that they cannot continue to make profits out of others' misery.'

Detective Chief Superintendent Stephen Ward of the Scottish Drug Enforcement Agency added that the SDEA, Scottish Police Service and Crimestoppers would continue to work together, and urged the public to continue calling Crimestoppers about any concerns they had about drug dealing activity in their area.

Licensing toolkit gauges alcohol harm

Practical help is available for local authorities to help them consider the effects of licensing changes in their area.

Alcohol Concern has developed a toolkit that highlights information sources to gauge the impact of extended opening hours. Experts from local authorities, police and health have contributed reports and statistics to provide a base of evidence for any proposed changes.

AC chief executive, Srabani Sen, said the easy step-by-step guide to finding relevant local statistics would 'be vital to making sure that [local authorities'] licensing policies are working for the local community'.

The toolkit has been funded by a grant from the Alcohol Education Research Council. It is available at www.licensingtoolkit.org.uk

'Person-centred' approach key to support

Any review of drug reclassification must be led by fact, not misconception, Lord Victor Adebowale told the International Drug Policy Conference in London.

The current debate on cannabis was dangerous for its misconceptions, and could be damaging for those who need support, said Lord Adebowale, chief executive of Turning Point.

A direct connection between cannabis and psychosis had not been proven, he said. Poverty, social exclusion and racism could all contribute, and a 'sophisticated and credible approach' was needed, with a focus on finding the appropriate interventions.

The gateway drugs were far more likely to be alcohol or cigarettes. 'But you won't see this in the papers, as it's an uncomfortable debate,' said Lord Adebowale.

The response to substance misuse needed to incorporate mental health, he told delegates. 'There's no point without looking at dual diagnosis. To miss this out is to miss the point.'

A major challenge – 'but one we must meet' – was to link up communication processes. Funding was too often led by personal likes and dislikes, when 'society needs a reality check on how we reach out to people on the margins of society'.

Any credible response could not ignore alcohol. One in 13 adults in the UK was dependent on alcohol, but there was a lack of investment in treatment services that showed the government was not facing up to alcohol problems across the UK.

Alcohol-fuelled public disorder was a symptom of a much greater disease, he said.

The government's tendency to focus on criminal justice was a key concern at Turning Point, said Lord Adebowale, and getting the right interface between treatment and criminal justice was essential.

'It's an outrageous situation that it's quicker to get into drug treatment through the criminal justice system. People who are labelled criminal are often very vulnerable. We mustn't deny people proper co-ordinated treatment.'

The drugs field could learn much from the mental health field on 'person-centred health', instead of the current 'one size fits all treatment,' he commented.

Lord Adebowale: 'It's an outrageous situation that it's quicker to get into drug treatment through the criminal justice system. People who are labelled criminal are often very vulnerable.'

Drug policy must have solid foundations in harm reduction

Reducing global demand for drugs is a question usually avoided, in favour of listing all the efforts and initiatives in place to cut supply, according to Martin Jelsma of the Amsterdam's Transnational Institute.

'It's much easier to list seized shipments and hectares destroyed,' he said, but there was no indication that the availability of drugs had been reduced substantially.

There was a failure to acknowledge when drug policy was not working: 'It reminds me of Monty Python's dead parrot sketch. Governments try to explain over and over again that the system is still alive.'

Drug policy needed to be shaped, learning from elements of policy that worked, said Mr Jelsma.

But solutions were not easy, and policy should be connected to poverty reduction, human rights, conflict and HIV prevention – 'the most important challenges today'. Aggressive eradication policies in countries like Columbia, Burma and Afghanistan had been caught up by replanting and replacement, resulting in the same opium output. There was a clear moral case for putting other livelihood programmes in place, and 'the law enforcement approach should refocus on harm reduction', he said.

International drug policy needed to have solid foundations in harm reduction – in particular to overcome the recent deadlock with the US. If this persisted, the situation should be taken to the UN secretary general.

'Matters are too grave to be left in the indecisive hands of the CND [Commission on Narcotic Drugs],' he said. The EU presented a united front on harm reduction issues, and policy must reflect the opinions of all countries.

Crime agency will take robust approach

The new Serious Organised Crime Agency will make a huge difference to organised crime, with drugs a core part of the agency's business, according to Lesley Pallett of the Foreign Commonwealth Office.

'We've learnt over the years that you need to do more than just supporting the police,' said Ms Pallett. Drugs were a central element of many issues – return of immigrants, high-tech crime, money laundering, excise fraud, gun smuggling, property theft – and the agency ran a range of projects linked to diplomatic and political engagement.

Overseas liaison benefited from structure, considering time, money and political capital.

'You look at where you have the best political engagement – where you get the best bang for buck,' said Ms Pallett.

The unit brought together resources and linked with international partners. Focus was on where there was most threat to the UK.

There was a suggestion that the co-ordinated approach between countries was not working at all, such as in Afghanistan, where the UK was leading as the G8 lead nation, she said. But they were seeing results on Afghan police seizing crops, she told delegates, and there were hints that Afghan farmers were choosing not to cultivate opium poppies this year.

The way forward was about ensuring work between the UK and other agencies became 'more structured and systematic', according to Ms Pallett.

'Drugs and crime need to be tackled in a much more robust way,' she said. 'We need a more integrated approach'.

Drug use linked to culture not law

Shifting cannabis policy away from prohibition is 'the beginning of a tectonic shift' away from prohibition, Craig Reinerman of the University of California told Conference.

'Even in the US we see a shift in this direction,' he said, with drug law reform bills being debated in 30 states.

Evidence from a Dutch study had contradicted widespread propaganda that relaxation of marijuana legislation would lead to 'all hell breaking loose'. Prof Reinerman had conducted research with Peter Cohen from CEDRO in Amsterdam that showed prevalence rates for different drugs were higher in San Francisco than in Amsterdam. (The two cities had been chosen as having similar liberal and tolerant characteristics.)

The study had revealed no evidence of drug policy having an impact, he said. Other data had suggested that cannabis users were selective about when they found cannabis use appropriate. Most said they did not use during work or study, and were most likely to use at home or parties.

Prof Reinerman suggested that there was a protective element inherent in cannabis users' culture, with a tendency to limit the extent of the drug's effect on their life. Cannabis use was not driven by law, he said. 'It's important to understand how powerful culture is.'

In looking at the 'small minority' that get into trouble with cannabis, we should not point the finger of blame at the 90 per cent that aren't trouble, he said. An understanding approach was called for: 'We need to look at what else is going on in these people's lives, rather than creating more prison cells.'

With the general election just two weeks away, DDN gives you a quick guide to the main offerings on drugs and alcohol

Labour

On drugs...

We will crack down on drug dealing and hard drug use to reduce volume crime.

We will expand drugs testing and treatment, and tackle the conditions – from lack of youth provision to irresponsible drinking – that foster crime and anti-social behaviour.

We will expand drug-treatment services for young people.

Communities know that crime reduction depends on drug reduction.

We will introduce compulsory drug testing at arrest for all property and drugs offenders, beginning in high-crime areas, with compulsory treatment assessment for those who test positive. Offenders under probation supervision will be randomly drug tested to mirror what already happens to offenders in custody.

From 2006, the Serious Organised Crime Agency will bring together over 4,000 specialist staff to tackle terrorism, drug dealers, people traffickers and other national and international organised criminals.

On alcohol...

Excessive alcohol consumption fuels anti-social behaviour and violence. The new Licensing Act will make it easier for the police and councils to deal with pubs and clubs that cause problems. Local councils and police will be able to designate Alcohol Disorder Zones to help pay for extra policing around city centre pubs and clubs, with new powers to immediately shut down premises selling alcohol to underage drinkers, and bans from town and city centres for persistent offenders. Police will be able to exclude yobs from town centres for 24 hours when they issue a Penalty Notice for Disorder.

From the Labour Party election manifesto

Conservatives

On drugs...

It is essential that we break the link between crime and drugs by getting young people off drugs and stopping them turning to crime to finance their habit. Conservatives will give the police powers to send addicts to treatment without going through the courts. In the first phase of our policy, young addicts arrested for minor offences will be offered a choice by the police and prosecution service: to go immediately to a residential rehabilitation centre or to face prosecution in the criminal justice system. As the number of young addicts is reduced we hope to extend this policy to older addicts.

The great majority of drug addicts wish to come off drugs completely – not to have their habit 'managed' by state-supplied methadone. A Conservative Government will help people to live drug-free lives by ensuring that an increased proportion of funding is devoted to rehabilitation courses which offer a drug-free programme.

Young people receive mixed messages from the Government. Much (undoubtedly important) information provided by Government agencies about drugs adopts a neutral stance on whether children should actually use them. But there can be no equivocation on drugs. A Conservative Government will fund a major advertising and advice campaign with a clear, consistent anti-drugs message.

Labour have downgraded the classification of cannabis from B to C. This has caused considerable confusion as to the legal status and the risks of cannabis. A Conservative Government will restore the B classification to cannabis. This will resolve the current confusion and send a clear message that the drug is dangerous.

On alcohol...

Currently, local communities are unable to stop the culture of binge drinking because of prescriptive central guidelines. A Conservative Government will give local councils real control over licensing in their areas – including stronger powers to turn down applications for licences where there is already a concentration of pubs and clubs. And we will ensure that pubs and clubs which sell alcohol to minors, or to those who are already drunk, are closed by the police.

From the Conservative Party election manifesto

Liberal Democrats

On drugs...

We would establish a standing Drugs Commission to advise on drugs policy, with a remit extended to cover legal substances such as alcohol, solvents and tobacco. The Commission would keep the classification of cannabis (along with other drugs) under review in the light of new scientific evidence as it emerged.

We would end the use of imprisonment as a punishment for possession for own use of illegal drugs of any class. Drug addicts should wherever possible be in treatment not in prison – unless they have committed other serious crimes (e.g. robbery to feed a crack cocaine habit) in which case prison must remain an option.

We would re-classify ecstasy from Class A to Class B to reflect the fact that it is less harmful than heroin and cocaine, but not re-classifying it further unless recommended by the Drugs Commission subject to evidence on long-term health effects.

We would extend the use of drug treatment and testing as an alternative to other criminal sanctions.

We would develop specialist heroin treatment clinics where heroin or heroin substitutes can be administered under controlled conditions, with other medical treatment and testing, and counselling and withdrawal programmes available.

We will allow GPs to prescribe short term or emergency maintenance doses of heroin,

We will crack down on illegal drug trafficking and drug affected driving.

On alcohol...

Clear labelling with numbers of units should be mandatory. Alcohol problems must be treated as seriously as drug problems.

From the Liberal Democrats Policy Briefing. There is no mention of drugs or alcohol in the LibDem election manifesto.

Monster Raving Loony Party Manicfesto

We fully back the government's policy of discouraging binge drinking by opening pubs for 24 hours. We believe that 24 hours is not quite long enough and propose to make the length of a day 32 hours long so that the pubs can be open for even longer. We also rather like the government idea of coming down hard on drugs by legalising them. Regarding tobacco it will now only be legal to smoke it with cannabis. Anyone found to have a ciggy not containing any cannabis will be made to walk to Coventry with a stone in their shoe, unless they come from Coventry in which case an alternative major city will be substituted on the advice of a committee who will meet far too often and eat dope cakes.

Anyone caught breaking the law will be made to mend it.

Missed opportunities: user involvement must be more than a token exercise

We read your editorial letter in the latest issue of *DDN* (4 April) with interest. Progress is a charitable non-statutory structured Day Care Treatment Centre, funded by contributions from local business since 2003 in order to provide qualified and affordable care for addictions for the community here in Essex.

We are in communication with the Essex DAT and we are aware that they are addressing their position with regard to structured day care. However we knew nothing of this meeting and the service users we have in treatment were therefore not present. If they had been, they would have been vocal on the lack of adequate service provision. In particular, we are in a position to be aware of the fact that many of those on a DTTO do not receive treatment, they just get drug tested and have a short talk with their key worker. They are then out on the streets with no support.

There is some good work being done around the county (in particular, Open Road run a structured day care centre in Clacton) and everyone is working hard, but what we find frustrating is that we are here and waiting to give structured day treatment. This week's *Essex Chronicle* listed more than 20 who had been given DTTOs by the courts – where are they having treatment? Or does the word 'treatment' in the court order not mean anything robust?

We find it a great shame that our service users were not given this opportunity to be involved in the setting up of user groups, when they have so much to say on the subject.

Thank you for keeping us informed.

Tim Chiswell, Senior Addictions Counsellor, Progress Counselling

Consultation is the way to set up policy on disclosure

In reference to Cathy Chabo's letter (*DDN* 4 April) and her concerns of employing drug users, I would recommend that in developing policies that the Shaw Trust hold focus groups with all stakeholders to develop robust policy that manages the risks that are of concern.

Furthermore why do people have to be in recovery to be employed? There are many people that work who make an informed decision to use drugs without any problems. I do not feel a disclosure policy is helpful – if an individual is experiencing problems with drugs or alcohol then this should be managed on an individual case by case.

I do not recommend that you break people's confidentiality in reference to present or previous problems with drugs or alcohol. Each individual applying for employment or voluntary work should be interviewed and demonstrate how they meet the person specification at the time of application and interview.

Each individual should then be assessed on their skills, knowledge, experience and ability to be able to carry out the functions of the job description being asked of them. If people are not competent or do not have the relevant skills in order to carry out the job description then they should not be employed or taken on irrespective of previous or present drug or alcohol use.

If individuals' lives are still chaotic or there are still difficulties in managing drug and alcohol use, or people are feeling vulnerable, then they need not apply for positions until they feel they are ready. It is up to each individual to decide when the time is right for disclosure and not the employer, as long as it is not interfering with the person's ability and performance at work.

There are many work-based policies and good practice in the employment of drug users to be found. My suggestions would be to gather as much information and policies together and then hold a stakeholders' meeting to develop your own for the Shaw Trust.

I hope this has been of some help and assistance.

Jaye Foster, drugs worker, London

Harm reduction in Belfast: science or social movement?

The International Conference on the Reduction of Drug Related Harm convened in Belfast for its sixteenth meeting drawing over 1,000 delegates from dozens of countries to hear the latest on harm reduction policy and practice. There were sessions on Hepatitis C, needle and syringe sharing, overdose, drug consumption rooms and safe injecting, and young people, amongst others. The predominant focus throughout these sessions was on the harms experienced by the individual drug user rather than the harms which drug users cause to others: loved ones, family, friends and the wider community. Reflecting this it was perhaps unsurprising that the session focusing on the impact of parental drug use on children attracted less than 10 per cent of the 1,000 plus delegates present.

It is an exaggeration, but only slightly, to say that the tenor of the conference was very much to do with a celebration of the drug using lifestyle; the right of the individual to use his or her drugs of choice with the least harm and to be treated with respect by services when they get into difficulty. In the four days attending the meeting I did not hear a single presenter talk about the issue of challenging drug users as a way of enabling them to move along the road to recovery or indeed much about the idea of recovery at all.

'It is an exaggeration, but only slightly, to say that the tenor of the conference was very much to do with a celebration of the drug using lifestyle; the right of the individual to use his or her drugs of choice with the least harm and to be treated with respect by services when they get into difficulty.'

The second thing I missed at this conference was what one might call the critically reflective practitioner. Almost all of the sessions I attended were presented as a rallying cry for harm reduction. Whilst one might have expected as much in the earliest days of the conference, in the sixteenth year of its iteration one might have expected rather more in terms of critical self examination from those working in the harm reduction field. There was a real unwillingness to discuss some of the challenges of harm reduction. In the session on drug consumption rooms, for example, we were provided with only the briefest mention of a death of an injector within an injecting room. One would have thought that such a death would have prompted a critical consideration of the dangers as well as the benefits of harm reduction within such a setting, but what we had was a death marginalised in a moment in preference to setting out the benefits of consumption rooms.

The reticence to reflect critically on practice was also evident on the part of some of the researchers present at the meeting. I asked one of the researchers evaluating a harm reduction service in Australia, what he would do if he identified negative practices within the agency he was evaluating. The depressing answer was that he would emphasise the positive findings so as not to damage an already vulnerable project. The dilemma here is acute – are we to have independent research evaluating the impact of harm reduction, or are we to have a social movement which uses research selectively to perpetuate itself? When our researchers edit their findings to show services in the best light, they may do this in the belief that they are helping the services in question, but they are undermining the very principle of independent academic research.

The Harm Reduction Conference needs to make up its mind whether it is an occasion to look critically, but positively, at the practice of harm reduction or the most visible expression of a world wide social movement. If it is to be a conference of the former kind, then it needs to provide much greater space for discussions involving presenters and delegates. At the Belfast conference you could have distilled the time for discussion from the conference floor into a teacup.

In many parts of the world, harm reduction has become the orthodoxy. As a result, whether at this conference or at some other, we need to have an unfettered discussion of the pros and cons of harm reduction if we are to form a realistic assessment of what it can achieve. If the conference remains at the level of social movement, it will be long on rhetoric and short on critical self reflection, and drug treatment services will have been diminished in the process.

Neil McKeganey, Professor of Drug Misuse Research, Centre for Drug Misuse Research, University of Glasgow

Breaking the cycle

Hidden harm is a painful subject. It's about the children of drug and alcohol-misusing parents suffering for years behind closed doors. It's difficult to quantify and difficult to reach, but we have to make sure these children's voices are heard, not least by government, says Rosie Brocklehurst

Are you sitting comfortably? Then I'll begin

I could tell you about Patrick whose father left home when he was five, and became a park-bench drinker on Camberwell Green and died long before his son stopped using. Patrick was raised in children's homes, and abused there. His last injection of heroin was in 2003 and he became drug-free at the age of 39.

Or, I could tell you about Lara, introduced to heroin by the father of her child. Lara's mother was addicted to drink when she was growing up. Yet Lara's daughter was sent to live with her gran when Lara was jailed for a drug-related crime. Or you might prefer to hear about Mark, whose father introduced him to heroin when he was 14, and now he has a prison record as long as your arm and lives by dealing. Of course there is much more to Patrick's, Lara's and Mark's stories than I have space for here, and many more stories to tell. They are the stories told in hindsight, when clients either got sick and tired of using or were coerced into treatment services. They are stories that should never have happened.

These stories tell us about the cycle of generational damage. They are all about hidden harm.

We have been neglecting the children of drug and alcohol-misusing parents in the UK for years for want of hard data, a policy and a means to respond. It's been hidden from the public consciousness. It has scarcely cut across the news media's radar. Yet the hidden harm of drink and drugs misuse is the unstable fault-line lying beneath all attempts to regenerate communities across the land.

Of course we don't see the disasters waiting to happen until they happen. Confidentiality and Child Protection laws necessarily obscure the alcohol and drug-related tragedies and dramas that go on in families behind closed doors. We get used to reading the shock news when it's all over for a child – perhaps the 14-year-old boy with a string of joy riding convictions, who hanged himself in a young offender institution because his dad was in prison for drug dealing, and his mother had turned to prostitution to pay for her fixes. Of course, tragedy happens so often, society can become apathetic about it, unless it becomes clear that something can be done that isn't being done. Hidden harm is not as easily understood an issue as say Jamie's school dinners, although it falls into the general area of prevention and reducing the future burden of harm.

To campaign in this area also signals another risk, by shifting focus on what the parents' misuse is doing to the children. The potential stigmatising repercussions come along with the territory.

But, when the Advisory Council on the Misuse of Drugs tackled the issue and published their report in June 2003, using statistics now five years old, we found out for the first time that an estimated 350,000 children in the UK were deemed to be at risk from parental drug misuse. One million children are estimated to be at risk from alcohol misuse.

In summer 2004, BBC Panorama's programme *Invisible Kids*, drew out from the shadows the voices of children who related their experiences of hidden harm caused by parental drug misuse. Child actors represented the real voices of children as they struggled to articulate their anger and pain because their childhood had been stolen from them by drugs.

On 17 March this year, the government, via the DfES, published its response to hidden harm. 20,000 young people each year become adult drug users the report tells us. The ACMD report, like the recent response, was published to a whimper rather than a bang.

But some things are being done. The Zurich

Community Trust, the charitable wing of the international Insurance Company, has just given drug treatment charity Addaction the first tranche of £1 million for transformational work over four years, around hidden harm. Three pilot services will be set up in Cumbria, Derby and London (Tower Hamlets), and Addaction is already using the money to lever in extra funds from some DAATs. Moves are afoot to find funding and partners to set up a simultaneous alcohol pilot. Called Breaking the Cycle, the work itself will provide the evidence base which is a pre-requisite of strategy and policy, to be presented to government. Our family workers in the pilots will make home visits, and won't see children in adult services. Our projects will work at several tiers of referral, assessment and engagement, and work with those who self-refer.

Every one of over 70 Addaction services collects data about children of parents who are clients. All staff will be trained in child protection not just in the pilots. Campaigning around hidden harm will be part of the initiative. As Peter Martin, CEO of the charity says:

'We could actually transform British drug treatment through this work. Just think about it. The whole focus so far has been on the chaotic adult drug user, principally referred through the criminal justice system. When we know that children in families where adults are using drugs are seven to eight times more likely to use drugs themselves[1], and half of all users we see are parents, then I don't think we have any choice but to respond now in a way that will have real impact.'

In Scotland there are already about four small services working with families with children who have been identified by social services as being at risk. For four years in Cardiff, Option 2 as reported in *DDN* (10 January) exemplifies the determination, albeit isolated, by individuals and the Welsh Assembly who fund it, to act to reduce harm. In England meanwhile, we have been waiting for the road map for delivery of children's policy.

In England and Wales the comprehensive data collection needed to provide a detailed picture of the scale of harm is still a long way off, although there are plans 'for the future'.

Nationally, so far, there is no overarching co-ordinating body to act as a catalyst to this work, involving a range of partners. Addaction's steering group and the Children's Society STARS project funded by the DfES,could be a useful start.

Now for the first time, we have a children's minister, a children's commissioner, and a children's policy. Children's policy around drugs and prevention is still at that early stage of defining roles and responsibilities. It is the bureaucratic tarmac required before the multiplicity of services, from maternity units to adult treatment interventions, provide us with a more direct route to finding effective solutions.

There is also a wider context to consider. What will happen to drugs policy after 2008? A refocus on prevention would seem to be on the horizon, mainstreamed into areas such as children's policy. As far as health is concerned, under public sector reform, treatment could become a matter of local choice as to whether a service is provided or not.

There has perhaps never been a more optimal time to alter drugs policy and put children at its centre but in the drug treatment sector, despite our responsiveness and flexibility, we are perhaps seen as peripheral to the core work around children and families. All the unknowns impact on our potential for delivery. The tension as ever is between delivery and process.

While Addaction gathers the evidence through evaluation and data collection from day one that Breaking the Cycle starts, we also have a role to play in influencing government to better understand the work going on on the ground and the best means of delivering it. It is clear to us for example that assumptions are sometimes made that the care system is the best option for children of drug misusing parents. We need to open up the debate and challenge those assumptions.

Stigmatisation of drug users because of a criminal justice driven drugs policy can easily segue into a perception by a wider society of all drug-using parents as irresponsible child abusers, rather than as parents with a drug problem who need help to change.

Addaction is concerned that less attention will be paid on how to identify and respond to those children at risk whose parents and carers haven't yet come to the attention of the authorities. Fears about the consequences of family break up if they do seek treatment, militate against it. It is true that the climate in which we work encourages secrecy around addiction and dependency.

The government has rejected ACMD recommendation 32, that asked for residential care to be an option of last resort, because now, there is a document, a policy, which covers good practice. But many people who have worked in social services (now to become children's services and adult services), and observed the reality, recognise the gaps between the theory of good practice and effective implementation.

But nothing should prevent us from co-operating and helping government to deliver on children's policy and drugs misuse. But we must make government listen to us. They will only do so if we make sensible, valuable and loud noises, and provide the evidence.

There is also the ever-present danger that complexity makes the media skim over the surface of difficult drugs issues. Selling papers can often mean the media tends to focus on the sensational failures rather than the examples of success. We must continue to find ways to keep the media interested.

Of course, just because we are drugs treatment experts, charitable and driven by the cause that inspired us from our beginnings, does not mean we have a monopoly on compassion towards the parent who is a client and the children who are affected. Children's charities are also crucial to this work as are many other agencies.

But the work to provide the evidence begins now with Breaking the Cycle. We are determined to draw back the curtains.

Rosie Brocklehurst is Director of Communications at Drug and Alcohol Treatment Charity Addaction.

1 Neil McKeganey et al, Centre for Drugs Misuse Research, University of Glasgow. 2003

Neale Atkinson / Addaction

'We have been neglecting the children of drug and alcohol-misusing parents in the UK for years... It has scarcely cut across the news media's radar. Yet the hidden harm of drink and drugs misuse is the unstable fault-line lying beneath all attempts to regenerate communities across the land.'

Learning from the experts

Starting up a user group

User groups sound like a useful initiative for connecting service users with value for money treatment – but how do you get a group going? And more importantly, how do you make sure your group doesn't fall apart before you've done anything meaningful? DDN investigates.

So, we're all agreed that user involvement is a good idea. Drug action teams have service level agreements to consult with service users. The National Treatment Agency's new user and carer programme manager says the NTA is determined to make the involvement of service users standard practice in planning and delivering treatment. Most importantly, service users themselves are seeing the value of forming groups and taking an active role in influencing their own treatment.

But how do you make sure that your user group is not just a decent idea on paper and falls apart in practice? The starting point, according to those who are in the know – *ie* those who have been through the process through trial and error – is to establish the purpose of the group, and to plan its structure.

'The first thing you need to consider is, what's a user group for?,' says Nigel Munro, who works at Norfolk DAT as user involvement co-ordinator. Munro suggests an active 'working group' approach, rather than a support group.

'A support group is like AA. A working group has aims and objectives, and takes part in different groups and boards. That's what user involvement's about.'

Munro has been co-ordinating activities with service users in Norfolk for the last six months, and is working on starting the fourth group in the county. Starting up the first group, he realised that there were people who could get it off the ground – 'I just needed to identify and support them,' he says.

So he set up a steering group to see where user involvement money from the DAAT was to be spent, and contacted service users by meeting managers and their teams through attending their team meetings.

It's easier to start small when setting up the group, he suggests. 'Then you can listen to people's own experience of the system.' A word of caution – you need to be aware of when people's experiences of treatment happened to make sure concerns are completely relevant, he says. Services in the 1980s tended to be 9 to 5pm with no weekends, for example, so a user's experience might be quite different.

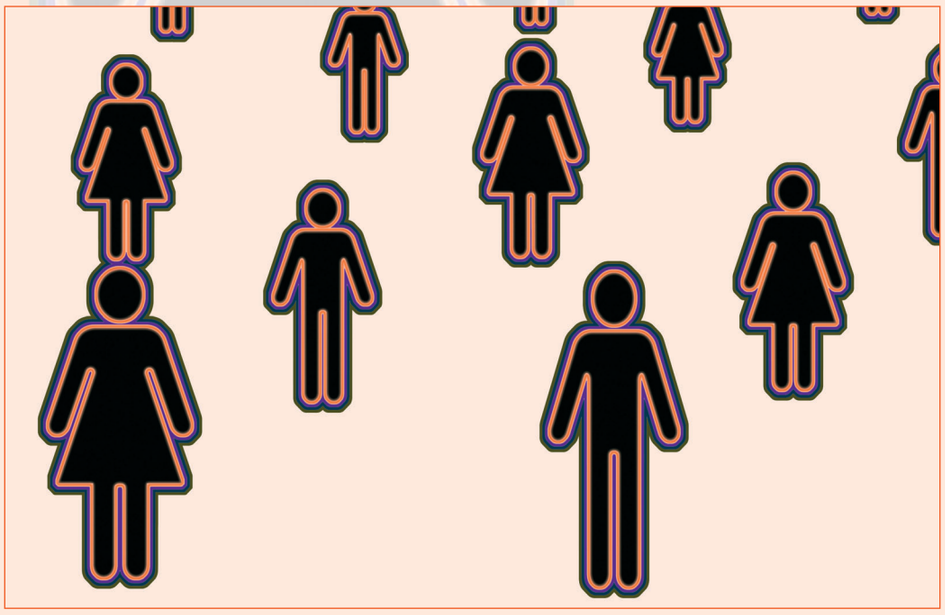
Once you have the core group established, it's a good idea to make sure people have the facilitation skills they need, says Munro. Not everyone is used to a meeting culture and might benefit from training – on running effective meetings, for example. Once they're engaged, help people to stay engaged with the purpose of the group. Keep the culture inclusive, use plain language, and make it as easy as possible for people to contribute their valuable life experiences.

Giving participants a feeling of involvement is an important part of keeping the group going – it has to be a meaningful experience for them to give their time. Get the group to set its own rules (such as don't use alcohol or drugs on the premises) and consider the strengths of the group's members.

An obvious strength, Munro points out, is that drug users to be very good networking, as they've had to do it for years to maintain a habit. 'So you turn it into something useful – turn a negative into a positive.'

Once your group's got a structure, start to invite allies to meetings, such as a representative from the primary care trust, to explain their areas of interest. This will add to your group's wider support network and share the responsibility for keeping the group going.

Above all, take whatever help you can get, advises Munro. 'Don't reinvent the wheel. There's stuff out there



'It's not about two sides fighting each other... it's about giving service users the know-how to work the system. Knowledge is power. People can then start taking charge of their own treatment.'

to make forming a user group easier.'

Glenda Daniels of Oxford User Team (OUT) agrees that there's help out there – and she advises making full use of it. A former 'noise-maker' for service users, she's made the transition to being paid by Oxfordshire DAT for her work managing the team.

Daniels is evidence that user groups can work with the system, and says 'it's not about two sides fighting each other, we have to work together'. She has no intention of being compromised through her role, and will 'always maintain autonomy'; it's about giving service users the know-how to work the system.

'Knowledge is power. People can then start taking charge of their own treatment,' she says.

OUT has certainly proved itself capable of action. The team has brought about significant changes to service provision within Oxfordshire, including preventing needle exchange outlets from being closed and having citric acid included in SWOP packs; getting involved with individual advocacy cases (with advice from the Alliance); participating in consultations and providing information. They won the contract to run the harm reduction needle exchange in Oxford city.

The core business of a user group is to consult with as many users as possible, says Daniels. The objective is to make sure people get treatment that's quicker, better – and the right treatment for them. 'It's not to do with service users running treatment. It's about using experiences to profit services,' she says.

Daniels has useful advice on keeping going, once you've started.

'Have a good facilitator,' she says, 'and give them training on dissolving awkward situations. 'Make sure people always have support, and make sure they're not left alone if the group isn't fulfilling their needs.'

For those thinking of setting up user groups, she acknowledges that 'the most difficult thing is cash'. But she points to the fact that DATs have service level agreements to consult with service users and says that 'there isn't a shortage of money for user groups – it's about using it and knowing where it's available from'.

A good starting point could be the Millennium Scheme (that funded setting up the OUT office), DrugScope, the Tudor Trust (where she funded volunteers), donations, and consultancy work by the group.

A brave approach pays off, Daniels suggests. 'You have to try and aim high for big money bids. Another route is to get charitable status and apply for funding from the NTA and your local DAT, she says.

A well organised service user group can soon settle into a mutually beneficial relationship with the NTA, via their drug action team. 'Why do the NTA want user involvement? For improved treatment, improved access to treatment, improved outcomes, best use of cash and customer satisfaction,' says Glenda Daniels. 'And why do users want user involvement? The same.'

Four years on… and going strong

'Our project has been running for almost four years now and we have eight very successful and active groups running across the region. There were 14 at one time, but as the sole worker at the time I found that I couldn't split myself into so many pieces to cover them all. I now have a part time worker and an admin assistant, so the load has been lightened.

The groups consist mainly of people with a drug misuse background, although we also have two very successful alcohol misuse groups. The aim of the project is to help users and ex-users to form groups that will have an input into the type and levels of service on offer to them.

What the individual groups want to do is really up to them, and dependent on who is in attendance. They may choose to act as peer support in methadone maintenance, harm reduction, or they may want to organise social or educational activities. Groups regularly choose to do training, such as advocacy, presentation skills, or research skills.

We regularly deliver drug awareness sessions in schools, colleges, youth clubs, Universities and to social workers. This is very well received by both students and tutors. We also have a trained team of researchers and have done research on behalf of the two DATs in the area (especially for the Models of Care co-ordinators), the NTA, Lincoln University, Lancashire University and the local treatment services.

We've carried out our own satisfaction survey, interviewing people as to what they thought of the treatment provided in the area. This was very illuminating and was taken on board by the DATs, and appropriate changes have been (and still are) being implemented.

It's not all hard work though. I run a Community Chest from which the groups can apply for up to £500 per month each to have a social outing. Members have recently been off road karting, to Alton Towers, bowling, to the cinema, out for meals, paintballing. You name it, we have probably done it! It's a good way of getting people interested in the groups and stops any sense of boredom creeping in.

For the last three years we have been funded by the Home Office Recovered Assets Fund, but sadly this has come to an end. The money is probably going into Criminal Justice now, like everything else – so we are currently looking at new funding.'

Steve Swales, Senior Development Worker for the Hull & East Riding of Yorkshire User Involvement Project.

Casting the net for wider involvement

'The Forum on Changing User Services (FOCUS) meets once a fortnight. It has its own office in the town centre and a bank account. The group was recently successful in attaining £5000 from the lottery in addition to a grant from the Primary Care Trust (£6000 pa).

Currently on the agenda is setting up a self-help group for hepatitis carriers and publishing an information leaflet relating to hepatitis. This will be funded by our regional NTA.

Members of the group receive training and attend national conferences on a regular basis. They have representation on the local Drug Reference Group and the Joint Commissioning Group.

User involvement in Gateshead is looking to cast a wider net to get more people involved.

Together with a multi agency team of staff and FOCUS members, I'm involved in rolling out a number of open events, inviting drug users in treatment to come along and find out about user involvement. We have speakers from the NTA, NA and most significantly ex service users who now work in the field, who used FOCUS as a stepping-stone to their success.

Almost all those who attended said that they would like to be consulted and involved in future activities and put their names forward to be part of a 'User Network'.'

David Brady, Service User Development Worker, Gateshead Primary Care Trust

Why do we want user involvement?

'We need to pool resources of knowledge for positive outcomes.'

'We should make sure funds are spent best from the users' point of view – and have access to where funds are spent.'

'We have to improve the chaos of sharing information.'

'Anything that brings users together to influence services is a good thing.'

'I'm getting the feeling that people are unhappy with services. It would be great if service users would work with powers to get the resources we want.' (Comment from a nurse.)

'User groups can have everything explained to them, It would be a lot clearer.'

'Service users don't get enough interaction, so there will be no movement forward without groups.'

'I'm interested in meeting people with like experiences.'

'User involvement certainly works in mental health. It's critically important if we want services to change. We need user involvement and we need it properly organised.'

'Much of treatment is focused on criminal justice and community safety, rather than on our own health needs. Unless we campaign around services like this, we will suffer.'

'Treatment works best as a partnership. Users must have input.'

Comments from the Essex drug and alcohol service users' conference held in Chelmsford on 23 March.

When a group of students from Stoke of Trent College visited Amsterdam, they had a chance to see at first hand how policy and practice compared with their experiences back home. Outreach worker Brian Street describes highlights of the study visit.

The Netherlands has been unafraid to address its drugs problems in ways that have often seemed, to us in the UK, to be too permissive. It was therefore tremendously exciting for us to have the chance to see how things worked practically and at ground level.

As part of our course and underpinning the theoretical aspects we cover in class, our group spent three days in Amsterdam visiting projects relevant to the work we do at home. Members of our group work with various aspects of drug dependency in the UK, and the projects we visited enabled us to compare the Dutch approach to our own.

We spent time at the KDO project which dealt with the children of addicted parents; visited the drug free unit in Overamstel prison; looked at the Amsterdam heroin prescribing unit; and saw a project concerned with the protection of women involved in the vice industry. Most of these projects were operating with the approval of, and benefiting from, funding by their government. The exception was the drug free prison facility, run by Jellinek (an umbrella organisation that uses different approaches to provide treatment options for drug and alcohol users). On the final day of our visit, we had time with Dr Peter Cohen from Amsterdam University, who gave us an unorthodox view of the Dutch drug scene and much to consider and evaluate on our return home.

Amsterdam is a small but cosmopolitan city, with diversity of culture and until recently, a liberal and tolerant municipal governing body. It is a city that is comfortable with itself and unafraid of trying unusual methods to address the problem of illicit drugs. Their decriminalisation of cannabis and its availability in the 'coffee shops' is interesting, in that it has not resulted in an increase of cannabis use. We were told that presently, the Netherlands has the lowest rate of cannabis use in Europe and much lower than that of the USA.

Amsterdam's liberal attitude is not always the case in other Dutch cities and their approach to drugs and other social problems varies from region to region, much as it does in the UK.

The Netherlands has a total population of 16 million and of these 25,000 are considered problematic drug users. In the past decade, the main drug of choice has changed from heroin to crack cocaine.

Outreach project for prostitutes

The project started in 1988 and was later extended to help illegal women immigrants who had been trafficked.

The evolution of the sex industry in Amsterdam saw a change from a majority of Dutch women workers to women of different ethnic origins. Project workers from the same ethnic backgrounds, or who had previously worked in the sex industry, had the language to communicate and could empathise with clients.

Legislation in the year 2000 made brothels legal and required owners to fulfil certain requirements before applying for a licence. Women employed in licensed brothels were safer, more accessible to project workers, and had better access to health provision. Illegal immigrants, however, were unable to work in licensed brothels and they moved to alternative places of work.

At this time there was an official tolerance zone existing in Amsterdam, which saw a big increase in the number of women working there, as the new legislation came into force. Numbers of women in this small area increased to 130 and numbers of customers kerb crawling could be as many as 600 cars per night. The problems this caused the city, combined with increased criminality in the area, forced the mayor to close down the tolerance zone in 2001. Many women subsequently moved to other cities, escort agencies or alternative unlicensed working areas, where it was difficult for the project workers to make contact.

Even women living legally in the country were often reluctant to work in licensed brothels for various reasons. Some were reluctant to pay tax or social benefit contributions; others did not want to be listed officially as prostitutes and many of these women were opposed to the new legislation.

When asked if the police had a positive attitude to complaints from working women, project worker Theresa said that this was generally the case. Difficulties arose when women in the country illegally were asked to pursue cases further, as this meant disclosing names and personal details, risking expulsion from Holland. At one point, the project employed seven peer educators, who jointly spoke 14 different languages.

Theresa felt that it was advantageous to work with the police. She also felt that although some agencies in Holland considered collaboration with brothel owners wrong, she considered it necessary to gain access to the women working there.

Prison drug free unit

Overamstel prison (known locally as the 'Bijlmer Bajes') was built to a new design and opened in 1997. A central corridor and a low-lying building, which houses offices and admission facilities of six tower blocks, connect the layout, with capacity for 670 inmates.

Our party visited the drug free unit, which offers help to 24 inmates. The unit has two Jellinek drug workers who help prison staff to treat addiction problems. We were told that 70 per cent of the prisoners have an addiction problem of drugs, alcohol or gambling and that treatment is now being offered for smoking and medication addictions.

Inmates applying for treatment are referred by the judiciary, who ask Jellinek for an assessment as they enter the remand system. Help is designed to prepare inmates for treatment after release, or a continuation programme after detention.

New inmates are given medication to help withdrawal symptoms, and methadone prescriptions are provided after release. Inmates on the drug free unit are tested daily for drugs. A positive test for soft drugs will result in a five-day suspension for the first offence and a seven-day suspension for a second offence. Positive testing for hard drugs will mean suspension of the programme and a return to one of the normal prison towers. The inmate will then need to re-apply for a place on the drug free unit.

During treatment in this unit, inmates will participate in group therapy, which includes examining the reasons for lapsing. They are encouraged to engage in 'positive thinking' sessions, examining their social structures outside prison and how best they can make changes to address their drug problems.

The provision of care after release is determined at meetings between Jellinek staff and outside support workers, who jointly agreed an aftercare plan for the inmates. We were told that in Holland, addiction is considered a 'chronic disease'.

'Although this facility is very modern by UK prison standards, I felt it to be an institution of social

exclusion. Tall tower blocks, accessed by internally connected passageways, surrounded by a wall and a moat, made it almost medieval in concept. Had we been examining prison structures instead of drug treatments, any ideas of Dutch liberalisation would have been stretched to breaking point.

'We were told that there is a care plan in place for those inmates returning to mainstream society. Hopefully they will be more progressive, far reaching and reflecting the needs of the clients than the vision we were offered during our visit.'

Brian Street, voluntary outreach worker

Heroin prescribing project

In 1997, the government initiated a heroin-prescribing project, which began operations in the following year.

Applicants to the programme are at least 25 years of age, have a five-year addiction and are resident in Amsterdam. (Illegal immigrants are excluded, as they have no medical insurance.)

Clients are referred by either doctors or other methadone outpatient programmes, and there is no direct access or self-referral. Those that are accepted are likely to use heroin or methadone 12 times a month or more.

The entrance to the treatment facility leads to the methadone-dispensing machine, and from there clients move to either the injecting or smoking rooms. Both rooms are starkly functional, with stainless steel surfaces. The injecting room also has a low sink for clients who are injecting in their legs or feet. Large windows give an uninterrupted view of the rooms from the central office, and it is from here that ready prepared doses are administered. Injecting clients are required to place used syringes into a bin in order for project staff to check that doses have been used. Time for these clients to complete their treatment is limited to 30 minutes, after which they are required to leave.

After 12 months, treatment is discontinued and clients return to their original treatment regimes in order to observe the effects of the programme. Heroin prescribing is considered more cost effective than normal methadone only prescription, as it has been shown to result in less associated crime and anti-social behaviour.

It is the object of the programme to promote the recognition of heroin prescription as an effective treatment and to register it as a medicine for the treatment of addiction.

'After visiting the experimental service provision for heroin prescribing, my attitude totally changed. My expectations were of clients using heroin in rooms full of other clients in a very sociable setting. As a practitioner I didn't know where I sat with this. The visit totally changed my view; it was very clinical and followed the medical model. It was for about 75 clients who had long histories of drug use. There were two rooms; one for injecting and one for smoking, and in the middle were the supervising staff. There was an intense routine, which involved attending up to four times a day. This method would not be appropriate for a lot of people, but I think there should be a choice of treatment available; this must be the way forward.'

Claire Pattison, women's worker (with prostitution) at a voluntary agency

Support project for children of addicted parents

This project operates to co-ordinate the support network for parents and children and avoid 'ad-hoc' working practices. It acknowledges that vast numbers of parents who use drugs are coping well, but that some support opportunities are missed when agencies do not work together. The project seeks to fill that gap and encourages basic care, and aims to support parents in bringing up their own children.

'I found the level of compassion towards drug users in Amsterdam a real eye-opener. I feel that society sees drug users as the lowest of the low, which I think is mainly due to ignorance.

'Visiting the project for children of drug users left me with a quote from the manager, that I know that I will never forget: 'they are parents with a problem – not drug users with children'. I think this sums up the difference in attitudes I have encountered here and in Holland.'

Vikki Kent, counsellor

The Btec Professional Diploma in Management of Addiction course, at Stoke on Trent College, offers a progression route from a range of popular courses in General Drugs Awareness and Addiction. The courses are mapped to DANOS, with assessment of practical workplace competence throughout, and at Level 4 provide evidence for FDAP registration and accreditation.

Second year students are offered an opportunity to visit projects and treatment providers in the UK and in Europe. They meet with fellow drug workers and discuss practice and policy.

For further information about the courses, contact the course team leader, Jane Rowley, at Stoke on Trent College, tel: 01782 208208; email: jrowl1sc@stokecoll.ac.uk

Jane would be interested to hear from any projects that would be willing to meet with small groups of students and discuss their work.

'...there was an official tolerance zone which saw a big increase in the number of women working... Numbers of women in this small area increased to 130 and numbers of customers kerb crawling could be as many as 600 cars per night. The problems this caused the city, combined with increased criminality in the area, forced the mayor to close down the tolerance zone in 2001.'

Diary of a heroin addict

In part three of his story, David Wright comes to the harsh realisation that all's not cosy in his drug and alcohol lined existence, and decides he has to seek help.

I did not always go with Scott to Moss Side and this was one of those occasions. Being left behind to wait was a killer, because no matter how you tried, your eyes keep on drifting to the clock. And it's a two-hour journey, so there and back four hours... but then there is that bit in the middle... scoring, having a hit, filling the car with petrol... so all in all you were looking at five hours. I could not stand the wait, and on this particular day I broke the golden rule – I went to the pub for a drink. Never have a hit after you have been drinking, it's gambling with your life. I only planned having the one pint of lager but you know how it is; I was soon chasing an alcohol buzz. I kept an eye on the clock and five hours later I headed back to the commune. I had drunk five pints of strong lager.

To my pleasant surprise, when I got back they were gouched out with the bag of heroin and spoon on the table. I fixed myself a big hit – as they all had their eyes closed I could have a bit extra and get really shitfaced. I was having trouble getting a vein, so I roused Nick and he gave me the hit and I sat down. That's the last thing I remember.

My next memory is being propped up in the hallway by Scott, who was telling me the ambulance was on its way. I felt a warm sensation and I wanted to close my eyes and drift to the warmth. My face was slapped hard and there was a shout – 'don't you go on me again', or words to that effect. After Nick had given me the hit, I had sat down behind him but his sixth sense had told him to turn round. My lips were blue and I had stopped breathing – all hell then broke loose. Scott was barking the orders; he sent Nick to phone the ambulance and then stash the gear. Mike was ordered to fill bowls of cold water and throw them over me and repeat. Ann took my trainers off and was pinching the bottoms of my feet while Scott walked me round, slapping my face. It took the ambulance 20 minutes to arrive, but by then my friends had brought me round.

Today's overdose manuals tell you not to walk the person round, but to put them in the recovery position and wait for the ambulance. If they had done that I would be dead; I was dead, but they brought me back. I was taken to hospital and given Naltrox, which is supposed to wash the opiates away from the receptors in the brain. But I tell you what, that night was one of the most pleasurable nights I have ever had on opiates. I spent the night in the TV room, chain smoking with the window open, gouching until the most beautiful nurse would rouse me and ask 'are you OK?', to which I would reply 'wonderful'.

This should have been a wake up call, but I went back to my opiate life. The alcohol was becoming more of a problem though; I used to pull any money I had out of my pocket and count it up in pints of beer – or to be precise, snakebite. Once I got to the magic number of six pints, relief swept through me, as I knew that was just enough to take me to a place where fears of self-analysis disappeared. I could fall back into the role of classroom clown; the one I used to play without the need of a chemical confidence booster, when I was at school.

I was never one of those drinkers that drank first thing in the morning, then ended up going to AA meetings. I used alcohol purely as a sedative and a confidence booster. It had got to the stage that even when I stayed in, I had to have four cans of Kestrel Super. So it was at this point in my life that I realised I needed help. I booked an appointment to see a GP.

'Today's overdose manuals tell you not to walk the person round, but to put them in the recovery position and wait for the ambulance. If they had done that I would be dead; I was dead, but they brought me back.'

I sat in the waiting room with a million thoughts going through my head – the main one: 'what am I going to say to him?' I was called in, and as soon as I mentioned my drug use, out came the pen. He started to make a record of what drugs I was doing, how often, how much I was drinking. He examined me and had a good look at the track marks on my arms. He then looked me straight in the eye and asked, 'do you think you are mad?', to which I replied 'yes'. He booked me to see a shrink at the hospital psychiatric department.

The appointment came, and thank God, he was a lovely guy. We went through each drug, including solvents, one by one, all the usual questions: When? How much? How often? Method of taking the drug? He wrote about eight sides of A4 paper. At the end of the session he prescribed me some Hemill Herverin (which is rarely used now, as they say it's too addictive) and told me not to drink and to see him in a week's time.

I lasted three days. The tablets were weird; when you took two or three of them, after five to ten minutes you would get this warming sensation in your nose. Then you would feel the slight sedation. I say 'slight', because I was used to being very liberal with the amount of drug taken to achieve the desired result. If I needed sedation it would be either half a gram of heroin, or six pints of snakebite, or 10ml of diazepam, plus a couple of mogadon. But as I started to find out, hospitals did not take that into account.

So a week later, I saw him again. I told him I had managed to go three days out of the seven without a drink. Then for some reason, a tidal wave of emotion hit me and I started to cry. Not just a little weep – I was in floods of tears, totally out of control. As the sobs started to subside, I remember saying to him that I was mad, and his reply has stayed with me ever since: 'No, you are not mad, as you have just proved by saying that you are. Real mad or psychotic people think they are sane and blame everyone else for their condition.'

I then asked him if he thought I was paranoid, to which he gave the same answer: people suffering from paranoia think they are OK – but he did say I had paranoid thoughts and ideas. Then he dropped a bombshell, by telling me I needed to be on the ward for a few weeks to detox me and see what was going on with my mind.

Part four in DDN next issue

Historical Perspectives: Opium, morphine and opiates

Professor David Clark traces the history of the opiates, from use in Summarian and Assyrian civilisations through to the Opium wars between China and Britain and the cultural impact of opium smoking by Chinese in the Californian gold fields.

Opiate, or opioid, refers to any drug, either natural or synthetic, that has properties similar to opium or its main active ingredient, morphine. Opium comes from one type of poppy, Papaver Somniferum.

Opium was used by the Summarian and Assyrian civilisations as long ago as 4,000 B.C. It is mentioned in Egyptian medical scrolls dating to 1550 B.C. Greek and Roman physicians made medical use of opium.

The use of opium spread from the Middle East with the expansion of the Islamic religion. While the Koran forbade use of alcohol and other intoxicants, opium was not banned. When tobacco smoking was banned by a Chinese emperor in 1644, the Chinese invented the practice of opium smoking.

Europeans became aware of opium in the early 1500s, the drug being imported from the East. Opium use in Britain dramatically increased in the 19th century. It was available as a medicine in many formulations from food stores, pubs, and even peddlers on the street. The most popular form was laudanum, which was opium dissolved in alcohol. Preparations were even made for children and babies, *eg* Streets's Infant Quietness.

Opium use spread to all levels of British society. The Fens area of Eastern England became specially known for its opium production. Opium was sold on market days, in shops and by travelling salesmen.

Samuel Taylor Coleridge was so addicted to opium that in one attempt to break his habit he hired a man to follow him about and prevent his entry into any druggist's store. Other well-known opium users were Thomas De Quincey, who wrote the classic Confessions of an English Opium-Eater, Wilkie Collins, Byron, Shelley and Keats.

There as no concern about opium use until the 1830s. At this time, it was becoming apparent that opium was being used as a cheap pleasurable alternative to alcohol.

In 1803, Frederick Sertuerner isolated a potent alkaloid from opium he called morphine, after Morpheus, the God of sleep and dreams. Morphine remained more under the control of the medical profession and was not sold in shops like opium. Morphine was more commonly used by upper and middle classes, since the lower classes seldom saw a doctor.

'It was estimated that between 16,000 and 26,000 shops sold opiates in Britain in the 1850s. One London chemist had 378 different opiate preparations on his shelf.'

Public concern over opiates, which was influenced by the Temperance Movement, was directed at opiate use by the lower classes. It was believed that working women in industrial towns doped their babies when they went to work. The upper classes could have their addictions, but not the working class, who needed to be protected from themselves.

It was estimated that between 16,000 and 26,000 shops sold opiates in Britain in the 1850s. One London chemist had 378 different opiate preparations on his shelf.

In 1868, Parliament passed the Pharmacy Act, which restricted the sale of drugs to pharmacists' shops. It was harder for the masses to get drugs, but use by the upper classes did not change. Although consumption fell, it returned to normal levels with a few years of the act.

The invention of the hypodermic syringe in the 1850s strongly influenced use of morphine, since doctors realised that intravenous injections gave more rapid and intense responses when compared with previous routes of administration. The rapid pain-relieving properties of injectables morphine made it the treatment of choice during recovery from serious wounds. However, withdrawal from the drug was often more difficult than recovery from the wound.

Morphine dependence was so common during the American Civil War, it became known as Soldier's Disease. Opium was cultivated in both Union and Confederate territories. It was used to treat endemic dysentery, and as a preventive against malaria and diarrhoea. By 1906, there were 50,000 patent medicines containing opiates in the U.S.

China had long exercised the upper hand in economic relations with the West. Silks, tea, fine pottery and other items flowed West, but China needed little itself. Attempts to redress this balance provided a major impetus for Western expansion.

The growing popularity of opium smoking provided a partial solution to trade imbalances with China. Throughout the 18th century, the British East India Company had a monopoly where they bought opium from farmers (particularly from India) and then sold it to independent wholesalers.

Opium production provided a living for peasants, merchants, bankers and government officials. Exports to China earned hard currency, reducing the trade imbalance. Monopolising opium buying in India provided revenue for hard-pressed colonial administrations.

Official China considered opium smoking a moral vice and an economic threat. In 1729, Peking issued an Imperial Edict against the practice, but this had little effect. Further Imperial edicts in 1796 and 1799 led to the development of a thriving illicit drug trade.

In 1838, a new Imperial commissioner tried to control trafficking in Canton. This precipitated the Opium War with Britain and an embarrassing defeat. In subsequent years, the Imperial government could not enforce dictates against the drug. By the turn of the century, opium permeated all aspects of Chinese society and economy.

The cultural impact of Chinese opium smoking was felt further afield. The Californian gold rush of 1848 created a high demand for Chinese mine workers. Some had smoked opium before leaving for America, but their new harsh working circumstances were conducive to addiction. Many Westerners believed overwrought reports concerning the spread of the opium habit. Although grossly exaggerated, fears about the opium den's effect upon young white men and women fed resentment against the Chinese.

To be continued in the next issue of DDN

Sentenced to Treatment – meeting the needs of drug using offenders

29th June 2005
Venue: Hamilton House
London WC1H 9BD

A one day conference organised by the Centre for Crime and Justice Studies

Please contact 020 7848 1688

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We have a comprehensive database of specialist substance misuse personnel

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

www.SamRecruitment.org.uk

YOUTHWORCS
WORCESTERSHIRE YOUTH SERVICE

Education:	**Youthworcs**
Job Title:	**Substance Misuse Youth Workers x 2**
Base:	**Worcester**
Salary:	**Youth Support Range 2nd Level 14 – 17 £20835 - £22690 pa** *This salary is based on the proposed JNC National Framework, which is yet to be ratified.*
Contract:	**Fixed term for two years**

These are new posts, managed by the Youth Service and working with SPACE, a multi-agency substance misuse service for young people.

Substance **P**revention **A**cceptance **C**onfidentiality **E**ducation

We are now seeking to appoint two youth workers to this team. Line managed through Youthworcs, the Worcestershire Youth Service the workers will develop links with youth work projects, ensure the delivery of curriculum approaches to education around substance misuse in a variety of settings and work to establish a detached youth work approach.

For further details call Dave Evans on 01905 765417
For an application pack call Sue Daniels on 01905 765459 or email Sue: sdaniels@worcestershire.gov.ok

Closing date 10 May 05
Interviews during the week commencing 23 May 05

worcestershire countycouncil

West Kent NHS
NHS and Social Care Trust

We don't just look after our patients >>>

>>> we take care of our staff too

West Kent Substance Misuse Services

Substance Misuse Workers

£22,328 - £30,247 p.a. depending on experience
37.5 hours per week
Base: Medway
Ref: WKT/SPE/119/0405

This is an opportunity to work within a dynamic and developing Young Persons Drug and Alcohol Service. This service demands high standards from all staff and this is reflected in the quality of care that is provided to our clients. In order to maintain these standards we are committed to a programme of specialised training. Although the work is challenging at times, the working environment is supportive as well as being progressive.

The focus of the work will be with young people under the age of 19 years. This involves assessment of young persons' drug and alcohol related needs and the development and delivery of individualised care programmes, often working in collaboration with other professionals or agencies. You must posses a relevant qualification to Diploma level or above in either Nursing, Youth Work, Social Work, Psychology or Counselling, and to have at least two years' experience in the field of addiction. You must have the capability to work independently as well as part of a team, and be able to make decisions about the management of clients.

You must have the ability to travel between different sites as agreed with your manager, in a timely and reasonable manner.

To be effective, you must be able to conduct yourself in a manner, which is perceived as highly competent, and inspires the confidence of colleagues as well as other professionals.

For further information or an informal visit, please contact Frank Costigan, Team Manager of Young Persons Drug & Alcohol Team on 01634 827951.

For an information pack, please contact Shannon Ratchford, Team Administrator, Elm House, 15 New Road Avenue, Chatham, Kent ME4 6BA. Tel 01634 827951.

All staff working with young people will be screened by the Criminal Records Bureau.

Closing date for returned application forms: 10 May 2005.

Benefits include:

■ **Flexible working options** ■ **Final salary pension scheme** ■ **Training and Development**
■ **Minimum 27 days annual leave plus Bank Holidays (pro rata for part-time)**

To find out more about the Trust and opportunities available, visit our website: www.kentandmedway.nhs.uk

The Trust is an equal opportunities employer and has a no smoking policy.

POSITIVE ABOUT DISABLED PEOPLE

INVESTOR IN PEOPLE

The Nour Al-Shorouk Centre

The Nour Al-Shorouk Centre is a pioneering program established in Beirut, Lebanon to provide first class treatment for substance abuse and addiction, and counselling programs to individuals whose lives have become unmanageable as a result of addiction, while introducing them to a new and better way of life. Treatment is provided by an expert staff of counsellors, therapists, and professionals in the field of substance abuse treatment and includes counselling, education, and training in the tools of recovery and how these tools will apply to a new lifestyle free from drugs. The centre is currently seeking to appoint an experienced Clinical Psychiatrist. A highly attractive remuneration package will be offered to the right candidate.

Clinical Psychiatrist – Beirut, Lebanon

Responsibilities include:

- Providing direct psychiatric services through the comprehensive evaluation, diagnosis, and treatment of patients, including prescribing and administering medications.
- Providing professional consultation to staff, participating in staff conferences, and serving on clinical committees.
- Handling psychiatric emergencies, including mental health evaluations.
- Completing necessary medical records and reports.
- Participating on quality assurance, educational, and professional committees as assigned by the Clinical Director.
- Developing and/or participating in research protocols

The Ideal Candidate Should Have:

- A degree in medicine, osteopathy or equivalent
- Familiarity with and support for a 12-step approach to treatment and recovery for clients in the program
- 3-5 years of psychiatric residency from an approved program.
- Expertise in use of psychotropic drugs.
- Knowledge and competency in all facets of mental health treatment.
- Strong interpersonal skills. Ability to communicate with colleagues in a professional manner.

Interested candidates who meet the above requirements are invited to submit an application, with a detailed resume/curriculum vitae in English to email:alshorouk@btinternet.com.

Deadline for submission is May 13th, 2005.

We thank all candidates for applying, but can only acknowledge those under consideration.

DDN
Drink and Drugs News

Don't monkey around

Subscribe NOW

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

INVESTOR IN PEOPLE

CLOUDS

ADDICTIONS COUNSELLOR/SENIOR COUNSELLOR

Salaries from £19,510 to £23,075

Since 1983, the charity Clouds has directly and indirectly helped thousands of people from all walks of life to recover from the effects of alcohol and drug addiction. Clouds has always worked tightly to the vision that it would offer help, hope and freedom from drug and alcohol dependency by providing interrelated services of the highest quality and effectiveness, all of which have a clear and ethical basis and which meet the REAL needs of our clients.

To continue the good work that Clouds has accomplished, we are seeking to recruit qualified Addictions Counsellors and Senior Counsellors, who will be able to provide a full range of Counselling services to our beneficiaries.

Clouds House is situated within stunningly beautiful countryside – so you can enjoy a lifestyle that matches your valuable skills and experience. We offer competitive salaries and benefits packages, including a personal pension scheme, minimum of 25 days holiday, and Death-in-Service benefit.

Interested?

*Give the Human Resources Team a call on 01747 830733, or email them on **human.resources@clouds.org.uk***

Closing date for this vacancy is 29th April 2005

SEFTON PARK

a residential home for the treatment of alcohol and drugs dependency

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

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

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

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

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

Written applications with a detailed CV setting out your experience and qualifications to

Graham Maguire, Sefton Park Rehabilitation Centre, 10 Royal Crescent, Weston-super-Mare BX23 2AX
or by email to: enquiries@sefton-park.com

Closing date for applications; 12th May **www.sefton-park.com**

Half of all violent crime is alcohol related

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

ALCOHOL STRATEGY PROGRAMME MANAGER

PERMANENT POST

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

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

The hours of work are 37.5 per week.

Salary subject to job evaluation circa £30,553k

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

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

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

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

Closing date: 27 May 2005.

Wirral DAAT Drug & Alcohol Action Team
Birkenhead and Wallasey NHS Primary Care Trust
Bebington and West Wirral NHS Primary Care Trust
Wirral Strategic Partnership Local Strategic
WIRRAL
WIRRAL COMMUNITY SAFETY PARTNERS Protecting our Community Together

WEST LONDON MISSION SOCIAL WORK MINISTRY

ST LUKE'S CENTRE

FOR PEOPLE WHO MISUSE DRUGS AND/OR ALCOHOL

Based in Kennington SE London

AN EXPERIENCED SUBSTANCE MISUSE WORKER THAT HAS UNDERTAKEN DANOS TRAINING

NJC Scales, S.C.P 25 to 30, plus Inner London Weighting
(currently £22,668 to £26,277 p.a. inclusive)

St. Luke's 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 Substance Misuse Worker to join our team. 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 and people with complex needs.

We offer in return, a fantastic opportunity to develop your skills and knowledge in a 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 5 May

working for healthier lifestyles

CDP delivers an accessible, non-judgemental, client-focused service to people with drug problems in the South London area.

We offer a range of benefits including a contributory pension scheme, generous holiday entitlement, flexible working and a comprehensive training programme.

Registered Charity No. 293959.

Community Drug Project

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

Southwark Contact Team – Camberwell SE5

The Contact Team is a development of the Enhanced Arrest Referral Service which now provides one of the key gateways within the new DIP initiatives. The service works within police custody areas and magistrates courts offering advice and support to those entering the criminal justice system via arrest.

Project Workers £22,638 - £26,238 pa + £1,000 retention bonus Ref: 002/PWCS/DADN

We are looking to recruit Project Workers to this dynamic team, working within the local police stations and courts.

- You will assess clients and develop care plans.
- Work closely with the police within custody suites.
- Manage a small caseload of clients.
- Provide outreach support to engage and retain clients whilst awaiting treatment.

Please note that this post is subject to security clearance.

You should have experience of assessing chaotic drug users and the ability to make effective interventions as well as building good working relationships with a wide range of agencies.

Lambeth Harbour, Crack Service – Brixton SW9

Project Worker £22,638 - £26,238 pa Ref: 003/PWLH/DADN

Lambeth Harbour is a pioneering new service for crack users based in Brixton. It is a partnership between CDP and other voluntary and statutory service providers, offering a variety of services including complementary therapists, structured support groups and one-to-one sessions.

You will work as part of a team to facilitate all aspects of the crack service by receiving referrals, conducting brief and formal assessments, contributing to group work programmes, providing key work sessions and working within the drop-in.

RISE Day Programme – Camberwell SE5

Male Project Worker* £22,638 - £26,238 pa Ref: 004/PWR/DADN

The RISE Day Programme has recently been redesigned and is now delivering an innovative rolling 12 week programme from its new site in Southwark. The programme uses formal group work and individual skill-based interventions to support a range of drug users through a process of change.

We require a male worker to take the lead on running male-only groups as part of this programme. You should have considerable experience and knowledge of the process of change within a rehabilitative environment and groupwork. Life experience will be considered alongside work or voluntary experience.

* Section 7 (2) (e) of the Sex Discrimination Act 1975 applies.

Westminster Drug Project (WDP) and the Community Drug Project (CDP) have come together to form a unique partnership. Both organisations have a long and established history of delivering accessible, non-judgemental, client-focussed services to people with drug problems in the London area.

Specialist Targeted Engagement Programme S.T.E.P.

Project Practitioner £22,638 - £26,238 pa Ref: 005/PPS/DADN

In response to the opportunities presented by the DIP programme, we have developed an innovative approach to working with prolific drug using offenders.

The team currently consists of a manager employed by WDP and three Project Practitioners.

We are looking to employ a Project Practitioner within this partnership.

You will have:

- Knowledge and experience of the issues around substance misuse and the impact on offending behaviour.
- Experience of direct client work including assessment, care-planning and care co-ordination.
- The ability to work in partnership with Criminal Justice Agencies.

Please note that this post is subject to security clearance.

For an application pack for any of the above vacancies please telephone 020 7840 0099 or email: j.farquharson@communitydrugproject.org.uk quoting the relevant reference number.

Closing date for completed applications: Thursday 28 April 2005. www.communitydrugproject.org.uk