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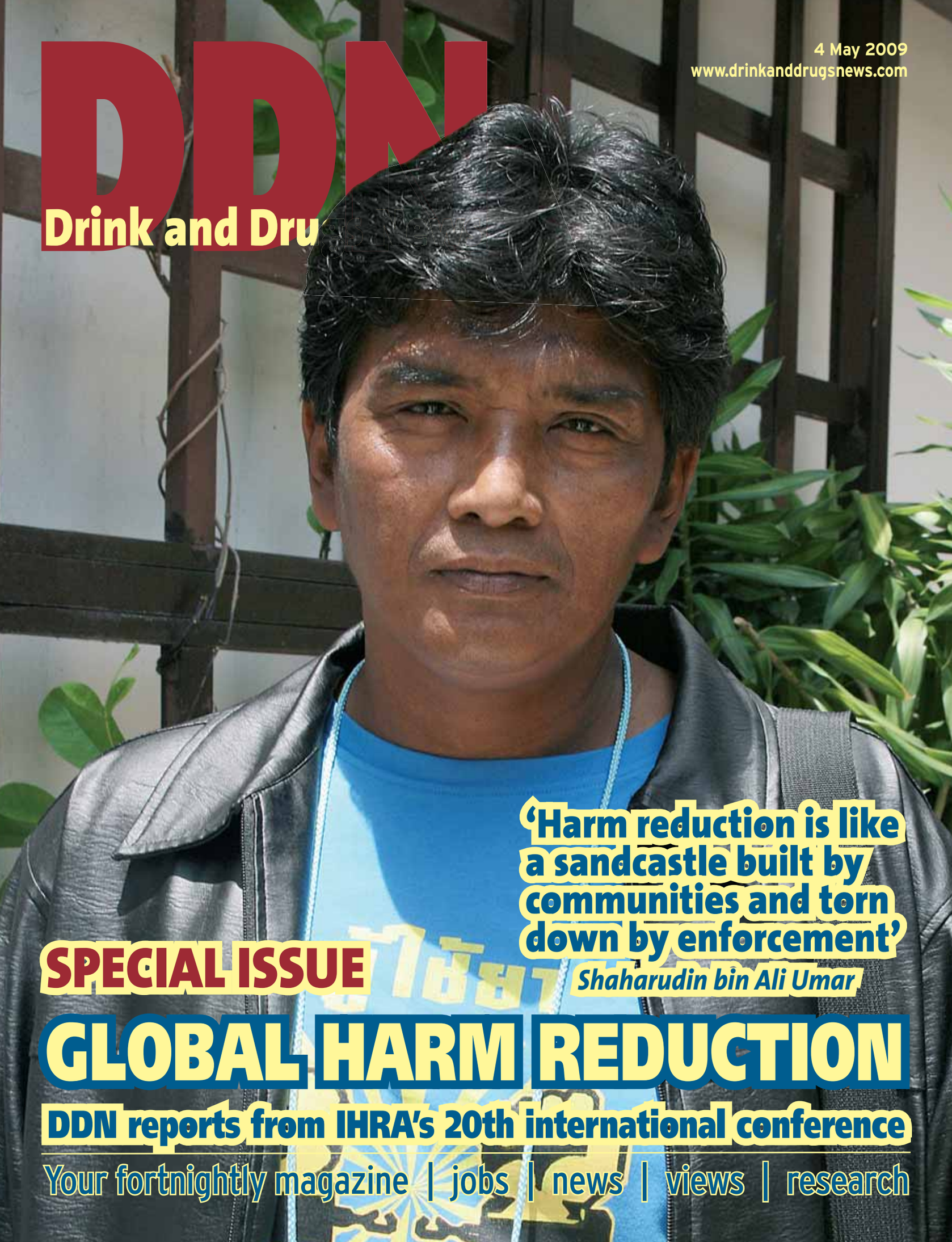

'Harm reduction is like a sandcastle built by communities and torn down by enforcement'

Shaharudin bin Ali Umar

SPECIAL ISSUE

GLOBAL HARM REDUCTION

DDN reports from IHRA's 20th international conference

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Editorial – Claire Brown

Life and death

Harm reduction at international level goes beyond choice

One slightly built young woman trembled on the platform at the International Harm Reduction Conference. She was introduced as a passionate campaigner for drug users' rights and a harm reduction pioneer, preventing overdose with naloxone in Cambodia. But when it came to Srey Mao's turn to speak, she just couldn't. The slides for her talk rolled behind her and showed her own face, looking through bars of a cage she was sharing with many others, young and old. In the end her colleague stepped up to give her talk for her, and it became obvious why she couldn't relive her torture in a compulsory drug treatment centre, where she also witnessed the deaths of two of her friends.

This woman was not an international drug baron. Neither was Shaharudin bin Ali Umar, on our front cover, and many others who attended the conference in Thailand. The location gave an opportunity for a completely eye-opening few days, right up to the IHRA film festival awards at the end. The winning film, 'A cleaner fix' featured Timotius Hadi, an HIV-positive former heroin user whose organisation, Karisma, distributed clean needles to drug using communities in Indonesia that have been devastated by HIV and Aids.

The conference tackled global drug policy and offered some inspiring international speakers, who demonstrated through facts and figures that ignoring harm reduction not only makes no sense in public health and financial terms, but also represents the reckless choice to proliferate bloodborne viruses. But what really struck me was the presence of the ordinary people whose lives had been scarred by their drug-using communities and who were trapped in a cycle of crime and punishment they were doomed to repeat. Harm reduction in many countries of the world takes on a different scale to some of our UK debates, and made me realise that the semantics at international policy level mean the difference between life and death.

This issue

Page 10

Page 13

FEATURES

REGULARS

News in Brief

One provider works

A county-wide service with a single provider managing all aspects of drug and alcohol treatment – from prescribing and needle exchange to psycho-social interventions and access to tier 4 treatment – can improve services and cut waiting times, delegates at the *Drugs and alcohol today* conference in London heard. Turning Point delivers an integrated service across the whole of Somerset in partnership with Drug Treatment Ltd, accessed via a single telephone number. 'We have proved we can deliver a totally integrated service for community drug services,' said Turning Point's clinical lead for Somerset, Dr Gordon Morse. 'We have increased the number of services provided to local people, removed all waiting times and now see 50 per cent more people across the county. By developing a structure that is suited to the locale, treatment provision is safe, effective, innovative and delivers added value for commissioners.'

Open season

The Advisory Council on the Misuse of Drugs (ACMD) is holding an open meeting on 14 May. The home secretary is obliged to consult the ACMD before making regulations, although its advice on the classification of both ecstasy and cannabis have been ignored in recent months (*DDN*, 23 February, page 4, and 1 December 2008, page 5). Attendance is free but places are limited – to register visit drugs.homeoffice.gov.uk/news-events/events/acmd-open-meeting-may-2009

Not so rampant now

A vodka-based 'test tube product' whose packaging urges down-in-one consumption and whose alcoholic nature is unclear has been removed from sale for breaching the Portman Group code. The marketing for Rampant TT was also found to 'promote sexual success and encourage irresponsible consumption', with the manufacturing company's website using images of people under 25 who appeared to be drunk, including a young woman holding a sign saying 'I am off my tits.' 'This type of dubious marketing worsens the drinking culture and invites criticism of the industry,' said the group's chief executive David Poley.

Call for shorter drugs sentences

An overhaul of sentencing for drugs offences, with a view to shorter sentences, has been proposed by the Sentencing Advisory Panel (SAP).

The proposals form part of a new consultation paper issued by the panel – the independent body that advises on sentencing principles – on sentencing for drug offences.

Large-scale drug dealers are more worried by loss of assets than jail, says the document, which proposes wider use of confiscation orders. At the moment Crown Courts can impose higher sentences for supplying drugs than for rape or serious assault – one of the most 'fundamental issues' the panel asks the public to consider is the relative seriousness of drug offences compared with 'violent offences, sexual offences and offences of dishonesty', it says.

The courts' approach to sentencing for supplying drugs is deterrent-driven – however, there is 'no evidence to show that lengthy sentences have the desired deterrent effect', the consultation says. The document proposes reducing the sentencing starting point for first time offenders found guilty of 'the most serious cases of importing or supplying drugs from 14 years to 12 years, within a range of 10 to 14 years'. The proposals are linked to the class and quantity of drugs, as well as the offender's role in the offence – 'the most serious offenders will face the toughest sentences,' it says.

'We are not suggesting in any way that drug offences have become less serious or that a robust sentencing approach is not appropriate,' said the panel's chair Andrew Ashworth. 'But our provisional view is that current sentencing levels sometimes go beyond the levels that are justified by the seriousness of individual offences. We have compared them with the starting points for other serious crimes such as rape and grievous bodily harm and we want to know what other people think about comparative levels of sentences.'

Under confiscation orders, drug offenders' legitimate assets can be removed along with the proceeds of crime. 'The starting points and ranges that we are proposing are more proportionate when drug suppliers face the very real threat of losing the proceeds of their crimes and those involved in the most serious offences will no longer enjoy lavish lifestyles,' said Mr Ashworth.

The paper also recommends harsher sentences for dealers who 'target locations frequented by vulnerable people', such as bail hostels, drug treatment centres, psychiatric hospitals and any educational establishment. 'Similarly those caught smuggling drugs into prison should receive higher sentences because of the impact on prisoners fighting drug addiction and the threat to good order in prisons,' it says.

The panel also calls for an end to the long sentences given to drug couriers for their 'minor roles in smuggling operations', as they are often 'naïve, vulnerable men and women from third world countries whose fates are totally disregarded by those at the top of drug supply chains'.

Release said the proposals gave genuine cause for optimism. 'We were particularly pleased to note that the panel states that drug mules, who have hitherto suffered disproportionately long sentences, should receive no more than two years,' it stated.

Consultation paper available at www.sentencing-guidelines.gov.uk/docs/drug_offences.pdf Consultation closes 15 July.

Scotland unveils new treatment framework

A new system of alcohol and drug partnerships (ADPs) will replace existing alcohol and drug teams across Scotland, the Scottish government has announced.

Each ADP will be responsible for developing and implementing local strategies, identifying need, getting the most from investment and making sure partner agencies are making a full contribution.

The announcement follows the government's pledge to reform services and make them more responsive to local need, in the wake of reports by Audit Scotland and Information Services Scotland that highlighted waiting times of more than a year and services not based on need or evidence of what works (*DDN*, 6 April, page 4). The partnerships will use NHS performance management targets, and from next April there will be a HEAT (health improvement, efficiency, access, treatment) target to reduce waiting times for drug treatment for the first time. The government is 'examining the scope' to extend that to alcohol treatment, it says.

The partnerships – the result of an agreement between the Scottish government, NHS and local authorities signed last month – will be part of the community planning process for each local authority area. A delivery commission will be established to drive forward the reforms, to include representatives from the police, local councils, voluntary sector, NHS boards and clinicians. This will 'operate at arms length from the government, in contrast to the ministerial advisory committee it will replace,' says the government. Members of the voluntary, public and academic sectors will also form a Scottish drugs recovery consortium, a new charitable trust to offer support and training and promote a focus on recovery.

'The framework represents a significant and positive change in how substance misuse will be tackled locally,' said community safety minister Fergus Ewing. 'By clarifying roles, responsibilities and accountability arrangements between partners, we can work more effectively to ensure the most appropriate services are in place at the right time to help those struggling with drug and alcohol problems to recover and live full, rewarding lives, Convention of Scottish Local Authorities (COSLA) health and wellbeing spokesman Ronnie McColl said the new arrangements represented a 'step change' in tackling drug and alcohol misuse.

Meanwhile Scotland's Youth Commission on Alcohol – made up of 14 to 22-year-olds – has held its first meeting in Glasgow. Established by the government and national youth information agency Young Scot, the aim is to make sure young people's views are represented in strategies to tackle alcohol misuse. 'Young people are directly affected by alcohol misuse – whether through their own consumption or as a result of other people's drinking – so they must be part of the solution,' said public health minister Shona Robinson.

Government plans to extend welfare reform to alcohol

The government is to 'commission new research' into extending its controversial welfare reform proposals to people with alcohol problems, it has announced.

There will also be an internal review by the Department of Health (DH) and Department for Work and Pensions (DWP) to look at how to 'make the benefits system work effectively for alcoholics'.

The Welfare Reform Bill contains proposals to withhold benefits from problem drug users who fail to seek treatment and allows for extensive information sharing between the criminal justice system and the DWP (*DDN*, 28 July 2008, page 4), proposals widely attacked by the field as punitive and unworkable (*DDN*, 3 November 2008, page 4). However work and pensions secretary James Purnell said extending the proposals to include people with alcohol problems would 'build on the current welfare programme which provides real help for those who need it to get off benefits and back into work'.

'We need to look through the eyes of the person defeated by an addiction that keeps them out of work and on the outside of the community and give them the help they need,' he said. 'We have introduced a new policy that will mean heroin and crack addicts get treatment in return for benefits. We will actually help them rather than simply handing them money which ends up in the pockets of drug dealers. But we can't abandon anyone to long periods on benefits without help to overcome problems. So that's why we are going to look at the arrangements for alcoholics on benefits, just as we did for problem drug users, so that people get the help they need to get sober, get their life back and get back to work.'

DrugScope said it welcomed the government's engagement with the problems faced by people with alcohol and drug problems when re-entering the jobs market but said there was 'no evidence that using benefit sanctions to compel people into treatment will be effective'. 'Withdrawing benefits could be counterproductive, driving some people further away from the support they need and potentially impacting on their families, financially and emotionally, in the process,' said chief executive Martin Barnes.

Meanwhile, assistant general secretary of the National Association of Probation Officers (NAPO) told the a meeting of the drug and alcohol treatment and harm reduction parliamentary group (*see story this page*) that the measures contained in the bill were 'not practical and not workable.'

Retention 'the wrong target' for treatment

Retention is the wrong target by which to judge the effectiveness of drug treatment, former chief executive of Rugby House, Andy Stonard, told a meeting of the drug and alcohol treatment and harm reduction parliamentary group last week.

Retention was chosen because of a reliance on 'one or two studies' that showed it may be a factor in people's recovery, he said. However, other studies had showed that different factors were equally important, he told the group, whose members consist of MPs, members of the House of Lords, and representatives from the drug and alcohol field. He also questioned the 'commercial models' imposed on third sector organisations and said the use of penalty clauses and other punitive measures was unhelpful – providers felt they 'were on a bus going to the wrong destination, but unable to get off,' he said. Chief executive of Compass, Steve Hamer, told group members that providers were 'not anti targets' but wanted the 'right targets'.

The parliamentary committee will sit again in late June. Reports available at http://tinyurl.com/parlcom

UNODC: West African cocaine challenges 'can be overcome'

The cocaine trade's destabilising effect on West Africa is a challenge that can be overcome, according to the UN Office on Drugs and Crime (UNODC).

More than 50 tons of cocaine from South America now pass through West Africa each year en route to Europe, with the associated crime threatening the security of the region, according to a recent UNODC report (*DDN*, 3 November 2008, page 5).

UNODC has promised renewed action to tackle the situation in partnership with the United Nations Office for West Africa, Interpol and the Economic Community of West African States (ECOWAS), among others. An ECOWAS action plan will 'build national and regional capacities in the areas of law enforcement, forensics, intelligence, border management and money laundering' it says. It will also strengthen the criminal justice infrastructure, with specialised crime units in Sierra Leone, Liberia, Cote D'Ivoire and Guinea Bissau.

At the moment drug traffickers in the region are operating 'largely with impunity', the UNODC acknowledges. However UNODC special representative of the secretary-general for West Africa, Said Djinnit, maintained the challenges did not represent 'a fatality' and the impact of the new crime units 'could be felt quickly'. 'With strong political will, adequate resources and robust partnership between the subregion and the international community, these challenges can be overcome,' he said. UN secretary general Ban Ki-Moon said action was needed to 'roll back this dangerous phenomenon'.

News in Brief

Debating dual diagnosis

DrugScope is urging people to highlight the overlap between substance misuse and mental health issues at a series of consultation events for the government's forthcoming *New horizons* mental health strategy, and make sure the strategy sees the issues properly addressed. The events will be hosted by care services minister Phil Hope and national director of mental health Louis Appleby. See www.drugscope.org.uk for details. To have an input into the strategy email newhorizons@dh.gsi.gov.uk

Strategy a year old

The government is to develop the FRANK campaign to make more information available to parents, as well as focus drug strategy efforts on communities where drug dealing is a problem, according to *The 2008 drug strategy: one year on*. Report available at drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-2008-one-year-on?view=Binary

AC backs budget

Alcohol Concern has welcomed the increased alcohol duty in the recent budget and backed the chief medical officer's call for a minimum price for a unit of alcohol, a proposal the government seems unlikely to adopt (*DDN*, 23 March, page 5). 'Over the past 20 years successive governments stood by as alcohol became progressively more affordable,' said chief executive Don Shenker. 'The end result is that we now drink more than our parents ever did and have seen a dramatic increase in alcohol-related deaths and a high level of alcohol related crime and disorder. Increasing tax on alcohol would be a positive first step towards tackling this country's alcohol problems. But supermarkets should not be allowed to absorb duty increases and continue to deep discount and sell alcohol at a loss – introducing a minimum price would allow pubs and bars to compete on a level playing field.'

Story time

The NTA has issued a new report looking at the story of drug treatment in England and setting out its future priorities. 'Our goal remains to get more users into treatment, to help them recover from dependency and reintegrate them into society,' it says. *The story of drug treatment* available at www.nta.nhs.uk

Comment

Time to act!

This month offers an opportunity to join forces against viral hepatitis, says the World Hepatitis Alliance

Later this month the World Health Assembly will meet in Geneva to discuss the policies of the World Health Organisation (WHO) for the coming year, and for the first time ever viral hepatitis has made it on to the agenda.

In response to efforts by the World Hepatitis Alliance and national patient groups, Brazil, supported by China, Oman and Afghanistan, has succeeded in adding viral hepatitis to the agenda and has since submitted a resolution entitled *Proposal for the establishment of a world day for the struggle against viral hepatitis and other issues relating to the disease*.

The group of viral diseases that cause acute and/or chronic liver infection and inflammation (hepatitis) are major public health problems. Hepatitis B and C viruses (HBV and HCV) are the major causes of severe illness and death related to viral hepatitis infection, and in many areas of the world they are predominantly acquired through intravenous drug use. Viral hepatitis is a major world health challenge with up to 500m people chronically infected and an annual death toll of about 1m, while it is also estimated that 2bn people worldwide have had an HBV infection. These numbers make viral hepatitis as much of a threat as HIV/Aids, TB or malaria, and yet it has nowhere near the visibility or priority status of those diseases – although the success of a resolution on viral hepatitis at the World Health Assembly could change that.

The viral hepatitis resolution, which will be voted on by health ministers from around the world, calls for action to improve hepatitis awareness, prevention, treatment and support. It also calls for the WHO to support a World Hepatitis Day to increase awareness of the burden of viral hepatitis. The success of such a resolution is a vital step towards achieving action that will halt the death toll and improve the lives of people living with, or at risk from, chronic viral hepatitis.

On 19 May 2008 the World Hepatitis Alliance, a non-governmental organisation consisting of 200 patient groups worldwide, organised the first World Hepatitis Day to begin the process of acknowledging the importance of viral hepatitis and ensuring that more global funding is directed to tackling it. In its first year World Hepatitis Day received endorsement from organisations such as Médicins Sans Frontières, the GAVI Alliance and the Pan American Health Organisation, and support from several governments, including those of Algeria, Australia, Argentina, China, Scotland and the UK, while many more have pledged their support to the 2009 campaign.

The World Hepatitis Alliance is therefore issuing a call to action to ensure that we take advantage of this great opportunity for viral hepatitis to be given the priority it deserves at global, national and regional level. The alliance is asking that all patient groups and interested individuals get involved by writing to their health minister to ask for their government's support for the resolution at the 62nd annual World Health Assembly. More information about how to get involved is available at *www.aminumber12.org/WHOResolution.aspx*

It is a shocking statistic that one in 12 people worldwide is living with either chronic hepatitis B or hepatitis C. Exposure to blood through injections with non-sterile equipment or transfusion of infected blood products are common and preventable causes of HBV and HCV infections. Unsafe injection practices are estimated to be responsible for 21m new HBV and 2m HCV infections annually. Recognition by the World Health Assembly of the importance of preventing and tackling viral hepatitis as a public health priority is a crucial step towards reducing the global public health burden, and the alliance hopes that all WHO member states will support the resolution when it is discussed later this month.

Amino acid therapy, along with other positive nutritional medicine, has been successfully used to treat illness for longer than the 45 years I have been working in natural medicine.

Evidence based or evidence biased?

Well, well, well, the aggressive sceptics rear their heads (*DDN*, 6 April, page 9). One would wonder if such people are in the pay of the pharmaceutical companies. Amino acid therapy, along with other positive nutritional medicine, has been successfully used to treat illness for longer than the 45 years I have been working in natural medicine.

Unlike the pharmaceutical equivalent, little if anything is heard of adverse effects when used – like with anything else – with skill and knowledge.

It is strange that every animal and stock breeder pays a large part of their income to obtain the best possible nutritional advice, including supplementation of their animals' diet, to obtain the best possible performance and conditioning for their stock. Yet we humans live on de-natured, de-mineralised, irradiated, chemical laced, dead and highly manufactured 'stuff' – I cannot call it food – and expect to function at top grade.

Mention using even basic supplements like B complex and we are told that at best it is a waste of money or even dangerous, yet the government already laces basics like flour with 'improvers' and is contemplating adding folic acid as a matter of course. Double standards?

Is it not preferable to try to induce the body into a positive natural awareness of health rather than constantly rely on chemical induction of a false hope and suppression of mental capacity? Apart from addressing the psychology of addiction, the chemical overload of the modern human ecology also needs facing head on. Do a one-day survey of all the additives used in your food, cosmetics, body products, household products and working environment, that is if you can find them labelled, and don't forget the plug-in air fresheners and textile dressings.

We are told that all of these chemicals are present in permitted quantities, but what about the cocktail accumulation?

Add all that to caffeine, sugar, nicotine, alcohol, aspartame and salt, and it seems to me a potent amount of chemical/nutritional/psychological disruption is bound to take place.

The chemical and pharmaceutical companies are the only ones making anything positive out of it, and that is money.

Human flesh is so chemically loaded that if it were in the food chain it would have to carry WHO health hazard warning.

Is positive nutritional therapy so bad? I know which I would choose. Positive health, being careful what I put into and onto my body, being as nutritionally sound and natural as possible, and helping others to do the same.

Good evidence and references for amino acid use are out there. Try the book on amino acids in therapy by Leon Chaitow.

Christine Hudson,
registered homeopath and family support volunteer.

Back to school

I feel so strongly about the letter Kenneth Eckersley sent you (*DDN*, 23 March, page 6), I just wanted to know how he got his job with such a bad and ugly attitude to drug users.

Of all people, he should not tar everyone with the same brush. He would not be allowed to say 'all blacks are muggers, sell drugs, smoke hash and don't work'. Why is he permitted to say most users cause accidents, mug old ladies, burgle houses, sell to children and are prostitutes?

I'm a very good mother and worked until I had my baby, and most of my friends work on methadone. I know no prostitutes. I have never been arrested, I have been tested for HIV, hepatitis A,B, C, and TB and all are clear. Most of the rest of the populace haven't been tested so how can you make the comparison?

Going into rehab doesn't cure you and most go in over and over again, so that's the money-saving concept out. If you forced people to reduce or stop their methadone, or go into rehab, crime would go up, not down as people would have to support their habits, and how many children would then have to go into care? I know I couldn't get my child to school, dance or swimming without my methadone.

I'd love to know how he got into his *caring* profession. If he thinks what he is doing is so useless, he should give it up.

Name withheld

Food for thought

I must confess I found the article by Lisa, 'Support before therapy' (*DDN*, 6 April, page 9), poignant and thought provoking. As a service manager for a supported housing project, Lisa's comment gave me some food for thought.

I will ask the team to read her letter and to think about the expectations we may have around clients disclosing sensitive and personal information. I just wanted to thank Lisa for making me think.

Katie Pike, by email

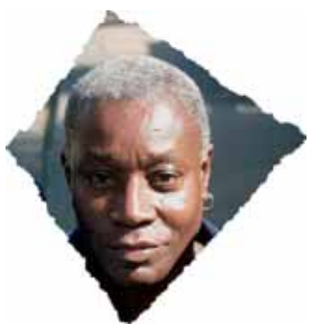
We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity. Visit our forum at www.drinkanddrugsnews.com

Partners in criminal justice

TRYING TO REBUILD A LIFE

In the fourth of our series, substance misuse practitioner at the Equinox drug programme, Tyrone Bravo, describes the barriers facing clients who are trying to make a fresh start



I'm a substance misuse practitioner at the Equinox drug day programme, based in Sutton, south London. It's been running since 2005 and is basically a Drug Rehabilitation Requirement (DRR) programme – we deal specifically with people within the criminal justice system. A few clients come via Drug Intervention Programme (DIP) teams but the majority come from the probation service following a DRR assessment. Some people do come in having self-assessed, but we'll still assess them to see if the programme is right for them, and we also deal with clients who've left prison and have been referred by the stepping out worker.

The programme has two staff and an assistant manager and offers structured day care in a 13-week programme – group therapy, CBT and a little motivational interviewing, as well as one-to-ones in terms of key work and support plans. Equinox is based across three boroughs – Sutton, Wandsworth and Merton – and we work as part of the Sutton Partnership, which includes the probation service, police, housing, community drug team and progress2work – called Eco-Active – so we'll refer clients on for services we can't provide but our partners can.

We have a very good relationship with the police and criminal justice agencies. If a client comes to us and is using chaotically we can refer them to the community drug team at Sutton Hospital where they're assessed and given a prescription for methadone or Subutex within days. Joined-up working is obviously essential – if you're offering service users a holistic treatment plan then you need to be joined up with other agencies. It works very well but there are problems.

It's not the problem areas that come with the territory of drug use, such as life skills and coping skills – those are the things we deal with, and our close links with Eco-Active mean we can help clients into employment and further education. The real sticking points are with accommodation and benefits.

Imagine a situation where a client has been entrenched in drug use for 15 or 20 years, with an offending pattern related to that drug use. The client detoxes in prison and comes out motivated to get treatment, go straight and return to the community, but has nowhere to live – obviously they're going to sofa surf with old associates, who are usually still using. There's also the issue of how long it takes benefits to kick in – if they're lucky they'll get their benefits within a few weeks but I've seen it take up to three months.

The situation is setting people up to fail. I don't know how clients are expected to exist without money or a place to live. It doesn't make sense to expect someone who's used to a life of crime to come out and exist for weeks with no money or housing without resorting to crime. Service providers know this is an issue and raise it time and time again but it needs to be addressed at government level.

At Equinox, for example, we have a dry house – if people come out of prison and have detoxed, or if they're on the day programme and have been testing clean for some time – then they can go there, if there's a vacancy. But that's only four places – we need ten times that. There should be a certain amount of housing set aside for this section of the population, because if we really want them to come back into the mainstream of the community then we have to make it possible for them to do so, and having somewhere to live is a prerequisite.

Understanding what is working and the 'pinch points' in the criminal justice system relating to drugs and alcohol is the aim of the Conference Consortium's forthcoming event, 'Somebody else's shoes', on 25 June in London. Visit www.conferenceconsortium.org for details. In the run-up to the conference DDN will be interviewing a selection of people working within the system, to give insight to different roles and how they relate to each other.

OUT OF HARM'S WAY

Harm reduction 'torn down by enforcement'

'The government has spent millions on drug rehabilitation – and people like me become guinea pigs,' said Shaharudin bin Ali Umar from Malaysia. 'They break you down to build you up.'

DESCRIBING EXPERIENCES THAT SPANNED 30 YEARS in Malaysian drug dependence treatment centres, Shaharudin bin Ali Umar showed photographs of weapons used to discipline him and the scars he had suffered from repeated beatings.

'If you are suspected as a drug user you are given compulsory treatment and kept under observation. If you relapse you get more jail sentences and lashes,' he explained. 'But the result is not effective – there is a 70 to 90 per cent rate of return to drug use.'

The military style discipline and abuse included beatings with baseball bats and bricks and being burned on his genitals with a lighter. 'The scars may finally have healed, but the bad memories remain forever,' he said. 'I was humiliated and beaten until I forgot what pain is.'

Interrogation began at the admission process. Then detoxification took between two weeks and a month, during which 'when the guard changed they started torturing us – humiliating torture I feel too shy to tell you'. A medical check-up and 'orientation process' were followed by a phasing system, which involved 'being beaten by a religious teacher and treated as animals'.

While hopeful that changes were on the horizon, he said progress was hampered by the impossibly large size of the rehab centres, lack of methadone for detox and constant beatings.

'Harm reduction in Malaysia is like a sandcastle – built up by community organisations and then torn down by enforcement activities,' he said.

Srey Mao from Cambodia – whose colleague took over her conference presentation when she became too traumatised to speak about her experiences in a detention centre – told of 'a place where living conditions are not for humans'. Packed into one room 'where they don't care what age or sex you are', and where there was no toilet, food, water, nor mosquito nets, she had seen her friend die from a beating, another drown trying to escape, and a fellow inmate electrocuted. The backdrop to her presentation showed Srey Mao reaching through bars of a crowded cage. 'Srey Mao would like this facility closed,' said her colleague. 'She would like the Cambodian government or anyone who can help, to close this down.'

Treatment or torture?

Human rights abuses are being committed in the name of drug dependence treatment, says Roxanne Saucier of the International Harm Reduction Development Programme (IHRD)

Flogging, chaining, isolation without medication, forced labour for 19 hours a day, psychiatric experimentation without informed consent – these are just some of the methods that countries employ to 'treat' drug users. These measures, common in many countries in Asia and the former Soviet Union, are not based on any evidence of effectiveness and violate fundamental human rights, including the right to health and the right to be free from torture and cruel, inhuman and degrading treatment and punishment.

A recent Human Rights Watch report described the conditions in the 're-education through labour camps' (RELC) in China: 'IDUs consistently reported that they were required to work long hours, from 7am until as late as 2am, seven days per week, and said that if they did not finish their work they were punished. Punishments could range from having food withheld, to not being allowed to sleep, to being beaten.'

In many cases, people are forced into such abusive settings against their will. Whether through mass roundups to 'beautify the streets' before public holidays, police corruption, allegations by vigilante community members or the result of a single positive urine test, it is not uncommon for people to be mandated to treatment without a medical assessment, a transparent judicial process, or the possibility of appeal. Sentences may last months or even years, without clear criteria for release.

One former detainee in Vietnam described the process of arrest in a recent focus group: 'If you've tested positive before, and now the police haven't filled their arrest quota and they see you wandering on the street, they'll just get out of their car and pick you up, no need to ask, no need for anything. Your file will be made up in the camp… I know some people who have never been an addict but were arrested and brought to the camp because they were wandering around at night, drinking… It was obvious that their tests were negative.'

Harm reduction has made huge inroads into the world of drug treatment in the last 20 years, but there is still a long way to go. DDN reports from the IHRA conference in Bangkok where delegates heard presentations from the inspiring to the harrowing

Drug users rounded-up, jailed, beaten and shot

Founder of the Korsang harm reduction programme in Cambodia, Holly Bradford, described mass round ups of drug users, sex workers and homeless children in Phnom Penh last June, which led to 40 of her programme's clients being detained at a former Khmer Rouge execution centre.

There were high rates of HIV and hepatitis C among injecting drug users in Cambodia, and arrests were seriously undermining harm reduction work, she said. 'There is little or no healthcare in detention centres – no medical treatment for HIV, TB or opiate withdrawal.' Detainees had also reported beatings and other abuses, and two clients had died in escape attempts. There were signs that the Cambodian government was trying to address the issues, although funding was almost non-existent. Many detainees had been released, although up to 85 were still detained – in marginally better conditions – and the centre had had no access to them despite writing to the government and the UN. 'Our main concern is that we'll be raided,' she said. 'The police could come in and round everyone up if they wanted to.' The project had now set up the Kamp Korsang initiative to offer drug users a range of services including 24-hour protection, counselling and overdose treatment. 'We'll continue to operate Kamp Korsang for as long as it takes, for as long as we can raise the funding and until drug users in Cambodia are treated as human beings,' she said.

Meanwhile Robin Pollini of the University of California described human rights violations against drug users in Tijuana, Mexico, a city on a major drug trafficking route to the US. Although sterile syringes could be bought without prescription, people were still arrested for carrying a syringe, a syringe wrapper or having track marks. 'These types of arrests are associated with higher levels of syringe sharing,' she said. Research participants reported police demanding money to avoid jail, as well as beatings, sexual assaults, the burning of possessions and even shootings.

Tijuana was in the grip of a major feud between drug cartels for control of the city, she said, which had seen law enforcement officials targeted as well as high levels of police corruption. 'This is not to say that all police are corrupt. But with the targeting of the police by the cartels, and involvement with the police by the cartels, it's difficult to get them to engage with issues of the human rights of drug users.'

Compulsory treatment denies human rights

Thai drug policy had the objective of treating addicts as patients not criminals, diverting them to assessment and drug treatment. The reality was somewhat harsher, said Richard Pearshouse of the Canadian HIV/Aids legal network, who had studied Thailand's compulsory drug rehabilitation system.

Conditions were deplorable in many of the 84 compulsory drug treatment centres, 50 of which were run by the military. Most people were detained for more than the maximum 45 days while they waited for the provincial sub-committee to determine whether they would be given a custodial or non-custodial sentence. They would be held in crowded conditions without water or access to medical treatment. 'We had to sleep on our sides,' reported one detainee. 'If I moved I might lose my space.' When the decision came, there was no right of appeal.

'One of my urgent concerns is to eliminate the use of pre-detention treatment while being assessed and enforce a minimum standard of care,' said Mr Pearshouse. 'The system needs comprehensive and rigorous assessment.'

Tran Tien Duc from the Futures Group in Vietnam reported that government drug policy in his country was based on zero tolerance.

'Officially the government encourages voluntary rehabilitation, but it is non-existent in the community – sooner or later you will go to compulsory rehab for up to two years,' he said.

The law entitled people 'who are in danger of relapse' to be kept in centres for up to two years, he said. They were channelled through stages that included detox, behaviour education, liaison therapy, drug relapse counselling, vocational training and post-rehab management, but there was no harm reduction in these closed settings.

'We call on everyone who has suffered to speak out.'

Health services were determined by the revenue available at individual centres based on their previous running costs, rather than by health needs. 'Health of residents is not a priority,' he said.

'With the lack of understanding of drug dependence and high levels of stigma, the relapse rate is very high – 90 to 100 per cent,' he added. 'Things could be changed more positively if they changed from being compulsory to harm reduction.' The system was as costly as it was ineffective: 'With the current approach of putting drug users in centres, 146.9m US dollars will be required from 2006-2015.'

Delegates reacted strongly to treatment being described by governments as a form of harm reduction – common to the presentations in this session.

'Many of us have been advocates of treatment as harm reduction, but when I look at some of the results of that I am appalled,' said Deborah Small from the US. 'We should agree on a language to call these centres concentration camps,' said another. A delegate from China described how he had been in treatment 11 times, which involved enforced labour from 7am, to 11pm. 'Is this something you could genuinely call drug treatment?,' he asked. 'We call on everyone who has suffered to speak out... we get human rights by fighting – not being passive.'

A public health approach must replace this 'senseless war on drugs'

Professor Michel Kazatchkine: 'In too many countries, in too many police cells, in too many prisons, drug users are treated as less than human.'

'WE ARE IN A MOMENT OF NEW OPPORTUNITY TO CONSOLIDATE GAINS AND BUILD ON OPPORTUNITIES,' said executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Professor Michel Kazatchkine. 'As we struggle, it's easy to lose sight of the progress made.'

Progress in expanding access to anti-retroviral drugs had been dramatic, with impressive declines in HIV-related mortality, he said, and harm reduction networks were increasingly vocal and respected. The prospect that the US could re-engage in harm reduction was also 'tremendously encouraging,' he stressed, calling on the US to 'firmly and emphatically' do so.

However, huge challenges undoubtedly remained. 'In too many countries, in too many police cells, in too many prisons, drug users are treated as less than human. The right to health, decent care, equality, privacy, education and to share in the advances of science are universal human rights,' he said.

Meanwhile, in terms of evidence, it was essential to continue to show why drug use was most effectively addressed as a human rights challenge. 'Punitive approaches that over burden criminal justice services are futile and counter-productive. What upsets so many in the harm reduction movement is the UN Commission on Narcotic Drugs' scandalous failure to appreciate how times have changed.'

A framework that focused exclusively on reduction of demand and supply was not acceptable and it was essential to continue to reject 'the myth that harm reduction promotes addiction'. By embracing harm reduction, countries moving from a law enforcement to a public health approach were 'on the right side of history', he said. However some were still determined to swim against the tide and pursue 'the senseless war on drugs'.

'Alarming evidence' was a principal tool for advocacy, he stressed, with the life expectancy of someone beginning anti-retroviral treatment 12 years lower for an intravenous drug user than a non IDU.

'It speaks to the scandalous failure to prioritise effective healthcare,' he said. But for every step back there were two steps forward. 'No matter how often evidence is denied we must continue to maintain hope and keep up the fight.'

Drug policies violating human rights

A human rights based approach had not yet been applied to drug policy, said UN special rapporteur on torture Manfred Nowak.

Most UN human rights treaties had reached universal ratification, he said, the main principles being participation, non-discrimination and the accountability of states. However, human rights needed to be mainstreamed into all policy areas of the UN.

Regarding the human rights implications of international drug policies so far, the victims were not just farmers and drug consumers, but people in need of pain relief and palliative care, he stressed. 'These are people totally out of this scene. Up to 80 per cent of the world's population has little or no access to pain relief – there are many reasons for this, but the war on drugs is one.'

There were numerous ways in which drug consumers were victims of human rights violations, he said. These included arbitrary detention, torture, inhuman prison conditions and excessive punishments, including the death penalty. Alongside these were antiquated methods of forced treatment and detoxification, as well as exposure to increased risk of HIV and hepatitis C.

A human rights based approach to drug policy, however, would be based on the principle of participatory decision-making, involving not just drug users but people in need of palliative care. Harm reduction itself was a human rights policy, he told the conference. In terms of the UN, however, the situation was that 'Geneva doesn't talk about drugs and Vienna doesn't talk about human rights'. It was essential to break this cycle, he said.

Among the comments from delegates were a questioning of the consistency of the language used by the UN, including 'derogatory language in well meaning documents' and calls for 'meaningful involvement of people who use drugs on every level'. On the question of whether human rights issues were merely discourse for 'lawyers and academics', however, Nowak asserted that 'human rights is a bottom up approach and multi-disciplinary – all kinds of people are fighting for human rights, and risking their lives.'

'If you really want a change in the legal status of drugs, the only people with a mandate to change it are parliamentarians.'

NGOs urged to engage

Civil society needs to think about how it communicates with parliamentarians, the audience at a parliamentary panel discussion on the decriminalisation of drug use heard.

'If you really want a change in the legal status of drugs, the only people with a mandate to change it are parliamentarians,' said chair of Pakistan's HIV/Aids parliamentary sub committee Dr Donya Aziz. 'If you're not talking to them you're not going to get anywhere,' she said. 'You're preaching to the converted and telling each other what you already know – you need to engage with the countries that are hindering your cause the most.'

Organisations also needed to make sure they communicated in a language that parliamentarians understood, she stressed. 'If you speak to parliamentarians about IDUs and MSMs they won't know what you're talking about.' The situation in her country was further complicated by its strong bureaucracy – a legacy of British colonial rule – its proximity to Afghanistan, and worsening security situation and ongoing battles with extremists. 'Social issues tend to get left behind,' she said.

Deputy speaker of the Indonesian government's upper house, Dr Laode Ida, said that his country had more than 2m regular drug users and about 40,000 people in prison without access to treatment. Criminalisation of drug users was not 'human treatment' he acknowledged, but at the moment the government and people of Indonesia would not be willing to embrace decriminalisation because of fears it would lead to an increase in use. In the meantime the country would focus on improving the quality and quantity of rehabilitation facilities and improving collaboration between government and NGOs, he said.

Cambodia's prime minister had pledged to 'extend a hand' to drug users and treat them as patients who needed help rather than criminals, said Cambodian MP Dr Ouk Damry.

'We know what we have to do but we need your help,' Thai senator Dr Pinit Kullavanijaya told delegates. 'We need reliable data and the best evidence – then I can brainwash my colleagues, in a nice way.'

Service coverage needs cash

'We haven't got to grips with increasing the amount of resources for harm reduction,' said IHRA executive director, Professor Gerry Stimson.

Coverage of harm reduction services was still poor, he said, with 74 countries not providing harm reduction measures and 95 per cent of injecting drug users (IDUs) in lower income and developing countries having no access to harm reduction services. Finding out what is currently being spent was difficult, he added, with 'back of an envelope calculations' putting the figure at around £200m on harm reduction in developing nations.

Viewed proportionately, 10 per cent of all new HIV cases were attributable to injecting drug use, so 10 per cent of Aids spend should be directed to interventions, said Prof Stimson. 'We need more donors and better distribution,' he added. 'Our aspirations have been too modest.'

Anne Bergenstrom, coordinator of the UN task force on HIV among drug users, reported on a study that estimated the resources required to provide harm reduction services in 15 Asian countries – a simple equation formulated by multiplying the cost of supplying resources by the population requiring them and targeting 80 per cent coverage. The preliminary findings showed a cost in excess of $2bn by 2015 to provide this. Ms Bergenstrom pointed out that this was only preliminary research based on limited data, and stressed that China contributed 60 per cent of resource requirements and cost.

COMMENT

Ethics, rights and drug use: why is it so hard?

Those of us working in civil society often readily invoke vague notions of 'rights' and 'abuse' in our conversations and presentations, but are frequently less clear about the specific principles underpinning our activity, *writes Ian Hodgson of Health and Development Networks, Thailand.*

Anand Grover, director of the Lawyers Collective HIV/Aids India, speaking about 'the right to health in Asia', reminded delegates that harm reduction is founded on strong ethical principles, and advocacy for drug users to give them the same civil rights as other citizens must be scaled up to make sure that harm reduction – in its broadest sense – reaches all who need it.

The effectiveness of harm reduction is now undeniable, but for many drug users across the Asia region access to services as low as 2 per cent in some areas. This, for Grover, is a clear and undeniable contravention of human rights.

Examples of the systematic abuse of many drug users confirm that legislation in many countries is based less on individual rights and more on command and control.

Grover described the imprisonment, torture, and compulsory treatment meted out to drug users in India, and may readers will know of other regions where the criminalisation of drug use creates a context where harm reduction is eschewed in favour of disproportionate punishment.

Citing the principle of proportionality – the notion that responses should match an action – how could capital punishment be a response to simply for possessing a drug?, he asked.

Other examples were shared, and many working in the field of harm reduction have their own case studies of people who use drugs suffering extreme privations from the state.

The value of this presentation is the reminder that the rights for which we advocate in civil society – autonomy, confidentiality, non-disclosure, health, consensual treatment – are all sound ethical principles, enshrined in the Universal Declaration of Human Rights, which codifies rights for all to physical and mental health.

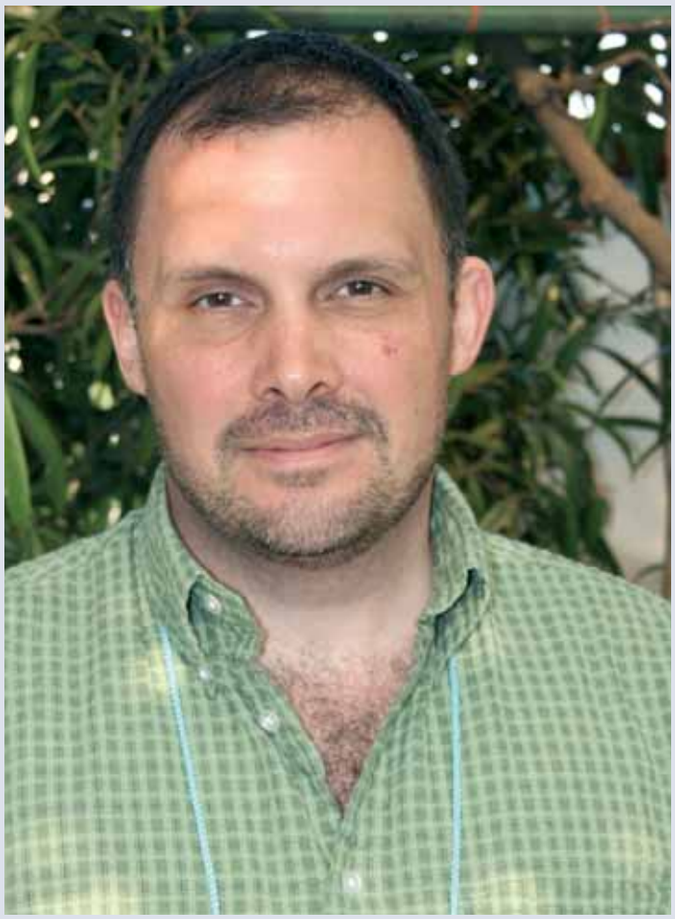
That drug users are denied this is simply flawed and – by using a rights-based approach – can be argued rigorously and robustly.

Grover closed by reminding us of another ethical concern – affected people being simply objects in harm reduction and advocacy interventions.

To prevent this, we must ensure that 'drug users should not be the objects, but the subjects of the process'.

As we develop our programmes, policy interventions and advocacy initiatives, using a narrative that includes key ethical principles could add a level of sophistication that helps prevent glib reiteration of tired responses to the ongoing threat to human rights and denial of harm reduction.

IHRA's deputy director Rick Lines talks to **DDN** about foregrounding drug policy issues in the mainstream global human rights agenda



Shifting the debate

'There were governments who actually support harm reduction domestically that, when push came to shove... opposed even the most ridiculously meagre harm reduction language.'

Despite a growing shift in opinion that has seen even traditionally conservative commentators begin to seriously question the effectiveness of the 'war on drugs', this year's UN Commission on Narcotic Drugs (CND) in Vienna saw yet another missed opportunity to seriously address issues of harm reduction.

There, deputy director of IHRA, Rick Lines, made a statement to the commission about the UN's silence on HIV prevention a decade before at UNGASS (UN General Assembly Special Session), the subsequent explosion of HIV infection linked to injecting drug use, and the fact that 'obstructionist governments' were still blocking references to harm reduction in the political statement this time around.

Why were these governments being so intractable? 'In terms of the CND process, that's a good question,' he says. 'Some of those governments have historically been very unfriendly, to say the least, towards harm reduction and consistently blocked it. But what was interesting at the high level discussions around the political declaration this year was that there were governments who actually support harm reduction domestically that, when push came to shove and there needed to be a show of hands, opposed even the most ridiculously meagre harm reduction language. We're talking about a reference in a footnote here.'

Does he have any optimism that things might improve? 'I think the one good thing that came out of the process this year was that it really illustrated the degree to which the whole system is in a shambles,' he says. 'CND is in an isolated bubble in the broader UN when it comes to support for harm reduction, and it's going to be increasingly difficult for them to sustain that. It just makes them look irrelevant.' All of this is a symptom, he believes, of the way that drug policy is refusing to engage with broader international realities. Where will change come from – is it the NGO sector and drug activist organisations that are helping to shape the agenda? 'One of the things driving our work at IHRA for the last couple of years is about being able to mainstream drug policy throughout the international multi-lateral agencies,' he says. 'We need to be putting those issues in the context that other UN agencies can understand – that's the work we've been doing from the human rights end.'

The key is to engage with organisations like UNICEF and UNAIDS and illustrate the ways in which drug enforcement has an impact, he says. 'It's a question of how they can see drug policy issues as relevant to their work. If we go to them just about drugs they'll quite rightly say "we don't have a mandate to talk about drugs", but what we say is that these are human rights issues – the right to health, the death penalty, extra judicial killings, torture – that are directly relevant to their mandate, but driven by drug enforcement. There are others, around the environment, with crop eradication, and security and development, so the challenge is how we wrap up a drug policy message in a way that places it firmly within the mandate of other UN agencies, and increasingly make the CND irrelevant.'

Human rights organisations, with notable exceptions, have been accused of shying away from drugs issues, partly out of a perception that it would be hard to mobilise public sympathy. Is anything changing for the better here? 'Definitely,' he says. 'We're starting to get high profile human rights bodies making statements about drugs which will inevitably get people thinking about these issues. One of the big things we're working on at the moment is with Amnesty International around 26 June, the international day against drug abuse and trafficking that a number of Asian governments choose to 'celebrate' with executions. We're looking at advocacy strategies, hooking up drug user activist and harm reduction organisations on our end with the anti death penalty groups and human rights groups that that Amnesty works with.'

Foremost among 'antagonist governments' have traditionally been Russia and the US. But the new American administration is already taking a different approach to needle exchange programmes than its predecessor. Does he think things might genuinely change for the better? 'Well it couldn't be any worse,' he says. 'The US delegation expressing support for needle exchange was one of the things that minimised the CND process this year, and that public statement was very much driven by civil society organisations – on the one hand the US delegation was still maintaining this incredibly hard line against harm reduction when the new administration was publicly supportive of needle exchange, and US harm reduction groups did a lot of good media work which made the Obama administration sit up and take notice.'

Though it ultimately had no impact on the content of the international declaration, it could prove to be a watershed moment, he believes. 'In terms of US policy – specifically US policy as a donor country – it potentially opens up huge opportunities to direct funding away from abstinence-only type approaches towards harm reduction. It's a significant shift – not as significant as we all wanted, or think is merited, but we shouldn't underestimate the impact it could have.'

Harm reduction 'must be scaled up'

'We have had significant progress on harm reduction in Asia, so what has been the regional experience of scaling up?' asked Mukta Sharma from WHO, while chairing a session reviewing drug use and HIV in Asia.

In 2005 coverage of harm reduction in Asia was less than 5 per cent. Three years on there had been progress, said Anindya Chatterjee, programme director at the HIV/Aids Asia Regional Programme. Injecting drug users (IDUs) in 21 countries had been reached with HIV prevention programmes and one in ten were on oral stabilisation treatment in nine countries, although needle exchange programme were still failing to reach more than 20 per cent of IDUs.

Harm reduction was typically part of HIV and Aids plans these days and national strategies were being joined up: 'There has been large scale change in the way we do things,' he said.

However there were vital missing pieces. Services needed better coverage and attendance and quality had to be improved, from understanding dosages to extending opening hours. 'Sustainability depends on money, people and the social policy environment,' commented Mr Chatterjee, adding that it was 'time to systematically develop the workforce on harm reduction'.

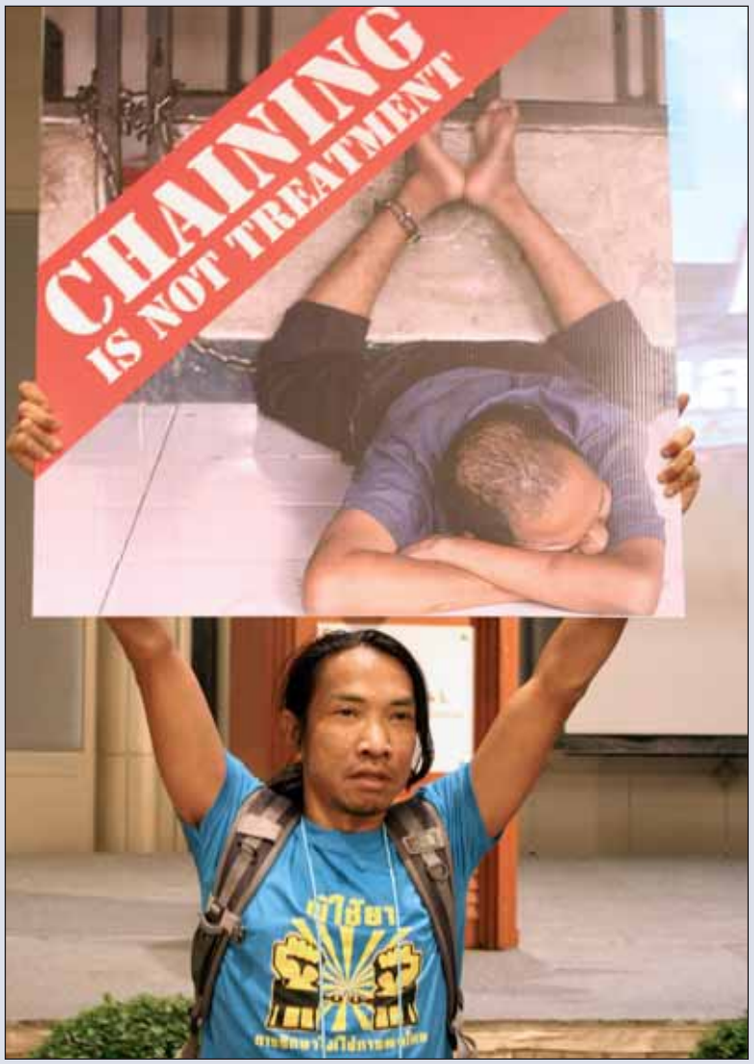
Although Asian harm reduction had come a long way, there was 'quite some way to go', he said. 'The building blocks are in place but we need to find ways of scaling up activism – activism has broken new ground for us', he said.

Tim Brown, senior fellow at the East-West Centre, said a slowing trend in HIV epidemics in recent years was now showing signs of reversing, and highlighted countries' 'ongoing failure' to contain epidemics. Efforts needed to be focused on all members of the population, he said, as all modes of transmission were active.

'We can reverse Asian epidemics by just doing what works,' he told delegates, pointing to basic measures like using substitution programmes to reduce injecting, introducing condom use in sex work and reducing needle sharing. 'We're making progress but we have a long way to go.' Targeting at-risk populations had most impact and was cost-effective, so countries must prioritise their budgets, he said.

Sujan Jirel from Youth Rise, a network to reduce drug-related harm, said skilling up on harm reduction was critical not just for drug users but also for families and communities. 'Reporting systems are not in place to track effectiveness,' he said, pointing out that young people were particularly vulnerable and needed school programmes and peer support.

Services for drug users in Asia were too few, but 'won't improve unless we are involved,' he stressed. 'Nothing about us without us.'



A member of the Thai Drug Users' Network demonstrates on the first day of the conference against the inhumane treatment meted out by the Thai government. Banner slogans included 'User rights are human rights, stop torture now'. Speakers from several Asian countries gave graphic descriptions of torture and humiliation they had suffered in the name of drug 'treatment', during the course of the conference.

Problems created by policy need effective engagement

The harm reduction movement had a good understanding of the role of prohibition in creating harm, but a lack of engagement in campaigning against it, said Steve Rolles of the Transform Drug Policy Foundation.

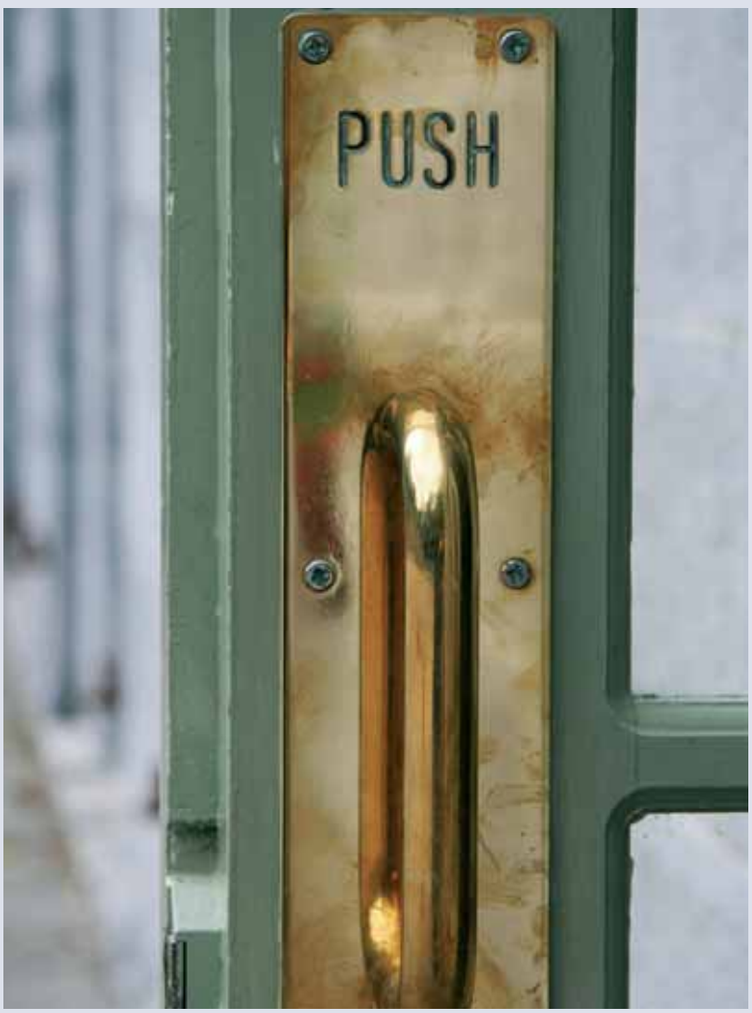
This meant harm reduction was a 'symptomatic' response, he said. 'Few harm reduction organisations have a substantive position on reform – the issues around a legally regulated production supply are rarely touched upon.'

Prohibition created crime, led to criminal justice crises, undermined public health and human rights and destabilised producer countries, he said. 'These are problems created by policy, not drug use. Harm reduction operates within a legal framework that maximises harm.' The movement had not grasped the nettle on this because of fear of political and funding constraints, he said. 'We need to have a meaningful discussion about policy alternatives.'

Substance use was part of human behaviour, said Donald MacPherson, Vancouver's drug policy coordinator, and policy development needed to start from that point of view. 'A sense of belonging is a non-negotiable human right, and criminalisation crushes that,' he said. 'Prohibition is old, it's tired, it's been around for a hundred years and it really doesn't do what it's supposed to do. It's a failed public policy – any other policy with similar results would have been disposed of long ago.' It was necessary to build policy on the evidence of what worked, not on 'ideology or wishful thinking', he stressed.

There had been cultural shifts, however, particularly in the US, said Sanho Tree of the Institute for Policy Studies. The election of Barack Obama was 'emblematic of a seismic shift' in that Obama did not have the political baggage of the cultural schism of Vietnam and the counter culture that had polarised debate since the 1960s. The extreme violence related to prohibition was also now a major concern in the US, as Mexican drug wars spilled over the border. 'It is now culturally and politically safe to criticise the war on drugs,' he said.

Winning hearts and minds



Employing drug users in harm reduction can give agencies unprecedented access to hard to reach communities. But only if it's done right, Mat Southwell tells **DDN**

A conference session called *'The good, the bad and the ugly'* looked at employing drug users in harm reduction from a number of angles – even running the organisation themselves. 'That raises the question of not having to hide things and play the game – allowing people to talk honestly and openly about their drug taking,' says INPUD board consultant Mat Southwell

Southwell has extensive experience of running drug services in London. 'This was before I came out publicly as a drug user,' he says. 'We had a team where more than half of the staff were drug users, either in treatment or not – there were problems, but there were real opportunities that came out of that as well.'

This was back in the '90s – has the situation changed since then? 'A very good indication is that all the drug using drug workers were sacked after I left,' he says. 'The big challenge in services is that people who are caught using drugs are basically told "have a clean reference and leave without making any noise". So the problems never get challenged. It's about saying "we have employed drug users very successfully in drug services". We were doing pioneering harm reduction work, but it wasn't sustainable because it was driven by individual managers and when they left everyone else went back to their fearful position.'

Does he have any sense of optimism that things might improve? 'The UK is particularly problematic, because we have this NTA-driven model that at best says "if you're in treatment or an ex-user you can be involved, but if you're still using you can't". It's completely tokenistic. We're told to shut up and accept it, but we did for ten years employ drug users and had an award winning team. I'm not trying to say there were no problems, but the benefits outweighed the problems.'

Among those benefits are valuable experience and insight, he stresses. 'That's not to say that experiential expertise is better than professional expertise – we had both. You also get a trust with the local using community – it immediately gives you a way in, especially with hard to reach communities – and you get the ability to intervene in the local scene. For instance, when crack broke you could see those trends coming because people are out there taking part in those trends. You get much better intelligence from the ground much more quickly.'

A key issue for agencies is about being brave enough to do the work, he says. 'One of the success stories of the HIV era was the way that drug users brokered relationships between new developments and practice, but it's hard to see that tradition continuing. It's also about using your peer expertise and your privileged access to pursue a community development approach. Just employing drug users doesn't automatically get you those things.'

Indeed he believes that the main downsides to employing drug users stem from the way it's done, rather than the process itself. 'I don't think there are negatives per se, but there are huge negatives if you do it badly,' he says. 'When I came into the field back in the late '80s I saw people appointed as outreach workers on methadone and stuck out there with no training to do one of the most complex jobs in the drugs field. And drug users are often put into that role – one of the most challenging and demanding – at half the salary rates of other professionals.'

'I saw people appointed as outreach workers on methadone and stuck out there with no training... at half the salary rates of other professionals.'

Agencies that employ drug users in a tokenistic way will find those workers cease to be a broker between the organisation and the drug using community, he says. 'They can be patsies, put up as "our nice reformed drug user" – organisations will just appoint their favourite drug user and say "we've done it".' The problem is it alienates that drug user from the community and makes people feel even more marginalised. If you give people participation without power it actually increases their sense of powerlessness.'

Employers also need to be realistic with people, he stresses. 'The biggest problems come with not offering training, proper supervision or a safe environment where they can talk about the inevitable risks and challenges posed by going back into the using community and working in it,' he says.

Rushing into the process without thinking about the implications can carry huge risks, he warns. 'The danger is that it can sabotage the whole process. Back in the 1980s, because of these few cases that were very poorly managed – even though there were good intentions – the idea of employing drug users in outreach in that period was discredited. There's a policy impact if you don't do this right.'

A question of liberty

Deputy director of Release, **Niamh Eastwood**, looks at how the civil rights of drug users are being eroded

THE UNITED KINGDOM GOVERNMENT is often perceived as a leader in the implementation of harm reduction initiatives and in its pursuit of ensuring treatment as a cornerstone of any drug policy.

There is no doubt that the UK is far ahead of many other countries, and that the financial investment in treatment since 1998 has been unprecedented. However there has been little discussion of the worrying infringement of the civil rights of drug users, infringements that would be considered completely unacceptable for any other section of society.

Since 2005 a number of new laws have been introduced which have directly targeted drug users. They have included drug testing on arrest and mandatory treatment if found positive, pre charge detention for up to eight days, the closure of premises for up to six months where there is suspicion of Class A drug use and confiscation orders in respect of those found guilty of minor drug offences. These new laws have gone unchallenged and some have been quietly introduced to the wider public – it seems drug users are being treated as guinea pigs.

The criminal justice arena is not the only area where drug users face unusual and degrading treatment. In the provision of their healthcare they can receive treatment that would not be acceptable to the rest of society. Guidelines issued by the National Institute for Health and Clinical Excellence (NICE), the body responsible for ensuring good practice in healthcare, have clearly stated that everyone should receive treatment if diagnosed with hepatitis C – this includes those actively using drugs. Yet many senior medical consultants still refuse to provide this treatment, based on their own prejudice.

Release, the UK's centre of expertise on drugs and drugs laws, is positioning itself to challenge some of these laws through strategic litigation. This is a process whereby test cases are used to change policy or positions. It is important for the legal field to work closely with those in drug treatment to identify areas of potential action.

Young people being ignored

Even in countries with progressive harm reduction policies young people were still not being involved in policy and programme development, said Youth R.I.S.E coordinator Caitlin Padgett.

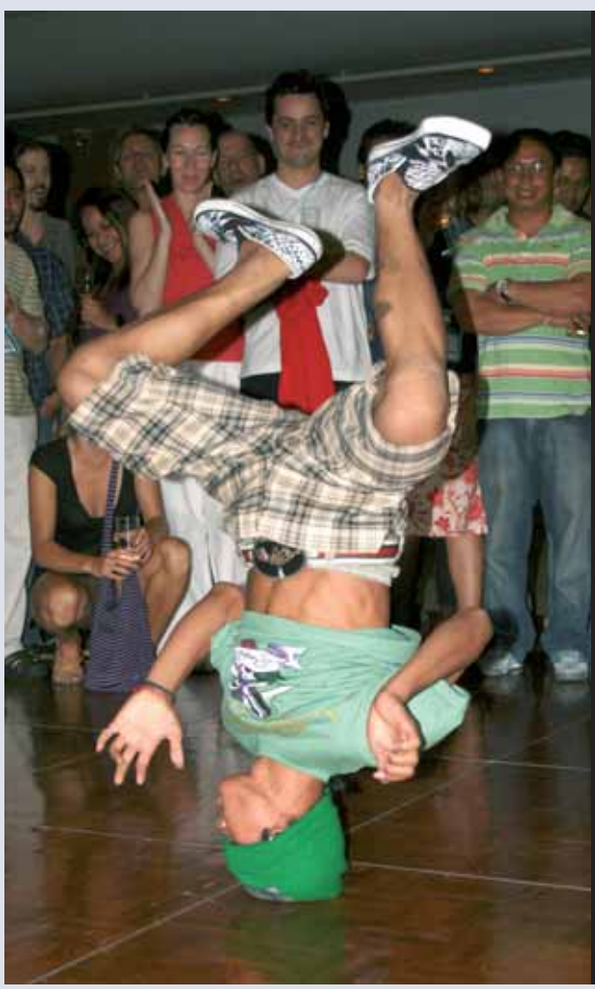
Young people were being criminalised for their drug use, she said, ending up in correction facilities and therefore at serious risk. Iulia-Veronica Broasca, project manager of the Romanian Association Against Aids, said her organisation had been running pilot projects in prisons, including two youth penitentiaries. They had offered free condoms and peer education but had come up against strong resistance from prison personnel. The institutions were extremely high risk environments where syringes and condoms were not allowed – 'minor prisons are a death sentence for minors,' she said.

However the Convention on the Rights of the Child – the most widely ratified of all human rights documents – could help provide a framework, said Ms Padgett. The guiding principles of the convention could help make the argument for harm reduction for young people, she said. These included non-discrimination, the right to life, survival and development and the right to be heard.

'Sometimes it's uncomfortable,' she said. 'People don't want to think about these issues. In some countries, for example in Eastern Europe, the average age for people to start injecting is 15 or 16 but they can't access services until they're 18.'

A coordinated response that included the UN family was essential, she said, so that people did not have to worry about providing services in case their funding was halted or they were accused of enabling drug use. She called for strong leadership at high level to change legislation to allow young people the services they desperately needed.

'There's resistance even within the harm reduction movement,' she said. 'But the reality is that without harm reduction services young people are dying.'



Break from the past: A member of Kormix, the hip hop group made up of ex-drug users in Cambodia, demonstrates the breakdancing skills that have inspired Cambodian street kids to swap drug use for dance, art and education, at a conference reception. Since being deported from California five years ago, KK set up Kormix and a dance school, Tiny Toones, to inspire children from Phnom Penh's poorest neighbourhoods. 'Breakdancing didn't exist in Cambodia,' KK told DDN. 'We're giving kids a chance to dream and do what they want. All the kids who are involved are now clean. From being a nobody they know they can now become a star in Cambodia.'

Masculine culture leaves no room for women

'My mother told me she would rather have a child who is a prostitute than a junkie.' Niphattra Haritavorn gave this quote from her research in Bangkok to demonstrate the obstacles and prejudice faced by drug-using Thai women.

Viewed as unacceptable in society, drug-using women were stigmatised both inside and outside the family, at more extreme levels than men. One of the women who participated in the survey said neighbours had asked her mother: 'How can you raise your daughter to be a drug addict?'

For many, the 'good daughter' image was replaced by a 'junkie' image. 'They keep an eye on me like I'm going to steal something from the house,' another survey respondent had said. The word 'ra-aa' had become commonplace – meaning 'to be bored with', and used to describe the family's reaction to their drug-using daughter when they are resigned to being unable to change their behaviour.

Many families reacted to the embarrassment and shame they felt by enforcing their own social punishment on their drug user. One girl described how her family did not tell her when her father had died. Others explained how the traditional Thai family support structure of using parents and grandparents to help with childcare had turned against them when they had been denied access to their own children by families who believed the child would lead a better life away from the drug user.

For many women, violence and degradation – from partners, police and even from others within the drug-using community – had become a depressing part of daily life. Motherhood was often unplanned because of drugs' influence on irregular periods and their interference with effective condom use. Male pride was another barrier to harm reduction, where men saw their partners' request for a condom as a sign of infidelity: 'You are my wife, why do I have to use a condom?', one man asked his partner.

In other cases, women assumed that because their partner was HIV positive there was no point in wearing a condom, as they would get the disease sooner or later, 'so why not now?'.

'We need a holistic intervention programme applicable to women,' Ms Haritavorn stressed. 'Much of the activity around drugs is an overtly masculine world.'

Niphattra Haritavorn: 'For many women, violence and degradation – from partners, police and even from others within the drug-using community – has become a depressing part of daily life.'

Asian countries suffer alcohol industry's power

Maritona Victa Labajo: 'Ours is a highly urbanised society with high levels of deprivation – the tendency is to drink your problems away.'

The economic power of the alcohol industry was helping to fuel increased rates of problem drinking across South East Asia, delegates at the session looking at drinking patterns in Asian countries heard.

Maritona Victa Labajo of the Social Development Index in the Philippines told delegates that one of the main problems in her country was aggressive advertising.

'More than 80 per cent of the price of a bottle of beer goes to advertising costs,' she said, with the entire month of October traditionally given over to a heavily sponsored beer festival. 'Alcohol companies make a lot of money for the Philippino economy and sales have not been affected by the economic downturn. Ours is a highly urbanised society with high levels of deprivation – the tendency is to drink your problems away.'

Alcohol was present in all cases of domestic violence, reinforcing the power imbalance between the country's men and women, she said, and liver cirrhosis and liver cancer were now among the country's top 15 causes of death. Western solutions, however, were not necessarily effective. 'When alcohol tax increases, Philippinos do not restrict their drinking – they just give less money to their families for food.' The country even lacked drink driving laws, she said. 'It's only a violation when it causes an accident, and even then you will often be asked to drive yourself to the hospital.'

Korea was ranked first among OECD countries for levels of binge drinking, Dr Surnggie Cho of the Korean Alcohol Research Foundation told delegates. Eighty per cent of the 50m population drank, with the percentage of binge drinkers increasing from 53 per cent to 68 per cent in recent years, and harmful drinkers from 10 to 15 per cent.

Sixty three per cent of homicides were now drink related, and the country faced an annual bill of $20bn in alcohol related public health costs, amounting to 2.9 per cent of GDP.

'Alcohol harm is increasing,' he said. 'Western style control policies are not working – we need more targeted harm reduction activity.'

The highest levels of drinking – and binge drinking – in Thailand, meanwhile, were found in Bangkok, said Professor Tassanee Laknapichonchat of Thamasat University. During this year's week long Songkran (New Year) celebrations, 373 people had been killed in road accidents, mostly drink related.

Even in rural areas, however, where 80 per cent of Thais lived, farmers made their own alcohol from distilled rice, and young Thais saw drinking as a way of reacting against Buddhist values. 'Alcohol consumption and production has seen a very rapid rise in recent years and is becoming a major public health concern,' he said.

'It's not just a question of the alcohol industry – the governments of these countries are dependent on the taxes that come from alcohol,' Ian Newman of the University of Nebraska told the session. 'They're not going to take away their source of income.' This meant the companies had enormous lobbying clout.

'When the alcohol industry comes up against public health, public health tends to lose out,' commented one delegate.

Focus on Indonesia's culture of macho risk-takers

Sudirman Nasir: 'We need to talk about the broader issues of daily life – unemployment, dignity and status.'

Studying young male injecting drug users in the slum areas of Makassar, Indonesia, had revealed a culture of macho risk-taking, said Sudirman Nasir, offering a different perspective in the 'risk environments' session.

Interviewing 18 young male IDUs at a local drop-in centre had revealed risky injecting as a major mode of HIV transmission among the urban poor of the 'Larong' slum area. Their 'cluster of disadvantages' included high level unemployment and few prospects of a better standard of living, and there was interplay between their socio-economic marginalisation and their pursuit of 'rewa' – the local construct of masculinity. Participation in gangs was a characteristic of Larong's risk environment in initiating and maintaining a drug injection career.

'You are not a real Larong boy if you don't put a brave face against dangers... using drugs or injecting putaw (street grade heroin) are part of our daily life,' said one respondent. Another added: 'Most of us are unemployed and of course we are depressed because there is nothing meaningful to do. Being involved in a gang, using drugs and injecting putaw makes us busy and I forget our despair, at least for a short period of time during the high.'

Analysing the results of the study, Sudirman Nasir said harm reduction initiatives needed to be complemented with wider community-based programmes that addressed socio-economic deprivation.

'We need to talk about the broader issues of daily life – unemployment, dignity and status,' he said. 'We need more mixed method studies to take this forward.'

Communities must reflect local cultural values

'Just as individuals deny their alcohol problems, so do communities,' said Ian Newman of the Community Alcohol Policy Project (CAPP).

And when these were finally acknowledged because of a crisis, the response was frequently not thought through, he said. Often the reaction was applying policies used elsewhere, irrespective of how effective or appropriate.

Alcohol use was increasing in China but, while western strategies were based on taxes, opening hours, advertising and age limits, Chinese values focused more on self-respect, moderation and family. Raising taxes in China, for example, could lead to more non-commercial alcohol production, he warned – the challenge was to avoid denial, reflect local cultural values and maintain engagement. 'We're looking to communities to develop policies based on their local situation,' he said.

Andrea Fischer of the Burnet Institute's Centre for International Health, described a project looking at non-commercial alcohol and HIV risk in Papua New Guinea, which aimed to reduce levels of intoxication and risky behaviour, such as unsafe and unwanted sex – 40 per cent of females had reported being forced to have sex in the last six months. It was important to base interventions on facts, not beliefs, and focus on empowerment, she said. 'Simple and low cost interventions work.'

Social marketing: tough messages for a tough problem

An alcohol policies and social marketing session looked at attempts to use the media to try and change drinking patterns.

Tuari Potiki of the Alcohol Advisory Council (ALAC) in New Zealand described an entrenched drinking culture where young people learned their drinking behaviour from adults and older peers.

'New Zealand has a very similar drinking culture to countries like England, Ireland and Scotland,' he said. 'People go out to get tanked. Eighty per cent of the population describe themselves as regular drinkers, so it's very difficult to change behaviour.'

Seventy per cent of police time was spent attending alcohol related incidents, and there were significant problems with cheap alcohol and alcohol licensing, he said. 'It's very easy to get a liquor licence, and very hard to lose it.'

ALAC had been trying to raise awareness, taking a whole population approach. 'We didn't want to vilify young people for their drinking when they're just mimicking the behaviour of adults,' he said.

'Social marketing is perceived by some as a soft option, but it is an important way to get your message across,' he told delegates – 26 per cent of people reported drinking less a year after the campaign. The organisation had run into controversy with a series of hard hitting television adverts depicting people vomiting and children being injured by drunken adults, but it felt it had needed to make an impact.

'There were a lot of New Zealand drinkers who didn't see their drinking as a problem to them or anyone else,' he said. 'But that's not what our research was telling us.'

Post-its from Practice

Lessons from Thailand

Hearing about drug users in Asia is a humbling experience, says **Dr Chris Ford**

I was asked to see Apinum while attending the 20th International Harm Reduction Conference in Bangkok. He was unwell and complaining of a very painful thigh and a temperature.

Apinum has been an injecting drug user for more than 12 years and is a member of the amazing Thai Drug User Network. I asked to see his thigh and was confronted by cellulitis in a severely scarred leg. It didn't look like injecting damage, so through his interpreter I asked about the origins of the scarring. Apinum became acutely embarrassed, but eventually revealed that he had been tortured while in enforced drug treatment.

The first time I saw Apinum at the conference he was taking part in a protest march before the opening ceremony and the crowd was chanting 'user rights are human rights, stop torture now'. People were carrying placards with statements like 'Thai drug users are dying for harm reduction', 'Torture is not a cure', and many others.

The three days between the protest and our consultation had been packed with learning. I had learned that the human rights of people who use drugs are regularly violated and abused across Thailand and the whole of Asia. People who use drugs are routinely arrested, detained, beaten and forced into detoxification. In some countries treatment, which in most other places would be classed as torture, is compulsory. The death penalty is still legal in many countries and used for people who use drugs.

Although the effectiveness of harm reduction is undeniable, access to harm reduction services is between 2-5 per cent in many areas of Asia – clearly a contravention of human rights. As Manfred Nowak, the UN's special rapporteur on torture put it, 'harm reduction is human rights' and he spoke passionately about the need for a human rights-based approach to drug policy.

Apinum had experienced compulsory drug 'treatment' in one of the growing number of Thai military drug centres – these have had no evaluation and have a relapse rate of at least 96 per cent in the first week post discharge. Thailand's official drug policy is that drug users are 'patients', not criminals, but the reality is very different.

However harm reduction has moved forward since I attended my first IHRA conference 12 years ago. The 2009 conference was opened by Professor Michel Kazatchkine, executive director of the Global Fund to fight AIDS, TB and malaria. He reminded us how 'alarming evidence is a principal tool for advocacy – with the life expectancy of someone beginning anti-retroviral medication 12 years lower for an IDU than a non-IDU'. He went on to say how this 'shows the scandalous failure to prioritise effective healthcare' and 'no matter how often evidence is denied we must continue to maintain hope and keep up the fight.' These sorts of statements used to be only made by us – people who use or have used drugs, and workers – in previous years.

But all is not bleak in Asia. Many of the innovative harm reduction services are completely run by people who use or have used drugs, often in difficult circumstances with little or no funding. People distribute good quality information and clean injecting equipment from their homes or the back of their mopeds.

Apinum is a volunteer harm reduction worker and spends most of his time distributing injecting equipment and doing amazing health promotion work. He is 29 years old and has known he is HIV positive for four years. He has little access to HIV medication or pain relief.* I was able to help his cellulitis with clarithromycin I had brought from UK, in case, and some tramodol for his pain. He improved dramatically in 24 hours and the highlight of the conference for me was his amazingly polite and discreet thank you as we parted to go back to our usual lives.

I learned much more than I gave and am returning to UK feeling humble and remembering – even if we need to continue to fight for better treatment and resources – just how lucky we are in the UK with drug treatment and harm reduction services.

**80 per cent of the world does not have access to effective pain relief*

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP.

Evidence denial 'based on fear'

'Blatant and wilful denial of the evidence' was getting in the way of international harm reduction, said Craig McClure, executive director of the International Aids Society, in the conference's closing keynote address. Russia's refusal to legalise methadone was an obvious example of denial of evidence by policymakers and abuse of power by members of the medical profession, in preventing the introduction of substitution therapy, he said.

The country had more than 2m injecting drug users – the highest per capita in the world – yet the Russian government maintained that there was no evidence that methadone worked to prevent HIV infection or reduce harms. Around 70 per cent of all HIV infections in Russia were linked to injecting drug use.

'This kind of blatant and wilful denial of the evidence can only be based on deep-seated fear,' said Mr McClure. 'This denial of evidence is so profound that the government even dares to boldly distort the facts in international fora, such as the high level meeting of the Commission on Narcotic Drugs in Vienna last month.'

This kind of denial was not limited to Russia, he added, but could be seen in his own country, Canada, where harm reduction studies and trials had been 'dogged by government interference since their inception'.

The medical profession was also driven by fear to administer abuses such as forced detention and isolation, electro-shock therapy, forced participation in medical experiments and other abuses 'that many of us might refer to as torture'.

'Doctors who administer these abuses under the guise of drug treatment are not just wilfully denying the evidence, they are violating human rights and the Hippocratic Oath,' he said.

The International Aids Conference to be held in July 2010 in Vienna would focus on injecting drug use and human rights and would be a chance for us all to 'confront the fear that was rampant at the Commission on Narcotic Drugs in Vienna in 2009',' he said. 'Let us move towards a unified voice where public health and human rights are two sides of the same coin.'

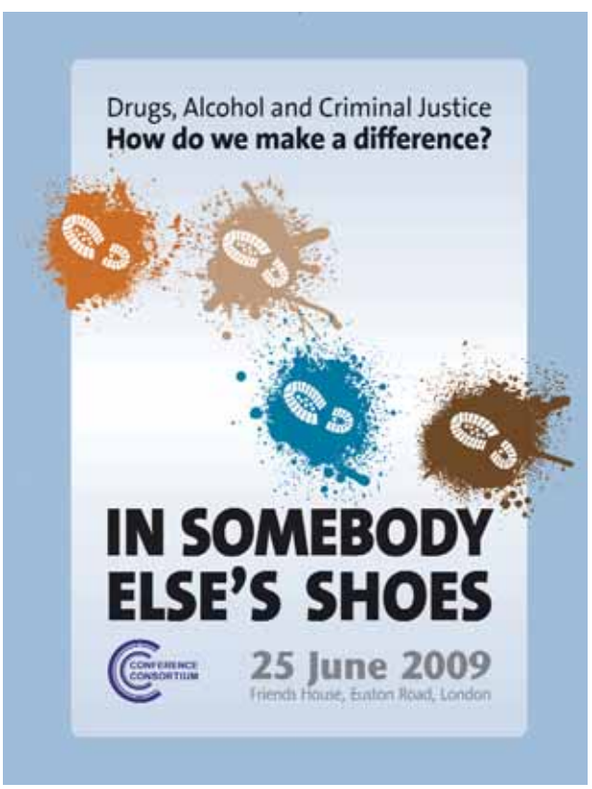
IHRA's 20th International Conference was organised by the Conference Consortium, www.conferenceconsortium.org. DDN produced daily updates for each day of the conference – they can be found in full on www.ihra.net and on our own website, www.drinkanddrugsnews.com. Next year's event will be in Liverpool on 24-29 April 2010.

How do we make a difference?

The Conference Consortium in partnership with *DDN*, CNWL Health Trust and Coventry and Warwickshire Partnership Health Trust are running a conference: *Drugs, alcohol and criminal justice – how do we make a difference?* which will take place on Thursday 25 June 2009 (10.30 to 4.30) at Friends House, Euston Road, London.

The conference will focus attention on criminal justice interventions from arrest, arrest referral, assessment and pre-court work, health stabilisation, sentencing and the delivery of DRR through medium and high intensity (community and residential) treatment as well as working with prisoners through sentences, pre and post-release.

It will examine both what is working and the 'pinch points' in the delivery of services within the context of often overlapping, and sometimes contradictory, strategies and frameworks created by different government bodies. The aim is for delegates to 'unpick' confusion and barriers where they exist, identify ways to address them and improve practice and service delivery.



DDN caught up with Andy Stonard (who is running the conference on behalf of the partnership) to ask him what the conference is trying to do:

'We are trying to deliver something different at this conference, a truly interactive and participative conference for everyone. The idea is to have everyone discussing the individual's journey through the drug criminal justice process. We know parts of it are working and parts are not. This is an opportunity to talk directly to those in parliament about how we would like best practice rolled out across the whole criminal justice programme.'

DDN, as part of the build up to the conference, is running a series of interviews with colleagues from the police, probation, courts, CARAT, commissioning and treatment sectors as well as, most importantly, the individuals who have to navigate their way through all this.

The one day event will conclude with the conference delegates taking their discussions and conclusions to a panel of parliamentarians for future action.

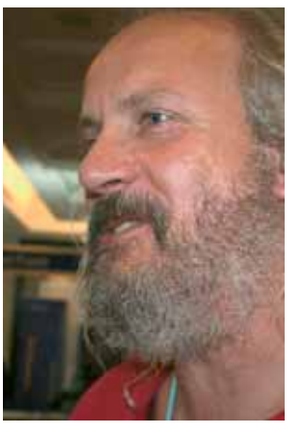
'There are no speakers and presenters at this event, just facilitators to bring out the views and experiences of everyone at the conference. It is becoming increasingly difficult to enable staff to meet together from across the country, and across the disciplines, without being talked at or told how to think.'

Stonard says he thinks that colleagues are tired of top down instructions on how to work.

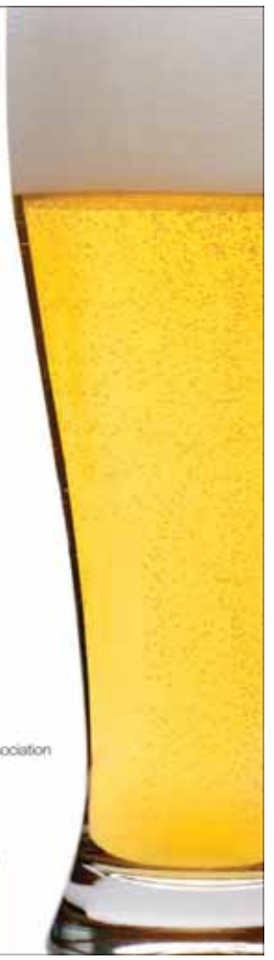
'Everyone welcomes the investment and some of the improvements this has brought, but it has killed innovation and creativity and is especially frustrating when resources are available but are not delivering treatment locally in the way we know would be most effective for local populations. Those people who access services, the providers and the commissioners are all in the same boat.'

The conference is on 25 June at Friends House and costs £145 + VAT (there is a free user place for every three places booked and two free places for every five booked).

www.conferenceconsortium.com
michelle@conferenceconsortium.com



Andy Stonard: 'This is an opportunity to talk directly to those in parliament about how we would like best practice rolled out across the whole criminal justice programme.'



NHS Norfolk

TACKLING DRUGS CHANGING LIVES

Family Interventions Pilot – Supporting families to manage the impact of a parent's alcohol misuse

NHS Norfolk and The Young People's Joint Commissioning Group of the Norfolk Drug and Alcohol Partnership invite tenders for a time limited pilot service that assesses the effectiveness of interventions using psychosocial methods to support family members to manage the impact of a parent's alcohol misuse; meeting the needs of substance misusers as parents and enabling them to better support the young people in their families. Referrals will come from adult alcohol treatment services.

Funding for the Family Interventions Pilot will come from NHS Norfolk.

Please visit

www.nordat.org.uk

for more information

my county council

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Treatment Commissioning Manager

£34,107 - £38,463 pa Ref: 23818

County Hall, Northampton

Fixed term contract until 31 March 2011

Northamptonshire DAAT is seeking a dynamic, focussed individual to lead on the development, commissioning and delivery of treatment services for substance misusers. The role has a high degree of autonomy reporting directly to the strategy manager.
Good communication skills and an analytical mind are essential.

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For an informal discussion please contact Clive Jekyll on 01604 237604.

For additional information about these roles and to apply online or download an application pack, please go to www.northamptonshire.gov.uk/jobs

If you require an application pack in an alternative format, please contact 01604 237666.

Closing date: 12 noon on 21 May 2009.

Your local library has internet access, just ask if you need help.

Northamptonshire County Council

www.northamptonshire.gov.uk

Blenheim

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

Substance Misuse Counsellor

£25,921 - £29,197 pa pro rata
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Temporary one year contract

The Eban Project delivers an extensive range of services for primary crack cocaine users resident in Haringey including: a daily drop-in, outreach, one-to-one keywork sessions, counselling, healthcare and complementary therapies.

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To request an application pack, please telephone our response handling line on 01206 570706 or email: info@peterlockyer.co.uk quoting the reference number. Alternatively, you can download an application pack from our website www.blenheimcdp.org.uk

Closing date: 18 May 2009.

Blenheim CDP:
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We value diversity in our workforce and welcome applications from all sections of the community.

Face the challenge of substance misuse

WDP is a leading drug and alcohol treatment provider, delivering a variety of substance misuse services across the South East of England. We recognise the importance of career progression and place great faith in our talented team, resulting in a highly motivated and diverse workforce always eager to seek out and take on new experiences and challenges.

Volunteer Development Manager

• Central London • £32,000 - £37,000

This role is pivotal to the continued success and growth of WDP, and a key management role within our organisational development team. You will manage the strategic development, recruitment and provision of learning and development services for service users, peer mentors, volunteers, students and carers.

Structured Day Programme Manager

• Harrow Road, Westminster • £25,219 - £33,000

You will lead the delivery and coordination of a structured day programme for criminal justice clients, providing a clear programme of defined activities for a fixed period of time and with specified attendance criteria. You'll also manage and deliver individual and group work services to drug users, working in partnership with other voluntary sector and criminal justice providers.

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• Harrow Road, Westminster • £25,219 - £33,000

In this diverse, challenging role, you will coordinate various aspects of the open access programme, including overseeing caseloads and managing allocations systems and processes. You will manage a team of staff, ensuring high standards in service delivery and achieving output targets, as well as managing a small caseload of clients.

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Interviews: w/c 18/05/09.

WDP

To apply, please visit: www.wdp-drugs.org.uk

Westminster Drug Project is an equal opportunities employer and welcomes applications from members of BME communities.

Reducing harm caused by substance misuse

Lighthouse Project is one of the leading providers of services to substance misusers, and those affected by substance misuse, in the UK. Established for over 40 years, we are one of the largest independent drug agencies in the North West.

Substance Misuse Workers Ref: DSMW

Liverpool DIP. Fleet Street SCP 26 - 29 £21.937 - £24.331 pa 35 hrs pw

As a result of Lighthouse Project's successful tender for the Liverpool DIP contract we now have further vacancies. This is an exciting time to join a dynamic and experienced team in a rewarding role.

Working in partnership with Merseyside Police, Probation and other appropriate agencies, you will manage an identified caseload of clients embroiled within the Criminal Justice System. You will also be responsible for a mixed caseload of opiate and stimulant users, some of whom will be subject to bail and other statutory orders.

A valid driving licence is a prerequisite for this post and use of a vehicle would be an advantage. Appointment is also subject to an Integrity Check with Merseyside Police.

For further information and to apply for these vacancies please download an application form from www.lighthouseproject.co.uk Alternatively, please email: recruitment@lighthouseproject.co.uk or contact Head Office on 0151 530 2566 for a postal application pack.

Application Forms must be submitted before noon on Wednesday 20 May 2009. CV's will not be accepted.

Lighthouse Project is an Equal Opportunities employer and welcomes applications from all sections of the community. We are committed to staff training and development in line with national occupation standards - DANOS and Learning & Development.

Lighthouse Project Registered Charity No: 519859

Liverpool NHS Primary Care Trust

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www.lighthouseproject.co.uk

lighthouse project

Social Care and Health

County Commissioner - Substance Misuse

£65,281 - £70,177 pa plus car benefit c£4K

Walton Building, Stafford, ST16 2DH

The Staffordshire Joint Commissioning Unit is working closely with partners to lead the development of a co-ordinated approach to the delivery of services for local people with substance misuse needs.

You will be the strategic lead for Substance Misuse across Staffordshire, working with partners to deliver this agenda, and leading a team combining the work of the Drug and Alcohol Action Team, Primary Care Trusts, the Local Authority and the Community Safety Partnership activity.

You will have substantial experience of working at a senior level within an organisation, across a range of partnerships as well as engaging directly with service users and carers with substance misuse needs.

You can view and download an application pack by visiting our website at www.staffordshire.gov.uk/SCH970 or request a postal pack by ringing 0845 452 0539 (24 hour answerphone) quoting job reference number SCH970.

Closing date: 29th May 2009.

This position is subject to a "disclosure" check under the "Rehabilitation of Offenders Act 1974". Further details regarding this check and Staffordshire County Council's employment policy will be found within the application pack.

This Authority is committed to safeguarding and promoting the welfare of children and young people/vulnerable adults and expect all staff and volunteers to share this commitment.

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Staffordshire County Council

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AWP is a major provider of prison drug services in the South West. This includes CARATS (Counselling, Assessment, Referral, Advice and Throughcare), we also deliver rehabilitation programmes and community-based drug work within the criminal justice system. We welcome applications from people who have a history of problematic substance misuse.

Prison Drug Services, HMP Erlestoke

CARAT

Carat Worker (Drug & Alcohol Practitioner)

Job Ref: 342-DA015-0509 ***Hours:*** f/t 37.5 pw
Salary: Band 5 £20,710 - £26,839 pa

You will be part of a multi-disciplinary team providing assessment, 1:1 support, groupwork and referral for prisoners with a history of problematic drug use.

For further information about this post, please email: Suzanne Greatwood, Treatment Manager, on: Sue.L.Greatwood@hmps.gsi.gov.uk

12 Step Treatment Worker (Drug & Alcohol Practitioner)

Job Ref: 342-DA016-0509 ***Hours:*** f/t 37.5 pw
Salary: Band 5 £20,710 - £26,839 pa

You will be part of a team providing a prison-based treatment programme within 12 Step philosophy. You will encourage prisoners to address offending behaviour and respect others. Applicants should have good groupwork and 1:1 skills. Applicants will attend an assessment centre and be asked to prepare a presentation.

For further information about this post, please contact Juliet Fenne, Treatment Manager by email: Juliet.fenne@hmps.gsi.gov.uk

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Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Prison Drug Services throughout the South West

Bank Band 5 Carat Workers

Job Ref: 342-DA017-0509
Salary: Band 5 £20,710 - £26,839 pa pro rata

Bank Band 4 Carat/ IDTS Support Workers

Job Ref: 342-DA018-0509
Salary: Band 4 £17,732 - £21,318 pa pro rata

We are looking for people to join our pool of bank staff to cover for our permanent CARAT workers in HM prisons Gloucester, Eastwood Park, Leyhill, Bristol, Dorchester, Erlestoke, Guys Marsh, Portland and the Verne.

Are you looking for a rewarding career that fits in with you? As the largest provider of CARAT (Counselling, Assessment, Referral, Advice, Throughcare) in the South West, we offer the chance to see your skills develop whilst enjoying the flexibility you want.

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For more information, please contact by email, Richie Morton, Area Manager, richiemorton@aol.com

Applications will be welcomed until our staff quota is met for bank roles.

Apply online at www.recruitment-awp.nhs.uk

Closing date for all posts: 21 May 2009.

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Salford City Council

Salford Drug & Alcohol Service (Eccles)

Social Workers x 2

QSW Grade J - L, SCP 29 - 38 £24,402 - £31,439 p.a., 36 hpw

Alcohol Social Worker

(Ref: 60311)

We require an experienced and motivated Social Worker to join our multi-disciplinary service. You will provide assessment, care planning and social work support to service users who have experienced alcohol problems, their carers and families.

Dual Diagnosis Social Worker (Drugs)

(Ref: 60309)

You will provide assessment, care planning and social work support to service users who have substance misuse and mental health problems. You will take on a liaison role between substance misuse and mental health services, supporting and advising the staff teams.

For both roles, you will work to promote the social care perspective within the team and work closely with health service colleagues in a multi-disciplinary team setting.

Salford Drug and Alcohol Service is a joint service provided by Salford Community and Social Services Department and Greater Manchester West Mental Health NHS Trust.

If you have knowledge and an understanding of current policy and practice issues in social work with adults, and feel you have the ability to work with substance users in a community setting, we would like to hear from you.

For further information after receiving the application form, please contact Jackie Bell, Service Manager on 0161 787 7813.

Information pack and application form from

the Head of Human Resources, Salford City Council, Civic Centre, Chorley Road, Swinton M27 5BN or our Customer Contact Centre. **Tel: 0161 909 6503 (24 hours)**. Minicom: 0161 909 6527 (special line for the hearing/speech impaired). Please quote reference number at all times.

Closing date: 15th May 2009.

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Joint Commissioning Officer

£35,067 - £37,692 per annum inclusive **Ref: 4038**

We are seeking an organised and committed individual with knowledge of commissioning, contract-monitoring processes and good IT skills for the Safer Merton Joint Commissioning Officer's role.

Working as part of the Safer Merton team, you will assist the Safer Merton Strategic Manager in commissioning services to tackle substance misuse and community safety in Merton.

Key functions of the role include:

- Monitoring and inspection of Service Providers to ensure they meet their requirements in respect of Contracts and Service Level Agreements
- Assisting the Strategic Manager with drafting and monitoring the Substance Misuse Treatment Plan, Needs Assessment and Healthcare Commission Improvement Review
- Collection and analysis of National Drug Treatment Monitoring System data and preparation of reports recommending action
- Monitoring and analysis of DAAT financial activity.

A CRB check will be required for this post.

For an informal discussion please contact Mark Robertson on 0208 545 3946.

Closing date: Tuesday 19 May 2009

We encourage applications irrespective of age, disability, gender, race, religion and faith, sexual orientation and gender re-assignment. We are particularly keen to receive applications from the Asian community and from people with a disability, who are currently under-represented at all levels within the authority.

In the search for a rewarding career and an affordable and pleasant place to live, people increasingly come to Merton. Whatever you may be looking for, from a supportive, dedicated management team to a real commitment to your development and training opportunities, we're confident we'll have something to suit you. The benefits of working for Merton include membership of the local government pension scheme, 26 days' annual leave rising to 31, flexible working, excellent learning and development opportunities and access to subsidised leisure facilities.

www.merton.gov.uk/jobs

Further information about these jobs can be found on our website at www.merton.gov.uk/jobs where you can apply online.

Recruitment packs are also available in large print or braille.

merton

POSITIVE ABOUT DISABLED PEOPLE INVESTOR IN PEOPLE

Creating Equal Opportunities for all

Come and see the all new, all singing, all dancing...

www.drinkanddrugsnews.com

PRIORY

The Priory Hospital Woking is a 26 bedded in patient unit offering treatment for patients suffering from acute mental health problems. We also offer a specialised treatment programme for patients suffering from addiction problems within an abstinence based, 12 step group programme.

We are currently looking for a Team Leader and part-time Therapist to join a team of highly skilled Addiction Therapists providing a 6 day treatment programme to in, day and out patients. Abstinence based 12 step programme is the core of the service.

Addiction Treatment Programme Team Leader

37.5 hours/week – 1.0 WTE

Candidates will be qualified as an Addiction Therapist or equivalent and have a minimum of 4 years experience in facilitation of group and individual therapy within the addiction field. Previous experience of working as a Senior Therapist with staff responsibilities and service management is required along with proven record of excellent conversion skills from assessment to admission. FDAP membership and accreditation or evidence of working toward this is required.

Addiction Treatment Programme Therapist

30 hours/week – 0.8 WTE

Candidates will be qualified as an Addiction Therapist or equivalent and have a minimum of 2 years experience in facilitation of group and individual therapy within the addiction field. FDAP membership and accreditation or evidence of working towards this is required. Experience with eating disorders and family work is desirable but not essential.

For an informal discussion, please contact Fiona Clark, Clinical Services Manager or for an application form please contact Joan Bendy in Human Resources on Tel: 01483 489211 or email: fionaclark@priorygroup.com or joanbendy@priorygroup.com

Closing date for applications is: 18th May 2009

Successful candidates will be required to apply for a Disclosure at the Enhanced Level from the Criminal Records Bureau. Further information can be found at www.crb.gov.uk

We are an Equal Opportunities Employer.

www.priorygroup.com

CITY & HACKNEY alcohol service

Group Practitioner

Therapeutic Alcohol Group Day Programme
21 hours per week
Starting salary NJC sp. 29-31 £27,589 inc. ILW pro rata

A unique opportunity to work within a therapeutically focussed service

As a key member of a therapeutic structured day programme, the post-holder will facilitate a mixture of psycho-social and exploratory groups; weekly keyworking with a small case-load of clients is included; an integrated team culture has been developed in this service, which has facilitated the establishment of a self-empowering base and successful outcomes for the client group. Clinical supervision provided fortnightly.

Diploma level counselling / group therapy qualification or equivalent required, as is experience of working in the addictions field and structured group experience.

Closing date: Friday 15th May 09
Shortlisting: Tuesday 19th May 09
Interview Date: Wednesday 27th May 09

For an application pack email
Sally.Coverdale@chalcoholservice.org.uk
Or call 020 8525 1313

We value diversity and aspire to reflect this in our workforce
Registered Charity No. 1082248

www.chalcoholservice.org.uk

Drug and Alcohol Foundation

Senior Counsellor

DAF is looking to recruit a counsellor with at least three year's experience of providing treatment to men and women suffering from addictive disorders.

This is a full time post and attracts a salary of £29-31K

Experience of line management and clinical supervision is essential. An application form and information pack can be downloaded from our website:

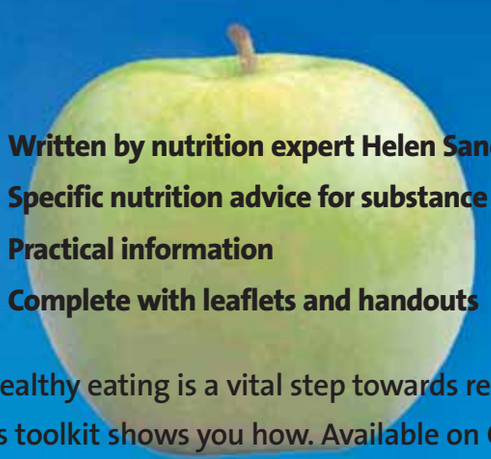
www.daf-london.org.uk

Alternatively please contact Olivette Stanislas on tel: 020 7233 0400 or e-mail: admin@daf-london.org.uk

Closing date for completed applications is 19-5-09.
Interview date 27-5-09
DAF is an equal opportunities employer.

The DDN nutrition toolkit

"an essential aid for everyone working with substance misuse"



- **Written by nutrition expert Helen Sandwell**
- **Specific nutrition advice for substance users**
- **Practical information**
- **Complete with leaflets and handouts**

Healthy eating is a vital step towards recovery, this toolkit shows you how. Available on CD Rom.

Introductory price £19.95 + P&P

To order your copy contact Charlotte Middleton:
e: charlotte@cjwellings.com t: 020 7463 2085

THE GROVE

Diploma / Advanced Diploma in Working Therapeutically with Addiction

An integrative training, bridging 12-step with psychodynamic and humanistic approaches. 20 days at weekends in central London, taught by our renowned team of tutors experienced in the field of addictive and compulsive behaviours.

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www.thegrovepractice.com

RAPt THE REHABILITATION FOR ADDICTED PRISONERS TRUST
stopping addiction. stopping crime.

RAPt Trustee (Clinical)

RAPt is the UK's leading provider of prison-based addiction treatment programmes and also manages a range of services in the community that aim to move drug using offenders away from a life of addiction and crime. We have almost 300 staff working in projects across the country.

The Board of Trustees for RAPt meet quarterly at our head office in Vauxhall, London. Meetings are held in the evenings. There are also various trustee sub-committees held and Trustees would be expected to sit on at least one of these sub committees. Daytime availability would be required for these meetings. There would also be an expectation that trustees attend various other meetings/events/project visits etc, therefore flexibility is important.

RAPt Trustees are seeking a new Trustee with relevant clinical experience to join the Board and to serve on the Clinical Standards Sub-Committee. The Clinical Standards Sub-Committee is responsible for the setting and oversight of the clinical standards of the organisation. A trustee serving on this committee requires an understanding of the 12 step treatment programme and of its delivery in a treatment setting. A working knowledge of the 12 step fellowships, and knowledge /experience of the delivery of 12 step treatment is essential. The value of assessment and motivational enhancement as performed by our CARAT teams is another essential, as is the understanding of training, both of future staff and of staff in post, to guarantee high standards.

If you would like to apply for this position, please email Natasha Simpson on natasha@rapt.org.uk for an application pack. Closing date for completed applications is 29th May 2009. Selection will take place shortly after the closing date but may take 3-6 months

This position will be subject to an enhanced CBR disclosure.
Registered Charity No: 1001701

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

Cambridge Centre drug & alcohol services

The Cambridge Centre is a non-statutory drug and alcohol provider of Tier 2 & 3 services covering Scarborough, Whitby and Ryedale. The Centre was established in 1983 & has an excellent reputation for delivering good quality services to the drug & alcohol using community.

Applications are invited from suitably qualified and experienced persons for the following position:

CORE SERVICE TEAM LEADER/ ALCOHOL WORKER

SCARBOROUGH
Salary £25,146 FT, 37 hrs per week

We are seeking a dynamic individual to be responsible for the day to day operational activity and supervision of the Core Service Team which consists of four drug & alcohol workers. You will also carry a caseload, complete comprehensive assessments, offer one to one support, provide structured care planned interventions, offer harm minimisation advice, promote relapse prevention strategies, provide advocacy and offer referral into other services. We require a minimum of two years experience working with drug and/or alcohol users, as well as relevant professional qualifications, experience of team leadership is desirable.

For an informal discussion ask for Nikki Orrell, Chief Executive.

Closing Date: 18th May 2009
Interview Date: 1st June 2009

Application pack available from Nix Fishburn, Deputy Admin Team Leader (Tel: 01723 367475) or email: nix.fishburn@cambridgecentre.org

INVESTOR IN PEOPLE

want to join a
successful, dynamic, expanding team?

RECRUITING NOW!

Leading 12 Step Substance misuse treatment provider

We are a growing force in the UK and are initially seeking to recruit dynamic, forward-thinking staff for our exciting new Day Care ventures located in Coventry and the North West. We need experienced Managers and diploma level, Counsellors, Trainee Counsellors, Administrators and Family Therapist /Counsellors. 12 Step programme experience essential for counselling applicants. Managers need a minimum of 2 years experience in managing Tier 3/4 services.

Competitive salaries offered

For an informal chat in the first instance, contact david.durand@ttpcc.org 0845 241 3401 for an Application Form and Job Descriptions

TTP is an equal opportunities employer. Those with personal experience of addiction or dependency on drugs/alcohol and who are at least two years drug free/sober are encouraged to apply for the above positions.

ttp counselling alcohol and drug rehab www.ttpcc.org

CRI

CRI North West and West Midlands

HM PRISON SERVICE

CRI works to create safer and healthier communities.
We help people to break free from harmful patterns of behaviour by delivering innovative services which have a measurable impact on both health and community safety issues. Our services are hallmarked by an emphasis on quality, a responsiveness to local priorities, and an outstanding record of achieving targets.

INVESTOR IN PEOPLE

CRI are delighted to have been commissioned to deliver new Integrated Drug Treatment Services (IDTS) at HMP Shrewsbury & HMP Stoke Heath and at HMP Risley & HMP Thorn Cross. IDTS teams will work closely with existing CARAT services in each establishment to provide integrated clinical and psycho-social elements of drug treatment. We are now looking to recruit to a number of key posts within each service

HMP Shrewsbury & HMP Stoke Heath

Shropshire County NHS Primary Care Trust

IDTS Service Manager *(Ref NM189)*

Salary: £33,325 – £35,113 • Full-time 37.5 hours per week

With significant experience of delivering substance misuse services and a thorough understanding of treatment interventions, candidates will need to demonstrate strong leadership and relationship building skills, and competencies in managing finance, staff and data. The post holder will lead the development of IDTS including the existing CARAT teams across both prison sites and have experience of working within custodial environments.

IDTS Speciality Doctor *(Ref NM190)*

circa £80,000 • Full-time 37.5 hours per week

Working closely with CRI's Medical Director and the IDTS Project Manager, the post holder will lead the medical elements of the IDTS service across both establishments. Candidates must be able to demonstrate experience and a qualification in substance misuse, current registration, team working and be able to work within CRI's clinical governance structures. The post will require some early evening and weekend cover.

IDTS Senior Nurse *(Ref NM191)*

Salary: £29,099 – £30,492 • Full-time 37.5 hours per week

With significant experience of substance misuse services and a thorough understanding of treatment interventions, candidates will hold a current nursing qualification, be able to demonstrate supervisory experience, work effectively with Prison Healthcare & CARAT teams and be able to join a staffing rota that will include some early evening and weekend cover. Candidates will have experience of working within custodial environments.

IDTS Nursing Posts x 6 *(Ref NM192)*

Salary: £25,884 – £27,487 • Full-time 37.5 hours per week

With experience of substance misuse services and a thorough understanding of treatment interventions, candidates will hold a current nursing qualification, work effectively with Prison Healthcare & CARAT teams and join a staffing rota that will include some early evening and weekend cover. Ideally candidates will have experience of working within custodial environments.

IDTS Administrator *(Ref NM193)*

Salary: £16,704 – £17,450 • Full-time 37.5 hours per week

Candidates should possess good all round administrative skills, be able to operate and maintain a database, work well in a team and be able to represent the IDTS teams professionally as a first point of contact.

HMP Risley & HMP Thorn Cross

NHS Warrington

IDTS Project Manager *(Ref NM194)*

Salary: £32,267 – £34,209 • Full-time 37.5 hours per week

With significant experience of delivering substance misuse services and a thorough understanding of treatment interventions, candidates will need to demonstrate strong leadership and relationship building skills, and competencies in managing finance, staff and data. The post holder will lead the development of IDTS across both prison sites and have experience of working within custodial environments.

IDTS Senior Nurse *(Ref NM195)*

Salary: £29,099 – £30,492 • Full-time 37.5 hours per week

With significant experience of substance misuse services and a thorough understanding of treatment interventions, candidates will hold a current nursing qualification, be able to demonstrate supervisory experience, work effectively with Prison Healthcare & CARAT teams and be able to join a staffing rota that will include some early evening and weekend cover. Candidates will have experience of working within custodial environments.

IDTS Nursing Posts x 3 *(Ref NM196)*

Salary: £25,884 – £27,487 • Full-time 37.5 hours per week

With experience of substance misuse services and a thorough understanding of treatment interventions, candidates will hold a current nursing qualification, work effectively with Prison Healthcare & CARAT teams and join a staffing rota that will include some early evening and weekend cover. Ideally candidates will have experience of working within custodial environments.

IDTS Administrator *(Ref NM197)*

Salary: £16,704 – £17,450 pro-rata • 22.5 hours per week

Candidates should possess good all round administrative skills, be able to operate and maintain a database, work well in a team and be able to represent the IDTS teams professionally as a first point of contact.

Closing date for all positions: 11th May 2009

Only electronic applications will be accepted via www.cri.org.uk

All posts are subject to satisfactory enhanced CRB checks.

In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

Committed to anti-discriminatory practice, CRI aims to be an equal opportunities employer.
Crime Reduction Initiatives is a registered charity in England and Wales (1079327) and in Scotland (SC039861), Company Registration Number: 3861209 (England and Wales).

Safer communities, healthier lives