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DDN
Drink and Drugs News

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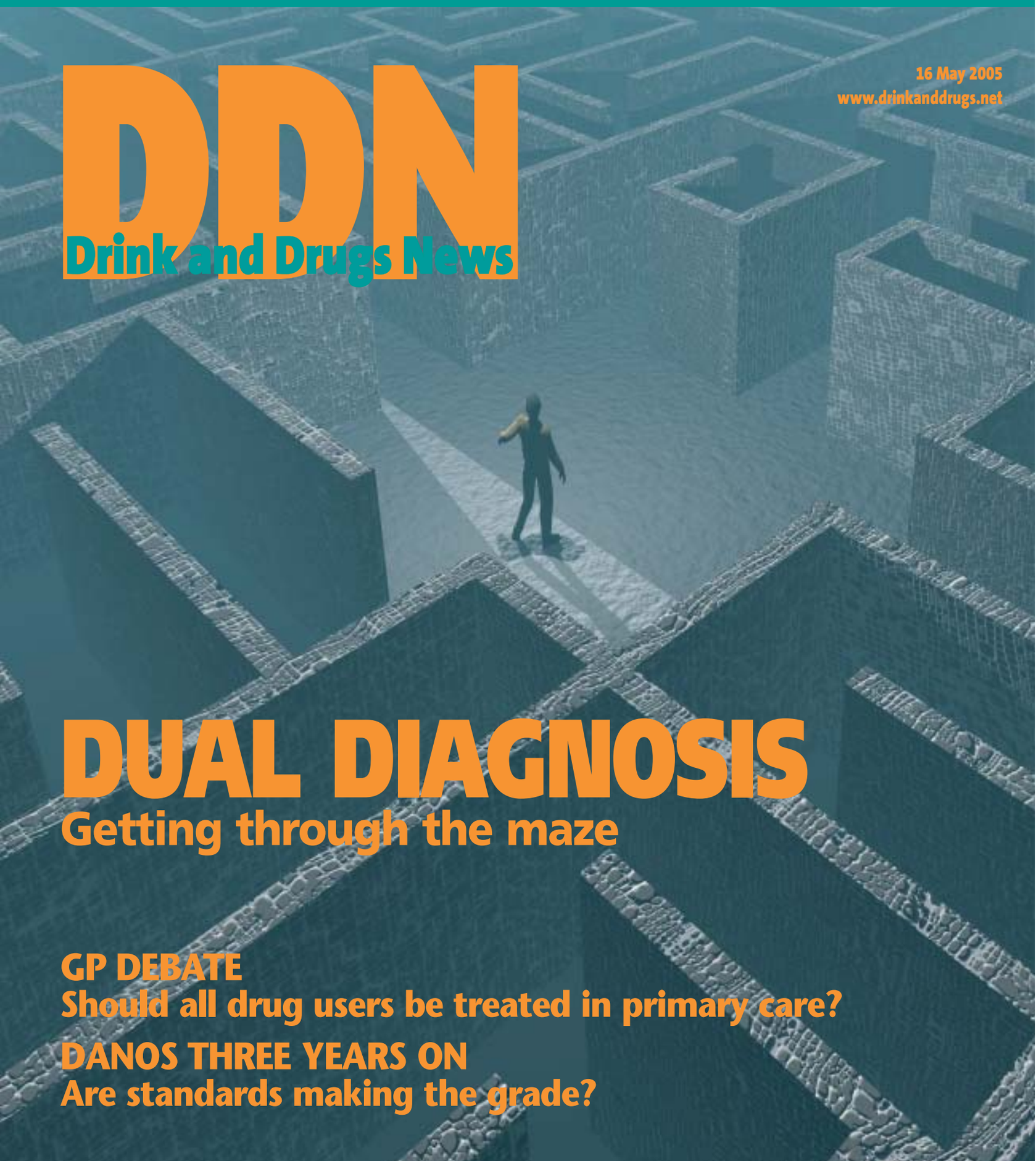

DUAL DIAGNOSIS
Getting through the maze

GP DEBATE
Should all drug users be treated in primary care?

DANOS THREE YEARS ON
Are standards making the grade?

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RELEASE

SMMGP

Drink and Drugs News

16 May 2005

Editor's letter

A very warm welcome to SMMGP this issue, who join our merry band of partner organisations. The ten-year-old organisation for Substance Misuse Management in General Practice has done much to put GP involvement on the map.

Ten years ago, the relationship between service users and their GP was often an uneasy one. These days SMMGP see a bright future for primary care drug treatment, and if the enthusiasm of delegates at the recent RCGP is anything to go by, there's every reason to be optimistic. The workshop which found a meeting of minds between GPs and service users is particularly encouraging – see page 12.

Not least, there is obviously a good dialogue and robust debate going on about issues that affect service users and those who work with them, which we hope to benefit from through their link as a DDN partner.

'Dual diagnosis' seems to be the subject of considerable confusion – not least for the sufferer with mental health, substance misuse, and often a host of other complications in their lives. One problem may lead to the other, and while there's plenty of expertise available on either area, the complexities make it difficult to size up a client for a 'one size fits all' solution. The number of people being diagnosed with both mental health and substance misuse problems is rising year on year, but are we catering for them in the same proportion – or assuming that 'the other side' does it better?

Turning Point and Rethink have done useful work on educating practitioners in substance misuse and mental health, including the all-important wider social care field (see page 8). Please let us know if you have policies that work or inspirational practice in your workplace.

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In this issue

Media watch

A drug user created his own cannabis factory – using gear bought from the police. Mark Batty set up a cannabis-growing operation at his home with equipment that had been snapped up at a public auction held by the West Yorkshire force. Police discovered 85 Cannabis plants when they raided the 32-year-old's home. The equipment he used came as a result of an auction sale conducted by the police... even to the point that it still had on it the labels 'West Yorkshire Police Force'.
Yorkshire Evening Post, 11 May

A senior policeman has blamed binge-drinking for a leap in the number of reported rapes. Chief Superintendent Charlie Common says too much booze in both attackers and victims is a significant factor behind the 50 per cent rise in rape cases in the Scottish Borders – 30 in the past year. He is warning women to watch how much they drink and take sensible precautions on nights out.
Daily Record, 3 May

The price of the drug ecstasy is now little more than that of a can of Coke as dealers target younger and younger teenagers. The pill, which has claimed the lives of more than 200 young people in 15 years, cost as much as £25 in the 1980s, but can now be bought for the pocket money price of less than £1. Gloucestershire Constabulary Drugs Unit officers conducted a test purchase operation just before Christmas and were shocked at the prices they were offered.
Gloucester Citizen, 12 May

A hard-hitting play that tells the story of a drug addict blackmailing her parents is to be performed in Irvine in a bid to reach families in similar situations. Funded by the Fullarton Health House, the play, Father's Day, tells the story of a family ripped apart by drugs and has toured six venues across the country as professionals and families affected by drug addiction relate to the believable story.
The Irvine Herald, 12 May

The party is over for Birmingham's political elite, who have been told they can no longer drink alcohol at the council taxpayer's expense. Meetings of city councillors will be limited in future to sandwiches, biscuits, tea and coffee, with the bill not to exceed £15 per head.
Birmingham Post, 11 May

Paul Goggins: assigned responsibility for drugs portfolio

Goggins takes lead on drugs as Flint leaves Home Office

Caroline Flint MP has left the Home Office to be reassigned to the Department of Health, in this week's cabinet reshuffle. Ms Flint's new role will be Parliamentary Under Secretary of State for Public Health.

Responsibility for drugs passes to Paul Goggins, who continues as a Home Office minister, supporting Hazel Blears on policing, security and community safety. Mr Goggins has been responsible for drugs in prisons in his role as Parliamentary Under Secretary of State for correctional services and reducing re-offending. He moved from the Department of Education and Employment with David Blunkett in June 2001.

Baroness Scotland will continue at the Home Office, leading on offender management and criminal justice reform, supported by Fiona Mactaggart.

Tony McNulty has joined the Home Office team to lead on immigration, citizenship and nationality, supported by Andy Burnham.

GP delegates reach consensus on drug services

Two days of presentations, vigorous debate and workshops to 600 delegates, confirmed the Royal College of General Practitioners' tenth national conference as a major event for those involved in management of drug users in primary care.

The event involved generalist and specialist GPs, shared care workers, pharmacists, joint commissioners, as well as service users, and included debate on priority issues for all parties.

At the end of the conference, Dr Berry Beaumont summed up and presented the following consensus statement on behalf of delegates:
1. We recognise the importance of meaningful user engagement in the commissioning and delivery of drug treatment services, and call for secure funding and structures to support this.
2. We welcome the large increase in funding for drug treatment services in recent years, but there needs to be an urgent review of the evidence base underpinning how services are accessed and delivered to ensure that they optimise health gain for drug users.
3. The primary care team needs to work in partnership with all other drug treatment services to assess and address the problems of individual drug users within a holistic framework.

Eco-therapy energises rehab clients

A conservation therapy scheme is being launched to treat people with drug and alcohol addictions, by getting them involved in environmental restoration work.

Drug and alcohol charity Phoenix House has joined forces with government environmental agency English Nature to pilot the programme at two sites in Derbyshire and County Durham. Clients from Phoenix House's residential rehab centres have been involved in sustainable restoration, including dry stone walling, river clearance, footpath repair and hedge laying. The charity reported that early research showed that participants in the scheme were 20 per cent less likely to drop out of treatment. Its chief executive, Bill Puddicombe, said Phoenix House planned to roll the project out to five other residential treatment centres across the country over the next few years.

Rehab clients have reported feeling energised and regenerated from being involved in 'eco-therapy'.

Rehab clients have reported feeling 'energised' and 'regenerated' from being involved in 'eco-therapy'. Ex-service user John Crane said: 'Seeing a job through to its conclusion and doing it properly was immensely rewarding. After all my years of drug abuse, where I seldom completed a task, it was reassuring to learn that I could function as an individual within a team and see a job through.'

Waiting times down, workforce up, says NTA

Waiting times for drug treatment in England are down by 6.5 weeks since December 2001, according to latest performance figures released by the National Treatment Agency.

The NTA reports that the average waiting time for treatment is now 2.46 weeks, not including clients being treated in prisons. Waiting times for entering drug intervention programmes are consistently lower than the national average, at 1.9 weeks.

The increase in the numbers of people entering treatment is on track to double by 2007/08, against a baseline figure of 100,000 people in treatment in 1998/99, according to the NTA.

The number of workers in the drug treatment sector has just been released, showing an increase in the workforce of 1,000 people in the past year, to 10,025.

Waiting times and workforce data is monitored on a quarterly basis, and available since the NTA started monitoring them in 2001.

London alcohol strategies emerge despite lack of funding

Alcohol strategies are being put in place across London, despite the lack of funding to resource them, according to a survey by the London Drug and Alcohol Network (LDAN).

Half of all London boroughs had, or were in the process of developing, a local alcohol strategy. Those without a strategy in place blamed lack of resources they would need to meet the demand for services outlined in last year's Alcohol Harm Reduction Strategy, or said they could not afford a consultant. Others said that alcohol targets and actions were part of their community safety strategy.

Other DAATs had bitten the bullet and tackled the process of complex and time-consuming needs assessments, consultations and targets, liasing with local agencies, PCTs and police.

Lambeth DAAT had piloted a local alcohol strategy toolkit developed by LDAN and was in the final stages of developing a strategy and action plan – the end of a long process, according to Scott Buchanan, Lambeth alcohol co-ordinator. Early initiatives were likely to focus on tackling anti social behaviour and alcohol related violence, particularly in view of licensing changes, but the wider agenda included improving treatment quality, education and reducing health inequalities.

Health and support issues also featured. Among the initiatives, Hammersmith and Fulham had a target of bringing 20 per cent more street drinkers in contact with alcohol services.

LDAN's alcohol strategy toolkit is available at www.localalcoholstrategies.org.uk

Vocational training can get jobless service users back on track

Addressing the vocational needs of drug and alcohol users promotes recovery and encourages social inclusion through education and employment, according to 'Idle Hands', an article in the May issue of *Drug and Alcohol Findings*.

Authors Nigel South, Shakeel Akhtar, Rachel Nightingale and Mike Stewart examined links between problem drug users in treatment clinics and their employment status: the vast number were unemployed, and there was a strong negative link:

'What we can be sure of is that unemployment is not good news for addiction, and addiction is not good for employment.'

While unemployment was unlikely on its own to be a major determinant of the onset of drug problems, employment was a major factor in preventing relapse. Through a study in Essex, the authors found that when they became dependent, drug users invariably dropped out of employment. Residential rehab and other programmes needing daily attendance made employment very difficult.

Vocational training programmes could make a significant difference, as 'addicts are neither unemployable nor are the obstacles so formidable that unemployment is unrealistic,' according to the authors. Teaching 'employability skills' such as how to find suitable openings and present themselves to an employer were a key part of vocational rehabilitation, but were frequently not covered by treatment services.

For subscription information on Drug and Alcohol Findings, visit www.drugandalcoholfindings.org.uk or email findings@alcoholconcern.org.uk

Europe plans action on highest ever drug use

The European Action Plan on Drugs will be a 'dynamic policy instrument', not a 'static list of political objectives' that will provide a framework for a balanced approach to reducing both supply and demand, according to the Commission of the European Communities.

With up to 2 million problem drug users in Europe, use was at historically high levels especially among young people, according to the Commission.

Two consecutive four-year action plans were being produced as part of the EU Drug Strategy for 2005-2012. The strategy covered crosscutting themes of international co-operation, research, information and evaluation to tackle improved health protection, public security and co-ordinated international action.

Actions should be realistic, measurable and cost-effective, according to the Commission.

This house believes that all drug users should be treated in primary care

For the motion...

Dr Tom Gilhooly, GP and medical co-ordinator, Glasgow Shared Care (drug misuse), proposes the motion

I WOULD LIKE TO SAY FIRST OF ALL that I am a living example of why all drug users should be treated in general practice. Last year I was due to speak in the debate at this conference in Cardiff. But just like one of our patients missed the bus to the clinic, I missed the plane and didn't turn up. Now any other conference organised by any other self-respecting professional body would never have asked me back for another year! Only a profession as tolerant and understanding as general practice would have had the compassion and understanding to offer me a second chance and that's what our patients need time and again.

Can I just define what I mean by primary care. This is where the primary health care needs of the patient are met. Not some broom cupboard in a health centre where someone hands out methadone scripts after a sterile discussion about how they are doing. No, primary care is where the whole person is looked after. Everyone wants to be a specialist, I suppose you feel special if you are a specialist but we in primary care are the holistic medicine specialists. We do not look at the patient's addiction in isolation from his physical and mental health and wellbeing. And our patients deserve to have this type of care. Addiction is not rocket science, it is fairly straightforward and the key element to it is the therapeutic relationship that is built up between the patient and the clinician.

If you belong to the David Nutt school of neurobiology of addiction, then it would appear that permanent changes take place in the brain receptors when drugs have been used for a long time. It would explain the abject failure of most detox programmes and the little long-term publications on this subject do not offer much comfort. Mortality rates of between 10 and 20 percent annually compared to 1-2 per cent in maintenance programmes; indeed in Glasgow we have just recorded an annual mortality of 0.7 per cent for methadone maintenance which is lower than your average Glaswegian! So it seems there is a structural reason why drug users should be treated in primary care. The long term nature of the condition means they will have to be in treatment for a long period and this will only result in longer waiting times if specialist care is used.

This is not to say that drug users could not be referred as appropriate to a psychiatrist or any other specialist, but if they do not receive their treatment in primary care they will miss out on the vital health care that they should not be denied.

> 'It would appear that permanent changes take place in the brain receptors when drugs have been used for a long time. It would explain the abject failure of most detox programmes and the little long-term publications on this subject do not offer much comfort.'

Dr Stefan Janikiewicz, clinical director, drug and alcohol directorate, Cheshire and Wirral Partnership NHS Trust, seconds the motion

NORMALISATION SHOULD TAKE PLACE rather than ostracisation in drug use in primary care. There are no agencies that will pick up any contract for the things that are now expected for drug misuse. Primary care physicians or primary care teams now do all of the following: detoxification on a community and residential basis; overseeing outreach teams; harm reduction and needle exchanges; benzodiazepine management and withdrawal; stimulant user workers; GP Liaison Teams; counselling; dual diagnosis workers; all GMS work including other chronic diseases such as asthma, diabetes and chronic obstructive pulmonary disease; contraception; pregnancy; cervical smears; STDs; clinics for working women and men (prostitution); having psychologists working on personality disorders; HIV, Hep C, Hep B work; and alcohol misuse.

Less than 5 per cent of people with mental health problems would need the close care of psychiatry. If housing and poverty could be addressed a lot of the above would be unnecessary.

Against the motion...

Dr Emily Finch, consultant addiction psychiatrist, South London and Maudsley NHS Trust and clinical team lead, National Treatment Agency, opposes the motion

THE PROBLEM WITH THE MOTION is that 'all' is clearly the wrong word.

Drug users are a heterogeneous client group, from highly functioning people with simple dependence problems, to individuals with a whole range of psychological, social and medical problems. Some of them will always need specialist care.

The treatment system has to cope with complexity. Treatment is not just about prescribing (although it is important). It is about understanding that a 19-year-old with a one-year history of smoking crack needs a very different intervention from a 40-year-old entrenched methadone maintenance client. It is about understanding the natural history of the disease and how the needs of the client change. Methadone maintenance can be a relatively straightforward process – but what about when, 10 years on, that client comes and says they would like to achieve abstinence now? Is that process so simple? It is about running inpatient detoxification for high-risk clients and providing highly skilled psychological interventions.

prevalence of severe depression of 27 per cent in drug treatment populations and 47 per cent in alcohol treatment populations. Even more worryingly, they found 75 per cent of drug clients and 86 per cent of alcohol clients had some sort of psychological diagnosis. Strathdee screened their primary care population for dual diagnosis and found that 63 per cent were depressed. What about high levels of Posttraumatic Stress Disorder and trauma associated with physical and sexual abuse – very high in substance users. All these need skills to manage them, such as cognitive behaviour therapy, but these may not be generalist skills, and may not be available in primary care.

Challenging behaviour is not the norm and may even be rare, but specialist teams are better set up to deal with it. In practical terms, what about the clients who never attend an appointment – then turn up drunk? They are not easy for surgery-based GPs to manage.

Specialists of whatever type hopefully have a full understanding of their speciality. Addiction is a complex problem – not explained by one model. We have to understand psychological mechanisms for addiction, as well as the genetic and biological ones. There is a moral and ethical dimension to the care of addiction clients. Can a non-specialist manage all that? Do they have time, when they have to do the same for heart disease?

Like all specialities, substance misuse has new developments; research is done and specialists are needed to keep us up to date on this.

Addiction is a chronic relapsing condition for many people and it has its highs and lows. Like any chronic disease, much of the time management can take place in primary care. But like diabetes and asthma, specialist input is required for difficult clients and for many clients at some periods in their lives.

Why are substance misusers not entitled to in-depth work by skilled specialists? Are their problems easy to cope with? Can anyone manage them? Are our clients not entitled to more? Client choice is also important.

> 'There are... complex social needs, eg homelessness, which it would be impractical to respond to in conventional primary care. And what about sitting in child protection conferences and spending hours on the phone to social workers?'

There's no suggestion that primary care should manage combination therapy for hepatitis C virus. There are also complex social needs, eg homelessness, which it would be impractical to respond to in conventional primary care. And what about sitting in child protection conferences and spending hours on the phone to social workers?

What about dual diagnosis? Do we need psychologists? We can argue about prevalence and certainly about methodology and definitions, but the recent COSMIC study published in 2001 showed a

We're all interested in working with this interesting, challenging and rewarding client group. Many other professionals, especially doctors, are not. There are many clients to go around, and although waiting lists have gone down, treatment of any kind is in short supply. By having this sort of debate we waste time when we could be treating clients and planning good local services. Other professionals not in the substance misuse treatment world must wonder what we are arguing about. We should all use the skills we have, to give our clients the best deal we can.

Dr David Young, clinical director, drug and alcohol directorate, Cheshire and Wirral Partnership NHS Trust, seconds the opposition

THE SECOND BRAIN REPORT IN 1965 led to the extinction of primary care involvement in the field of addiction and the handing over of the responsibility for this field of medicine to psychiatrists. There was no mixed economy, there was no mixed training and so when the first wave of brown heroin hit this country in the late '70s and early '80s there was a massive cohort of untrained and unprepared doctors who tried to deal with the problem. As a result of the work done by the people who had the vision to set up the first Drug Treatment Conference and bring together other primary care doctors who had been battling in isolation in this field, primary care produced an incredible response, a revolution culminating in the certificate training and the massive attendance at this conference today. We would have benefited from a mixed economy of service provision from 1965 and we reject that approach at our peril.

I believe the majority of drug users can and should be managed in primary care. However, when I was at the lower end of my learning curve there were many patients with complex needs, particularly those at the lower end of the age spectrum, whom I did not feel clinically confident to care for in isolation without support from my peers in addiction psychiatry. I sought their advice and they supported me. I would suggest there are many people at the conference today who are also at the lower end of their learning curve in this field and who would not feel comfortable in being told that they had to look after all patients of all levels of complexity in primary care.

In this country we do things best by compromise, by a middle road and I believe a mixed economy approach to drug users is the best approach, or we have failed to learn the lessons of the second Brain Report.

All drug users should be registered with a GP and all drug users should have access to general medical services. But like all chronic disease management, different levels of complexity within the patient require different levels of response from primary, secondary and tertiary care.

This debate was held at the RCGP's tenth national conference on the management of drug users in primary care on 28 and 29 April.

Two thirds of delegates voted to support the motion.

Getting a grip on dual diagnosis

Dual diagnosis has been acknowledged – and filed away under 'complicated'. From a perspective of seeing people fall in the gap between substance misuse and mental health services, Turning Point and Rethink are trying to make co-ordinated treatment a more obvious first step.

Dual diagnosis. It implies two lots of expertise, double the resources, twice the chance of successful treatment. Reality: a mental health problem and a substance misuse problem in the same person. Prognosis? Uncertain. It's difficult to know which problem to treat first.

And as complicated as that may sound, it's still a simplistic view. 'Dual diagnosis suggests that there are only two problems of mental health and substance misuse,' says social care charity Turning Point's chief executive, Lord Victor Adebowale. 'The reality is that the majority of clients we work with face multiple difficulties. Co-ordinated personalised treatment and recognition of a person's need for home, friends, money and meaningful activity is critical.'

Over the last few months *DDN* has reported valiant attempts to pin dual diagnosis firmly onto the notice board. 'Patchy provision and frustrated staff make it difficult to integrate substance misuse and mental health' was a typical comment at the 'Mind the Gap' dual diagnosis conference, at the end of last year. 'We tend to forget we've come a long way in the last few years – ten years ago in the UK, dual diagnosis didn't really exist,' said another speaker.

So we're making a little progress – but why is it taking so long? According to Turning Point and mental health charity Rethink, a third of mental health patients have a substance misuse problem and around half of drug and alcohol patients have a mental health problem. It's not a new issue – but establishing a co-ordinated approach to it is still a long way off.

The two charities launched a dual diagnosis toolkit last August, in an attempt to 'build bridges and promote mutual learning'. For while 'holistic care' sounds logical enough, it's a different matter in practice to break down barriers between established services.

According to Lord Adebowale, there's no excuse for refusing to look at the two problems in tandem. 'The response to substance misuse needs to incorporate mental health,' he told last month's International Drug Policy Conference. 'There's no point without looking at dual diagnosis. To miss this out misses the point.'

Whatever the practical difficulties, there is no doubt that those working in substance misuse services would benefit from a better understanding of mental health services, and vice versa.

Sufferers often find it difficult to access the support they need, and professionals and agencies are unsure how to meet the full range of needs, according to Caroline Hawkings, Turning Point's policy and campaigns officer, who was involved in drafting the toolkit. She quotes Lucy, a service user:

'Mental health services seem to have a block on dual diagnosis even though many services have had drug or alcohol problems. What need to be addressed are the underlying problems that cause someone to use. When I have also used alcohol and drugs, overdosed or self-harmed, I was deemed as "acting out", being manipulative or attention seeking.'

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had drug or alcohol problems. What need to be addressed are the underlying problems that cause someone to use. When I have also used alcohol and drugs, overdosed or self-harmed, I was deemed as 'acting out', being manipulative or attention seeking.

The situation is the same for other patients suffering mental health problems who encounter substance misuse services first. Staff in both settings will offer treatment to the best of their knowledge, but the approach may be narrow, and its benefits limited.

The Department of Health's dual diagnosis good practice guide, published in 2002, provides 'a framework within which staff can strengthen services so that they have the skills and organisations to tackle this demanding area of work' and advises closely co-ordinated mental health and specialist substance misuse services. Yet there's a perception that targets haven't been achieved.

'There's been a lack of training and a lack of strategies,' according to Caroline Hawkings. 'Training needs to be broader, and there's a need for better collaboration – starting with being aware of what's in your area.'

The toolkit is a useful start, she says. It shouldn't replace training, but should help to get those in social services, housing, prisons, probation and other services talking to each other – a step at least towards a co-ordinated approach and a practical, holistic care plan.

The guidance in the toolkit explains in detail the various treatment stages and interventions, and gives structures for effective service delivery – but at the same time warns against getting bogged down in unnecessary detail at the expense of actually answering clients' needs.

'It's important that practitioners don't get caught up with the question of "what came first",' says Hawkings. 'Many practitioners become preoccupied with establishing whether a person's substance misuse is primary or secondary to their mental health problem or vice versa.'

The two charities want to stop people from falling through the gaps in services – being shunted between substance misuse and mental health without either service taking overall responsibility. As they point out, there is little point in providing treatment unless service providers also recognise that people need homes, meaningful activity, adequate income, social networks and access to jobs and training. Co-ordinating services in a more deliberate and structured way is a vital basic stage.

The Dual diagnosis toolkit comprises a practical guidebook, A2 poster of relevant services, suggestions booklet, and a families and carers booklet, produced with Adfam.

Download materials from Turning Point at www.turning-point.co.uk (or call 020 7553 5220 to order) or Rethink at www.rethink.org/dualdiagnosis (or call 0845 456 0455).

Extreme lessons

Mike Ward has been on homicide inquiry and drug death review teams. Here he shares the need for better co-ordinated services, in its most extreme context.

In 1992 Christopher Clunis stabbed Jonathan Zito to death on Finsbury Park tube station. The inquiry into the treatment and care of this mentally disordered man remains one of the most significant influences on the development of mental health services in this country. Since 1994 it has been a statutory requirement to hold a published, independent inquiry, whenever someone under the care of mental health services kills someone.

The media coverage and indeed, the professional response, to these inquires emphasised the mental health aspects while ignoring the fact that in three quarters of the cases studied substance misuse played a large role in both the perpetrators' illness and, often, the homicide itself. In 1998 I published *The Unlearned Lesson* a study of the role of substance misuse in inquiries into homicides by mentally ill people – this was a study which highlighted the way in which alcohol and drug misuse was being ignored in studies of these tragic incidents.

Since *The Unlearned Lesson* these inquires have paid much more attention to this issue and as a result such inquiries contain potentially important lessons for those planning and providing substance misuse services and, by default, dual diagnosis services.

A steady stream of such inquiries has continued to be published. In January this year, there was yet another inquiry highlighting problems of substance misuse. (You can see the report at www.lnrsha.nhs.uk) In 2002 Dale Pick killed a man named Michael Doherty. This report into Mr Pick's care highlights both the need for drug and alcohol services and DAATs to learn lessons from these inquiries and, sadly, the ongoing need for inquiry teams to be encouraged to make specific recommendations about alcohol and drug misuse.

Mr Pick is described in the report as having a 'history of alcohol and substance abuse. He commenced drinking in his early teens and appears to have become dependent upon alcohol...There were occasions when he would commit acquisitive offences in order to raise money for both alcohol and drugs. Dale Pick also has a history of drug abuse. These drugs have included cannabis, LSD, amphetamines, heroin and cocaine. He has received treatment for heroin addiction. There was evidence of use of amphetamines at the time of the homicide'.

The report concentrates much attention on the decision prior to the homicide to discharge a man from inpatient care who clearly posed a risk because of the combination of mental disorder and substance misuse. Alongside this, as with many such clients, there was a significant debate about diagnosis. Was this man's problem primarily connected to a combination of personality disorder and substance misuse or did he, as the inquiry believes, have a psychotic illness?

The report quotes the mental health trust's internal inquiry report into the killing. This makes extensive and very useful recommendations about the care of the dually diagnosed. These include:

- The need for mental health services to thoroughly follow up referrals to other agencies such as substance misuse services.
- The importance of implementing the Department of Health's 2002 guidance on managing the dually diagnosed.
- The need for any strategy on dual diagnosis to link the CPA policy explicitly with the implementation of Drug Testing and Treatment Orders and to include an agreed trigger to a full multi-agency approach to the assessment of clients with a dual diagnosis.
- The importance of training and clinical guidance to support staff working with the clinical challenges presented by multiple diagnosis and the associated processes for risk assessment.

Sadly, as in other inquiries, although endorsing the internal inquiry's recommendations, the report itself makes no specific recommendations about the management of the dually diagnosed. This is surely a missed opportunity to make clear statements about the management of this very difficult client group.

Inquiries into homicides by the mentally ill, as well as other inquiry processes such as Part 8 Child Death reviews and mental health trust serious untoward incident reports, can have invaluable lessons for substance misuse services. It is surely time to ensure that these lessons are being passed on to the NTA and DAATs. It is equally important that inquiry teams are drawing on the skills of substance misuse services to help develop guidance to aid the management of some of the most complex substance misusers in the community.

Mike Ward has been a member of both homicide inquiry and drug death review teams. He is available to provide training inputs to staff on these lessons and can be contacted on Michaeljohnward@btinternet.com.

Danos – three years on

DANOS – the Drugs and Alcohol National Occupational Standards – are three years old this month. Trevor Boutall, the consultant who has led the development of DANOS on behalf of Skills for Health, reports on progress to date and highlights the issues still to be addressed.

On the third anniversary of the publication of the Drugs and Alcohol National Occupational Standards, it is useful to reflect on how far we have travelled and consider the obstacles that lie in the road ahead.

The time-line in the figure below shows the major events since work started, in January 2001, on developing standards for all those working in the substance misuse field.

Early in 2001, Healthwork UK, the predecessor of Skills for Health, published the occupational and functional map of the drugs and alcohol sector, entitled *A Competent Workforce to Tackle Substance Misuse*. This called for the development of a set of National Occupational Standards – a combination of both existing standards from health, social care, justice housing *etc*, and new standards covering functions unique to the substance misuse field – which would define the quality of performance expected of all those working to improve the quality of life for individuals, their families and communities by minimising harm associated with substance misuse.

Work began on the development of what eventually became known as the DANOS standards in September 2001. This work was completed in May 2002 and the standards were accredited by the UK education regulatory authorities in October of that year.

Since then, the DANOS Project Board, with funding from the National Treatment Agency for Substance Misuse (NTA), the Home Office Drug Strategy Directorate and the Welsh Office, has supervised the implementation of DANOS. This has involved launch events for commissioners and services throughout England and Wales during the summer of 2003, workshops to assist trainers and educationalists to align their courses with DANOS in November 2003, and the launch of the DANOS website, funded by Skills for Health, in January 2004. The NTA encouraged all adult substance misuse treatment services to align job descriptions to DANOS by December 2004, and the first qualification specifically based on DANOS standards, the Health and Social Care National Vocational Qualification (NVQ), became available in January this year. This was closely followed by the launch of the Federation of Drug and Alcohol Professionals' certification scheme, again based on DANOS.

Uses of DANOS

A recent survey* of 250 commissioners, service managers, human resource managers, trainers, people delivering front line services, service users and ex-users shows that the DANOS standards are being used by over three-quarters of those in the substance misuse field.

Many DANOS non-users in the survey are new to the field and have not yet got to grips with DANOS. Amongst the non-users, however, there is a small but articulate group who have dismissed DANOS as being bureaucratic, complicated, simplistic and a total waste of time and money.

Once they are familiar with them, most users find DANOS clear, straightforward and easy to use. However, not all DANOS users have found the standards simple to implement with limited time and financial resources. A number of respondents to the survey reported initial difficulties in understanding DANOS themselves and in encouraging others to use them. One commissioner summarises this difficulty and how he was able to overcome it: 'The problem was mainly getting people to understand the purpose of DANOS and how they work. Initial reactions are often one of feeling threatened in some way, or perceiving DANOS as an extra layer of work and a bit of a "pain". Most people respond well when they see how DANOS can help – especially around things like job descriptions, setting work targets, and knowing what areas of competency staff have. Problems were mainly overcome by encouraging managers to "try it out" – starting with job descriptions/competencies, where managers appreciate some help. We have sent managers on Alcohol Concern's DANOS training as well, which has demystified the process a lot. I would say the best way we have overcome problems is by discussing how DANOS can help, rather than seeing it as some kind of imposition – using it to serve us rather than allowing an impression that it is there to "police" us.'

Encouragingly, respondents to the survey say they are using DANOS for a wide range of human resource (HR) development and service development purposes, although many admit that they are still in the early stages of using DANOS for these reasons.

By far the most popular uses of DANOS are for training and development, and job design, job descriptions and role profiles. Around 40 per cent of respondents say they are also using DANOS for other HR purposes such as continuing professional development (CPD), qualifications, recruitment and selection, career development, induction and performance management. A smaller percentage (between 17 per cent and 34 per cent) are using DANOS more strategically for workforce planning, organisational development, service design, succession planning and partnership development.

Ten per cent of respondents are using DANOS for other purposes, such as:

- keeping up-to-date with policy developments
- an audit tool
- developing service specifications
- developing and updating organisational policies and procedures
- curriculum development
- commissioning
- Federation of Drug and Alcohol Professionals (FDAP) professional certification.

Benefits of DANOS

Most respondents took some care to identify the benefits to different groups of using DANOS. However, for many, these are anticipated benefits rather than benefits confirmed through experience.

Benefits for workers include:

- clear guidelines for practice
- better understanding of their role and the standards they should be working to
- clarity about the knowledge and skills they require
- tool to measure their own performance, be clear about the knowledge and skills they need to develop and be able to negotiate the training they require
- structured training and professional development in line with national standards
- ability to evidence their training and experience
- professional qualification and status
- greater confidence, pride and self-esteem
- recognition, transferable skills, employability and career progression
- fairer system – everyone working to the same standards.

Benefits for the organisation can be summarised as:

- reliable, competent staff
- quality assurance
- recognition and respectability – able to prove quality to service users and commissioners
- national benchmark against which to audit the organisation
- ready-made structure for human resource planning and development
- clear differentiation of roles
- recruitment of staff from a wider field with the prospect of a professional job
- retention of staff because they have opportunities to progress
- tool for training needs analysis and developing training plans
- culture of constant review
- tool to support change.

There is broad agreement amongst those using DANOS that the key benefit to service users would be a quality service delivered to a common standard across the country by well-trained, qualified workers. Service users who wished to volunteer or find work with a substance misuse agency would be helped by DANOS clarifying the knowledge and skills they need to develop, to work in the field.

Issues for the future

The issue at the front of most respondents' minds is how workers should demonstrate their competence through qualifications, performance management and supervision processes. They are looking for a strong lead from the NTA to clarify what qualifications, or means of demonstrating compliance with the DANOS standards, is required of which worker groups (both unqualified and professionally-qualified) and the timeframe for achieving this.

To support the qualifications and competence issue, there will also need to be a national strategy to develop external assessors and train managers to be able to use DANOS effectively to assess their own staff. Closely linked again to the question of qualifications, many respondents would like to see a system of accreditation of training to help them understand what areas of competence the training will support.

If the workforce is to be properly accredited, DANOS users will need additional resources over the next 12 months or so for the training and assessment of their staff in line with the standards, including the backfill costs. National agreements on funding, and guidance of how to access this funding, are required.

People have largely implemented DANOS under their own initiative. They would now like clearer, practical guidance in a number of areas, a fuller exchange of experiences with colleagues and a schedule of activities so that they are able to plan in advance. Those in Wales, Scotland and Northern Ireland would like to see their national authorities supporting DANOS.

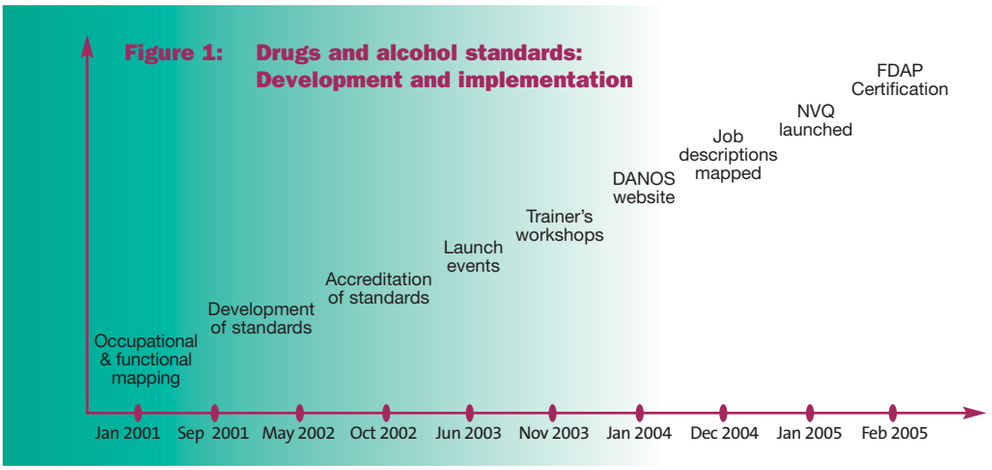
Conclusion

In three years, much has been achieved with DANOS at national, local, organisational and individual levels. There is a significant body of knowledge and understanding about DANOS in the substance misuse field and the standards are beginning to be widely used, not just for job descriptions and training, but across a range of HR and organisational development areas.

There is much goodwill and enthusiasm (tinged with healthy scepticism!), but this is in danger of being eroded if momentum is not maintained. There are a number of complex issues which must be resolved speedily if the benefits to workers, their organisations and ultimately service users are to be achieved.

In the past year or so, many individuals and organisations have travelled a steep learning curve and gone through the pain barrier of getting to grips with a new system. In the next 12 months, they will expect to see tangible results from their investment.

**DANOS – Three Years On: A Report of a Survey of Users of the Drugs and Alcohol National Occupational Standards* can be found on www.themsc.org.



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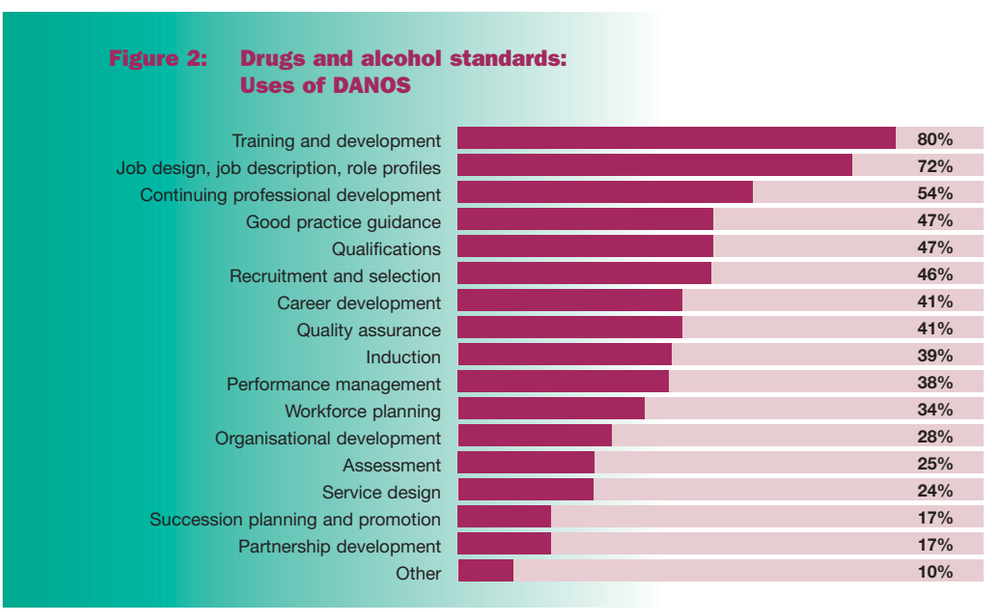

How can GPs provide a better primary care service for drug users?

Why not ask both parties, the Royal College of General Practitioners decided at this year's conference. Daren Garratt, one of the workshop trainers, shares results that show a surprising match in the wish lists and a lot of hope for future service user involvement.

A fortnight ago, the Royal College Of General Practitioners (RCGP) hosted their tenth national conference on the management of drug users in primary care. In celebration of this milestone, the RCGP decided that the focus of the conference would be 'looking back, moving forward' and that one of the key tasks of the conference would be to encourage GPs to consider how they might be able to effectively move towards the establishment of a 'perfect primary care service' for drug users. Further, to this, the RCGP also decided to build upon the excellent feedback and response to last year's 'user-led workshops' and seize the opportunity to support and enable users to facilitate this session and encourage active engagement and debate with GPs as peers and equals.

So, in accordance with Dr Chris Ford's favoured rallying cry of 'nothing about us, without us', 24 users were trained in a simple participatory appraisal exercise that would stimulate discussion and the rationalising of ideas, without being prescriptive or too heavily focused on one individual's experience or viewpoint. The trainers, Anna Millington and myself, wanted to try and create a 'shared experience' that would allow all users and GPs to participate in the same exercise. The intention was that any emerging results and ideas could then be compared, providing a unique opportunity to see if/how the views of provider and patients converge or contrast.

To achieve this, the user facilitators spent the day before the conference completing the exercise themselves. This not only gave them the experience of being participants in their own exercise, but it also allowed the facilitators to compile a 'user's view' of the perfect service which could later be compared to the views of attending GPs.

The exercise was simple yet effective.

Each participant was asked to spend five minutes 'blue sky thinking', and writing down what they felt the key component of a perfect drug service in primary care would be. The facilitators asked each participant to write their ideas down on post-it notes, one idea per post-it.

The participants were then brought together in groups of four or five, and asked to discuss their ideas and then rank them in a grid depending on what they considered the impact would be on service delivery, and the relative ease of implementing their suggestions.

The facilitators were most interested in identifying what the users felt would be 'high impact' suggestions that were easy to implement.

The user reps identified the following:

- Regular health checks – blood borne viruses, smear tests, etc
- Access to advocacy and user groups encouraged
- Low waiting times between first contact with service and prescribing/ Fast to triage
- Better provision for crack users
- Treating users to be a core GP role not an add-on
- Key worker/GP builds good relationship to promote honest feedback
- Pick and mix options that are more relevant to users
- Needs of older users and pain management
- Needle exchange
- Exit strategies for supervised consumption
- It starts at reception
- Treatment plan (with patient)
- GP with special interest (GpwSI) led/run clinics in the community

Finally, the group were asked to identify what they felt would be the three most important and effective suggestions to take forward to the RCGP.

They suggested:

1. Respect, compassion and trust
2. Equal access
3. Drug treatment a core part of the GPs service and not an 'add on'.

When the exercise was repeated with GP colleagues on the Friday afternoon, some of the user reps were surprised to find how similar the results of both cohorts were.

Virtually all the GP groups cited 'equality of access' as a major factor, and many called for a 'wider range of treatment options' and 'comprehensive evidence-based treatments'. Addressing the 'attitudes of all staff' was also felt by many groups to be a crucial issue in the improvement of service provision.

And what of the experience of working collaboratively with users?

Well, thankfully, the conference evaluations were overwhelmingly supportive of this alliance, with comments featuring 'pleasing to see more service user involvement' and 'user input made it excellent'.

Indeed, some delegates felt the user-facilitated workshops were 'more useful than anything' and 'really valuable. Put everything into context. Reminds us why were in this job'.

Finally, one delegate said, 'working formally with the service users has been a long time coming but worth the wait.'

This is possibly the most heartening and encouraging statement from the whole conference, for that is exactly what the facilitators were hoping to achieve. And we hope that it's a message that is increasingly adopted by primary care because, to quote the exercise cited above, if it's a high impact development and it's easy to implement, why aren't you doing it?!

Get stuck in!

Getting a user group together and keeping it going for 10 years must mean you're doing something right – particularly when your group is going from strength to strength. DDN asked Frank Bond of BADSUF for his tips for success

'The NTA were talking about getting a user group together the other week. And I'm sitting there thinking "we've been going for ten years, we set up a group without any help from the drug czar…"'

Frank Bond has strong views on how you set up a user group and keep it going. He is advocacy manager for the Bournemouth Alcohol and Drug Service User Forum (BADSUF), which will be celebrating a decade of user involvement in September, and has been involved from the very beginning.

He remembers the beginning as being hard work, but there was 'nothing like the NTA around then'. There was recognition of wanting service users involved, but no-one was quite sure how you went about it. Bond knew there was a lot of misunderstanding of client needs, so he set about tunnelling through the layers of committees, managers team meetings, commissioning groups and interview panels.

His weapon was dialogue; getting to know the decision-makers, finding who was responsible for services that he needed to link to Bournemouth's service users. He reels off a list of groups he was involved with. Life in 1995 must have felt like one long round of boring meetings…? 'It was,' he confirms grimly.

Still, the lesson was one of persistence and inside knowledge, 'being in the right places where decisions are made'. Bond was now in a position to be involved in monitoring the DAT's service level agreements, questioning why service users slipped down the priority list. The director of social services was head of the DAT, so he'd 'got everything covered'. He could go to him if there was a problem with housing, and to the head of the healthcare trust for advice on all kinds of issues.

The extensive badgering was used to good effect, to make sure the services interlinked. 'We've got street services, a service for people still using, a prison liaison officer, triage system… we can find accommodation, a night shelter, detox…'

Five workers now take care of different areas. A support worker goes into every treatment provider in the Bournemouth area, and into the HIV clinic, methadone prescribing service and needle exchange. They ask questions, listen to views, take up the dialogue with GPs and the PCT, and raise whatever's important to their service users. Provoking discussion where there would otherwise be none, is an important part of BADSUF's role, according to Bond.

'We remind people that there are all sorts of different options… There are alternatives to methadone – there's Subutex, there's an abstinence model.' It's about representation, and about giving greater choice.

So how do you get a user group to the stage of achieving objectives, rather than just taking about what's not working?

Bond is obviously a great 'doer' and has surrounded himself with colleagues who are equipped to network effectively and be persistent in getting the right contacts. 'I will mentor new people, shadow them, or they shadow me,' he says.

He is used to speaking his mind – 'you've got to put the action in, and if that means kicking some arse…' – but stresses that manner and diplomacy are all-important at the negotiating table.

'There are people who think the way forward is to attack, but you can't behave in that manner. It's all about the way you put things across.'

Liaison has certainly paid off, in establishing the advocacy service, for example, which has now really taken off: 'I had the police come to our office. They said they had no problem with us providing advocacy… it was quite a big shift'. The group now has a 'lovely system set up', with links to support services.

'The other day someone was discharged from a dry house for drinking. We were able to fix him up with a B&B, so he didn't go back on the streets.'

They've helped girls come off the street, and intervened when someone's been taken off a methadone script for being 10 minutes late.

'They can't cope and get very angry and violent.' Their group takes up the argument for them.

Getting new members involved in the group often comes from BADSUF's open days or through their newsletter. They also send mailshots to service users, GPs and health authorities. Some patients phone the helpline, perhaps wanting to be referred to a voluntary organisation, or maybe to the clubhouse, an aftercare project for those who have been off drink and drugs for a few days.

Bond's efforts to get to know everyone else's involvement in services has made him impatient with those who don't know the system – from DATs who don't seem to understand the traffic light system for user involvement targets, to 'officials' who keep trying to reinvent the wheel in starting up user involvement.

As far as he's concerned, there's no excuse for poor user involvement – 'it wasn't that hard to set up' – but he's impatient to see it move to the next stage.

'I don't think people really know where we are with service user involvement,' he says. He's serious about moving the agenda on, and would like to see a national conference for service users, at least once a year.

'If we're realistic and want movement on service user involvement in three or four years time, we need to start now'.

Diary of a heroin addict

In part five of his story, David Wright leaves his comfort zone for rehab and realises it wasn't an easy choice. Is there any going back?

So here I was sat in the passenger seat of my social worker's car being taken to 'Ty Palmyra', in a town in South Wales called Newport – the place where you go to get a passport. I think if I had the money then I would have got a passport to do a runner. But I remembered the wise old words, 'you can't run away from yourself'.

My social worker Jim let me listen to my music on the way there, so that helped me relax, but as we pulled up into the driveway my heart was in my chest. I had been there the week before for an interview, but that was a blur. I can remember asking this lady Tina (who would turn out to be my key worker) that I was afraid of being somewhere without my heroin/alcohol shield, to which she replied, 'how do you think everyone else feels who comes here?' She told me there were two types of people – the ones who hide their fear by being loud and brash, but the other residents see through that. The others were like frightened rabbits. I was a frightened rabbit type.

I was shown to my room and my stuff was brought up. An old '70's radiogram was going to keep me sane. They left me to settle in, so I put up my posters and listened to Mike Oldfield's Tubular Bells to help calm my nerves.

What was about to happen next helped change the policy of the rehab. The change was that new arrivals did not have to go to full house groups for the first month. You see there were three groups there: Alpha for people in their first two months, Beta for people who'd been there three to five months, and a group that let you come and go throughout the day, to do voluntary work. Sixty per cent of residents did not get through the first month. And on my first day, which was a Friday in March 1994, I was led into the big group room that was full to the rafters, a full house group, with someone about to do their life story.

The life story is something you worked on from the first month you were there, remembering incidents, times and places. As your chemical-free mind began to function properly again, you remembered things in your life that had been forgotten and you would write them down. Gradually a picture would begin to appear of your life, then after five months you presented your life story in front of the whole house.

So I walked into this packed room, not realising that the guy I sat next to was about to do his life story. All eyes were looking in my direction. After five minutes I had developed a flinch, which as the downward spiral of paranoia increased, became so intense I got up and ran out the room. I was quickly followed by a member of staff who calmed me down, and I spent the rest of the day in my room.

The evening came, and with it, one of those moments that change your life forever. I did not realise then that the telly was banned all through the week, then allowed on at 5pm on a Friday until Monday, when the groups began again. Hours were relaxed to allow you out for four hours on Saturday and Sunday, instead of 30 minutes at lunchtime and early evening. So Friday night everyone was buzzing with weekend activity.

I was sitting on my own in the kitchen, with the room behind me full of talk and laughter. But I did not know about the weekend routine, and heard the laughter through my intense paranoid mind as being directed at me. I was translating bits of conversation as, 'that weirdo in the kitchen – what's wrong with him?' Of course they were not saying that, but people who understand paranoia will know what I'm talking about.

Eventually I was noticed, so a few of the guys came in to see if I was all right. I was that rabbit stuck in the headlights – no beer to swig like I would on the outside. No gear (heroin) on me so I can go and have a quick hit and come back and say 'yeah, no problem'. I was trapped, naked in front of a group of people for all to see. I had to tell the truth; the words came out, 'no I'm not alright'.

'What's wrong?' was a gentle question. There was no going back now, 'I think you're all laughing at me'. I expected them all to burst out laughing and call me a nutter. But the same gentle voice: 'No-one's laughing at you mate. Sorry, we forgot you were here with the telly and all that.' That sentence changed my life. They carried on to tell me that some people refuse to come out of their room for the first few days; it was OK to feel like this. Relief. Twenty years of self-delusion banished in a five-minute talk. That delusion that kept me doing drugs had been dispelled.

I met real friends – Cockney Andy who said those kind words to me, and Bristol John a man who's still brimming with life's energy, both survivors. A man came to give a talk at the rehab who had previously been a resident, before being chucked out for 'using' – but he said the rehab had planted a seed. Well that's what it did with me. You see, 99 per cent of people use within the first week or two, when they leave the rehab. You can't just walk out of addiction.

I realised how deep it went into my soul when I went on weekend leave, after being there nearly six months. I arrived at my mom and dad's in the afternoon, had a meal with them, but all that was on my mind was having a pint and some opiates. So after tea I said I was going for a walk to see my mate Chris. Chris is one of my soulmates, him and Scott. Chris drank a bottle of vodka a day, smoked a quarter ounce of dope a day, and took around 30 DF118s a day. So I made for his place. I had to walk across woodland area to get to his house. I started the walk, began to walk faster; I was picturing the drink as I began to trot. The trot became a run, the run became a sprint, I fell over twice, but I was a man possessed.

By the time I got to the house I was exhausted and there was no-one in. I ran to the pub he used to go to – and there he was on stage with a band, playing the harmonica. I ran into the bar and ordered a pint of cider. As strange as it sounds, if the landlord had turned round to me and said 'you're not supposed to drink', I would have said 'I know' and ordered a coke. Conditioning. He gave me the cider and I felt like holding it up like a trophy: 'look what I've got!' But of course, no-one was taking any interest.

As I drank it I remember feeling slightly let down; it was not as powerful an experience as I had imagined. Chris came in and we embraced; I started to ask if he had any DFs and he finished the sentence off for me. We sat down I took the DFs, down in one, and we started to talk. But as the opiate feeling enveloped me, somehow it felt different. It felt false, plastic, almost as if it was spoiling a clarity.

A month later I had left the rehab, moved into a flat and was busy selling everything in it – £800 of social services grants – for heroin. I was back to square one, but this time there was a difference: I could feel that seed that had been planted beginning to stir.

Part six in DDN next issue

Historical Perspectives: Opium, morphine and opiates (part 3)

Professor David Clark concludes his brief history of the opiates by looking at the massive increase in heroin use that occurred in America and the UK during the later parts of the 20th century.

The number of addicts known to the Home Office (mostly heroin addicts) grew from 2,400 in 1979 to around 18,000 in 1990 and almost 45,000 by 1996.

After the Second World War, the heroin problem escalated greatly in both the US and UK, with the former being at least ten years ahead. The Mafia became the main suppliers in America, with the main route for heroin entering the country being from Turkey via France and Italy. This was the so-called 'French Connection'.

The American problem really took off in the 1960s with the increased supply of cheap black market heroin. There were about 50,000 heroin addicts in 1960 and this number rose to 500,000 by 1970. Heroin use became increasingly associated with ethnic minorities and urban poverty. The drug rooted itself in social deprivation. Property crime became an integral part of the American heroin epidemic and occurred at a level never seen before.

The American government responded by passing a number of severe laws, starting with the Boggs-Daniel Bill of 1956 that included provision of the death penalty for selling heroin to minors. A ten-year minimum spell of imprisonment was mandated for a second offence of possessing heroin (or marijuana). The rate of imprisonment for drug-related offences rose sharply and prisons started to overflow with drug users.

The closing of the 'French Connection' and suppression of heroin production in Turkey as a result of UN pressure probably led to the fall in the number of heroin addicts seen in the mid-1970s. However, the vacuum in supply was filled by Burma – which forms part of the Golden Triangle with neighbouring areas of Thailand and Cambodia – and later by Afghanistan.

The number of heroin addicts in the US rose again to 500,000 by 1980 and it probably remains around this number today.

In the UK, there were only 94 heroin addicts registered on the Home Office Index in 1960. However, there was a substantial increase in the number of registered heroin addicts in the 1960s (2240 by 1968). This increase was due in part to the spill from the lax prescribing of a small number of medical practitioners in London. The new heroin addicts were younger and they were into buying and selling drugs. Some sought out doctors who they could pressurise into providing prescribed heroin.

'Today, there are thought to be 200,000 - 250,000 people suffering from a serious problem with illicit drugs in the UK – some people argue that this figure should be doubled. Heroin is the primary problem drug in the majority of these cases.'

The government set up a new Committee, chaired by Sir Russell Brain, to look into the situation. The report published in 1961 concluded that there should be no major departure of the recommendations of the 1926 Rolleston report. However, the Committee had to reconvene due to the deteriorating situation and published a second report in 1965.

This second report confirmed the basic Rolleston Principle that a doctor, acting in good faith, should be allowed to prescribe addictive drugs to an addict. It reasserted that 'the addict should be regarded as a sick person, he should be treated as such and not as a criminal, provided he does not resort to criminal acts.'

However, the 1965 Brain Report also made recommendations that restricted prescribing to doctors specially licensed by the Home Office and practising from agreed premises. Special NHS clinics were set up in 1967 that prescribed heroin. From 16 April 1968, ordinary medical practitioners could no longer prescribe heroin to addicts.

Over the next ten years or so, these NHS clinics shifted over to prescribing oral methadone, rather than heroin, following ideas from America. The level of heroin prescribing has been very low ever since.

The rate of increase in registered heroin addicts was fairly slow during the 1970s, but grew rapidly during the 1980s. There was a large increase in illicitly manufactured drug: supplies initially came from Turkey and Hong Kong, then from South East Asia, later Iran and then Pakistan. Today, a very high proportion of heroin comes from Afghanistan.

The number of addicts known to the Home Office (mostly heroin addicts) grew from 2,400 in 1979 to around 18,000 in 1990 and almost 45,000 by 1996. A new generation of heroin user smoked the drug, although many of these switched later to injecting. Like America, the drug became associated with poverty and unemployment. Acquisitive crime increased as heroin users sought to support their habit.

Today, there are thought to be 200,000 - 250,000 people suffering from a serious problem with illicit drugs in the UK – some people argue that this figure should be doubled. Heroin is the primary problem drug in the majority of these cases.

President Richard Nixon appointed Dr. Jerome Jaffe as America's first 'Drug Czar' in 1971. He increased the number of heroin addicts in federally funded treatment from 20,000 to 60,000 within a year. The availability of oral methadone played an important role in the expansion of treatment services in the US. The expansion of methadone-based treatment in the UK occurred later and more slowly.

The AIDS epidemic of the late 1970s had a strong influence on drug policy. The realisation that the virus could be transmitted between addicts, and that it could spread by sexual transmission to the wider population, stimulated attempts to get more people into treatment.

The UK reacted to the AIDS epidemic by greatly expanding community projects that provided clean needles and syringes and taught safe injecting practices. The teaching of safe sex and provision of condoms was also a key element of the approach. The American authorities have generally seen this harm minimisation as 'looking too like connivance and a compact with the heroin devil'.

Recommended reading:

Griffith Edwards (2004) *Matters of Substance: Drugs and why everyone's a user*. Penguin: Allen Lane.
Tom Carnworth and Ian Smith (2002) *Heroin Century*. Routledge.

Drug Dogs Report: D – must try harder

The issue of sniffer dogs in schools is hugely important. The widely-reported evaluation of a scheme in Buckinghamshire asserts that the use of sniffer dogs has been a 'success'. This alleged positive outcome has gone unchallenged by the media – including *Drink and Drugs News*.

However, scrutiny of the report reveals a poorly executed piece of research which in no way demonstrates that the use of dogs has been a success.

In the first instance, it is essential that any such evaluation is undertaken by a neutral body: in this instance it was undertaken by the John Grieve Centre for Policing and Community Safety. Without wishing to cast aspersions as to their academic neutrality, it would seem likely that such a Centre, established by former top Met copper John Grieve would be sympathetic to the use of sniffer dogs.

More worryingly, the methodology used by the report is riddled with flaws, and invalidates much of its findings. So for example, letters informing parents about the scheme were sent home with pupils, but due to 'prohibitive costs' these were not posted out and there were no reply slips. Such an approach maximises the chance that the letters do not get home and minimises the chance that they will be returned.

So it should come as no surprise that the response rate was pitifully low. Altogether, 260 questionnaires were returned to the researchers – of which 100 were from pupils and 88 from parents. The researchers fail to say how many questionnaires were distributed.

Given that five schools responded, this meant that on average 20 pupils per school replied – or three pupils per year. This is not a good sample population from which to draw conclusions.

One school had a response rate of 8 per cent for pupils and 9 per cent for parents: the highest response rate from any school was 38 per cent from pupils. Worse still, only five people aged 15 and six people aged 16 responded. Given that this is a key age group for substance use, the fact that only one 15-year-old per school responded is unacceptably low for a serious piece of academic research.

The researchers unfortunately did not see fit to include the questionnaire that they used in the report. So it is not possible to critically assess the way that questions were phrased – a crucial consideration in such a controversial subject.

Nonetheless, from the small number of people who responded, support for the use of dogs was undoubtedly high, with a high proportion of parents and pupils expressing support for the scheme.

From this, the researchers claim that the scheme has been a success. But being popular is not the same as being a success. The aim of the scheme was in part to act as a deterrent and also to identify pupils who may need assistance.

It is here that the report is utterly unable to demonstrate 'success'. What was the level of possession, use or supply before the pilot? We don't know and the report doesn't say. How did this change after the pilot? Again, we don't know. Were pupils discouraged from bringing drugs on site? No evidence of this in the report. And how many people were directed to Addaction for 'rehabilitative programmes?' Again, we are not told.

When the report was launched it was touted as 'proving' the worth of sniffer dogs. In fact, the report does nothing of the sort. It merely proves that people like the idea of sniffer dogs. And there is a world of difference between approving of a scheme and a scheme being effective.

Kevin Flemen
KFx

KFx has produced a booklet 'Drugs and Dogs and Schools' for parents and pupils who are unhappy about the implementation of Sniffer Dogs in schools. It explains the rights of the child when the use of dogs is proposed. It can be downloaded from http://www.ixion.demon.co.uk/drugs%20schools%20police%20and%20dogs.pdf

Children must be put at the centre of our focus

I would like to thank Rosie Brocklehurst for her interesting article regarding 'Hidden Harm' (Breaking the Cycle, DDN 18 April). As an organisation working specifically with the children and families of substance users, we echo much of what she said.

Our experience over the two years we have been running the CoreKids project is that it is incredibly difficult to get substance misuse services, funding bodies, and potential financial donors to see beyond the using adult. It is even harder to facilitate relationships between children and adult services so that appropriate referrals are made.

We have to remember that there is often a whole system of individuals profoundly affected by each adult's addiction. It is our experience that there is immense difficulty in 'seeing' this hidden group.

Our plea is simple: 'adults are not the only ones affected by addiction, the family needs attention too.' It is essential that we start the process now of putting children at the centre of our focus.

It is only by changing the patterns of trans-generational transmission of behaviours and parenting, patterns profoundly impacted by parental substance use, that we can hope to create environments where all our children can thrive and grow.

It is a worthy goal, and one that seems to have only recently come into awareness. It is not surprising that there has been reluctance; it is very difficult to think about the child daily injecting his mother with heroin aged only six, or the eight-year-old forced to hide under her bed when the dealer comes around for payment 'in kind'. It has been hard to hear the stories that these children tell, and to view the pictures they draw. But for us at CoreKids, it is a joy to watch these resilient young people reconnecting to the spirit of play and creativity that they have had to put aside whilst being their parent's carer. For us this process is only possible as the parents also engage in the difficult journey of taking the responsibility of becoming parents themselves, a process that for many is a responsibility that they accept for the first time.

At CoreKids we believe that we are charged with both an individual and collective responsibility. It is critical that we model healthy family dynamics to our clients. To achieve this we must develop effective systems of inter-agency working in order that we ensure that we hear the gradually more vociferous voices of this previously silenced minority.

CoreKids is a project working within the Core Trust, a structured day rehabilitation programme in Marylebone, Central London. Please contact corekids@coretrust.org or visit the website – www.coretrust.co.uk

Ian May, Project Director
The CoreKids project, London

'The researchers unfortunately did not see fit to include the questionnaire that they used in the report. So it is not possible to critically assess the way that questions were phrased – a crucial consideration in such a controversial subject.'

Flagship team was forced to change rules

With reference to the ongoing debate about user employment and the 2 year rule, HOT was indeed a flagship of good practice for a number of years – which is why I joined them as team leader in 2002. HOT has actively encouraged current drug users to apply for vacancies within the team in the past, running a successful Community Volunteer Training Scheme through which several volunteers were able to move on to permanent employment.

However, unfortunately some employees were not able to fulfil the 'fit for work' criteria or limit their drug taking to out of work hours and this is where the difficulties began, causing major management problems for a small team. During my time as Team Leader (2002-2004) I saw my fellow workers demoralised due to those employees who chose to abuse the opportunities they had been given and take advantage of working in a service user led environment. Several employees took extended periods of sick leave causing endless staffing problems. There were also suspensions for gross misconduct, lengthy investigations and ultimately dismissals leading me to question my own beliefs about how HOT could continue to provide an appropriate service to the local community. I am not surprised that the Trust has decided to impose the two-year ban even though I am passionately opposed to it.

It is tragic that HOT has had to change its philosophy because of the behaviour of those individuals who could have been pivotal to changing and challenging the assumptions of the majority that drug users can't hold down a job. It was not for lack of support, supervision or opportunities that the drug using employees were not able to fulfil their duties, but as they say you can take a horse to water but you can't make it drink...

Debbie Fowler, ex Team Leader HOT

RAPt

REHABILITATION for ADDICTED PRISONERS TRUST
'STOPPING ADDICTION, STOPPING CRIME'

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

CARAT Teams

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

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

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

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

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

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

Primary Rehabilitation Treatment Teams

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

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

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

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

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

The Island Day Programme

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

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

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

Closing date for completed applications: Monday 23 May 2005

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

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

RHOSERCHAN

Required: **Counsellor**

Starting Salary: **£17,500 per annum**

Rhoserchan is a busy residential care home for substance misusers based in Capel Seion, approximately 4 miles from Aberystwyth in West Wales. It is an abstinence-based unit has been operating for 17 years.

We are looking for a skilled and motivated person, preferably qualified to diploma level, to join our team of counsellors. The successful applicant will have counselling experience, but not necessarily in the substance misuse field. The ability to speak Welsh would be an asset.

The post will be full time, permanent and available from 1st July. Some weekend working will be essential.

If you have the necessary skills and would like further information, please contact Anette Rumble or Graham Menzies on 01970 611127. Interviews will take place on 15 June and any offer of a post will be dependent on appropriate CRB and POVA checks.

Rhoserchan is an Equal Opportunities Employer

PRIORY

Farm Place, Oxley Surrey - a dedicated addiction treatment unit

Coach House, a secondary care unit - stepping stone between primary treatment and a return to the Community

The Priory Hospital Woking, a hospital with a busy Addiction Treatment Programme

Counsellors x 2 Full Time

We are looking for skilled Counsellors to work full time at Coach House and Farm Place. We are also looking for **Bank workers across all 3 sites.**

Applicants need experience in a substance misuse setting, a good working knowledge of 12 step addiction work, FDAP accreditation or similar.

Please call Sue Rossetti on 01483 489211 or email suerossetti@prioryhealthcare.com

The successful candidate will be required to apply for a Disclosure at the Enhanced Level from the Criminal Records Bureau. Further information can be obtained from www.disclosure.gov.uk

www.prioritygroup.com

COMMUNITY & LEISURE

Hackney Drug Action Team

Hackney Drug Action Team Contracts Officer

£34,572 - £36,996 pa

Hackney DAT is a very successful partnership having expanded service provision as well as many new projects in recent years to meet increased treatment capacity demands. This has brought about a significant and ongoing reduction in our waiting times to treatment as well as increasing our numbers substantially in treatment over the last two years. In our quest to improve service delivery, we are constantly discussing with partners how this can be achieved and we undertake rigorous contract monitoring to ensure value for money.

The post we wish to recruit to will play a key role in contract development and contract monitoring and contribute to the overall effectiveness of the DAT in meeting national targets. This is an exciting job working with a very committed and highly skilled team. You will have considerable contract officer experience already and preferably in substance misuse commissioning. You will need to work well as part of a team and demonstrate clearly your ability to develop projects and meet deadlines competently.

This is a fixed term post for three years with the prospect of being extended. It is a serious and challenging job for a dynamic and go-ahead person with plenty of good partnership working skills. **Ref: CLSCP/60/G**

Hackney Drug Action Team Service User Development Worker

£27,717 - £29,169 pa

Hackney DAT is committed to providing service users with a real voice in the development of local services that meet their needs. You will already be familiar with the limitations as well as the possibilities in service delivery for this group.

Your job will be to support and co-ordinate the service users in providing the DAT with views on service delivery as well as ongoing consultation around a wide range of service needs that will assist users in engaging effectively with treatment and ongoing support. You will be an excellent, outgoing worker with plenty of people skills, able to forge strong and effective links with partner agencies and most of all, deliver tangible results with and for this client group. **Ref: CLSCP/61/G**

Join a winning team! If you wish to find out more about Hackney DAT, please visit our website on www.hackneydat.org.uk

To obtain an application pack, please telephone our Response Handling Consultants, TMP Worldwide on 020 7649 6044 or email Hackney@TMP.com quoting the appropriate reference and your full contact address and contact number(s).

The closing date for receipt of completed applications is 5pm, 27 May 2005.

One of the core values of the Council is an unequivocal commitment to the principle and operation of equality in terms of how we deliver the best services to our customers and all the people of Hackney, how we recruit, and how we support our staff. We welcome applications from people who can make that principle a reality.

Hackney

Solutions Action Management

Recruitment & Consultancy

Are You Looking For Staff?

We have a comprehensive database of specialist substance misuse personnel

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

Consultancy, Permanent, Temporary

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

Chief Executive- Slough PCT

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

www.SamRecruitment.org.uk

Chief Executive's Service

HARINGEY DRUG AND ALCOHOL ACTION TEAM

DAAT Team Leader

PO5, £35,586 - £38,004 (FIXED TERM CONTRACT)

HARINGEY COUNCIL CIVIC CENTRE, WOOD GREEN

Haringey DAAT is the strategic partnership charged with delivering national drug and alcohol strategies at a local level.

Reporting to the Drug and Alcohol Strategy Manager, this newly created post will lead on the implementation of our local Alcohol Strategy, develop a comprehensive Users/Carers Strategy for substance misusers, and be the lead in the DAAT for the Prolific and Priority Offender initiative. You will also manage a small team of DAAT staff.

You will have strong partnership skills, sound management experience, up-to-date knowledge of national drug and alcohol strategies coupled with the ability to translate this into practice.

For an application pack, please visit www.haringey.gov.uk or contact the Recruitment Team at LBHaringey@tmp.com or on 020 7649 6014, quoting Ref: ST/DATL/1593/43300. Calls may be recorded for monitoring and training purposes. Minicom No: 020 7406 5790.

Closing date: no later than 5.00pm on 3rd June 2005.

HARINGEY COUNCIL

Haringey Council wants its workforce to reflect the diverse community we serve

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1.6 m people in the UK are harmful drinkers. Help get them the services they deserve.

DIRECTOR OF POLICY AND SERVICES

£47,600 London

Alcohol Concern is the national agency on alcohol misuse. We work to reduce the incidence and costs of alcohol-related harm and to increase the range and quality of services available to people with alcohol related problems.

As Director of Policy and Services you will work at a strategic level, playing a pivotal role in shaping the policy and political agenda around alcohol issues. You will have at least five years experience in the commissioning or provision of alcohol treatment services. You will have a thorough understanding of alcohol policy and the issues affecting people with alcohol related problems. You will also have at least three years' management experience to include staff, budget and project management.

To apply visit www.alcoholconcern.org.uk or call our recruitment line on 020 7922 8699 or email recruitment@alcoholconcern.org.uk

Closing date: 12 noon, 1 June 2005.
Interview date: 16 June 2005.

Alcohol Concern has a strong commitment to equal opportunities.

Alcohol Concern

Lewisham Drug Strategy Team

Database, Research & Information Officer

£28,452 - £30,423 pa

Lewisham Drug Strategy Team (DST) is a small team based in the centre of Lewisham. The team's task is to ensure that the National Drug Strategy is implemented on a local level. There is a need to collect, collate, analyse and submit data and other information from various sources in order to get a true picture of need and the coverage of services. Additionally there is a need for information to be shared, updated and distributed. Research and information into aspects of drug use, community issues and crime informs the planning and commissioning of services and projects in the borough.

We need a person who can communicate well with a number of partner agencies. You will be someone who is well organised and has a good knowledge of IT systems that can be used to collect and analyse data. You will have the ability to analyse and present data in an understandable form to various audiences. You will need to be able to devise simple systems for small agencies to capture the necessary data.

A basic awareness of drug issues would be useful. Training and support are offered both formally and informally by the team and via line management. You will be working to deadlines and be in regular contact with Central Government Departments to whom the data is submitted. Data protection is an issue as information about clients is collected and shared.

To find out more and apply, please visit www.lewisham.gov.uk If you do not have web access, please telephone 020 8314 9999 between 8am and 6pm, Monday to Friday. Please remember to quote the job reference number **CSD848**.

We operate a final salary pension fund.
We are an equal opportunities employer.
Closing date: Noon, Friday 3rd June 2005.

www.lewisham.gov.uk Lewisham

Central and North West London NHS
Mental Health NHS Trust

The Caravan Project is a Tier 2 service that provides needle exchange, wound care and a variety of complimentary and support services to active drug users. Access is through a Drop In that is open daily.

Senior Drug Worker
£28,163 – £33,200 pa inc

The Central and North West London Mental Health NHS Trust is one of the largest specialist mental health trusts in London, employing approximately 2300 staff. We provide services for a highly diverse population of 1.4 million across a total of 7 boroughs. Within our catchment area are some of the most affluent areas and some of the most deprived areas in London. We provide adults, older people and child and adolescent mental health services as well as specialist mother and baby, eating disorders and substance misuse services.

The requirements for the post are CQSW/DipSW/RMN/RGN/BscOT OR Recognised and Accredited Counselling or Group work. Four years experience of working in the substance misuse field, 2 of which should include group work. Experience of assessment and key working is also required together with a comprehensive knowledge, ability and commitment to working within a Harm Minimisation framework. For an informal discussion please contact Mary Bell Macleod, Team Co-ordinator on 020 7886 1972.

Closing date 03/06/05

For an application form call the recruitment line 0870 066 0254 quoting reference J01-SM-584.